2019 Report

THE HEALTH GENERATION GREATER CINCINNATI / N. KENTUCKY

GEN-H CONNECT

Project Overview

In May 2017, **The Health Collaborative** (THC) was awarded one of the 31 Accountable Health Communities cooperative agreements by the Centers for Medicare and Medicaid Services' Innovation Center (CMMI). The five-year demonstration project pilots an innovative model of healthcare service provision.

The goal of Accountable Health Communities is to determine if addressing health-related social needs positively impacts Medicaid and Medicare beneficiaries, thereby reducing costs while improving health outcomes. For this project, THC serves as a community "hub," aligning model partners to optimize community capacity to address health-related social needs.

Through our model, branded **Gen-H Connect**, participating clinical delivery sites (CDS) screen community-dwelling Medicare and Medicaid beneficiaries (CDBs) for their health-related social needs (HRSNs) in five core domains: food insecurity, housing, utilities, transportation, and safety.

If needs are discovered CDBs receive a tailored community resource summary to identify resources that can help resolve their needs. CDBs who have identified needs and have had an emergency room visit two or more times in the previous 12 months become eligible for community navigation services.

Referrals for navigation services are made at the point of care, and within two business days CBDs are connected with a navigator for ongoing support. Screening and navigation activities are conducted through an online social needs platform called Healthify.

Project Partners

Powered by a mission to build a world where no one's health is hindered by their need, **Healthify** builds the infrastructure to support social determinants of health (SDoH) initiatives at scale. Healthify offers access to its carefully constructed accountable networks of social service organizations.

Each network is Geo-targeted and intervention-focused to ensure that the unique needs of each community are addressed. Healthify also works directly with social service organizations to develop and formalize contracts, ensuring accountability across its networks. Supported by an interoperable SDoH referral platform, partnering organizations can coordinate care with ease while ensuring their communities are receiving the services they need to thrive.

For more information about Healthify please visit www.healthify.us.

Gen-H Connect Clinical Sites
Responsible for screening Medicare & Medicaid beneficiaries

- Cincinnati Children's Hospital Medical Center
- The Christ Hospital Health Network
- TriHealth
- UC Health
- Centerpoint Health
- City of Cincinnati Health Department
- Crossroad Health Center
- Talbert House
- The HealthCare Connection
- Warren County Combined Health District

Gen-H Connect Navigation Agencies
Responsible for providing navigation services to Medicare & Medicaid beneficiaries

- CareSource
- Council on Aging of Southwest Ohio
- Cincinnati-Hamilton County Community Action Agency
- Health Care Access Now
- Molina Healthcare of Ohio

Gen-H Connect Community Partners

- United Way of Greater Cincinnati & Dayton
- Ohio Department of Medicaid

Health Information Exchange Infrastructure

The Health Collaborative is home to our very own Health Information Exchange called **HealthBridge**. By leveraging HealthBridge, we tap into our Master Patient Index (which has over 4.5 million patients) and our Admit/ Discharge/ Transfer feeds from participating hospitals to build a client list that serves as a unique go-between from electronic health records to Healthify.

Gen-H Connect Screening Data

All data collected from January 1, 2019 - November 30, 2019

Number of Screenings | 6,992

Number of Community Dwelling Beneficiaries | 6,153

Number of High-Risk Community Dwelling Beneficiaries | 1,400

Number of Health Related Social Needs Identified:

Utilities
1,302

Interpersonal Violence
417

Housing
1,531

Transportation
1,317

Food
2,183

Demographic Breakdown

Race/Ethnicity Community Dwelling Beneficiaries

Latinx | 439
Native Hawaiian | 24
Black or African American | 2,449
White | 3,890
American Indian | 162
Asian | 60

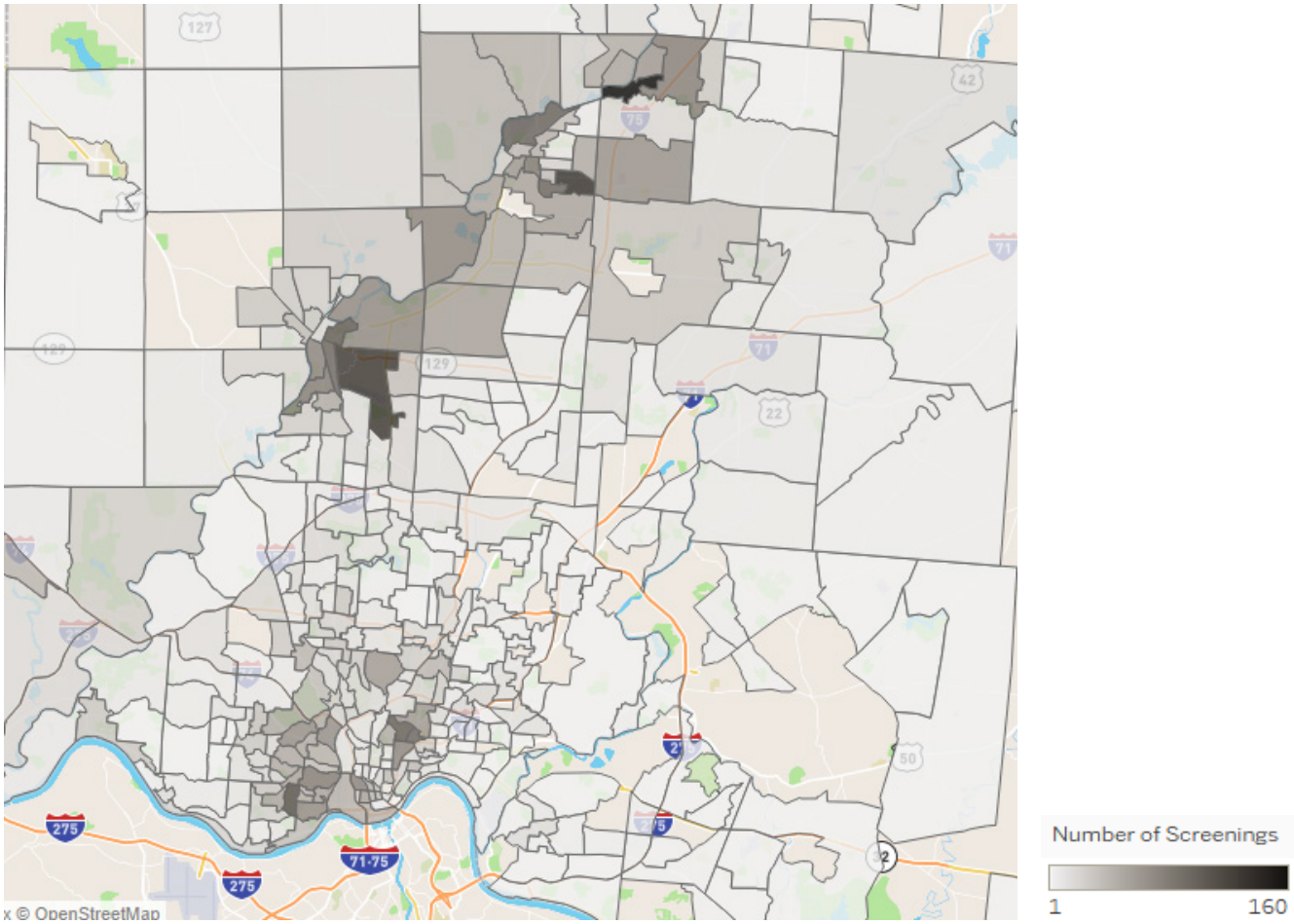
Gender

Male: 3,401 Trans-Male: 1 Female: 5,766 Trans-Female: 2

Average Age | 37

Southwest Ohio

Below is a map of the number of screenings by census tract. Out of the 6,992 total screenings, there were 1,260 referrals to navigation. 90% of High Risk Community Dwelling Beneficiaries were referred to navigation.



Beneficiary Success Story

"John" a 62-year-old year male, was screened at UC Health and referred to Health Care Access Now for navigation services. He screened positive for both housing and food needs. While John has income from Social Security, he also wanted to secure part-time employment and regain his independence after recovering at his sister's house from triple bypass surgery.

Through the direction and assistance from the Community Health Worker (CHW), John was directed to attend a job fair and as a result was able to secure a part-time position at the Freestore Food Bank. With assistance, he also applied and received Supplemental Nutrition Assistance Program benefits. John is currently submitting housing applications! He expressed his gratitude to the CHW by stating, **"You have really looked out for me and I'm grateful for that."**

Screening Site Testimonial

Darris Bohman MSN, RN, CEN | TriHealth Bethesda Butler Emergency Department

With Gen-H Connect in place at TriHealth Bethesda Butler and the tools to address the needs of vulnerable populations, Darris feels that, **"a weight has been lifted off and our staff can now ask questions about patients' social needs because they know somebody is going to find them the needed resources."** Among others in the Emergency Department, there is strong support to utilize screening and navigation tools now that there is a pipeline system for providers, nurses, and staff to identify needs and provide a resource for clients.

Darris views screening for health-related social needs as necessary in all settings for all people, but for now the work being driven by Gen-H Connect addressing health-related social needs is, **"... a better solution than a prescription or doctor visit ever could provide."**

Questions?

Contact us at genhconnect@healthcollab.org
Follw us on your favorite social media platform @GenH_CincyNKY

THE HEALTH COLLABORATIVE