Bridging the Gap Between Primary Care Clinics and Social Services in Cuyahoga County

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June 8, 2020
Special thank you to our funders

- The Sisters of Charity Foundation
- The Saint Luke’s Foundation
- The Cleveland Foundation
- The Centers for Disease Control and Prevention – Racial and Ethnic Approached to Community Health (REACH)
- The Ohio Cardiovascular Health Collaborative (Cardi-OH)
  - The Ohio Cardiovascular Health Collaborative is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this presentation are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.
Health Improvement Partnership-Cuyahoga

- Addressing the most pressing issues impacting the health of our residents

**OUR VISION**
Cuyahoga County is a place where all residents live, work, learn, and play in safe, healthy, sustainable, and prosperous communities.

**OUR MISSION**
HIP-Cuyahoga’s mission is to inspire, influence, and advance policy, environmental, and lifestyle changes that foster health and wellness for everyone who lives, works, learns, and plays in Cuyahoga County.

**CORE VALUE**
Building opportunities for everyone in Cuyahoga County to be healthy.

Learn more at: [WWW.hipcuyahoga.org](http://WWW.hipcuyahoga.org)
State of Health - Cuyahoga County

- Ranks in the **bottom third of all 88 counties** in Ohio for residents’ health outcomes.
- Despite ranking consistently in the top 10 in the state for clinical care, our residents are not healthier.
- Significant differences in life expectancy based on race & place.
- The worst health outcomes are in our urban core.
Life expectancy differs by well over 20 years between urban core & outer ring suburbs.

35% of Cleveland Residents live in poverty.

Heart Disease Deaths: Higher rates concentrated in the urban core.

Areas populated by people of color were redlined, limiting opportunities to build wealth & health.
Cuyahoga County REACH Project

Racial and Ethnic Approaches to Community Health

- Funded by the CDC – 5 year grant
- Priority population: African-Americans
- Priority areas with:
  - At least 20% of the population below 100% of the Federal poverty level.

Focus:
Policy, systems, and environmental changes toward:

- Access and opportunity for healthy eating and physical activity
- Quality chronic disease care / Clinic to community linkages
REACH Strategies

- **Healthy Eating, Active Living (HEAL)**
  - Improve *nutrition* and access to healthier foods
    - Food Service Guidelines: food pantries/congregant meal sites/community based cafes
    - Food Systems work with small and large retailers
    - Breastfeeding program at NFP
  - Improve access to safe places for *physical activity*
    - Cleveland based protective biking network

- **Clinic to Community Linkage (CCL)**
  - Increase opportunities for chronic disease prevention and risk reduction through *clinic to community linkages*
    - Chronic Disease Self-Management Program (CDSMP) workshops
    - Training & integration of Community Health Workers
    - 211 Bidirectional Referral System
Why Bidirectional System?

- Non-medical factors influence 80% of one’s health and well-being

- Health care and social services lack an efficient way to communicate

- Few communities have implemented and evaluated a scalable model for use across multiple EHR systems
List of REACH Accomplishments

https://hipcuyahoga.org/racial-ethnic-approaches-community-health-reach/
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STAY CONNECTED

facebook.com/hipcuyahoga
@hipcuyahoga
hip.cuyahoga@gmail.com
voicemail or text 216-309-CHIP (2447)
MetroHealth J Glen Smith Referral Process

MTA triages patient

Vitals are taken

BP elevated?

MTA explains & offers 211 referral

Yes

Patient accepts referral?

MTA notifies provider

No

No further action; Pt. receives AVS

Yes

MTA or provider sends referral in Epic

Referral order prints on AVS

Provider discusses program with pt.
# United Way 2-1-1 Process

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Referral received by United Way</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Step 2</th>
<th>Specialist connects with patient to help find resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Healthy eating, active living (HEAL)</td>
</tr>
<tr>
<td></td>
<td>Disease management</td>
</tr>
<tr>
<td></td>
<td>Healthy food options</td>
</tr>
<tr>
<td></td>
<td>Asthma management</td>
</tr>
<tr>
<td></td>
<td>Increase physical activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3</th>
<th>Specialist identifies other social and economic needs and finds resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Housing</td>
</tr>
<tr>
<td></td>
<td>Utilities</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td>Clothing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4</th>
<th>Specialist schedules follow-up call</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determine if needs were met</td>
</tr>
<tr>
<td></td>
<td>Will continue to work with patient until the need is met or determined to be unresolvable by both parties</td>
</tr>
</tbody>
</table>
Eligible Clients in the Program

- 10 and under: 105
- 11-17: 78
- 18-49: 82
- 50+: 45

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 and under</td>
<td>46</td>
<td>55</td>
<td>4</td>
<td>105</td>
</tr>
<tr>
<td>11-17</td>
<td>45</td>
<td>31</td>
<td>3</td>
<td>78</td>
</tr>
<tr>
<td>18-49</td>
<td>13</td>
<td>12</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>50+</td>
<td>48</td>
<td>34</td>
<td></td>
<td>82</td>
</tr>
<tr>
<td>No Age Recorded</td>
<td>17</td>
<td>20</td>
<td>8</td>
<td>45</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>169</strong></td>
<td><strong>152</strong></td>
<td><strong>15</strong></td>
<td><strong>334</strong></td>
</tr>
</tbody>
</table>
Number of Enrolled by Week
10/18 – 6/19
Number of Enrolled by Week
10/18 – 3/20
Number of Enrolled by Week
10/18 – 4/20

Better Health Partnership
Age Distribution of Eligible Clients

2018 Q3
2018 Q4
2019 Q1
2019 Q2
2019 Q3
2019 Q4
2020 Q1
2020 Q2

0% 25% 50% 75% 100%

10 and under
11-17
18-49
50+

Better Health Partnership
Potential Needs of Clients

29% of children ≤10 yr. reported poor housing conditions (water damage, mold/mildew, sewage, standing water, cockroach)

Percent of Clients on Food Stamps

- 10 and under: 71%
- 11-17: 50%
- 18-49: 58%
- 50+: 40%
Top Referral Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Transportation</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Legal</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Income Support</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Employment</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Donations</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Education</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>
A person needing a food referral was **6.7 times more likely** to also need a recreation referral.

**1 in 4**

Of assessed clients were identified to need referrals for **food, recreation, and health care needs**
Monitoring Program Process

45% of eligible clients were reached for a 2-1-1 referral

36% of eligible clients were reached for 2-1-1 referral **AND** stayed engaged through follow-up
Of those given a referral, 81% remained engaged through follow-up, with 100% reporting either at least one need resolved or “in progress”.
On average, 3 out of 4 people have a “positive” outcome to their referral.
Estimated Impact of Referral

Proportion of people where the impact of their referral was estimated to either be “Very Helpful” or “Extremely Helpful”

3 in 4 adults

9 in 10 children
Next Steps in Evaluation

QI Projects aimed to reduce loss-to-follow-up

Linking 2-1-1 referral data with Electronic Medical Record Data
Questions???