Session #9: Reducing Hospitalizations by Addressing Social Determinants of Health

Alicia Bauman
Saturday, Jan. 12, 2019
1:30 – 2:30 p.m.
Arbor Lakes
Alicia Bauman

Alicia Bauman is the director of community health at Lakewood Health System. Alicia has over 15 years of experience in leading and managing community health initiatives that focus on improving the health of populations through community-based strategies. Alicia leads initiatives that focus on addressing complex factors that impact both health and wellness at micro and macro levels. Alicia has experience leveraging clinical data for designing and implementing impactful systems and environmental strategies to improve health. Alicia has an undergraduate degree in community health, and an MBA in rural health care administration.
Reducing Hospitalizations by addressing Social Determinants of Health

The Lakewood Health System Journey
Lakewood Health System 2016-2018 CHNA: Top Priorities

The data above represents Morrison, Todd and Wadena counties. Data was collected in conjunction with Tri-County Health Care, CHI St. Gabriel’s Health, CentraCare Health – Long Prairie and Todd, Wadena and Morrison County Public Health Agencies.

The full Community Health Needs Assessment (CHNA) can be found at lakewoodhealthsystem.com.

Lakewood Health System: Food Access Initiatives

- Research demonstrates household food insecurity was associated with higher rates of diet related chronic illness, increase in ER utilization, and difficulties managing overall health.
- Wilder conducted a Adult Mental Health gap analysis across Region 5 and determined Senior Nutrition as a top 5 mental health gap across our region.
- AARP has conducted research identifying the strong correlation between just $10 in increased food support and an immediate and measurable impact for keeping seniors healthy by reduced healthcare expenditures.
Goals for Lakewood Health System Food Access Initiatives

- Advance targeted SDOH clinical & community processes.
- Establish synergy between community health & population health strategies for collective impact.
- Increase connectivity with community & social resources.
- Elevate relationships for advancing health.
Fresh Delivered

- Fresh Delivered is a nutritional access program primarily for seniors who live in multi-unit housing
- Bi-weekly shares of locally-grown produce are delivered to participating buildings during our summer months and monthly shares of lean meat and fresh produce delivered at 2 sites year round
- Annual SDOH screen/intervene & Healthy Days assessments
- Onsite education (cooking, budgeting, advance care directives)
- 6 Local Growers & Fare For All
- 3 Counties (Todd, Morrison, Wadena)
- 7 Multi-unit housing buildings
Screening

- Utilize the 2 question Hunger Vital Signs screen
- All Well Child Visits utilizing 5210 platform
- Select departments (Behavioral Health)
- Patient identified “red flags”
Intervene

• Acute Care pack offered at time of positive screen
• Consent to connect patient with our Community Health Coordinator – Navigation for internal & external resources
• Regional Food Access Guide provided in Acute Care Pack

Connect

• 75% connection rate from all positive screens / referrals
• Phone based – Intake, SDOH screen & B2B
• Connect to all external resource options based on B2B
• Identify appropriate Food Farmacy track
Food Farmacy: Medically Tailored

- 30 High Risk IHP participant
- Positive Hunger Vital Sign screen
- Risk score greater than 5
- Readiness / commitment level
- Every other week food pick-up: greater intensity of “dosing”
- Goal setting, brief education / motivational interviewing
- 2 Educational courses per year
- 12 Month commitment
- Tailored case management connections with social services and diabetic education

Food Farmacy: General Screen

- Lower “dose” – lighter “intervention”
- Criteria is a positive screen for food insecurity (no minimum risk score, no payer designation, no age / family size, income etc.)
- Once per month pick-ups – 5-7 lbs. of frozen lean meat and 12-15 lbs. of fresh produce
- 2 educational courses required or identified community events
- 100 families are served monthly
Addressing Hunger & Health for our Employees

- Health Risk Assessment & Claims Data: Not consuming enough F&V; high rates of diet-related chronic conditions
- Implemented “pricing strategies” to engage in increased consumption of fresh fruits and vegetables
- On-site access to Fare for All (average of 350 employees per month).
- Matching Farmers Market Bucks (Pay $5 Get $5)
- Discounted salad bar incentives
Organizational Support & Funding

- Farmers Market (Market Coordinator, EBT, Credit Card, Location, LHS Market Bucks)
- Employee Wellness: Culture of Health for All ($25,000 annual investment specific to food access)
- Investment allocations: Operational, LHS Foundation, Grants, IHP
- "In-Kind" Village Operations: DME, Executive Leadership, Committee Members

800 People Monthly

Over 4 Tons of Food Distributed Monthly

Expanding Across Todd, Wadena, Morrison and Crow Wing Counties
Partnerships

- SPROUT
- The Food Group
- Second Harvest Heartland
- 10 Local Growers
- Minnesota Extension
- Public Health: Onsite WIC clinic
- Central Lakes College
- Region 5

Case: 35 Year Old Male

- Enrolled in medically tailored Food Pharmacy March 2018
- Diabetic Educator: Coach
- A1C: 6.0 (March) 5.1 (October)
- Identified 15 days "mentally unwell" (March)
- Weight: 331lbs (March) 240 (October)
- Enrolled in SNAP – Weekly matched $ at LHS Farmers Market
- Smiles, improved disposition, excited for coaching, recipes and connection
Case: 32 Year Old Single Mom
Kids ages 3 & 5

- Hunger Vital Sign Screen + at well-child
- Separated from Husband
- Food & housing and legal risk identified with SDOH screen
- Enrolled in Food Farmacy 18 months ago
  - Secured safe housing (LSS & CARE Ministries)
  - Enrolled in SNAP & WIC
  - Connected with Legal Aid
  - Secured full-time employment
  - Cooking classes, farmers market SNAP utilization
  - Reconnected with faith community & greater hope for future

Contact Information

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Sources:


• Institute for Clinical Systems Improvement. Going Beyond Clinical Walls: Solving Complex Problems (October 2014)


• Seligman, H. e. (Jan 2014). Exhaustion of Food Budgets at Month’s End and Hospital Admissions for Hypoglycemia. Health Affairs, 33(1): 116-123.

Payer Mix: All Initiatives
Quality of Life Indicator
CDC Healthy Days

<table>
<thead>
<tr>
<th>DURING THE PAST 30 DAYS.....</th>
<th># OF DAYS PHYSICAL HEALTH WAS NOT GOOD</th>
<th># OF DAYS MENTAL HEALTH WAS NOT GOOD</th>
<th># OF DAYS PHYSICAL OR MENTAL HEALTH IMPACTED USUAL ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Farmacy</td>
<td>12 days</td>
<td>11 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Choose Health</td>
<td>8 days</td>
<td>10 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Fresh Delivered</td>
<td>7 days</td>
<td>5 days</td>
<td>5 days</td>
</tr>
</tbody>
</table>

SDOH Risk Screen

<table>
<thead>
<tr>
<th></th>
<th>Food Farmacy</th>
<th>Choose Health</th>
<th>Fresh Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hunger Vital Signs Screen</td>
<td>75%</td>
<td>100%</td>
<td>62%</td>
</tr>
<tr>
<td>Utility Shut-off</td>
<td>16%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Housing Insecurity</td>
<td>8%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Not enough money to cover basic bills</td>
<td>84%</td>
<td>75%</td>
<td>62%</td>
</tr>
<tr>
<td>Transportation barriers</td>
<td>28%</td>
<td>8%</td>
<td>13%</td>
</tr>
</tbody>
</table>
# Participant Data

<table>
<thead>
<tr>
<th>John Hopkins Risk Score</th>
<th>ER Visits 12 month roll</th>
<th>12 Month Cost (ACO &amp; IHP Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Initiatives</td>
<td>2.635</td>
<td>$15,484.84</td>
</tr>
<tr>
<td>Food Farmacy Medically Tailored</td>
<td>7.528</td>
<td>2.0</td>
</tr>
<tr>
<td>Food Farmacy General</td>
<td>1.83</td>
<td>.80</td>
</tr>
<tr>
<td>Fresh Delivered</td>
<td>2.258</td>
<td>.70</td>
</tr>
</tbody>
</table>