FAMILY HEALTH CENTERS AT NYU LANGONE

High Risk Patient Program

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Discussion Points

- **FHC at NYU**
- **Social Screening for SDOH in Brooklyn**
- **Recommendations**

FAMILY HEALTH CENTERS AT NYU LANGONE

Social Factors and Health

FIGURE 1

A house in Shelby, Bolivar County, Mississippi, 1966. (Much better than most, it has brick—not wood—construction and electricity).

Geiger, H. Jack. "The Unsteady March." *Perspectives in Biology and Medicine*, Winter 2005, p. 1+. *Gale OneFile: Health and Medicine*, https://link.gale.com/apps/doc/A128672693/HRCA?u=nysl_me_nyuniv&sid=HRCA&xid=424e3ef2. Accessed 2 Sept. 2019.

FAMILY HEALTH CENTERS AT NYU LANGONE

Family Health Centers at NYU Langone

- Federally Qualified Health Center Network (Est. 1967)
  - Services & Programs Include
    - 8 Full time Primary Care Sites (Level 3 NCQA)
      - Dental clinics co-located at 5 sites
    - 48 School- Based Health/Dental Programs
      - 10 Primary Care, Mental Health, and Dental
      - 12 Primary Care, Mental Health
      - 25 Dental Only Clinics
    - 10-site Community Medicine Program serving 7,000 homeless New Yorkers
    - Community Programming Locations
      (i.e. Multiple Day Cares, Family Support Center, PRY)
    - Behavioral Health
    - Rehabilitation/ Physical Therapy
    - HIV Services
    - 340 B Drug Assistance Program
    - Teaching Health Center
    - Post-Doctoral Dental Residency Program

FAMILY HEALTH CENTERS AT NYU LANGONE

FHC Community Based Programs

- SNAP
- ESL
- Domestic Violence Programs
- High School Equivalency/ GED
- Medication Assistance Program
- WIC
- Housing Assistance
- Career Counseling & Job Training
- Nutritional Support
- Immigration & Legal Support
- Project SAFE
- Neighborhood Centers
- Early Childhood Centers
- Reach Out & Read
- Faith Health Partnership

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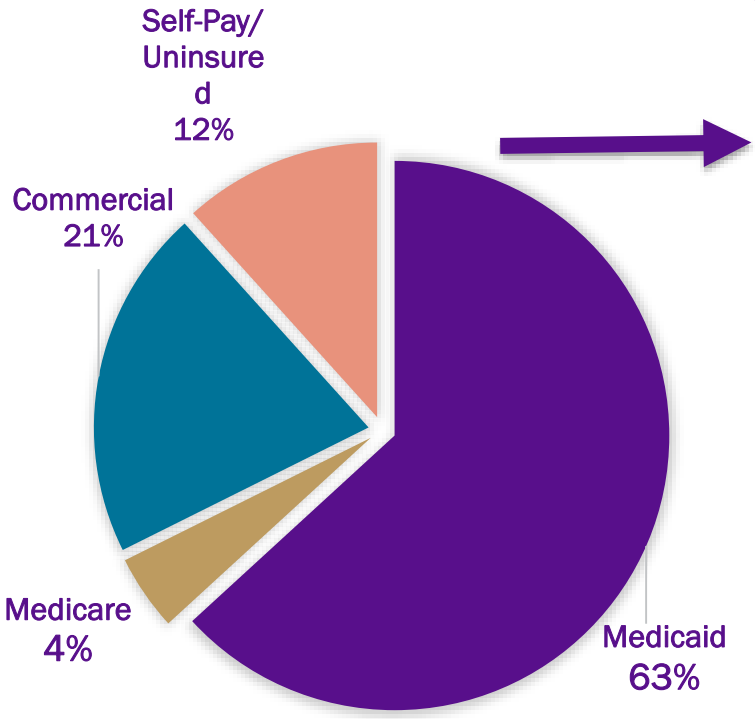
Medicaid is our payor



Sunset Park East has the highest percent of Medicaid beneficiaries of all New York City Neighborhood Tabulation Areas

More than 100,000 Medicaid beneficiaries reside in a Sunset Park zip code

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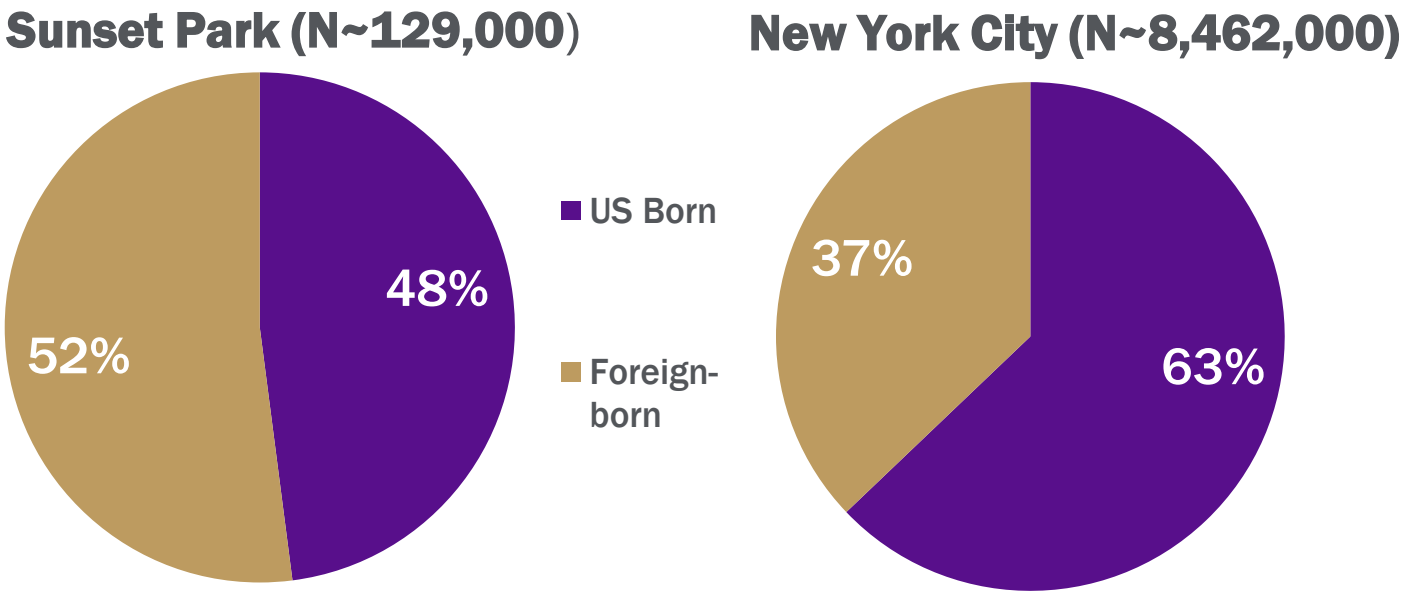
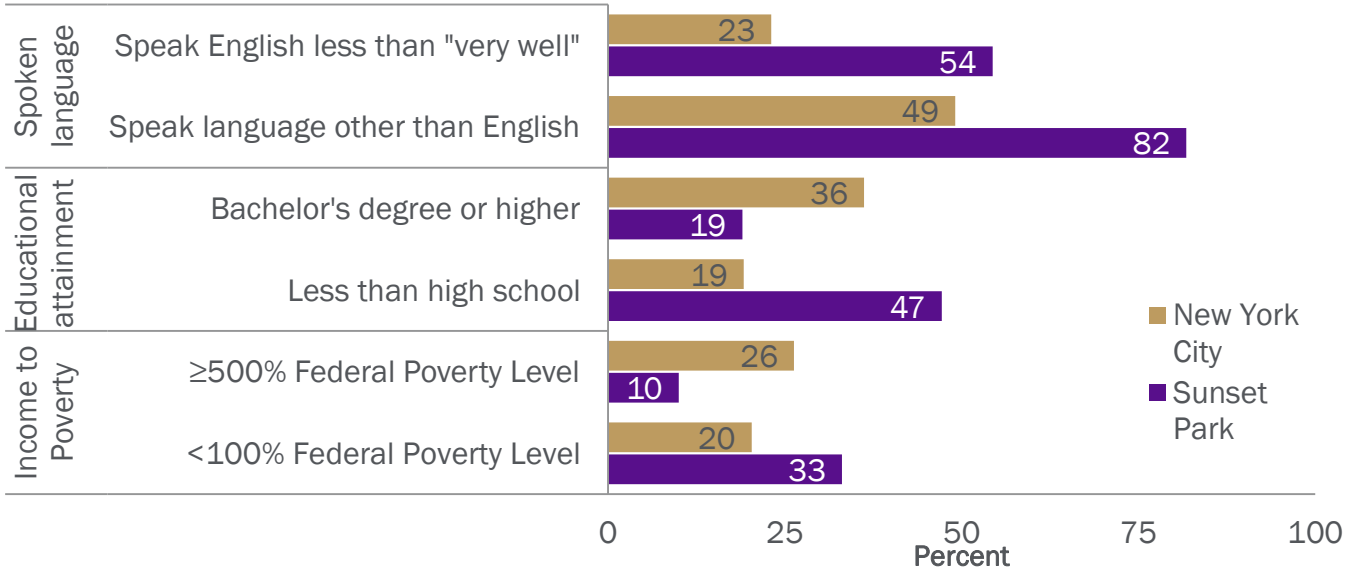
Sunset Park: A Community of Immigrants



FAMILY HEALTH CENTERS AT NYU LANGONE

English proficiency is limited, educational attainment is low, and poverty is very high in Sunset Park.

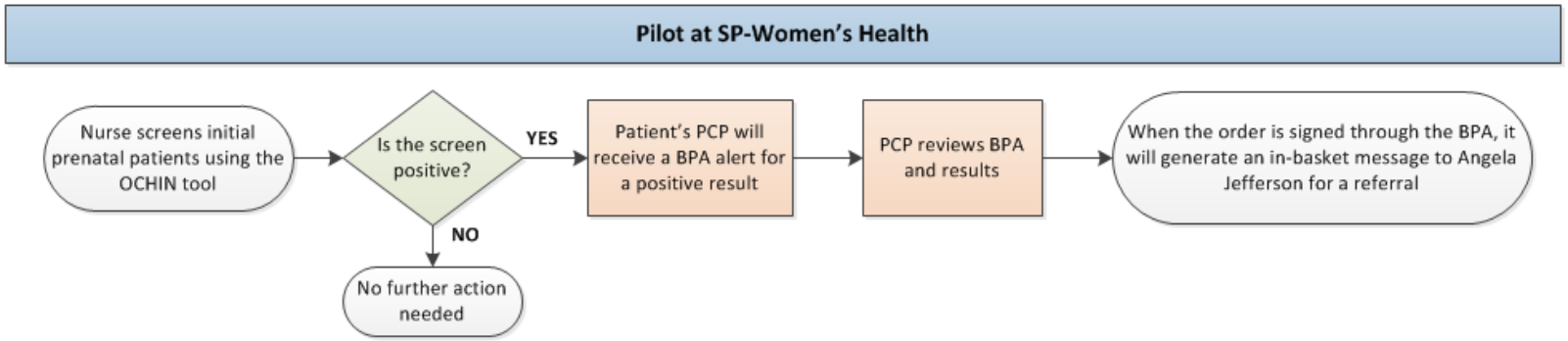


FAMILY HEALTH CENTERS AT NYU LANGONE

Goals of SDOH Screening

- Create Structured Data SDOH
- Increase use of ICD-10 codes
- Directly connect patients with Community Based Resources

Workflow: Nurse Led Screen

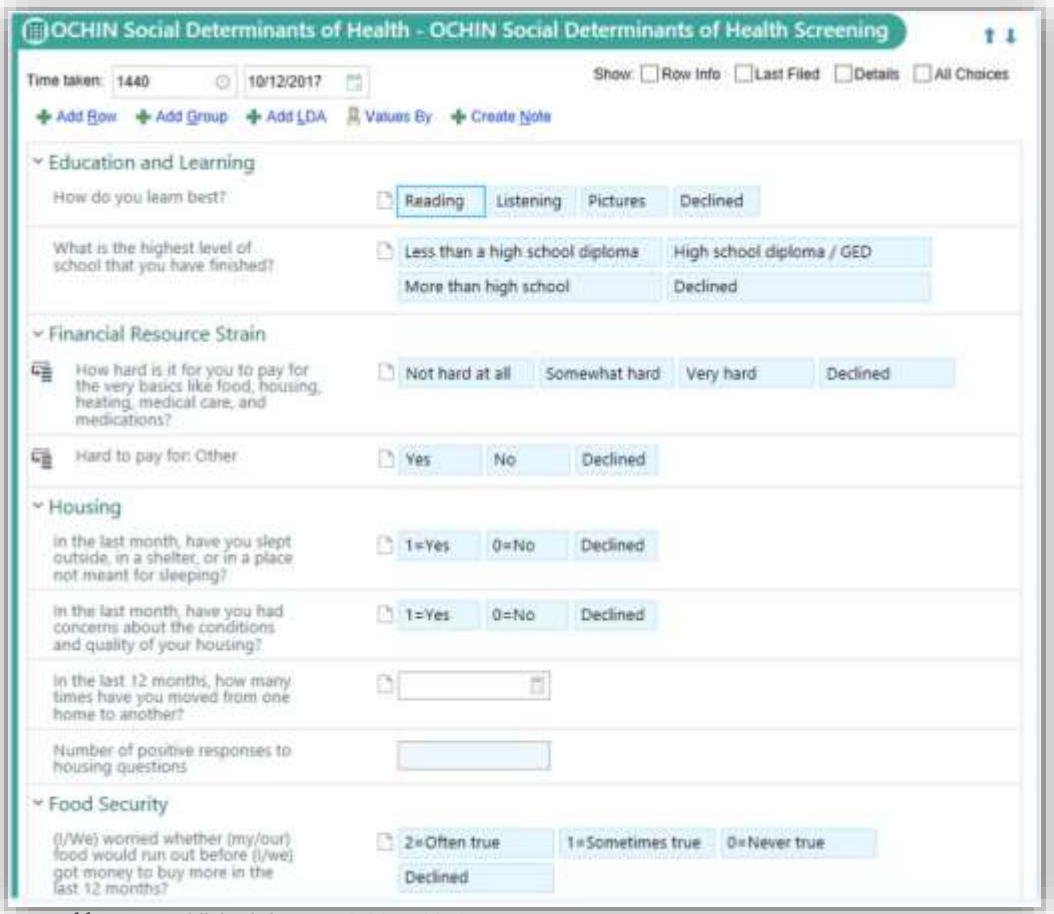


Unpublished data, FHC 2017-2018

Screening Tool and workflow

A 10 question SDH (OCHIN) tool and Best Practice Advisory Alert was created in the presence of positive responses

OCHIN tool embedded in EPIC

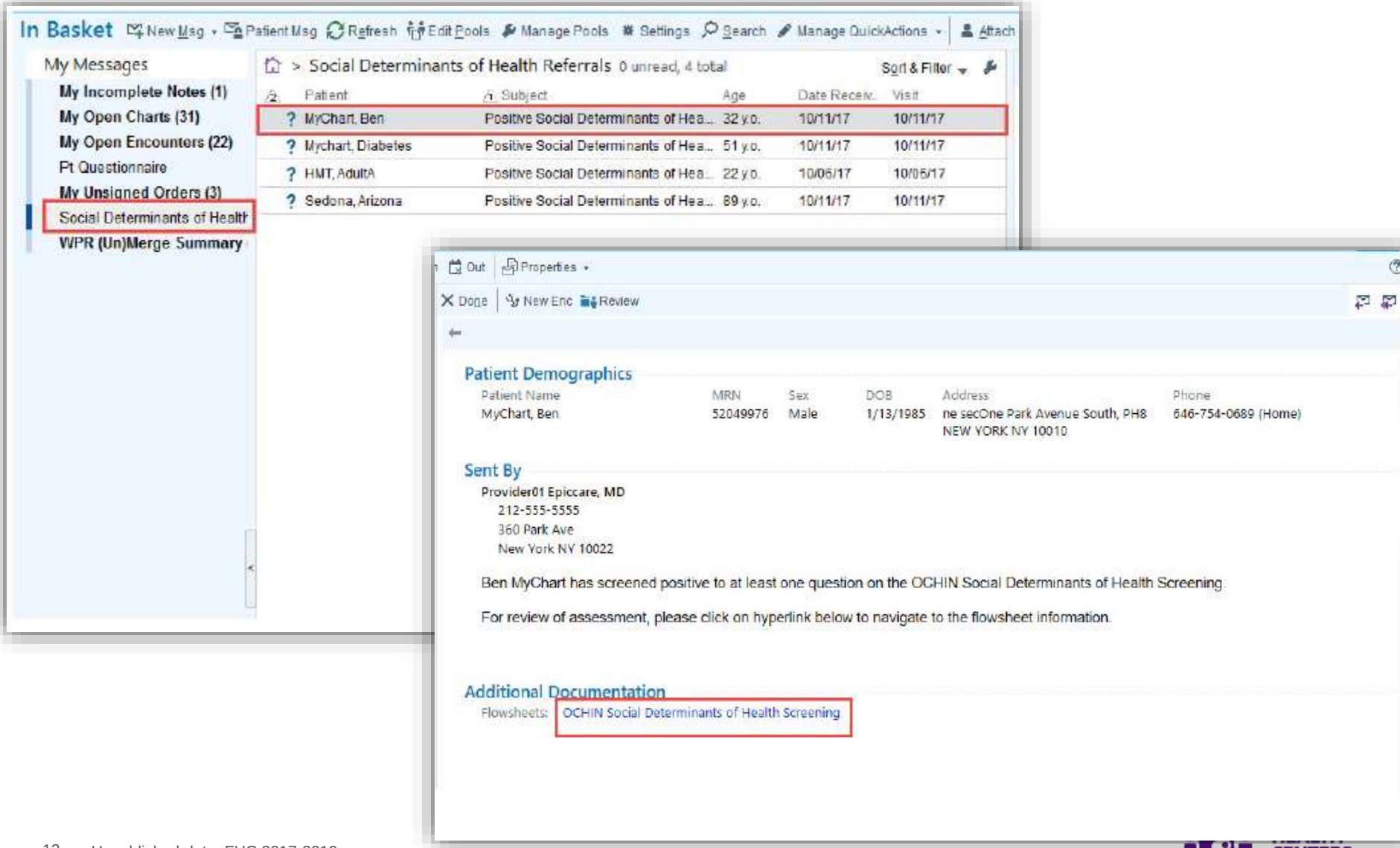


Best Practice Alert trigger SmartSet

Order Set with ICD 10 Capture and Referral

Unpublished data, FHC 2017-2018

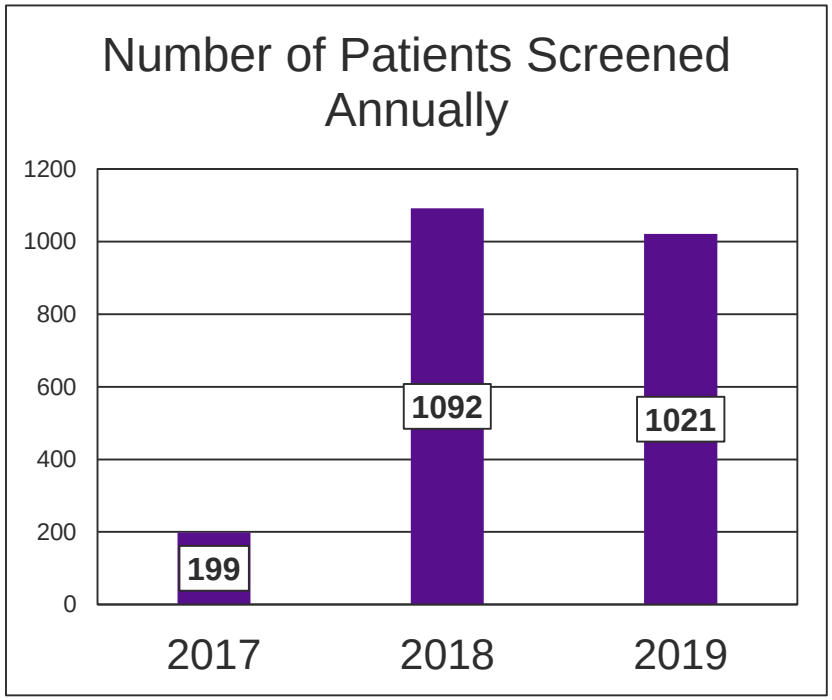
In Basket Referral



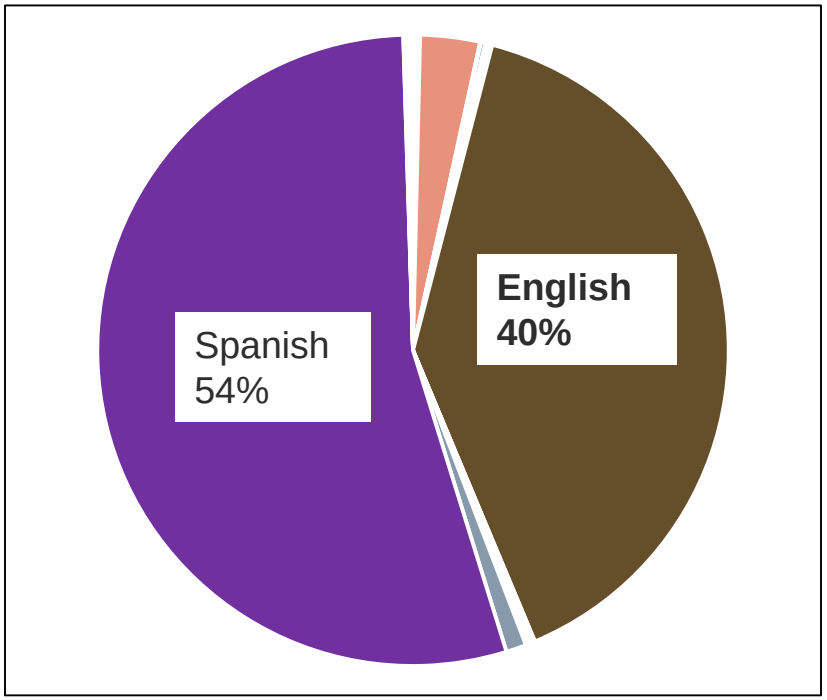
Unpublished data, FHC 2017-2019

Screening: As of June 2019

2312 patients screened



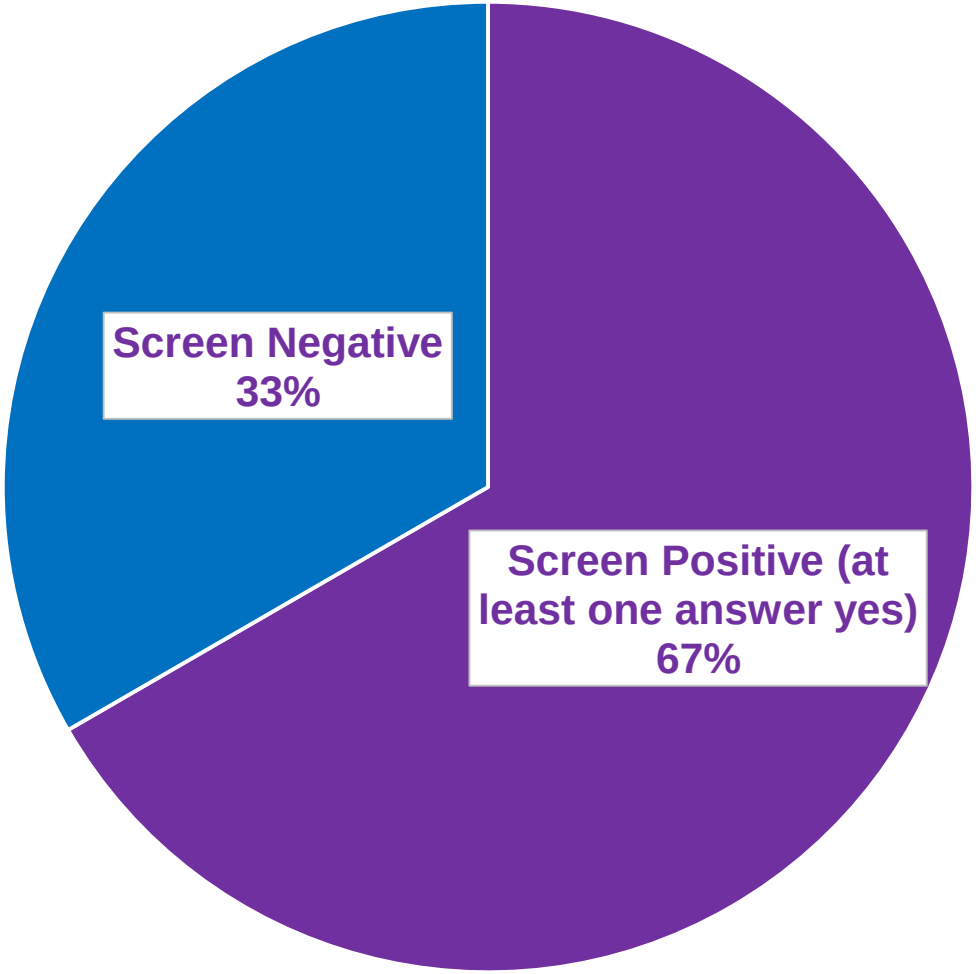
Most are Spanish-speaking



Unpublished data, FHC 2017-2019

FAMILY HEALTH CENTERS

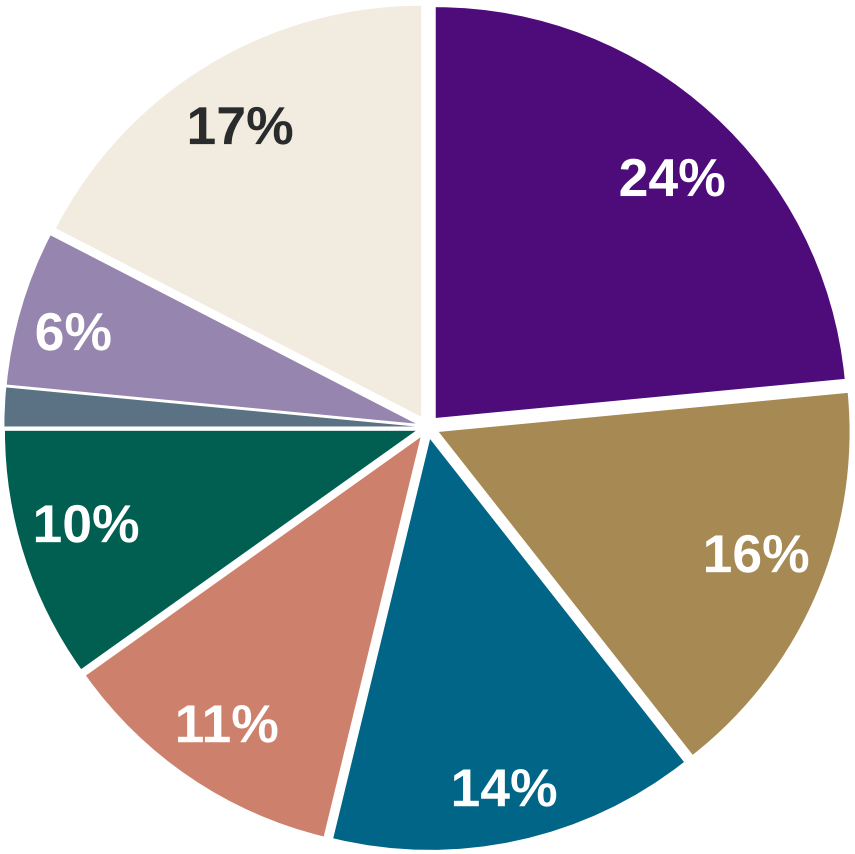
SDOH Screening Positive Rate



Unpublished data, FHC 2017-2019

FAMILY HEALTH CENTERS

Screen Positive Distribution for SDH



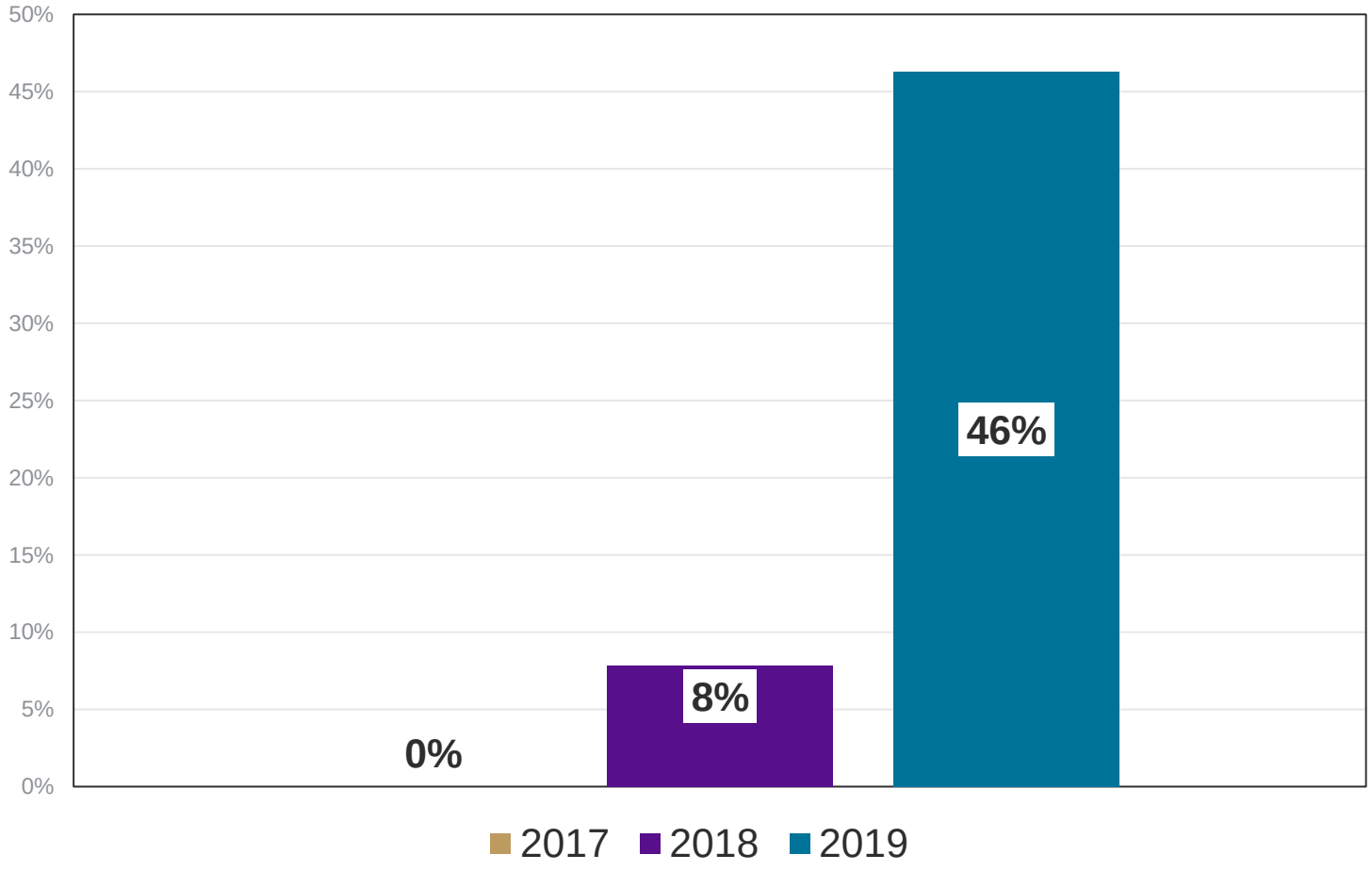
- Educational Underachievement
- Lack of Food
- Lack of Affordable Housing
- Lack of Access to Care
- Lack of Social Insurance
- History of Sexual and or Physical Abuse
- Inadequate Family Support
- Lack of Exercise*

*as defined as less than 150 minutes/ week of moderate strenuous activity

Unpublished data, FHC 2017-2019

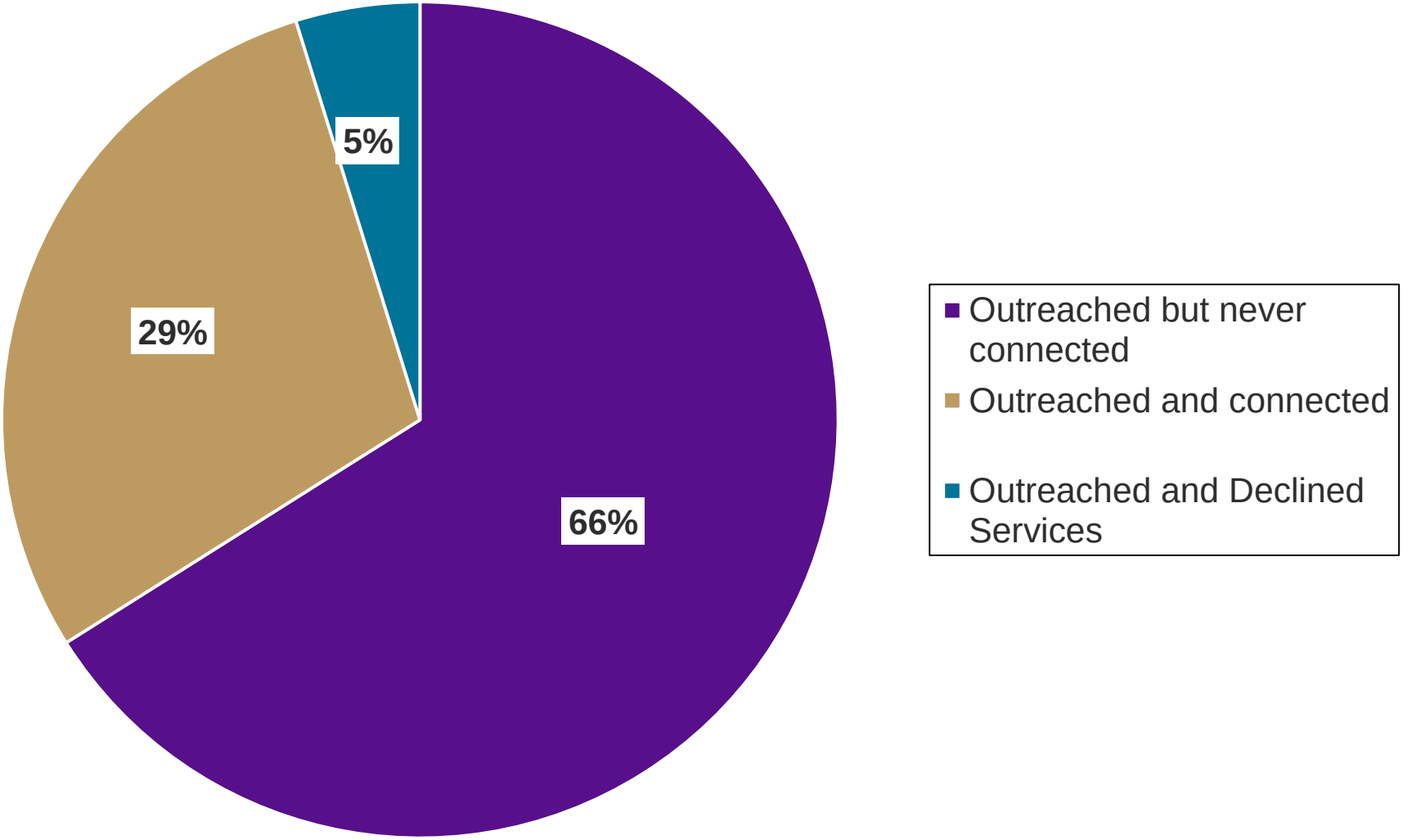
FAMILY HEALTH CENTERS

Closed Loop Documentation in EPIC (Positive Screens Only)



Unpublished data, FHC 2017-2019

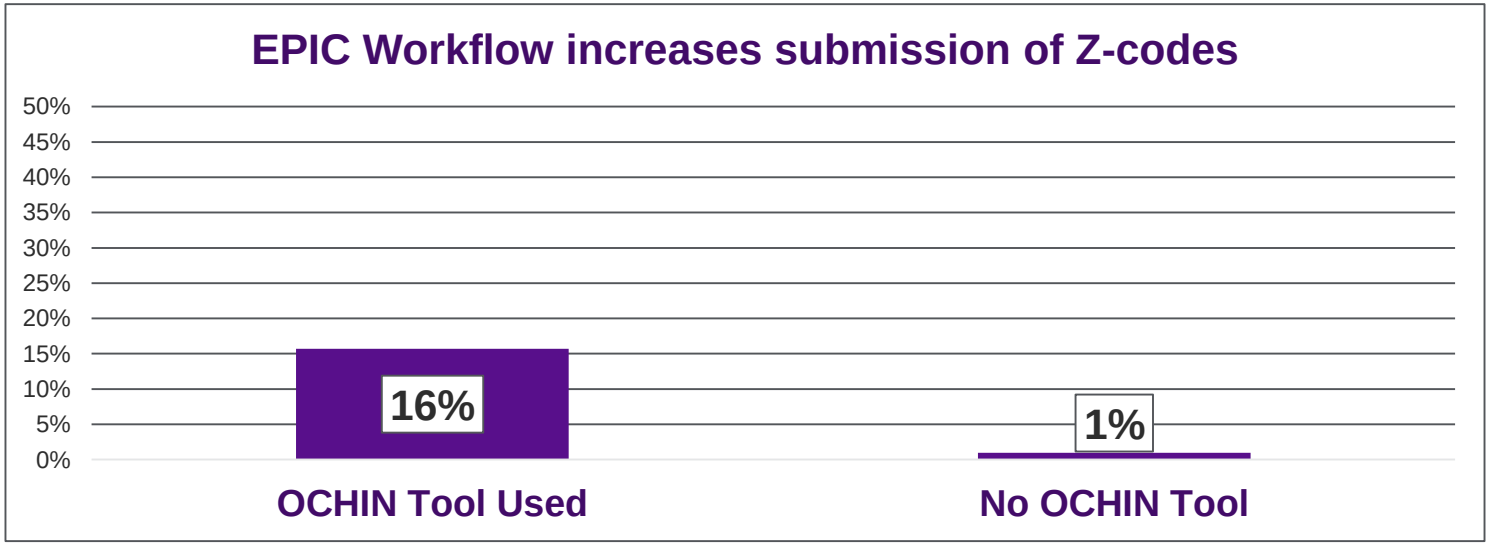
Closed Loop Patient Level Outcomes



Unpublished data, FHC 2017-2019

FAMILY HEALTH CENTERS

ICD-10 coding: Subgroup analysis



	OCHIN Tool Used	No OCHIN Tool Used
Z-code Submitted	141	2609
No Z-code Submitted	756	261480
Total	897	264089
P <.001		

Unpublished data, FHC 2017-2018

FAMILY HEALTH CENTERS

Current Opportunities for Shared Savings

FHC

FGP

IPA Partners

DSRIP

UnitedHealthcare Community Plan

healthfirst

Empire BlueCross BlueShield

FAMILY HEALTH CENTERS AT NYU LANGONE

Analysis of 500 HF Patients with Highest ED/IP Costs

Patients

4579

Total ED/IP encounters

Cost

$33.8M

Total ED/IP cost

Breakdown

42%

Had at least one BH related encounter

77%

Of BH related ED/IP cost is non-domestic

$17.2M

Total ED/IP cost for patients with at least one BH related encounter

58%

Had no BH related encounters

68%

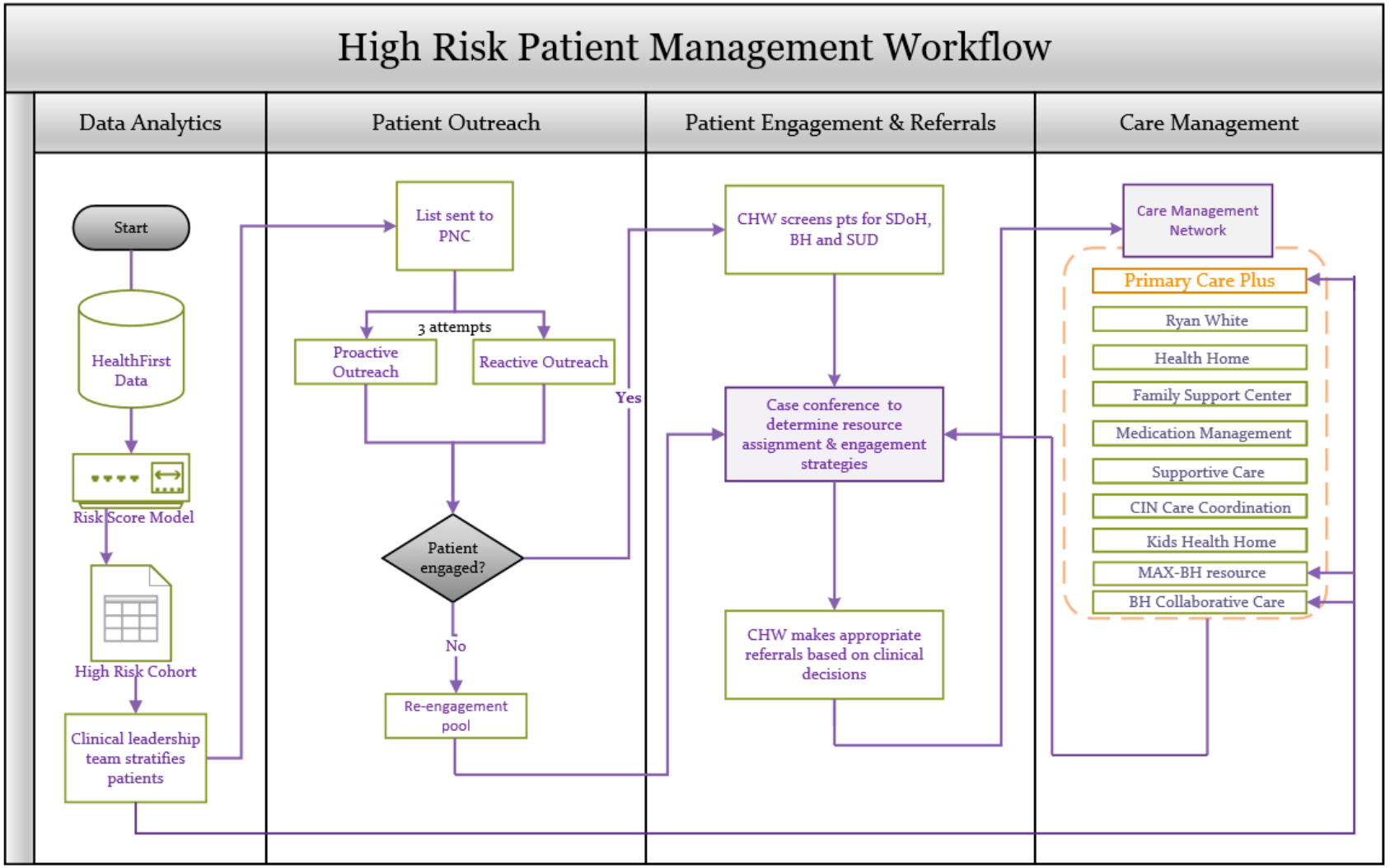
Of Non-BH related ED/IP cost is non-domestic

$16.5M

Total IP/ED cost for patients with Non- BH related encounters

FAMILY HEALTH CENTERS

Workflow



FAMILY HEALTH CENTERS AT NYU LANGONE

Primary Care PLUS

FAMILY HEALTH CENTERS
AT NYU LANGONE

TEAM

Physician
Hired

Nurse Practitioner
Hired

Administrator
Hiring in progress

Community Health Worker x 2

1 hired
Other hire in progress

FAMILY HEALTH CENTERS
AT NYU LANGONE

REFERRAL CRITERIA

PATIENT OF FAMILY HEALTH CENTER

PCPs must be known to FHC

AT RISK FOR A PREVENTABLE READMISSION

Ambulatory sensitive conditions including, but not limited to: COPD, Diabetes, CHF, Asthma, or other advanced end stage diseases

PAYOR BLIND

All insurances, as long as they are considered high risk

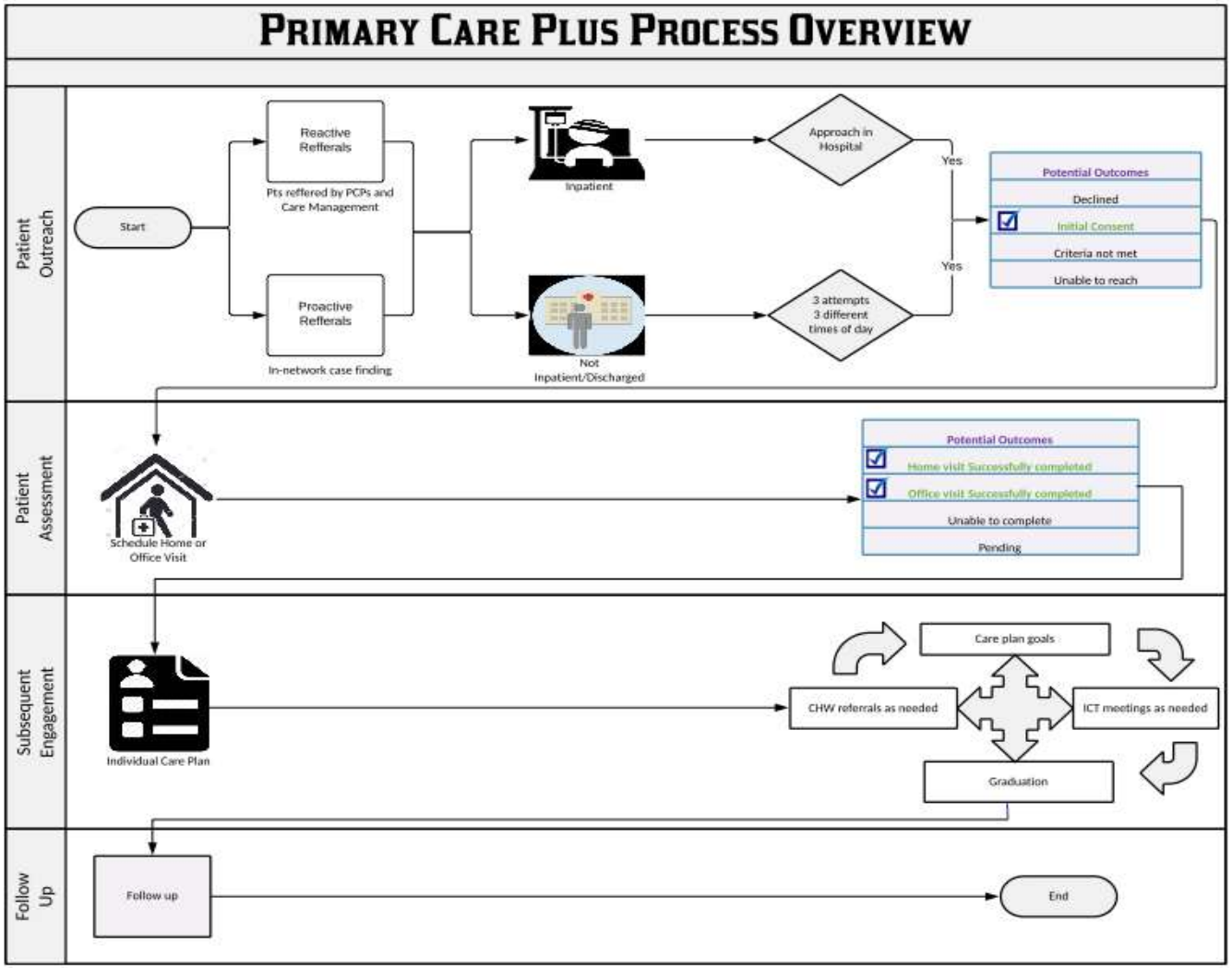
SOCIAL DETERMINANTS

Patient will benefit from intense engagement as suggested by:

- Complex care needs otherwise not met by current care setting
- Poor PCP follow up
- Non adherence

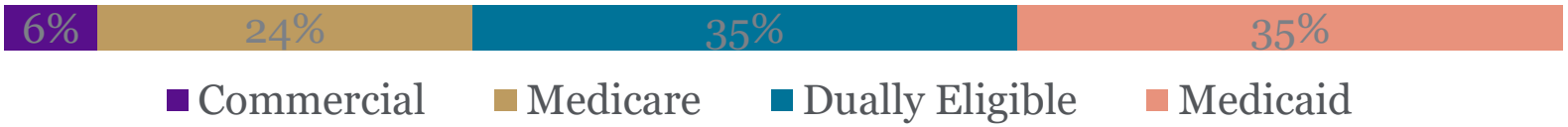
NYU Langone Health

FAMILY HEALTH CENTERS AT NYU LANGONE

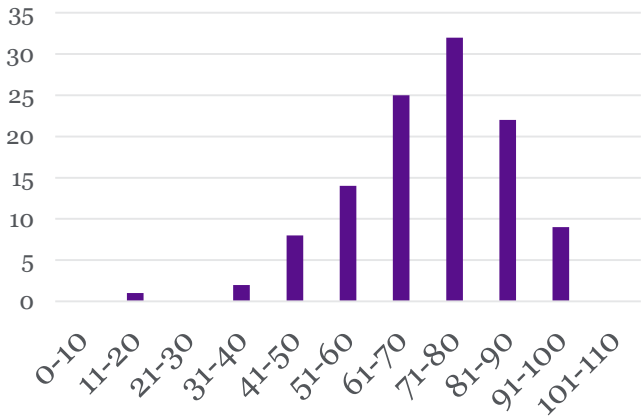

PRIMARY CARE PLUS PROCESS OVERVIEW
Patient Outreach
Start
Reactive Refferals
Pts reffered by PCPs and Care Management
Proactive Refferals
In-network case finding
Inpatient
Not Inpatient/Discharged
Approach in Hospital
3 attempts 3 different times of day
Yes
Yes
Potential Outcomes
Declined
Initial Consent
Criteria not met
Unable to reach
Patient Assessment
Schedule Home or Office Visit
Potential Outcomes
Home visit Successfully completed
Office visit Successfully completed
Unable to complete
Pending
Subsequent Engagement
Individual Care Plan
Care plan goals
CHW referrals as needed
ICT meetings as needed
Graduation
Follow Up
Follow up
End

PCP+ treats complex patient population…

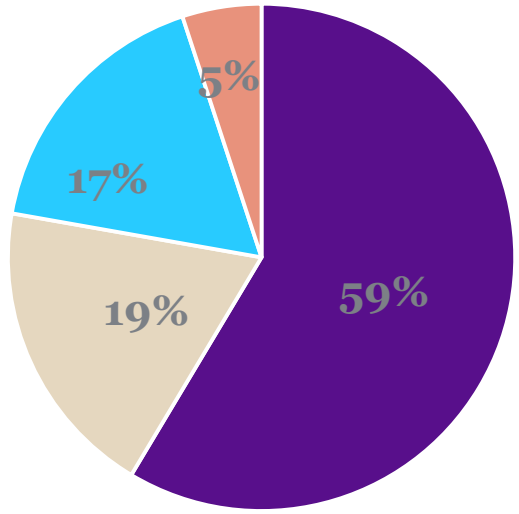
Payer Mix



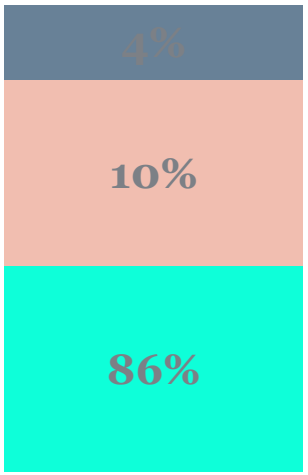
Age Range



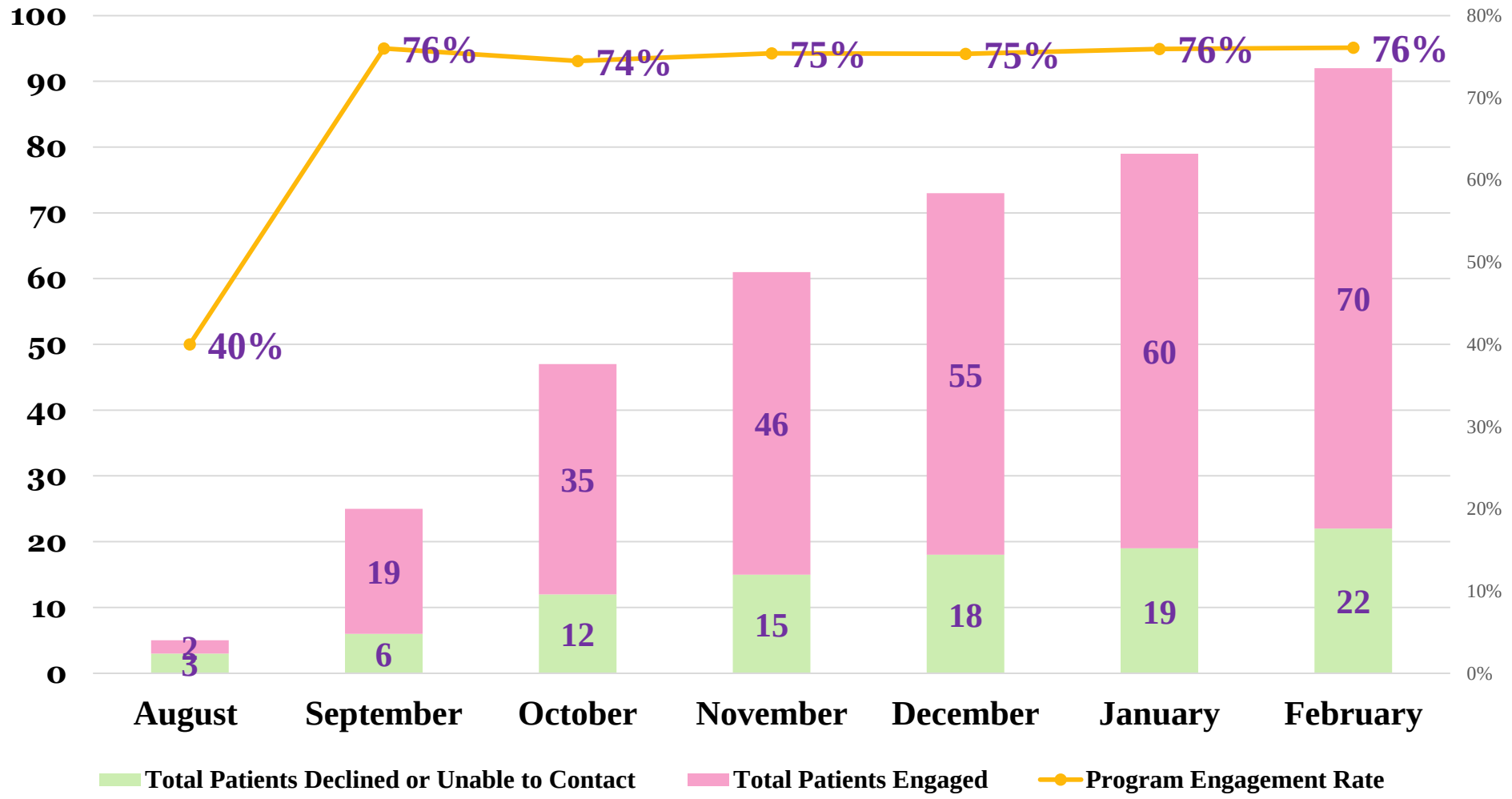
High Risk Comorbidities



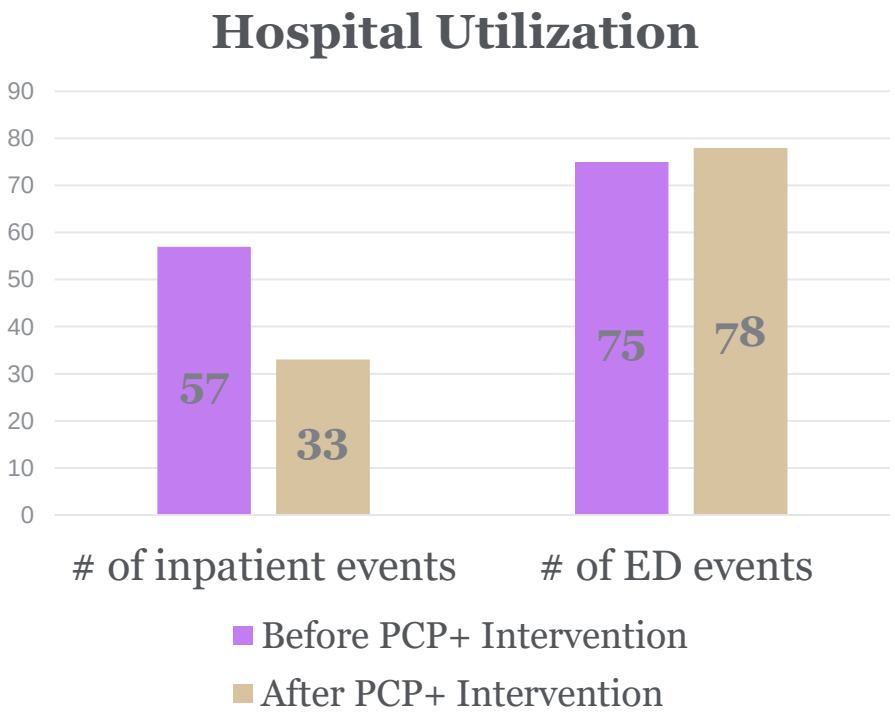
Poly Pharmacy

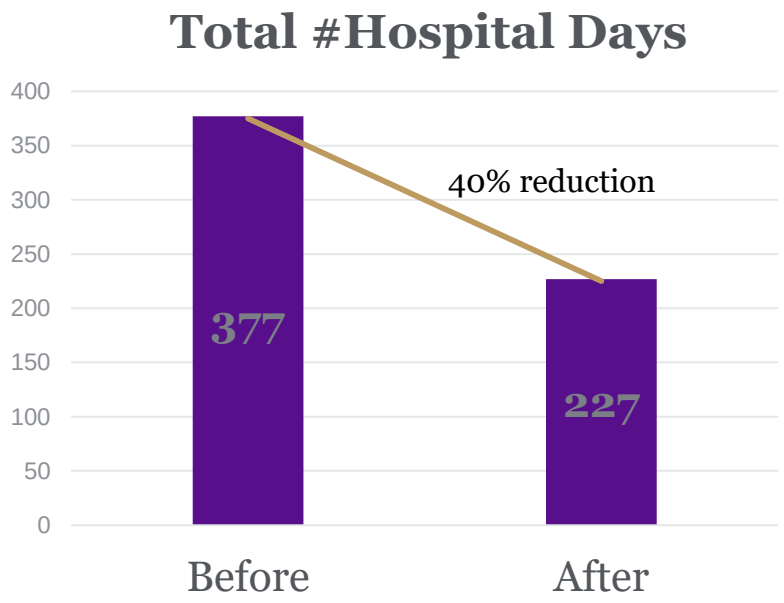


PCP+ patients have higher engagement rate…



PCP+ has a significant impact on hospital utilization…





A Success Story…

- Patient History: ST is a 60 year old male with history of uncontrolled hypertension, coronary artery disease, heart failure, substance use disorder with a history of **10 avoidable admissions and 12 ED visits** related to uncontrolled heart failure, hypertension, and COPD in the 2 years prior to enrollment

- Multi dimensional care plan includes:
  1. Regular CHW visits to reinforce: self management and monitoring of blood pressure and medication adherence
  2. Referral to food pantry
  3. Increased frequency of behavioral health visits
  4. Home based primary care every 4-6 weeks in addition to usual primary care to ensure adequate disease control

- Impact: in 9 months since engagement, the patient has had **0 hospitalizations, and only 3 ED visits**

FAMILY HEALTH CENTERS AT NYU LANGONE

Number of Engaged Patients

Primary Care Plus Month Engagement	Month	Actual New	Actual Engaged
Month 1 August 18, 2018.	August	2	2
Month 2 September 18, 2018	September	17	19
Month 3 October 18, 2018	October	16	35
Month 4 November 18, 2018	November	11	46
Month 5 December 18, 2019	December	9	55
Month 6 January 18, 2019	January	5	60
Month 7 February 18, 2019	February	10	70
Month 8 March 18, 2019	March	4	74

- Engaged: Refers to receiving in home services
- NP Start date March 2019
- Goal 200 patients (>%80 risk pool attributed)
- Primary target – Engagement
- Secondary targets – Utilization, Member months

FAMILY HEALTH CENTERS

Budget Breakdown and FFS Breakeven

Budget for Primary Care PLUS	
Revenue	
Encounter revenue for clinical visits (see Fee for Service tab)	$747,420
EMR improvement for attributed patients (10% decrease in preventable admissions- see shared savings tab)	$500,000
total revenue	$1,247,420
Expenses	
Medical Director	$210,000.00
Nurse Practitioner	$120,000.00
Care coordinator/LCSW	$75,000.00
Community Health Worker #1	$49,000.00
Community Health Worker #2	$49,000.00
Total salary	$503,000.00
Fringe	$241,440.00
Total	$744,440.00
Other than personel sevices	
Transportation estimates (see transportation tab)	$19,488
computer, cell phones and office supplies	$15,000
other total	$34,488
Revenue - expenses	$468,492

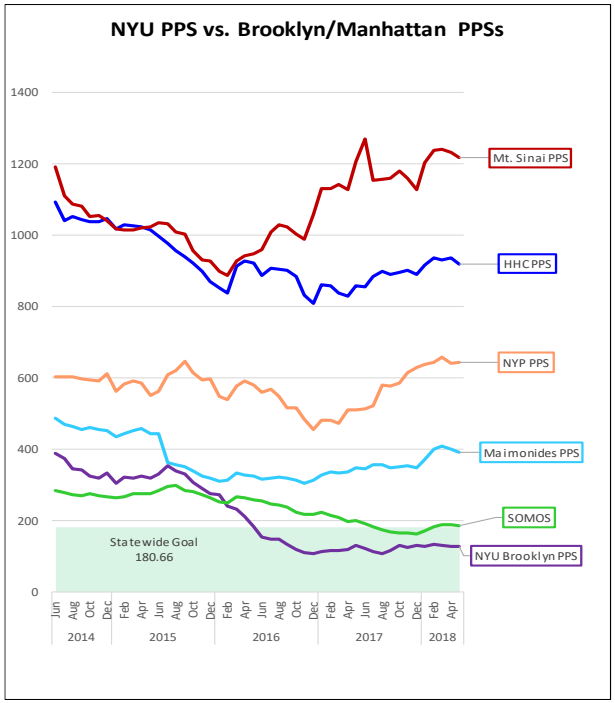
Fee For Service Breakeven Point			
Revenue Source	Encounters/ month	Revenue/ Encounter	Dollar
Health home	40	$295	$11,800
Telehealth	165	$84	$13,860
CCM	87	$95	$8,265
In-Person	197	$146	$28,680
			$62,605

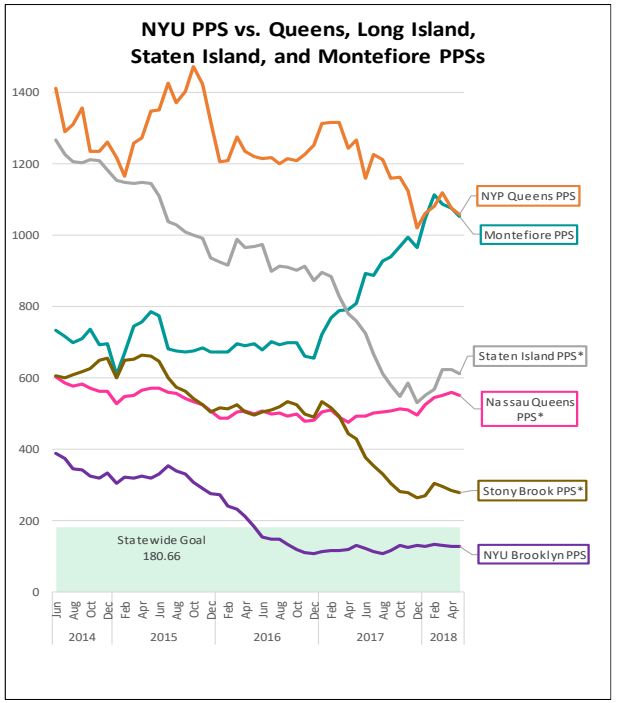
FAMILY HEALTH CENTERS AT NYU LANGONE

Potentially Preventable Readmissions (PPR)

June 2014 through May 2018

Potentially Preventable Measure





NYU Langone Brooklyn PPS achieving Statewide goal in PPR measure since May 2016

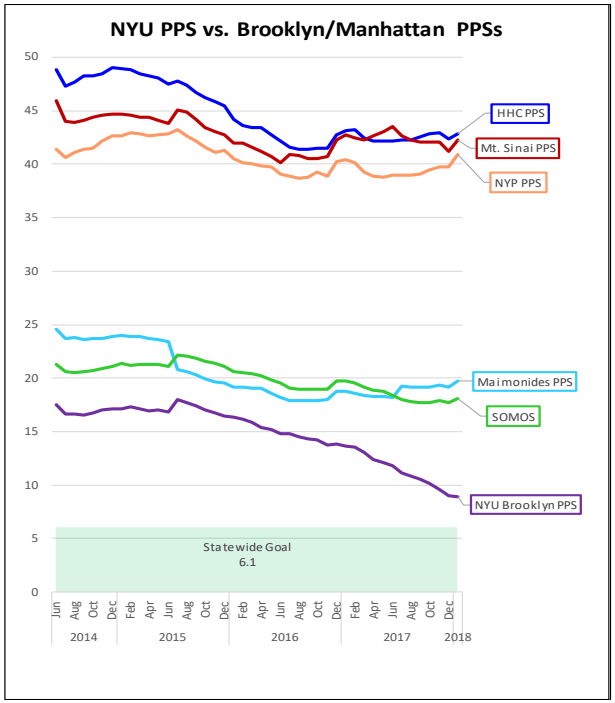
DSRIP Impact: Observation Unit implemented in 2015

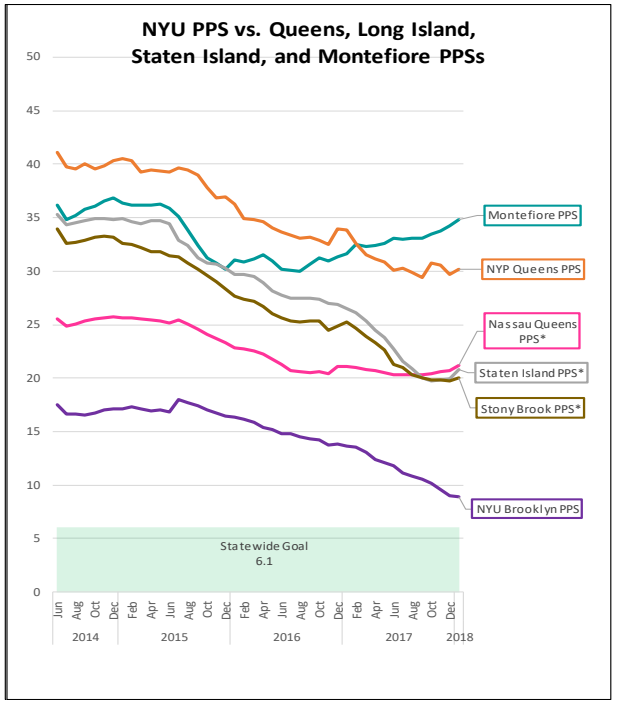
FAMILY HEALTH CENTERS AT NYU LANGONE

Potentially Preventable ED Visits (PPV)

June 2014 through January 2018

Potentially Preventable Measure





NYU Langone Brooklyn PPS achieving Statewide goal in PPR measure since May 2016

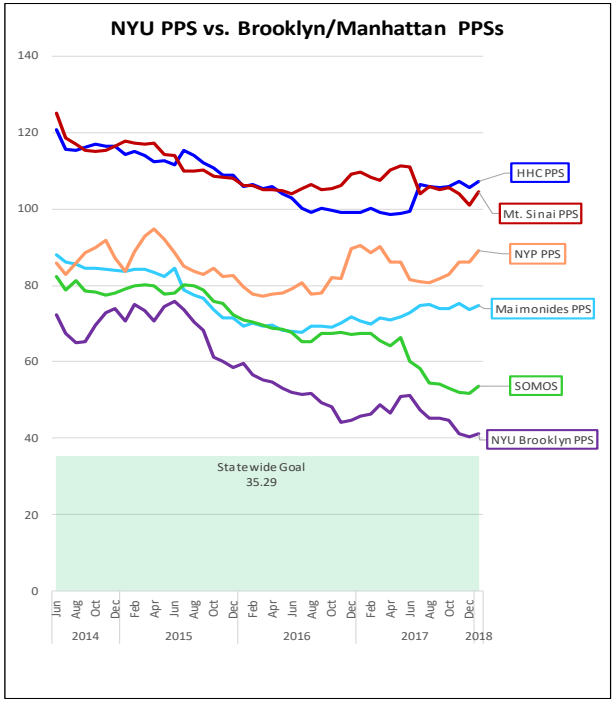
DSRIP Impact: Observation Unit implemented in 2015

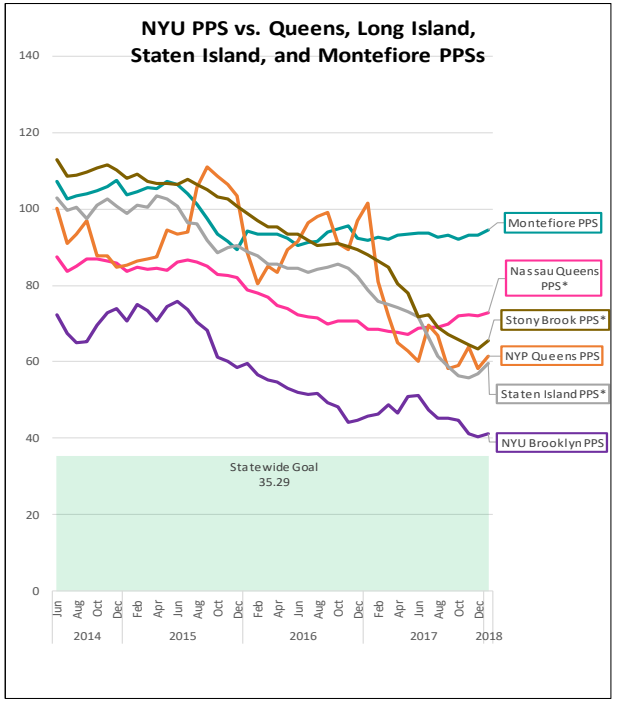
FAMILY HEALTH CENTERS AT NYU LANGONE

PPV – Behavioral Health (PPVBH)

June 2014 through January 2018

BH Measure





DSRIP Impacts: Behavioral Health Workgroup ramped up in 2016, MAX Series (ED and Inpatient High Utilizers) from 2016 to current, Observation Unit implementation

FAMILY HEALTH CENTERS AT NYU LANGONE

Key themes

- **SDH Screening is a new workflow**
- **EPIC Referral Requires Provider Education**
  - Is the tool being used the same way across providers and patients?
  - How to assess consistency with screening and referral process?
- **Successful Screening Program Requires Patient trust**
  - Do patients want help/want a referral?
    - How to best document this?
  - Do patients know FSS will be contacting them?
- **Connecting patients with services is challenging**
  - Many participants do not connect with resources
    - Telephonic followup has low success rate
- **Workflow increases ICD-10 coding rate**

FAMILY HEALTH CENTERS

Thank You!

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718-630-7906

FAMILY HEALTH CENTERS
AT NYU LANGONE

Appendices

FAMILY HEALTH CENTERS
AT NYU LANGONE

Appendix A:
PRAPARE Tool in EPIC

FAMILY HEALTH CENTERS
AT NYU LANGONE

Responses that are both “Positive” and “Abnormal”

Topic	Question	Positive Response	Abnormal Response	Referral Path
Education and Learning	What is the highest level of school that you have finished?	< High School	< High School	FSS
Financial Resource Strain	What is it hard to pay for? Food	Yes	Yes	FSS
Financial Resource Strain	What is it hard to pay for? Utilities	Yes	Yes	FSS
Financial Resource Strain	What is it hard to pay for? Medicine or medical care	Yes	Yes	FSS
Financial Resource Strain	What is it hard to pay for? Health insurance	Yes	Yes	FSS
Financial Resource Strain	What is it hard to pay for? Child care	Yes	Yes	FSS
Housing	In the last month, Have you slept outside, in a shelter, or in a place not meant for sleeping?	Yes	Yes	FSS
Housing	In the last month, Have you had concerns about the conditions and quality of your housing?	Yes	Yes	FSS
Exposure to violence	Have you ever been physically or emotionally hurt or threatened by a spouse/partner or someone else you know?	Yes	Yes	On-site SW
Physical Activity	Weekly physical activity (minutes per week)	<140	<140	Discuss with provider
Social Connections and Social Isolation	How often do you feel lonely or isolated from those around you?	Often or always	Often or always	FSS
Social Connections and Social Isolation	Do you have someone you could call if you needed help?	No	No	FSS

FAMILY HEALTH CENTERS

Responses that are “Positive” but NOT “Abnormal”

Topic	Question	Positive Response	Abnormal Response	Referral Path
Financial Resource Strain	How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?	Somewhat hard or Very hard	NA	NA
Financial Resource Strain	What is it hard to pay for? Transportation	Yes	NA	NA
Financial Resource Strain	What is it hard to pay for? Clothing	Yes	NA	NA
Financial Resource Strain	What is it hard to pay for? Rent/mortgage	Yes	NA	NA
Financial Resource Strain	What is it hard to pay for? Phone	Yes	NA	NA
Financial Resource Strain	What is it hard to pay for? Other	Yes	NA	NA
Housing	In the last 12 months, how many times have you moved from one home to another?	2 or more	NA	NA
Stress	During the past month, how much stress would you say you experienced?	A lot or moderate	NA	NA

FAMILY HEALTH CENTERS

Responses that are defined differently for “Positive” and “Abnormal”

Topic	Question	Positive Response	Abnormal Response	Referral Path (ABNORMAL)
Food security	I/we worried whether my/our food would run out before I/we got money to buy more in the last 12 months?	Often true or sometimes true	Often true	FSS
Food security	The food that I/we bought just didn’t last and I/we didn’t have the money to get more in the last 12 months?	Often true or sometimes true	Often true	FSS
Food security	I/we couldn’t afford to eat balanced meals in the last 12 months?	Often true or sometimes true	Often true	FSS
Social Connections and Social Isolation	Are you married or living together with someone in a partnership?	Used to compute SNI	NA	NA
Social Connections and Social Isolation	In a typical week, how often do you talk with family, friends or neighbors by phone, or video chat (ie, Skype, Facetime)?	Used to compute SNI	Never	FSS
Social Connections and Social Isolation	In a typical week, how often do you get together with family, friends or neighbors	Used to compute SNI	Never	FSS
Social Connections and Social Isolation	In a typical week, how often do you use email, text messaging, or internet (eg Facebook) to communicate with family, friends, or neighbors?	Used to compute SNI	Never	FSS
Social Connections and Social Isolation	How often do you attend church or religious services?	Used to compute SNI	NA	NA
Social Connections and Social Isolation	How often do you attend meetings of the clubs or organizations you belong to?	Used to compute SNI	NA	NA
Social Connections and Social Isolation	Social isolation score (SNI)	0-2	NA	NA

FAMILY HEALTH CENTERS
AT NYU LANGONE

Appendix B:
Narrative Review of Screening (based on 64 participants)

FAMILY HEALTH CENTERS
AT NYU LANGONE

What did you like about this screening process? Think about the form you filled out at the doctor's office, the process you went through to find a helpful resource, and your connection with the community resource itself.

- The people are so kind
- Everyone at the clinic was nice to me. I had no problem filling out the form.
- I like how nice they were at the clinic
- I like how they are people out there trying to help others
- I like how they offer to help people like me
- I liked that it was very helpful, they were very kind. I also liked the bunch of things they offered to help, it was very informative.
- I like that they helped me
- I like the idea behind the program
- I liked that they have contacted me
- I liked the attitude of the people and the help options they recommend
- I liked the idea and how they spoke to me on the first call
- I liked the interest that all of you are trying to help me
- I liked the questions they asked and the idea how you all want to help people
- I liked their good attitude and their patience in explaining things
- Like the questions the doctor asked, not every doctor asks about social needs
- Everything was good but wasn't called
- I can't say because I didn't receive a call
- I cannot answer because they did not call me
- I do not know because they did not call me
- I don't know how to respond
- I don't know how to respond since I was not called
- Nothing because they did not call me a second time and when they called the first time, I could not respond to the call
- The service did not call me, I do not know what to say

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What did you NOT like about this screening process? What could we do better? Think about the form you filled out at the doctor's office, the process you went through to find a helpful resource, and your connection with the community resource itself.

- I did not like how the nurses were asking personal questions in a public area, I preferred if these questions were asked in a private room.
- I would like them to continue insisting on helping, because they only called once and that's it. Also more Spanish speaking people to call because they called me in English
- I do not like that they did not call me, you need to call more
- Missed the appointment and they never followed-up
- The only problem I had was the day I filled out the form, I remember my appointment was late and I wanted it earlier
- They did not contact me
- They did not help me with my problem and to help people more
- Well they did not call me and I'd like them to help me better
- Everything, there was no way to get in touch with them
- I did not like how I was not called, I think the calls should not be as far apart because I barely remember the first survey
- I did not like how they couldn't help me so much because I am [not eligible]
- I did not like that they did not call me
- I did not receive a call from them, possibly work on that
- I didn't like that the service did not call me, the service should start calling their patients
- I do not like that they did not call me to help me find English classes
- I did not like how long it took

- I liked everything about the services they provide
- Everything is good
- Everything was good
- Everything was good and nothing
- I liked everything about the program
- I liked it all
- I was fine, I liked everything

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