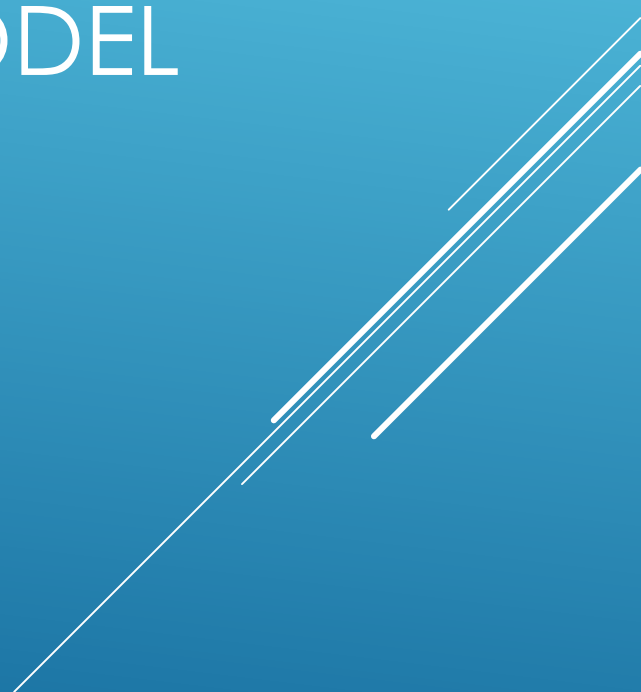


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TELEHEALTH HOME VISIT CARE MODEL

LAURIE LEVASSEUR MSN/MHA



- ❖ Services offered: Medical Care, OB/GYN Care, Newborn/Pediatric Care, Behavioral Health/Substance Abuse Services, Triage Nursing Team, Telehealth/Telehealth Home Visits (for homebound patient/those who lack internet access) Dental, and Ophthalmology, Case Management and Social Work, STD clinic (weekly) Outreach and Enrollment, SDOH Screening, Pharmacy and lab service on premises.
- ❖ 2020 UDS reports: Serving 17,000 patients. Populations served include: Black or African American, Spanish, Guianese, Arabic, Asian, Asian Indian.
- ❖ Two Locations: Schenectady NY Clinic is the main location.
- ❖ Amsterdam NY is our second clinic location that primarily serves a large Spanish speaking population.

CARE MODEL DESIGNED FOR HEALTH CLINIC

SOCIAL DETERMINANTS OF HEALTH MANAGEMENT

Telehealth Home Visit Program

Outreach and Enrollment Program

Primary Care (Clinic)

- ❖ Covid-19 Strategy to see patients who did not have the capability for web enablement.
- ❖ March 20, 2020 Telehealth Home Visits were designed to see patients who could not be seen using a telehealth app., home bound status or over the age of 65. (High risk patients).
- ❖ Social Determinants of Health (SDOH) assessment completed in EHR with each patient Telehealth Home Visit. (evaluate safety of home environment, food needs, etc.) Initially started with Prepare Tool and switched to Health Leads.
- ❖ Referral would be made to Case Manager for any patient who was identified as having a SDOH need.

HOW DID THE CARE MODEL BEGIN?

- ❖ A new Outreach and Enrollment representative on-boarded with our team in June 2020. Outreach and Enrollment job description re-designed to reflect SDOH assessment to be completed for every person in need of health insurance or not able to afford health insurance.
- ❖ Outreach and Enrollment trained to Unite Us/Healthy Together Platform. Any SDOH needs identified, the person is referred to Unite Us/Healthy together to meet their needs. If more than two needs identified; Case Management is notified.
- ❖ Nursing performing Health Leads Assessment while rooming patients in clinic. Nursing and Provider huddle to discuss SDOH needs identified. A referral is made to Unite Us/Healthy together based on needs. More than two needs identified is referred to Case Management. Patient is assessed for SDOH with each visit due to COVID-19 and an increase in SDOH needs statistically in the Capital District. (Pilot for one month).

WORKFLOW DESIGN

- ❖ Any patients who are showing signs of increased anxiety or express increased anxiety/COVID support. A Social Worker at the time of the visit will meet with patient in real-time, to evaluate need for counseling and assist patient with coping needs.

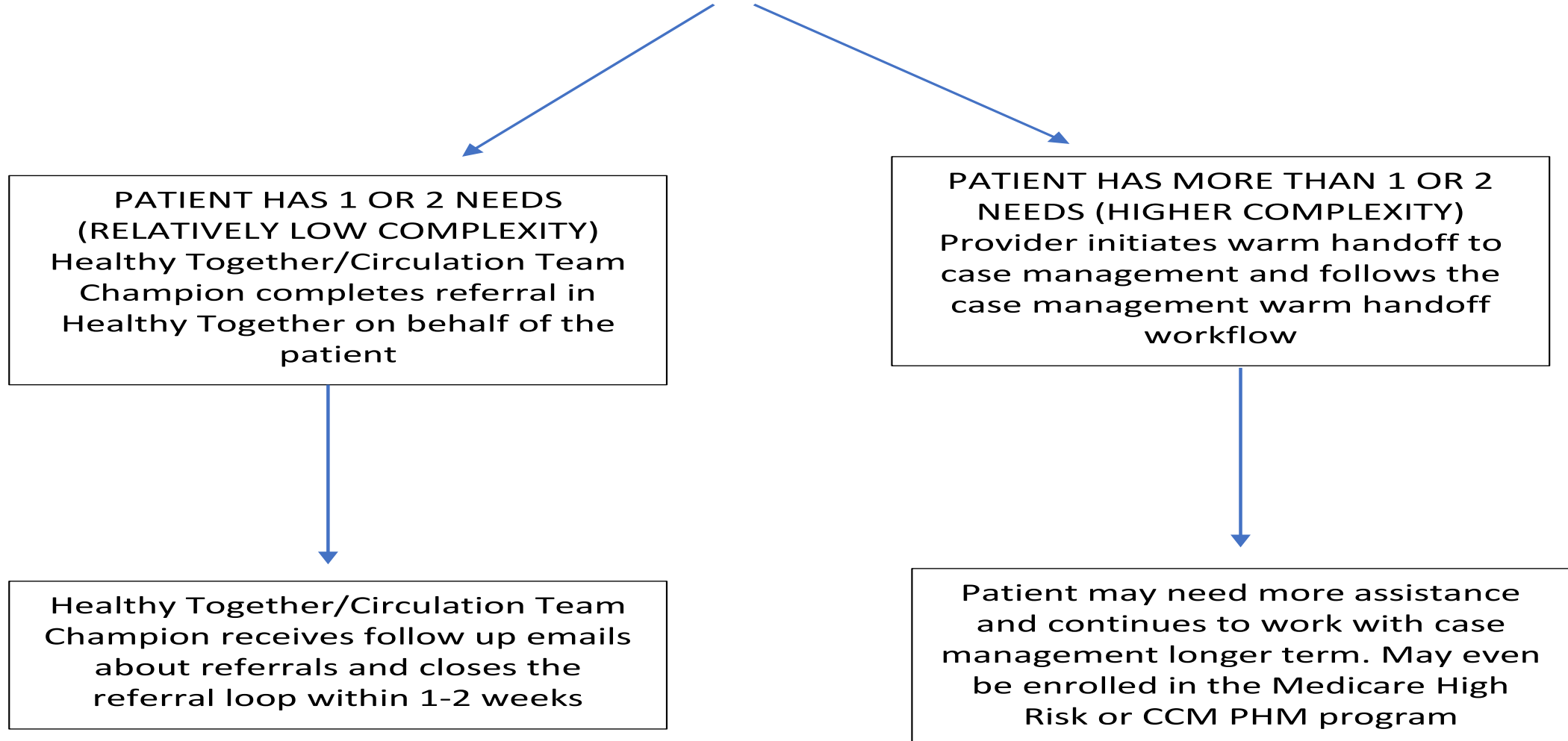


POLL QUESTION #1

At your respective health center, does your Outreach & Enrollment team screen patients for social needs using a standardized assessment tool such as PRAPARE, Health Leads, etc.? **Please select one**










- Yes
- No

SDOH Algorithm Workflow



SDOH INITIAL WORKFLOW: 10/14/20

In order to provide comprehensive healthcare to our patients and address all of the needs that affect their health, please provide answers to the questions below:

	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Yes	No
	In the last 12 months, has your utility company shut off your service for not paying the bills?	Yes	No
	Are you worried that in the next 2 months, you may not have stable housing ?	Yes	No
	Do problems getting child care make it difficult for you to work or study ? (leave blank if you do not have children)	Yes	No
	In the last 12 months, have you needed to see a doctor, but could not because of cost ?	Yes	No
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there ?	Yes	No
	Do you ever need help reading hospital materials ?	Yes	No
	Are you afraid you might be hurt in your apartment building or house?	Yes	No
	In the last 12 months, have you ever had to go without access to a phone ?	Yes	No
	If you checked YES to any boxes above, would you like to receive assistance with any of those needs ?	Yes	No
	Are any of your needs urgent ? For example: I don't have food tonight, I don't have a place to sleep tonight	Yes	No

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HEALTH LEADS SCREENING TOOL

- ❖ Unite Us/Healthy together is a platform used in partnership with Alliance for Better Health, IPA partnership. Hometown and the IPA have a shared governance towards its mission in “making a difference”/ “collaborating with other community organizations” related to SDOH/community needs for healthy outcomes (Health Improvement for patients/whole patient approach).
- ❖ Health clinic Partnered with Alliance to educate staff to SDOH/Unite Us/Healthy Together Platform.
- ❖ Education, food, shelter, clothing, utilities, employment, legal needs (to name a few) are referral options for patients in need.
- ❖ The platform has the capability to share documentation so all involved with the patients plan are able to communicate.
- ❖ Health Leads Assessment tool is used to assess SDOH. We have assessed a total of 1,261 patients for 2020.

WHAT IS UNITE US/HEALTHY TOGETHER

- ❖ Telehealth Home Visit Program has had 273 patient visits from March 1, 2020 to November 14, 2020. SDOH screening was also conducted.
- ❖ Pilot began mid October 2020 in our OB clinic (one team at a time) 96 referrals opened and closed for SDOH. **(OB patient answered Yes to all questions, engaged staff to the need for SDOH screening)**
- ❖ Unite Us/Healthy Together Platform: 29 users on boarded. Goal Met: All staff educated and performing SDOH assessment in clinic by Mid December 2020 (adding 10 more users/4 Teams).
- ❖ 786 total patient referrals to Unite Us/Healthy Together (includes: BH, CM).
- ❖ In the past 30 days 96 referrals had been placed and closed related to SDOH.
- ❖ Outreach and Enrollment increased patient capacity to 48 internal referrals for uninsured populations with SDOH screening from 10/1/20-11/11/20.
- ❖ Total of 1,261 SDOH screens conducted for year 2020.

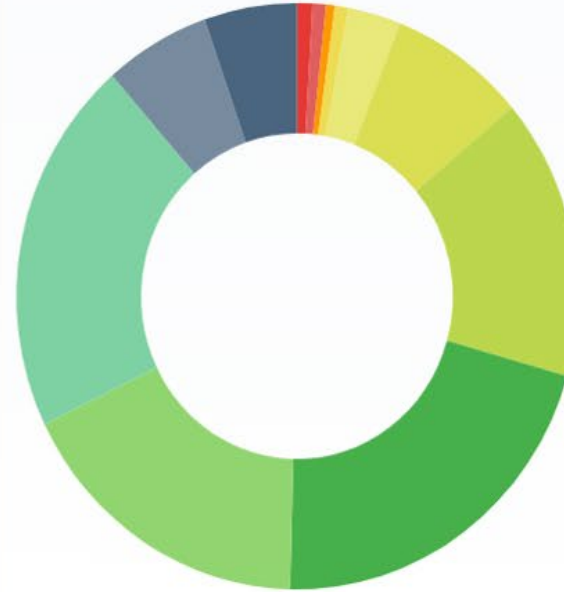
DATA/HISTORY

Gender



Gender		
Female	397	(51%)
Male	282	(36%)
Non-Binary	0	(0%)
Other	0	(0%)
Undisclosed	107	(14%)
Total	786	

Age



Age		
0-5 Years	7	(1%)
6-10 Years	6	(1%)
11-15 Years	4	(1%)
16-17 Years	6	(1%)
18-20 Years	24	(3%)
21-25 Years	62	(8%)
26-34 Years	122	(16%)
35-44 Years	165	(21%)
45-54 Years	137	(17%)
55-64 Years	163	(21%)
65-74 Years	48	(6%)
75+ Years	42	(5%)
Total	786	

UNITE US/HEALTHY TOGETHER DATA
COLLECTION: 3/2020-11/2020.

- ❖ Limited Staffing
- ❖ Patients requiring more needs/referrals due to COVID pandemic impact.
- ❖ Staff overwhelmed as a result
- ❖ This resulted in incomplete referral details for the Coordination Center, making it difficult for the Coordination Center to assist the patient.
- ❖ Frequent discussions with Alliance for Better Health (IPA)/Coordination Center to address challenges. (Continuous Collaboration). Alliance support/coaching, working with health providers has helped the health clinic to meet their goals/measures/outcomes, based on real-time data review.

RECENT CHALLENGES



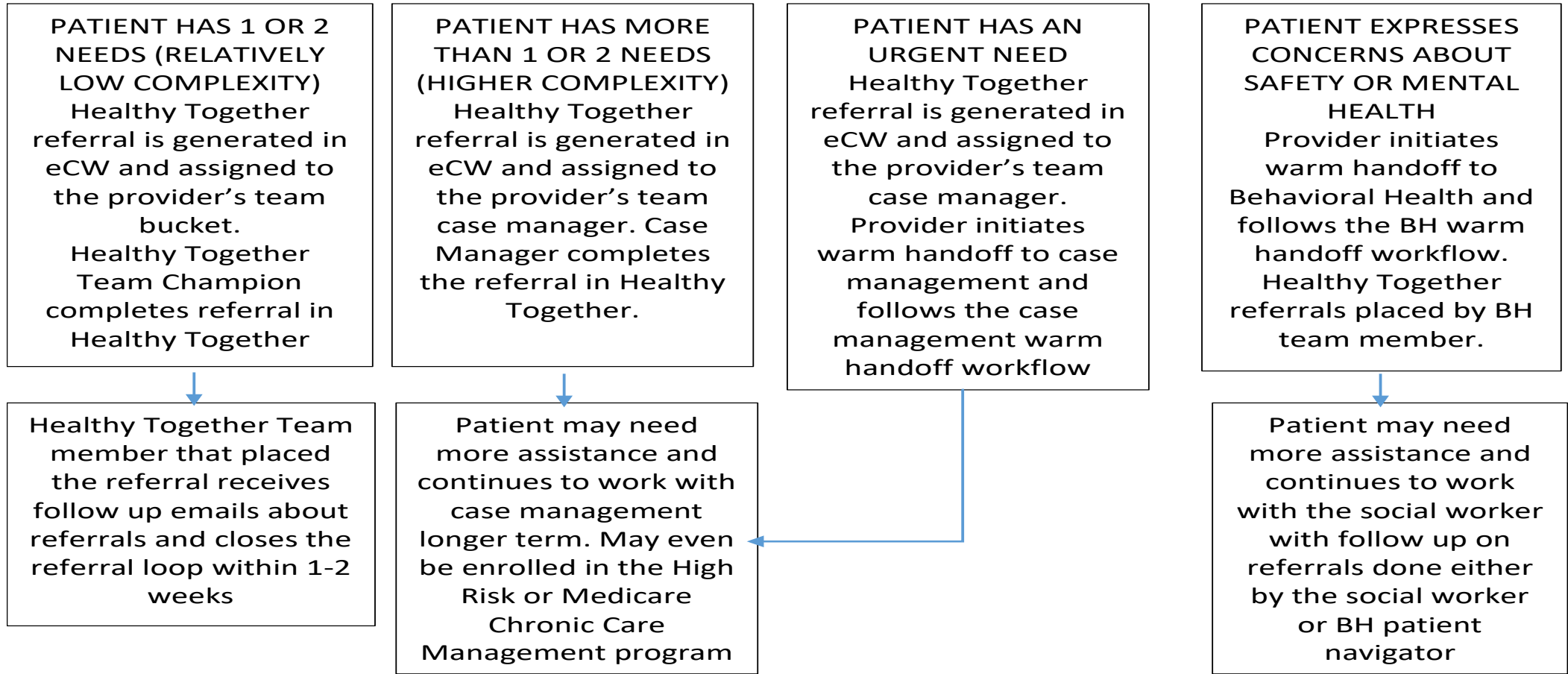
POLL QUESTION #2

What challenges has your organization encountered, if any, in supporting health centers in implementing patient-level SDOH screening and addressing their unmet social needs? **Select all that apply:**

- Challenges asking sensitive SDOH questions
- Lack of sufficient training and guidance to facilitate member implementation
- Frequent staff turn over
- No clear strategy for supporting SDOH work
- Too many competing initiatives
- Lack of reimbursement to sustain this work
- Challenges in bringing our SDOH screener(s) to scale across health centers
- Lack of community partners or resources to address social risk needs for health centers
- Challenges sharing data with community partners (e.g., for closed loop referral tracking)
- We have not experienced any challenges

- ❖ Registration staff provides patient SDOH screening tool for patient to complete while waiting for appointment. If patient requires assistance with the tool, assistance will be provided.
- ❖ SDOH Team Champions chosen as facilitators to the model
- ❖ Champions will place referrals and ensure referrals are closed out (closing the loop).
- ❖ All Staff educated to SDOH.
 - ❖ **Goal:** engaging all staff to the SDOH needs of our patient.
 - ❖ **Goal:** patients to have improve outcomes to health/compliance with chronic health needs.
- ❖ Behavioral Health now using Health Leads Tool to screen more frequently
- ❖ Dental staff educated to SDOH screening
- ❖ Patients being seen by the Eye Doctor will be screened

WORKFLOW CHANGES/EDUCATION



REVISED: SDOH WORKFLOW ALGORITHM (4/2021)

- ❖ Diabetes Type 2: Patient answering “Yes” to SDOH: 79. Out of 79 patients, all but 13 patients were noted to have improved HGB A1C by ensuring SDOH needs were also met. (11/20-2/2021)
- ❖ Patient examples:
 - ▶ HGB A1C 15.5 on 4/27/20 and repeated on 8/7/20: 11.8 = 23.87% improvement value.
 - ▶ HGB A1C: 8.7 on 10/28/20 and improved 1/21/21: HGB A1C was 4.8 = 44.83% improvement value.
- ❖ Blood Pressure Control: 49 patient screened “yes” for SDOH. Out of 49 patient, 26 patients were improved and controlled in our hypertension program. (11/20-3/2021)

CLINICAL METRICS OUTCOMES



POLL QUESTION #3

How frequently does the health center care team review the SDOH/social risk factor data with patients? **Please select one**

E.g., SDOH data part of the pre-visit planning/patient triage, care team connects patients with resources, review/addition of ICD-10 Z codes in the patients' chart, etc.

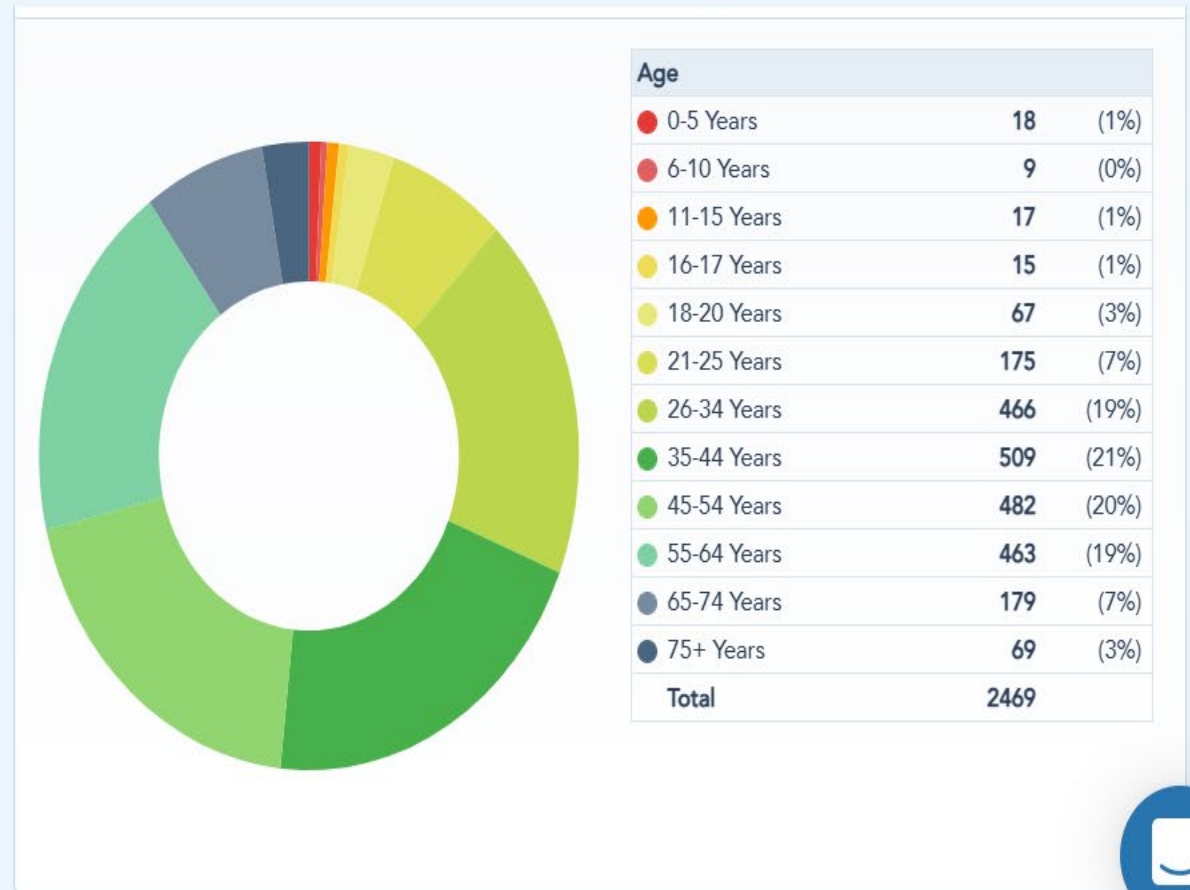
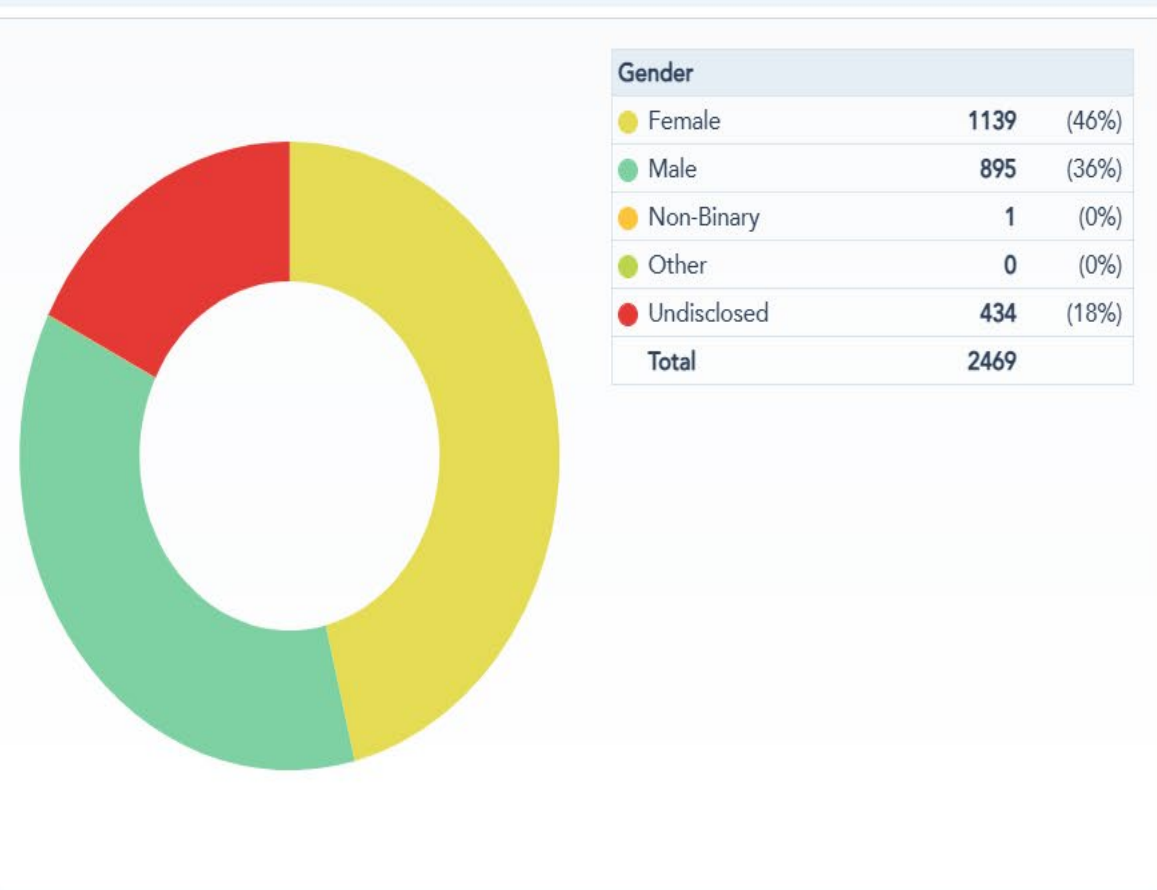
- At each visit
- Every 3 visits
- Quarterly
- Semiannually
- Annually
- Not conducting SDOH screening at this time

Unite NY (ADK Wellness Connections, CNYCares Referral Network, Healthy Together)

Showing data from 1/7/2021 to 4/7/2021

Population Services Network Performance

Last 90 Days



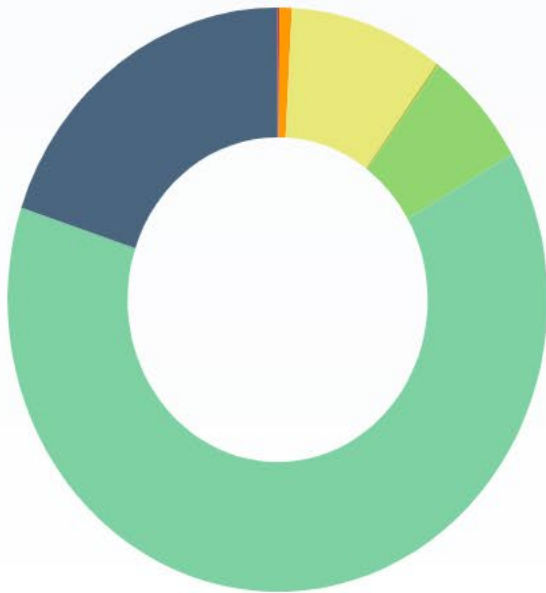
Unite NY (ADK Wellness Connections, CNYCares Referral Network, Healthy Together)

Showing data from 1/13/2021 to 4/13/2021

Population Services Network Performance

Last 90 Days

Race



Race		
American Indian or Alaska Native	3	(0%)
Asian	19	(1%)
Black/African American	239	(9%)
Native Hawaiian or Pacific Islander	4	(0%)
Other Race	170	(7%)
Undisclosed	1650	(63%)
White	518	(20%)
Total	2603	

Ethnicity



Ethnicity		
Hispanic or Latino	133	(5%)
Not Hispanic or Latino	727	(28%)
Undisclosed	1743	(67%)
Total	2603	



- ❖ Alliance for Better Health, IPA
- ❖ MVP Partnership (Telehealth Home Visit Program and Hypertension Program)
- ❖ HRSA Hypertension Grant Program
- ❖ Schenectady County Public Health: Maternal Health Focus with Schenectady Families Services Program. STD clinic. Primary Care Referrals for COVID positive patients.
- ❖ Social Determinates of Health Program
- ❖ Ultimate Goal: Mobile Health Clinic: Use of data mapping to serve high risk populations in the community and meet health disparity goals.

COMMUNITY PARTNERSHIPS

Question and Answer

Contact Information:

Laurie Levasseur MSN/MHA

Care Model Design

Phone: 518-928-3359

Email: daisy41@email.phoenix.edu

THANK YOU!!

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