NEW YORK STATE OF OPPORTUNITY. Department of Health

Social Determinants of Health in Primary Care: A Deeper Dive

January 15, 2019

SDH Screening & Linkages

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Jan 2019

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TWO SDH SCREENING TOOLS WERE ROLLED OUT ACROSS MONTEFIORE IN MARCH 2017

Both:

- Address housing, food insecurity, access to care or medications, financial issues, transportation, child care, & violence

SDH Stressor:

- Also addresses legal issues, loss, neighborhood violence, living with challenging relatives, social connections
- Uses "stress" approach
- None, some, a lot
- Validated against the PHQ4

SDH screen:

- Yes/No
- Based on validated Healthleads questions

PAPER VERSIONS: SDH SCREEN

Your care team is interested in your complete wellness. Please take a moment to answer the questions below prior to seeing your doctor. Once completed, please return this form to your nurse. **This is an optional questionnaire.**

Name:_____ Phone Number:_____

Preferred Language:_____ Best time to Call: _____

		YES / NO
	Are you worried that in the next 2 months, you may not have stable or safe housing? (risk of eviction or being homeless, housing has mold, rodents, peeling paint, moving currently homeless, etc)	Y N
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Y N
	In the last 12 months, have you needed to but not been able to see a doctor or buy medication because of cost?	Y N
	Are you worried that your utility company might shut off your service for not paying your bills?	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Y N
	Do problems getting child care make it difficult for you to work or study?	Y N
	Is there someone in your life who is hurting, threatening or frightening you?	Y N

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- 5th grade reading level
- Easy to navigate
- In multiple languages

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PAPER VERSION: STRESSOR SCREEN

Stress can affect your health. Let us know how you are doing. We want to help!

Name: _____ Phone Number: _____

Preferred Language: _____ Best time to Call: _____

		NO STRESS	SOME STRESS	A LOT OF STRESS
	Housing problems (being homeless, housing has mold, rodents, peeling paint, moving, etc)	○	○	○
	Financial problems (being unemployed or finding it hard to pay the bills)	○	○	○
	Legal problems	○	○	○
	Loss of a close family member or friend (separation, divorce, incarceration, moving to a new city or country, death, etc.)	○	○	○
	Seeing or involved in violence in the home (slapping, hitting, kicking, punching)	○	○	○
	Seeing or involved in violence in the neighborhood	○	○	○
	Living with a partner or family member with depression & other mental illness , including drug or alcohol problems	○	○	○
	Getting along with partner, spouse, or family members	○	○	○
	Not having enough food to last the month	○	○	○
	Needing more help with childcare or care for an elderly or sick adult	○	○	○
	Difficulty getting to your medical appointments or picking up prescriptions	○	○	○

SDH: Stressors v1
Legal disclaimer

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- Montefiore developed/ adapted
- Validated against PHQ4 scores

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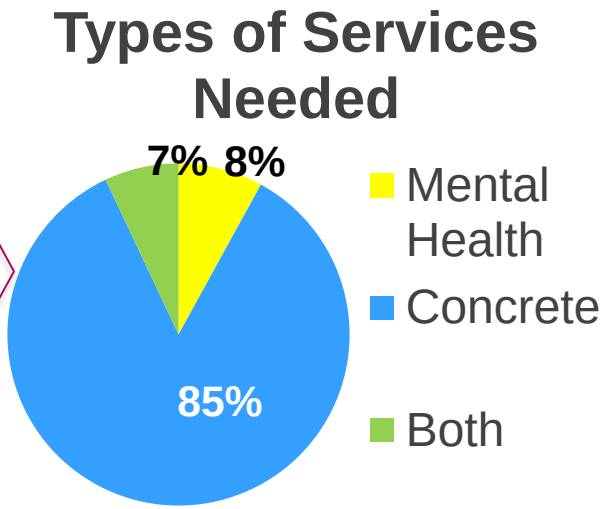
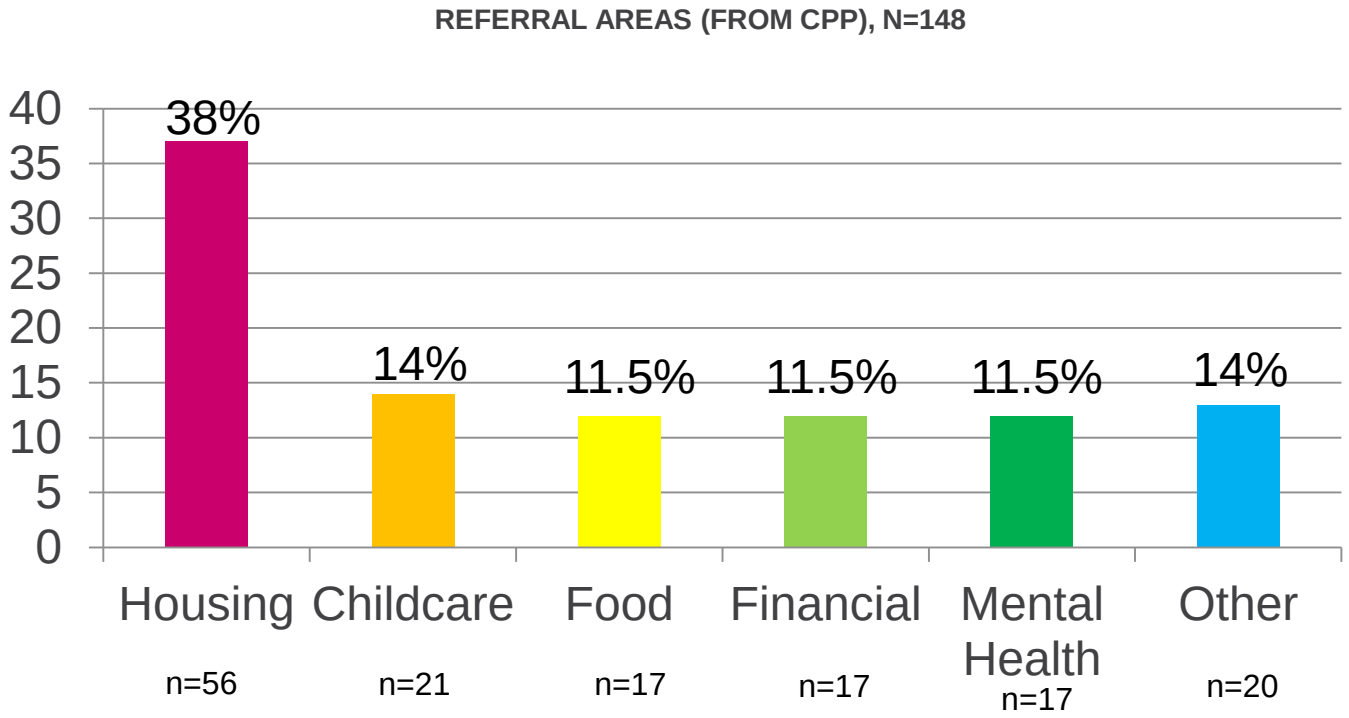
YOU CAN EXPECT THAT ROUGHLY 1/3RD OF PATIENTS WITH SCREEN POSITIVE AND MOST OF THEM WILL NEED CONCRETE SERVICES

- 33% (n=105) of those screened @ CPP requested or were offered services
- Generated 148 unique referrals
  - 68% (69/105) 1 referral
  - 28% (29/105) 2 referrals
  - 7% (7/105) 3 referrals



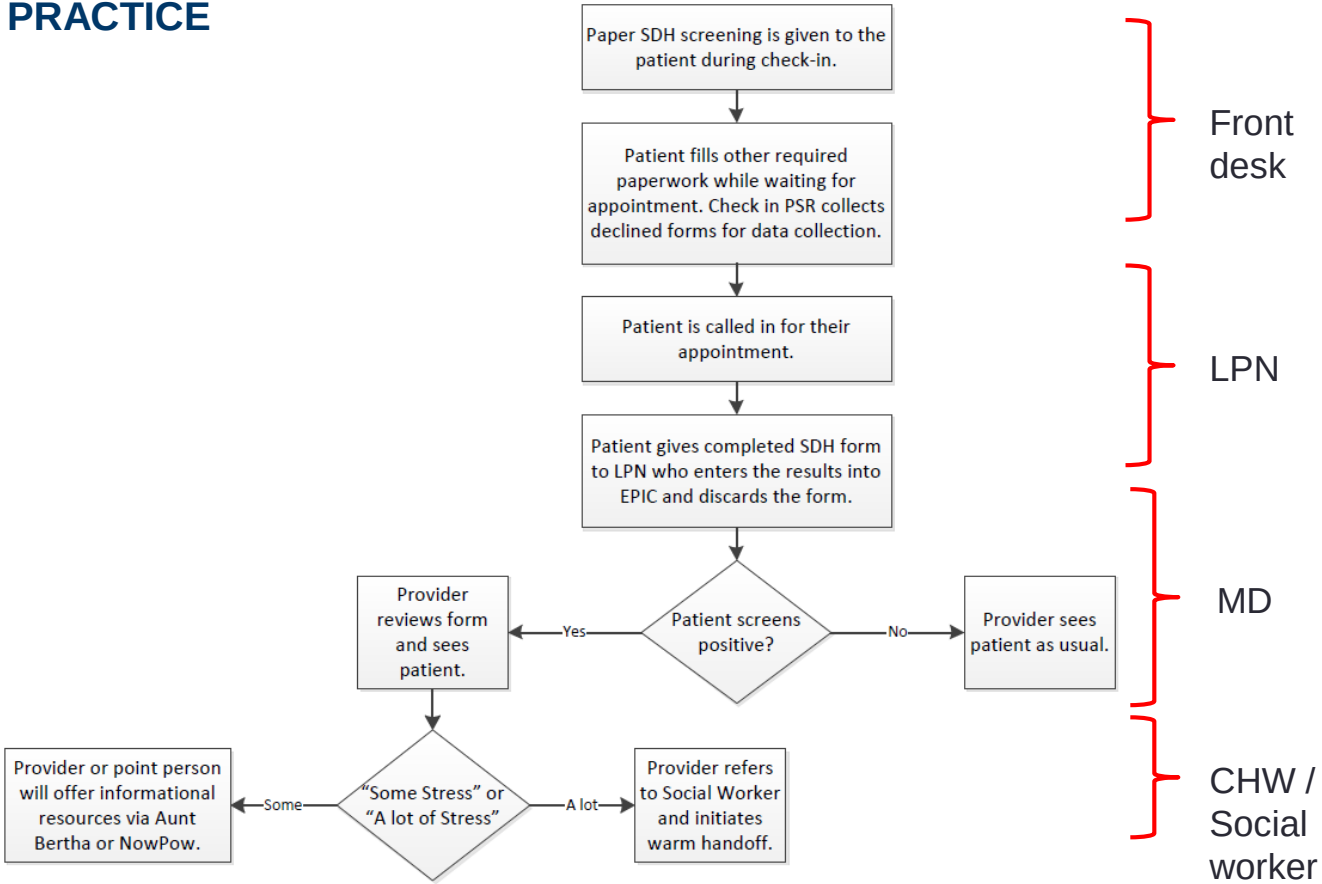
DURING THE PILOT, WE LEARNED MANY OF THE REFERRALS WILL RELATE TO HOUSING



CONSIDERATIONS IN WORKFLOW CREATION

- Respect privacy of patient (waiting room vs when roomed)
- More language (initially on in Spanish & English)
- Screening forms burden on patients (selecting which visits)
- Prioritize patient decision-making (What do patients want to work on?)
- Social Work & CHW availability and level of training
- Need to be able to track referrals

SDH SCREENING WORKFLOW AT UNIVERSITY AVENUE PRACTICE



SCREENING IMPLEMENTATION VARIES BY SITE…AND CAN VARY BY DEPARTMENT WITHIN SITES!

Social Stressor Sites

Primary Care Practice	Patient Population
Eastchester - IM	Annual Physicals (18-25)
MAP- IM	Annual Physicals (Dr. R and Dr. A)
MAP - Peds	Annual Physicals (Dr. S and Dr. K)
West Farms	OB patients and physicals
WACC	Social work patients
Grand Concourse- Peds	Not yet started
Community Pediatrics	Prenatal & Pediatric Visits at 4 & 15 month visits

Sites chose screening tool & populations of focus for roll-out.

+ Facilitated buy-in & alignment with site priorities

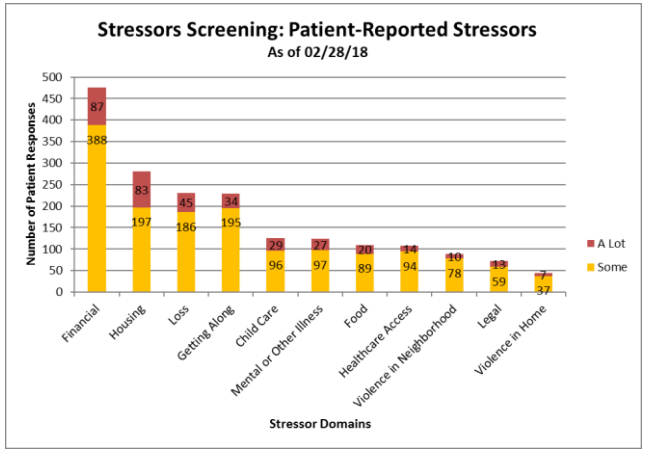
- Delayed standardization

SDH Screen Sites

Primary Care Practice	Patient Population
Astor Ave	Not yet started
Bronx East	On hold - pending Social Work hire
Castle Hill	SDA visits
CFCC-IM	all patients all visit types
CFCC-Peds	Not yet started
CHCC-IM	On Hold
CHCC- Peds	Annual Physicals/New Patients
Co-op Bartow IM	Hospital/ER discharge
Co-op Bartow Peds	Hospital/ER discharge, newborn visits, same day appointments
Co-op Dreiser IM	Annual Physicals
Cross County - IM	All new social work patients
Cross County - Peds	On Hold
FCC - IM	Hospital/ER discharge
FCC - Peds	Hospital/ER discharge with asthma dx
FHC	All new patients
Marble Hill	Newborns/new pediatric patients
Mount Vernon -OBGYN	Prenatal
Mount Vernon - Peds	Annual Physicals
Riverdale- IM	Provider Discretion
Riverdale - Peds	On Hold
University Ave - IM	All patients on Monday(AM) and Tuesday (PM) &Wednesday
University Ave FM	All patients on Thursday
University Ave - Peds	All patients on Monday (PM) and Tuesday (AM)
Via Verde	all physicals
Williamsbridge	Hospital & ER discharges

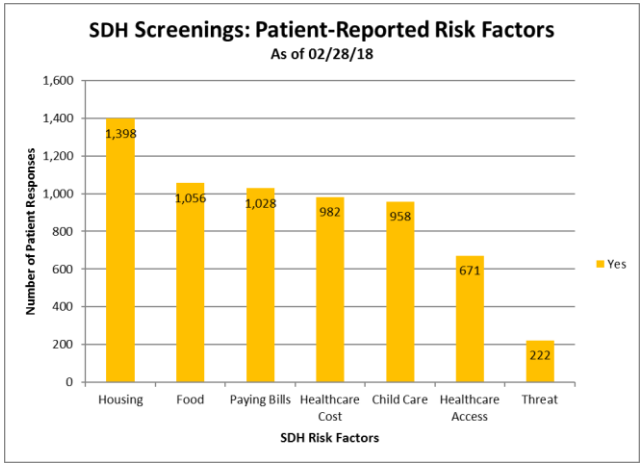
INITIAL SDH SCREENS (2 versions) LAUNCHED IN MARCH 2017

Housing Insecurity, Financial Stress, and Food Insecurity are frequently reported among our patients.



n=1632 patients screened

45% positivity



n=16,134 patients screened

21.5% positivity

SOURCE: REPORT NAME: SDH STRESSOR AS OF FEB 28th **DATA MEASUREMENT PERIOD**: MARCH 2017 – FEBRUARY 2018

DATA SOURCE: EPIC **REPORT DATE**: FEBRUARY 28, 2018 **REPORT AUTHOR**: E. FRANQUI

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WE HAVE RECENTLY REACHED CONSENSUS ON A SINGLE SCREENING TOOL

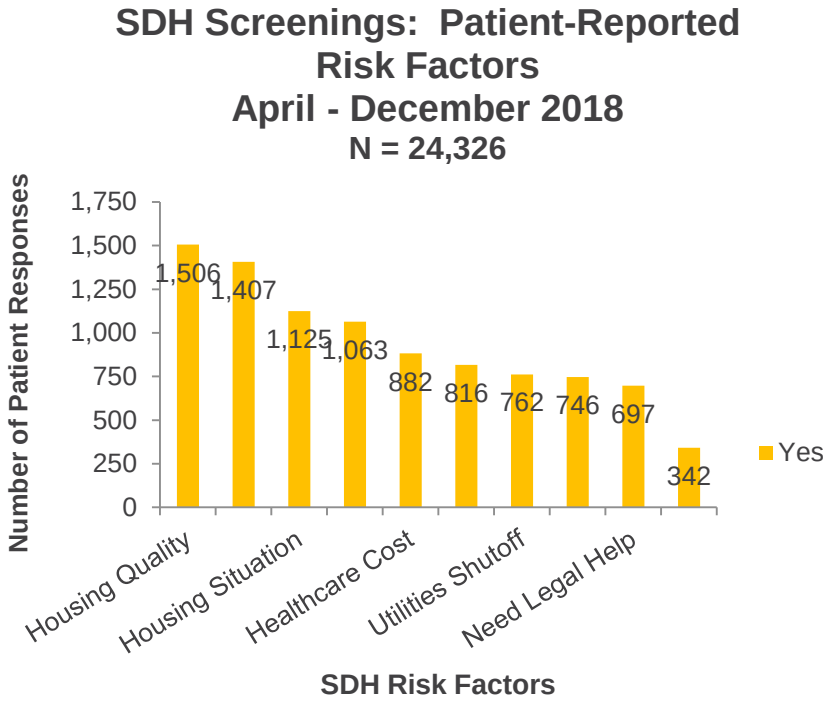
Social Determinants of Health Screening Tool

		Yes	No
1	Are you worried that in the next 2 months, you may not have a safe or stable place to live? (eviction, being kicked out, homelessness)		
2	Are you worried that the place you are living now is making you sick? (has mold, bugs/rodents, water leaks, not enough heat)		
3	In the past 12 months, has the electric, gas, oil or water company threated to shut off services to your home?		
4	In the last 12 months, did you worry that your food could run out before you got money to buy more?		
5	In the last 12 months, has lack of transportation kept you from medical appointments or getting your medications?		
6	In the last 12 months, did you have to skip buying medications or going to doctor's appointments to save money?		
7	Do you need help getting child care or care for an elderly or sick adult?		
8	Do you need legal help? (child/family services, immigration, housing discrimination, domestic issues, etc)?		
9	Are you finding it hard to get along with a partner, spouse, or family members?		
10	Does anyone in your life hurt you, threaten you, frighten you or make you feel unsafe?		

Revisions were based on:

- Lessons learned from MMG and Community Pediatrics experience with initial screening tools.
- Preference to align with existing evidence-based questions from Health Leads and CMS Accountable Health Communities Screening Tools.

HOUSING QUALITY & FOOD INSUFFICIENCY ARE THE TWO MOST PREVALENT SDH



SDH Screening: Patients Reporting Risk	Percent Reporting Risk
Housing Quality	**6.1%**
Money for Food	**5.7%**
Housing Situation	**4.6%**
Healthcare Transportation	**4.3%**
Healthcare Cost	**3.6%**
Getting Along	**3.3%**
Utilities Shutoff	**3.1%**
Child or Adult Care	**3.0%**
Need Legal Help	**2.8%**
Threats and Safety	**1.4%**

- Positivity rate **19.1%**
- **52.2%** of positives report only 1 issue

SOURCE: REPORT NAME: SDH REPORT AS OF DECEMBER 2018 **DATA MEASUREMENT PERIOD**: APRIL – DECEMBER 2018 **DATA SOURCE:** EPIC
REPORT DATE: JANUARY 7, 2019 **REPORT AUTHOR**: E. FRANQUI

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WE ALSO IMPLEMENTED NOW POW, A CBO DIRECTORY/ REFERRAL TOOL

Now Pow

- Allows us to find agencies that match the needs of our patients (age, location, time of day)
- Provides a print out for patients
- Can send the referral to the community organization
- Allows them to "check the patient in"
- Sends us back reports on usage

Replaces this →

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NOW POW WILL HELP US TRACK AND MANAGE CBO REFERRALS

NOW POW

- **CBO referral management software** developed at University of Chicago through CMS Innovation grant
- Dedicated team **curates & maintains** community-based organization referral database
- **Algorithms** automate recommended resources for patients
- EPIC integration options support patient “nudges” & **closed-loop referral tracking** to ensure that patients receive services
- Can save & **share favorite referral resources**
- **Reporting capabilities** to track referrals overtime by resource, patient condition, zip code, etc

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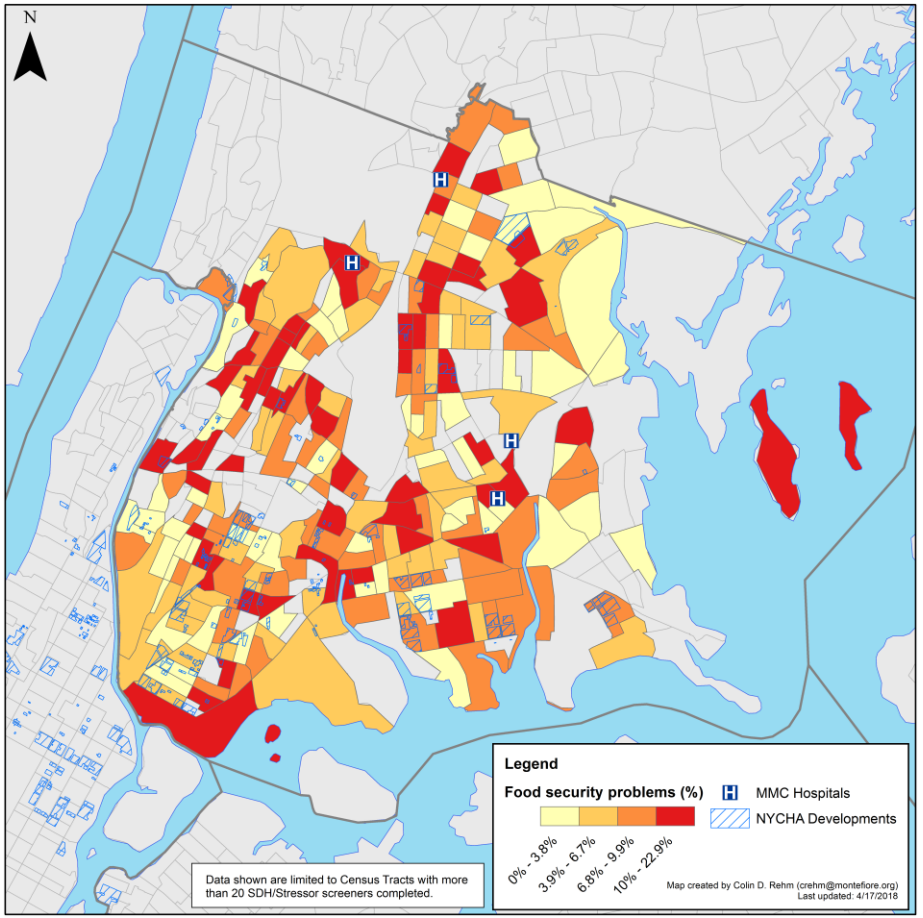
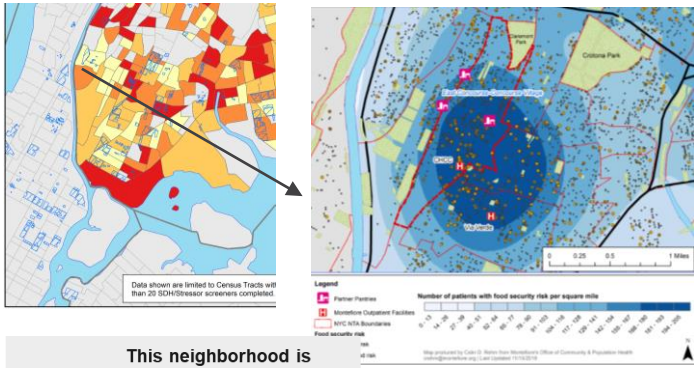
WE MAPPED FOOD INSECURITY DATA (PERCENT OF SCREENED PATIENTS WITH FOOD SECURITY PROBLEMS)

Data should be interpreted cautiously due to small numbers.



WE ARE LOOKING FOR WAYS TO ADDRESS FOOD INSECURITY WITH PARTNERS…

- City Harvest- Collects unused food & distributes it to food pantries
  - They have 50 high-priority areas for growth, 36 of which overlap with our hot spots
  - We agreed to work together on East Concourse- Concourse Village, which ranks #4 out of their 50 and a top priority for us (lots of food insecure patients, 28.6% of patients are risk patients (2630), though only 19% of the population is a Montefiore patient)



This neighborhood is located the in the south west part of the Bronx. They have a large immigrant community, about 40% if its residents are foreign born. They also have a large Hispanic community: 64% of the population identifying as Hispanic.

39%

"of Highbridge and Concourse residents live below the federal poverty level"

**NYC average is 21%*

18%

Unemployment

**NYC average is 11%*

63%

Rent Burden

**NYC average is 51%*

City Harvest identified 3 pantries in this neighborhood that can increase their capacity

- Grand Concourse SDA Church
- Vineyard International Christian
- Mid-Bronx Senior Citizen Council

82% of ECCV patients live within ½ mile of the 3 targeted food pantries

For $40,000, we can double the amount of food distributed yearly by these 3 pantries

- From 457k lbs per year to 1.1m lbs
- Cost cover
  - Refrigerators
  - Ramp
  - Stipends
  - Tables
  - Freezers

Funding secured last night from McKnight Family Foundation!!

WE CAN ALSO WORK INTERNALLY TO ADDRESS THE ISSUES

BxMpowerment Pantry, MMG

Location: 3058 Bainbridge Ave (Moses Campus)

Hours of Operation: Mon & Fri, 12-2:45p and Wed, 10am-2pm

Co-located programs: HIV testing, sexual health and wellness workshops, LGBTQ groups, PrEP/PEP referrals

Eligibility: Any low-income person in the Bronx can access resources. Some resources require proof of address (e.g. mail) or NYS ID.

WHY WE DON'T JUST FOCUS ON EDUCATING PATIENTS ABOUT THEIR DISEASES

"The opposite of poverty isn't wealth. The opposite of poverty is justice."

Bryan Stevenson, *Just Mercy: A Story of Justice and Redemption*

Questions?

Integrating SDH Screening in Ambulatory Setting:

Developing workflow & processes and tracking & monitoring mechanisms in EHR

Susan Yee, DrPH, MHA, Chief Clinical Operations
Annie Cummings, LCSW, Behavioral Health Manager
Community Healthcare Network NYC

January 18, 2019

Overview

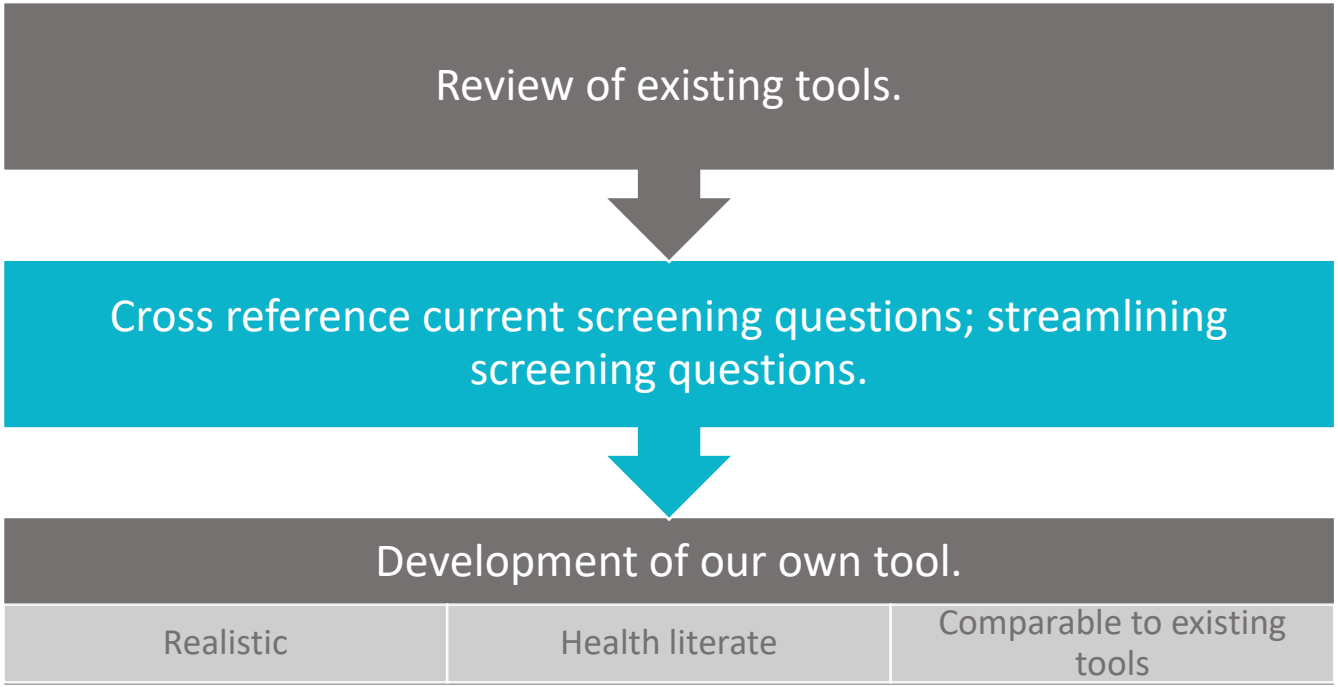
- CHN Background
- Developing screening tool and workflows
- Tracking and monitoring of SDH screening and referral rates
- Lessons Learned & Next Steps

Community Healthcare Network

- FQHC with 12 primary care clinics, 2 school based health centers and a fleet of mobile units spread between Brooklyn, Queens, Manhattan and the Bronx
- We provide each patient with a primary care provider and an expert team that includes social workers, health educators, nutritionists, dentists, podiatrists, psychiatrists and behavioral health therapists.

Screening Tool and Intervention Development

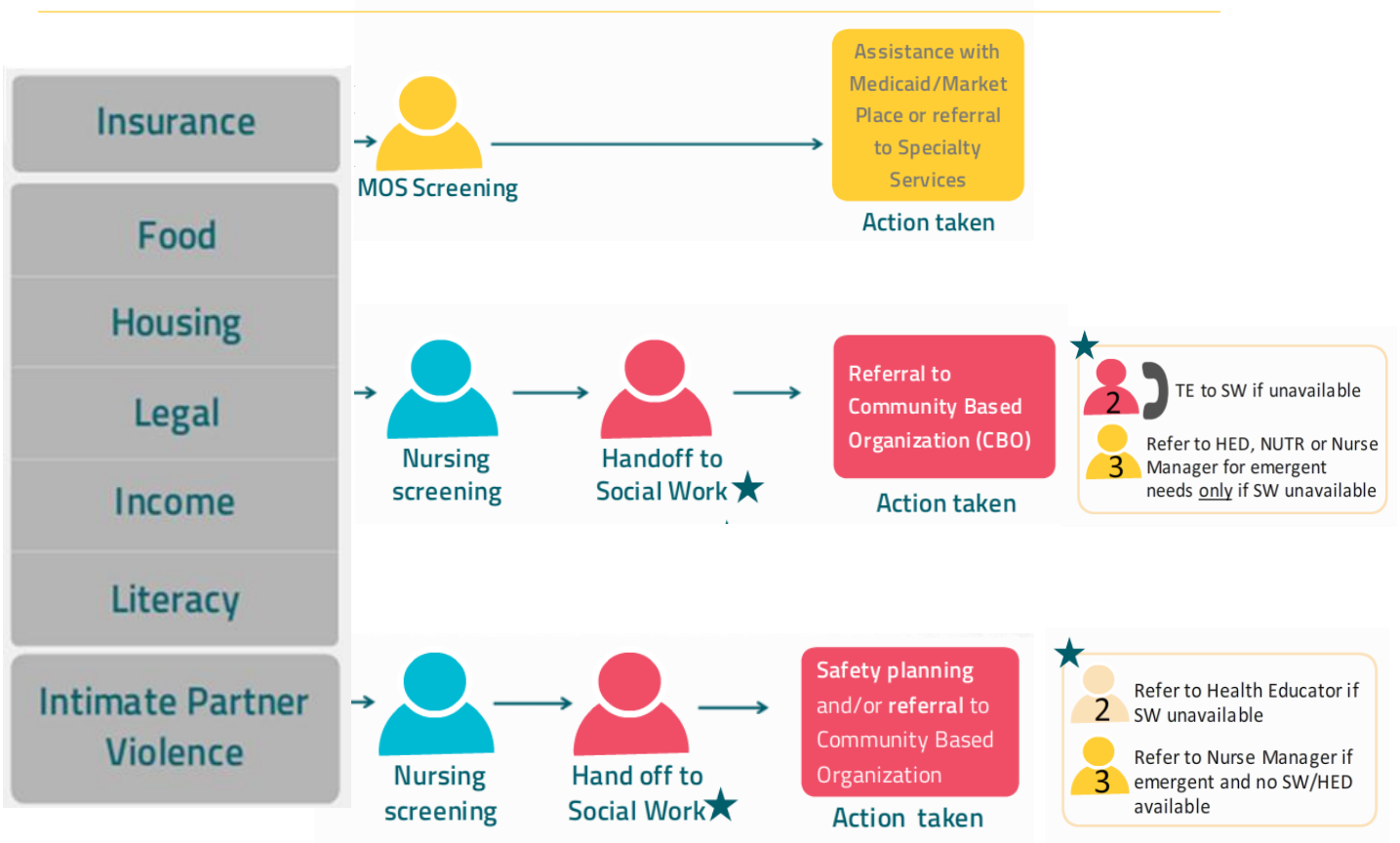
Screening Tool Development



Screening Tool Questions

Insurance	**Do you have health insurance?**
Food	**Do you or your family members ever skip meals because you cannot afford to buy food?**
Housing	**Do you ever feel like the place you sleep is not safe?**
Legal	**Do you need any legal help?** *Such as help with immigration, issues with your landlord, child support, etc.*
Income	**Do you ever have trouble paying for your basic needs?** *Such as medicines, utility bills, etc.*
Literacy	**Is it hard for you to read and understand healthcare information?**
Intimate Partner Violence	• **Have you ever been hit, slapped, kicked or in any way physically or verbally hurt by your partner?** • **Have you ever been forced to have sex, when you didn't want to?**

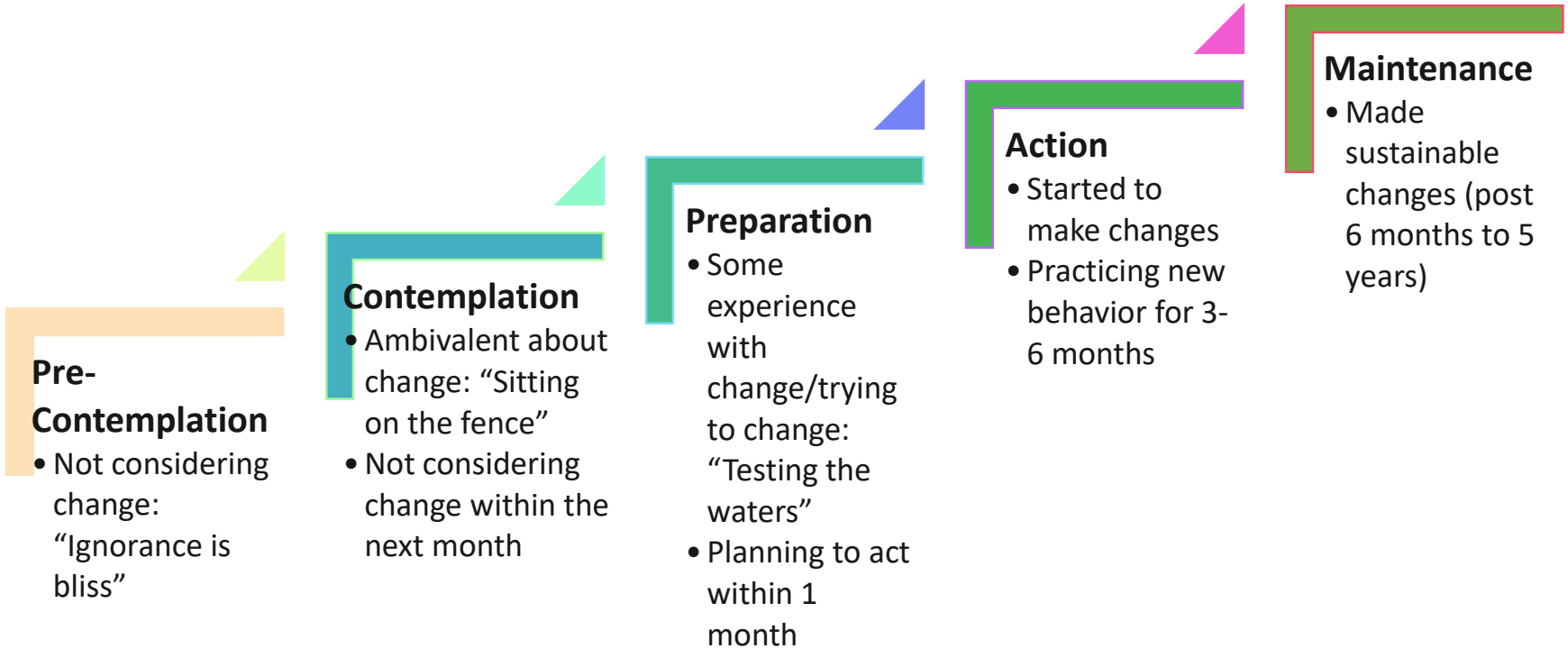
Workflow


Insurance
Food
Housing
Legal
Income
Literacy
Intimate Partner Violence
MOS Screening
Assistance with Medicaid/Market Place or referral to Specialty Services
Action taken
Nursing screening
Handoff to Social Work
Referral to Community Based Organization (CBO)
Action taken
2
TE to SW if unavailable
3
Refer to HED, NUTR or Nurse Manager for emergent needs only if SW unavailable
Nursing screening
Hand off to Social Work
Safety planning and/or referral to Community Based Organization
Action taken
2
Refer to Health Educator if SW unavailable
3
Refer to Nurse Manager if emergent and no SW/HED available

Intervention: Referrals to Community Based Organizations (CBOs)

- What does it mean to make a referral?
  - ✓Engaging patient in referral process and providing education about the CBO
  - ✓Calling a CBO with your patient to schedule the initial visit.
- How do you determine the appropriate method for making a referral?
  - ✓Stage of change
  - ✓Ability
    - Will contacting the CBO be a barrier for this patient?
    - Do they have the means to contact this agency (i.e. do they have a phone?)
  - ✓Does the method empower the patient? Does it *enable* them?

SDH Stages of Change



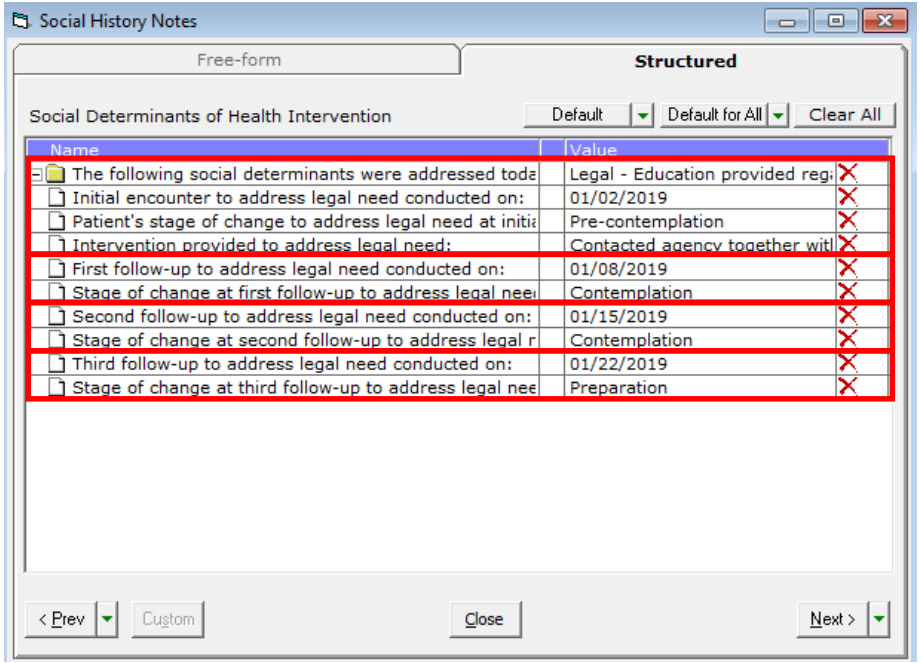
Tracking and Monitoring

Continuous Process Improvement

Electronic Tracking in EHR

- Screening compliance
- Prevalence of each SDH
- Primary focus of intervention and the patient's stage of change
- Numbers and types of referrals to CHN SW and partner CBOs

Intervention Overview



1.
2.

1. This is the documentation for the patient's primary focus after first meeting with the social worker.
2. Each subsequent contact with the social worker is then documented, along with the patient's stage of change.

Next Steps

- ✓ Scale intervention to other CHN clinical sites
- ✓ Continue to assess challenges within referral process
- ✓ Continue to educate staff

Questions?