Community Health Network Transformation Project

Prepared For: Community Health and Access Committee

Agenda

1. Context
2. Systems Overview
3. Pilot Program
4. Transformation Grant
5. Questions & Discussion

Terminology and Acronyms

- **Social Determinant of Health (SDOH)** : Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes (CDC)
- **Health Related Social Needs (HRSN):** An individual's unmet, adverse social needs that contribute to poor health resulting from their community's underlying SDOH
- **Community Based Organization (CBO)**: An organization of and driven mainly by individuals within the relevant community, with representation of institutions which provide scientific, financial and social support.
- **Case Management:** Refers to designated activities for the purpose of assessing and supporting a client's HRSN needs. Often used interchangeably with care coordination, navigation, and care management
- **Closed Loop Referral System**: a closed-loop referral is one that successfully secures the right resources for patients at the right time, ensuring that the patients' needs are met.
- **Community Information Exchange (CIE)**: A CIE® is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning (CIE San Diego)

Social Needs Landscape

Providers understand that unmet social needs are major drivers of adverse health outcomes.

They want to connect their patients with community resources, but have not had an effective way to do this.

Patients feel that their providers are **not aware** of the many factors that influence their health.

They want providers to ask about their social needs, offer support, and adjust how they provide care.

We need to standardize our approach to addressing the health related social needs within our community.

**Source: cayugahealth.org/about/chp/*

Lessons learned

From: San Diego 211, CIE Michigan Task Force, Accountable Health Communities Model

1. Few precedents
2. Technology is not a singular solution
3. More data doesn’t mean better outcomes
4. Closed loop referrals are not the only use case for a CIE

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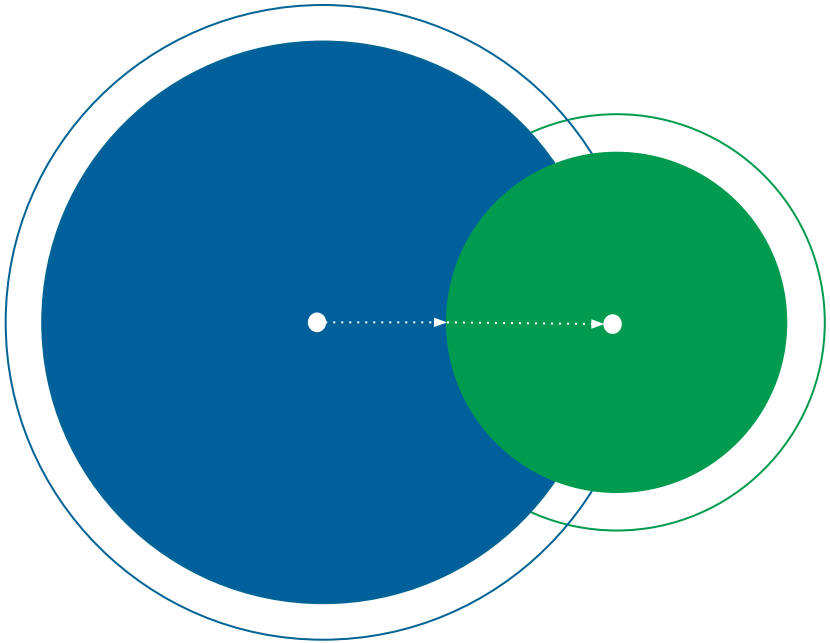
PtRefs: Referral Tracking and Management System

PtRefs is a referral management system that tracks referrals going into or coming out of one of Cayuga Health System's practices. It is an efficient way of tracking referral status and completion.

PtRefs: Referral Tracking and Management System

MACRO

- Understand and analyze the flow of referrals to and from a office.
- Visualize where referrals are coming/going.
- Understand how many referrals are made in a week.
- Access to the destinations (timeliness of visits)



MICRO

- Enable the user to see live updates to a referral status.
- Clearer picture of where a patient is in the process of being seen by destination provider/CBO.
- Reductions in sending follow up emails and/or phone calls about patient's referral status.

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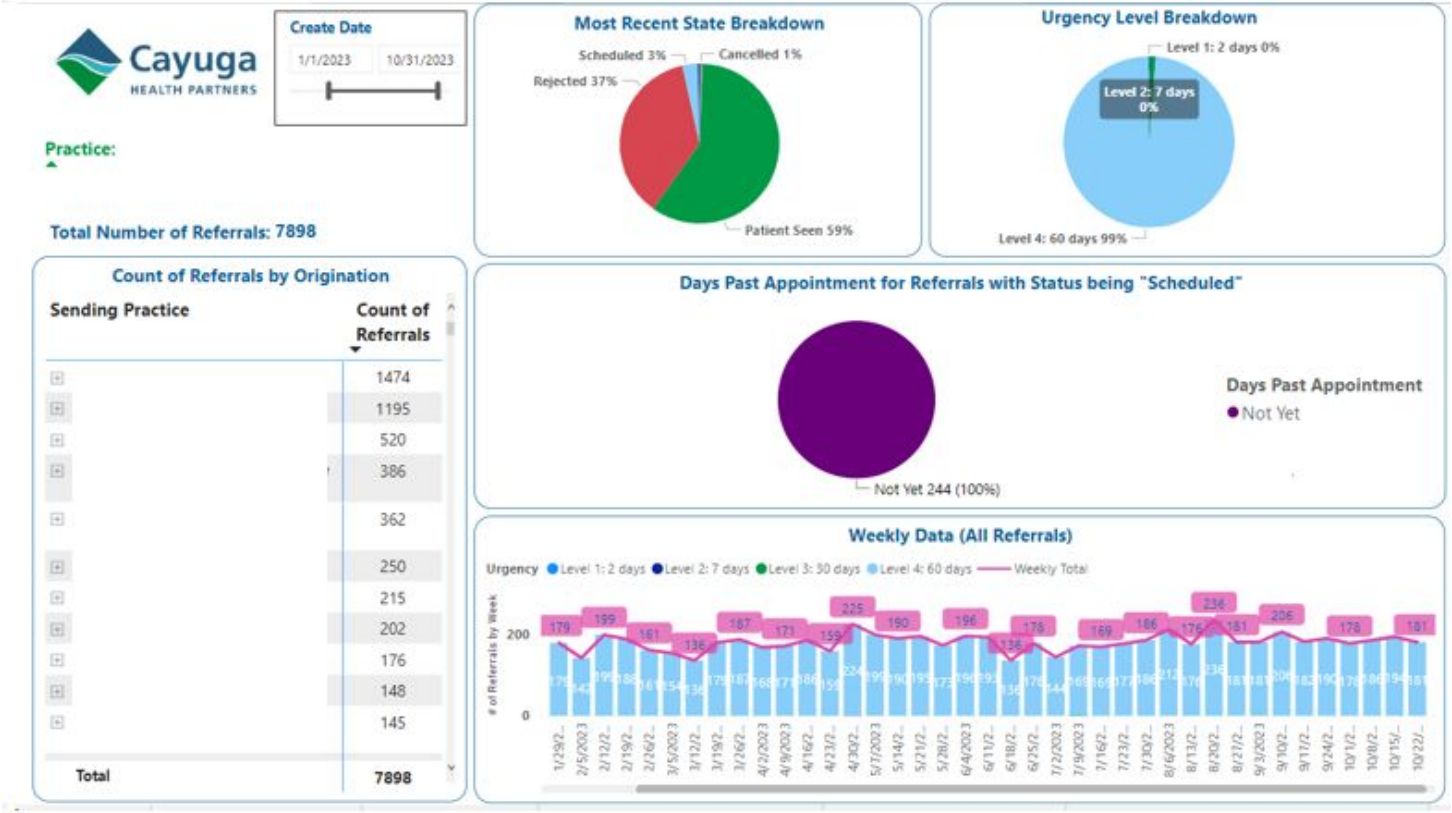

Reports allow practices to see the amount of referrals and where they are being sent from.

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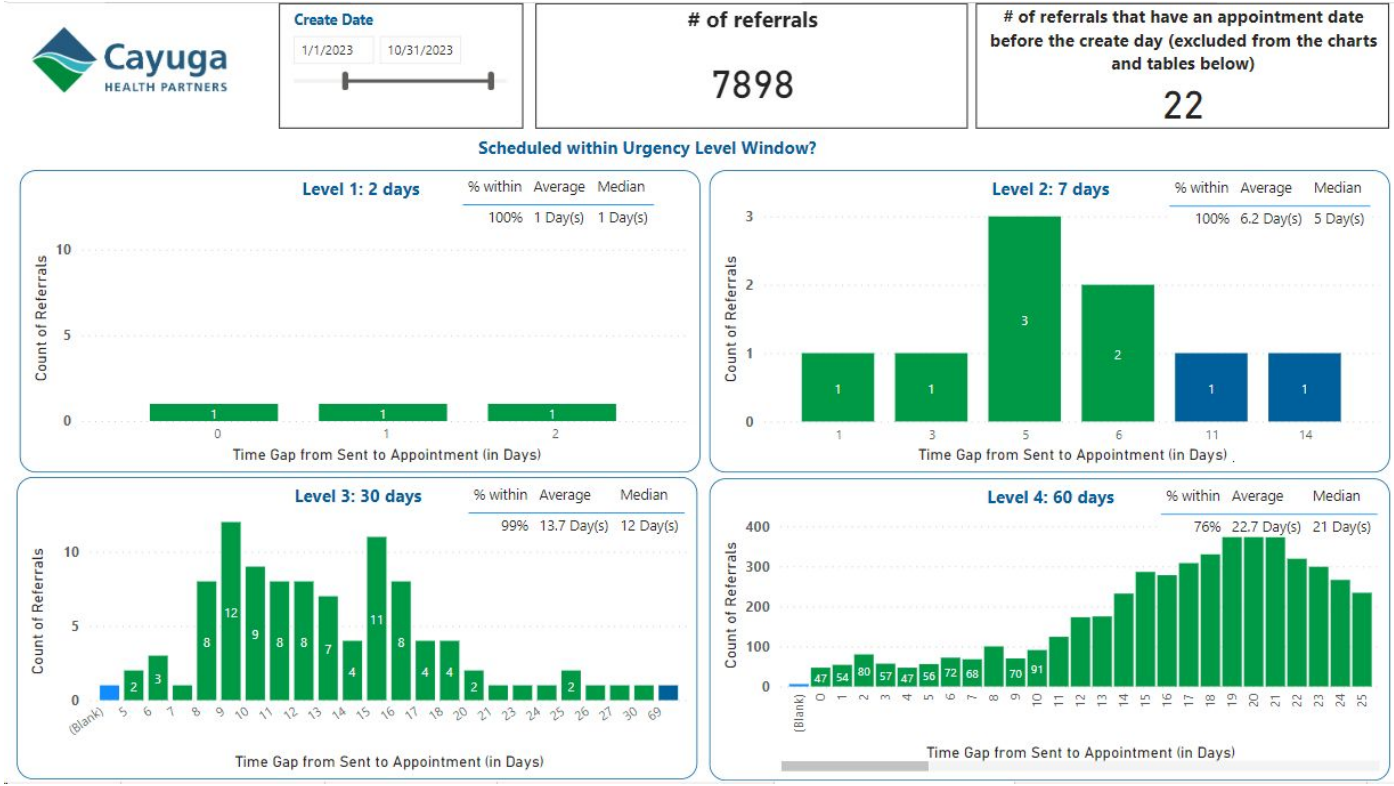

Reports create visible data trends by practice for scheduling patient appointments.

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PtRefs: Referral Tracking and Management System

What are benefits for participating organizations?

01	**Process improvement in administrative workflow**	• Reduction of back and forth phone calls between practices about patients status. • Streamline note sharing between offices. • Clean and clear work list
02	**Referral Visibility**	• Quickly identify appointment availability issues • Triage urgent referrals efficiently
03	**Referral Loop Closure**	• Support the referral of patient/client to the correct provider/office. • Receive updates about patient/client being seen at referred destination.

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Core Requirements

01	**Capability for Data Exchange**	• Adopt standards for data exchange to enable interoperability among organizations
02	**Resource Directory**	• Accurate source of resource directory information will be available and maintained
03	**Data Aggregation**	• Enable collection of longitudinal data about clients' social needs, risks, service-related activities and results

Social Needs Screening & Referral Pilot

Social Needs Screening

We care about everything that shapes your health. Please fill out this form and ask if you have any questions. We can let you know who to call for assistance. We also have staff who can help you find the best resources to meet your needs.

Name:_____ Date of Birth:_____ Language:_____ Date:_____

Questions	Yes	No
In the last year, did you ever eat less than you wanted to because there was **no food around** or **not enough money** for food?	☐	☐
In the last year, **has the electric, gas, oil, or water company told you they would shut off these services** in your home?	☐	☐
Are you worried that in the next 2 months you may not have enough **money for rent or to pay for housing**?	☐	☐
Is a need for **child care making it hard for you to work or study**? (leave blank if you do not have children)	☐	☐
In the last year, has it been hard to see a doctor or get medications **because of cost**?	☐	☐
In the last year, have you ever had **trouble getting a ride** to medical appointments or the pharmacy?	☐	☐
Are **instructions, pamphlets, or other written materials** from your doctor or pharmacy hard to read or not clear?	☐	☐
Do you often feel lonely?	☐	☐

Cayuga HEALTH cayugahealth.org

- Multi-year pilot project to screen all patients annually for unmet social needs in primary care practices, launched in 2021
- Collaboration with Cayuga Medical Center's Internal Medicine Residency Program, local CBOs and the Cornell Center for Health Equity
- In 2022, the pilot was expanded to enable direct referrals to CBOs
- An interdisciplinary team was formed to co-design the referral workflow
- New workflow includes a closed-loop system

Pilot Process Flow

Refer	Assess	Connect	Support	Document
Receive referrals of new clients after clinical social needs screening	Contact client to learn more about health & social needs, in addition to any current social service utilization / exploration	Connect clients to local resources to meet HRSN needs	Follow up to ensure client needs are met and complete warm hand-offs	Document all case management activities

***Limitations: Referrals are one way, not bi/multi-directional**

Pilot Results

26,000

screenings at 7 practices since 2021

22%

of patients screened identify unmet social need

13,000

Indicates the potential for future referral volume

**100% screening rate of Cayuga Patients @ 22% unmet need*

Most common need is social support followed by finances, housing, food, transportation, utility, literacy, childcare and social support

*Data collection spans January 2021 - YTD 2023

**Analysis conducted by Cayuga Health Partners

Transformation Grant

How can we streamline, improve and deepen the connection that we have as community-based organizations between ourselves and with healthcare providers?

Boundaries & Scope

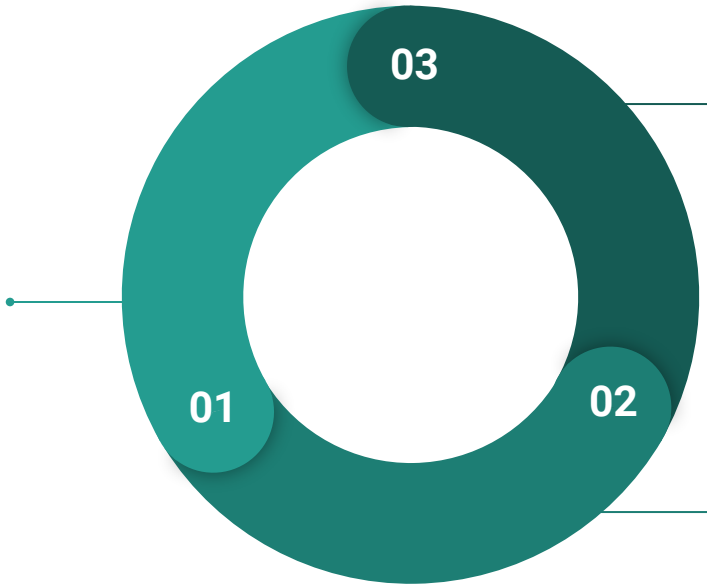
What it is

- ✔ Will benefit anyone in the area who is a client/ patient of the participating organizations
- ✔ Opportunity to co-design and create innovative network
- ✔ Build relationships and integrate with clinical / non-clinical providers

What it is not

- × Confined to Medicaid beneficiaries or specific insurance provider
- × Seeking/ subscribing to “off the shelf” product solution
- × Project is not service specific/ population specific

Who will this impact?



Community Based Organizations

Healthcare Providers

Individuals and Families With Unmet Social Needs

Cohort 1 Characteristics

- Organization has expertise in a priority HRSN service area
- Organization serves a priority population
- Organizations that are leaders in the county, who hold trust with partners and community members

- Organizational leadership is willing to commit the time and resources to participating in the pilot program

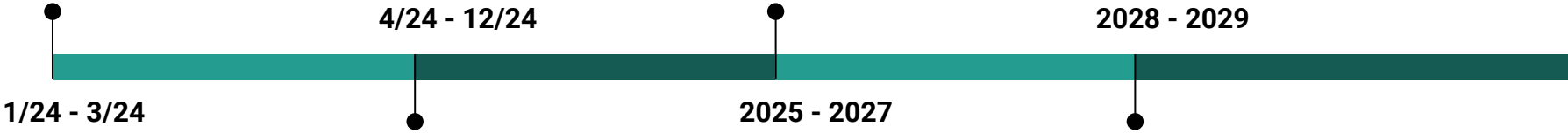
Proposed Timeline

Phase 1a - Initial Codesign

Group meetings with iterative feedback from CBO's & clinical partners in Cohort 1.

Phase 2 -Cohort 2

Onboarding of Cohort 2.
Continue referral management improvements.



Phase 1b - Development and Testing

Technical and operational development with ongoing testing from CBO's and clinical partners.

Phase 3 - Open Invitation

Welcome additional CBO's in the area to participate. Expand support and connection within the community.

Questions?

Contact: amoore@hsctc.org or lprince@cayugamed.org