Social Determinants of Health

Sarah Thompson, PharmD
Vice President, Clinical Operations

COASTAL MEDICAL

SDOH and COVID-19

- **Identification**
  - Digital Screening Forms
  - High Risk Lists
  - Vulnerable Patient Campaign
- **Addressing Needs**
  - Data
  - Team based care
  - External resources

COASTAL MEDICAL

Vulnerable Patient Campaign

3 Questions for COVID + or PUI

- Are you feeling scared, stressed, or overwhelmed?
- Do you have any other concerns about your health or well being?
  - Medication access/affordability
  - Basic needs (food, transportation, financial, supplies)
  - Stress, support system, caregiver or family concerns
  - Other
  - I have no concerns
- Would you like a telephone call from your care team
  - Yes, today
  - Yes, this week
  - No

COASTAL MEDICAL

Addressing Patient Needs

- **Data**
  - Upcoming appointments
  - Recently screened positive reports
- **Team Based Care**
  - Remote care conferences with providers
  - Increased referrals to social workers, RIPIN liaisons, Child and Adolescent Psychiatrist, and Pharmacy Technician team to assist patients
  - Used telemedicine solutions to connect with patients face to face
  - Closing the loop huddles
  - Developed resources for care teams and patients
- **External Resources**
  - Refer to resources in the community to address BH, SDOH, and SUD needs (ex: Community Health Teams, Providence Behavioral Health Associates, CODAC)

COASTAL MEDICAL

Screening and Addressing Social Needs During a Pandemic

Chelsea De Paula, MPH
Manager, Community Integration & SDOH Strategy
The Providence Community Health Centers , Inc.

PCHC's Response: SDOH Screening

* Screen all patients for SDOH, even those screened within the last 12 months
* Perform targeted outreach to high risk populations (elderly, homeless, those with pre-existing conditions & pregnant women)
  * Complete SDOH screen & PHQ9
  * Offer phone consult with PCP and/or Behavioral Health
  * Community Health Advocates address any SDOH needs with patient and connect to resources in the community
* Collaborate with community agencies to assess community needs

PCHC CHAs delivering food to patients of Clínica Esperanza

PCHC's Response: Addressing Food Insecurity

Collaboration with community agencies to:

* Distribute Food Boxes:
  * CHAs deliver food from local pantries and food boxes (pictured to the right)
  * Create care packages to deliver with food boxes with donations of thermometers, hand sanitizer, Tylenol & masks
* Deliver ready to eat meals to the elderly and those that are COVID-19 +
* Purchase and deliver groceries to patients that are in quarantine

144 family food boxes & 48 MRE boxes
(RI Food Bank & City of Providence)

PCHC's Response: CHAs Assisting Patients with Additional Social Needs

* Assisting patients that do not have access to a computer or smart phone with applying for benefits online
* Helping patients locate additional resources in the community that are available (e.g. rental assistance, cash assistance, baby supplies)
* Assisting with transportation to the grocery store, pharmacy and testing sites
* Connecting patients with legal supports

PCHC's Response: Analyzing SDOH Data Pre COVID-19 & During COVID-19

Providence Community Health Centers 2020 SDoH Screening Data												
Cohort	**Data Dates**	**# Unique Pts. Screened**	**% Pts. Replying "Yes"**	**Afraid of Harm**	**Can't Afford Meds**	**Food Insecurity**	**Housing Insecurity**	**Living Conditions Impact Health**	**No Transportation to Clinic**	**Utility Shut-Off**	**Said "Yes" to at least one SDoH Screening Question**	**Would like Assistance (Of Those Screening Positive)**
Pre-COVID	January 1, 2020 – March 15, 2020	11,679		0.9%	1.8%	2.9%	2.4%	1.8%	1.7%	1.7%	7.5%	6.9%
During-COVID	March 16, 2020 – June 5, 2020	4,415		2.9%	3.9%	6.2%	6.4%	4.1%	4.0%	4.1%	12.1%	15.9%

Congratulations to Graduating Practices - Job well done!

Adult Cohort 5	*PCMH Kids Cohort 2*
A to Z Primary Care PC	Aquidneck Pediatrics
Brookside Medical Associates	Barrington Family Medicine
CCAP - Primary Care Partners	Barrington Pediatrics
CCMA - Blackstone	Children's Medical Group
EBCAP - Barrington	Coastal - Bald Hill Pediatrics
Massasoit Internal Medicine	Coastal - Toll Gate Pediatrics
Michelle C. VanNieuwenhuize	East Side Pediatrics
Nardone Medical Assoc	Kingstown Pediatrics
Ocean State - Coventry	Northern RI Pediatrics
Ocean State - Westerly	Park Pediatrics
OSPC - Lincoln Primary Care	
PCHC - Randall Square	
Richard VanNieuwenhuize	
Robert A. Carrellas, MD	
Wayland Medical Associates	

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ADVANCING INTEGRATED HEALTHCARE

CONGRATULATIONS A TO Z PRIMARY CARE!

A TO Z PRIMARY CARE OCCUPATIONAL HEALTH

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

From 2017 to 2020

The Care Transformation Collaborative of Rhode Island/PCMH Kids commends your achievement of Practice Transformation and Improvement of Clinical Quality Measures and Patient Experience Survey Results!

CLINICAL QUALITY

- **+1.5% Progress** — **Adult BMI** (retired) score went from 95.1% in 2017 to 98. 6% in 2019
- **+24.6% Progress** — **Tobacco Cessation Intervention** (retired) score went from 56.1% in 2017 to 80.7% in 2019
- **-5.4% Progress** — **Hypertension BP Control** (as of Q3 2018) score went from 85.2% in 2018 to 70.8% in 2020
- **+41.6% Progress** — **Diabetes Control DM A1C (<8)** score went from 30.9% in 2017 to 72.5% in 2020
- **+28.6% Progress** — **Depression Screen and Follow Up** score went from 64.9% in 2017 to 93.5% in 2020
- **+50.7% Progress** — **Eye exams for Diabetic Patients** went from 39.5% in 2017 to 90.2% in 2020
- **+8.1% Progress** — **Colorectal Cancer Screening** went from 68.7% in 2017 to 76.8% in 2020

PATIENT EXPERIENCE

- **Top 5** Cohort 5: Year: 2020 — **ACCESS** (gaining access to care)
- **Top 3** Cohort 5: Year 2020 — **OFFICE STAFF** (Customer Service)
- **+2.62% Progress** — **COMMUNICATION** (between Patient and Provider)
- **Top 5** Cohort 5: Year 2020 — **SELF MANAGEMENT**
- **+3.3% Progress** — **CARE COORDINATION**

NCQA Standard Year 2018: 12/2/19 – 12/2/20

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ADVANCING INTEGRATED HEALTHCARE

CONGRATULATIONS AQUIDNECK PEDIATRICS!

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CLINICAL QUALITY

Child and Adolescent BMI and Plan of Care

★ Top 10

score went from 89.9% in 2017 to 88.2% in 2020

Developmental Screening

★ Top 10

score went from 83.1% in 2017 to 77.9% in 2020

Well Child Visits and Adolescents

★ Top 10

score went from 92.5% in 2017 to 76.1% in 2020

PATIENT EXPERIENCE

Top 10* ACCESS (gaining access to care)

Top 10* OFFICE STAFF (Customer Service)

Top 10* COMMUNICATION (between Patient and Provider)

Top 10* CARE COORDINATION

+2.1% ★ CHILD DEVELOPMENT

+2.0% ★ CHILD PREVENTION

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NCQA Standard Year 2018: 12/2/19 – 12/2/20

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ADVANCING INTEGRATED HEALTHCARE

COVID-19 Check-In and Primary Care Payment

Care Transformation Collaborative of R.I.

BREAKFAST OF CHAMPIONS
JUNE 12, 2020

Comprehensive Primary Care in Rhode Island— *Responding to the Emergency and Reorienting Health Care Delivery Post COVID-19* *Report submitted May 29, 2020* SUMMARY

Rhode Island's response to the pandemic:

- Led by the Governor, the RI Department of Health, and other state agencies, RI mounted a strong and effective response to the COVID-19 crisis.
- Assisting that response has been a vibrant and cohesive primary care/multi-payer collaborative, CTC-RI.

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COVID-19 Exposed System Weaknesses and Opportunities

- We gathered information and feedback through forums, CTC-RI and stakeholder meetings gathered input
- Governor and OHIC asked us for major need areas, recommendations

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Major needs

COVID-related—*Practices*	COVID-related—*Patients*
Lack of equipment	Missed routine in-person visits
Lack of tracking capacity—test results, vaccinations	Missed in-person beh. health visits (increase televisits)
Decrease in utilization	Missed pediatric vaccinations
Financial instability	Challenges telehealth access
Telehealth policies/payment inconsistent	Patients need SDOH support
Providers need support to reopen	Patients need reassurance to return to care

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Major need areas

Overarching system needs—*ongoing*
Short term practice stabilization –special attention to community pediatrics. Longer term encouragement CPC capitation
Health equity imbalance– Low Medicaid payment rates
Improved coordination, communication between primary care, hospitals, specialists and community providers
Lack of stable funding for Community Health Teams
HIT better support tracking, communication
Telehealth patchwork—payment, implementation, policies
Aging primary care workforce and provider dissatisfaction

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Key Proposed Activities

- **Pedi Immunization** QI Improvement (minimally PCMH Kids Cohort 3, hopefully statewide) – Gov announcement Cares Act funds to support practices that serve children.
- **"Thriving under capitation"** Learning Collab. / include reduce admin burden/ expand clin team/ "60% threshold"
- **"Reopening"** best practice sharing
- **Telemedicine** Learning Collaborative
- **Primary Care – Specialist Collaboration**
- **Reduce Low-Value Care** (need Cost Trend Committee endorsement and support)

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Additional Key Project Areas are Less Defined

- HIT/Current Care (Opt-out, multi-source data aggregation, etc.)
- Improving Hospital – Community collaboration
- Multi-payer/multi-sector system to strengthen community – clinical linkages to improve health and health equity to help overcome systemic effects of poverty and racism. How to calculate a fair "Population Health PMPM" **Important not to underfund.**

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Discussion

- What have we missed to help build resiliency in health care system going forward?
- What can we do to build on the current crisis to reduce avoidable ED visits going forward and encourage appropriate utilization?
- Other?

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ADVANCING INTEGRATED HEALTHCARE

Lessons from the Field to Care for Yourself and Others During Times of Prolonged Stress

NELLY BURDETTE, PSY.D, CTC-RI SENIOR IBH PROGRAM LEADER, PROVIDENCE COMMUNITY HEALTH CENTERS

HTTPS://VIMEO.COM/410635998#T=10M51S