



2019 Best Practices Forum

Social Determinants of Health

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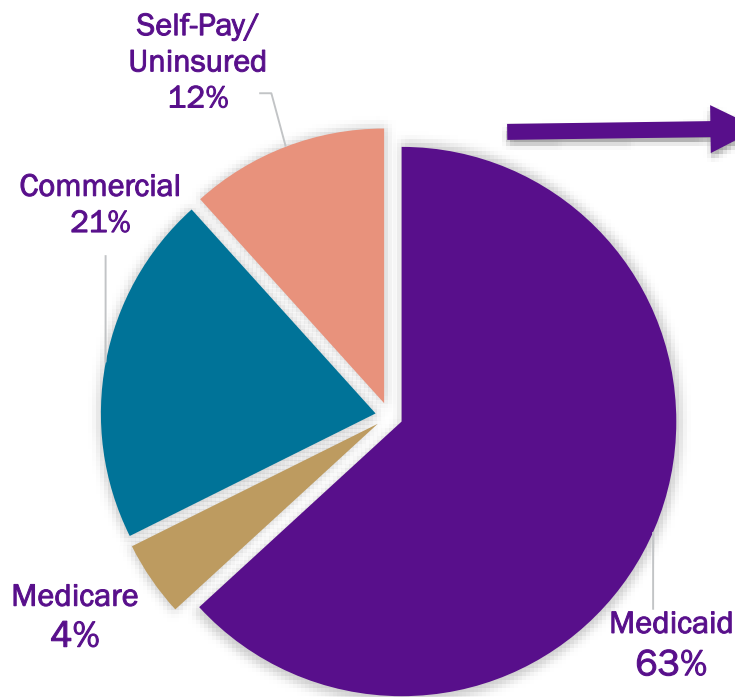
September 11, 2019

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



FHC Payor Mix



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



FHC Community Based Programs

- Continuous engagement with over 20,000 community residents through safety-net programming
 - Early childhood care and education
 - Youth development/after school programming
 - Community Development
 - Family support services
 - Services for older adults
- Oriented to needs of immigrant families from diverse origins: culturally competent, multilingual, multiple points of access, and free-of-charge

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

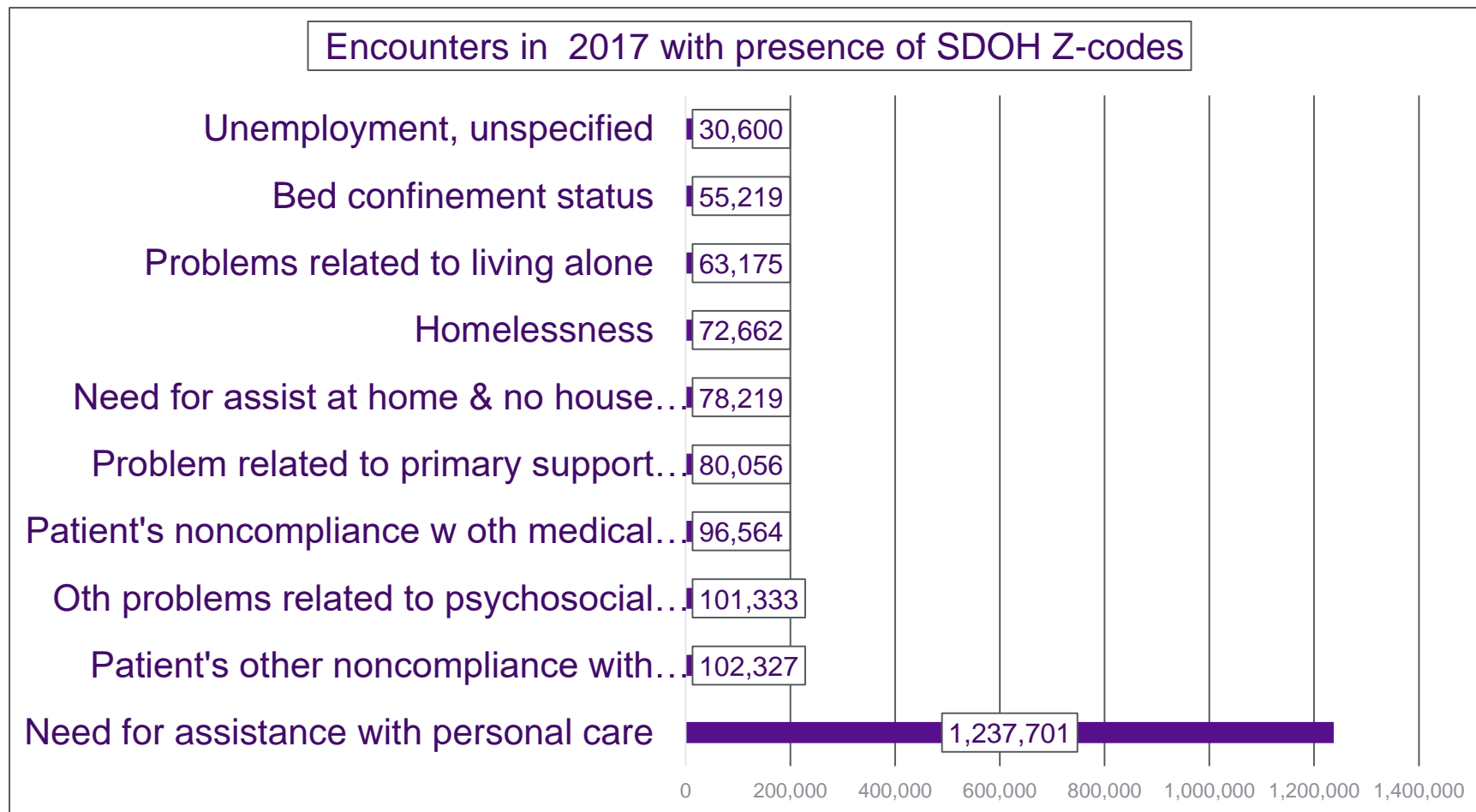
Faith Health Partnership



Z-codes as a mechanism to track SDOH

- No Current Incentive to use them
- What are current patterns of use
- What are they used for and why
- What is a useful mechanism to increase the submission of these codes

Medicaid Data Warehouse Year 2017 Most Frequent SDOH Codes (ICD-10 only)



Situation

- Given the high prevalence of socioeconomic disparities within the patient population serviced at the Family Health Centers, we sought to leverage the electronic health record to identify **Social Determinants of Health (SDH)** and automate processes for social services referral and risk adjustment.
- Project goal is to create a workflow within the EHR where SDH can be identified through standardized screening and once identified an automated referral process as well as claim capture is created



No Variance in Z codes regarding the Population Screened

ICD Z Code Description	Initial Prenatal Number of Times Z codes used	% of Z codes used	New Patient Number of Times Z codes used	% of Z codes used
Z55.3 Underachievement in school	534	27%	136	23%
Z59.0 Homelessness	24	1%	15	3%
Z59.1 Inadequate housing	230	12%	68	12%
Z59.4 Lack of adequate food and safe drinking water	207	11%	59	10%
Z59.7 Insufficient social insurance and welfare support	175	9%	73	13%
Z63.8 Other specified problems related to primary support group	93	5%	35	6%
Z72.3 Lack of physical exercise	354	18%	97	17%
Z74.2 Need for assistance at home and no other household member able to render care	69	4%	12	2%
Z75.3 Unavailability and inaccessibility of health-care facilities	209	11%	80	14%
Z91.410 Personal history of adult physical and sexual abuse	55	3%	8	1%
Grand Total	1950		583	

Background

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

OCHIN tool embedded in EPIC

OCHIN Social Determinants of Health - OCHIN Social Determinants of Health Screening

Time taken: 1440 10/12/2017 Show: ☐ Row Info ☐ Last Filed ☐ Details ☐ All Choices

+ Add Row + Add Group + Add LDA Values By + Create Note

Education and Learning

How do you learn best? ☐ Reading ☐ Listening ☐ Pictures ☐ Declined

What is the highest level of school that you have finished? ☐ Less than a high school diploma ☐ High school diploma / GED ☐ More than high school ☐ Declined

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications? ☐ Not hard at all ☐ Somewhat hard ☐ Very hard ☐ Declined

Hard to pay for: Other ☐ Yes ☐ No ☐ Declined

Housing

In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping? ☐ 1=Yes ☐ 0=No ☐ Declined

In the last month, have you had concerns about the conditions and quality of your housing? ☐ 1=Yes ☐ 0=No ☐ Declined

In the last 12 months, how many times have you moved from one home to another?

Number of positive responses to housing questions

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? ☐ 2=Often true ☐ 1=Sometimes true ☐ 0=Never true ☐ Declined

Best Practice Alert trigger SmartSet

BestPractice Advisories

This patient has screened positive on the Social Determinants of Health Assessment. Open SmartSet to refer patient to Social Work and add suggested Z code diagnosis.

Acknowledge Reason

☒ Accept (1)

Order Set with ICD 10 Capture and Referral

Social Determinants of Health Suggested Diagnosis and Referral

Social Work Referral

Social Work Referral

☒ AMB REFERRAL TO SOCIAL WORK ☐ External Referral, Routine

Diagnoses

UNDERACHIEVEMENT IN SCHOOL

☒ Underachievement in school [Z55.3]

INADEQUATE FOOD SUPPLY

☒ Lack of adequate food [Z59.4]

INADEQUATE HOUSING

☒ Inadequate housing [Z59.1]

LACK OF ACCESS TO HEALTH CARE

☒ Unavailability and inaccessibility of health-care facilities [Z75.3]

INSUFFICIENT SOCIAL INSURANCE

☒ Insufficient social insurance or welfare support [Z59.7]

HISTORY OF PHYSICAL AND SEXUAL ABUSE

☒ History of adult physical and sexual abuse [Z91.410]

LACK OF PHYSICAL EXERCISE

☒ Lack of physical exercise [Z72.3]

LACK OF FAMILY SUPPORT

☒ Lack of family support [Z63.8]

Additional SmartSet Orders

In Basket Referral

In Basket New Msg Patient Msg Refresh Edit Pools Manage Pools Settings Search Manage QuickActions Attach

My Messages

- My Incomplete Notes (1)
- My Open Charts (31)
- My Open Encounters (22)
- Pt Questionnaire
- My Unsigned Orders (3)
- Social Determinants of Health**
- WPR (Un)Merge Summary

> Social Determinants of Health Referrals 0 unread, 4 total Sort & Filter

Patient	Subject	Age	Date Receiv.	Visit
? MyChart, Ben	Positive Social Determinants of Hea...	32 y.o.	10/11/17	10/11/17
? Mychart, Diabetes	Positive Social Determinants of Hea...	51 y.o.	10/11/17	10/11/17
? HMT, AdultA	Positive Social Determinants of Hea...	22 y.o.	10/06/17	10/06/17
? Sedona, Arizona	Positive Social Determinants of Hea...	89 y.o.	10/11/17	10/11/17

Out Properties

X Done New Enc Review

Patient Demographics

Patient Name	MRN	Sex	DOB	Address	Phone
MyChart, Ben.	52049976	Male	1/13/1985	ne secOne Park Avenue South, PH8 NEW YORK NY 10010	646-754-0689 (Home)

Sent By

Provider01 Epiccare, MD
212-555-5555
360 Park Ave
New York NY 10022

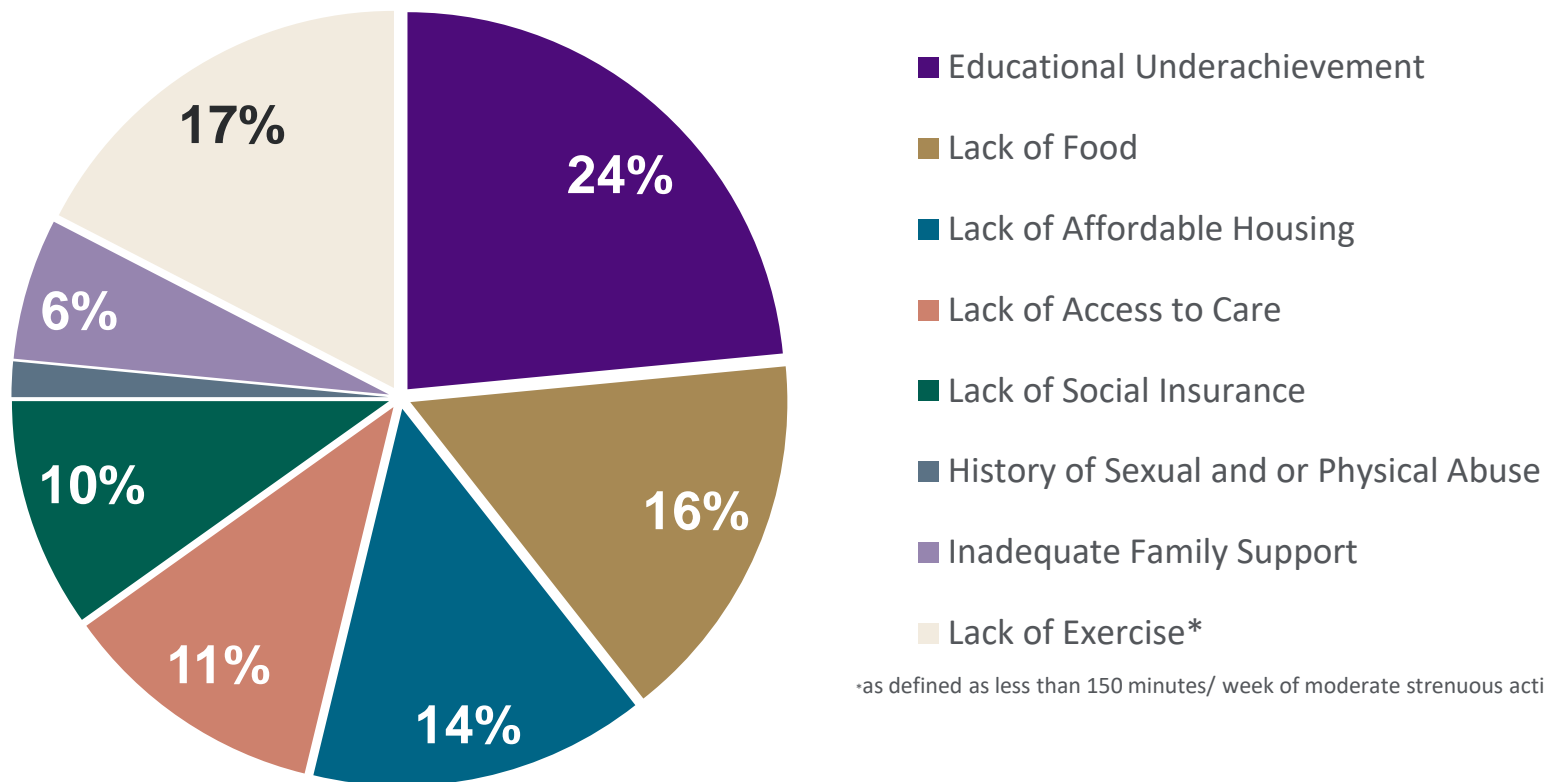
Ben MyChart has screened positive to at least one question on the OCHIN Social Determinants of Health Screening.

For review of assessment, please click on hyperlink below to navigate to the flowsheet information.

Additional Documentation

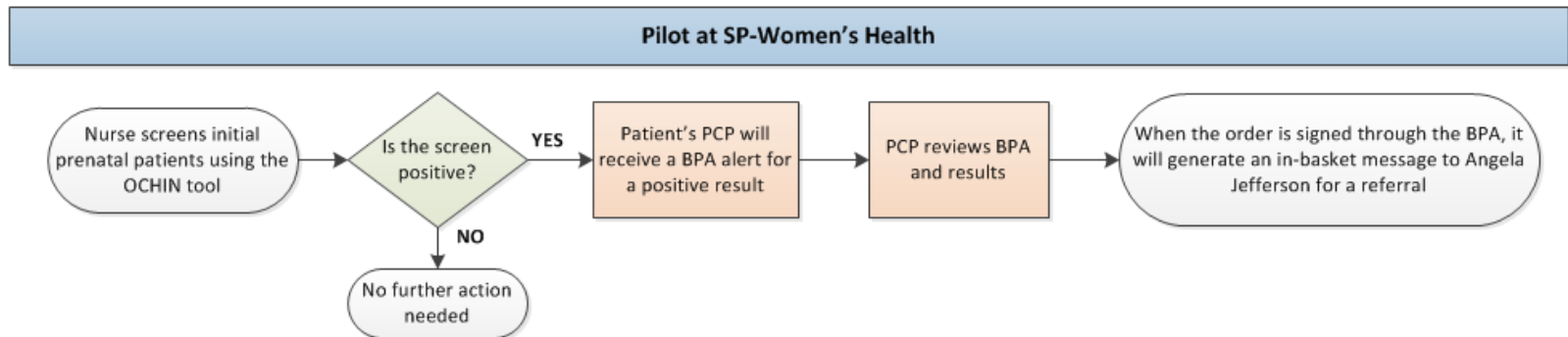
Flowsheets: [OCHIN Social Determinants of Health Screening](#)

Screen Positive Distribution for SDH



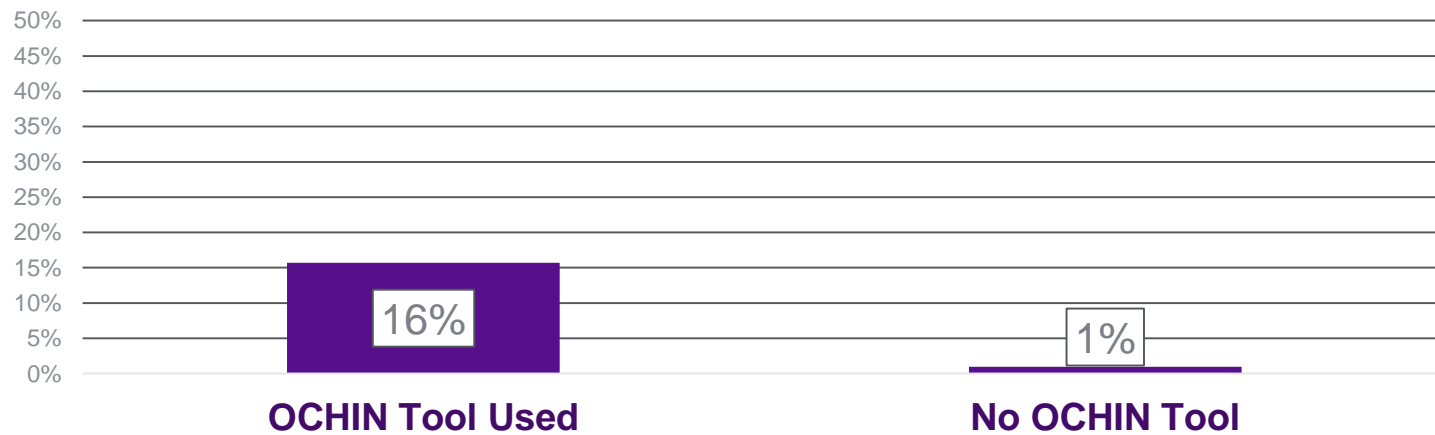
Workflow

- Staff at Women's Health Family Health Center received training on SDH by the Family Support Center Social Work and utilizing the OCHIN tool by MCIT staff



Sunset Park Family Health Center – Women's Health	Total Screened	Total Referred
Oct-17	27	4
Nov-17	82	15
Dec-17	79	11
Jan-18	82	15
Feb-18	73	11
Mar-18	65	4
Apr-18	78	7
May-18	101	10
Jun-18	46	5
Jul-18	69	12
Aug-18	91	15
Sep-18	69	13
Oct-18	35	6
Total	897	60

OCHIN Workflow increases submission of Z-codes



	OCHIN Tool Used	No OCHIN Tool Used
Z-code Submitted	141	2609
No Z-code Submitted	756	261480
Total	897	264089
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Recommendations

- Difficult lift to implement screening
- Provider value proposition is still outstanding
- Screening is about the intervention for positives
- Actual connection to resources still pending
- Cost factors still as yet undefined
- Churn management is an opportunity for limited groups (Homeless)

Pediatric Social Determinants Research

Needs Screened For:



Food Security



Adult Education



Child Supplies



Childcare



Housing Conditions



Housing Stability



Domestic Violence



Benefits



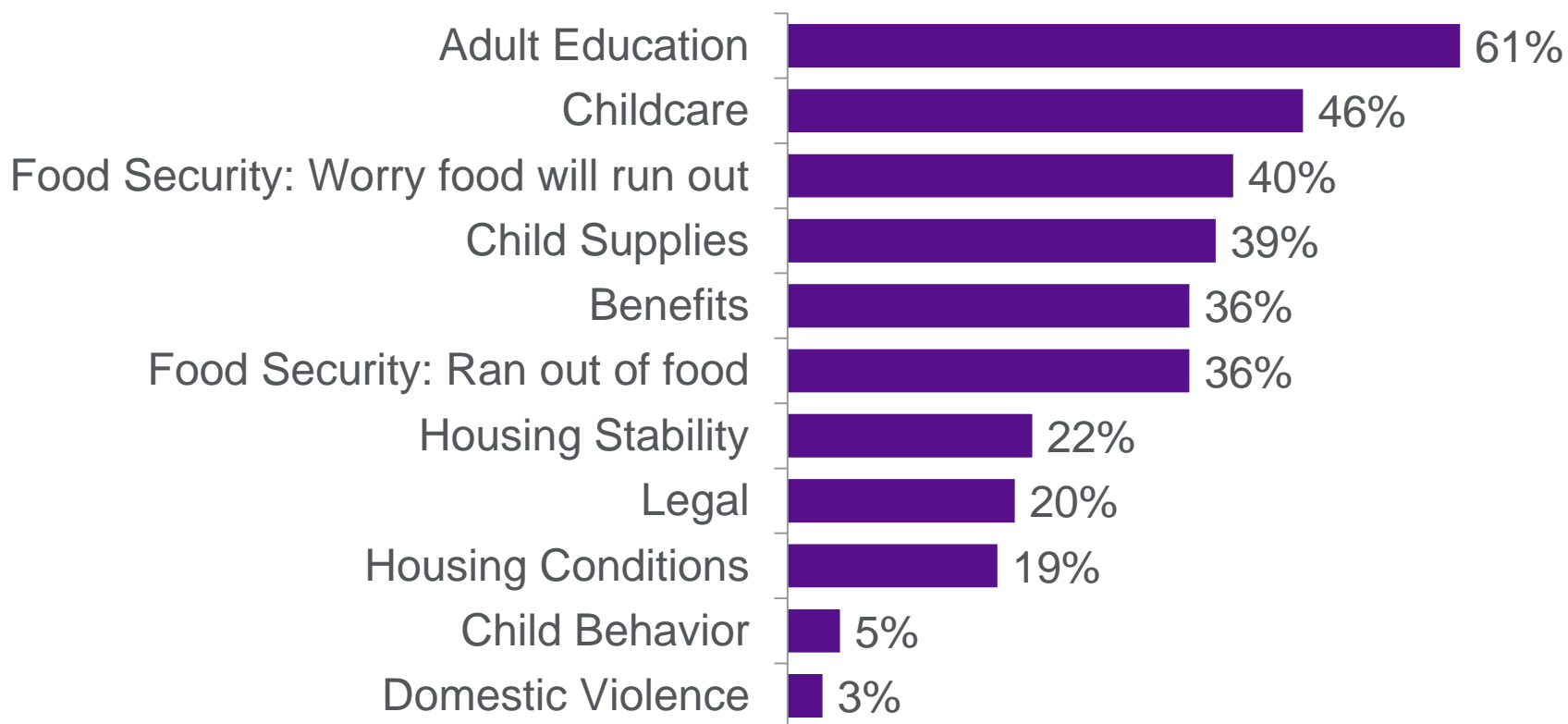
Legal



Child Development

Case Study: Pediatric Families Social Needs Screenings

In January 2018, adult education, childcare, and food security were the top needs (127 families)



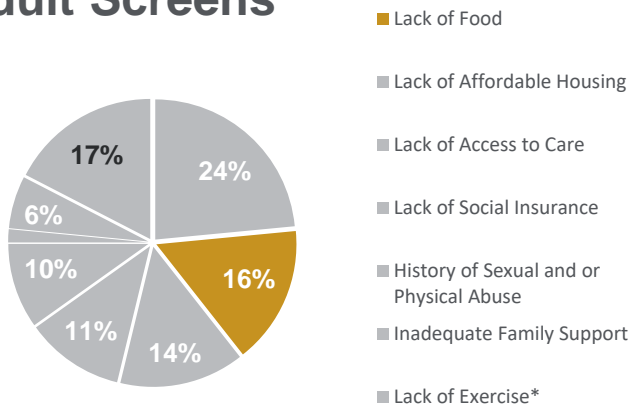
FOOD INSECURITY

SOCIAL NEEDS SCREENINGS REVEAL THAT PATIENTS STRUGGLE WITH A LACK OF FOOD

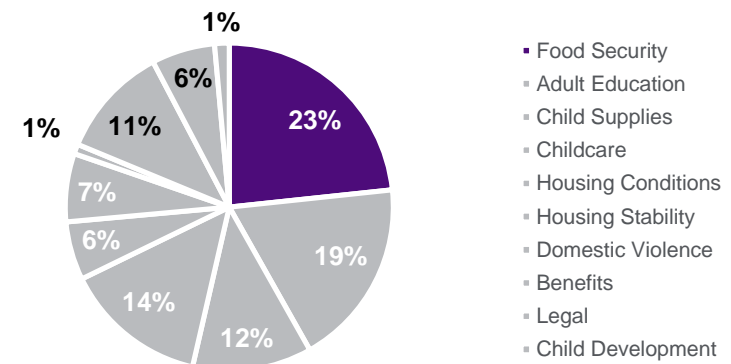
1 out of every 3 families screened

> Ran out of food in the past year and did not have money to buy more

Adult Screens



Child Screens



Food Insecurity and Health are Linked

Overview

- Food insecurity is detrimental to health and well-being.
- Can lead to poor health status, developmental risk, mental health problems, and poor educational outcomes.
- Food insecurity is especially problematic for children, as it can impact developmental growth, obesity, feeding practices and behavioral problems.
- Medical Providers play a critical 'first-responder' role to screen and identify patients who are at risk for food insecurity and connect them to programs to address food issues, before health outcomes deteriorate.



The Challenge

Sunset Park has higher than average rates of food insecurity

- Sunset Park has been identified as a community with high food insecurity in need of additional resources by the NYC Food Assistance Collaborative
- Poverty rate is 29% - nearly three times higher than the NYC average.
- Over 80% of our FHC patients experience poverty.
- 1 in 3 families screened at FHC are food insecure (see next slide for details)



IDENTIFYING & ADDRESSING FOOD INSECURITY AT A HEALTHCARE SITE



FHC at NYU Langone Response – Existing Interventions

- Universal SDOH screening for food insecurity
- On-site SNAP Enrollment and Outreach
- WIC (Women, Infant and Children) Supplemental Nutrition Program
- Emergency Food Voucher Program
- Family Support Center Food Pantry



Single Stop SNAP Enrollment Initiative

In 2018, Single Stop USA, in collaboration with the Robin Hood Foundation, awarded the Family Health Centers at NYU Langone a **\$200,000 annual grant for up to 5 years** to screen and enroll community members in Supplemental Nutrition Assistance Program, or SNAP, the federal government food stamp program.



Supplemental
Nutrition
Assistance
Program



SNAP Enrollment Model

Screening for food insecurity and SNAP enrollment has been **integrated into intake processes** across six health center sites and multiple community based programs including WIC, Healthy Families, Adult Education and Workforce, and the Faith Health Partnership.

By strategically placing food insecurity screening and SNAP enrollment within the health center, a trusted community resource, we are **increasing access to benefits** and empowering community residents to improve their nutritional health.



Single Stop SNAP Enrollment Impact

PROGRESS TO DATE:

- 1380 community residents screened
- 481 SNAP applications submitted
- The total drawdown of benefits so far is \$991,547 (average of \$2,916 per family per year)

WHO ARE WE HELPING:

The average household income of those that have been assisted is \$16,478 with an average family size of 3.



The Table Food Pantry

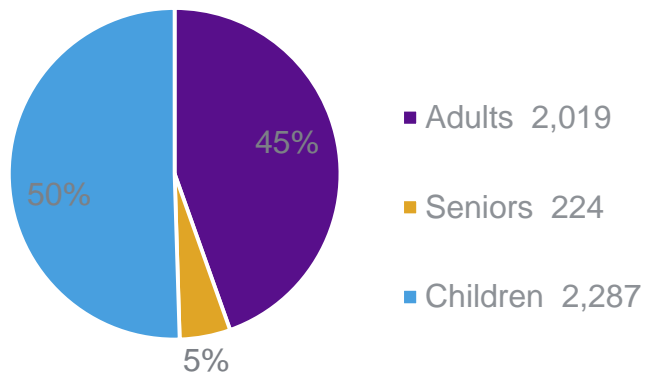
Launched in April 2019, The Table is meeting the need for emergency food services through a “client choice” model, conceptually similar to a grocery store. The Table is strategically co-located at the FHC’s Family Support Center, providing an opportunity to refer clients to the many social and health services available on-site well as through the broader Family Health Center network.



The Table Food Pantry Impact

PROGRESS TO DATE:

- Since the launch in April, the pantry has served a total of 4,530 people:



- A total food value of over \$26,220 has been distributed since April.



THANK YOU

