VIRTUAL CONVENING
Population Health in the time of COVID-19
Audio: Join with your computer audio, but you can also dial into the meeting with a phone. Please mute yourself!

Video: We want to see you today, especially during our breakout sessions and when you are asking questions! Feel free to turn your camera off during presentations.

Make sure your audio is paired with your computer if you’re calling in with your phone. The audio button will appear as a phone if you have done so correctly. Contact Tristan if you need help!
The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana’s most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

MPCA values integrity, collaborations, and innovation.

The Montana Primary Care Association is the support organization for Montana’s 14 Community Health Centers and 4 of our Urban Indian Centers. MPCA centers serve over 117,500 patients across Montana.
Breakout introductions!

We will break you out into small groups (turn on your camera and your video, if possible).

Have each person introduce themself:

- Name, the pronouns you use, role, and your organization
- Share one thing you are hoping to get out of today’s convening.
- Then, open another internet browser or the browser on your cell phone and go to www.menti.com. It will ask for a code: 30 01 68. Then put in a brief answer!
- You’ll have 3 minutes once we break out!
- If you don’t make it to your room, you can return to the main session and put your own feedback in Mentimeter.
If you are in the main room, you can still answer the question!

Go to [www.menti.com](http://www.menti.com). It will ask for a code: 30 01 68. Then put in a brief answer!
virtual convening agenda - morning sessions

Session #1: 10am - 11am  Join Session #1

Now is the time for social needs screening

The social determinants of health impact our patients every day, but that impact is only heightened during the global pandemic. Learn about the basics of screening for social needs and how clinics have integrated social needs screening and interventions into their clinic workflows and care teams.

- Albert Ayson Jr., Senior Program Manager, Training and Technical Assistance, Association of Asian Pacific Community Health Organizations (AAPCHO)
- Kevin Sandoval, Clinical Applications Coordinator/Business Office & Michelle Jones, Peer Support Specialist, Helena Indian Alliance
- Leslie Southworth, Director of the Health Center Controlled Network, Montana Primary Care Association

Session #2: 11:15am - 12:15pm  Join Session #2

Promising practices in managing chronic disease during COVID – 19

Even in the midst of the pandemic, preventable and manageable chronic disease continues to be responsible for most deaths worldwide. We cannot abandon managing and preventing chronic illnesses and disease, but instead need to find creative ways to reach patients while still minimizing the risk of COVID 19 to both staff and patients. In this session we will discuss the impact of COVID 19 on disease management and prevention and learn how different organizations and communities are continuing to provide patient centered care during this crisis.

- Molly Neu, Health Promotion Specialist, Flathead City- County Health Department
- Leslie Diede, Quality and Operations Manager, Flathead Community Health Center

Tips for virtual learning with Zoom!

Keep this PDF open throughout the convening. Each session is a different Zoom meeting. Just click on each meeting link and fill out the short registration. You can also register in advance.

Please have your computer camera and speakers ready, if possible. We want to see you during our virtual breakouts! Don’t have a microphone? Learn how to call in here.

Need help with your tech? We can help!

MPCA’s Tristan Shea can help make your technology work for virtual learning, before or during the convening.

e-mail: tshea@mpca.org
phone/text: (406) 431-1305

Learn about our speakers & check out their bios!

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virtual convening agenda - afternoon sessions

Session #3: 1pm - 2pm  Join Session #3

From the chronically homeless to homeless prevention, meeting the housing needs of Montana communities

Housing is healthcare, especially during a pandemic. Learn how different communities are working to meet housing needs, from the chronically homeless to those who are at risk of becoming homeless because of COVID – 19.

- Marge Bauck, Director of Quality Improvement, Partnership Health Center
- Charles Rouke, Behavioral Health Care Manager, Partnership Health Center
- Margie Seccomb, Director, Action Inc.

Breakout sessions: 2:15pm - 2:45pm

Understanding changes to the safety net – breakout conversations

- Housing - Kai Peterson, Executive Director, NeighborWorks Montana
  Join the housing breakout session.
- Food Security - Lorianne Burhop, Chief Policy Officer, Montana Food Bank Network
  Join the food security breakout session.
- Programs and services in Indian Country - Lesa Everson, Tribal Relations Manager, Director’s Office, Montana DPHHS
  Join the Indian Country breakout session.

Closing session: 3pm – 3:30pm  Join the closing session

Looking ahead

What does 15% unemployment really look like? How does this economic downturn compare to 2008? What can we expect in the next federal bill or the next legislative session? Join us for a closing conversation where we’ll try to better understand where we are at, what the future might hold for Montana families and communities, and how we can help support our patients and communities as we look toward recovery.

- Stacey Anderson, Policy Director, Montana Primary Care Association
- Heather O’Loughlin, Co-Director, Montana Budget and Policy Center

Don’t miss these upcoming virtual trainings:

- June 3rd & 4th, 10am - noon - Financial Planning in Unknown Times for health center CEOs & CFOs
- June 17th, 10am - Part of the Same Team: Quality patient care starts at the front desk

Check out all of MPCA’s upcoming trainings here.
Montana PCA Virtual Convening: Population Health in a time of COVID – 19

“Now is the time for social needs screening”

Albert Ayson, Jr., MPH
Associate Director, Training & Technical Assistance
Association of Asian Pacific Community Health Organizations (AAPCHO)
May 28, 2020
About AAPCHO

The Association of Asian Pacific Community Health Organizations (AAPCHO) was formed in 1987

National association of 32 community health organizations serving Asian Americans, Native Hawaiians, and other Pacific Islanders (AA and NHPIs)

Dedicated to improving the health status and access of these medically underserved communities

Bureau of Primary Care (BPHC) funded National Cooperative Agreement (NCA) to provide training and technical assistance to health centers
Partnerships
Learning Objective

Provide a basic overview of the social determinants of health (SDoH) and how those social determinants are shifting during the COVID 19 pandemic.
The Social Determinants of Health are the conditions that impact our health and well-being: the circumstances which we are born, grow up, live, work and age.

“Where we live, learn, work and play can have a greater impact on how long and how well we live than medical care.”

Why Is It Important for Health Centers to Focus on Social Determinants?

**What Makes Us Healthy**
- Clinical Care (20%)
- Health Behaviors (30%)
- Social Determinants of Health (40%)

**What We Spend On Being Healthy**
- Medical Services (88%)
- Other (8%)

*Source: RWJF County Health Rankings*

*Source: Derived from information from the Boston Foundation (June 2007).*
# The Shift & Intersection of SDoH and COVID-19

## Environmental Risk Factors:
- **SAFETY**: More likely to live in households with **unsafe living conditions** (i.e. mold, asbestos, lead, etc.) → possible health complications from shelter in place[^1.6]
- **HOUSEHOLD SIZE**: More likely to live in crowded households → increased risk of exposure and transmission[^2.3.4]
- **ACCESS**: Less likely to have **access to phone, fast internet and electronic devices** that enable distance learning, WFH, or telemedicine[^4.5.7]
- **INCOME**: More likely to live in areas of poorer air quality → increased risk of COVID-19 mortality[^5.6]

## Economic Risk Factors:
- **EMPLOYMENT**: More likely to be working jobs that can’t be done from home → increased risk of exposure[^4.8]
  - Less likely to have jobs that offer paid sick leave[^4]
- **HOUSING**: More likely to face eviction or foreclosure due to job/income loss[^1.4.9]
- **INCOME**: Less likely to have savings to cover COVID-related medical expenditures[^4.10]
- **INCOME**: Less likely to have savings that will allow stockpiling of food and medication[^4.10.11]
- **INCOME**: More likely to have children that rely on free/reduced-price school meals that are now unavailable[^4]
- **INCOME**: Lack of wealth and low-income jobs → will be disproportionately and deeply impacted by the economic recession[^10]
- **TRANSPORTATION**: More likely to rely on public transportation → increased risk of exposure[^4]
  - Public transportation restrictions → impeded ability to access food, medical care, etc.[^3.4]
- **CHILDCARE NEEDS**: Less likely to be able to afford childcare for school-age kids that are now homebound[^4]

## Health Risk Factors:
- Higher rates of underlying conditions (respiratory illnesses, heart disease, diabetes) and behavioral risk factors (smoking, obesity, substance abuse) linked with increased COVID-19 severity/mortality[^4.8.12]
- **ACCESS**: Restricted access to health care:
  - Less likely to have health insurance and more likely to be underinsured[^4.8]
  - Less likely to have a general practitioner to call if they develop coronavirus symptoms[^4]

[^1]: National Association of Community Health Centers, Inc.
[^2]: Association of Asian Pacific Community Health Organizations
[^3]: Quantum Health
[^4]: Oregon Primary Care Association
[^5]: AAPCHO
## Race/Ethnicity of SDoH and COVID-19

<table>
<thead>
<tr>
<th>African Americans/Hispanics</th>
<th>Asian Americans, Native Hawaiians, and Pacific Islanders (AA&amp;NHPI)</th>
<th>Native Americans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disproportionate impact of COVID-19 already manifesting even with the limited racial/ethnic data we have(^2,13,14,15,16)</td>
<td>• Higher rates of predisposing conditions among AA&amp;NHPI groups</td>
<td>• Higher rates of asthma, heart disease, hypertension, and diabetes (\rightarrow) increased risk for COVID-19 severity/mortality(^3)</td>
</tr>
<tr>
<td>• More likely to have pre-existing medical conditions linked with COVID-19 severity/mortality(^2,14,16,17)</td>
<td>• Native Hawaiians and Pacific Islanders have high rates of cardiovascular disease, diabetes, obesity(^21,22,23,24)</td>
<td>• Higher rates of poverty (\rightarrow) impeded health care access, greater financial vulnerability(^3)</td>
</tr>
<tr>
<td>• Overrepresented in many essential work industries (\rightarrow) increased risk of exposure(^18)</td>
<td>• Filipino Americans have high rates of diabetes and asthma(^25)</td>
<td>• Often live in small and crowded conditions(^3)</td>
</tr>
<tr>
<td>• Less likely to receive high-quality of medical care because of discrimination in health care, uninsured, and mistrust of the medical system(^2,14,16,17,18,19)</td>
<td>• Asian Americans as a whole have high rates of diabetes(^26)</td>
<td>• Restricted health care access</td>
</tr>
<tr>
<td>• Higher rates of incarceration (\rightarrow) increased risk of exposure and limited access to quality health care(^20)</td>
<td>• Lower rates of health insurance(^27)</td>
<td>• Tribal governments generate money mainly through businesses (\rightarrow) economically vulnerable(^3)</td>
</tr>
<tr>
<td></td>
<td>• Face language and cultural barriers in health care settings (\rightarrow) barrier to in-person care and telemedicine(^28,29)</td>
<td>• Elders are central to Native American communities (\rightarrow) isolation/death of elders threatens cultural and community life(^3)</td>
</tr>
<tr>
<td></td>
<td>• Large immigrant population (\rightarrow) restricted access to government benefits(^30)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coronavirus-related racism and hate crimes (\rightarrow) potential impact on mental and overall health(^31,32)</td>
<td></td>
</tr>
</tbody>
</table>
Other Vulnerable Populations

**The Elderly**
- Increased risk for COVID-19 severity/mortality
- Already suffering from high rates of loneliness, anxiety, depression → quarantine, shutting down of social/exercise programs, and visitor limitations to elderly homes will exacerbate these
- Difficulty working with technology and accessing the internet → barriers to communication and telemedicine
- Difficulty accessing food b/c of fear of public exposure and transportation barriers
- Less likely to have funds to stockpile groceries and medication

**The Homeless**
- 500,000 homeless as of 2018, 1.5 million at risk for becoming homeless
- Inability to quarantine b/c often living in close quarters (homeless shelters, encampments, group homes)
- Inability to access basic hygiene (water, soap, showers, etc.)
- Reduced access to healthcare b/c of hospital crowding, no general practitioner to call if symptoms develop, no internet/phone to access telemedicine

**Substance Abuse**
- Higher risk of complications for those who smoke tobacco, marijuana, vape, use opioids or meth b/c of these drugs’ impact on respiratory health
- Drug-related-stigma → potential barrier to care, esp. if hospitals are pushed to capacity
- Quarantine will reduce access to syringe services, medications, and other support systems
- Restricted access to frequent treatments (i.e. methadone) due to restrictions in public transportation

Other Vulnerable Populations

**Rural Populations**
- Live further from health care centers\(^8,11\)
- Health care centers have limited intensive care capacity\(^36,37\)
- Limited access to fast internet connection → barrier to telemedicine, WFH, schooling\(^11\)
- High populations of older adults and people with chronic conditions\(^11,38\)

**Undocumented Immigrants**
- 10.5 million undocumented immigrants as of 2017\(^39\)
- Fear of accessing health care due to fears of deportation\(^40,41\)
- Restricted access to unemployment benefits and health insurance\(^41\)
- Completely uncovered by the CARES act\(^41\)
- Disproportionately employed in essential industries and industries undergoing layoffs\(^42\)

**Incarcerated Individuals**
- 2.2 million incarcerated individuals as of 2016\(^4\)
- Living in extremely close quarters where there is an inability to social distance\(^4,40\)
- Half of all incarcerated people have at least one chronic disease\(^43\)
- History of poor health care in American prisons\(^44,45\)
References

References (continued)

27. https://www.apiahf.org/focus/health-care-access/
29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6628721/
43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5982810/
45. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/
Learning Objective

Review the PRAPARE as one example of a social needs screener
The Importance of Standardized Data

Health centers now collect standardized data on social determinants of health and enabling services. Here’s why:

- **Individual level**: Better understand patients and provide appropriate care and treatment plans based on patient’s socioeconomic circumstances.
- **Organizational level**: Design care teams and services to better manage patient and population needs.
- **System/Community level**: Integrate care through cross-sector partnerships. Develop community-level redesign strategy for prevention.
- **Payer level**: Execute payment models that sustain value-based care by incentivizing services, interventions, and partnerships that address social risk.
- **Policy level**: Demonstrate value of health centers to health care system. Ensure capacity for serving complex patients, including uninsured patients.

What Is PRAPARE?

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.

Customizable Implementation and Action Approach

Assess Needs  →  Respond to Needs

At the Patient and Population Level

### WHAT QUESTIONS ARE IN PRAPARE?

#### Core

<table>
<thead>
<tr>
<th>1. Race*</th>
<th>10. Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Ethnicity*</td>
<td>11. Employment</td>
</tr>
<tr>
<td>6. Income*</td>
<td>15. Transportation</td>
</tr>
<tr>
<td>7. Insurance*</td>
<td>16. Housing Stability</td>
</tr>
<tr>
<td>8. Neighborhood*</td>
<td></td>
</tr>
<tr>
<td>9. Housing Status*</td>
<td></td>
</tr>
</tbody>
</table>

#### Optional

| 1. Incarceration History |
| 3. Domestic Violence |

| 2. Safety |
| 4. Refugee Status |

#### Optional Granular

| 1. Employment: How many hours worked per week |
| 3. Insurance: Do you get insurance through your job? |

| 2. Employment: # of jobs worked |
| 4. Social Support: Who is your support network? |

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

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26 translations of PRAPARE now available!

Find the tool at [www.nachc.org/prapare](http://www.nachc.org/prapare)

<table>
<thead>
<tr>
<th>PRAPARE Domain</th>
<th>UDS (HRSA reporting)</th>
<th>ICD-10</th>
<th>IOM</th>
<th>Meaningful Use</th>
<th>CMMI Accountable Healthcare Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Farmworker Status</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran Status</td>
<td>X</td>
<td></td>
<td></td>
<td>Explored, not adopted</td>
<td></td>
</tr>
<tr>
<td>Preferred Language</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Insurance Status</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Instability</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Education</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X (supplemental)</td>
</tr>
<tr>
<td>Employment</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Explored, not adopted</td>
<td>X (supplemental)</td>
</tr>
<tr>
<td>Material Security (incl. food insecurity, utilities, financial strain)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X (and in supplemental)</td>
</tr>
<tr>
<td>Social Integration</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X (supplemental)</td>
</tr>
<tr>
<td>Stress</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

CMMI adopted PRAPARE transportation and housing questions
<table>
<thead>
<tr>
<th>5 Rights</th>
<th>Workflow Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Information—WHAT</td>
<td>What information in PRAPARE do you already routinely collect?</td>
</tr>
<tr>
<td></td>
<td>• Part of registration</td>
</tr>
<tr>
<td></td>
<td>• Part of other health assessments or initiatives</td>
</tr>
<tr>
<td>Right Format—HOW</td>
<td>How are we collecting this information and in what manner are we collecting it?</td>
</tr>
<tr>
<td></td>
<td>• Self-Assessment</td>
</tr>
<tr>
<td></td>
<td>• In-person with staff</td>
</tr>
<tr>
<td>Right Person—WHO</td>
<td>Who will collect the data? Who has access to the EHR? Who needs to see the information</td>
</tr>
<tr>
<td></td>
<td>to inform care? Who will respond to needs identified?</td>
</tr>
<tr>
<td></td>
<td>• Providers and other clinical staff</td>
</tr>
<tr>
<td></td>
<td>• Non-Clinical Staff</td>
</tr>
<tr>
<td>Right Time—WHEN</td>
<td>When is the right time to collect this information so as to not disrupt clinic workflow?</td>
</tr>
<tr>
<td></td>
<td>• Before visit with provider? (before arriving to clinic, while waiting in waiting room,</td>
</tr>
<tr>
<td></td>
<td>etc.)</td>
</tr>
<tr>
<td></td>
<td>• During visit?</td>
</tr>
<tr>
<td></td>
<td>• After visit with provider?</td>
</tr>
<tr>
<td>Right Place—WHERE</td>
<td>Where are we collecting this information? Where do we need to share and display this</td>
</tr>
<tr>
<td></td>
<td>information?</td>
</tr>
<tr>
<td></td>
<td>• In waiting room? In private office?</td>
</tr>
<tr>
<td></td>
<td>• Share during team huddles? Provide care team dashboards?</td>
</tr>
</tbody>
</table>
## SAMPLE WORKFLOW MODELS FOR PRAPARE DATA COLLECTION

<table>
<thead>
<tr>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>How</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical staff (patient navigator, community health workers)</td>
<td>In waiting room or in staff office</td>
<td>Before of after provider visit</td>
<td>Administered PRAPARE with patients who would be waiting 30+ mins for provider</td>
<td>Provided enough time to discuss SDH needs. Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patient’s ability and motivation to respond to their situation.</td>
</tr>
<tr>
<td>Nursing staff and/or MAs</td>
<td>In exam room</td>
<td>Before provider enters exam room</td>
<td>Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager</td>
<td>Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info</td>
</tr>
<tr>
<td>Care Coordinators</td>
<td>In office of care coordinator</td>
<td>When Completing chart reviews and administering Health Risk Assessments</td>
<td>Administered PRAPARE in conjunction with Health Risk Assessments</td>
<td>Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA</td>
</tr>
<tr>
<td>Any staff (from Front Desk Staff to Providers)</td>
<td>No wrong door approach</td>
<td>No wrong door approach</td>
<td></td>
<td>Allows everyone to be part of larger process of “painting a fuller picture of the patient” and taking part in helping the patient</td>
</tr>
<tr>
<td>Patient Self-Assessment</td>
<td>At home, in waiting room, etc.</td>
<td>Before visit with provider</td>
<td>Self-administered using email, mobile, tablets, kiosks, etc.</td>
<td>Low burden on staff to collect data. Privacy for patient to complete assessment. Utilize time when patient would otherwise be waiting. Staff time can be used to discuss results with patients to address needs.</td>
</tr>
</tbody>
</table>

Resources

• Health Center Resource Clearinghouse
  https://www.healthcenterinfo.org/

• The Social Determinants of Health Academy
  https://medical-legalpartnership.org/sdoh-academy/

• PRAPARE
  www.nachc.org/prapare

• Enabling Services Implementation Toolkit
  https://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/
PRAPARE Implementation and Action Toolkit

10 Chapters: Data Collection Preparation, Collection, Assessment, and Responding

PRAPARE Assessment Tool is now available in 26 languages, including over 15 AA and NHPI languages.

http://www.nachc.org/research-and-data/prapare/
Enabling Services Data Collection Toolkit

- Needs Assessment
- Readiness Assessment
- Workflows
- EHR Integration
- Database Strategy
- Training Guidelines
- Report Cards

http://EnablingServices.aapcho.org
NEW UDS Questions for 2019

- Appendix D: Health Center Health Information Technology (HIT) Capabilities

- Questions 11 and 12
  - “Does your health center collect data on individual patients’ social risk factors…?”
  - “Which standardized screener(s) for social risk factors… do you use?”

http://www.bphcdata.net/docs/uds_rep_instr.pdf
Thank You!

http://www.aapcho.org
Helena Indian Alliance

ADDRESSING MEDICAL, MENTAL HEALTH, SOCIAL NEEDS AND DETERMINANTS DURING COVID-19
March 16, 2020

- Face to face encounters were temporarily suspended pending PPE procurement
- Seniors and youth programs were halted
  - Senior meals delivered directly to homes
- Helena Indian Alliance went live with Telemedicine
- Facility was on temporary lockdown for reorganization and workflow redesign
- All but 2 staff members continue to keep working out of 30
Top 5 Patient Advocate Activities that have continued

- Medicaid enrollment
- Unemployment Insurance sign up (COVID)
- Housing application and updates – warm hand off with Helena Housing
- Home Health Aides/Assistance (COVID)
- Housing rights assistance for eviction (COVID)
- Case Management services
  - Position vacant since February 26
Top 5 Provider and Counselor Concerns during COVID-19

- Diabetes
- Medications
- Alcohol and Drug Dependence
- Mental Health
- Hypertension
Monitored Critical Population

PATIENTS AGE 65-99

- Ambulatory
- Telemedicine
- Total Patients

Graph showing the number of patients in the age group of 65-99 for January to May.
HIA Staff Repurposing

- Peer support staff and medical assistants were asked to call patients directly to check in on them.
- Staff members were all trained to utilize the GAD-7 and PHQ-9 screenings for Telehealth and Telephone check-ins.
- Callers are to assess for referrals/appointments with either medical or behavioral health staff.
Follow-up on Referrals

Telemedicine and Telephone check in staff are required:

- Make visit notes and document the encounter
- Electronically tag and notify providers/counselors of which patients are flagged for follow-up
- Create face to face appointments with receptionists
Currently interviewing for vacant Case Management position
Patient advocate is getting overwhelmed with appointments related COVID-19 fallout.
Currently redesigning HIA entry point for COVID screenings to accommodate face to face visits
Preparing for COVID-19 testing at HIA
HIA Alternate Entrance
Alternate Triage and Exam Tents
Sterilization Lights
Social Needs Data

Now is the time for Social Needs Screening

Leslie Southworth, Director of Montana HCCN
Montana Primary Association
What is Social Needs Data?

- Age
- Gender
- Race/Ethnicity
- Zip Code
- Veteran status
- Insurance type
- Education
- Transportation
- Gender Identity
- Sexual Orientation
- Food Insecurity
- Housing Insecurity
- Intimate Partner Violence
- Incarceration
Why collect Social Needs Data?

- Baseline of information about the patient
- Share information about patient with healthcare partners
- Make decisions about the type of healthcare to provide
- Grant and reporting requirements
What are other ways to utilize Social Needs data?

- Identify patient populations
- Identify the most vulnerable patient populations
- Tell the story
- Collecting the data shows value
Where is the data collected?

***the following slides only contain sample or test patient data***
By the Front Desk

- On paper
- On a tablet or kiosk
- Verbal
Date Of Birth: 12/11/1972
Age: 46 Y
Sex: Male
Marital Status: Married
Language: English
Race: White
Ethnicity: ...
During the Exam

- On paper
- A tablet
- Verbal
**Social History:**

**Social Determinants of Health**

SDH Entered/Updated: **12/01/2015**

What is your housing situation today? *I have housing*

Are you worried about losing your housing? *No*

What is the highest level of school that you have finished? *High school or GED*

What is your current work situation? *Part time work*

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. *Food, Utilities, Child care*

How often do you see or talk to people you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, attending church or meetings) *Less than once a week*

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled. *Somewhat*

In the past year, have you spent more than 2 nights in jail, prison, detention center, or juvenile correctional facility? *I choose not to answer this question*

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? *Yes*

Are you a refugee? *No*

What country are you from? *Country other than USA (please write in notes) Mexico*

What year did you come to the US? *2008*

Do you feel physically or emotionally safe where you currently live? *I choose not to answer this question*

In the past year, have you been afraid of a partner or ex-partner? *No*
Tracking & Reporting Social Needs Data

The Montana network of community health centers is utilizing Azara Healthcare’s Data Reporting and Visualization System (DRVS)
<table>
<thead>
<tr>
<th>HOUSING SITUATION</th>
<th>NUMERATOR</th>
<th>% TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doubling Up</td>
<td>207</td>
<td>1.5%</td>
</tr>
<tr>
<td>Homeless Shelter</td>
<td>338</td>
<td>2.4%</td>
</tr>
<tr>
<td>Ignore</td>
<td>236</td>
<td>1.7%</td>
</tr>
<tr>
<td>Not Homeless</td>
<td>12,920</td>
<td>90.7%</td>
</tr>
<tr>
<td>Other</td>
<td>91</td>
<td>0.6%</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>14</td>
<td>0.1%</td>
</tr>
<tr>
<td>Street</td>
<td>156</td>
<td>1.1%</td>
</tr>
<tr>
<td>Transitional</td>
<td>241</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

TY May 2020

- Doubling Up
- Homeless Shelter
- Ignore
- Not Homeless
- Other
- Permanent Supportive Housing
Diabetes A1c > 9 or Untested (NQF 0059)

**MEASURE**

- **PERIOD:** TY May 2020
- **CENETERS:** All Centers
- **RENDERING PROVIDER:** All Rendering Providers
- **SERVICE LINES:** Primary Care

**HOUSING SITUATION**
- All Housing Situation

**MEASURE ANALYZER**

- **Targets & Metrics**
  - SELECTED: 30%
  - Baseline: 3% (TY May 2019)
  - 1,105 / 3,689
  - 2 Exclusions
  - QDI Target
  - PRIMARY 15%  SECONDARY 16%

**BENCHMARK**

- 30% Center Average
- 30% Network Average
- 20% Best Center

_Last Processed 5/23/2020_
Questions?

You can type them in the chat box or unmute yourself (clicking “unmute” button on Zoom toolbar or #6 if you are on a telephone).
What’s next

virtual convening agenda - morning sessions

Session #1: 10am - 11am  Join Session #1

Now is the time for social needs screening

The social determinants of health impact our patients every day, but that impact is only heightened during the global pandemic. Learn about the basics of screening for social needs and how clinics have integrated social needs screening and interventions into their clinic workflows and care teams.

- Albert Ayon Jr., Senior Program Manager, Training and Technical Assistance, Association of Asian Pacific Community Health Organizations (AAPCHO)
- Kevin Sandoval, Clinical Applications Coordinator/Business Office & Michelle Jones, Peer Support Specialist, Helena Indian Alliance
- Leslie Southworth, Director of the Health Center Controlled Network, Montana Primary Care Association

Session #2: 11:15am - 12:15pm  Join Session #2

Promising practices in managing chronic disease during COVID - 19

Even in the midst of the pandemic, preventable and manageable chronic disease continues to be responsible for most deaths worldwide. We cannot abandon managing and preventing chronic illnesses and disease, but instead need to find creative ways to reach patients while still minimizing the risk of COVID 19 to both staff and patients. In this session we will discuss the impact of COVID 19 on disease management and prevention and learn how different organizations and communities are continuing to provide patient centered care during this crisis.

- Molly Neu, Health Promotion Specialist, Flathead City- County Health Department
- Leslie Diede, Quality and Operations Manager, Flathead Community Health Center