Sixteenth Street & CUPH: Partnering to Address Community SDOH

CUPH 20th Anniversary Seminar Series

July 15, 2022
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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
Spotlight On: Social Determinants of Health

Rosamaria Martinez | VP of Community Health Initiatives
Sixteenth Street Community Health Centers
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.
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
HEAR FROM OUR PATIENTS

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

Rosamaria Martinez | VP of Community Health Initiatives
Sixteenth Street Community Health Centers
Planning & Pilot

How should we screen patients?
- Waiting room
- Front desk
- Appointment

Who should screen patients?
- SSD staff members
- Volunteers
- Patient fills out form

Pilot, what we have tried so far...

We are looking to implement a model that is personal, efficient and realistic.
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
Funding

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.”

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
Project Evaluation

Michelle Corbett | Researcher/Evaluator

Center for Urban Population Health
Effective/Outcome

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

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

Evaluation Approach

Responsive
Utilization-Focused
Equity-Driven
Continuous
Intentionally Engaged

.40 FTE Staffing Interns @700 hrs. to date
Implementation Model

Anna Klonowski | SDoH Integration & Outreach Manager
Sixteenth Street Community Health Centers

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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
Expanding Capacity

Interns & Volunteers
• Serve as Patient Screeners
• 45 interns & volunteers

HealthCorps Members
• Serve as Resource Navigators
• 11 full-time members
Screening Form

PRAPARE Screening Tool

• National Association of Community Health Centers

• Form modified based on patient feedback

• 70% of screens occur in Spanish
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
Learning from the Data

Michelle Corbett | Researcher/Evaluator
Center for Urban Population Health
Community Stakeholder Perspectives

2019 Latino Health Equity Summit Survey
10 most cited causes of “housing insecurity”.

Low wages/low income

Systemic racism/discrimination

Government policies

Segregation

High rent/lack of affordable units

Legal/immigration status

Poverty

Job instability

Neighborhood safety

Landlord practices
Provider/Staff Perspectives

Satisfaction with Screening & Navigation Process

- It helps my patients: 90%
- It saves time because someone else is handling the referrals: 57%
- More of my patients’ needs are being met: 57%
- It helps me: 48%
- Volunteer screeners/resource navigators have been integrated seamlessly into the care team: 29%

2022 (N=21)  2021 (N=15)  2020 (N=13)
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

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

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2021 Most Reported Needs

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

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

- **Doesn’t Feel Safe**: 8.7%
  - Black, Non-Hispanic

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

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

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

- **Dental**: 5.7%
  - Reported similarly across groups
Housing Insecurity = \uparrow \text{Other Needs*}

- 7.1% vs 1.8% Vision
- 21.8% vs 11.9% Socially Isolated
- 17.1% Housing Insecure
- 17.5% vs 6.9% Doesn’t Feel Safe
- 3.7% vs 1.1% Transportation
- 10.2% vs 2.2% Utilities
- 18.2% vs 3% Food
- 13.7% vs 5.2% Legal Issues
- 12% vs 1.8% Clothing
- 3.7% vs 1.5% Fear of Partner/Other
- 13.8% vs 5.8% Very Stressed

*2021 screening data

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Responding to Needs*

Response to Expressed Need

- Referral/Resource Provided: 77%
- No Referral/Resource Provided: 23%

Why No Referral/Resource Provided

- Any Need: 47%
- Housing Loss Worry: 23%

- Appropriate Referral/Resource Does Not Exist
- Patient Declined
- Other Reason
- Already Receiving Assistance

*May 2021 – May 2022
Changes in Needs*

- Afraid of Partner (n=39): 80%
- Doesn't Feel Safe (n=65): 72%
- Social Isolation (n=90): 67%
- Very Stressed (n=69): 67%
- Legal (n=47): 64%
- Food Need (n=50): 56%
- Housing Insecurity (n=119): 54%

*% 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.
Community Impact: Looking Forward

Rosamaria Martinez | VP of Community Health Initiatives
Sixteenth Street Community Health Centers
Partnering for Community Impact

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

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

Questions?

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