Duke Division of Community Health

NC COMet - October 8, 2021

Organizing Communities and Human Service Organizations to address Adverse Social Drivers

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A little about me

Prior to Duke (2003) COO Resources for Seniors in Raleigh NC (Exposure to NC Medicaid began 1992)

Prior to North Carolina – Ex.Dir. of NTAP (Massachusetts) - an innovative Industrial Development Corporation in Tailored Woven Clothing Manufacturing ecosystem.

Community Organizer (Saul Alinsky Model) first national campaign concluded with the signing of the Community Reinvestment Act in 1976.

- Duke Primary Responsibilities
  - Duke – Lincoln (QHC) Four Micro Clinics – 1st opened in 2003 and 1 High School Clinic
    - Operated Testing and Vaccine site (2 evenings and Saturday) July 2019 – July 2021
  - Design and Develop systems/services that address Root Cause of health care disparities.

Improving Community Outcomes at the Intersection of Health, Place, and Equity

History (est.1998)

Values

Trust, Trust, Trust - *things happen at the speed of trust*

- Bilingual - Bicultural
- Inclusive
- Intentional

Our Approach:

- Increase access to primary care in communities of color
- Launch services and campaigns addressing root cause
  - Service Delivery (e.g. Covid 19 SSP, SOAR workers, CHWs, ACEs)
- Build capacity within communities we serve to address inequities
  - Align clinical and community-engaged strategies
  - Regional Network of CBOs to address Adverse Social Drivers

Addressing Root Cause

Goal

Establish CBO Back Bone Organization

Objectives (Learn and Do)

- Inter and Intra county issue strategies (e.g. domain specific such as transportation – climate change, racial equity, community social capital and resilience)
- Regional “Learning” collaborative
- Cross –sectoral collaboration

7 Cs - *Think Regionally Act Locally*

Three Year Journey

7 Counties: Wake, Durham, Granville, Vance, Warren, Person and Franklin

- 2 Urban – 2 Suburban 3 Rural (County Health Care Disparity)
- Except for Wake – Original Duke NPCC counties
- Relationships built over many years

- 2016 – Began Organizing ACEs Awareness Campaign (Movie *Resilience* 89x) my first hand exposure to leadership of non medical HSOs.
- Prior to 2017 introduce CHWs, SOAR workers, BEC as well as launched integrated care models with LME and Prenatal program with local WICs
- 2018 Medicaid SDoH RFA released: Invited by County Managers and HSOs to be lead organizer

7 Cs Organizing Approach

- Organized Domains (Food, Housing, Transportation and Interpersonal Violence)
  - Studied each ecosystem (stakeholder interviews and Qualtrix Survey) Inventory of service providers within all counties that align with draft service definitions
  - Identified domain assets (strengths) as well as domain ecosystem barriers and gaps (potential organizing handles)
- Organized Urban County and 5 County (Non-Urban)
  - Natural inclination
  - Studied their ecosystem (Discovered a North South divide or an East-West axis that we are utilizing as a foundational organizing handle).
  - Identify which HSO provided which service in each county.
  - Tag teamed with NCCRES360 – together we introduced HOPS RFA submission plan and enrolled each HSO in NCARES360
  - "Resolution of Support" from each County Boards of Commissioners: Wake, Durham, Vance, Granville, Franklin and Warren
- Organized monthly town halls with everyone including PHPs, LMEs, County Managers Office, Statewide Advocacy Groups

HSO Capacity Framework

Service Delivery Example - Covid 19 SSP

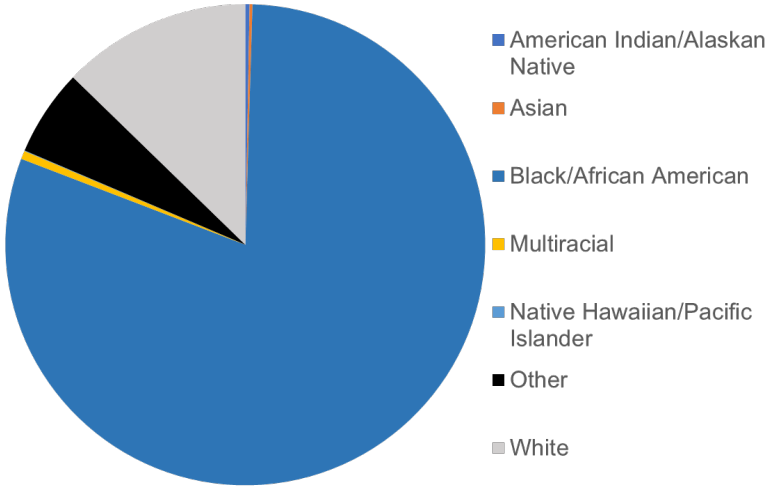
- DUHS Covid 19 Social Support Services
- Platform involved: Synergy, Collaboration, Communication, and Capital
  - SDoH HSOs
  - NCARES360
  - CHWs
  - Delivery Logs, Match Making & Personal Checks

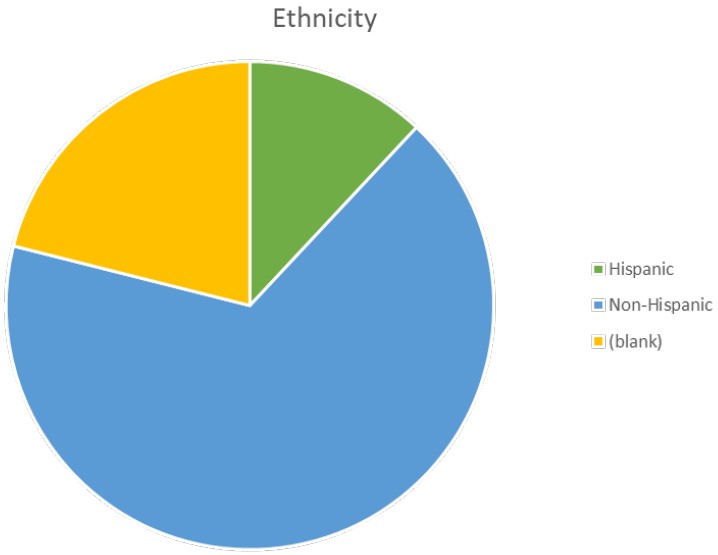
Services delivered 9/9/2020 through 4/30/2021

	Durham	Granville	Vance	Wake	Warren	Franklin	Nash	Total
# Unique Clients Paid	2,773	201	612	1,081	89	77	152	4,985
$$ Paid	2,186,525	15,7357	482,677	829,000	70,700	55,800	110,400	$3,892,460
Individual Food Boxes	5,081	317	1,327	947	353	225	741	8,991
Household Food Boxes	2,966	350	617	1,283	42	291	236	5,785
Total Food Boxes	8,047	667	1,944	2,230	395	516	977	14,776
Meals	53,992	1,496	279	11,038	42	250	291	67,388
Transportation (# of Rides)	223	0	0	23	1	0	0	247
Medication Delivery	2	0	1	0	0	0	0	3
COVID supplies	5,395	1,712	2,103	2,016	552	493	936	13,207
Total Unique Households Served	3,335	777	1,399	1,264	363	252	817	8,207

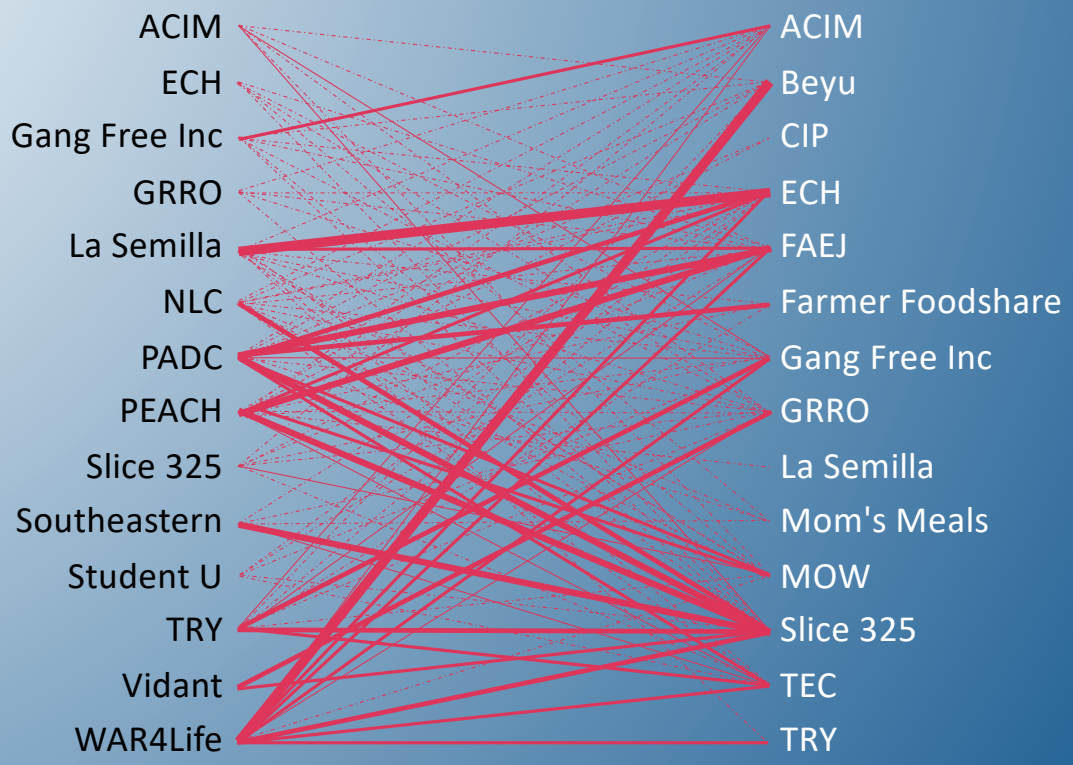
- *35,000+ Individuals Served - 79% Black/African-American, 17% Hispanic/LatinX*
- *88% of clients surveyed reported they were able to fully isolate/quarantine*
- *88.5 new FTE positions across all partner organizations/46.5% of all employees working on SSP were new hires (DUHS, CBOs, CHWs)*

Clients Served

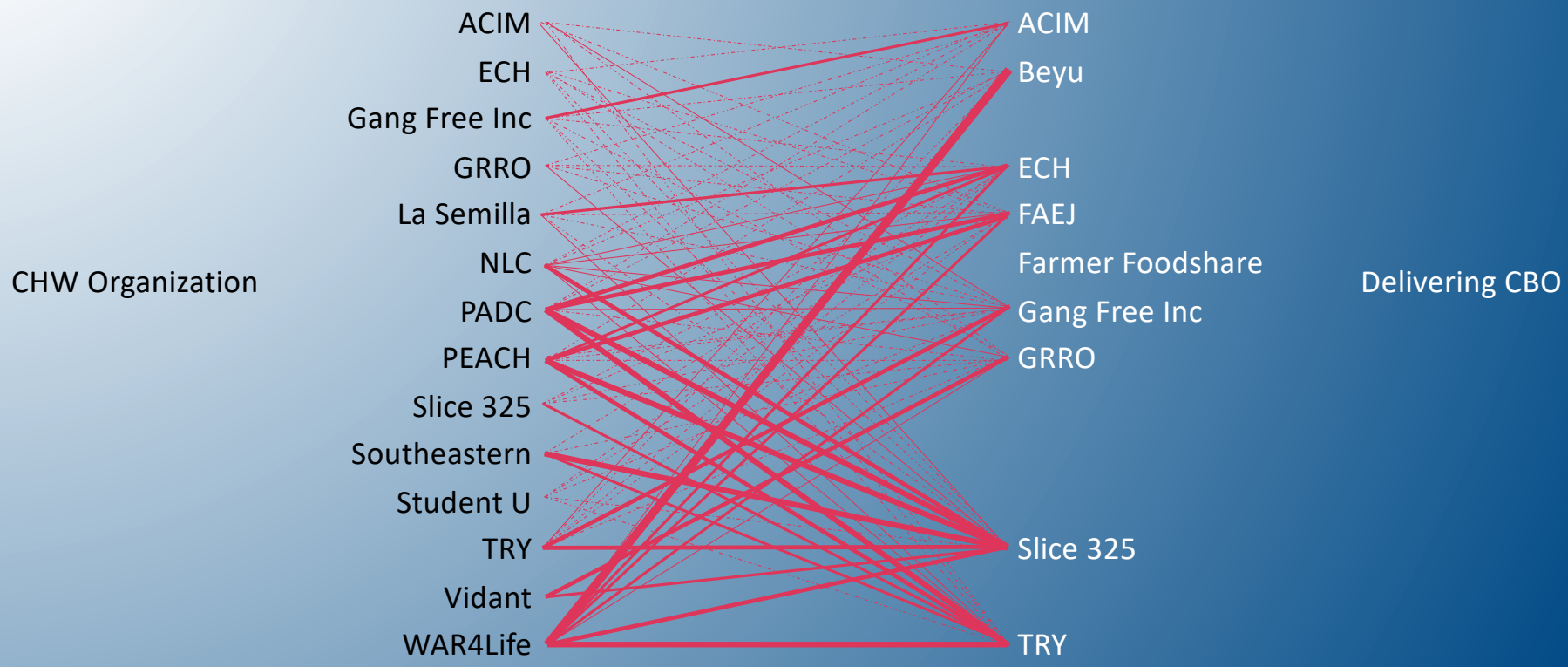




CHW—CBO Network: Food



CHW—CBO Network: COVID Supplies



Key Lessons Learned from COVID-19 SSP

- **Capacity of vendors is extremely important**
  - Cash reserves and need for up-front funding
  - Staff capacity or partnerships
  - Experience with technology, data monitoring, and reporting

- **Relationships with community members and organizations is key**
  - Trusted members of the community and trusted local organizations were vital in reaching NC residents
  - Existing partnerships enabled the program to launch and scale quickly

- **Need for technical assistance and learning collaboratives**
  - High need for in-depth, one-on-one technical assistance and training as well as collaborative forums for vendors to share experiences, issues, and lessons learned

- **Need for the Department (HHS) to be nimble, iterative, and collaborative**
  - Focus on speed and simplicity
  - Iterated regularly in response to real-time learnings
  - Cross-divisional effort (Division of Social Services, Medicaid, Office of Rural Health, Office of Healthy Opportunities)
  - Turning design into reality

- NCARES360

  - *Rome wasn't built in a day*

In order to implement NCCare360 we needed to implement screening for Social Drivers of Health in Epic

- What Questions to Ask
- Where to Document
- How, Where, When?

DukeHealth

NCCare360, Social Drivers of Health

- **NCCare360 Operational Committee Meeting**
- Meet our community neighbors
- NCCare360 Referral Stats through August 31, 2021
- 360 on NCCare360

Referrals in NCCare 360 – through Aug 2021

Overview									
Metric	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**YTD Total**
# Patients (unique)	8	33	52	52	99	199	216	152	767
# Referrals	19	90	158	167	403	819	607	380	2643
Avg. Referrals per patient	2.4	2.7	3.0	3.2	4.1	4.1	2.8	2.5	3.4
# Referrals not Recalled*	19	64	138	115	289	519	442	270	1856
# Cases	5	21	37	38	88	187	166	102	644
Referral Acceptance Rate	26%	33%	27%	33%	30%	36%	38%	38%	35%
# Cases Resolved	2	13	27	21	45	101	78	36	323
Case Resolution Rate	40%	62%	73%	55%	51%	54%	47%	35%	50%
Referral Resolution Rate	11%	20%	20%	18%	16%	19%	18%	13%	17%
Avg Days Referral to Case Closure^	65	49	48	32	18	20	16	8	24
Median (Range)	68 (5-104)	71 (0-100)	58 (0-149)	25 (0-108)	10 (0-99)	8 (0-83)	12 (0-54)	6 (0-28)	13 (0-149)

What We've Accomplished

- Socialization that social drivers impact health
  - CE/CME Modules/ Intranet/ Multiple Meetings
- Integration of NCCare360 into Maestro Care
  - In-line, Patient and Dashboard views
- Established workflows (paper, verbal, mychart/tablets) to screen for social drivers
- Established reporting for NCCare360
- Established dashboard for who has been screening in what clinical context
- Established workflows for using NCCare360, how to obtain ROI, consent, and who follows up
- Partnered with Student Help Desk
  - Formalizing Volunteer Role
- Partnering with PHMO to establish centralized social care support

ARPA - American Rescue Plan Act

Organizing HSO's in each county for ARPA funds

Utilizing Medicaid 4 Domains, Service Definitions and fees (with exceptions) plus adding a few new services

- Liquid nutritional supplements
- Freezers for Pantries
- Glucometer supplies

Deployed Home Grown Capacity Building Survey (Identify start up funds)

Utilizing NCARES 360

Utilizing CHW Platform

Payer Agnostic

High Social Vulnerability Index Census Tracts

Quantifying and explaining variation in life expectancy at census tract, county, and state levels in the United States

Antonio Fernando Boing, Alexandra Crispim

Social Drivers like where you were born or live contribute to disparities in health outcomes

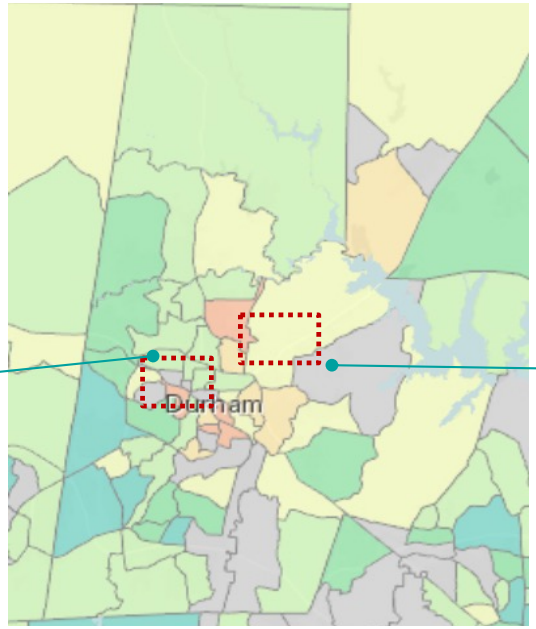
Neighborhoods 20 minutes apart have a 10 year difference in life expectancy

11 YEAR DIFFERENCE!

Census Tract 6:
82.4 YRS

Compared to

Census Tract 5:
71.3 YRS

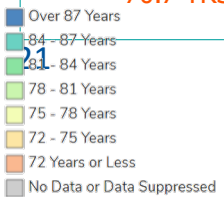


10 YEAR DIFFERENCE!

Census Tract 17.08:
80.4 YRS

Compared to

Census Tract 17.09:
70.7 YRS



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https://www.communitycommons.org/

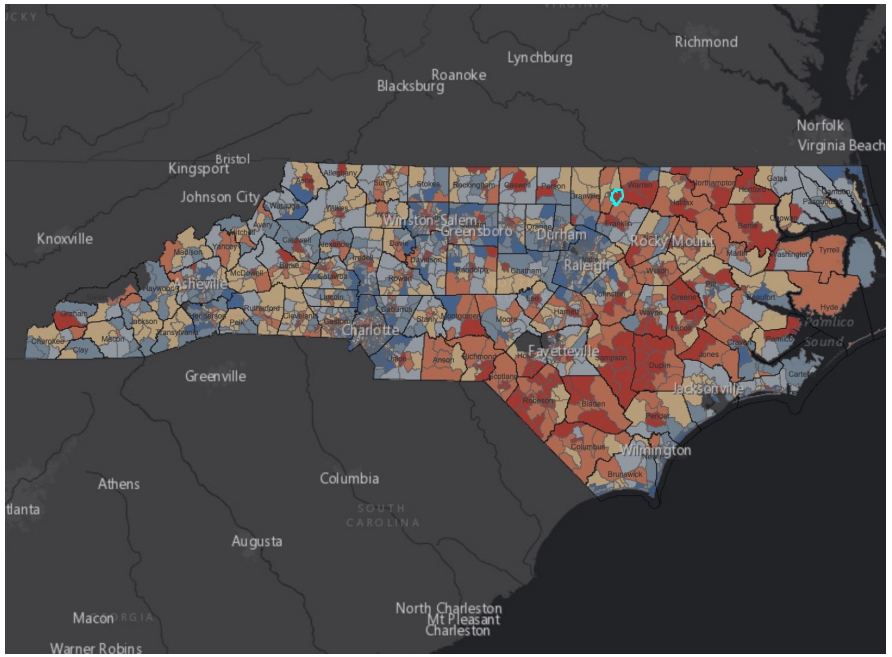
Social Vulnerability Index (SVI)

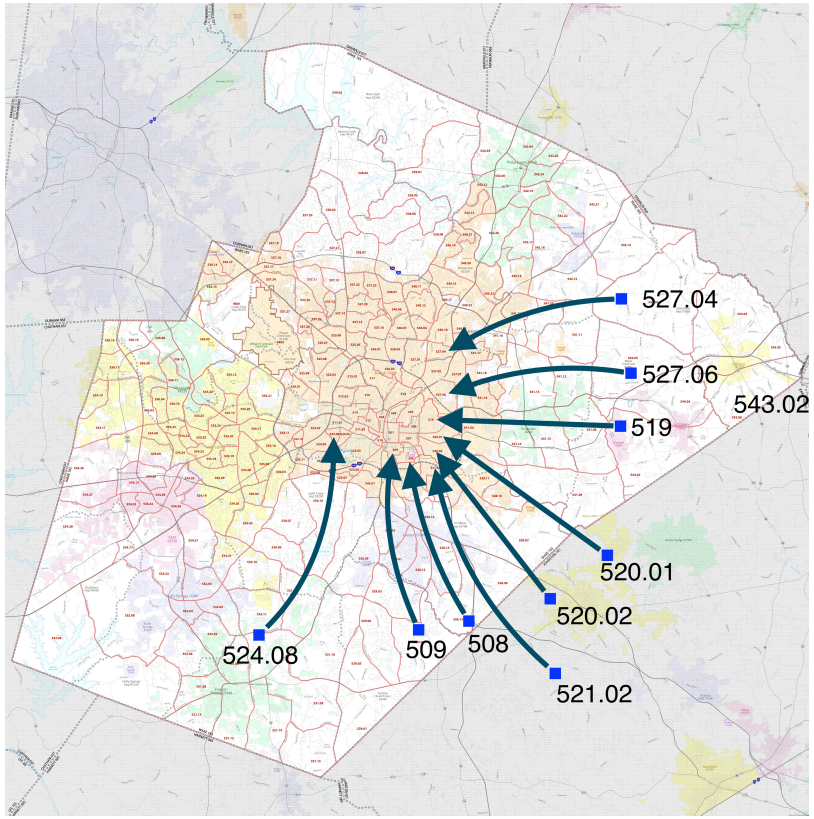
In short…

SVI is a flexible set of recent data which allows you to account for situational context and organizational focus to assess resilience and prioritize response by geographical region.

What is SVI?

- Means of ranking Socioeconomic factors that asses community resilience.





Wake County

Tract	SVI	Flags	Population
520.01	.9833	10	4632
508	.9584	9	4066
520.02	.9542	8	5663
509	.944	8	3200
521.02	.925	6	6992
519	.9051	2	5212
524.08	.8982	4	3485
527.04	.8783	5	6399
527.06	.8621	4	5076
543.02	.8218	2	7649

Summary - *Organizing*

Focus on the Goal – Trusted Backbone Organization

Support, Utilize and Integrate NCARES360 and CHWs

Think Regionally Act Locally (Engage your CIN/ACOs, PHPs, LMEs, County Managers office, Academic Researchers, COG etc.)

Place Base SDOH Interventions – Identify Impact Metrics (Qualitative and Quantitative data) at the Census Tract level

Campaign Issues: Racial Equity, Climate Change, Barriers or Gaps in the SDOH Ecosystem (know the ecosystem).

Questions

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