BETTER DATA. BETTER HEALTH EQUITY.

Panel: Exploring Community-Based Programs and Closed-Loop Referrals

Moderator: **Terri Stewart**, SYNCRONYS

Panelists:

- **Jennifer Romero**, MSW, Administrative Program Manager, Santa Fe County Health Care Assistance | CONNECT
- **Christa Hernandez**, MS, Youth and Family Services Program Manager, City of Santa Fe | CONNECT
- **Antoinette "Toni" Grinstead**, Senior Program Manager, Presbyterian Healthcare Services
- **Brian Ethridge**, MD, FAAP, Pediatric Services Medical Director, Hidalgo Medical Center
- **Prudence Vincent**, BSN, RN, Director of Customer Operations and Engagement, Idaho Health Data Exchange
- **Wendy Wintermute**, Resources Manager, New Mexico Alliance of Health Councils

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Christa Hernandez, MS
Youth and Family Services Program Manager
City of Santa Fe | Community Health and Safety Department | Youth and Family Services Division

Jennifer Romero, MSW
Administrative Program Manager
Santa Fe County Health Care Assistance

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CONNECT

A CITY OF SANTA FE + SANTA FE COUNTY PARTNERSHIP

SYNCRONYS HIE Sixth Annual Users' Conference

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Shared Data and Alignment

- CONNECT navigators utilize the Unite Us platform collecting the same data points on: demographics, needs, outcomes and flexible fund use.
- All navigators screen for the Social Determinants of Health and conduct an evaluation screening.
- All participants are asked the same questions from SDOH needs to behavioral and physical health and more.
- This is a step forward in aligning data, using the same terms/questions across a network of over 60 programs across the city and county of Santa Fe.

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Any Door Approach

Find a navigator at **any CONNECT organization**

Online self-referral portal: www.santafenm.gov/connect or www.santafecountynm.gov/connect

Call 2-1-1 (United Way of Central New Mexico)

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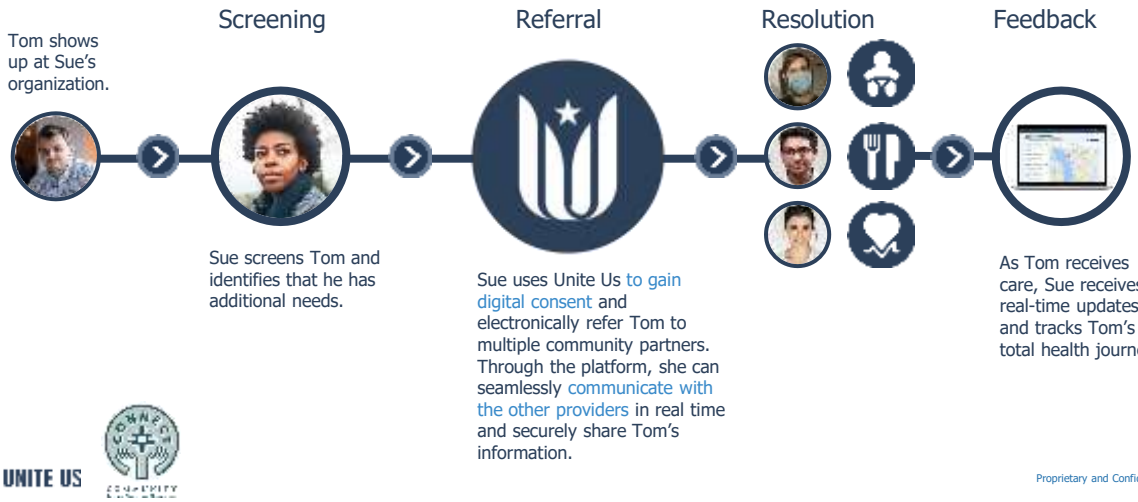
CONNECTing People to Care



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April 2019 - April 2022

CONNECT Drives Outcomes

6,472
Clients Served

Needs Met

- **89%** Emergency/One-Time Financial Assistance
- **60%** Rent/Mortgage Payment Assistance

94%
Food Needs Met

66%
Housing & Shelter Needs Met

83%
Income Support Needs Met

UNITE US

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Antoinette “Toni” Grinstead, MPA

Senior Program Manager
Presbyterian Healthcare Services
Community Health

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PRESBYTERIAN
Community Health

CENTRAL NEW MEXICO
Accountable Health Communities
LINKING OUR COMMUNITIES TO HEALTH & WELLNESS

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September 22, 2022

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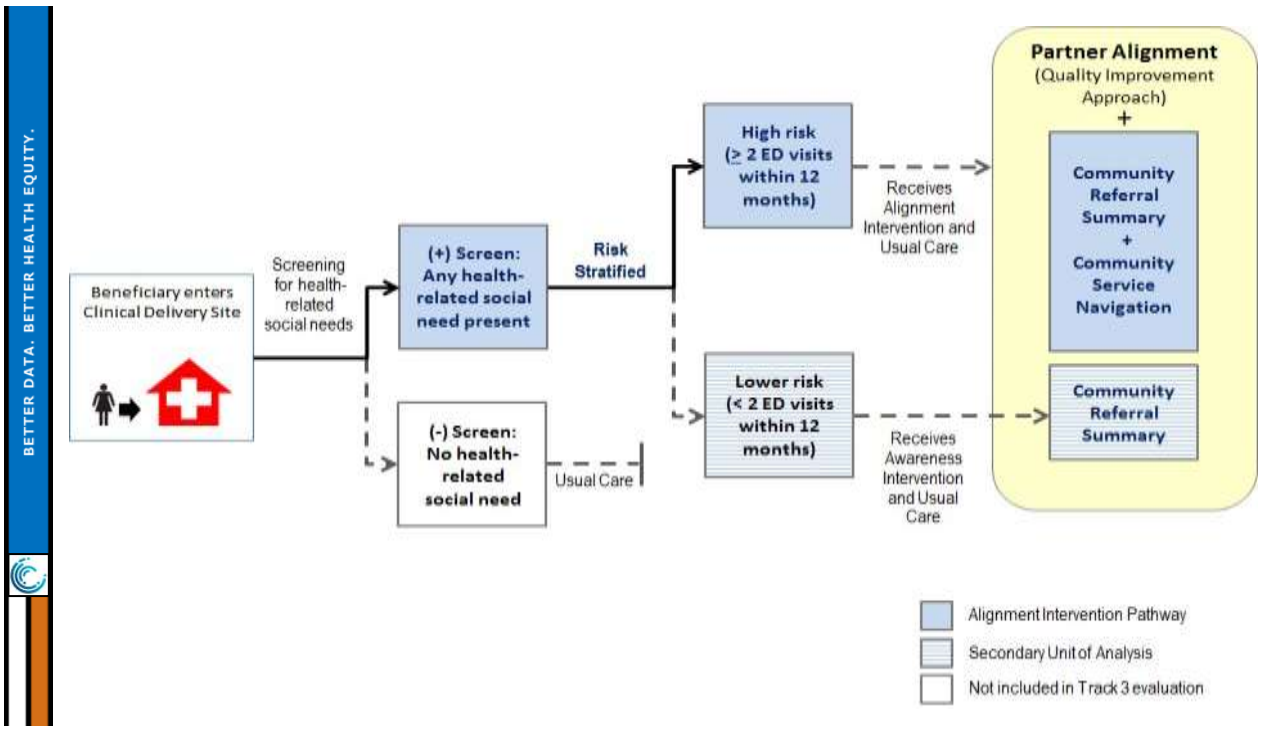

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Tracked Referrals Sent: Sept 2018-Apr 2022

Process Outcomes

Average Days to Acceptance	Average Days to Closed Status
7	44

Average Acceptance Rate	Average Service Received Rate	Average Success Rate
93%	33%	31%

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Brian Etheridge,
MD, FAAP
Pediatric Services Medical Director
Hidalgo Medical Services

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One Degree

in partnership with Grant County Pediatric Healthcare Collaboration, Hidalgo Medical Services, Grant County with startup funding provided by the Robert Wood Johnson Foundation

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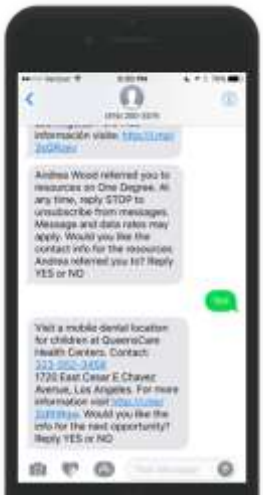
Free, Public-facing, Tools & Features

- Searchable, comprehensive resources across nine areas of need
- Resources updated every six to 12 months, based on usage
- Desktop, Mobile, SMS Text-to-Search (keyword)
- HIPPA Compliant
- Add/Edit organizations and opportunities
- Refer clients to resources, send automatic reminders, and track their progress
- Customized Assessments with automated generation of recommended resources based on assessment findings (Diabetes Risk, Depression, Food Insecurity, Housing Insecurity, PRAPARE, Medicaid and SNAP eligibility, COVID-19 Resources



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Usage

- Needed system for public/agencies
- Average 800 searches per month
- 62% Mobile Based
- Top Searches, Deposits and Rent Assistance, Cash for Utilities, Vaccinations, Emergency Financial Assistance, Baby Supplies, Applying for Benefits, Childcare, Emergency Services
- Closed Loop Referrals

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Prudence Vincent
BSN, RN
Director of Customer Operations and Engagement
Idaho Health Data Exchange

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Idaho Health Data Exchange:

A MODERN HEALTH INFORMATION EXCHANGE - Integration of Healthcare & Community Support Services

Prudence Vincent, BSN RN
Director of Customer Operations and Engagement

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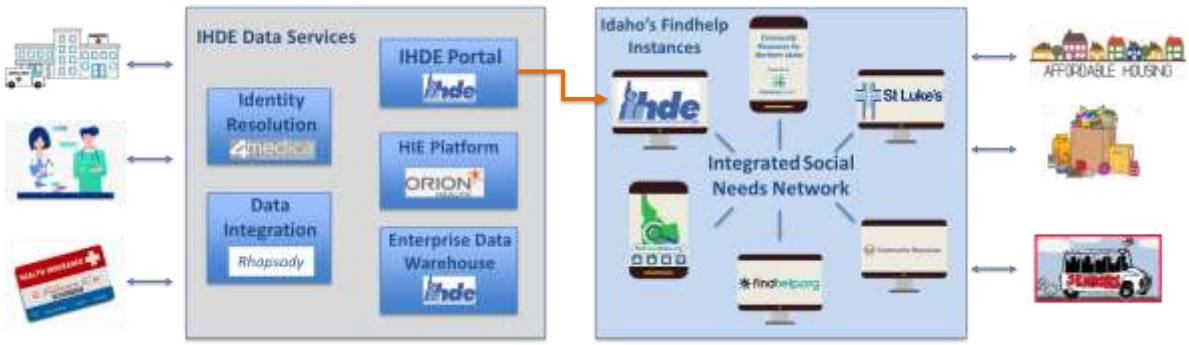
Establishing an Equity-Based Interoperable Data Ecosystem

Idaho Health Data Exchange

Integration of Healthcare & Community Support Services



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Creating Learning Collaboratives and Building Relationships

VISION FOR STATE:

To leverage our network of over 2,800 programs and the power of a collective approach to drive maximum community impact on the well-being of Idaho's population

BE THE PLATFORM THAT MEETS USERS WHERE THEY ARE

Know our end user workflows and build the tools to make it easy to coordinate care.

STRATEGICALLY IDENTIFY AND CLOSE PROGRAM GAPS

Continuously optimize our program network to ensure it has the breadth, depth, accuracy and efficiency to meet seeker needs.

BUILD THE COMMUNITY NETWORK

Build strong partnerships with customers and community organizations leveraging a data-driven and targeted approach to identify and meet key regional needs.

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Idaho Collaborative Partners

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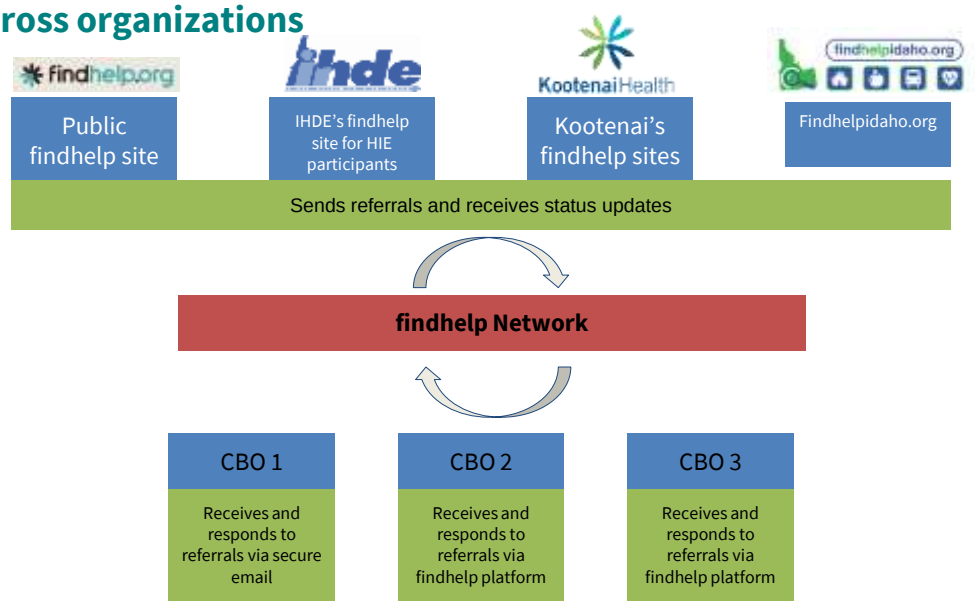
Our Approach: Use your findhelp platform to facilitate referrals across organizations



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Driving Success and Sustainability

Challenges and Lessons Learned

- Adoption & Routine Use
  - Access through clinical data portal
  - Volume of participants
  - PRAPARE
  - Transitioning from resource packets to Findhelp
  - The right people to coordinate and communicate
- Data Integration
- Communication
  - IHDE participants
  - Community Based Organizations- responding to referrals
- Time to Market
- Aligning participants
- Partnering with community-based organizations

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CONTACT US

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Prudence Vincent- Director of Customer Operations & Engagement

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- 208-803-0048

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Wendy Wintermute,
PhD
Resources Manager
New Mexico Alliance of Health Councils

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New Mexico Social Determinants of Health Collaborative

Launched July 2022

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Group Purpose

Proposed Vision: All New Mexicans live in communities with equitable access to adequate community-based resources to live their healthiest lives.

Proposed Goal: Improve health and reduce costs by increased access to care and services

Proposed Group Mission:

- Clarify the problem and desired outcomes
- Create a structure and focus for the group
- Commit to work together for a solution

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Proposed Values

- Equitable access and outcomes
- Cross-sector alignment, collaboration, and integration
- Built on NM assets
- Community-informed, community led
- **Bold, ambitious, achievable**

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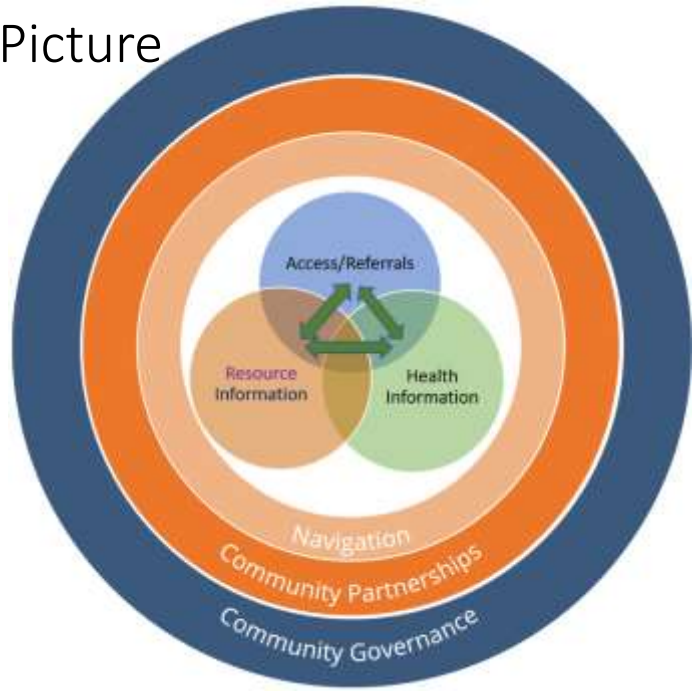
The Big Picture



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Going Forward

- Community – open to all
- Planning Team
- Workgroups

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Workgroups

- Charter: Vision, Mission, Structure, Governance
- Community outreach & engagement
- Action Plan: Logic Model, Timeline, Phases (Pilots to Scale)
- Technical infrastructure & Standards
- Financing/Sustainability

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Contacts

Planning Team

Katy Anderson
Leigh Caswell
Sharon Finarelli
Kyra Ochoa
Jessica Osenbrugge
Terri Stewart
Wendy Wintermute

Next meeting date: September 30, 1:00-2:30

Public Folder: https://bit.ly/3wDBuek

Contact: Wendy@NMHealthCouncils.org

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How HIE Supports the Unhoused Population

Nadia Fazel
DMD, MPH
Chief Clinical Officer
Albuquerque Health Care for the Homeless

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Objectives

- Understand the nuances of special populations in healthcare.
- Evaluate how tools like health information exchanges aid in improving access to quality healthcare.
- Appreciate the role SYNCRONYS has in helping AHCH providers treat our patients by having timely access to comprehensive medical records.
- Learn how other healthcare facilities can adapt our model for their own use.

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Understanding Healthcare for the Unhoused

- Homeless healthcare relies heavily on the need for care coordination and collaboration.
- For activities to be coordinated, each clinician must have adequate knowledge about their own and others' roles and available resources.
- Lowering barriers for patients to access quality healthcare is essential to successful patient care.
- Health information exchanges lowers a significant barrier in patient care management.
- Continuity of care in communities that are migratory relies on access to information exchanges.

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Case Examples

Patients are not good historians!

- Recently, we had a patient who went to the ER with a vague cardiac complaint. Couldn't remember any details about the circumstances. Provider was able to access SYNCRONYS to read the ER note and see the lab work completed. Our provider was able to make important treatment decisions based on that.
  - Previously – huge hurdles in Medical Records access.
- Many of our psychiatry patients deny having a history of psychiatric diagnoses. SYNCRONYS can easily tell the provider the accuracy of those statements.
- Patients almost never bring their post discharge paperwork from ER visits.
  - Reducing duplicative care – driving costs.
- When patients no-show for visits, we can follow up with the referral to other providers or discover perhaps why a patient no-showed (they are in the hospital, for example).
- Hepatitis C management is a HUGE component of successful chronic disease management.

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Contact Information

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505-767-1111

References

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How HIE Supports Unhoused Populations

Krista Luna

Clinical Assistant
Heading Home / ABQ Street Connect

HEADING HOME

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