

# Operational Thinking with Clinical Action



## Identifying and Addressing Social Determinants of Health by Integrating Community Health Workers Into the System Of Care

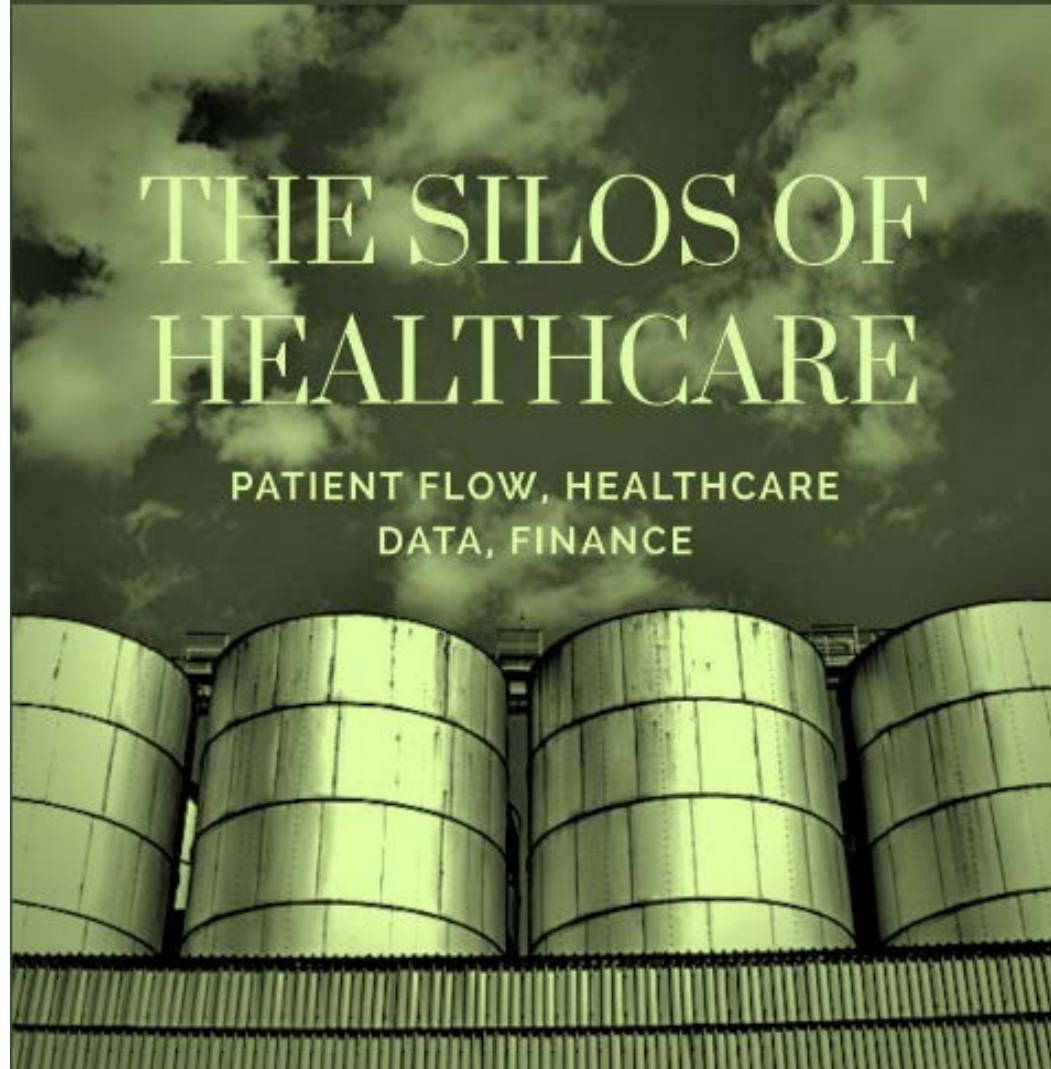
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[jgaudet@genhealth.org](mailto:jgaudet@genhealth.org)

[WWW.genhealth.org](http://WWW.genhealth.org)

- **Generations Family Health Center, Inc. is a not-for-profit Federally Qualified health Center with 7 stationary locations covering a 920 square mile service area in Eastern Connecticut.**
- **The Mission** is to provide quality, compassionate and professional health care that is affordable, easily accessible and without discrimination to all members of the communities we serve.
- **The Vision** is to strive to provide access to quality health care that is patient-focused in delivery and maximizes all available resources.
- **Our Values**
  - We believe every individual has the right to quality health care that is respectful and considerate.
  - We are committed to providing continuity of care throughout our entire health care system.
  - We create an atmosphere for patients and staff that is safe, accessible, and free of discrimination.
  - We believe in the continuous improvement of our staff and health center systems to provide the highest quality of care to our patients.

# It's Time To Break Down The Silos



  
**GENERATIONS**  
FAMILY HEALTH CENTER

# What Is A System Of Care:

- Is the framework within which healthcare is provided, offering services to identify healthcare barriers and link patients and families to services and supports both in-house and within the community. Often times utilizing Community Health Workers.
- It builds meaningful partnerships with families to address health, social, cultural and linguistic needs to achieve improved functionality in the community and throughout life.

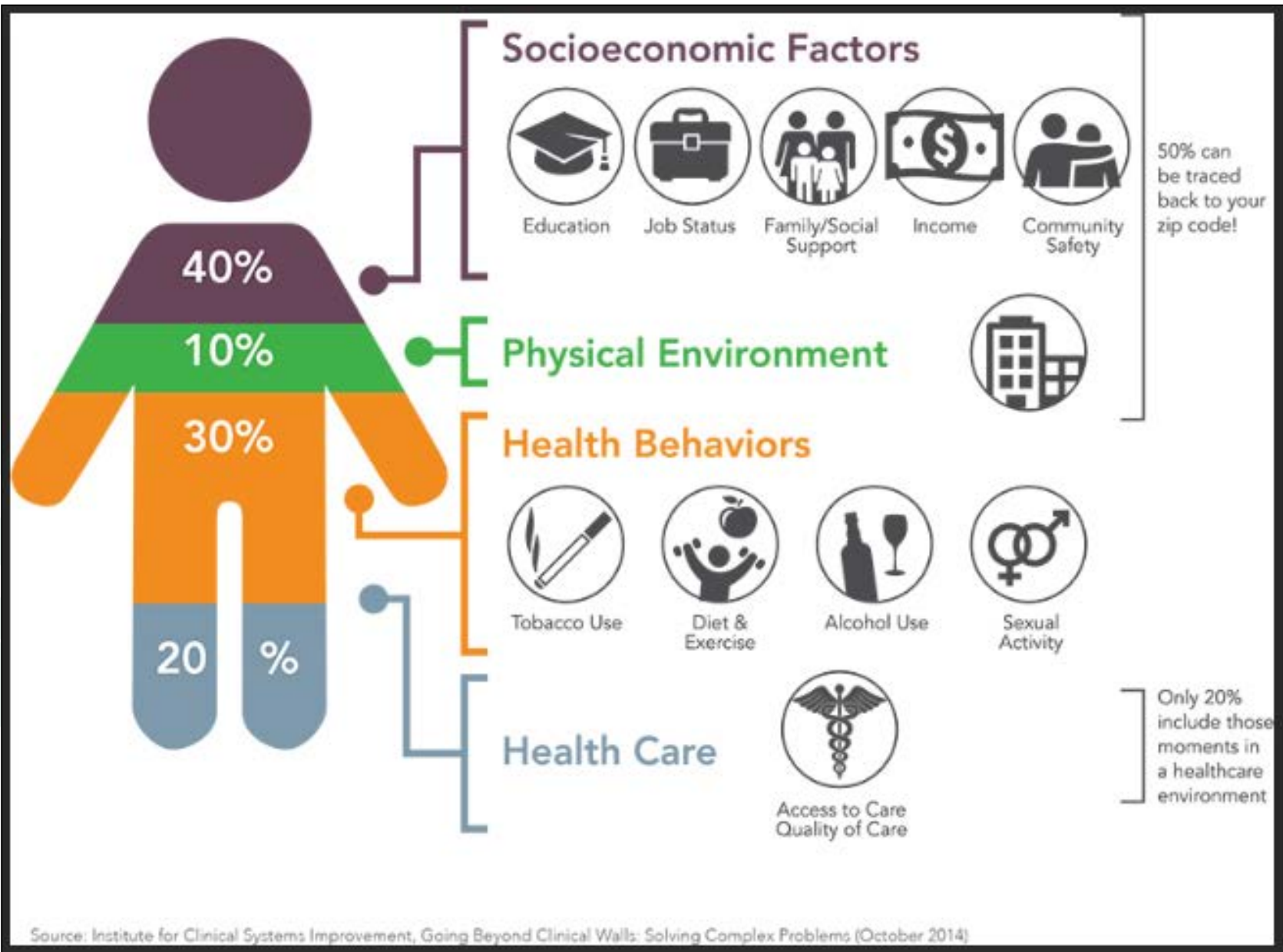


## Community Health Workers:

- Meet the needs of underserved populations within the community.
- Walk patients through their medical neighborhood by integrating health and social services.
- Ensure personalized care taking into consideration the patient, the family and the community as a whole.

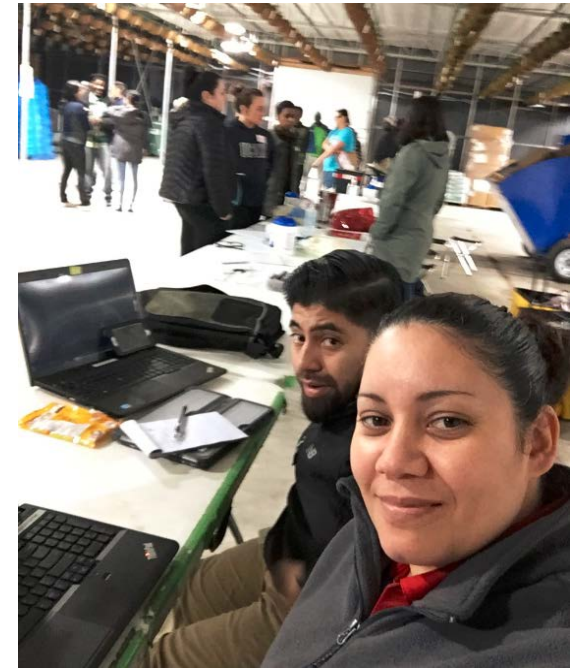









# How Do We Engage Patients At The Farm?









**Coming together  
is a beginning.  
Keeping together  
is progress.  
Working together  
is Success.**

**(Henry Ford)**

Select Encounter

TEST, HE2 ⓘ 08/26/1953 66y F

View: Recent Encounters Only

Encounter Date	Encounter	Reason	Location	Provider	Confidential	Status	Progress Note
08/29/19 02:53 pm	975198	[Patient Encounter]	WM	Glasser, Morton MD		Sealed (non-billable)	Signed
				DiGeronimo, Danielle...		Open	WIP
				NB, Doctor		Open (non-billable)	
				Ericksen, Sherri DC		Open (non-billable)	WIP
				Holybee, Terry A APRN...		Open (non-billable)	
				Holybee, Terry A APRN...		Open (non-billable)	

New Encounter

TEST, HE2 ⓘ 08/26/1953 66y F

Date: 08/31/19 Time: 09:57 AM

Provider: Doctor NB

Location: Generations FHC, Inc. (Willimantic - Medical)

Reason: Migrant Farm Worker

Encounter Class: Default Encounter Class

☐ Encounter Documents Confidential

☐ Billable Encounter

Save

Cancel

New

Edit

OK

Cancel

- Cervical Spine - CT
- Audiology - CONSULT
- Audiology - CONSULT
- BH Discharge/Transfer - BH

Chart

Flowsheets

Note

Orders/Charges

Care Plan

Forms

Last Form

Marker

Draw

Text

Vitals

Cite

E & M

Favorites

Prev. Enc.

Fam. Hx

Intake

Section

Save

Cancel

Print

Sign

Form: CHW 2018

Auto Neg

Uncheck All

Search

Outline

Preview

CHW 2018

Care Coordination

CRVFHP Form

Social Determinants of Health

TAY Assessment

Non GFHC Resources

Non GFHC Resources Dan/Put

Non GFHC Resources Dan/Put

Non GFHC Resources Dan/Put

Non GFHC Resources -Willimantic

NON GFHC Resources - Norwich

Draft

CRVFHP

Enrollment & Worker Status

Farm Worker Program Enrollment:

Y

Referred In by (use free text to list community agency/resource)

Y

Migratory Worker (H2A)

If Pt is homeless, complete SDOH form and update special populations in Intergy.

Y

Patient Is Homeless

Person Demographic Information

Country of Origin:

Interpretation:

Contact:

Y

Intellectual Disabilities

Y

Physical Disability:

Y

Sliding Fee Application

Services Provided

Contact:

Y

Farm

Interpretation:

Care Management:

Y

Care Management Follow-Up

Food Resources:

Transportation:

Y

Pharmacy/RX Assistance

Y

Patient Assistance Fund Used

Y

Referred to: (use for free text)

Y

Community Resources Provided

Y

Dental Services

Y

Optometric Services

Y

Referred To Local Mental Health Center

Y

Diagnostic Imaging

Y

Labs

EOH Screening

Y

N

Exposure to sun and high temperatures

Y

N

Do you wear sunscreen

Y

N

Do you wear a hat

Y

N

Are you exposed to pesticides

Y

N

Does your work limit access to drinking water

Y

How much water do you drink a day. (Free text amount)

Y

Sun Safety Education Provided

Y

Hydration Education Materials Provided

Y

Patient & Community Education:

Condoms Provided

SOCIAL HISTORY

Alcohol use

If any concerns refer for CAGE AID(3 or more drinks)

Y

N

Therapy For Alcohol Abuse/Dependence

Y

N

Drug Use

If Yes refer for CAGE AID

Y

N

Counseling And Surveillance For Drug Abuse

Smoking Status/Smoking Hist...

Y

Exposure to secondhand cigarette smoke

CRVFHP Form

JG 5/2019

Positive Pregnancy

Patient is Pregnant and in prenatal care as follows

Estimated delivery date

Y

N

Referral to OB/Prenatal Care.

Post-Partum

Y

Recently Gave Birth (Complete Pregnancy Questionnaire)

Baby's Birth Weight

Y

< 3 lbs 5 oz (1500 grams)

Y


3 lbs 5 oz TO 5lbs 8 oz (1500 - 2499 grams)

Y

> 5 lbs 8 oz (2500 grams)

Y

Preventive Medicine Screening For Depression Postpartum


  
**GENERATIONS**
  
 FAMILY HEALTH CENTER



**Forms**

Last Form

Markers

Draw

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Vitals

Cite

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Fam. Hx

Intake

Section

Save

Cancel

Print

Sign

Form: **CHW 2018**

☒ Auto Neg ☒ Uncheck All

**Search** **Outline** **Preview**

CHW 2018 | Care Coordination | CRVFHP Form | Social Determinants of Health | HC Resources | Non GFHC Resources Dan/Put | Non GFHC

CRVFHP

Enrollment & Worker Status

Farm Worker Program Enrollment:

☐ Y Referred In by (use free text to list community agency/resource)

☐ Y Migratory Worker (H2A)

If Pt is homeless, complete SDOH form and update special populations in Intergy.

☐ Y Patient Is Homeless

Person Demographic Information

Country of Origin:

Interpretation:

Contact:

☐ Y Intellectual Disabilities

☐ Y Physical Disability:

☐ Y Sliding Fee Application

New Applicant  
Existing Applicant

Assessment of patient medical and/or social service needs  
Establishment of Care Plans  
Maintenance of referral, tracking and follow-up systems  
Provide eligibility assistance

Care Management:

☐ Y Care Management Follow-Up

Food Resources

Transportation:

☐ Y Pharmacy/RX Assistance

GFHC Interpretation  
Language Line  
American Sign Language Interpreter  
Other

Face-To-Face interactions  
Telephone interaction  
Other program agency staff  
Letter Sent To Patient

☐ Y Dental Services

☐ Y Optometric Services

☐ Y Referred To Local Mental Health Center

☐ Y Diagnostic Imaging

☐ Y Labs

Chart   Flowsheets   **Note**   Orders/Charges   Care Plan

Forms   Form: CHW 2018   Auto Neg   Uncheck All

Search   Outline   Preview

CHW 2018   Care Coordination   CRVFHP Form   Social Determinants of Health   TAY Assessment   Non GFHC Resources   Non GFHC Resources Dan/Put   Non GFHC Resources Dan/Put   Non GFHC Resources Dan/Put   Non GFHC Resources -Willimantic   Non GFHC Resources - Norwich   Draft

CRVFHP

Enrollment & Worker Status

Farm Worker Program Enrollment: [dropdown]

☐ Y Referred In by (use free text to list community agency/resource)

☐ Y Farm

Services Provided

Contact: [dropdown]

EOH Screening

☐ Y ☐ N Exposure to sun and high temperatures

**Section**

Save

Cancel

Print

Sign

**SOCIAL HISTORY**

**Alcohol use** [dropdown]

If any concerns refer for CAGE AID(3 or more drinks)

☐ Y ☐ N Therapy For Alcohol Abuse/Dependence

☐ Y ☐ N Drug Use If Yes refer for CAGE AID

☐ Y ☐ N Counseling And Surveillance For Drug Abuse

**Smoking Status/Smoking Hist...** [dropdown]

☐ Y Exposure to secondhand cigarette smoke

CRVFHP Form JG 5/2019

**No alcohol use**  
2 drinks / day or fewer  
3 or more drinks / day  
Being a social drinker  
Declined to answer alcohol usage

**Current everyday smoker**  
Current some day smoker  
Former smoker  
Never smoker  
Smoker, current status unknown  
Unknown if ever smoked  
Heavy tobacco smoker  
Light tobacco smoker

GFHC Resources Dan/Put Non GFHC Resources -Willimantic NON GFHC Resources - Norwich Draft

**EOH Screening**

☐ Y ☐ N Exposure to sun and high temperatures

☐ Y ☐ N Do you wear sunscreen

☐ Y ☐ N Do you wear a hat

☐ Y ☐ N Are you exposed to pesticides

☐ Y ☐ N Does your work limit access to drinking water

☐ Y How much water do you drink a day. (Free text amount)

☐ Y Sun Safety Education Provided

☐ Y Hydration Education Materials Provided

☐ Y Patient & Community Education:

☐ Y Condoms Provided

7 8 9  
4 5 6  
1 2 3  
+/- 0 .  
C Done

- Hypertension
- Diabetes
- A1C
- Diabetic Plate
- Tick Borne Illness
- Oral Health
- Eye Care/Vision
- Cervical Cancer
- Testicular Cancer
- STD/Condom Use
- HIV/AIDS

oz (1500 - 2499 grams)

tum

Chart   Flowsheets   Note   Orders/Charges   Care Plan

Forms   Form: CHW 2018   ☒ Auto Neg   ☒ Uncheck All

Search   Outline   Preview

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Positive Pregnancy

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Estimated delivery date

☐ Y ☐ N Referral to OB/Prenatal Care.

Post-Partum

☐ Y Recently Gave Birth (Complete Pregnancy Questionnaire)

Baby's Birth Weight

☐ Y < 3 lbs 5 oz (1500 grams)   ☐ Y 3 lbs 5 oz TO 5lbs 8 oz (1500 - 2499 grams)

☐ Y > 5 lbs 8 oz (2500 grams)

☐ Y Preventive Medicine Screening For Depression Postpartum

CRVFHP Form   JG 5/2019

- ☐ Y TAY (Transition Aged Youth) Assessment (Age 16-24) ☐
- ☐ Y Social Determinant of Health Assessment ☐

## LIVING CONDITIONS

- ☐ Y Difficulty with activities of daily living ☐
- ☐ Y Homebound assisted by paid help ☐
- ☐ Y Living in a nursing home ☐
- ☐ Y Housing inadequate for habitation ☐
- ☐ Y Patient Is Homeless ☐

8. Are you worried about  losing your housing?

## DIET/EXERCISE

- ☐ Y Unable to do one's own cooking ☐
- ☐ Y Click if diet is adequate (if it is not select one of the next findings) ☐
- ☐ Y Inadequate caloric intake due to unavailability of food ☐
- ☐ Y Inadequate caloric intake due to lack of money ☐

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

How many minutes on average did you exercise.

## RISK/UTILIZATION

- ☐ Y Needs additional Care Plan Management Support: ☐
- ☐ Y Recent ER visit within the past 90 days. ☐
- ☐ Y Inpatient Admissions within 90 days. ☐
- ☐ Y Patient Disch From Inpatient Facility Within Last 60 Days ☐

## ADVANCE DIRECTIVES

- ☐ Y Patient provided advance directive, it is on file. ☐
- ☐ N Patient declined to provide advance directive. ☐

## CULTURAL/BARRIERS/SD

- ☐ Y Barriers to meeting treatment goals. ☐
- ☐ Y Religious practices immunizations contravene beliefs ☐
- ☐ Y Cultural background ☐
- ☐ Y Barriers to taking medication ☐
- ☐ Y Intellectual Disabilities ☐
- ☐ Y Additional Sources of Income (SNAP, SSI) ☐
- ☐ Y CLA - Daily needs. ☐
- ☐ Y CLA - Economic/Employment ☐
- ☐ Y CLA - Uninsured. ☐
- Legal Issues
- ☐ Y CLA - Language Barrier/Low Literacy ☐
- ☐ Y CLA - TAY (Transition Aged Youth) ☐
- ☐ Y CLA - Transportation/Social Issues. ☐

## EDUCATIONAL/FINANCIAL/TRANSPORT

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

What is the highest grade or level of school you have completed or the highest degree you have received?

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. (14P)

Food

Clothing

Utilities

Child Care

Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

Phone

Other (please write):



















Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. (15P)

Patient kept from medical appointments or from getting medications





































Patient kept from non-medical meetings, appointments, work, or from getting things that he/she needs



## Referral Resources Willimantic

- ☐ Y ACCESS Energy, Food Bank, Shelter, ... 
- ☐ Y CCAR - Windham Recovery Center 
- ☐ Y Covenant Soup Kitchen 
- ☐ Y CT Breast & Cervical CA Early Detectio... 
- ☐ Y CT Dept. of Social Services & Family Su... 
- ☐ Y CT Works 
- ☐ Y Domestic Violence Program Hotline 
- ☐ Y Head Start 
- ☐ Y EASTCONN Community Learning Center 
- ☐ Y Holy Family Shelter 
- ☐ Y No Freeze Hospitality Shelter 
- ☐ Y Perception Programs - Drug Treatment ... 
- ☐ Y United Service 
- ☐ Y WAIM - Windham Interfaith Ministry 
- ☐ Y Windham Housing Authority 
- ☐ Y WRCC - Windham Regional Community... 
- ☐ Y DDS - Department of Developmental S... 
- ☐ Y NAMI Support Group Windham County 
- ☐ Y CT Statewide Legal Services 

## Referral Resources - Norwich

- |   |  |
|---|--|
| <input type="checkbox"/> Y WIC   | <input type="checkbox"/> Y Dept of Developmental Services         |
| <input type="checkbox"/> Y Homeless Shelters                                   | <input type="checkbox"/> Y Dept of Social Services                |
| <input type="checkbox"/> Y Safe Futures                                        | <input type="checkbox"/> Y Healthy Start                          |
| <input type="checkbox"/> Y Soup Kitchen:                                       | <input type="checkbox"/> Y Homeless Hospitality Center (New L...  |
| <input type="checkbox"/> Y SCADD   | <input type="checkbox"/> Y Homeless Women Desrve Treatment        |
| <input type="checkbox"/> Y Stonington Institute                                | <input type="checkbox"/> Y Mobile Outreach                        |
| <input type="checkbox"/> Y Department of Social Services (DSS)                 | <input type="checkbox"/> Y Norwich Human Services                 |
| <input type="checkbox"/> Y Thames Valley Council For Community Action (TVCCA)  | <input type="checkbox"/> Y Norwich Police Dept                    |
| <input type="checkbox"/> Y Madonna Place                                       | <input type="checkbox"/> Y Norwich Senior Center                  |
| <input type="checkbox"/> Y Adult Probation                                     | <input type="checkbox"/> Y Reliance Health                        |
| <input type="checkbox"/> Y American Job Center (Formerly CT ...                | <input type="checkbox"/> Y Safe Futures (Formerly Womens Ce...    |
| <input type="checkbox"/> Y Backus Hospital                                     | <input type="checkbox"/> Y SAAD                                   |
| <input type="checkbox"/> Y Bethsaida Community Programs                        | <input type="checkbox"/> Y Southeastern Mental Health             |
| <input type="checkbox"/> Y Birth To Three                                      | <input type="checkbox"/> Y Social Security Administration         |
| <input type="checkbox"/> Y Breast and Cervical Cancer Grant P...             | <input type="checkbox"/> Y Sound Community Services             |
| <input type="checkbox"/> Y Catholic Charities                                | <input type="checkbox"/> Y St Vincent DePaul Soup Kitchen       |
| <input type="checkbox"/> Y Child and Family Agency                           | <input type="checkbox"/> Y Stonington Institute                 |
| <input type="checkbox"/> Y Dept Child & Family Services                      | <input type="checkbox"/> Y TVCCA                                |

Info

Reminders

Problems

Meds

TEST, HE2

08/26/1953 66y F

Chart

Flowsheets

split

Note

Orders/Charges

Care Plan

Documents

All Providers

All Document Types

Migrant Farm Worker

NB, Doctor

08/31/2019

In Progress

[Patient Encounter]

Glasser, Morton MD

08/29/2019

Archived

Acute

DiGeronimo, Danielle A. DNP FNP-BC

08/23/2019

In Progress

\*Non Face to Face Data Entry

Ericksen, Sherri DC

08/21/2019

In Progress

Forms

Last Form

Marker

Draw

Text

Vitals

Draft

Search

Outline

Preview

Patient:

65734 - HE2 TEST

DOB:

08/26/1953

Date:

08/31/2019 09:57

Provider:

NB, Doctor

Encounter:

Migrant Farm Worker

**Patient:** 65724 - HE Patient Test  
**DOB:** 03/09/1962

**Date:** 09/07/2019 18:20  
**Provider:** NB, Doctor  
**Encounter:** Migrant Farm Worker

### **SOCIAL HISTORY**

**Behavioral:** Smoking status: Current everyday smoker.

**Alcohol:** Alcohol use 2 drinks / day or fewer.

**Drug Use:** Not using drugs.

**Habits:** On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? 60 min and Days of moderate to strenuous exercise in the last 7 days ? 6 d.

**Ethnicity:** A migratory worker.

• Transportation: Gas Card; • Sliding Fee Application

### **FAMILY HISTORY**

Country of Origin: Dominican Republic

### **COUNSELING/EDUCATION**

• Patient & Community Education: HIV/AIDS

### **PLAN**

- Condoms five
- Community resources

### **PRACTICE MANAGEMENT**

Farm Worker Program Enrollment: New Applicant.

### **SCREENING TOOLS**

Exposure to pesticides and an exposure to a lot of bright sunlight.

Using sunscreen. Not wearing hat for sun protection.

No work restrictions - access to fluids to drink.

### **SUMMARY & RECOMMENDATIONS**

Case Management: Assessment of patient medical and/or social service needs.

Contact: Face-To-Face interactions.

Community resources Covenant Soup Kitchen - 423-1643.

### **SOCIAL HISTORY: LANGUAGE AND LEARNING**

Interpretation: GFHC Interpretation.

Main
 Properties
 Quick View
 Data Lists

**Refine Selection: (4)**

Pat Person Nbr Equals  All  AND  
 Patient Age Range  AND  
 Pat Name sort Equals  All  AND  
 Enctr Occur Date Range  AND  
 Worker Status Multiple Occurrences  AND  
 Medcin ID Multiple Occurrences  AND  
 Medcin Description Equals  All  AND  
 Finding Clinical Code Desc Equals  All

### Detail Information



	Pat Person Nbr	Patient Age1	Pat Name sort	Enctr Occur Date	Worker Status	Medcin ID	Medcin Description	Finding Clinical Code Desc
	64935	39		8/14/2019	Seasonal	1000656	Case Management:	Assessment of patient medical and/or social service needs
	7760	30		8/7/2019	Seasonal	1000656	Case Management:	Assessment of patient medical and/or social service needs
	22223	26		8/21/2019	Migrant	1000656	Case Management:	Assessment of patient medical and/or social service needs
	17164	43		8/21/2019	Seasonal	1000656	Case Management:	Assessment of patient medical and/or social service needs
	70033	44		8/2/2019	Migrant	1000656	Case Management:	Assessment of patient medical and/or social service needs
	27963	28		8/14/2019	Seasonal	1000656	Case Management:	Establishment of Care Plans

Selected Item	Pat Person Nbr	Pat Person Nbr
Calculation	Count	Count Distinct
Global Query	7429	409
Case Management Follow-Up	616	303
Case Management:	794	359
Comments:	181	149
Community Resources	256	153
Community Resources Food	241	150
Community Resources Pharmacy	4	4
Contact:	1166	396
Country of Origin:	972	398
Eligibility Assistance:	456	267
Farm Worker Program Enrollment:	363	341
Farm:	670	333
Generations Facility:	121	101
Interpretation:	1050	362
Location:	2	2
migratory worker	61	43
Outreach:	469	289
referred to [use for free text]	1	1
Soup Kitchen:	2	2
Transportation:	4	3



UDS	Indicator	PI or Req	Goal	Baseline Num/Den	Baseline Measure 2018	2019 Q1 Num	2019 Q1 Den	2019 Q1 %	2Q Num	2Q Den	2Q %
6B 11	Cervical Cancer Screening 23-64	CRVFHP UDS	60.00%	44/89.	49.00%	43	95	45.26%	39	70	55.71%
6B 13	Age 18 Up BMI & F/U If Needed	CRVFHP UDS	90.00%	77/180.	79.31%	179	224	79.91%	191	219	87.21%
6B 14a	18 & Up Screened Tobacco U/C	CRVFHP UDS	100.00%	133/145.	82.50%	141	153	92.16%	235	253	92.89%
6B 16	Age 5-64 Persist Asthma Approp Med	CRVFHP UDS	100.00%	2/2.	100.00%	3	3	100.00%	3	3	100.00%
6B 21	12 & Up Dep Screen and F/u as needed	CRVFHP UDS	98.00%	165/185.	89.00%	175	214	81.78%	208	216	96.30%
6B 22	Sealants for Children 6-9 at elevated Risk	CRVFHP UDS	1.00%	1/1.	100.00%	1	1	100.00%	1	1	100.00%
7 Sec B	HTN pts will have BP control	CRVFHP UDS	90.00%	23/28.	82.00%	28	35	80.00%	30	35	85.71%
7 Sec C	Improve Diab control >9 A1c	CRVFHP UDS	25.00%	8/22.	36.00%	6	19	31.58%	15	78	19.23%

What are some of the  
evidence based benefits  
linked to incorporating  
Community Health  
Workers as part of the  
healthcare teams?

# Glory Cruz, CHW & Vlad Rivera, CHW

