Memorial Healthcare System

Board Community Relations Meeting
November 2023

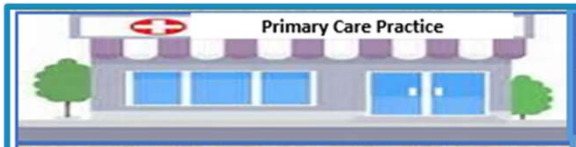
Patient story with SDOH

A 65-year-old male who has uncontrolled Diabetes, high ED utilizer 18 visits, and 24 Inpatient admissions since 2014. The patient was referred to the social worker (SW) for a home safety check. Upon meeting with the patient, the SW learned that the home was in foreclosure. When SW entered the home, it was unkempt and had newspapers all over the floor. SW also learned that the patient was not taking his insulin regimen as prescribed because he could not afford it. The SW shared this with the patient's health coach. The health coach applied for a medication assistance program through Silversripts. The patient was able to receive his medications at a discounted rate. Referral was placed for a Nurse Case Manager for chronic care and medication management education. The SW also assisted the patient with securing transportation through TOPS transportation services.

The patient was referred to Legal Aid Services to assist with his housing to see what could be done to prevent foreclosure. The attorney reviewed the case, and it was determined that there was nothing that could be done to save the house. The SW worked with MHS CS to find housing placement for him. Through CS's partnership with community landlords who provide subsidized housing, the patient was able to secure housing without any deposit.

Today, the patient is living independently, is following his medication regimen, and had only one ED visit and no Inpatient admissions in 2023.

COMMUNITY ENTRY POINT



Memorial Primary Care

PCMH
Population Health

NCQA PATIENT-CENTERED MEDICAL HOME RECOGNIZED PRACTICE

Access to Care and Information

- Same day/ Walk In Appointments
- Telehealth Visits
- Mobile Clinics
- After hour access coverage.
- Urgent Care Centers
- Home visit

Emergency Department Navigator

- Targets High ED utilizers
- Identifies barriers to alternative healthcare services
- Educates patient on alternatives to ED for non-emergent care
- Schedules appointments with PCP
- Practice Provides community resources
- Coordinates the Transition of Care

Wellness Programs

Group Visit

Integration of Primary Care and Behavioral Health

Nova Smoking Cessation Program

Glucose / BP Check

Health Fair

Food Pantry / Soup Kitchens

Health Coach

- Outreach post ED visit w/l to coordinate care
- Target High ED Utilizers
- Identifies Social Determinants of Health (SDOH) and provide resources
- Ensures compliance with HEDIS Preventive Screenings

Tools/ Partners for Managing Care

- Hospital or ED Risk % Score
- Emergency Department / Admissions, Discharges, &Transfer Notifications (ED/ADT)
- Disease Registries
- Utilization Reports
- HCC Risk Coder
- Pharmacy MTM

MPC Social Worker

- Care coordination for high risk/ complex population
- Assesses Social Determinants of Health (SDOH)
- Links patient to community resources
- Conduct home visits
- Completes forms for social services (transportation, Medicaid, financial and food assistance)

Physician/ARNP/PA Engagement

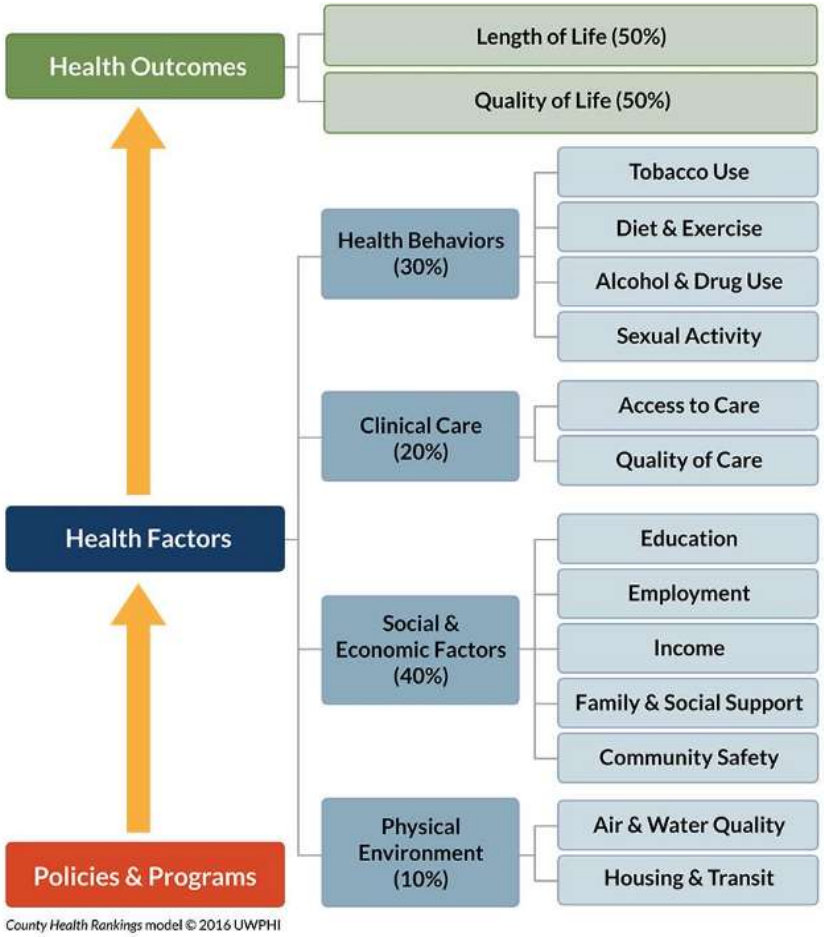
- Diagnose and treat medical conditions
- Personal connection with patients
- Provide high quality cost effective care
- Leads multidisciplinary care team
- Daily huddle
- Co-management with specialist
- Wellness Champion

Care Managers & Disease Managers

- Transitions of Care
- Chronic Disease Management
- Care Planning/ self-management
- Nurse Visits
- Multidisciplinary Case Staffing
- Compliance with HEDIS Chronic Care
- Wellness Education

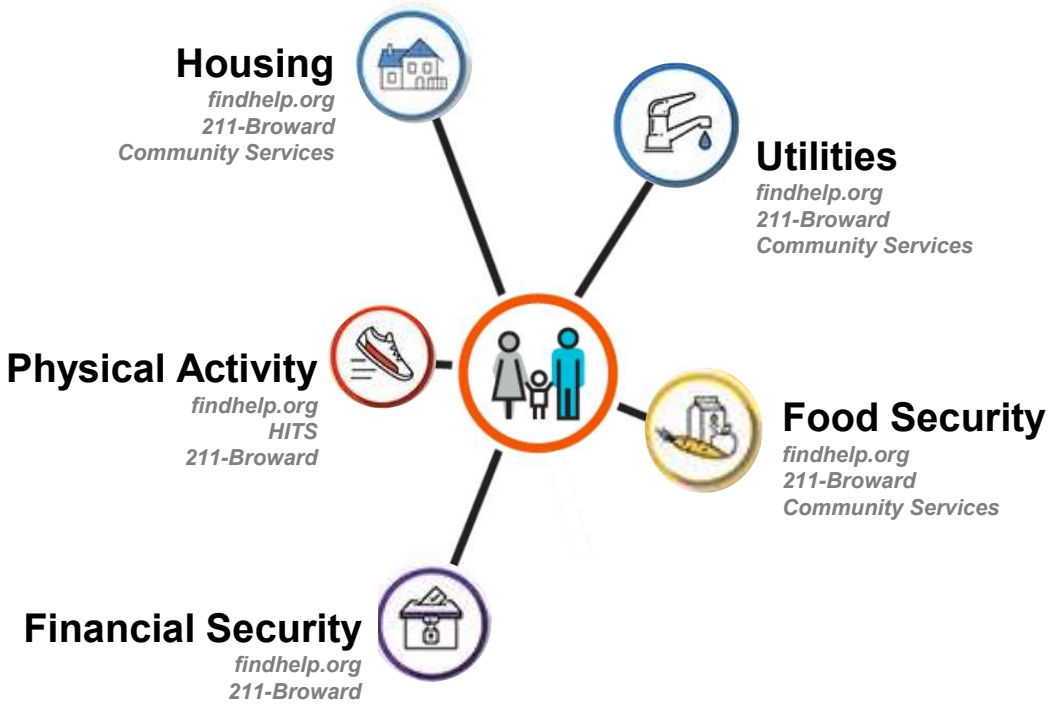
Mobile Health Centers

Addressing Social Determinants of Health Impacts Health Outcomes



1. Medical care alone is insufficient for ensuring better health outcomes.
2. SDOH are influenced by policies, systems, and environments, and when addressed, are associated with better health outcomes.
3. Addressing SDOH as a healthcare system requires adopting a new culture that values SDOH, new skill sets, realignment of resources, measurement & evaluation, and a commitment to quality and affordable healthcare.
4. We must learn to intervene without medicalizing SDOH by collaborating with existing community resources, forming/joining community partnerships, and listening to the communities we treat.

SDOH | HUB Model – Coordinated Follow-up



The Hub helps our patients navigate through the fulfillment of health-related social needs.

All screening and referral information will be DOCUMENTED IN THE EHR.

CS HUB | What we do

Housing | Utilities | Food Insecurity | Financial Strain | Social Connections

- Break down every barrier to meet the needs of the patient/family
- Connect patients and families with community resources at no/low cost
- Assist in completion of benefit applications, including Medicaid, Medicare, Kidcare, SSVF, SSI, SNAP (food stamps), housing and utility assistance, employment, free/reduced lunch, school/education, transportation assistance, and more.
- Develop resumes, assist patients seeking employment
- Home visitation, when necessary

CS HUB | Program Evaluation

- SDOH/Pop Health team will leverage all documentation in Epic and any external claims data to evaluate the impact of the CYS HUB intervention on populations serviced by the HUB.
- Outcomes data to be evaluated *(with REAL and SOGI for disparity comparisons)*:
  - Readmissions
  - ED Visits
  - PCP Visits
  - Total of Cost of Care

MHS OCAT Sponsorships/Partnerships Impact

Education Access and Quality

BROWARD EDUC. FOUNDATION

- Book bags to OCAT schools
- Innovative teaching grants
- Scholarships to HS students in OCAT schools

MHS SCHARLORSHIPS

- $2,500 scholarship to six NP partners servicing at risk youth
- 5 Scholarships to OCAT Cities in FY25

Economic Stability

ARC Broward

- Workforce Pipeline for MHS (adults with disabilities)

Job Fairs:

- Koinonia, Dania Bch
- Broward Partnership/Homeless

Health Care Access and Quality

YMCA

- Health Education Classes
- Sports safety & Rehab

Social and Community Context

COMMUNITY-BASED CONNECTIONS

- Value of Family Togetherness classes – 5 OCAT cities
- Fatherhood Role classes – 5 OCAT cities

SEARCH PROJECT WITH SCHOOLS

* On job training for adults with disabilities and pipeline

Neighborhood and Built Environment

FLIPANY

- Nutrition Classes
- Cooking Classes
- Donate 2 weeks of food
- 2 OCAT Cities

WOMEN IN DISTRESS

- Teen Dating Violence Education
- Domestic Violence Support
- Training for MHS clinical staff

MHS Sponsorships' Impact on SDoH

Early Childhood Development and Education	Financial Literacy	Health Care Access and Quality	**Social and Community Context**	Neighborhood and Built Environment
• High School Graduation • Higher Education/ Vocational Education • Language and Literacy	• Employment • Medical Bills/Insurance	• Access to Health Services • Access to Primary Care/Well Care • Health Literacy	• Civic Participation • Discrimination • Disabilities • Incarceration • Family Strength • Social Cohésion	• Access to Healthy Foods • Crime and Violence • Environmental Conditions • Quality of Housing

Memorial Healthcare System

Questions?