# Community Health Network

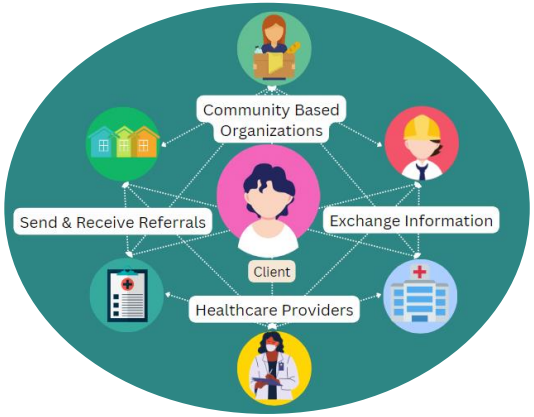
Prepared For: Homeless & Housing Taskforce

**February 7, 2024**

# Community Health Network

Strengthen the connection between social care and healthcare providers

- Exchanging essential services information:
  - From Healthcare providers to Community Based Organizations
  - From Community Based Organizations to Healthcare providers
  - Between Community Based Organizations.



# Terminology and Acronyms

- **Health Related Social Needs (HRSN):** An individual's unmet, adverse social needs that contribute to poor health resulting from their community's underlying Social Determinants of Health (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)

# Healthcare Social Needs Perceptions

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.

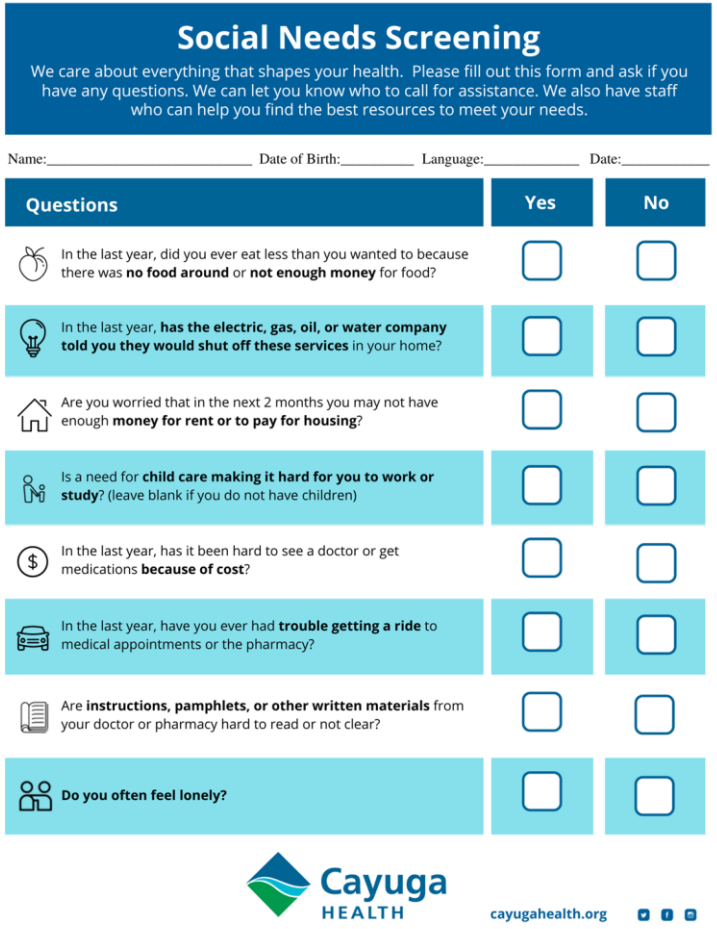
We need to **standardize** our approach to addressing the health related social needs within our community.

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

# Social Needs Landscape

Lessons Learned: San Diego 211, CIE Michigan Task Force, Accountable Health Communities Model & Social Needs Pilot Screening

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



## 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

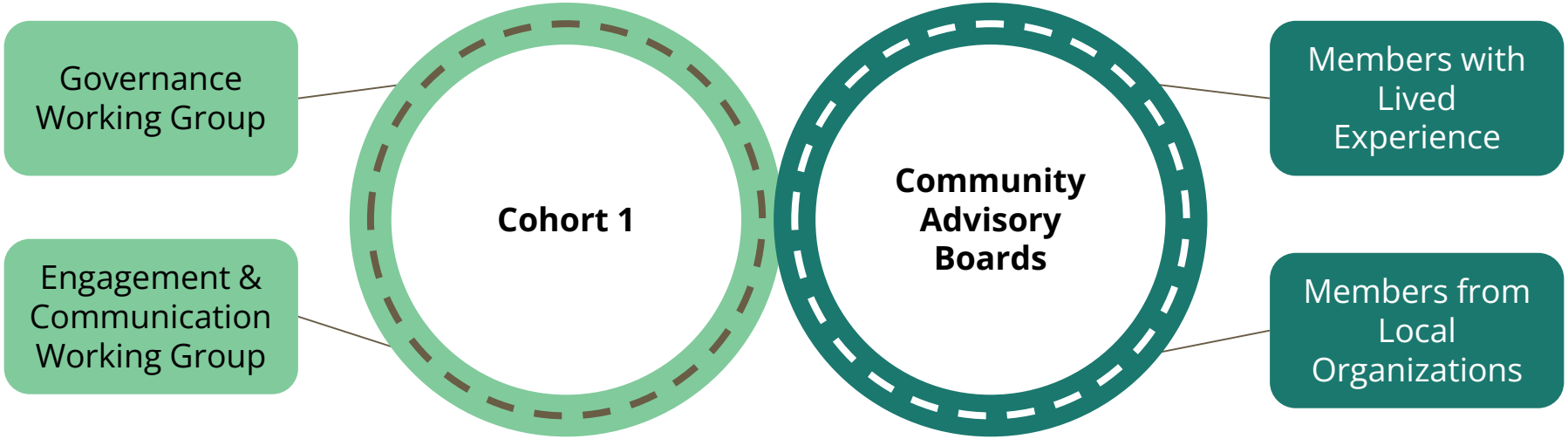
cayugahealth.org

# 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 |

# Cohort 1 Participants

# Structure & Timeline




January - April 2024

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

April - December 2024

**Phase 1b - Cohort 1**
Technical and operational development with ongoing testing from CBO's and clinical partners.

2025-2027

**Phase 2 - Cohort 2**
Onboarding of Cohort 2. Continue referral management improvements.

2028

**Phase 3 - Open Invitation**
Welcome additional CBOs to participate. Expand support and connection within the community.

# Community Advisory Board - Opportunities

**Who can Participate?**
We're looking for members of the community, or caregivers, of those who get their health or social care in Tompkins County with a preference for individuals who have had, or attempted, multiple interactions with different types of care.

**What is the Commitment?**
There are many opportunities to participate including regularly scheduled board meetings, focus groups, and 1:1 interviews. We will work to find the best fit for your engagement preference and schedule.

**What is the Compensation?**
The compensation is $25 per hour.

CHN@hsctc.org