SDOH Screening & Referrals to Support Diabetes Control

Module 3: Referrals to the Community & Closing the Loop

February 1, 2023 2:00pm EST

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

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Recording

This session will be recorded and available to view with all supporting materials on the learning series Google Site.

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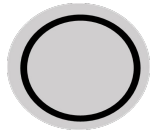
Chat

Raise Hand



Recording

Continuing Education Credits

- Offered in partnership with the Clinical Directors Network
- Attend entire session & complete the 5-question quiz
- CE quiz will be available after completing the session evaluation
- Please complete the evaluation regardless if you seeks CEs

Regina Neal, MS, MPH

Senior Consultant, Systemwide Quality Improvement

Comagine Health

Closing the Loop on Social Needs Referrals

Your patient has screened positive for an SDH.
Now what?

Moving to Action

Referring patients to sources of support

Learning Objectives

By end of the session, you will be able to:

- Identify improvement approaches and tools to develop referral workflows for SDOH support and use measures to assess and sustain progress
  - Starting point: Assess current care coordination processes and staffing. Adapt and test for SDOH coordination processes.
- Identify, get to know, build relationships with community-based partners to provide specific SDOH support services to your patients
- Engage patients
  - To understand their needs and goals as part of the SDOH referral process
  - To provide feedback on the experience of the referral process and the support received from community resources.
- Assess all aspects of processes and resources to promote, ensure equity

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Foundation Stones

Every system is ***perfectly designed*** to produce the results you get.

"[Better] performance is not simply – it is not even mainly – a matter of effort; it is a matter of design" - *Don Berwick*

Knowledge is power if we know how to use it

Knowing is not enough, we must do

Begin with the Principles of Improvement

- Start small – there is power in small steps
- Identify a specific population of focus for the initial work – there is a lot to learn
- Take the time to use the tools for building processes
- Use small, rapid cycle tests of change to learn what works, continue testing to finalize and then to scale, anchor and spread
- Use questions to help find the answers[1]
- Remember: if this was easy, we would have done it already.

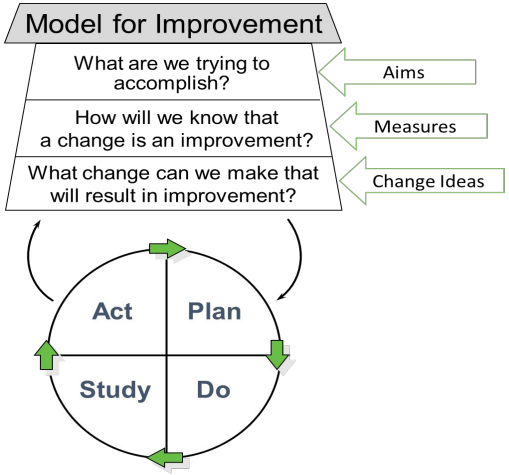
https://hbr.org/2021/01/good-leadership-is-about-asking-good-questions

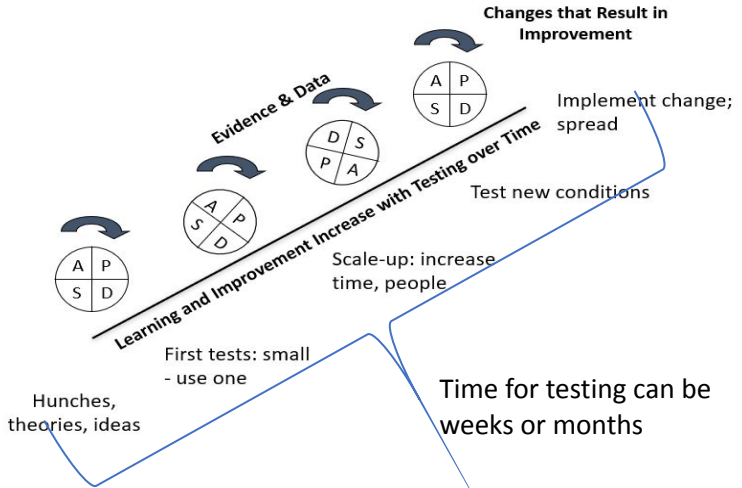
Upward Cycle of Learning and Improvement

[1]-https://hbr.org/2018/05/the-surprising-power-of-questions

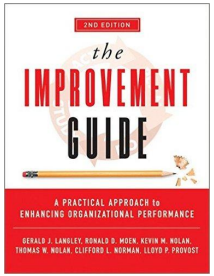
Use the Model for Improvement

- Don’t just implement a new process and hope for the best
- Test at small scale to learn what works and what needs adjustment or what needs a new idea altogether
- Continue testing as you scale up your process.





The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. G. Langley, K. Nolan, T. Nolan, C. Norman, L. Provost.



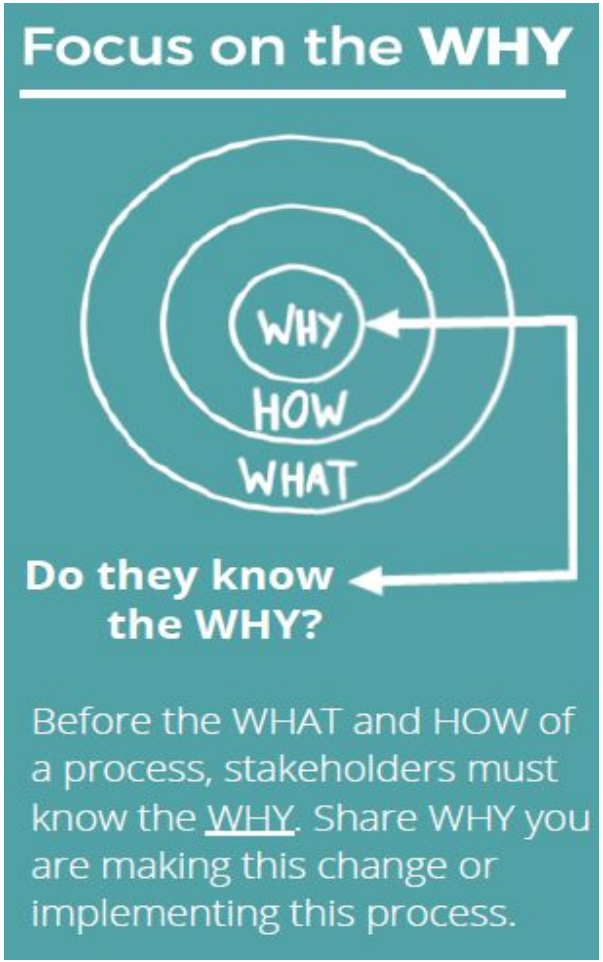
Also See IHI.org

https://www.ihi.org/Topics/ImprovementCapability/Pages/GettingStarted.aspx

Where Do We Find Ideas for Changes?

- Bright Spots, Promising Practices – something that has worked for another organization working on similar improvements
  - Must test it to adapt it to your organization
- Knowledge, hunches, theories of staff,
  - Front-line staff and providers (experts in the system); feedback from patients
  - Feedback and ideas from Patients – the ***WHY*** of our process design
- The best available evidence; change packages; knowledge sources (e.g., IHI, Agency for Healthcare Research and Quality, aka, AHRQ, IHQI UNC)

Building Processes to Support SDOH Referral



Source: IHI

Building the System for SDH Referrals

Start with your existing care coordination processes

- Current care coordination processes – do one or more align with the needs of a process for SDOH referrals? Are these processes effective?
- Can one or more of these be used as starting points to build a referral process for SDH referrals?
- Does anything need to be added, revised?
- Either way, a necessary step is to specify a workflow for SDOH referrals and test it using the Model for Improvement (rapid cycle testing) to ensure that it works for SDOH referrals

https://hbr.org/2018/05/the-surprising-power-of-questions

Build Process Workflows to Support Standard Work & Reliable Execution

A. Develop and use high-level flow chart to describe the details of each process step to support reliability of process

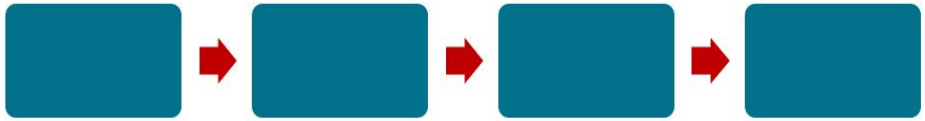
B. Use and update as you test, finalize when you get to a process that works

C. Develop the process map as you build the process to support standard work

D. Use both to train staff and provide for staff to use as they work and to counter “human factor issues”

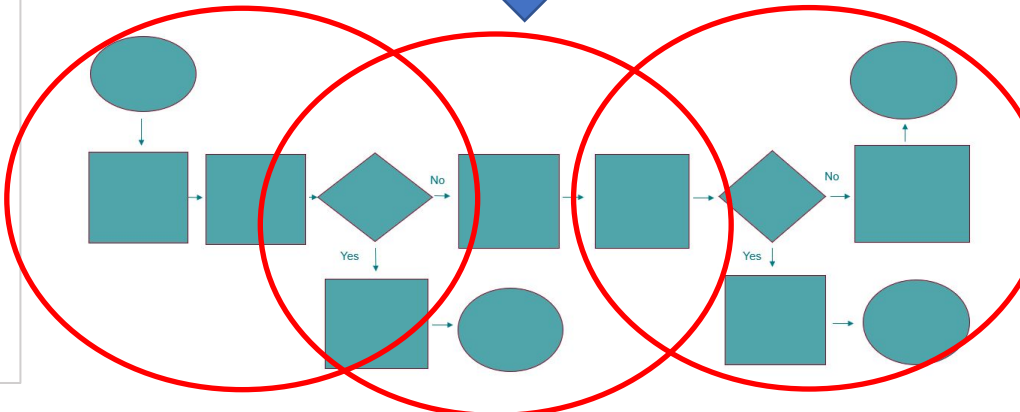
E. Don’t laminate the final flow chart or process map! Conditions or requirements can change over time and workflows may need to be updated and/or revised.

High level flow chart



Attributes for each step: Who, What, When, Where, How

Process map



Key Questions for Building an SDH Referral Process

Who will respond to social determinants data?

- A dedicated staff person?
- Any staff person who administers PRAPARE with the patients?
- The provider?

Where will referrals and/or resource provisions take place?

- In a private office?
- In the exam room?

When will referrals take place?

- Immediately after need is identified?
- After the patient sees the provider?
- At the end of the visit?
- Will it depend on patient and their needs?

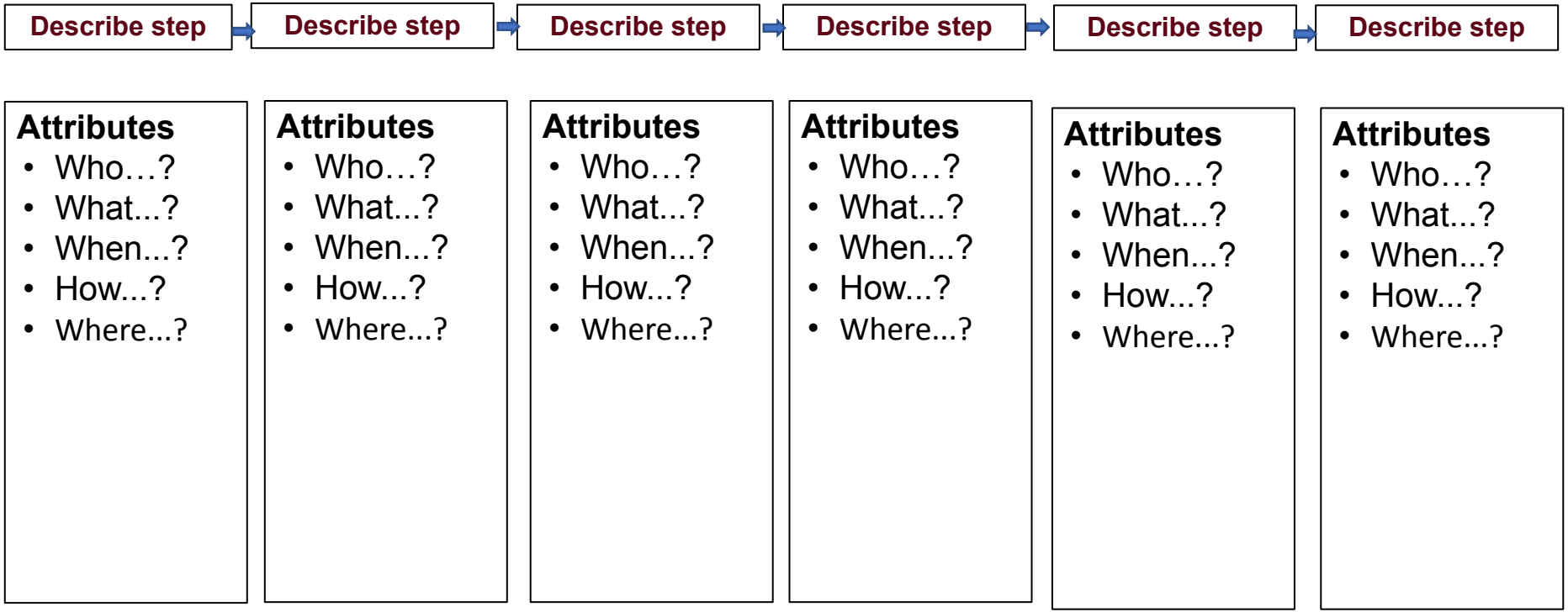
What information and resources do you have to respond to social determinants data?

- Up-to-date community resource guide and referral list with accurate information?
- Searchable database of resources (in-house or through a partner or CRP)?
- Printed resource for patients to take with them?

How will patients be connected to a community resource and how do you close the loop?

- Warm hand-offs? For all or some patients?
- For which patients is the referral most important? (Use a population health risk lens to assess)
- Which patients and/or for which needs can patients connect with resource on their own?
- How will you document and track referrals to close the loop?

High-Level Workflow Chart
for Design, Testing, Training, Observation



Process: Screening Patients for SDH

Process Step: Patient is screened

What: PRAPARE Screening Tool

When: At annual visit for each patient

Who: front desk gives patient the PRAPARE form and asks them to complete the screening tool

Where: patient completes the screening tool while in waiting room

How: Manual – paper and pen

Materials: PRAPARE screening tool, clipboard, pen or pencil

Process Step: Information from PRAPARE entered into the patient's medical record

What: Enter the data from the PRAPARE into patient record in EHR

When: As soon as patient completes it if before patient is called back to the exam room; otherwise, MA who is supporting provider enters the data after rooming the patient, so data is available to the provider for the visit

Who: Front desk clerk or M.A.

Where: Front desk or exam room

How: enter data into E.H.R.

Materials: screening tool with answers from patient and E.H.R.

Process Step:

What

When

Who

Where

How

Materials

Process Step:

What

When

Who

Where

How

Materials

Process Step:

What

When

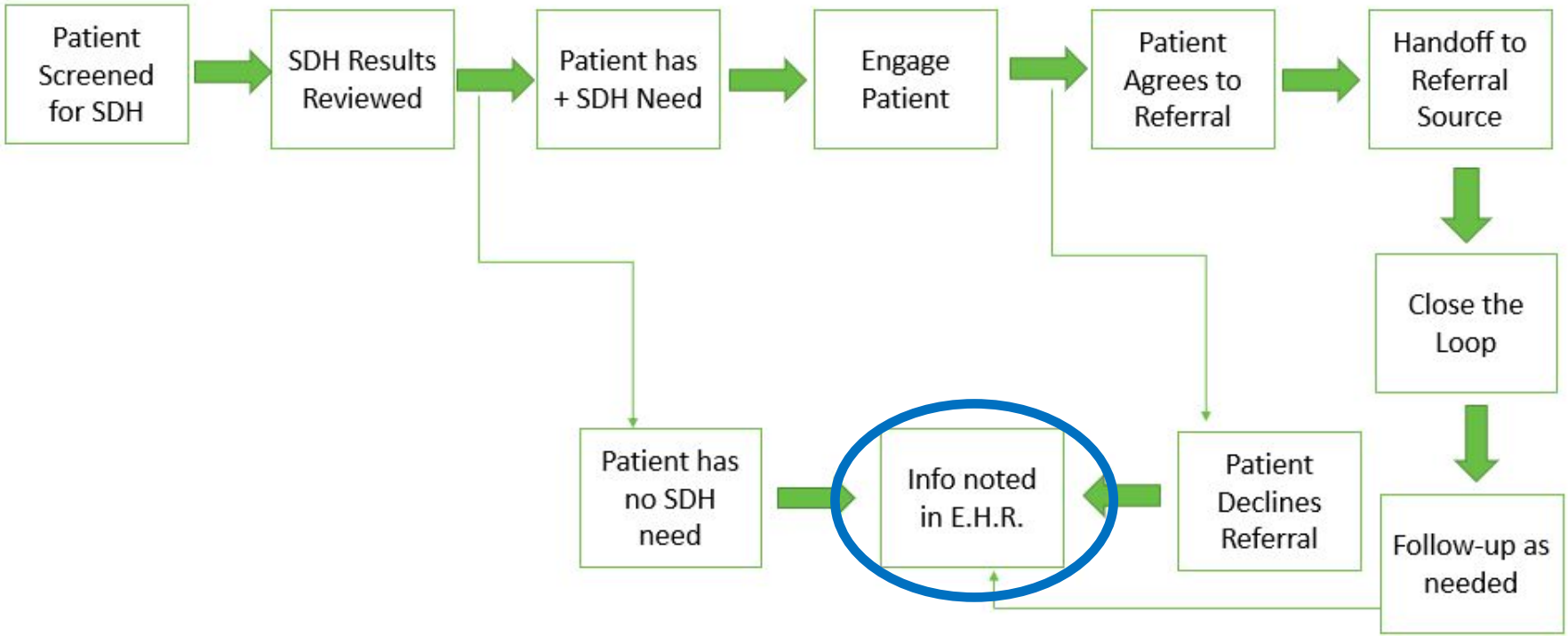
Who

Where

How

Materials

Example of a Process Map for SDH Referrals



Staffing the SDH Referral Process

Specific staff used for the referral process depends on:

- Staffing capacity and capability at any role or title level
- The specific SDH that has been identified for referral

Non-clinical staff: patient navigators, community health workers, outreach staff

Clinical staff: nurses, medical assistants, behavioral health specialists

Care coordinators and/or care management staff

Chronic disease management staff, both clinical and non-clinical staff, e.g., nurses, health educators, social workers, dieticians

Behavioral health, substance use staff

Design with Patients in Mind

Connecting with the Patient to Engage & Build Trust

Photo source: The Wellness Coalition
https://www.thewellnesscoalition.org

Use an approach designed to engage the patient (empathic inquiry, motivational interview, talk story approach, etc.)

Focus is on the activation and inclusion of the patient (nothing about me without me)

Goal – seek to understand the patient's view of their needs and goals; what matters to them. Encourage their questions; assess their readiness and interest

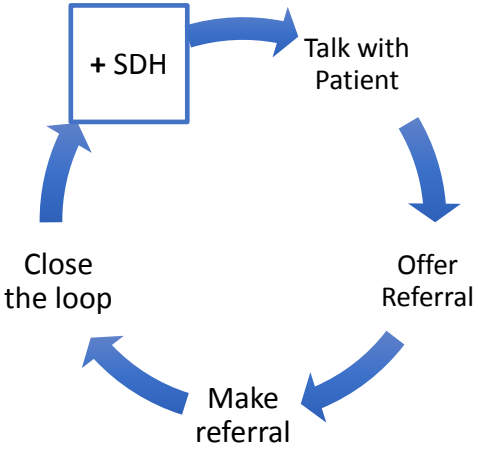
Describe why the SDH needs matters & why we care about them; Inform on how the referral works. If patient requests time to think about it, build in a step to follow-up so it does not slip through the cracks. Accept a decline; follow-up next visit

Train the staff who will meet with the patient for these conversations.

Designing the Process for Making the Referral and Closing the Loop

What Will Best Support the Patient?

- How able is the patient to follow-up on the referral for an SDH need on their own?
- In the context of risk, how important is it to ensure the patient gets the support for the identified SDH(s)?
- Use these factors to determine which patients need to have a warm handoff to one or more support resources
- For those at most risk, closing the loop will also need a more active approach and process
- For those who do not need warm handoff how will you provide resources and close the loop for any referral you provide or suggest?
  - Evaluate the mechanism for finding and/or connecting with a resource to avoid barriers that could create or amplify a disparity for the patient



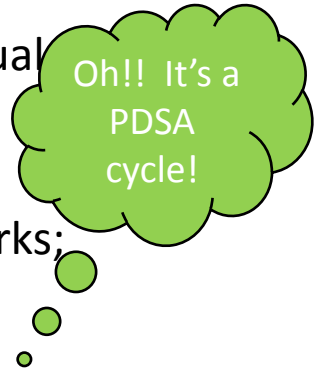
Get Feedback from Patients on Referral Process, Resources

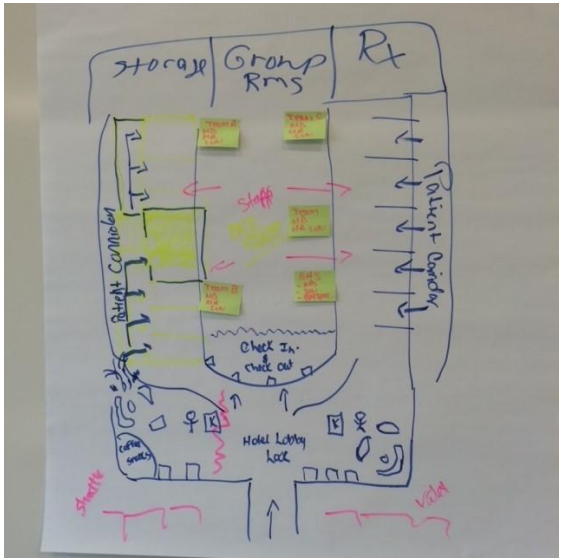
For any community-based resource you refer patients to:

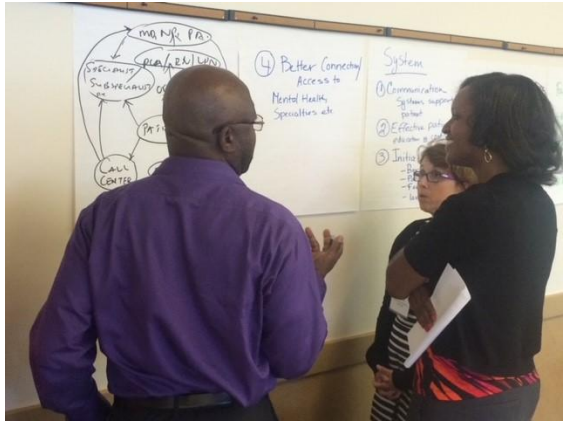
- Include the referral process in your small tests of change to test your process
- Assess the effectiveness of the community-based resource to meet patients need for support
  - Get feedback from patients on their experience with your referral process
  - Ask about the experience and usefulness of support they received
- Based on what you learn through the testing process, evaluate and revise your workflows and the resource partners to ensure the most effective results for patients.

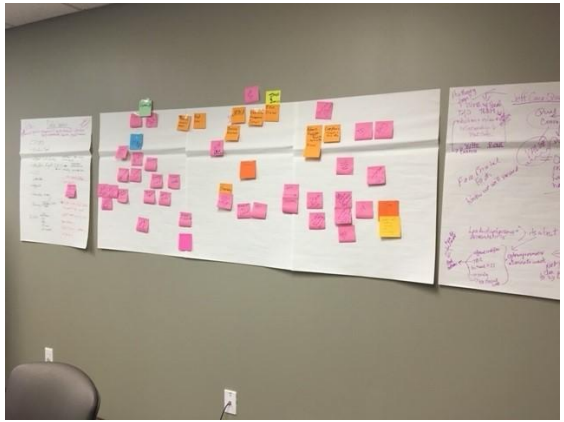
Approach for developing and testing your workflows

- Use paper and pen/pencil and/or post-it notes on the wall to free yourself to do as many drafts as necessary.
- Ask staff involved to work with you and/or to give you feedback. Using visual tools gives opportunity to stand back and look at it.
- Don't seek perfection – it is an iterative process of learning and discovery
- You will test it before you decide it is final – this is how you'll know if it works; make changes and retest as needed to develop final process
- You will use the learning from testing to move toward a final version
  - Could take a few or many rounds of testing, learning, tweaking, testing, learning, tweaking, etc., to get to the version you will adopt/use
  - Get patient feedback as you test to consider patient experience as an important input for designing the process
- This becomes "they way we carry out this process here"
  - Requires several steps: train staff, observe and help ensure everyone knows how to carry out the process
  - Implement steps to sustain for standard and reliable use




Storage
Group Rms
Rx
Patient Corridor
Patient Commons
Staff
Check In · Check Out
Hotel Lobby Lock
Coffee Snacks
Shuttle
Valet


Specialists Surgeons
Call Center
4 Better Connectivity Access to Mental Health, Specialties etc
System



Identifying Resources for Support

Identifying Resources for Support

- Does your organization have relationships with, or knowledge of existing community resources?
- Do you have a database of resources for various categories of SDH?
  - Who maintains it?
  - How do you continue to build it?
- Where are the gaps in resource availability? How can you address these?
- Have you explored or are you using any of the Community Resource Platforms? Which one(s)?
- Who in the organization is or should be leading the work to develop and maintain the resource network you need to support your patients?

Resource Packet

Salvation Army of Johnson City (423) 926-2101
204 W Walnut St., Johnson City, TN 37604
https://www.salvationarmyusa.org/usn/contact/
Hours of Operation: Monday-Friday: 9:00 AM - 4:00 PM
Description: The Salvation Army is a Christian organization, which works with adults, children, and families who are in need of assistance. They provide food to the hungry, safe shelter to the homeless, clothing for those in need of a transition wardrobe or simply something better, cleaner, or warmer. The appreciate donations.

Source: **Brittany McCoy, BSN, RN**
Care Coordinator, East TN State University (Johnson City Community Health Center)

Consider Community Resource Platforms (CRPs)

Access to a resource directory that is typically geographically specific and often wide-ranging in types of resources

Resources can be filtered by a patient's location and their identified social need.

Information on resources can include hours of operation, required documentation, capacity, and other details.

Resource directories can also be accessed by patients or staff on behalf of patients to find resources

Referral Management & Integration Using CRPs

There are typically costs for this level of service

- Platforms provide the ability for clinics to create client profiles, integrate with their existing E.H.R. (may not support all E.H.R.s), and track the status of patient referrals.
- Allow health centers to conduct closed loop referrals including referral acceptance, patient contact, receipt of services, need resolution

If interested, review platforms for your geography carefully to determine which would be most beneficial for your health center

Then call and get to know them. How receptive are they to the conversation. Test them before committing.

Track referrals & automate follow-up

- Sync referrals with Salesforce or other CRM
- Automate follow-up with text messages and emails to clients

Customized intake & screening forms

- Screen for disease, resource insecurity, and more
- Design a custom intake process to serve clients' needs faster

Customize your referral database

- Build a list of preferred referrals just for your clients
- Share notes and resource collections with colleagues

"One Degree Plus makes our work faster and more effective. We can quickly generate reports for ourselves and our funders to see our impact. It's easy-to-use for our staff and the homeless families we work with.

Powering Care Across Communities: Through COVID-19 and Beyond

Healthcare organizations need to urgently address the surge in health-related social needs and access disparities. To support people today and move toward a better—more equitable, value-driven—normal, we must power community care.

NowPow connects people to the right community resources so they can stay well, meet basic needs, manage with illness and care for others more effectively. NowPow's personalized community referral platform fits into existing workflows, making it easy for clinicians, case workers, resource coordinators, payers and others to make high-quality referrals to trusted community services.

From food banks, in-home nursing care service, and diabetes management, to cancer support, mental health counseling and respite care, NowPow helps people know where to go when needs arise—throughout all of life's ages and stages.

Match	Filter	Engage	Close the Loop	Analyze
Identify health and social needs (with or without a screening) and automatically map those needs to optimal services using NowPow's evidence-based algorithms	Funnel results by critical access factors like COVID-19 operating status, location, preferred language, documents needed, insurance status and other eligibility requirements	Make personalized referrals to people via text, email or print in 100+ languages and send nudges to encourage follow through—or, give people direct access to search in support of self care	Track or coordinate referrals with community partners and stakeholders at all points throughout the referral process for enhanced support and measurement	Use generated data to understand outcomes at the individual, partner, population and community levels, assess resource gaps, and inform reimbursement strategies and policies

UNITE US

At a Glance

People don't live in hospitals, they live in communities. Our intuitive and seamless technology, coupled with our experts working locally, is changing the traditional care delivery model to one that holds providers accountable and goes beyond the referral.

Why work with us?

A clear mission
We connect health and social care.

Roots in the community
Dan Brillman and Taylor Justice founded Unite Us in 2013 to serve veterans, which has grown into a national movement in communities to **connect everyone to the care they need.**

A proven track record
In the past seven years, communities in **over 42 states** have launched local networks with workflows configured for each organization and optimized to meet the needs of the people seeking services. We also received $150 million for series C in March 2021.

Rapid growth across the map
We currently have **over 600 team members** with offices in New York, North Carolina, Oregon, California, Kentucky, Louisiana, and Washington, D.C.

A focus on outcomes
Our platform tracks actual service delivery outcomes – **100% of the time.**

Strategic network configuration and implementation
We believe there should be no wrong door for people seeking services, and we have the resources, people, and processes to build **truly engaged and accountable networks.**

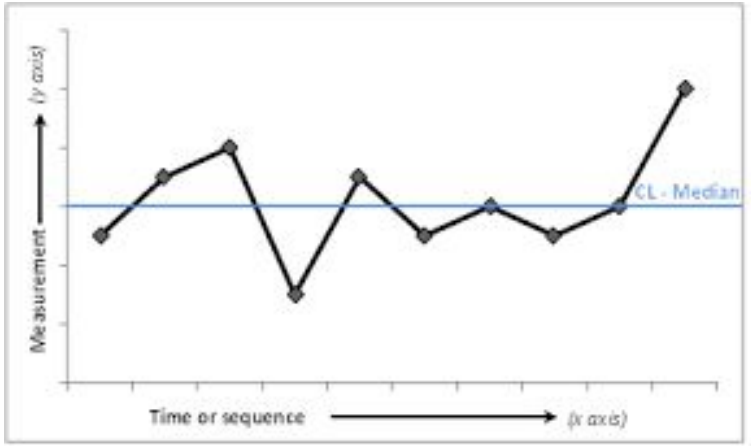
A scalable solution
Over **37,000 network partner organizations** provide more than **113,000 programs** through Unite Us, delivering services such as housing, mental and behavioral health, transportation, education, employment, legal, food, and benefits assistance.

The most innovative cross-sector partnerships
Some notable partners include:

lyft · United Way · CVS Health · NC Department of Health and Human Services · Humana.

Measurement Matters: How are you measuring progress?

- What's working? What's making a difference? What are patients saying?
- What are you measuring about your SDH activities? Start with one or two
  - # patients screened
  - # with positive SDH
  - Positive screens by type
  - Referrals made
  - Feedback from patients about experience and usefulness of resources
  - # of closed loops
- How are you displaying the data? With whom do you share the data?
- How does the data inform the need for changes or improvements in workflows?



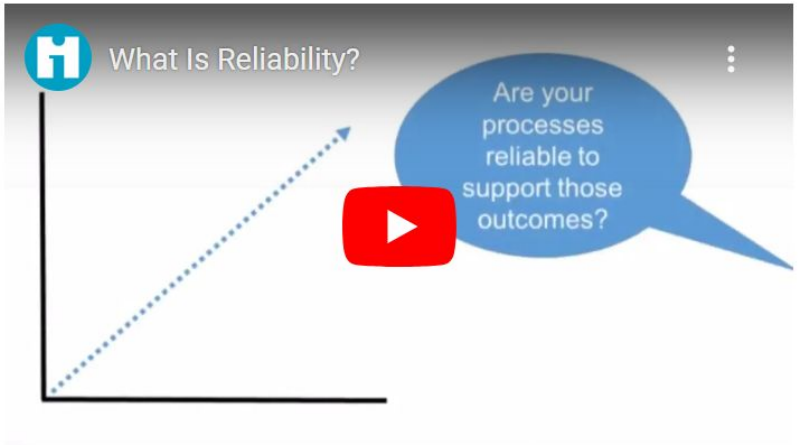
Idea to Action: What is One Thing We Can Try?

Is there one idea from today's session that resonated for you as you think about your work to develop high performing, reliable and patient-centered SDH referral processes

Resources

What Is Reliability? (Part 1 of 5)

Frank Federico, RPh, IHI Executive Director



Have trouble viewing this video? Read the transcript.

This is the first video in a 5-part series. Click here to watch the next video and learn about how you can make processes reliable.

Learning Objectives: At the end of this activity, you will be able to:

- Define reliability.
- List several examples of reliable designs.

More in this series:

What Is Reliability?

How Can You Make Processes Reliable?

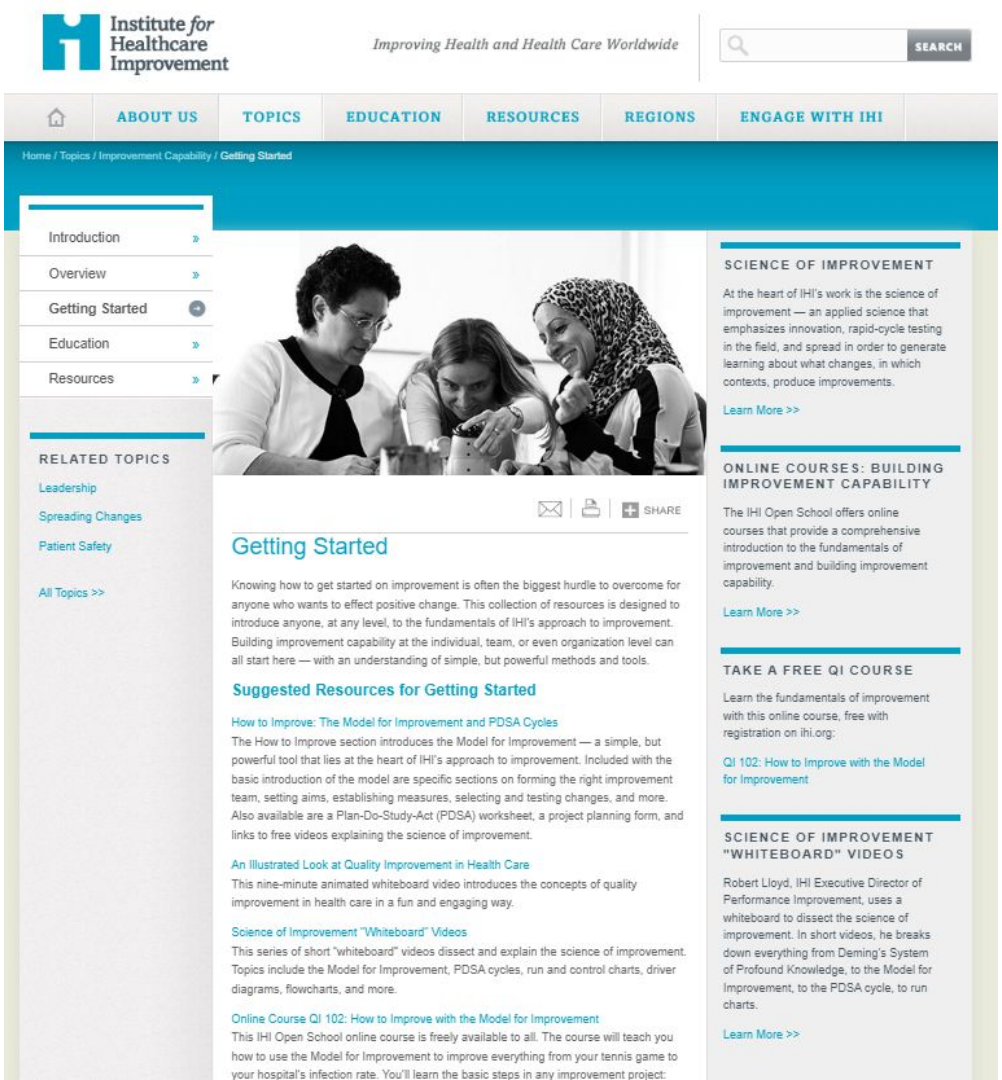
What Is the Goal of Reliable Design?

Why Do You Need a Back-Up Plan?

How Can Data Drive Reliability?

Bonus: IHI's Whitepaper on Improving the Reliability of Health Care

https://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/FrankReliability1.aspx



https://www.ihi.org/Topics/ImprovementCapability/Pages/GettingStarted.aspx

https://prapare.org/prapare-toolkit/

TABLE OF CONTENTS

Click on the chapters below to view resources and best practices on that implementation step. Building off of the roots of the PRAPARE name, chapters are organized based on whether they help users **"PREPARE"** for social determinants data collection, **"ASSESS"** social determinants of health data, or **"RESPOND"** to social determinants of health data. There will be webinars on each chapter to highlight examples from the field.

Questions to Guide the Development of Screening and Referral Processes and Workflows for Social Determinants of Health

- For which Social Determinants of Health (SDH) are you interested in screening patients and providing referrals for support for those who screen positive?
- Which patients (be specific) are being screened and when/how frequently or at what specific intervals or at which specific visits?
- Which Screening tool(s) are being used? Are they use in whole or are you selecting only some questions from the screening tool? If you are selecting only some questions, which ones and why these questions?
- How is the screening carried out? Who does it, when is it done, where and how?
- How is the screening info entered into or moved to your E.H.R. to make it available as part of the patient's information? Is the information in the E.H.R. as structured data to enable tracking and reporting?
- Do the patients' care teams know to review the SDH screening results as part of the care process, and do they have a process for reviewing the results with patients? Who talks with the patient about the results and the options for support when the patient screens positive for an SDH?
- What is the process for working with a patient who has screened positive to address the options for support?
- How do you identify resources for providing support for the SDH(s) you screen for? Do you have established community-based resource providers with whom you have a relationship and to whom you refer patients? And/or do you use one or more of the community resource platforms that are available?
- How are patients connected to a resource? Do you use cold and/or warm hand-offs? Or a mix? If a mix, when do you use the warm handoff and who is managing it?
- Regardless of handoff type, how do you follow-up with patients about the referral, whether they got support and if the support they received was helpful to them? What other feedback about the experience are patients able to provide? Do you record this information in the patient chart or some other database?
- What data do you track these processes and how and how frequently do you use the data to evaluate the process and outcomes for patients? Do you share it with others in your organization? Care teams? Leadership? Governance entity? Do you use the data to monitor results and improve your SDH screening?

rneal@comagine.org

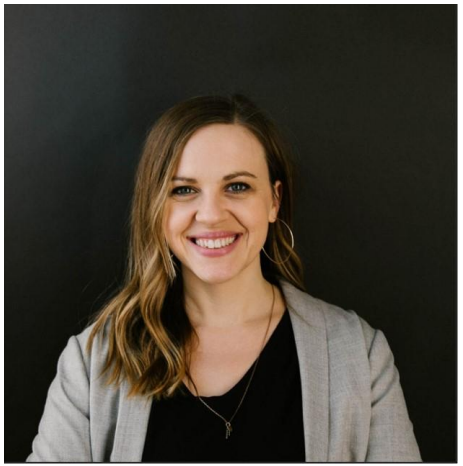
Questions?

Regina Neal

Rneal@comagine.org

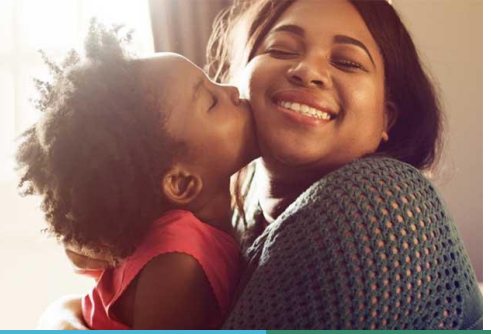
COMMUNITY
CARE COOPERATIVE

Kim Prendergast, RDN, MPP
Vice President, Social Health
Community Care Cooperative



Molly Totman
Director, Quality
Community Care Cooperative

COMMUNITY CARE COOPERATIVE



Improving Diabetes Control through Quality Improvement and Social Health Interventions

Kim Prendergast, Vice President, Social Health
Molly Totman, Director, Quality

Agenda

- About Community Care Cooperative (C3)
- Our Quality Program, Social Health Strategy & MassHealth Flexible Services Program
- Leveraging Social Health Interventions for Quality Improvement

Community Care Cooperative (C3)

We are a 501(c)(3) not-for-profit organization created and governed by Federally Qualified Health Centers (FQHCs).

Our Vision is to transform the health of underserved communities. We unite FQHCs at scale to advance primary care, improve financial performance, and advance racial justice.

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www.communitycarecooperative.org

Our Current Statewide Footprint

1. Hilltown Community Health Center
2. CHCFC
3. Holyoke Health
4. Family Health Center of Worcester
5. Edward M. Kennedy Community Health Center
6. Lynn Community Health Center
7. NSCH
8. Charles River Community Health
9. Fenway Health
10. New Health
11. UCHC Upham's Corner Health Center
12. The Dimock Center
13. Brockton Neighborhood Health Center
14. Community Health Center CHC
15. Community Health Connections
16. Springfield Partners for the Homeless
17. Island Health Care
18. Kronos Health

New Health Centers
Effective 4-1-23

19. Greater Lawrence Family Health Center
20. Greater New Bedford Community Health Center
21. Outer Cape Health Services
22. Duffy Health Center
23. Caring Health Center

Medicaid ACO

An ACO is a provider-led entity (e.g., a group of providers or a health system), that includes PCPs

ACOs are expected to deliver a coordinated and improved member experience

ACOs are financially penalized for overspending budgets and/or not meeting quality goals

ACOs are expected to build explicit coordinated care teams with providers across the care continuum

ACOs are rewarded financially for achieving costs and quality measures

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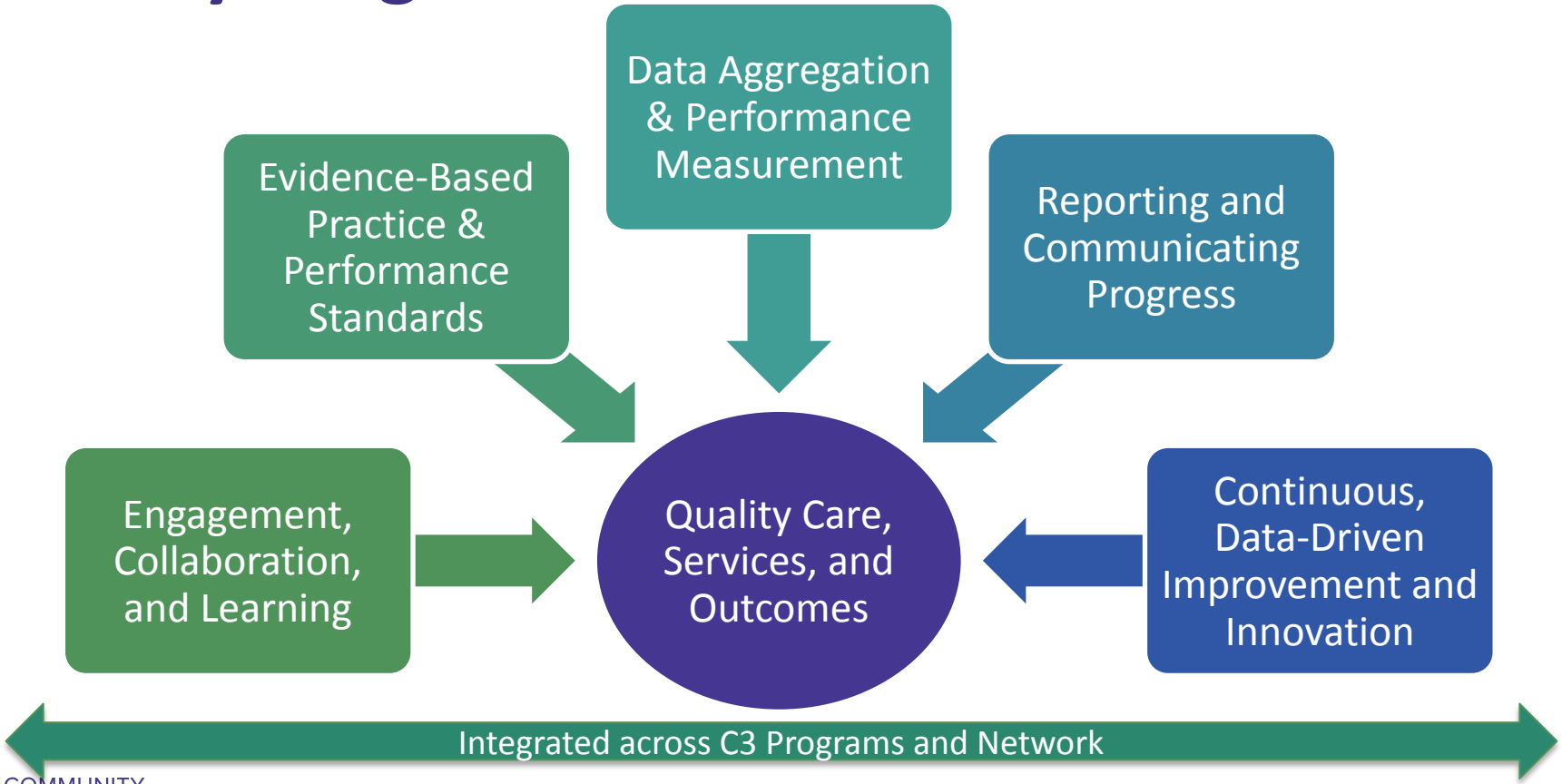
Quality Program Framework



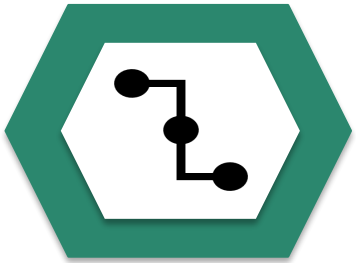
Performance Measurement

- Slate of Quality Measures across several value-based contracts.
- MassHealth Quality Measures within this presentation:
  - Diabetes Care: HbA1c in Poor Control (>9%) (Inverse)
    - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year.
  - Health Related Social Needs Screening
    - The percentage of ACO attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

Our Approach to Addressing HRSNs

Identify & Understand Health Related Social Needs

- Annual universal screening for HRSN
- Use Accountable Health Communities screening questions
- Ongoing Performance Measurement



Connect Members to Community Resources

Equip health center and C3 staff with tools and expertise to refer members to resources to address their needs:

- findhelp.org
- Partnerships for SNAP and WIC enrollment
- Training & webinars related to available programs and resources for members

Invest in Programs and Advocacy Efforts

- Create new programs and interventions where existing resources are insufficient for members' needs
- Advocate for policy changes that improve community conditions and promote good health

Massachusetts Flexible Services Program

Program Overview	• Medicaid funding to address food security & housing needs.
Goal	• Improve members' health outcomes (**Diabetes Control**) and reduce Total Cost of Care.
Program Eligibility	• Medicaid ACO members who meet specific criteria for both health and social needs.
Delivery of Services	• ACOs should partner with high-capacity Social Service Organizations to provide services.

Our Flexible Services Program Approach

We built a portfolio of 20 programs with social service organization partners to address the nutrition and housing needs of our most complex members.

Food Security

For members with food insecurity, our partners assure that eligible members have the necessary assistance and navigation to meals, groceries, nutrition education, and SNAP to support a healthy diet.

PARTNERS

Project Bread
The Food Bank of Western Massachusetts
Eat Well
AF
ESWA Elder Services Of Worcester Area
Community Servings Food Heals

Tenancy Supports

For members with housing instability, our partners provide navigation to housing benefits programs, assistance with housing search and placement for homeless members, and supports for tenancy preservation and eviction prevention.

PARTNERS

Metro Housing Boston
Project Hope Boston
bhn
MOC Making Opportunity Count
Housing Assistance
Eliot
SMOC Everybody Matters
Massachusetts Coalition for the Homeless
Father Bill's & MainSpring Nobody Should Be Homeless

Food Security Interventions

Food Referral Coordination

Connect members to a Nutrition Coordinator for resource navigation, including referrals to programs like SNAP and WIC.

Provide direct services including:

- Food purchasing power and grocery access through **food vouchers**
- Rides **to the grocery store**
- Support disease management and increase healthy eating and cooking skills through **nutrition & diabetes education and coaching**
- Encourage safe and healthy cooking through provision of **kitchen items and appliances**

Other Nutrition Supports

MTM

Medically Tailored Meals

Home delivered prepared meals for members who require diet-specific meals to manage their health condition or who lack the ability or social support to prepare appropriate meals.

Meal Kits

Meal Kits

Home delivered meal kits with ingredients and easy to follow recipes, providing members with a fun cooking experience and healthy eating skills.

Fresh Produce

Produce Prescriptions

Increase access to healthy food by providing food purchasing power for fresh produce or direct delivery of produce boxes.

Tenancy Interventions

Housing Navigation & Case Management

Homelessness

Pre-tenancy supports include case management services for housing search & placement including:

- Reviewing and addressing barriers to housing
- Completing affordable housing applications
- Finding and visiting apartments
- Supporting members with transition into new housing through payment of set up costs

Eviction Prevention

Tenancy sustaining supports include case management services to provide:

- Education and advocacy on tenancy rights
- Assistance with applying for state or federal benefits, including existing programs for financial assistance with rental or utility arrears

Healthy Home Goods

Home modifications to improve housing quality including:

Pest Control

Supplies or extermination services to get rid of bugs, ants, or mice.

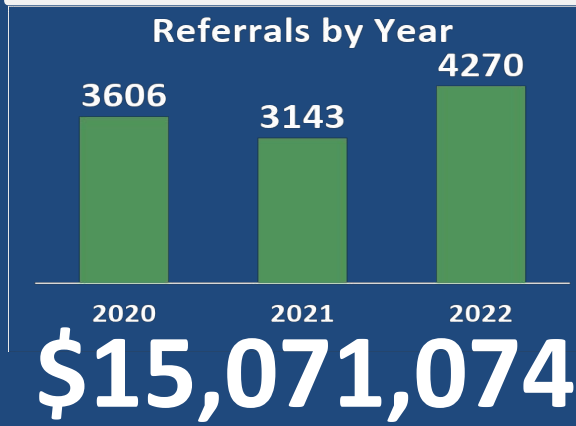
Household Supplies

Such as air purifiers and HEPA vacuum cleaners to improve air quality in the home.

Flexible Services Program (April 2020 – December 2022)

9,673
Members Referred

92% Members successfully connected and received support



$15,071,074
Total spend on services and goods

Referral Source

9,063
Nutrition Referrals

2,560
Housing Referrals

Services and Goods Provided

Nutrition Program

- Over $4.8 million in **food vouchers**
- Over $2.1 million in **home delivered medically tailored meals**
- Over $1 million in **kitchen supplies and appliances** for members to prepare and store healthy food

Housing Program

- Over 1,950 members receiving **individualized case management support** for **housing stabilization** or **housing search**
- Over 447 members received **healthy home goods** or **home modifications**
- 200 members received financial support from Flexible Services for transition into new housing

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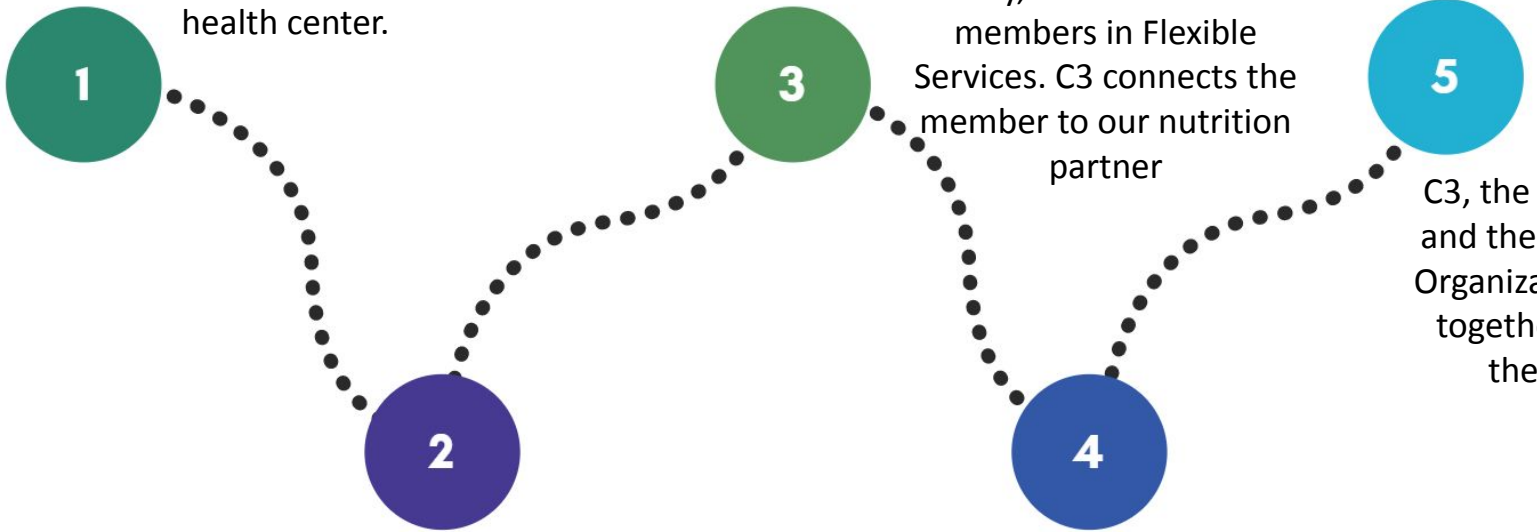
The Member Experience



The member meets with their CHW or RN at the health center.

A CHW completes the HRSN screening and asks the member about their social circumstances and assists with resource navigation.

If a member has diabetes and is experiencing food insecurity, the CHW enrolls the members in Flexible Services. C3 connects the member to our nutrition partner

The member gets a call from the nutrition program staff. They begin receiving goods & services for the six- month program.

C3, the health center, and the Social Service Organization staff work together to support the member.

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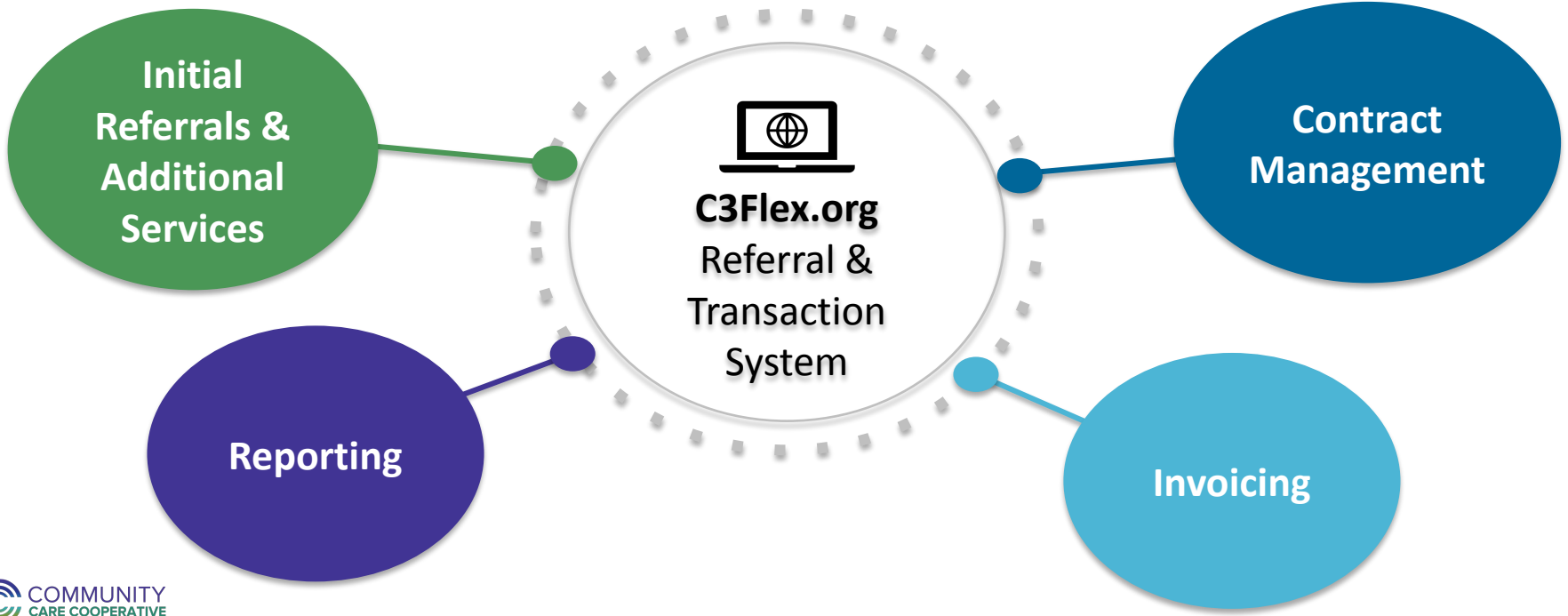
Technology Supports our Work

Customized case management system supports program activities



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Nutrition Program Outcomes

Successful Connection to Resources

- 92% of members referred to Flexible Services receive services
- 67% of members complete the program
- SNAP participation increased from 64% to 72%

Improved food security, diet quality & perceived health

- Access to foods appropriate for diabetes increased from 2 to 3 weeks/month
- Fruit & Vegetable intake increased by ½ serving per day
- >90% of members report that their health status is improved or greatly improved

Improved diabetes control and reduced total cost of care

- **Medically Tailored Meals:** Average HbA1c decline of 0.9%, with decline of 2.4% for those with HbA1c >9.0% upon enrollment
  Total Cost of Care Reduction of $5,552 (p<.001)
- **Gift card & Nutrition Education Program:** *Early analysis* shows average HbA1c decline 0.9 for those poorly controlled upon enrollment

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Contact Us

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Read more about our Flexible Services program here:
FSP.CommunityCareCooperative.org

Q&A

NNCC Future Trainings

- The Role of Community Health Workers in Breast Cancer Screening Equity
  February 8, 2023 at 2:00pm EST
- Mental Well-being and Burnout
  February 8, 2023 at 1:00pm EST
- RN/CHW Care Team Model for Infectious Disease Treatment: From Research to Practice
  February 23, 2023 at 1:00pm EST

Wrap Up & Evaluation

Please help us measure our impact with this session by filling out the evaluation survey that will pop up on your screen as you exit Zoom.

You must complete the survey to be redirected to the CE link.

Recordings, presentation slides, and resources from Session 3 will be added to the Google Site.

THANK YOU!