BEHAVIORAL HEALTH COMMUNITY OF PRACTICE:

ADDRESSING PATIENT BARRIERS WITH COMMUNITY RESOURCES

Facilitator:
Trudi Matthews, MA
Senior Director of Quality and Value Strategy
UK HealthCare

LET'S HEAR FROM YOU!

Do you have a process for referring patients to community resources?

Which resource directories do you use to refer your patients to community-based organizations?

Patient Health Equity, Social Drivers of Health and Barriers with Community Mental Health Resources in Eastern Kentucky

Addressing Patient Barriers to Health Care with Community Resources in Eastern Kentucky

Health Equity

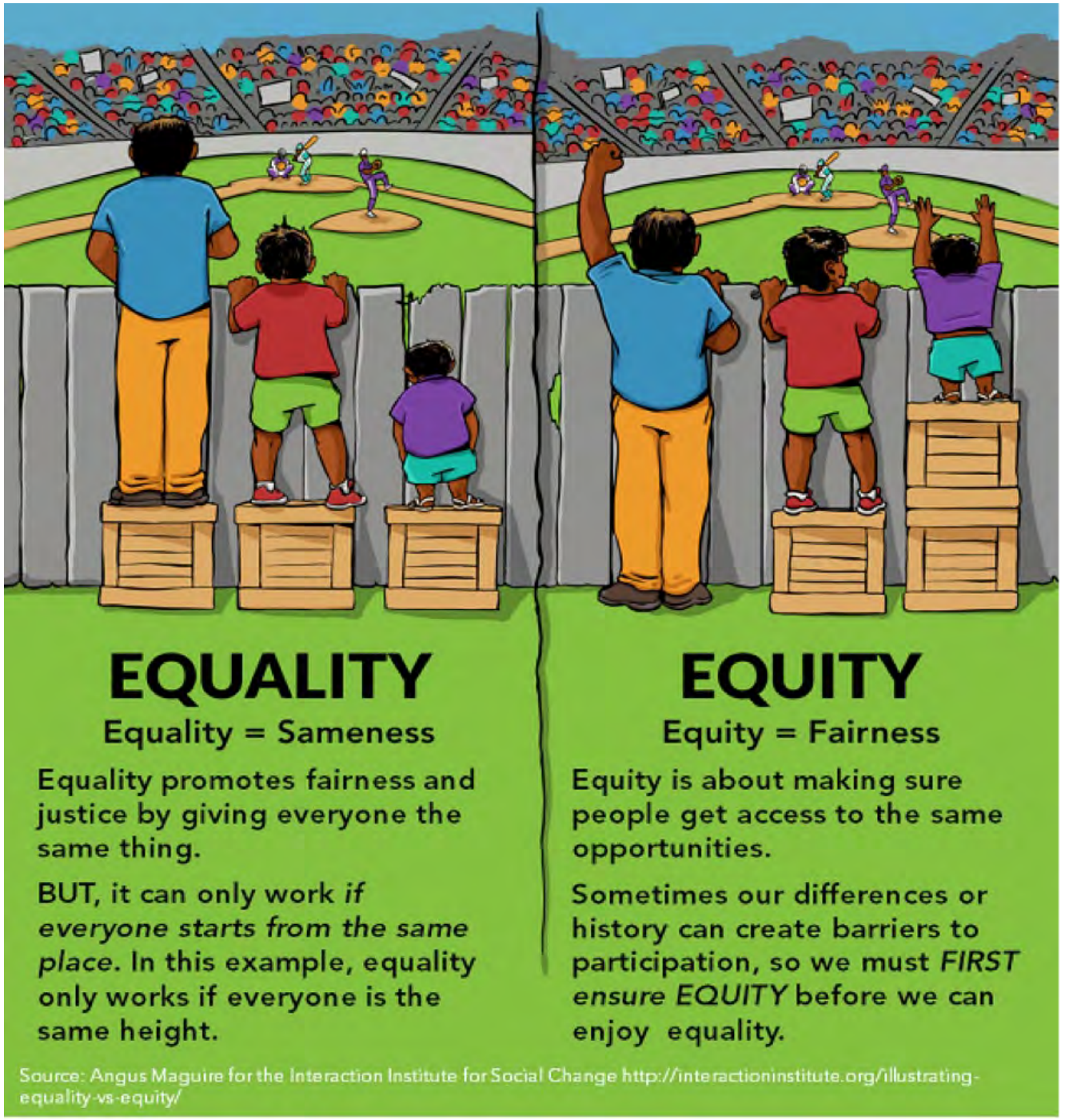
What is health equity?

- According to CDC, “health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities”.

Health Equality verses Equity

What is the difference?

Equality refers to the same access for everyone, while equity aims to change resources for disadvantaged groups to make an even playing field.



Improve health care equity NPSG.16.01.01

According to the Joint Commission improving health care equity is a quality and patient safety priority.

How can healthcare facilities achieve health equity?

- Assess the health-related social needs of each patient.
- Identify any health care disparities in the patient population that is being served by compiling quality and safety data.
- The quality and safety departments to coordinate efforts to address health care disparities.
- Putting technology programs in place.
- Staff training and education activities.
- Create new or improve current processes.
- Improve the organization’s ability to help address patients’ health-related social needs.

Social Determinants of Health

- According to Healthy People 2030 social determinants of health (SDOH) “are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”.

Examples of Social Determinants of Health

- Safe housing
- Transportation
- Finances
- Access to nutritious foods
- Access to physical activity opportunities
- Literacy skills

How does KDMC Screen for Social Determinants of Health?

A social support screening is completed during office all visits, during post ED or admission follow-up calls. This screening consist of 3 important questions which are:

- Are you able to afford your medications?
- Do you have transportation to your healthcare appointments?
- Do you find yourself going without food and/or utilities?

All positive screens are addressed and any available resources are discussed with the patient.

Steps Ambulatory Case Managers Take to Identify Social Determinants:

- Identifying a social need can be done multiple ways:
    - Extend assistance beyond the admission for a social determinate that was identified during admission in the outpatient setting.
    - Identify need through screening questions during an office visit or patient contacting the office with a need.
    - Risk Stratification of patient population

The Role of the Registered Nurse Ambulatory Care Manager in Primary Care

Actively partner with patients and families to provide collaborative transitional and longitudinal care including:

- Physical
- Emotional
- Social
- Financial
- Coordination of care

The Role of the Registered Nurse Ambulatory Care Manager in Primary Care

- Coordinate follow up with Primary Care Provider within 7-14 days of Hospital/ED discharge.

- Provide linkage/referral(s) to community resources or specialty providers to help meet the need.

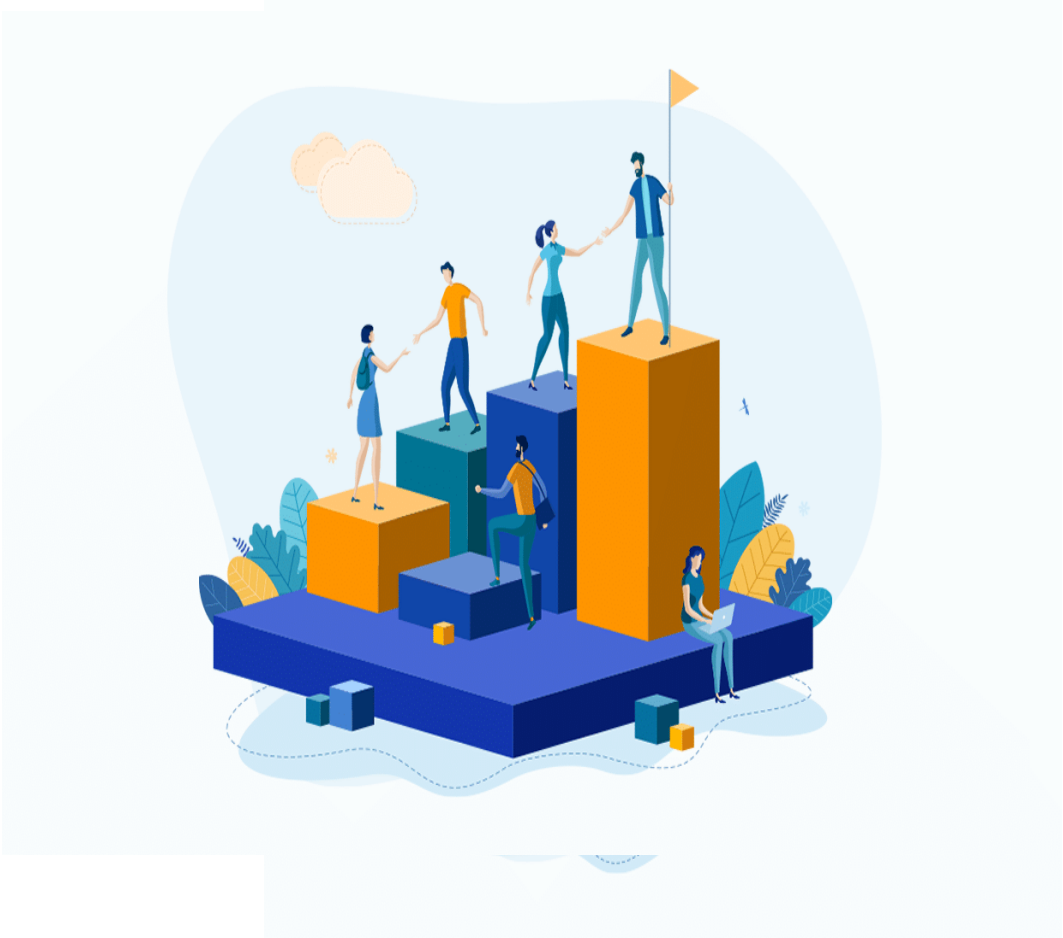
- Follow up with the patient or family to ensure need has been met.

The Role of the Registered Nurse Ambulatory Case Manager in Behavioral Medicine

- Role is similar to that of the Primary Care RN Ambulatory Case Manager.
- Assist to get referrals in timely
- Coordinate outgoing referrals for services not offered at our facility.
- Uses Motivational Interviewing Techniques to identify social, and emotional needs.

The Role of the Registered Nurse Ambulatory Case Manager in Behavioral Medicine

- ED or Hospital Follow- up appointments for patients with mental health diagnosis.
- Needs Assessment
- Screening for Social Determinants
- Provide resources for determinants/barriers.
- Track social determinants identified in clinic and provide to administration.



Barriers in referring to a Behavioral Health Services in Eastern Kentucky

- Not taking new patients
- Shortage of clinics that accept Medicare or Medicaid
- Long waits for next available appointment
- Difficulty finding providers that accept commercial insurance
- Lack of providers accepting children under the age of 14.

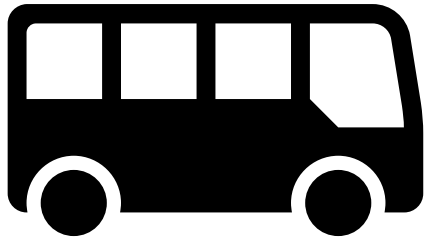
Community Mental Health Resources for Eastern Kentucky and Southern Ohio

- Pathways
- Mountain Comprehensive Care
- Regroup
- Comprehend Mental Health Services
- Shawnee Mental Health (Ohio)
- Community Action Organization (Ohio)

Resources KDMC Uses to Assist with Common Barriers

Transportation:

- City Buses
- Medi Cab



KDMC Van Ministry

Resources KDMC Uses to Assist with Common Barriers

Access to nutritious foods:

- The Neighborhood
- Local Food Pantries
- Assistance with applying for food stamps

- KDMC Basket

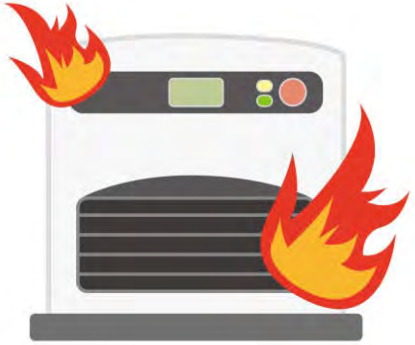
Resources KDMC Uses to Assist with Common Barriers

Utilities:

- Resources for programs that assist with electric/gas bills

Housing:

- Emergency shelters
- Assistance with applications for low income housing



Resources

- https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE
- Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough A. (2017, May 17). What is health equity? And what difference does a definition make? Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.
- https://www.cdc.gov/about/sdoh/index.html
- https://www.leadmn.org/EDI-series1
- https://www.hrsa.gov/
- https://www.cdc.gov/nchhstp/healthequity/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/cdc-strategy.html
- https://health.gov/healthypeople/priority-areas/social-determinants-health

QUESTIONS?
PLEASE DROP QUESTIONS FOR THE SPEAKER IN THE CHAT

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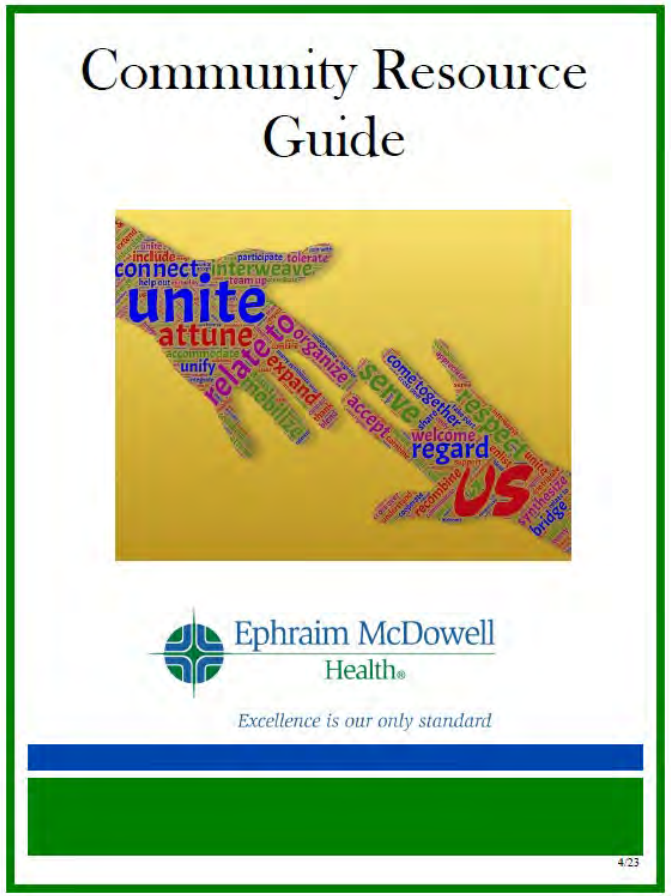
COMMUNITY RESOURCE GUIDE: EPHRAIM MCDOWELL HEALTH



- County-specific listing of community resources
- Family services, health care, housing, legal services, meals, mental health, protective services, public assistance, school resources, senior services, substance use treatment, transportation and vocational rehabilitation

KENTUCKY HEALTH INFORMATION EXCHANGE (KHIE) AND SOCIAL DETERMINANTS OF HEALTH

Andrew Bledsoe, Deputy Executive Director
Commonwealth of Kentucky CHFS Office of the Inspector General

Tracy Williams, Executive Advisor
Kynect Resources

kynect resources

Together for a better Kentucky.

kynect resources

Addressing Patient Barriers with Community Resources

kynect resources Overview

kynect resources is a directory of programs, services, and supports throughout the Commonwealth.

Onboarding to **kynect resources** allows organizations to access tools for referral management, organization metrics, and capturing social determinants of health through a needs assessment.

Categories of help include:

• **Housing**	• **Finances**
• **Food**	• **Education**
• **Employment**	• **Mental health and addiction**
• **Transportation**	• **Legal**
• **Health**	• **And more**

Connecting people to help

Referrals, or requests for help, are made by residents, Community Partners, state agencies, and provider offices. Organizations respond to referrals to close the loop in providing services to the resident.

Community Partners

Manage incoming and outgoing referrals
· Coordinate care across organizations
· Conduct Social Determinant of Health Assessments
· Access an organization metrics dashboard

Social Determinants of Health information is displayed in **kynect resources** from the Needs Assessment or from the Kentucky Health Information Exchange (KHIE).

Onboarding

kynect resources can be used by anyone, though Onboarding steps must be completed for organizations to access the tools and resident information.
Onboarding steps include:
1. claiming your site;
2. creating a Kentucky Online Gateway (KOG) account; and
3. completing the **kynect resources** required training.

benefits

- **Closed loop** referral process to guide **improved outcomes,** strengthen partnerships, promote wrap around services to residents.
- Collect **insights** and **key metrics** concerning **SDoH** to help inform policy, processes, practices and identify potential gaps in services

kynect.ky.gov/resources

Search by keyword or category

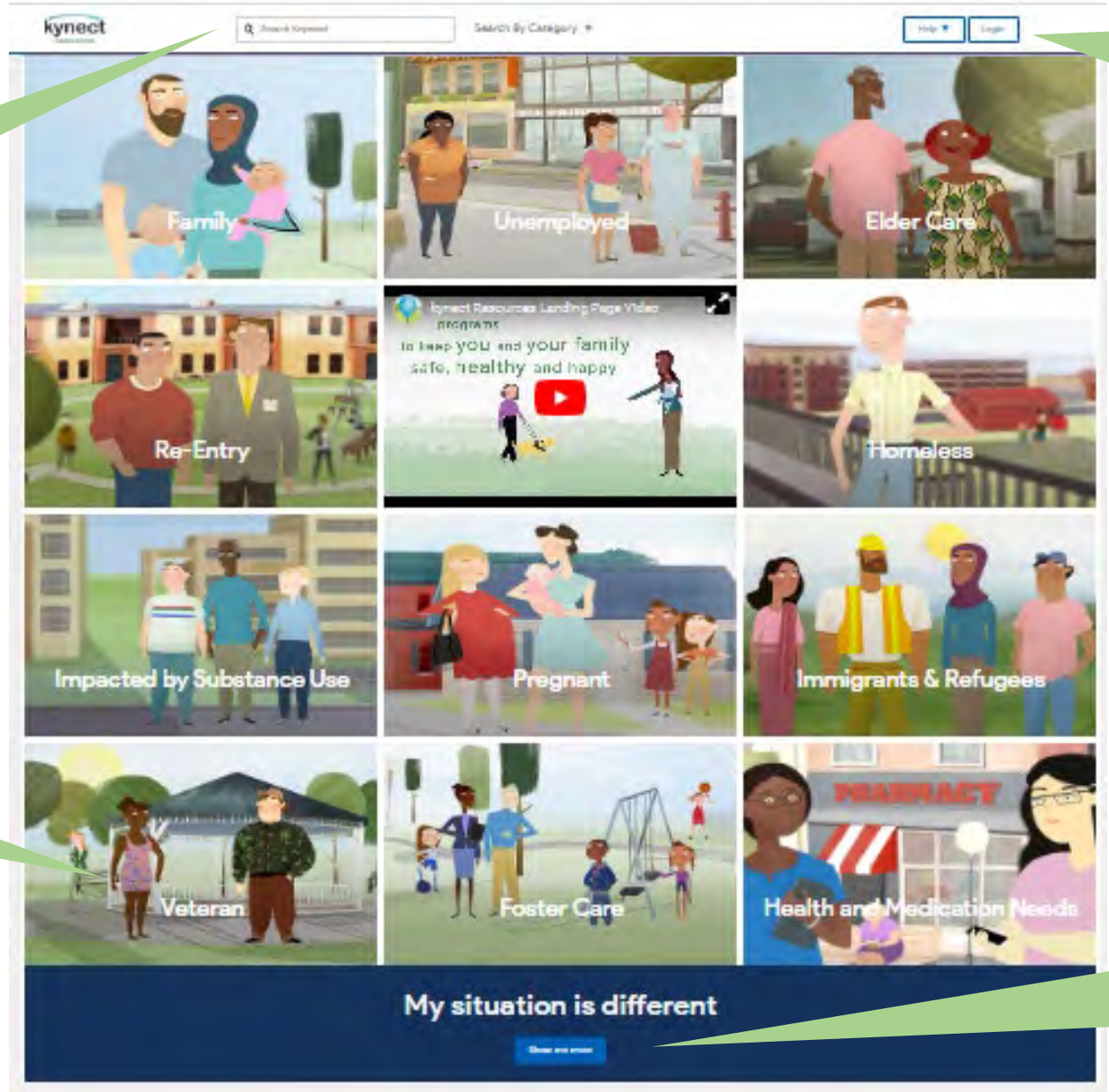
Existing KOG credentials may be used by residents to login

Residents browse programs or services in the community by situation, keyword, or category. Complete Needs Assessment, Create Plan, and share resources

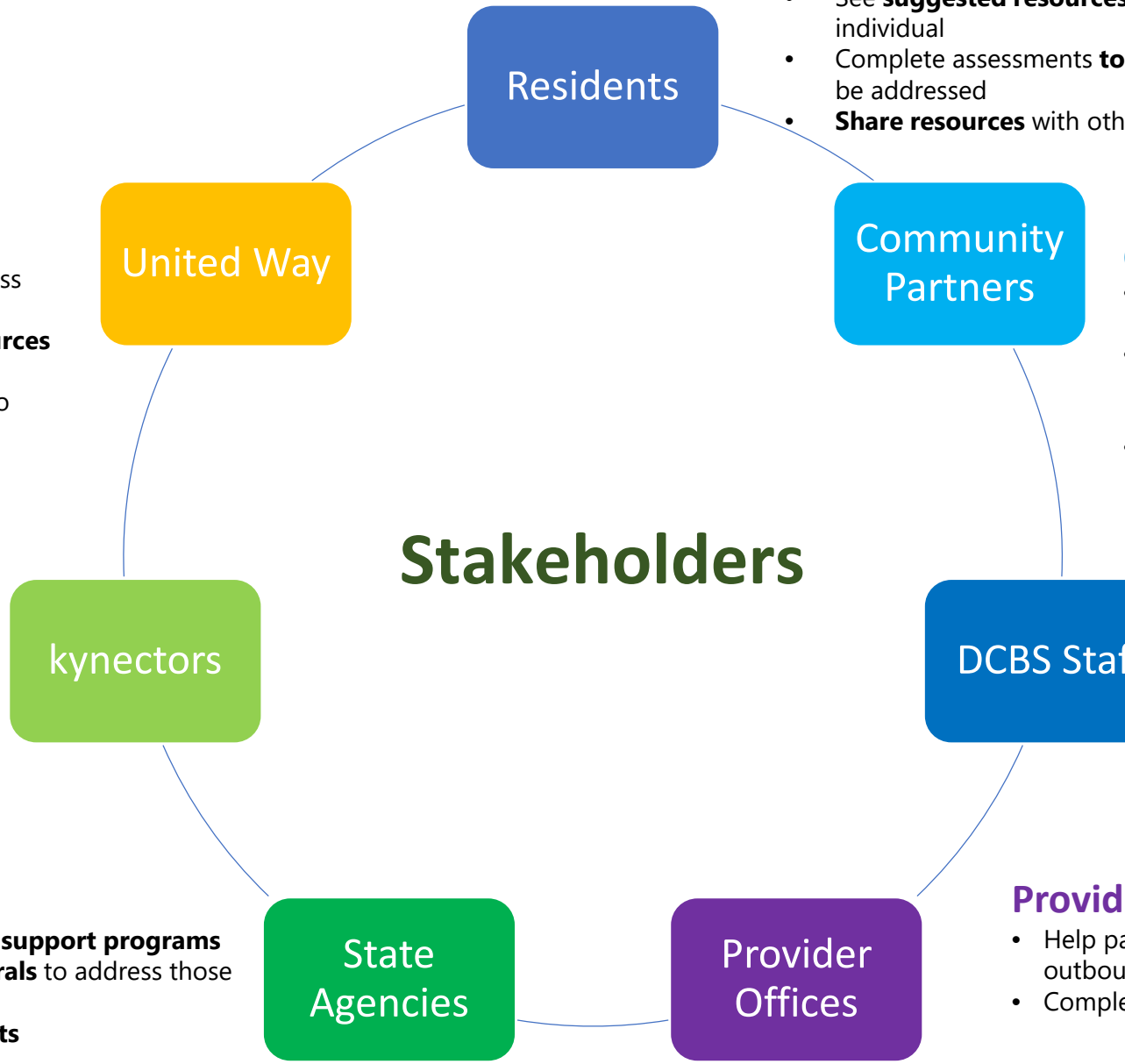
Community Organizations and Programs can manage referral activity and work together with residents and other organizations to address needs

Search by situation

Take a Needs Assessment for a list of resources based on specific needs



Stakeholders



Residents
- **Browse resources** available in the area and connect with them by creating a referral
- See **suggested resources** that could be helpful to the individual
- Complete assessments **to identify areas of need** that could be addressed
- **Share resources** with other Kentuckians

Community Partners
- Support residents by **managing referral activity** in a timely manner
- **Track metrics** related to how your organization is utilizing kynect resources
- Help Kentuckians by **creating referrals** to organizations

DCBS Staff
- Help Kentuckians by **creating referrals** to organizations that could help them
- Help resident **complete assessments**

Providers
- Help patients connect to organizations via outbound referrals
- Complete SDOH Assessments

State Agencies
- Help Kentuckians with **support programs**
- **Find and create referrals** to address those in need
- **Complete Assessments**

kynectors
- Help Kentuckians **find health coverage and create referrals** for resources
- Help residents **address any needs and complete Assessments**

United Way
- Helps Community Partners access
- **kynect resources**
- Provides the **database of resources**
- that Kentuckians connect with
- Provides **2-1-1 Phone Access** to
- Resources
- **Referral Support Specialists**

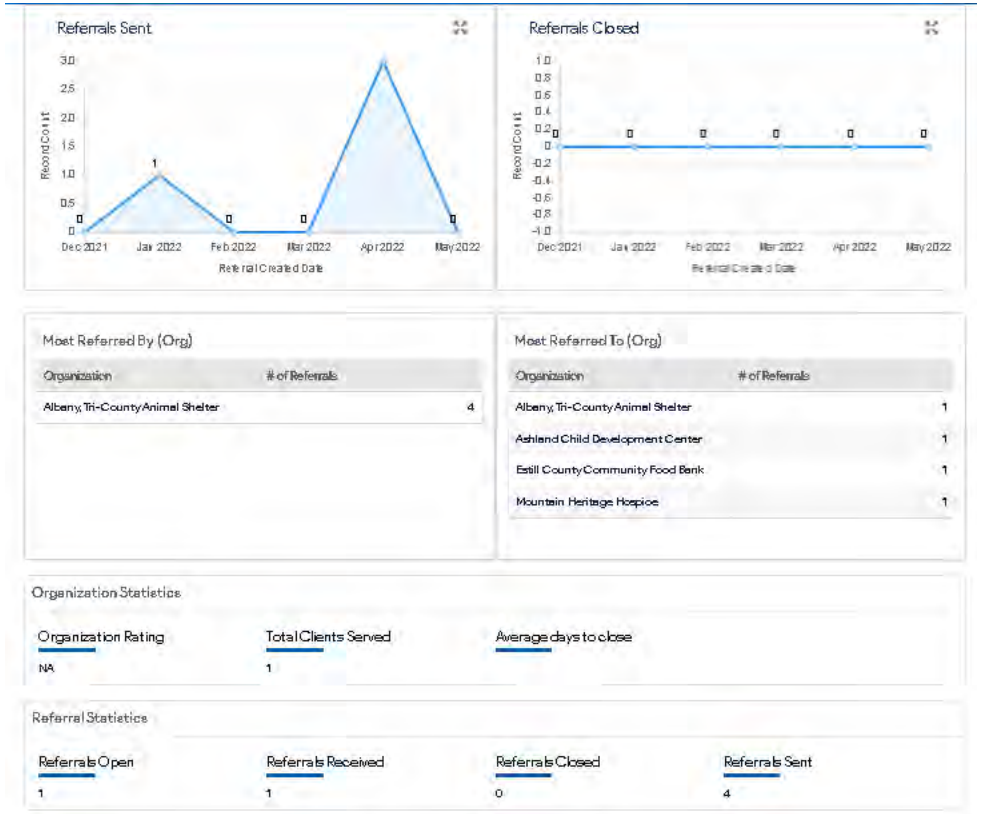
In partnership with: United Way

Community Partner Workspace

kynect resources

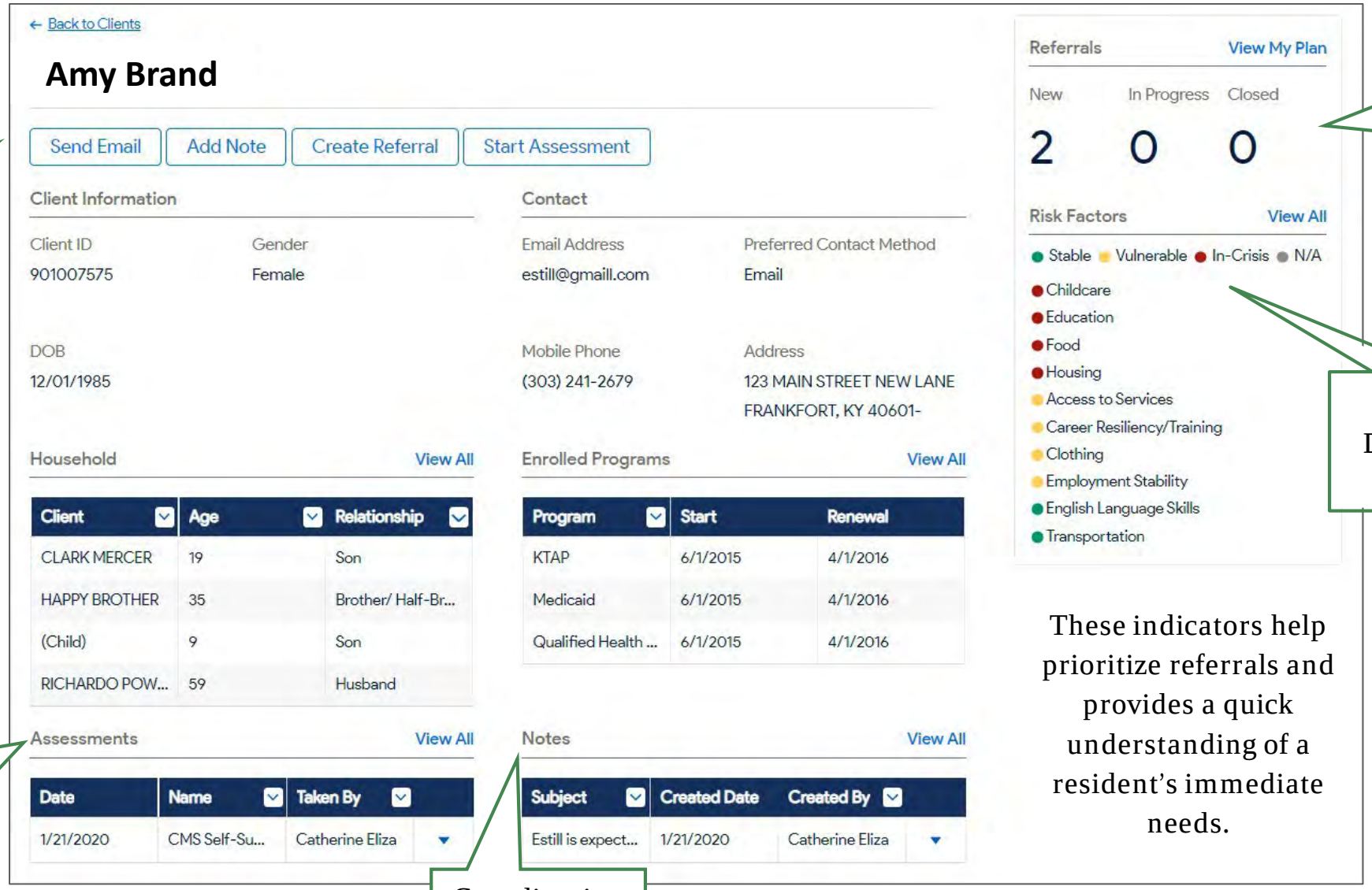
- My Workspace
- Referral Inbox
- Referral Outbox
- Referral Dashboard
- Reports
- Client Search
- My Favorites
- Organization
- Resources
- Staff

- View and respond to referrals received
- Send referrals
- View Dashboard with key metrics specific to the organization
- Search for Clients or view existing clients
- Create a Favorites list for quicker referral generation
- Add and Edit Staff



In partnership with: United Way

Resident Information Screen



Quick Action Buttons

Integrated IEES Data Sources

Assessments inform SDOH data. This tab indicates the date of last assessment and from where it came.

Coordination across partners

Referral Activity

Social Determinants of Health

These indicators help prioritize referrals and provides a quick understanding of a resident's immediate needs.

kynect resources Metrics

Metrics as of 5/03/2023

Referrals Created

95,508 referrals created

Created 2023 **13,970**

3,102 **last 30 days**

Referrals Closed

83,587 Referrals closed

Closed 2023 **8,280**

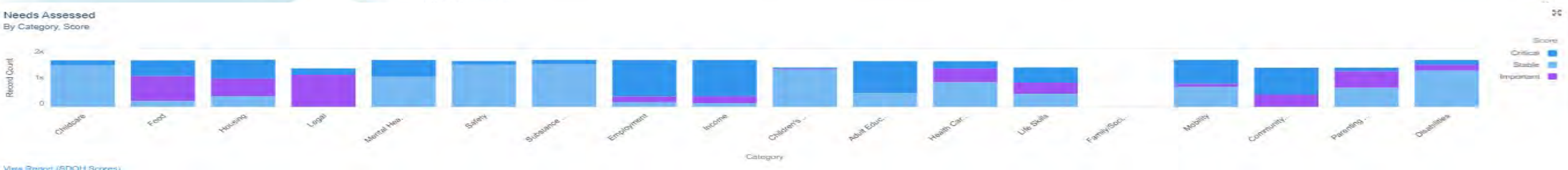
Community Partners Onboarded

433

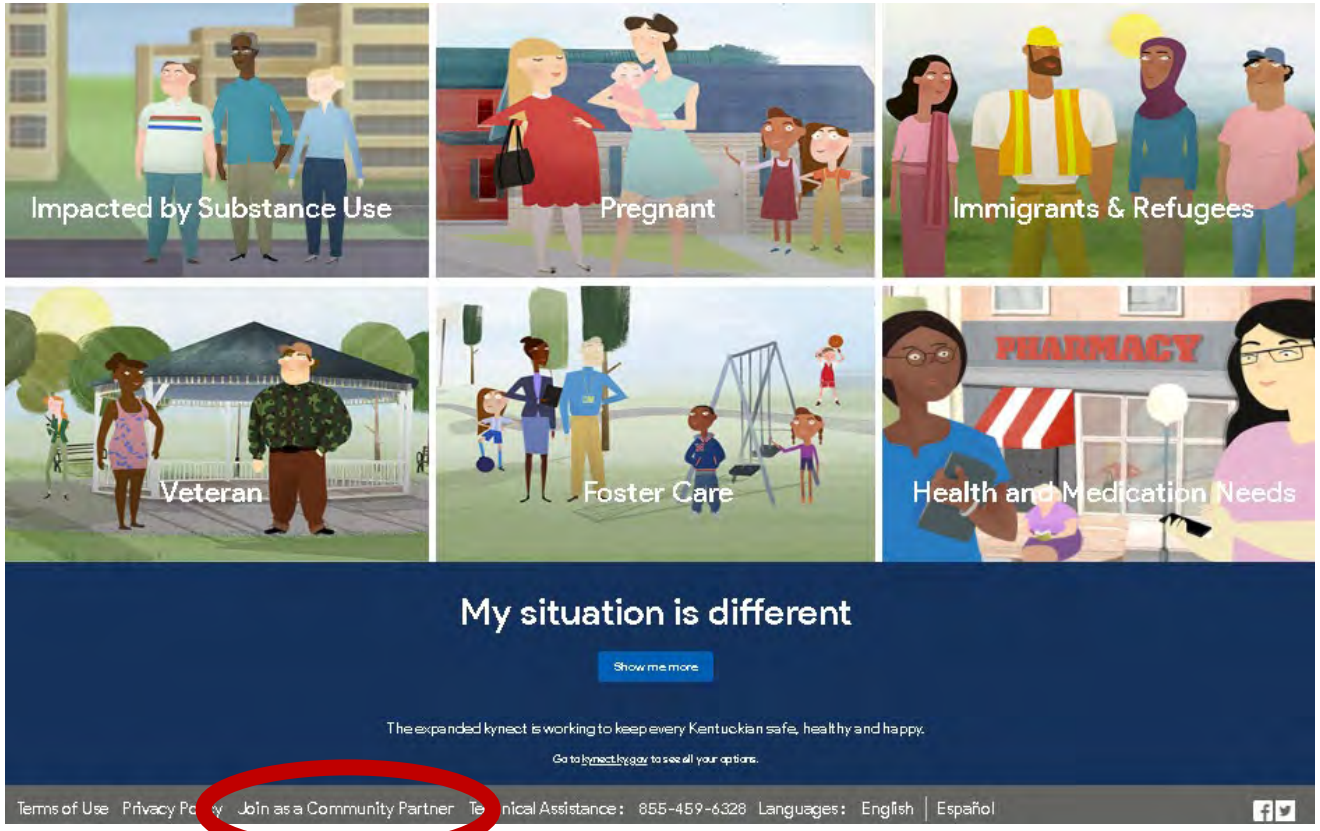
Since 1/1/2023 **43**

2023 SDOH Assessments taken

203



Join As A Community Partner



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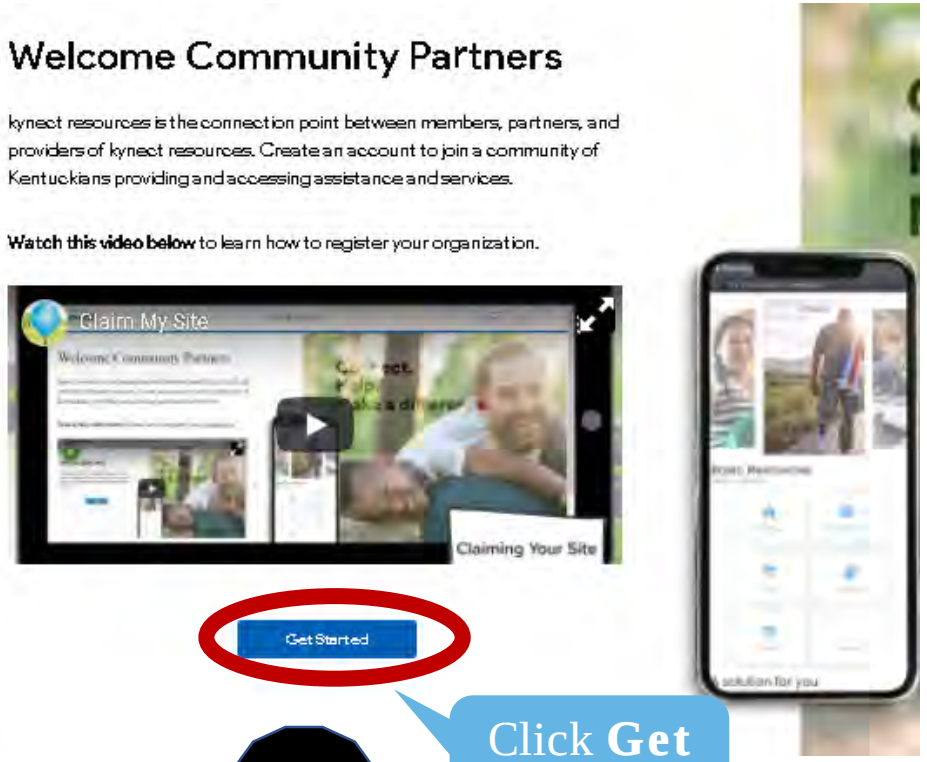
Click **Join as a Community Partner**



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Click **Get Started**

In partnership with: United Way

Thank You

For questions or to schedule a session please email
kynectresources@ky.gov

TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

KHIE
KENTUCKY
HEALTH INFORMATION EXCHANGE

Integrating the Two Technologies

Bi-Directional Exchange of SDoH Data

KHIE created an in-house tool that standardizes the incoming SDoH data from KHIE participants and kynect resources in a uniform format so that doctors and case managers can make informed decisions based on a more holistic SDoH dataset.

Collaboration Between KHIE and kynect resources

From KHIE's Perspective

1

Evaluate

A healthcare provider evaluates a patient, entering the patient's health data into hospital's EHR system, **sending the data to KHIE**.

2

Standardize

KHIE analyzes the health data and **standardizes the SDoH indicators across the 18 domains**, sharing the data with kynect resources.

3

Refer

Through KHIE, healthcare providers **can access kynect resources at the point-of-care**, referring the patient to the local resources for assistance.

Patient Summary | Medications & Allergies | Clinical Documents | Laboratory & Pathology | Reports | Encounters | Immunizations | Uncategorized | Patient Demographics | SDoH

SDoH Domain Indicators

DOMAIN	LAST ASSESSMENT DATE
Adult Education	06/23/2021
Employment	06/23/2021
Income	06/22/2021
Housing	06/23/2021
Food	06/21/2021
Life Skills	06/22/2021
Disabilities	06/22/2021
Transportation	06/23/2021
Community Involvement	06/22/2021
Family Involvement	06/22/2021
Legal	06/22/2021
Child Care	
Substance Abuse	
Mental Health	
Healthcare Coverage	
Safety	
Parenting Skills	
Children Education	

LEGEND

Critical | Important | Stable | No Data Available

Individual Determinants Impacting Health

kynect resources

DATE	DOMAIN	DETERMINANTS	RESPONSE	SOURCE	SDoH INDICATOR EVALUATION
06/23/2021	Housing	Housing	Present	kynect resources	Yes, determinant considered
06/23/2021	Employment	Change of job	Present	UKHC	Yes, determinant considered
06/23/2021	Employment	Employment	Present	kynect resources	Yes, determinant considered
06/23/2021	Adult Education	What is the highest grade or level of school you have completed or the highest degree you have received	11	MCCH	Yes, determinant considered
06/23/2021	Family Social Relations	Other specified problems related to primary support group	Present	MCCH	Yes, determinant considered
06/23/2021	Transportation	Transportation	Present	kynect resources	Yes, determinant considered
06/22/2021	Income	How hard is it for you to pay for the very basics like food, housing, medical care, and heating	Somewhat bad	MCCH	No, determinant not considered
06/22/2021	Housing	Homeless	Present	UKHC	Yes, determinant considered
06/22/2021	Life Skills	Problem related to life management difficulty, unspecified	Present	MCCH	Yes, determinant considered
06/22/2021	Disabilities	Need for assistance with personal care	Present	MCCH	Yes, determinant considered
06/22/2021	Legal	Conviction in civil and criminal proceedings without imprisonment	Present	MCCH	Yes, determinant considered
06/21/2021	Income	Low income	Present	MCCH	Yes, determinant considered
06/21/2021	Food	Food	Present	kynect resources	Yes, determinant considered
06/21/2021	Community Involvement	Are you now married, widowed, divorced, separated, never married or living with a partner?	Married	MCCH	Yes, determinant considered

First Back 1 Next Last

Maximum 15 entries per page

Test Data for Presentation Purposes

Referral Lifecycle Scenario

How it Looks In Practice

Brandon Norman lives in rural Kentucky with severe asthma. He rarely seeks medical treatment as he **lacks appropriate access to health services** due to **financial status** and **unavailability of needed healthcare facilities** in his local area.

Some weeks he needs to choose **between buying food for himself** or **paying for his asthma medication**. He knows he needs to keep his asthma in check, but it is hard when his money can go to other necessities like food and groceries.

Referral Lifecycle Solution

How It Looks In Practice

Follow the journey of getting Brandon connected with resources that he needs.

Evaluate:

Hyden's Emergency Department Physician, evaluates Brandon and enters the patient history and medical evaluation into Hyden's EHR system, transmitting it to KHIE.

Standardize:

The LOINC and ICD 10-Z codes for food, healthcare coverage, and income are matched against KHIE's SDoH standardization tool, assigning them the appropriate color and domain.

Refer:

A Case Manager sees Brandon's real-time SDoH domain indicators in kynect resources and/or in KHIE's ePartnerViewer. Casey creates a referral for Brandon to connect with a local Community Partner that offers free transportation to the closest hospital.

Questions?

Khie.ky.gov

QUESTIONS?
PLEASE DROP QUESTIONS FOR THE SPEAKER IN THE CHAT

UK HealthCare

WHO WE ARE- WHAT WE DO

A Brief Introduction Presented by:

Kelly Gunning, M.A.

NAMI | Lexington

National Alliance on Mental Illness

NAMI Lexington was founded in 1985 to provide education, support, and advocacy for persons whose lives are affected by serious mental illness.

NAMI Lexington

National Alliance on Mental Illness

Since its inception, NAMI Lexington has been a front-runner in:

- **Family education**
- **Peer program development**
- **Peer-empowerment**
- **Community collaboration**
- **Inclusiveness**
- **Diversity**
- **Cultural competence**
- **Scope of services**

NAMI Signature Programs offered FREE to the Community

In Our Own Voice

People with a mental illness share their powerful personal stories

NAMI Connections

A recovery support group program for people living with a serious mental illness

Family and Friends

Education Course for people who have loved ones with a serious mental illness

NAMI
National Alliance on Mental Illness
Lexington

NAMI Signature Programs offered FREE to the Community

Family-to-Family

Eleven-session course taught by trained family members

Support Groups

Peer-led support group for family members and caregivers

NAMIWalks

Annual mental health awareness and fundraising event

NAMI National Alliance on Mental Illness | Lexington

NAMI Lexington
National Alliance on Mental Illness

A sampling of other significant programs and trainings that we offer FREE to our community

- **PARTICIPATION STATION** –
  Peer-operated recovery center co-sponsored by New Vista

- **QPR SUICIDE PREVENTION** –
  Gatekeeper Suicide Prevention Training

- **WRAP** –
  (Wellness Recovery Action Plan) Workshops

- **WARM LINE** - Peer operated non-emergency phone line for anyone who "just needs someone to talk to"

- **EASTERN STATE HOSPITAL** - Adult Peer Specialists team providing daily education and support

- **FAYETTE MENTAL HEALTH COURT** - based on therapeutic jurisprudence / restorative justice principles

NAMI Lexington

National Alliance on Mental Illness

A sampling of other significant programs and trainings that we offer FREE to our community

.

- **YOUNG ADULT SUPPORT GROUP** –

Meets monthly to provide information and fellowship for young adults, ages 18–35, experiencing serious mental illness. tracynamilex@gmail.com

- **DOUBLE TROUBLE IN RECOVERY (DTR)** –

Support Groups for individuals with co-occurring serious mental illness and substance-use disorders

- **KYSTARS** - Statewide Recovery Support Groups, Recovery Oriented Training and Technical Assistance, Leadership Academy Peer Leadership Skills Training

- **GUEST SPEAKERS** - for local Nursing, Psychology and Social Work classes at UK, EKU, Midway College, Asbury, Georgetown College, and Kentucky State University

- **INTERN PROGRAMS** – We partner with regional Universities to provide field education for student interns

NAMI Lexington also offers

AFFORDABLE STAFF AND EMPLOYEE TRAINING PROGRAMS such as:

Mental Health First Aid

The Mental Health First Aid program is an interactive 8-hour educational program.
It can be conducted in one full day or two half-day events.

Mental Health First Aid introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common treatments.

NAMI National Alliance on Mental Illness | Lexington

You are not alone…

We are here for you.

For more information on NAMI's FREE and Affordable programs and trainings please see http://namilex.org or call 859-272-7891.

NAMI Lexington

National Alliance on Mental Illness

QUESTIONS?
PLEASE DROP QUESTIONS FOR THE SPEAKER IN THE CHAT

UK HealthCare

DISCUSSION: ADDRESSING HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

I don’t know who to refer to

I struggle to identify what level of social care the patient needs

There aren’t enough staff to manage SDOH referral process

Patients are under/uninsured

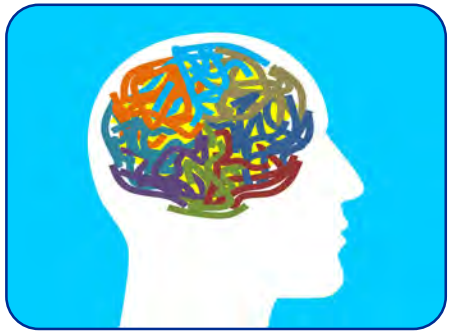
Patients lack transportation to care

Patients not open to SDOH referral

RESOURCES

General SDOH Resources

- https://kynect.ky.gov/resources/s/?language=en_US
- Call 211
- https://www.findhelp.org/



Mental Health Community Resources

- NAMI - https://nami.org/Home
- Find your CMHC - https://dbhdid.ky.gov/cmhc/
- UKHC Tip Sheets - https://ukhealthcare.uky.edu/community-commitment/mental-health/resources

UK HealthCare

THANK YOU FOR PARTICIPATING!

HealthCare
Kentucky Regional Extension Center

KYREC@UKY.EDU

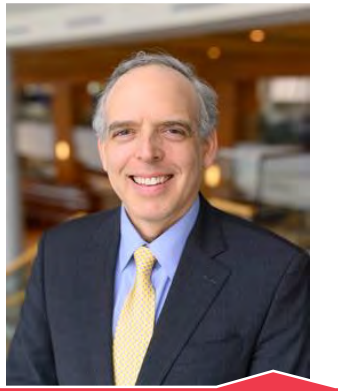
859-323-3090

We want to hear from you!

Please scan this QR code to take the survey.

HealthCare

BEHAVIORAL HEALTH COMMUNITY OF PRACTICE LEADERSHIP TEAM



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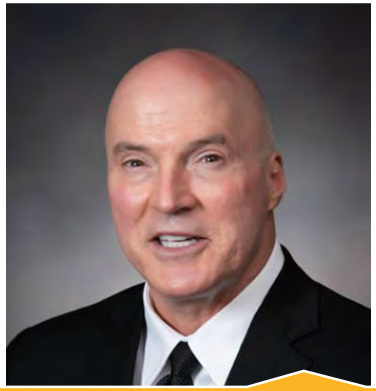

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UK HealthCare

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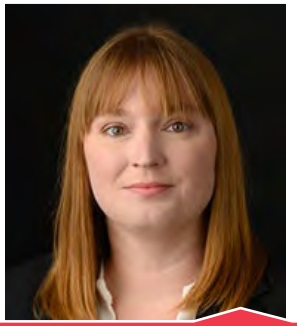

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