Hartford HealthCare Medical Group

Connect to healthier.

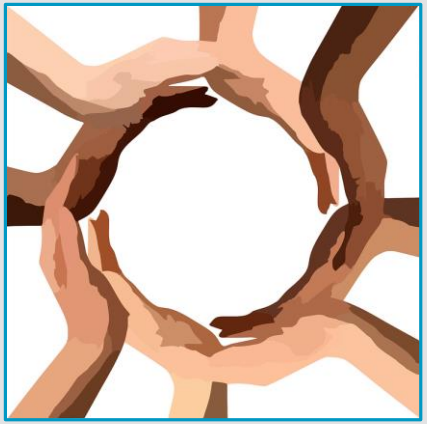
Hartford HealthCare Medical Group: Connecting Primary Care to the Community Around Us

Presenters:

Jillian Dubrosky, Clinical Transformation Specialist
Hilary Maynard, Community Resource Coordinator
Jennifer Pothen, MD, Primary Care Physician
Roxanne Rotondaro, Director, Quality & Safety

January 8, 2020

Race & Ethnicity Category Expansion: Who is in our Community?



Phase 1: Current State Analysis (prior to 8/27/19):

- More than 50% of patients either had no race/ethnicity data or were listed as "declined"
- EHR only allowed for collection of limited federally-mandated categories
  - Not clear reflection of patients' self-identification
- Significant opportunities for improvement in collection rate and accuracy of data

Race & Ethnicity Category Expansion Strategy

Phase 2: Pilot Survey

- 2 week pilot survey in 12 practices to determine appropriate expanded categories
- Health Equity Solutions data (provided by OHS) used for pilot categories
- Data analysis proved most patients self-identify with more than 1 race/ethnicity
- Results bolstered request for resources to expand race/ethnicity categories in Epic across all of Hartford HealthCare

Phase 3: Implementation of Category Expansion

- Expanded category options built into Epic registration fields
  - Fields not "required" to register
  - Patients self-identify. Staff does not make any determinations
  - Patients can select multiple categories, with an "Other" category available
    - Over 12% selected 3 or more categories
    - Apx. 50 patients selected a category that was in previously listed (*Data thru 0/19)
- Rolled out to all of Hartford HealthCare Medical Group as of October 2019
- Fields available to all of HHC and data collection is being seen

Race & Ethnicity Category Expansion & Health Equity

Phase 4: Disparity Identification & Intervention Design

- Focus on patients with Diabetic conditions in relation to health equity
- Identified disparity in A1C between current state race (White vs Black/African American vs Hispanic vs All Other categories)

Race & Ethnicity Category Expansion & Health Equity

Data Analysis Findings:

- Higher average HbA1c and greater use of insulin not surprising.
- More frequent appointments was surprising and Dr. Samson audited 19 charts from disparity groups.

Audit Results:

Element	Yes	No
ED in 2019	52.6%	47.4%
Hospital admission in 2019	21%	79%
Saw a PCBH clinician ever	0%	100%
Contact with Care Manager in 2019	16%	84%
Under care of endocrinologist	11%	89%

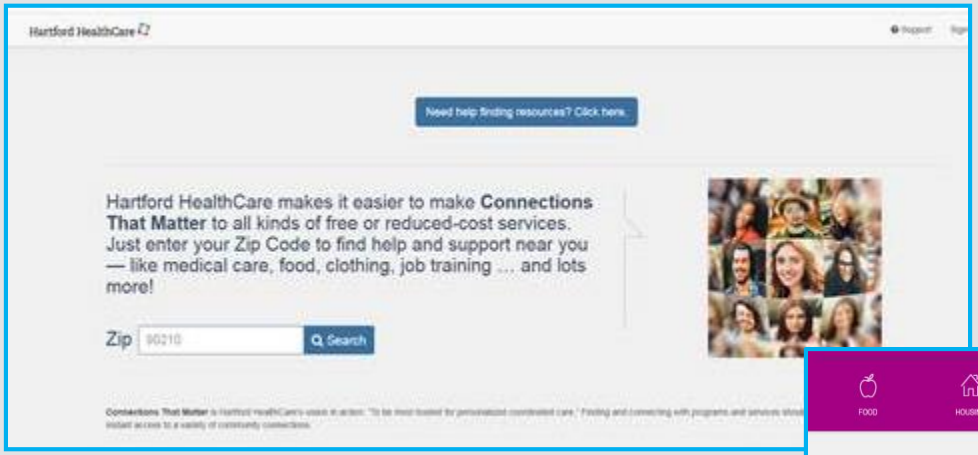
Connections That Matter:
What is it & Why is it Important?

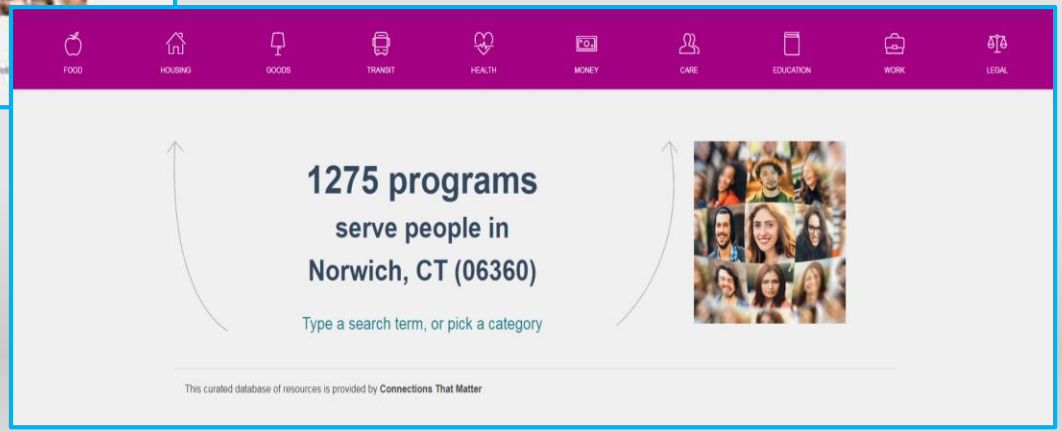
- Online community referral platform powered by Aunt Bertha
  - Connects patients and providers to Community Based Organizations that provide resources including, but not limited to transportation, housing, food, financial, etc.
  - Provides medical professionals with a resource, at the tip of their fingers, to help patients without having to be social service experts
- Integrated into Epic for ease of use by staff but can be launched by anyone in the community via website link
- Allows for more complete care of the patient by expanding care beyond the realms of traditional medicine into all realms of a patient's experience

Connections That Matter
Implementation Milestones

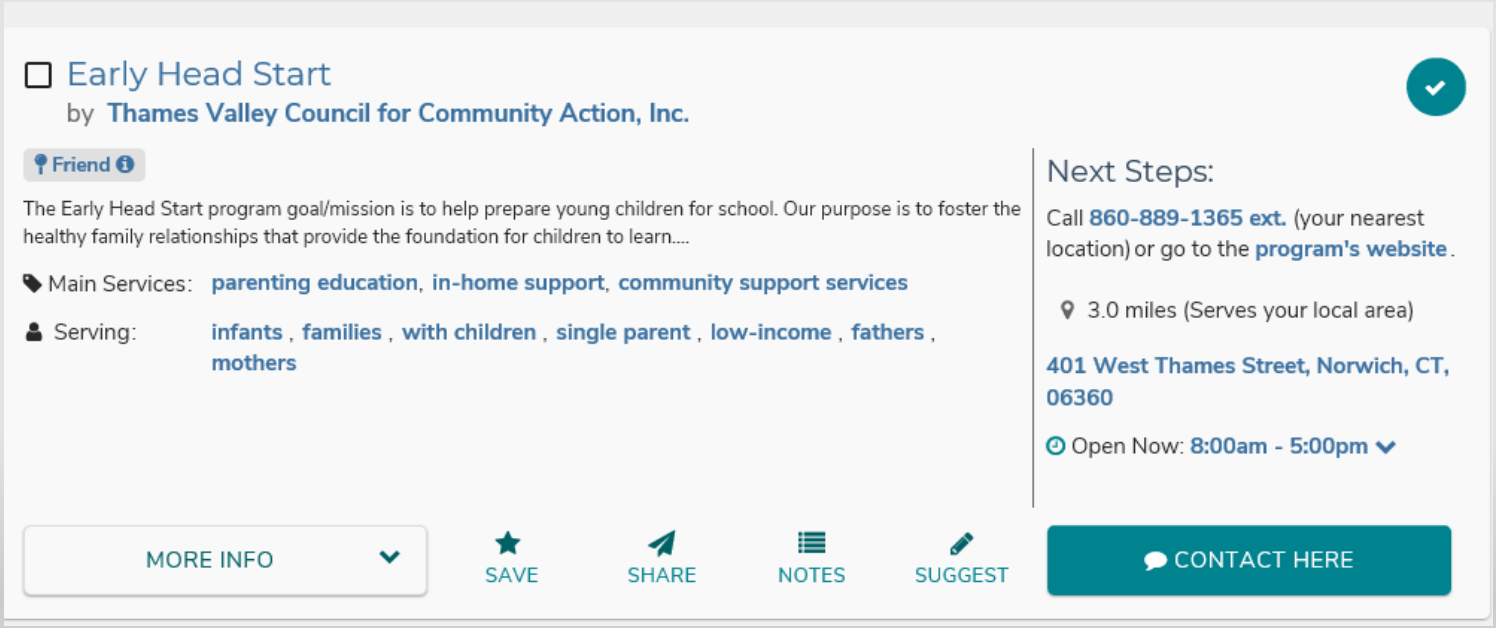
October 2018	HHC MG awarded CCIP grant from Office of Health Strategy
April 2019	Aunt Bertha Kick Off
June 2019	Epic Build Kick Off
July 2019	Training for Pilot Participants & Community Based Organizations Included: 12 Primary Care Pilot sites, ICP Care Managers, BH Clinicians, HH ED
August 2019	Pilot participants go live in Epic
October 2019	Go live for all remaining HHC MG sites (Primary Care & Specialty)

Connections That Matter:
Identifying Needs & Connecting Patients to Community Resources





Connections That Matter:
Resource Program Cards



Connections That Matter:
A Primary Care Physician's Perspective

Why Do I Use Connections That Matter?

- Primary care physician in the Norwich community for 6 years
- Clear understanding of needs of this patient population
- Connections that Matter is an important tool that gives providers the ability to answer the needs of our patients.
- Patients leaving knowing there is a plan to address their needs reducing anxiety and stress
    - Answering these needs will help them achieve better health and well-being for themselves and their families

Connections That Matter:
How It Works for Us

- **Example 1**– Suzy has a wheelchair bound son and was struggling with medical transportation for him. Dr. Pothen was able to refer Suzy to a program for transportation assistance.
- **Example 2** – Joe's company moved out of state. He felt his identity was tied to his job and losing it not only affected his financial status but his overall wellbeing. Dr. Pothen provided job training and placement information through the platform.
- **Example 3** – Patients with food insecurities have been referred to the local food pantries. Providing a connection to these resources helps improve vital nutrition for the patients and their families.

This is how we use it.

How would you use it?

Connections That Matter is available for everyone.

www.connectionsthatmatter.org

connectionsthatmatter@hhchealth.org