UCI School of Medicine

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SeniorServ
Nourishing Home, Health & Heart

Using Technology to Facilitate Coordinated Care Across Clinical and Community Service Settings

Aging in America Conference

April 17, 2019

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westhealth institute

Acknowledgements

Special thanks to:
Dr. Lisa Gibbs

Team: Brenda Schmitthenner, Cheryl Hassoldt, Florence St-Onge, Sara Pashaee, Dr. Sonia Sehgal, Dr. Dara Sorkin, Dr. Dana Mukamel, Holly Hagler, Gio Corzo

Session Expectations

What to expect?

- Learn how we designed, implemented and evaluated a technology-enabled care coordination model
- Recognize possible barriers or facilitators that may apply in your organization, including those specific to technology
- Identify opportunities for you to apply some of these practices in your own organization

*Note: there will be ongoing opportunities for participation!

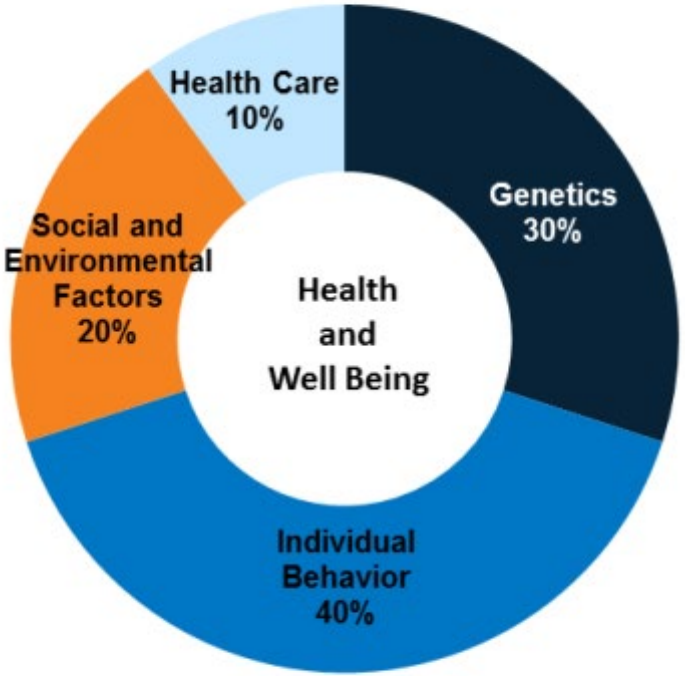
Participation!

Quick poll!

- Familiarity with terms?
  - Social determinants of health
  - Health-related social needs
  - Social prescribing

Health-Related Social Needs

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

- Social determinants of health significantly impact health and well-being across the lifespan
- Older adults are likely to have health-related social needs (HRSNs)
  - HRSNs are modifiable, individual-level risk factors
  - These can influence their ability to age in place

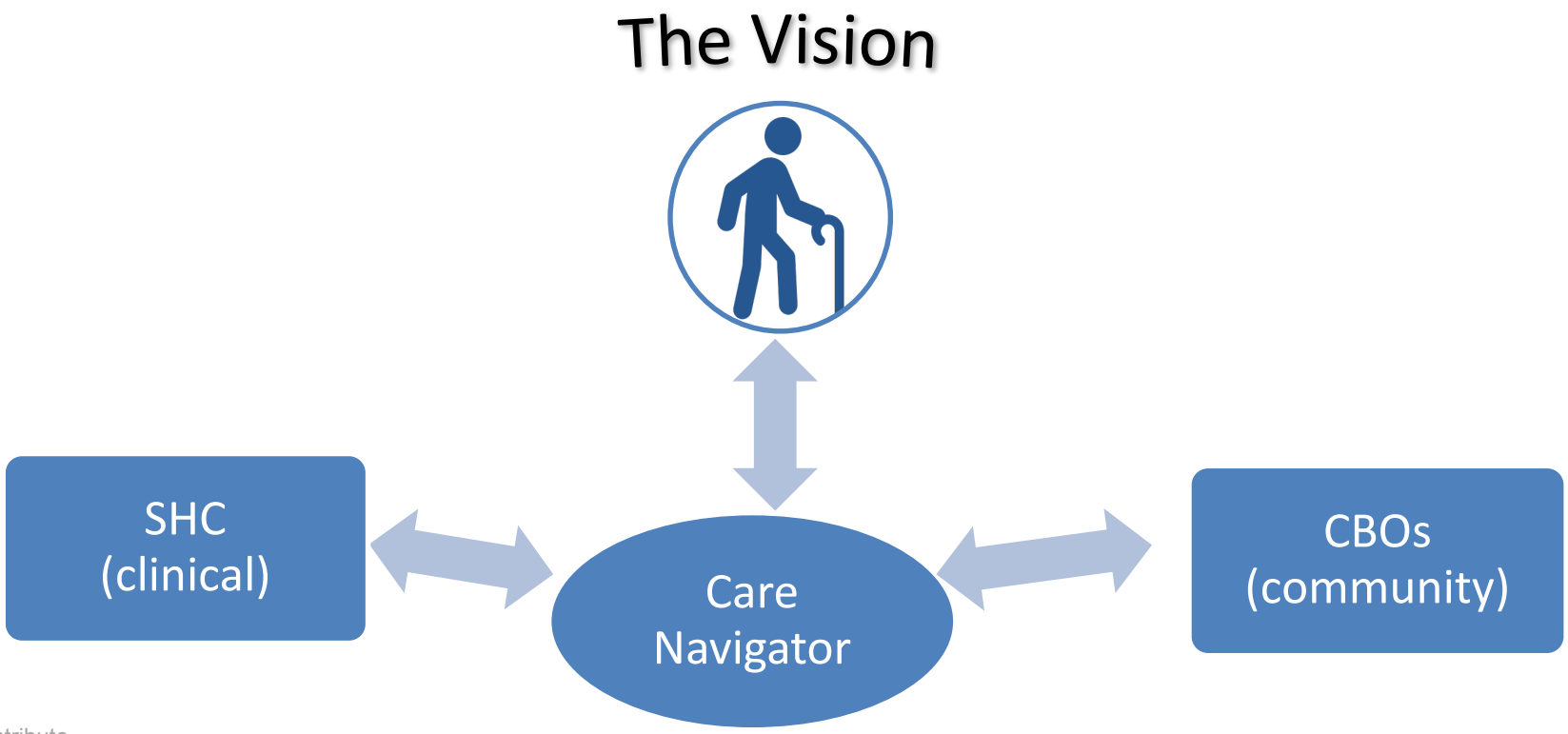
Social Prescribing

- Social prescribing: a way of identifying HRSNs in clinical settings and linking patients to the supports and services in the community
  - Delivery systems are fragmented and often siloed

Image credit: Alliance for Healthier Communities available at https://www.allianceon.org/Rx-Community-Social-Prescribing

Comprehensive Patient-Centered Care

- Goal to develop a technology-enabled care coordination model to:
  - Systematically identify HRSNs in a clinical setting
  - Address HRSNs by linking to community-based resources
  - Facilitate ongoing communication across settings in real-time

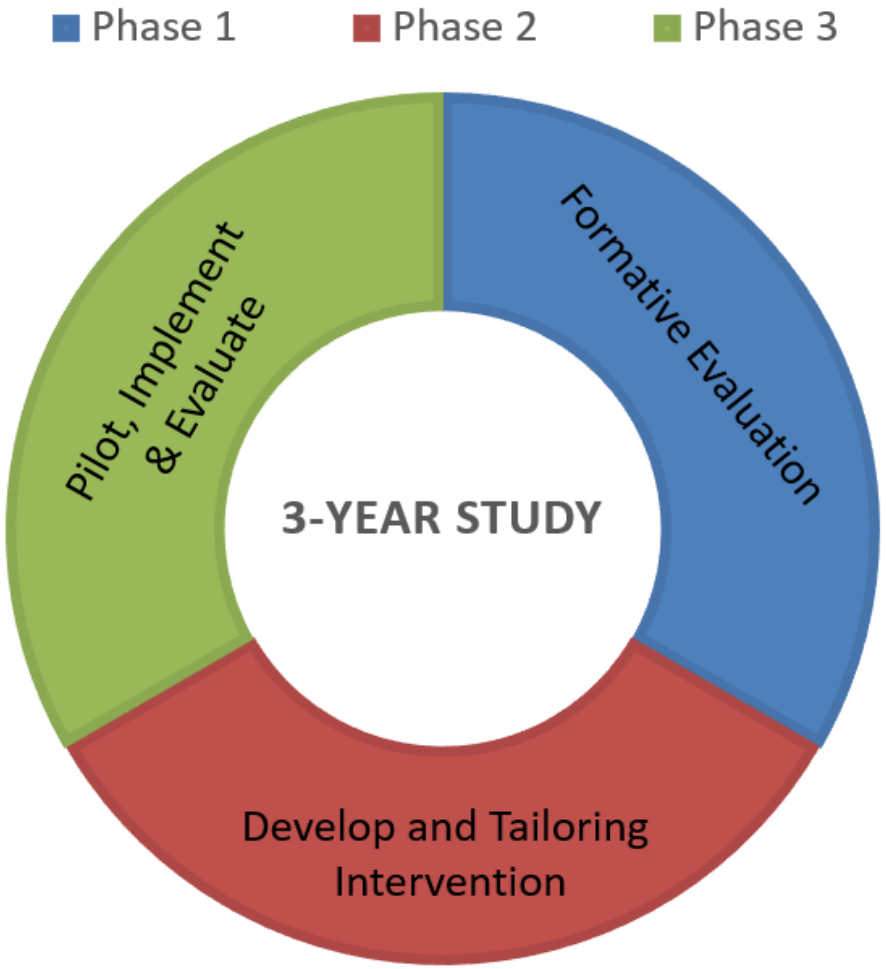


Study Background

- Key components of the 360° Caregiving Solution Model include:
  - Care Navigation using a community-based social worker
  - Systematic screening for HRSNs
  - Technology enabled connection with community supports
  - Bi-directional communication across settings

Study Details

Study Design:



Partners:

UCI School of Medicine

SeniorServ
Nourishing Home, Health & Heart

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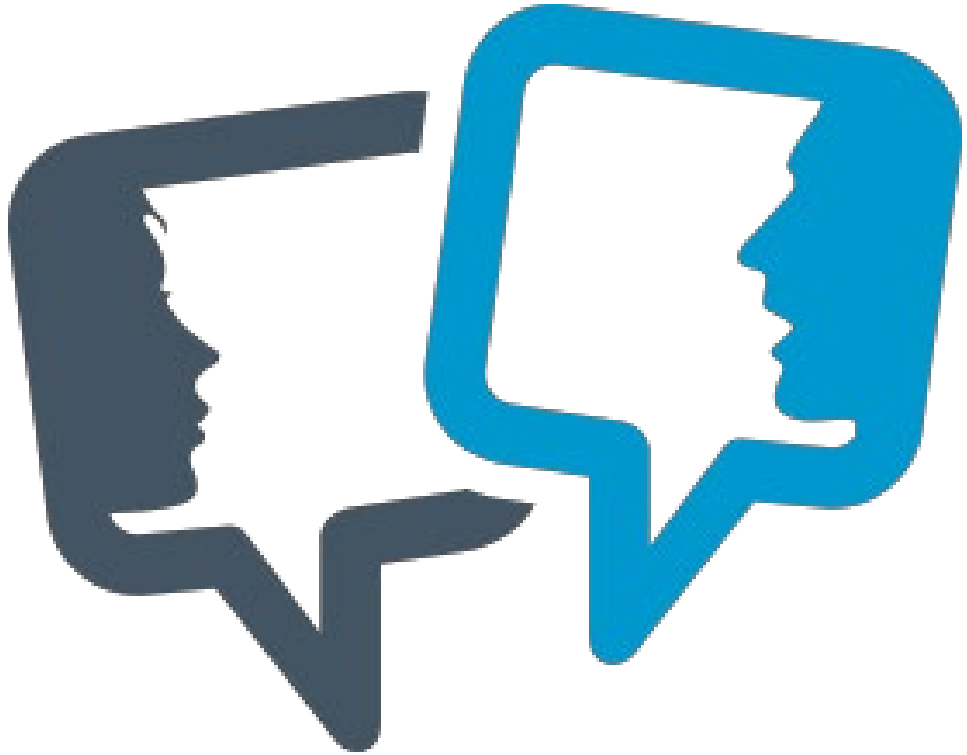
Setting:

UCI SeniorHealth Center (SHC)

PHASE 1:

Formative Evaluation to Understand the Local Context



Formative Evaluation Approach

- Methods for formative evaluation:
  - Semi-structured interviews:
    - SHC (n=7)
    - SeniorServ (n=6)
  - 2-hour focus group with SeniorServ staff (n=14)
  - 25-item survey to SHC clinical providers (n=12)
  - Patient Family Advisory Council (PFAC)

- Across efforts, participants were asked to:
  - Discuss perspectives on HRSNs
  - Describe screening and referral processes
  - Identify opportunities to improve coordination

Key Learnings: Barriers and Facilitators

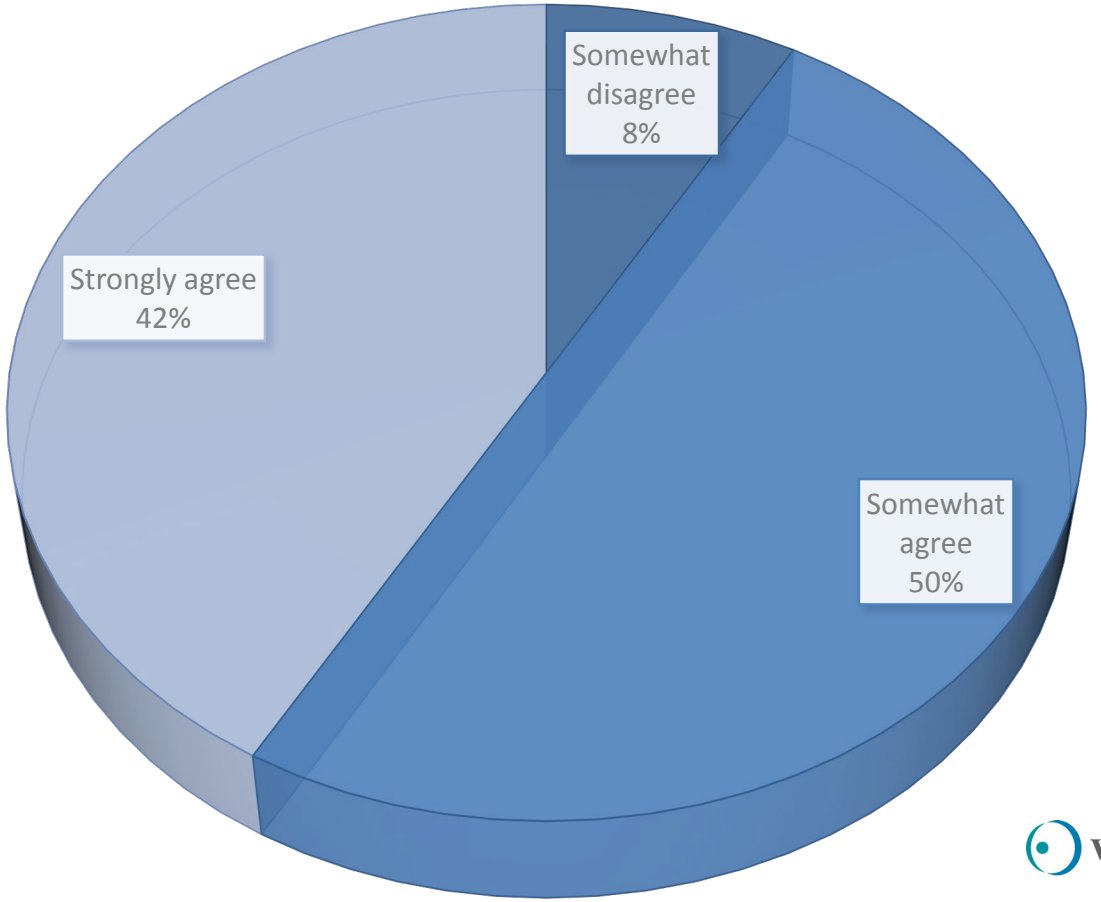
Perspective	Opportunities	Challenges
Clinical (SHC)	1. Recognized the link between social needs and health 2. Approaches to address HRSNs varied 3. Saw the value in coordinated care	1. No systematic HRSN screening 2. Limited knowledge of community-based service providers 3. Minimal communication with CBOs
Community (SeniorServ)	1. Ongoing contact with patients/clients 2. Relationships with clinical staff help communication 3. Saw the value in improved coordination with clinical staff	1. Few standardized assessments 2. Often difficult to reach clinical staff 3. HIPAA and patient privacy impede sharing patient data

Opportunity to Redesign Care Delivery for Seniors

Shared findings:

- Identify and address HRSNs
- Referral and communication
- Improve coordination
- Provide better whole-person care
  - Technology

"PATIENTS EXPRESS HEALTH CONCERNS CAUSED BY UNMET SOCIAL NEEDS THAT ARE BEYOND MY CONTROL AS A PHYSICIAN"



Participation!

With the 2-3 people around you, please discuss the following:

Does your organization currently assess for any HRSNs in your organization?

- If so, how? Is it a standardized process?
- Do you see any opportunities or benefits to standardizing the process?
- Did you experience or do you foresee any resistance or barriers?

Share out from each group

PHASE 2:

Developing and Tailoring the Intervention

Identifying and Selecting a Technology Platform

- **Conducted comprehensive scan of care coordination platforms**
  - >100 vendor products identified
  - 13 selected for further review
  - 5 assessed on set of functional requirements
  - 3 invited to conduct in-person demos

- **Key requirements included:**
  - Shared vision
  - Facilitate bilateral communication
  - Integrate with Epic (EHR)
  - HIPAA compliant

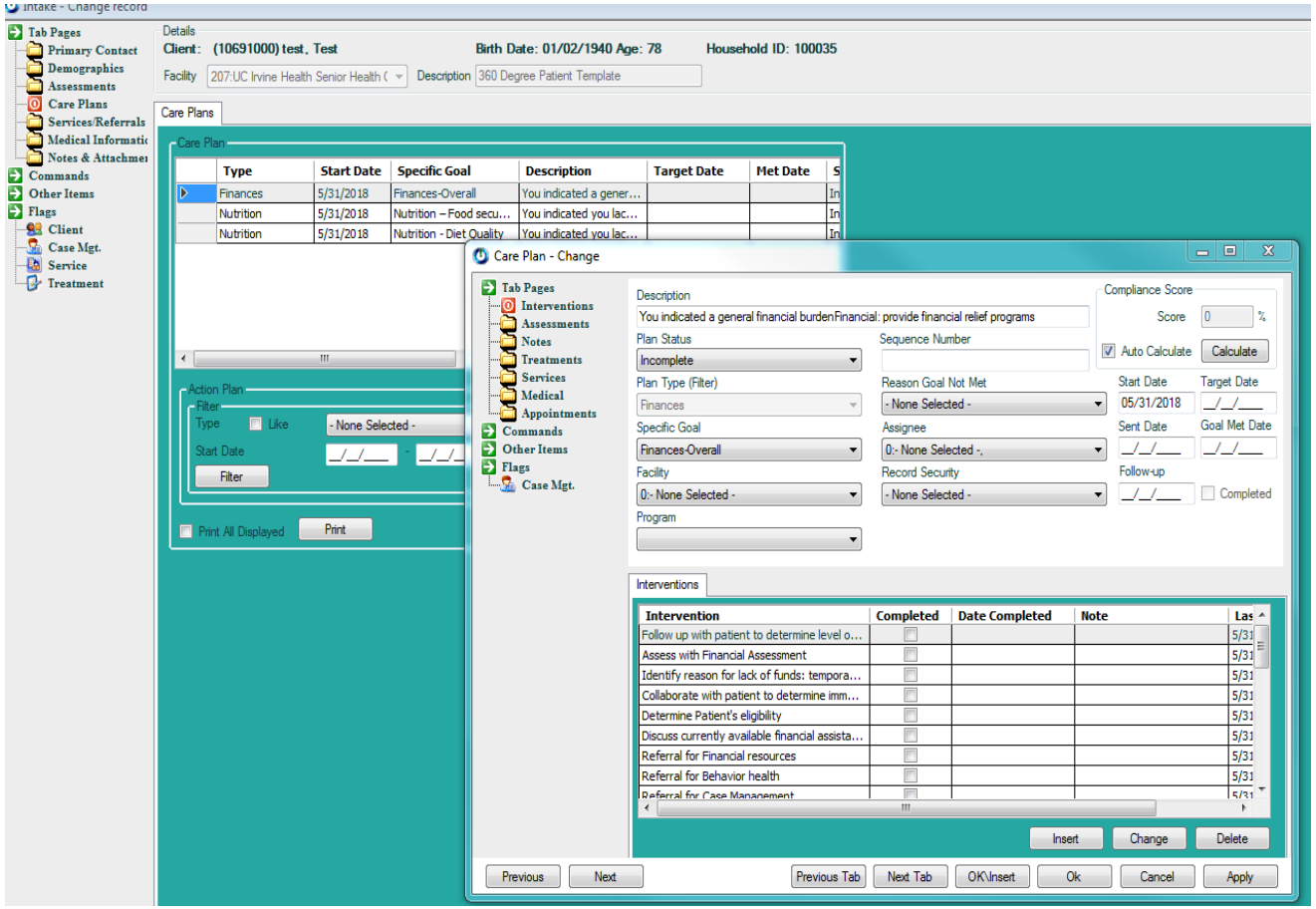
Developing and Testing Tools and Processes

Key activities:

1. Developed and tested a senior-focused social needs screening tool

2. Identified follow-up assessments and developed workflows for screening, follow-up and response

3. Conducted configuration, user testing and Epic integration of electronic platform



Senior-Specific Social Needs Screener

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SHC Social Needs Screener

Patient Name: _____ Epic ID: _____

		Circle the best answer
	1. 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 friend or family, going to church.	Less than once a week [1] 1-2 times/week[1] 3-5 times/week[0] More than 5 times/week[0]
	2. Are you **satisfied with the amount of social interactions** you have every week?	Yes[0] No[1]
	3. **Do you need help from another person or service animal** with any daily activities, such as bathing, dressing, eating or doing household chores?	Yes[1] No[0]
	4. Can you **easily and safely move around** your home?	Yes[0] No[1]
	5. Do you have family members or other **people willing and able to help you** when you need it?	Yes[0] No[1]
	6. In the last 6 months, were you **able to afford to eat healthy** meals?	Yes[0] No[1]
	7. In the last 6 months, did you ever **eat less than you felt** you should?	Yes[1] No[0]
	8. Are you worried about **losing your housing**?	Yes[1] No[0]

UC Irvine Health

	9. In the past 6 months, **has lack of transportation** kept you from medical appointments?	Yes[1] No[0]
	10. In the past 6 months, **has a lack of transportation** kept you from attending social events (e.g., church, senior center) or getting things needed for daily living (e.g., groceries, clothes)?	Yes[1] No[0]
	11. Do you ever **have problems making ends meet** or being able to afford everything you need?	Yes[1] No[0]
	12. In the last 6 months, has your utility company, (e.g., electric, gas, or water company) **shut off or threatened to shut off your service** for not paying your bills?	Yes[1] No[0]

FOR STAFF USE ONLY

Staff Name: _____ Date Administered: _____

Is this a new SHC patient? (circle response) Yes No

How was the screener administered? (circle response)

Self-Administered By proxy (caregiver or family member)

Screener Total Score (add up all responses with a value of "1"): _____

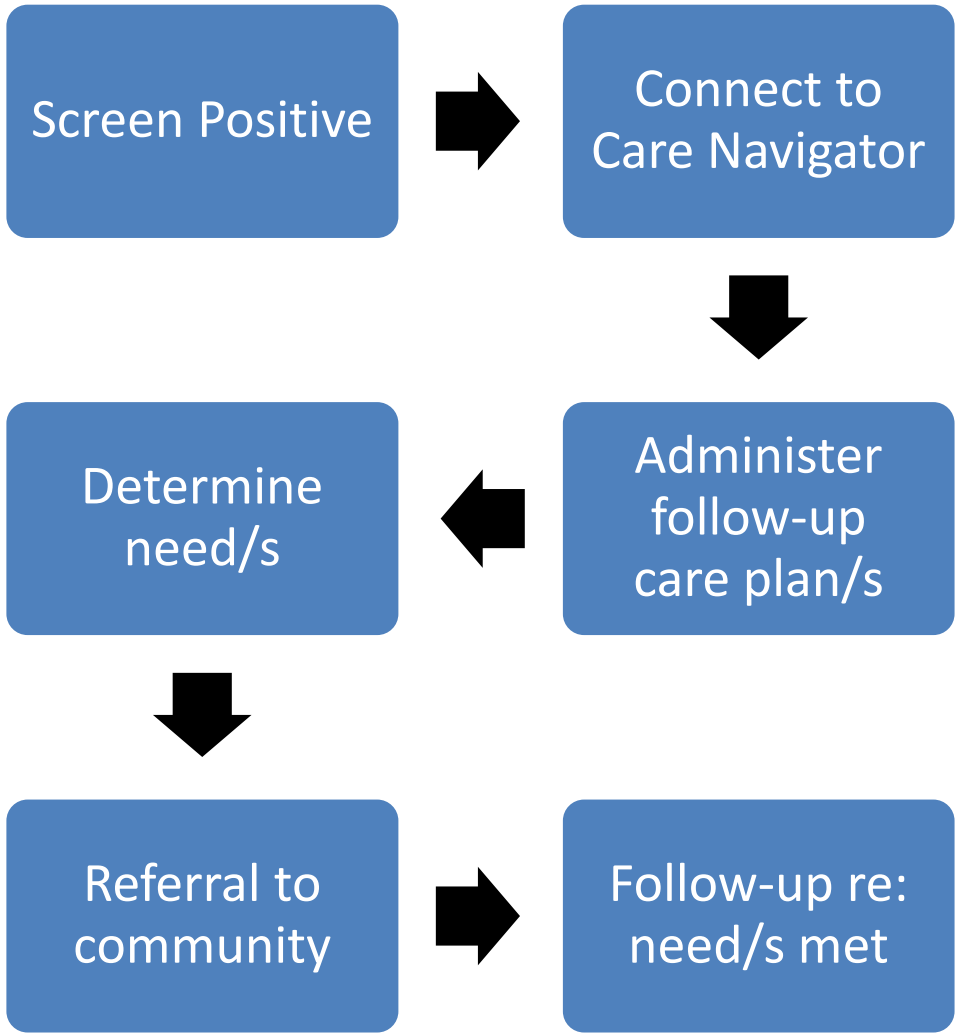
Negative screen, but requested information related to: (circle all that apply)

Not Applicable
Social Connection/Isolation
Daily living/mobility
Caregiver Needs
Food/nutrition
Housing
Transportation
Financial

High-Level Screening and Response Workflow

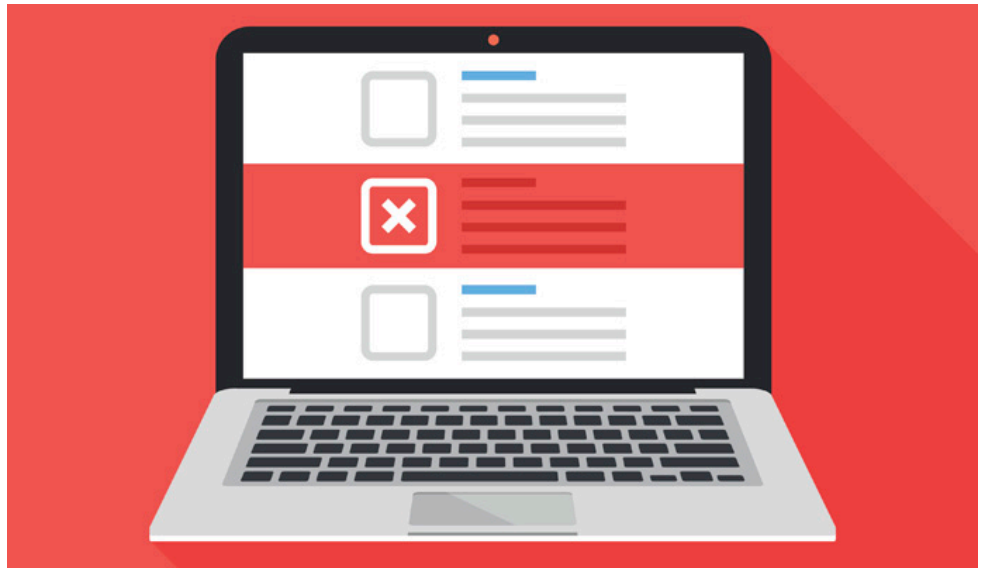
Screen positive on any one question across HRSN domains:

1. Social Connection/Isolation
2. Daily Living/Mobility
3. Caregiver Needs
4. Food/Nutrition
5. Housing
6. Transportation
7. Financial



User Testing of Electronic Platform

- Assessed barriers and facilitators
  - With technology
    - Time to “build,” test and tailor
    - Highly configurable
    - Programmers’ requirements and “language”
    - Different versions
    - Pushed boundaries of platform’s original design
  - With multiple users
    - Resistance to technology
    - Anticipatory concerns
    - Training and practice



Participation!

With the 2-3 people around you please discuss the following:

Are you or your organization using technology to facilitate care coordination?

- If so, what challenges have you faced?
- If not, what challenges do you anticipate?
- What are some likely or realized advantages to using technology to improve care coordination?

Share out from each group

PHASE 3:

Piloting, Implementing and Evaluating the Intervention

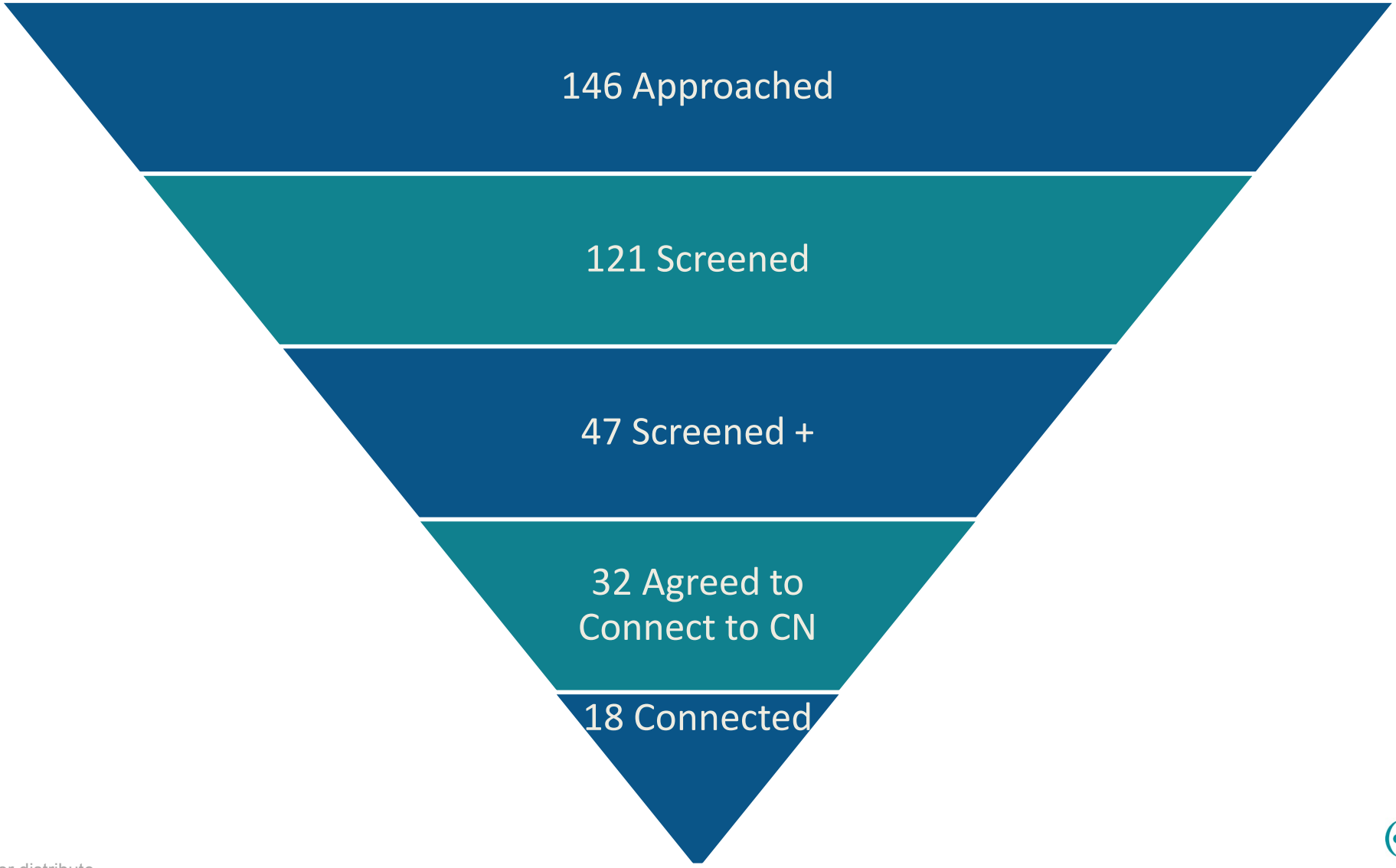
Implementing and Evaluating Efforts

- Pilot
  - Launched August 2018
  - Rolling recruitment (completed February 2019)

- Ongoing process evaluation
  - Continued rapid cycle testing
  - Tracking adaptations
  - Patient satisfaction and acceptability

- Collecting additional data points for evaluation purposes
  - Patient-reported outcomes
  - Baseline and 3-month follow-up

Preliminary 3-Month Data: Screening and Response



Creating Additional Partnerships

- Efforts to identify CBO partners
  - Referral volume
  - Aging Collaborative
- Onboarding and testing
  - Shared patients
  - Messaging
- Sharing data across settings

Key Lessons Learned

- Opportunity to use technology
- Co-design and get buy-in
- Identify and reinforce shared visions
- Consider broader context
- Start small, test and establish processes
- Use barriers to inform training
- Conduct ongoing evaluation

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Questions?

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