CARDI·OH

Ohio Cardiovascular Health Collaborative

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

In partnership with:

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

COLLEGE OF MEDICINE AND LIFE SCIENCES THE UNIVERSITY OF TOLEDO

OHIO Heritage College of Osteopathic Medicine

Northeast Ohio MEDICAL UNIVERSITY

University of CINCINNATI FAMILY AND COMMUNITY MEDICINE

Boonshoft School of Medicine WRIGHT STATE UNIVERSITY

MedTAPP

OHIO COLLEGES OF MEDICINE GOVERNMENT RESOURCE CENTER

Ohio Department of Medicaid

Disclaimer for sharing or use of any of this presentation

Addressing Social Determinants of Health: Connecting Disadvantaged Primary Care Patients to United Way Community Resource Navigation

Jonathan Lever, MPH, NRP[1]

Program Manger

Ohio Cardiovascular Health Collaborative 2nd Annual Statewide Conference

May 17, 2019

Shari Bolen, MD, MPH[1,2,5]; Samantha Smith MA, MS[3]; David Bar-Shain MD[1,2]; Elvira Ordillas RN[2]; Wanda Ali-Matlock RN, BS, MBA[1]; Joseph Daprano MD[2;] Matthew Finley, BA[4]

1: Better Health Partnership 2: The MetroHealth System 3: Cuyahoga County Board of Health 4: United Way of Greater Cleveland 5: Case Western Reserve University

Disclosure-None

The following planners, speakers, moderators, and/or panelists of the CME activity have no financial relationships with commercial interests to disclose:

Jonathan Lever, MPH, NRP

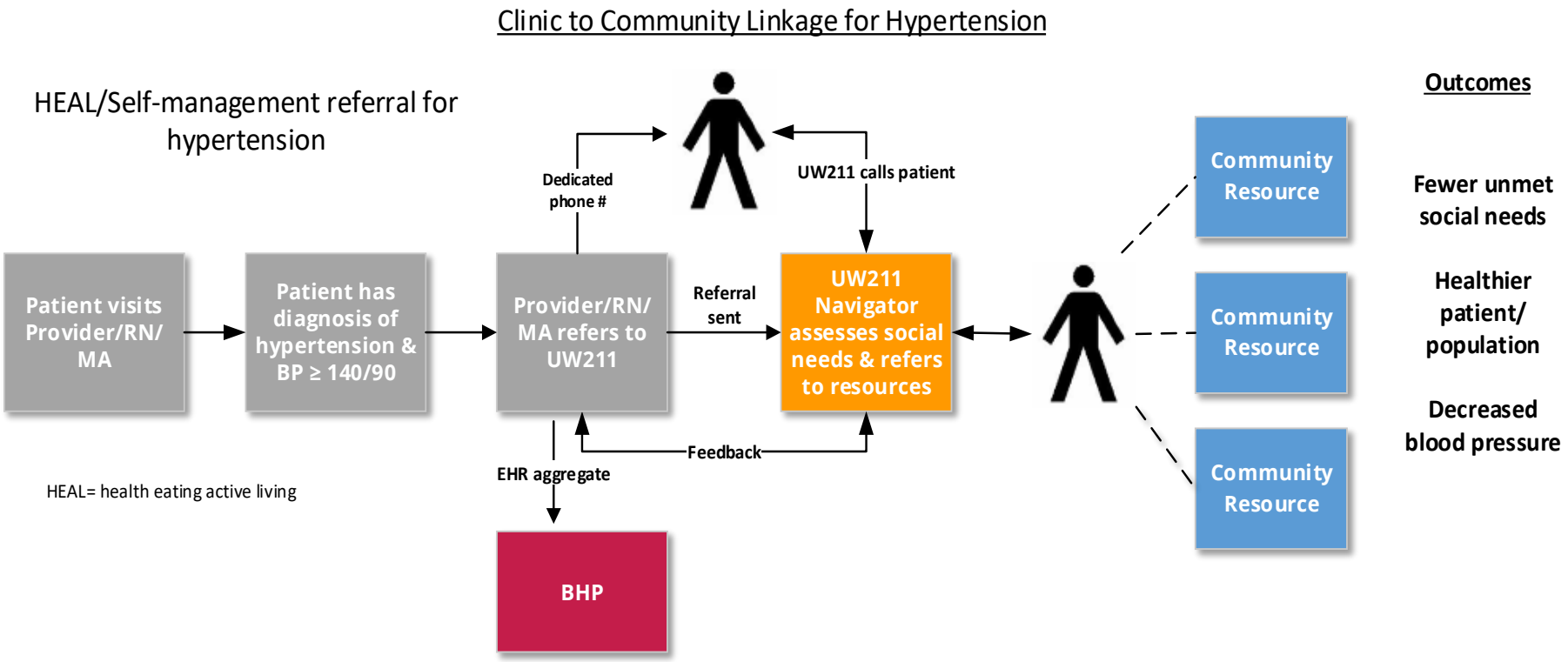
Background & Problem

- About 1 of 3 U.S. adults (~75 million people) have hypertension[1]
- Non-medical determinants can have a significant impact on patients with hypertension
- Many communities and health systems are experimenting with ways to address SDOH
- Few communities have implemented and evaluated a scalable model for use across multiple EHR systems

1: CDC website
https://www.cdc.gov/bloodpressure/index.htm
Accessed 4-7-2019

MetroHealth HiP CUYAHOGA Health Improvement Partnership United Way GREATER CLEVELAND Better Health Partnership

Program Description



MetroHealth

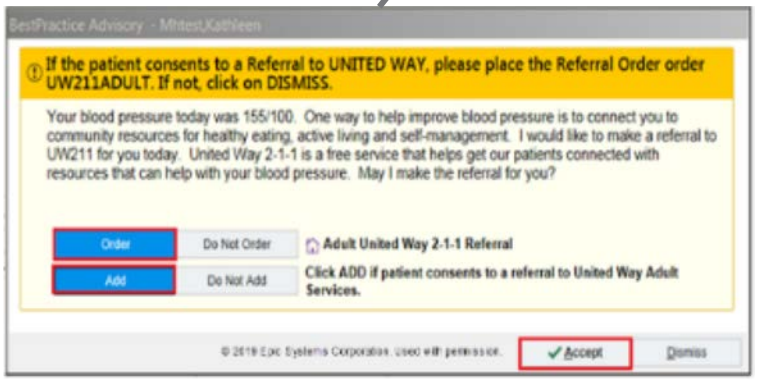
HiP CUYAHOGA Health Improvement Partnership

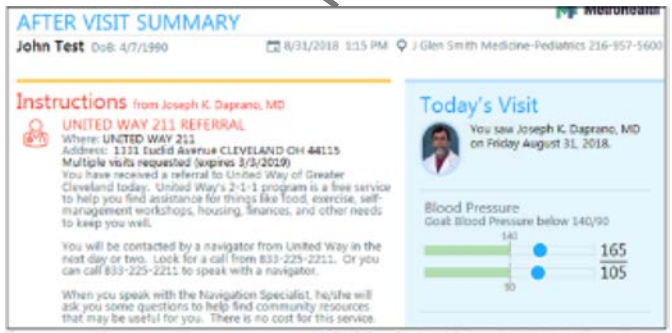
United Way GREATER CLEVELAND

Better Health Partnership

Workflow

BP #1 elevated → Repeat BP → BP #2 elevated → BPA → UW 211 referral



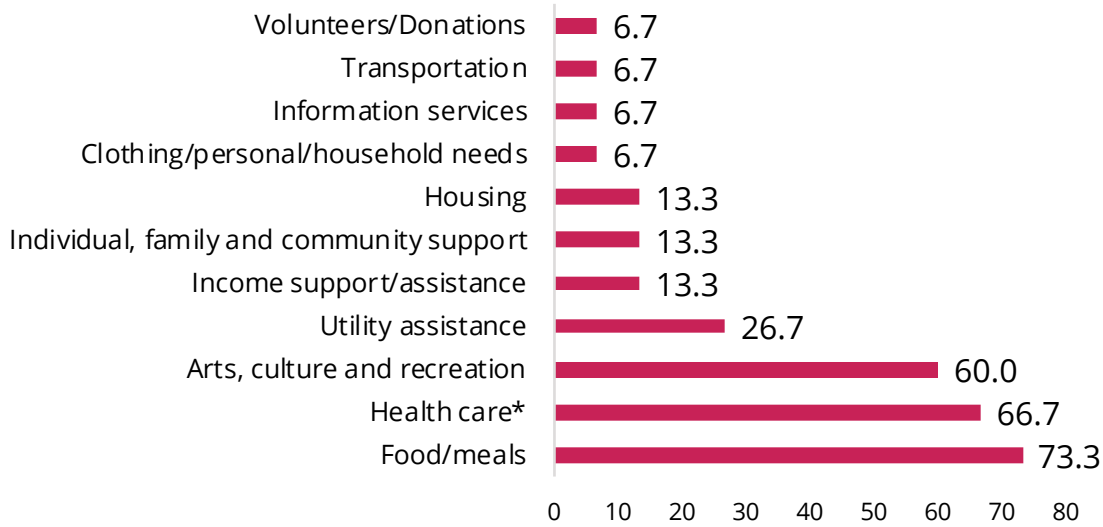


MetroHealth · HiP Cuyahoga Health Improvement Partnership · United Way Greater Cleveland · Better Health Partnership

Key Outcomes

- 27% of eligible patients referred to date
- 15 patients reached
- 44 needs identified
- 124 total referrals provided
- 4 (Range 1-8) = Average number of needs per patient
- 8 (SD 4) = Average number of referrals to community resources

% of Patients by Need (N=44) for first 15 Patients (9/24/18-10/28/18)



* includes healthcare & nutrition education/self management, BP screening, & prescription assistance

MetroHealth HIP CUYAHOGA United Way GREATER CLEVELAND Better Health Partnership

Summary

- Patients with elevated blood pressure are interested in being referred to UW2-1-1
- Patients reported an extensive set of needs
  - Majority included food insecurity, health education, physical fitness opportunities, and utility assistance
- Whether addressing these needs impacts overall health is not yet known, but something we will be evaluating
- This serves as a scalable model across EHRs to connect patients with community resources to better address the social determinants of health

MetroHealth HiP CUYAHOGA Health Improvement Partnership United Way GREATER CLEVELAND Better Health Partnership

Acknowledgements

- Co-authors:
- J Glen Smith MetroHealth Clinic Providers and Staff
- MetroHealth Informatics Teams
- United Way Team
- Funders:
  - The Cleveland Foundation
  - Centers for Disease Control and Prevention REACH grant
  - St. Luke's Foundation
  - Sisters of Charity Foundation
  - Mt. Sinai Health Care Foundation
  - United Way of Greater Cleveland Community Impact HUB

Questions

Email: jlever@metrohealth.org