Social Determinants of Health: 201

Capacity Building

April House

VP Population Health & Performance Excellence

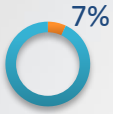
SAN YSIDRO HEALTH

Mission

Improve the health and well-being of the communities we serve with access for all.

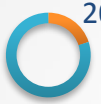
Chronic Disease Burden

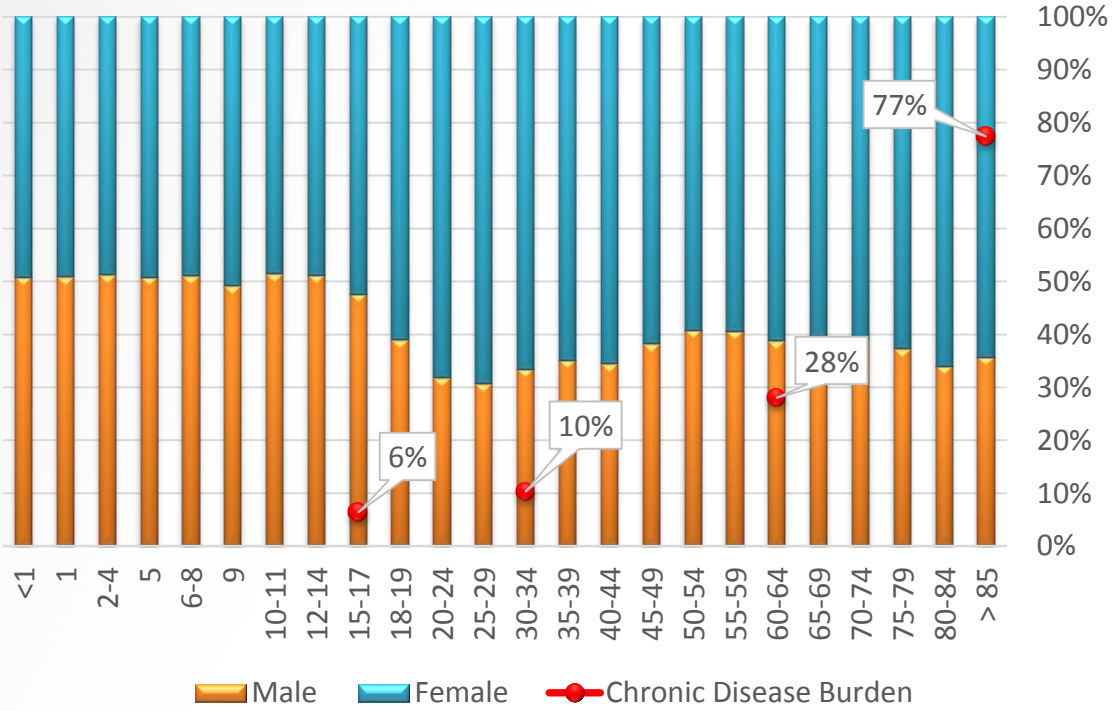
Asthma



Diabetes

Hypertension





Total Burden

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PRAPARE Pilot & Findings

Target Population

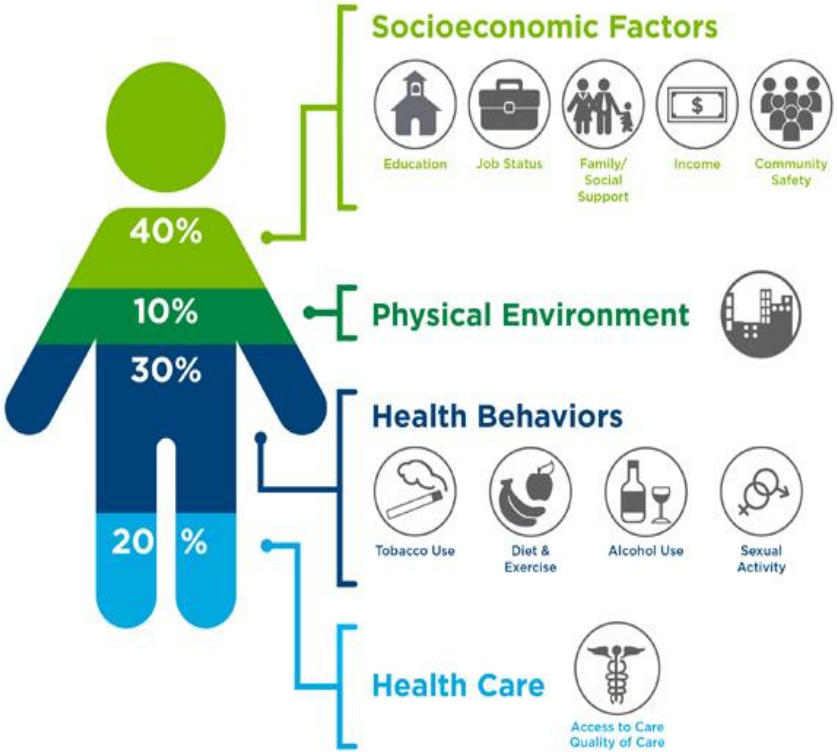
- Care Coordination Enrollees
- Diabetes and/or Hypertension
- Behavioral Health Diagnosis
- 653

Implementation

- EHR & Paper Based Deployment
- Point of Care (15%)
- Patient Reported (15%)
- Client Interview (70%)

Lesson Learned & Plans

- Implement where intervention is most likely, and raise awareness of internal capabilities
- Client interviews were most successful method of meaningful data capture
- Develop the pre-primary care experience
- Transportation was the most immediate concern
- Housing Support, Education, and Employment were identified the most after transportation



Social Determinants of Health (SDOH)

- 1,300 Homeless
- 5,400 Public Housing Assistance
- 55% Unemployed or Underemployed
- 54% High School Graduate or GED
- 48% Reported Moderate to High Stress Levels

SYHealth Model of Care

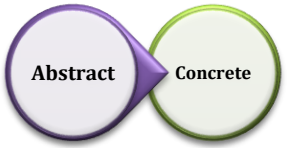
Intensive Primary Care Vision

Abstract

Optimize process of care resulting in the delivery of safe, high quality care that improves health outcomes by leveraging and elevating the capabilities of the care team.

SYHealth Model of Care

Intensive Primary Care

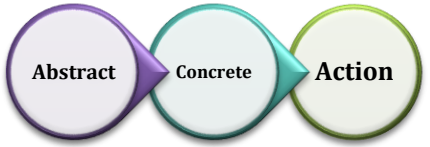


Pre-Primary Care	Point of Care	Post-Care

Optimize process of care resulting in the delivery of safe, high quality care that improves health outcomes by leveraging and elevating the capabilities of the care team.

SYHealth Model of Care

Intensive Primary Care



Pre-Primary Care

Point of Care

Patient Check-In → PAR Process → MA Process → Provider Process → Other Services → Patient Checkout

Post-Care

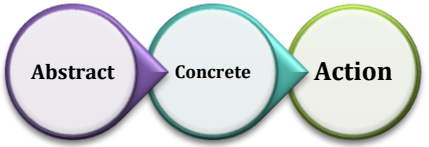
Optimize process of care resulting in the delivery of safe, high quality care that improves health outcomes by leveraging and elevating the capabilities of the care team.

	Pre-Primary Care	Point of Care	Post-Care
Goals	➢ Initiated/Completed Assessment ➢ Initiated Plan of Support	➢ Fully Informed Patient Interaction	➢ Plan of Support ➢ Education ➢ Navigation ➢ Ongoing Support
Roles	▪ **Patient Navigator/Social Worker** ▪ Call Center ▪ Patient Access Representative ▪ Behavioral Health ▪ Care Coordination/Management		▪ **Patient Navigator/Social Worker** ▪ Call Center ▪ Patient Access Representative ▪ Behavioral Health ▪ Care Coordination/Management ▪ TOC Specialist

Pre-Primary Care | **Point of Care** | **Post-Care**

SYHealth Model of Care

Intensive Primary Care



Pre-Primary Care

Point of Care

Patient Check-In → PAR Process → MA Process → Provider Process → Other Services → Patient Checkout

Post-Care

Optimize process of care resulting in the delivery of safe, high quality care that improves health outcomes by leveraging and elevating the capabilities of the care team.

Goals

- Initiated/Completed Assessment
- Initiated Plan of Support

Roles

- **Patient Navigator/Social Worker**
- Call Center
- Patient Access Representative
- Behavioral Health
- Care Coordination/Management

Implementation Highlights

- Developed an Organizational Assessment Tool Incorporating Standard Assessment Elements
- Pre-Primary Care Initiation of Assessment
- Train Staff in Phased Assessment Approach
- Escalation & Stratification Criteria
- Plan of Support Management

Key Components

- Additional Staff/Revision of Roles
  - Costs
  - Opportunity
- Leverage Technology
  - Visibility Across the Process of Care
  - Connectivity to Resources
- **COLLABORATIONS & PARTNERSHIPS**

DISCUSSION

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