Sixteenth Street
AT THE HEART OF OUR HEALTHY COMMUNITY

Sixteenth Street & CUPH: Partnering to Address Community SDOH

CUPH 20th Anniversary Seminar Series

July 15, 2022

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Rosamaria Martinez

VP of Community Health Initiatives

SSCHC

Anna Klonowski

SDoH Integration & Outreach Manager

SSCHC

Michelle Corbett

Researcher/Evaluator

CUPH

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In This Presentation

- Spotlight On: Social Determinants of Health
- Project Background & Evaluation
- Implementation Model
- Learning from the Data
- Community Impact: Looking Forward

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Spotlight On: Social Determinants of Health

Rosamaria Martinez | *VP of Community Health Initiatives*

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Sixteenth Street Mission

To improve the health and well-being of Milwaukee and surrounding communities by providing quality, family-based health care, health education and social services, free from linguistic, cultural and economic barriers.

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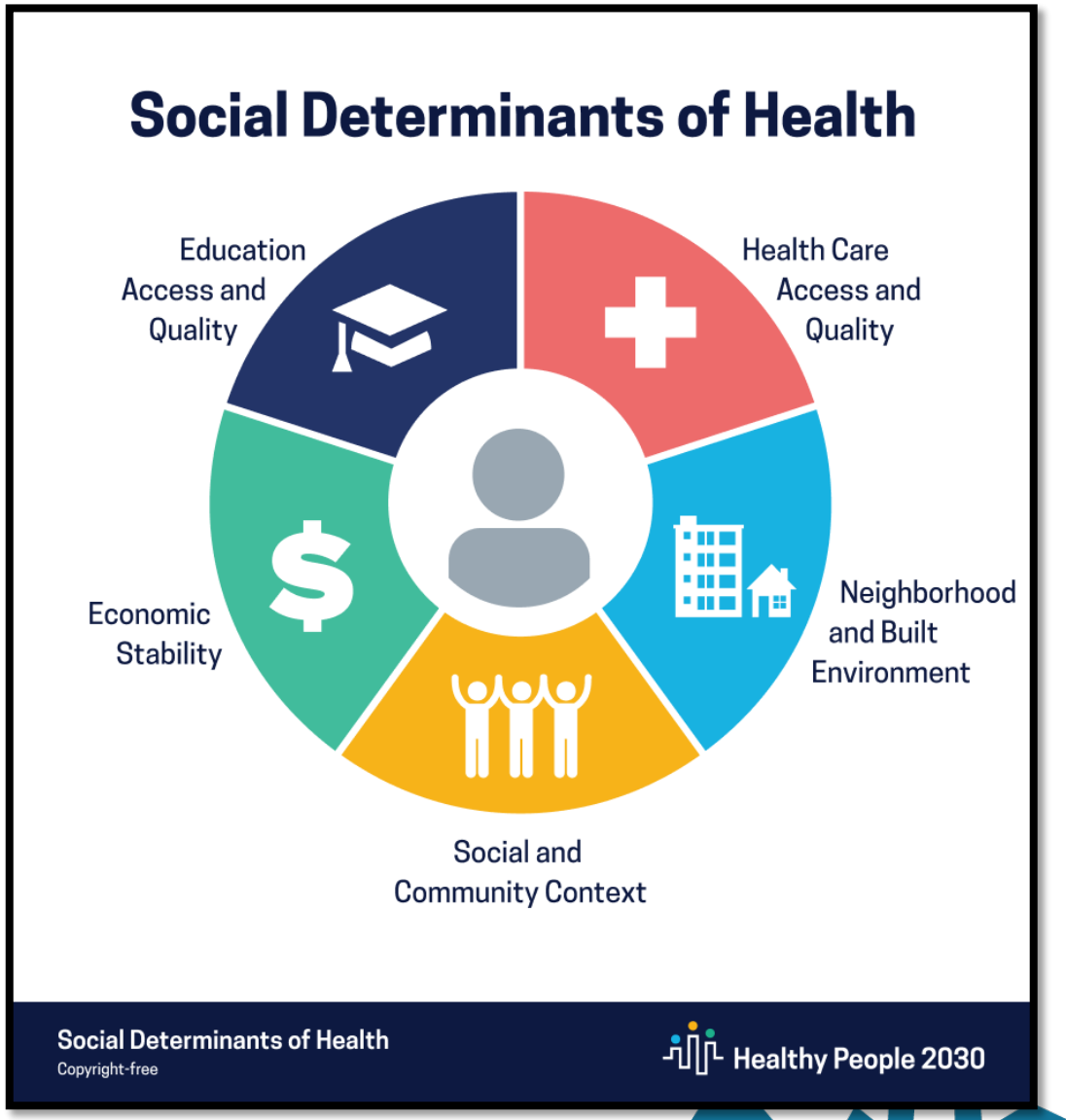
Expanding our Idea of Healthcare

Who is Using SDoH?

- World Health Organization
- Centers for Disease Control
- Medical providers & organizations
- Funders

Where Does It Come From?

- Psychosocial models of care



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HEAR FROM OUR PATIENTS

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https://www.youtube.com/watch?v=SqhdeuKa9QQ

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Project Background

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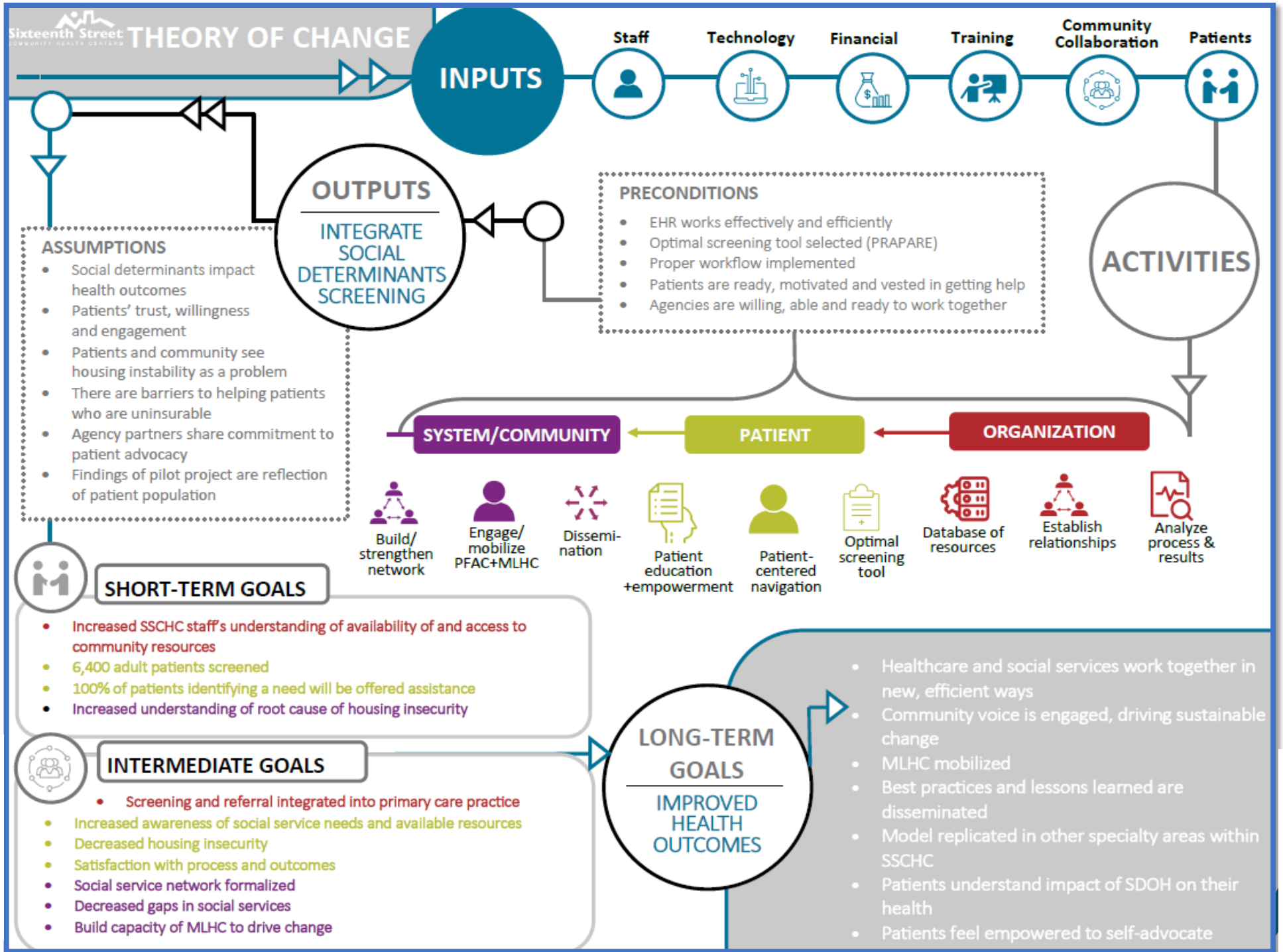
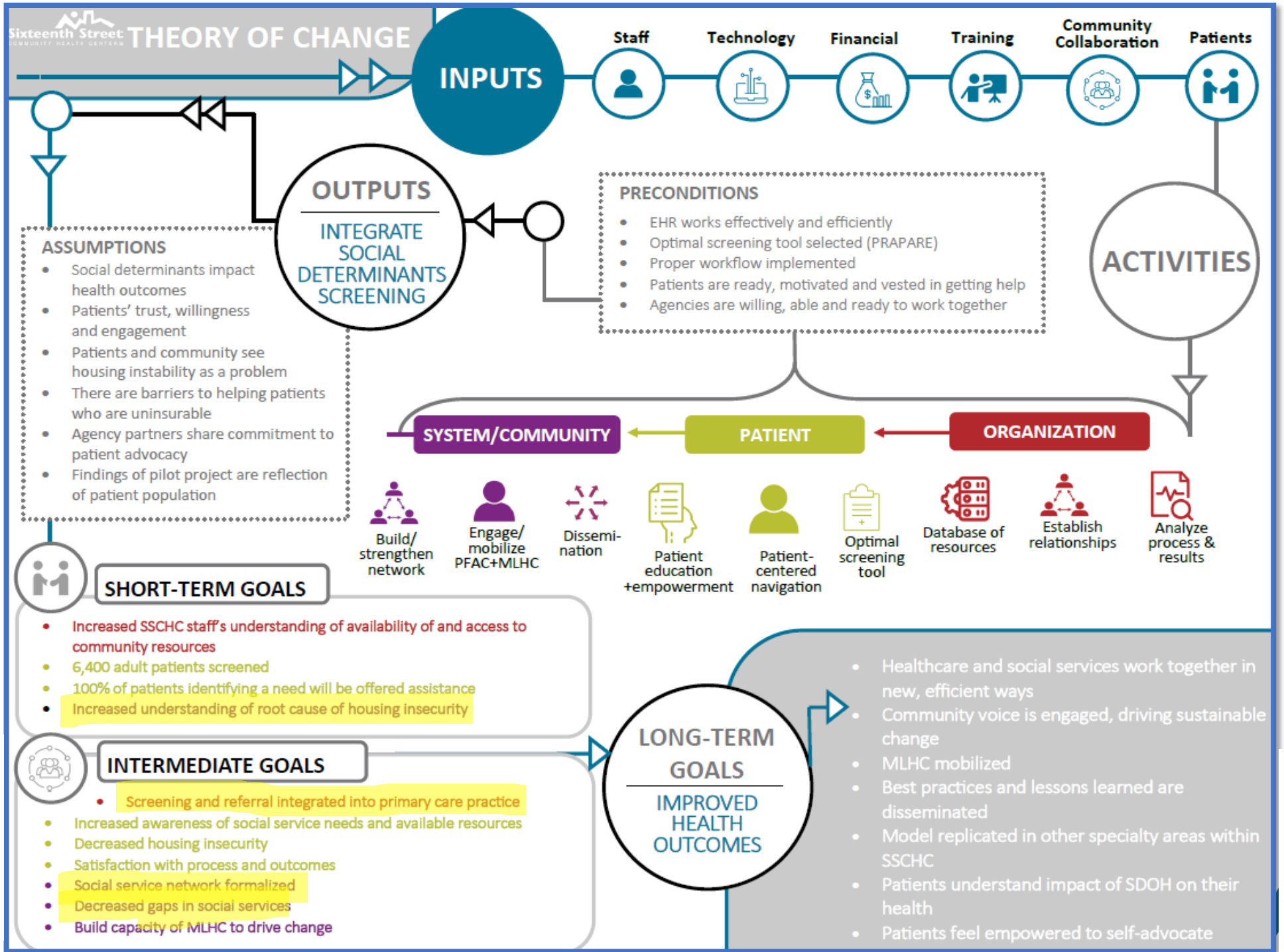

Sixteenth Street Community Health Centers
THEORY OF CHANGE
INPUTS
Staff
Technology
Financial
Training
Community Collaboration
Patients
OUTPUTS
INTEGRATE SOCIAL DETERMINANTS SCREENING
ASSUMPTIONS
Social determinants impact health outcomes
Patients' trust, willingness and engagement
Patients and community see housing instability as a problem
There are barriers to helping patients who are uninsurable
Agency partners share commitment to patient advocacy
Findings of pilot project are reflection of patient population
PRECONDITIONS
EHR works effectively and efficiently
Optimal screening tool selected (PRAPARE)
Proper workflow implemented
Patients are ready, motivated and vested in getting help
Agencies are willing, able and ready to work together
ACTIVITIES
SYSTEM/COMMUNITY
PATIENT
ORGANIZATION
Build/ strengthen network
Engage/ mobilize PFAC+MLHC
Dissemi-nation
Patient education +empowerment
Patient-centered navigation
Optimal screening tool
Database of resources
Establish relationships
Analyze process & results
SHORT-TERM GOALS
Increased SSCHC staff's understanding of availability of and access to community resources
6,400 adult patients screened
100% of patients identifying a need will be offered assistance
Increased understanding of root cause of housing insecurity
INTERMEDIATE GOALS
Screening and referral integrated into primary care practice
Increased awareness of social service needs and available resources
Decreased housing insecurity
Satisfaction with process and outcomes
Social service network formalized
Decreased gaps in social services
Build capacity of MLHC to drive change
LONG-TERM GOALS
IMPROVED HEALTH OUTCOMES
Healthcare and social services work together in new, efficient ways
Community voice is engaged, driving sustainable change
MLHC mobilized
Best practices and lessons learned are disseminated
Model replicated in other specialty areas within SSCHC
Patients understand impact of SDOH on their health
Patients feel empowered to self-advocate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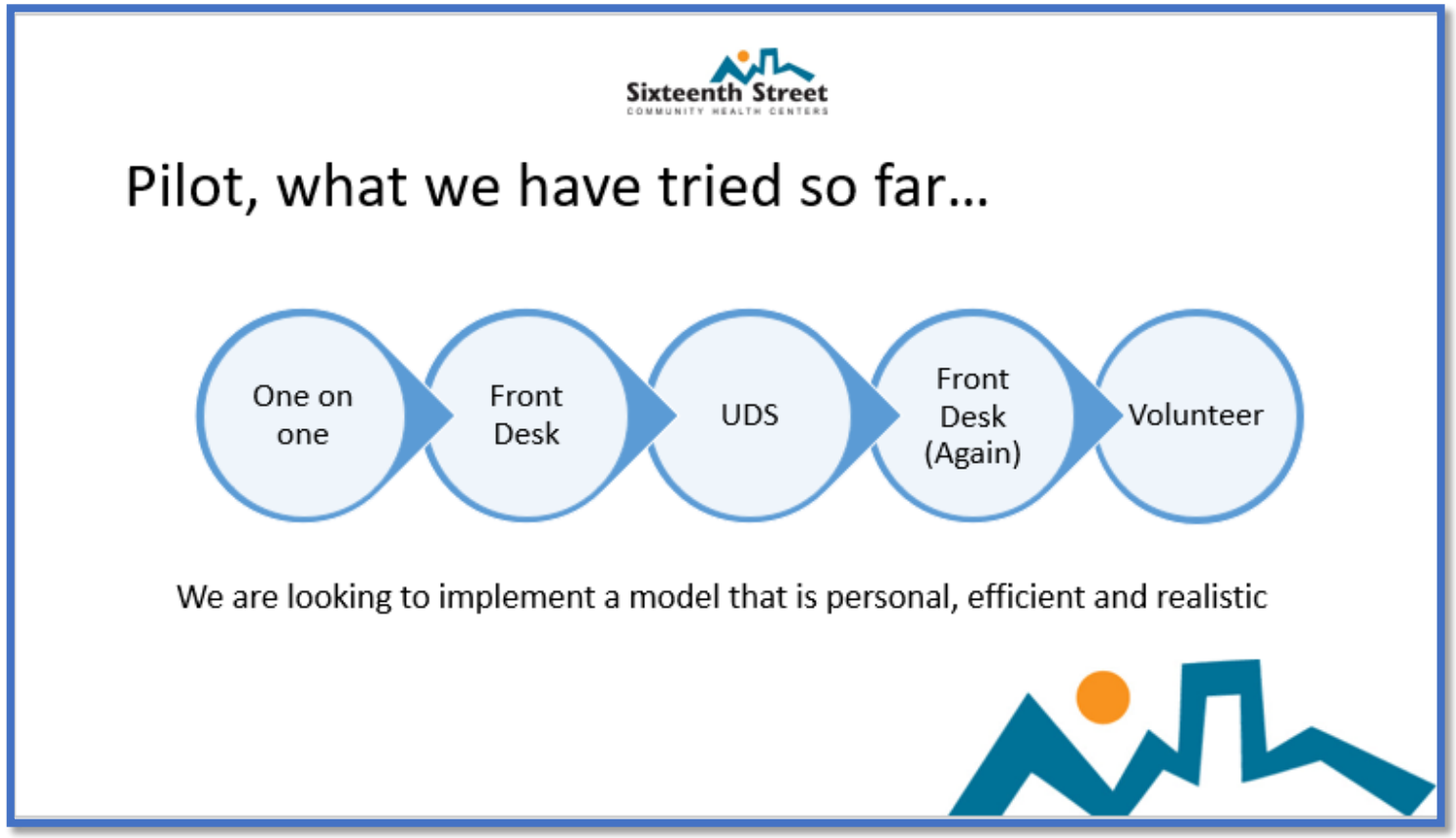
Planning & Pilot

How should we screen patients?

- Waiting room
- Front desk
- Appointment

Who should screen patients?

- SSD staff members
- Volunteers
- Patient fills out form



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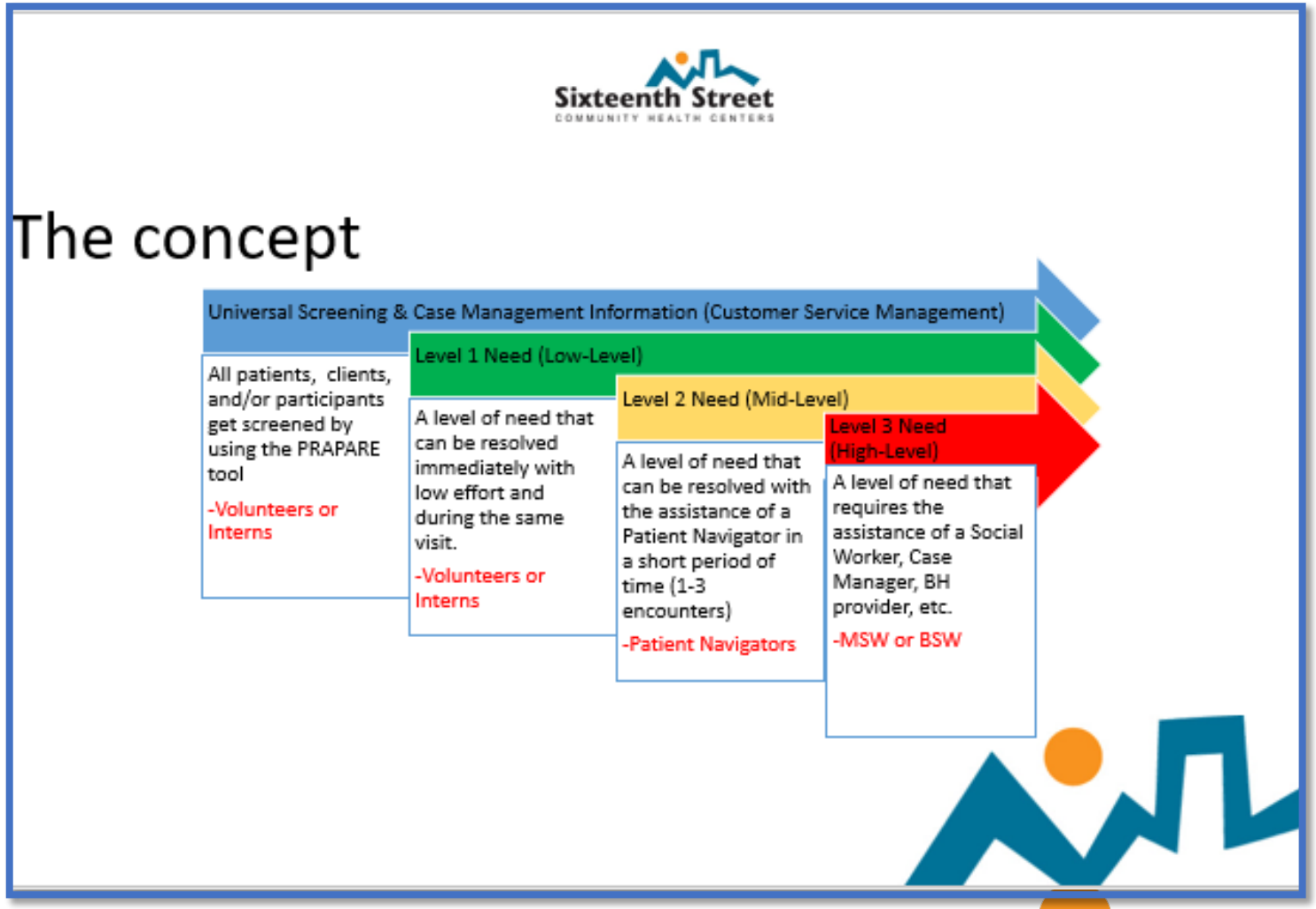
Planning & Pilot

Planning and pilot: 2017-2018

Addressing:

- Understanding patient social needs
- Adapting SSD staffing to best meet patient needs
- Reducing housing insecurity for patients



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Funding

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

Wisconsin Partnership Program

"Community Impact Grants provide up to $1 million over five years to support large-scale, evidence-based, systems and/or environmental changes that will improve health, health-equity, and well-being in Wisconsin."

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Improving Health Outcomes by Proactively Integrating Social Determinants Screening into Primary Care Practice

Sixteenth Street Community Health Centers

Presented by:
Dr. Julie Schuller, President and CEO, Sixteenth Street Community Health Centers
A. Michelle Corbett, MPH, CHES, Associate Researcher, UW Center for Urban Population Health

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Project Evaluation

Michelle Corbett | *Researcher/Evaluator*

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Evaluation Approach

Responsive
Utilization-Focused
Equity-Driven
Continuous
Intentionally Engaged

Implementation/Process

- *Informs:* Decision-making, program development, quality improvement, stakeholder engagement
- *Includes:* qualitative and quantitative patient, provider, staff, volunteer, and broader stakeholder feedback, screening and referral/ resource data

Effectiveness/Outcome

- *Measures Changes*: patient and staff knowledge, skills, and self-efficacy, patient needs, system relationships, SSCHC and system resources

.40 FTE Staffing
Interns @700 hrs. to date

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Implementation Model

Anna Klonowski | *SDoH Integration & Outreach Manager*

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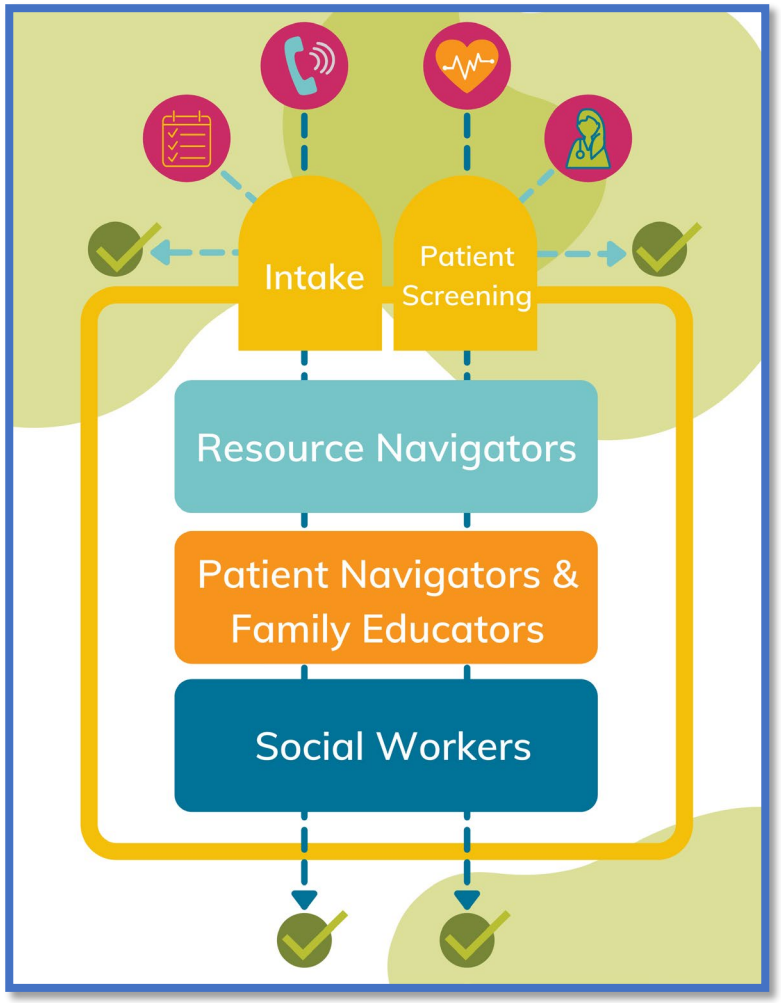

Scope of Services

•Resource Navigators

- Clothing
- Food
- Social Isolation
- Referrals

•Patient Navigators

- Transportation
- Phone Access
- Utilities Assistance

•Social Workers

- Housing
- Legal Services
- Domestic Violence

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Expanding Capacity

Interns & Volunteers

- Serve as Patient Screeners
- 45 interns & volunteers

HealthCorps Members

- Serve as Resource Navigators
- 11 full-time members

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Screening Form

PRAPARE Screening Tool

- National Association of Community Health Centers
- Form modified based on patient feedback
- 70% of screens occur in Spanish

Patient Label/ID #:

Name of Screener:
Date Screen Occurred:
Patient's Provider:

Social Determinants of Health Screening Tool

We are asking these questions to all our adult patients to help identify items in your life that may have an impact on your health and to connect you with resources that can help with those needs. All information you provide is strictly confidential within Sixteenth Street.

1. What is your housing situation today? (Please select one)

a. ☐I have housing (rent or own or I live with someone)	b. ☐I do not have housing (staying with others temporarily, in a hotel, in a shelter, living outside on the street, on a beach, in a car, in a park, under a bridge or in a tunnel)	c. ☐I choose not to answer

2. Are you worried about losing your housing or your current living situation?

a. ☐Yes	b. ☐No	c. ☐I choose not to answer

3. Do you feel physically and emotionally safe where you currently live?

a. ☐Yes	b. ☐No	c. ☐I choose not to answer

4. Are you afraid of your partner or ex-partner, a family member, or a person close to you?

a. ☐Yes, Partner	b. ☐Yes, another person	c. ☐No
d. ☐Unsure	e. ☐I choose not to answer	

5. Have you or the people you live with been unable to get any of the following when it was really needed?

a. ☐ No	b. ☐ Food	c. ☐ Clothing	d. ☐ Utilities
e. ☐ Child Care	f. ☐ Medicine	g. ☐ Medical Care	h. ☐ Mental Health
i. ☐ Dental	j. ☐ Vision	k. ☐ Phone	l. Transportation ☐ Medical ☐ General
m. ☐ I choose not to answer	n. ☐ Other_____		

6. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

a. ☐Less than once a week	b. ☐1 or 2 times a week	c. ☐3 to 5 times a week
d. ☐5 or more times a week	e. ☐I choose not to answer	

7. Do you have any legal needs?

a. ☐Immigration ☐Evictions ☐Detention/arrest ☐Guardianship ☐Other	
b. ☐No	c. ☐I choose not to answer

8. How stressed are you? (Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled)

a. ☐ Not at all	b. ☐ A little bit	c. ☐ Somewhat
d. ☐ Quite a bit	e. ☐ Very much	f. ☐ I choose not to answer

Thank you for your responses; we will try and contact you while you are at your appointment. If we miss you, is it ok for our Patient Navigators to contact you by phone? ☐ Yes, to this number_____. ☐ No, do not call me

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Workflow with Patient Screeners

1. Collaborative process – patient screeners work alongside the clinical team to screen patients during an already scheduled appointment
2. Minimally intrusive – screeners take advantage of natural breaks in the appointment to speak with patients about their social health (SDoH)
3. Using the universal screening tool, screeners identify patient needs and provide individualized resources and referrals to the patient based on needs identified in the screen
4. In upcoming days and weeks, patients connect with the resources and referrals they were provided during their screening

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Learning from the Data

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Community Stakeholder Perspectives

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2019 Latino Health Equity Summit Survey

10 most cited causes of “housing insecurity”.

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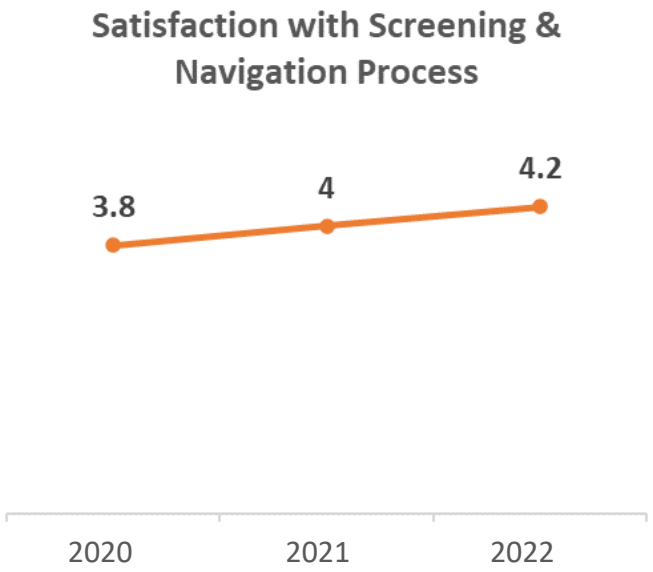
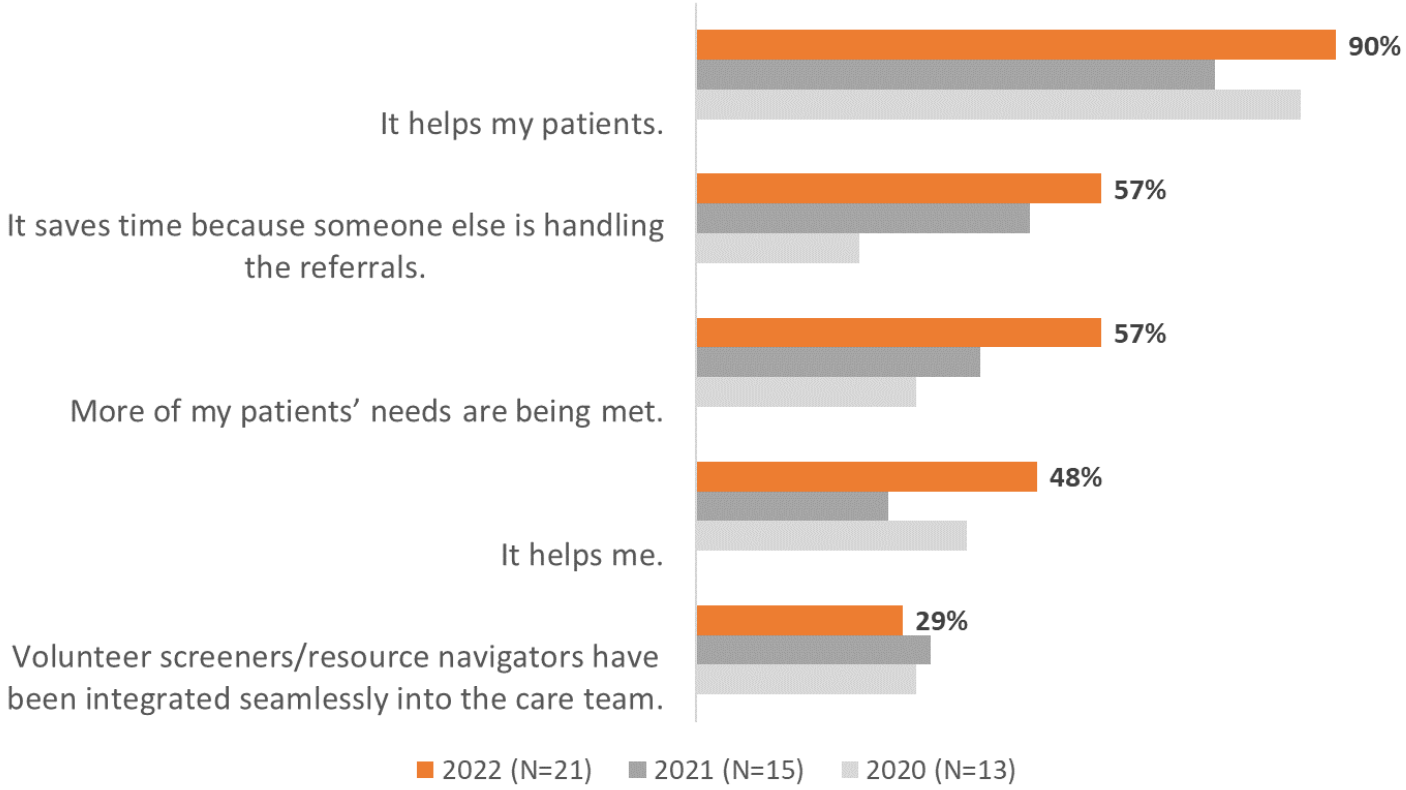
Provider/Staff Perspectives





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Provider/Staff Perspectives

On reintegrating in-person screening "post-COVID"...

"Thinking about your patients, position and responsibilities, and general clinic workflow, how well would each work?"

1 = Not at all - 5 = Extremely well

Protocol	SDoH Screening Experience (n=14)	No SDoH Screening Experience (n=67-69)	All respondents (n=81-83)
Patient completes the screening tool independently via **myChart** prior to their medical visit.	2.43	2.67	2.63
Patient is screened by a **scheduler** when they make a medical appointment.	2.50	3.12	3.01
Patient is screened by a **facilitator** at check in for their medical appointment.	3.00	3.04	3.04
Patient completes the screening tool independently using a docked computer system at **check in** for their medical appointment.	2.36	3.13	3.00
Patient is screened during the medical appointment by a member of the **medical team**.	3.14	3.39	3.35
Patient is screened during the medical appointment by SSD volunteers/staff.	**4.50**	**3.85**	**3.96**

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2021 Most Reported Needs

17.1%
Housing Insecure
Non-Hispanic, Men,
Gay/Lesbian/Other orientation,
1 Dependent, 100% or below poverty

13.8%
Socially Isolated
Spanish-speaking,
Gay/Lesbian/Other orientation,
45-64 years

8.7%
Doesn't Feel Safe
Black, Non-Hispanic

6.6%
Legal Issues
Immigration – Hispanic, Spanish
Non-Immigration – Non-Hispanic, English

7.2%
Very Stressed
Non-Hispanic, English-speaking, Female,
Gay/Lesbian/Other orientation,
<65 years, 0-1 Dependent

5.7%
Food
Non-Hispanic,
Gay/Lesbian/Other orientation,
1 Dependent

5.7%
Dental
Reported similarly
across groups

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Housing Insecurity = ↑ Other Needs*

7.1% vs 1.8%
Vision

21.8% vs 11.9%
Socially Isolated

17.5% vs 6.9%
Doesn't Feel Safe

13.7% vs 5.2%
Legal Issues

17.1%
Housing Insecure

3.7% vs 1.1%
Transportation

3.7% vs 1.5%
Fear of Partner/Other

13.8% vs 5.8%
Very Stressed

10.2% vs 2.2%
Utilities

18.2% vs 3%
Food

12% vs 1.8%
Clothing

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*2021 screening data

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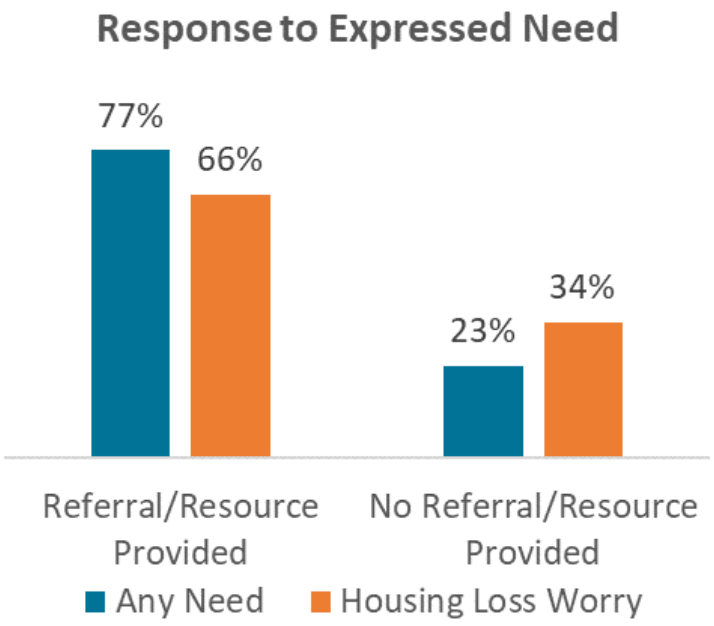
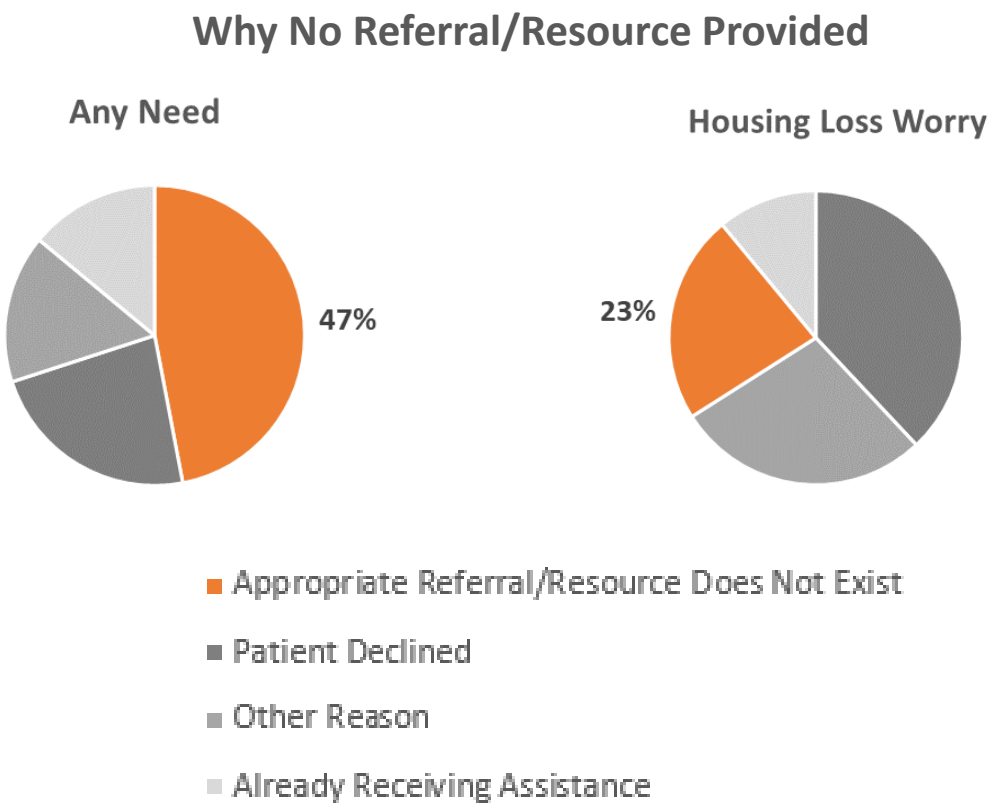
Responding to Needs*





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*May 2021 – May 2022

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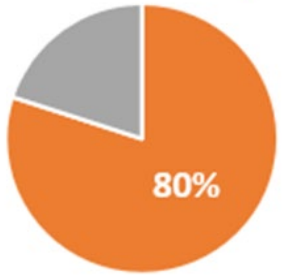
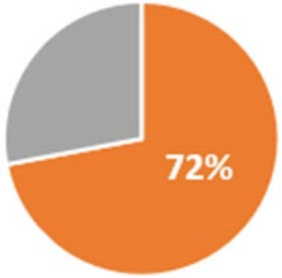
Changes in Needs*

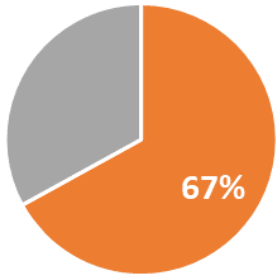
Afraid of Partner (n=39)



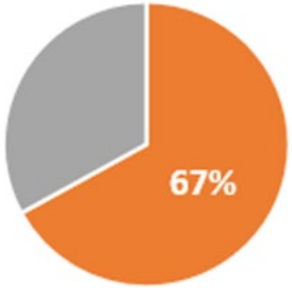
Doesn't Feel Safe (n=65)



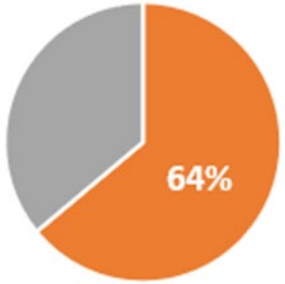
Social Isolation (n=90)



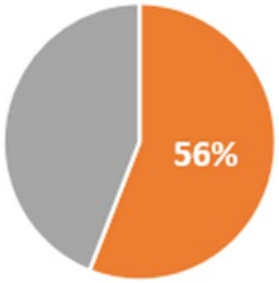
Very Stressed (n=69)



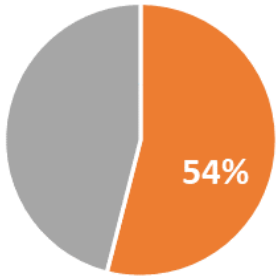
Legal (n=47)



Food Need (n=50)



Housing Insecurity (n=119)



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*% of patients with two screens between **January 2019 and May 2021** who reported the need at their first screening and ***did not*** report the need at their second screening.

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Community Impact: Looking Forward

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Partnering for Community Impact

- Benefits of CUPH partnership
- Other partnerships that support the work and move it forward
- Next steps

IMPACT Connect

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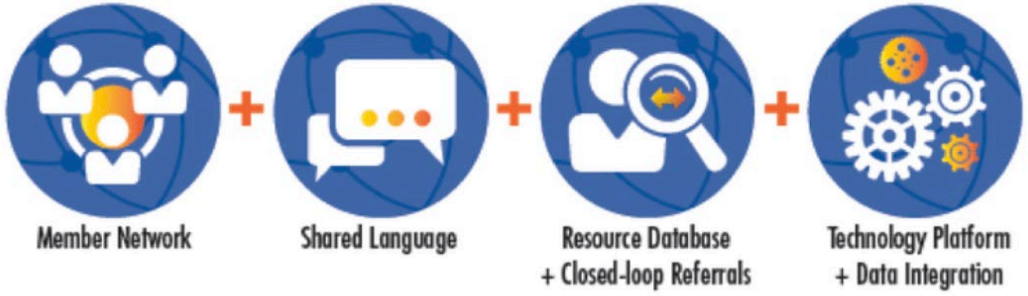
IMPACT Connect is a Community Information Exchange – a collaborative network of systems and agencies to make social services accessible and navigable



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Thank you!

Questions?

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