

# Building a Connected Community

## Patient Care Intervention Center & Houston Food Bank

Kallol Mahata, CEO, PCIC  
Nicole Lander, CIO, HFB

December 10, 2020



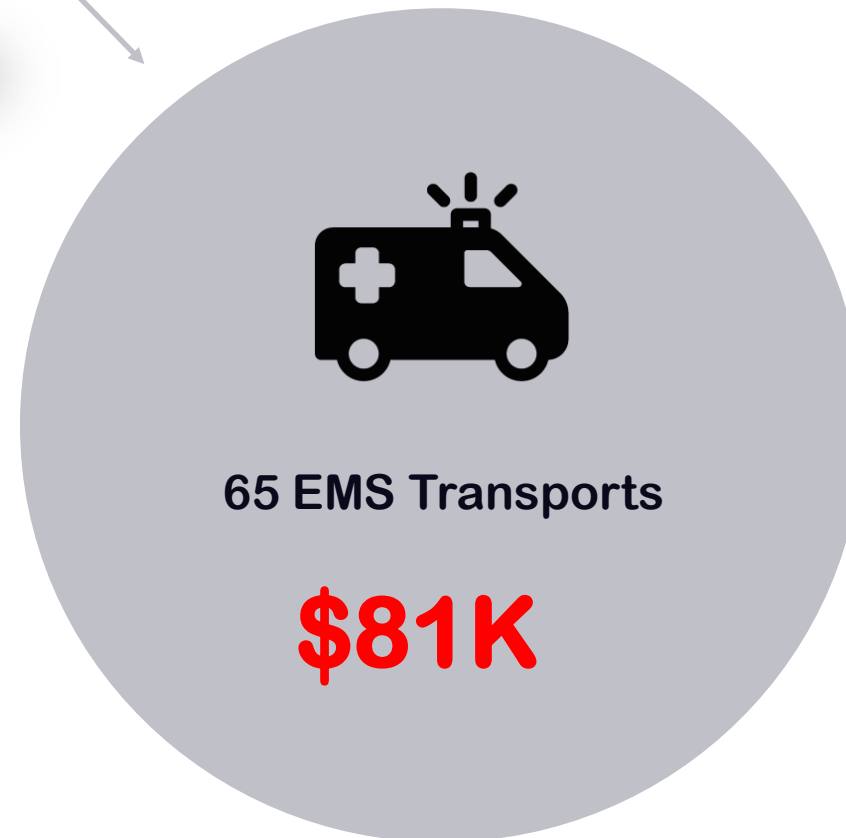
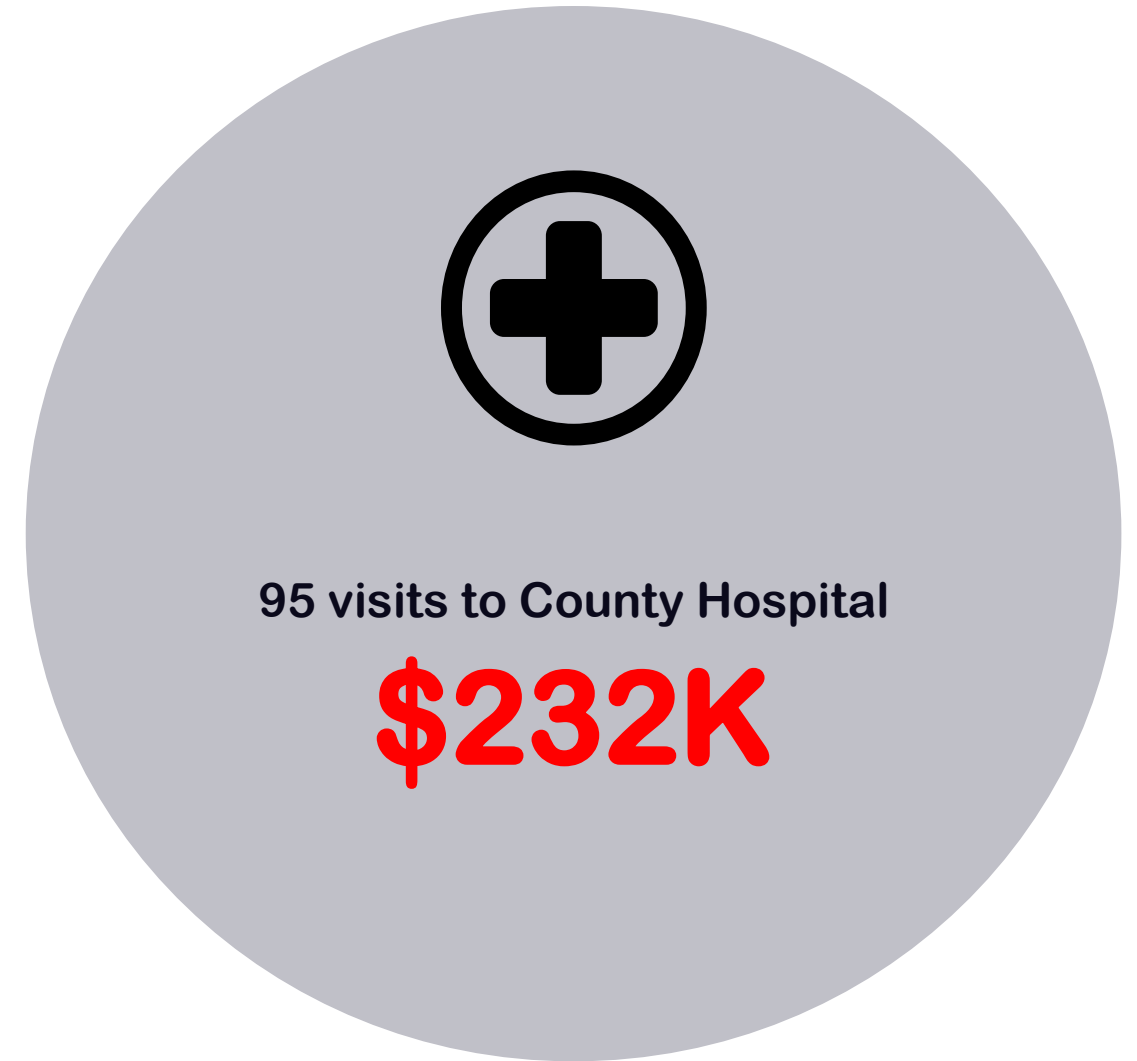
houston   
**foodbank**

*PCIC's* mission is to improve healthcare quality and costs for the vulnerable in our community through data integration and care coordination.

*HFB's* mission food for better lives.

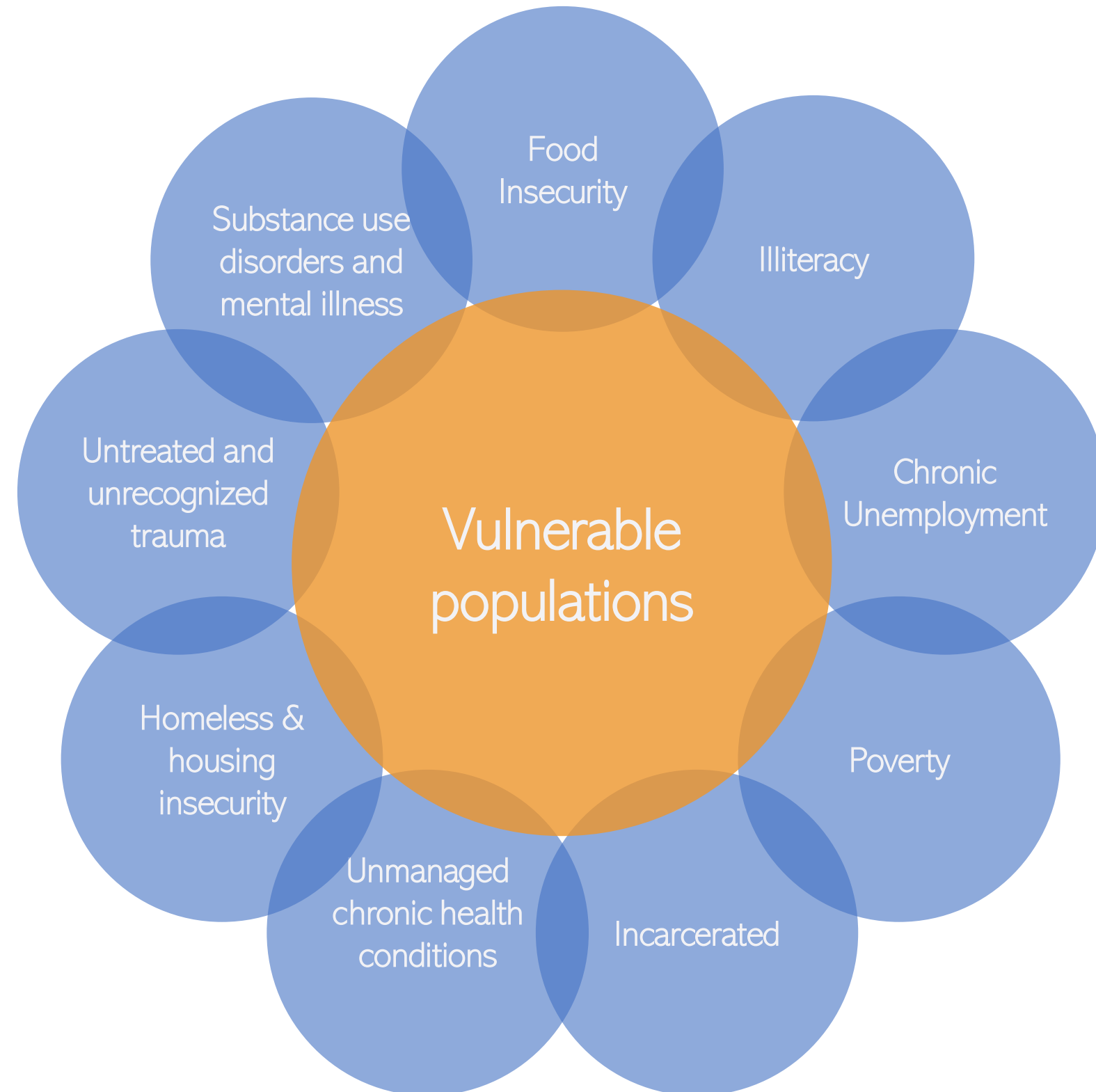
# The Need for Collaboration

**\$439,600 =**  
Mr. J's utilization in 1 year



# Vulnerable populations

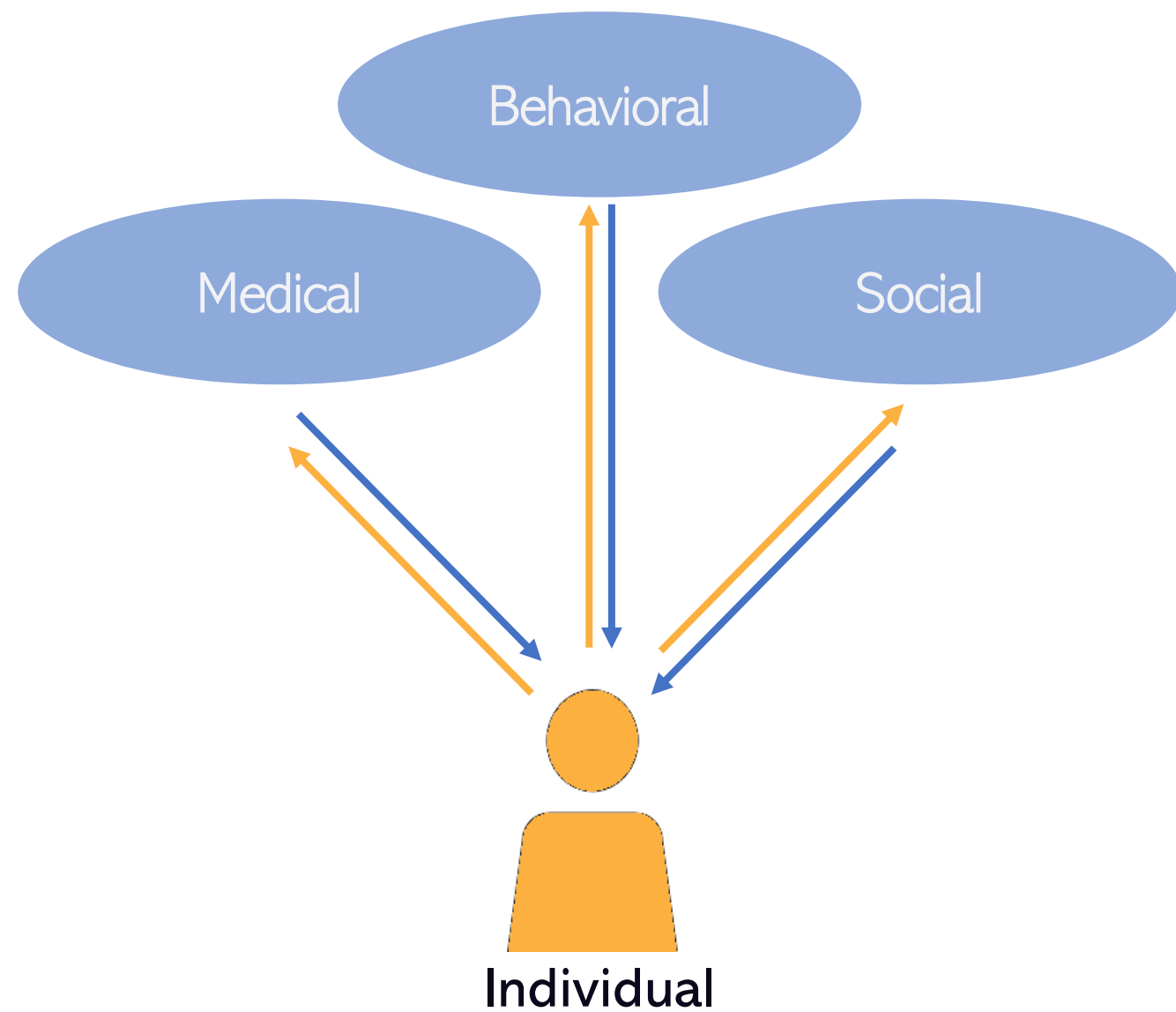
## Multiple interrelated root causes



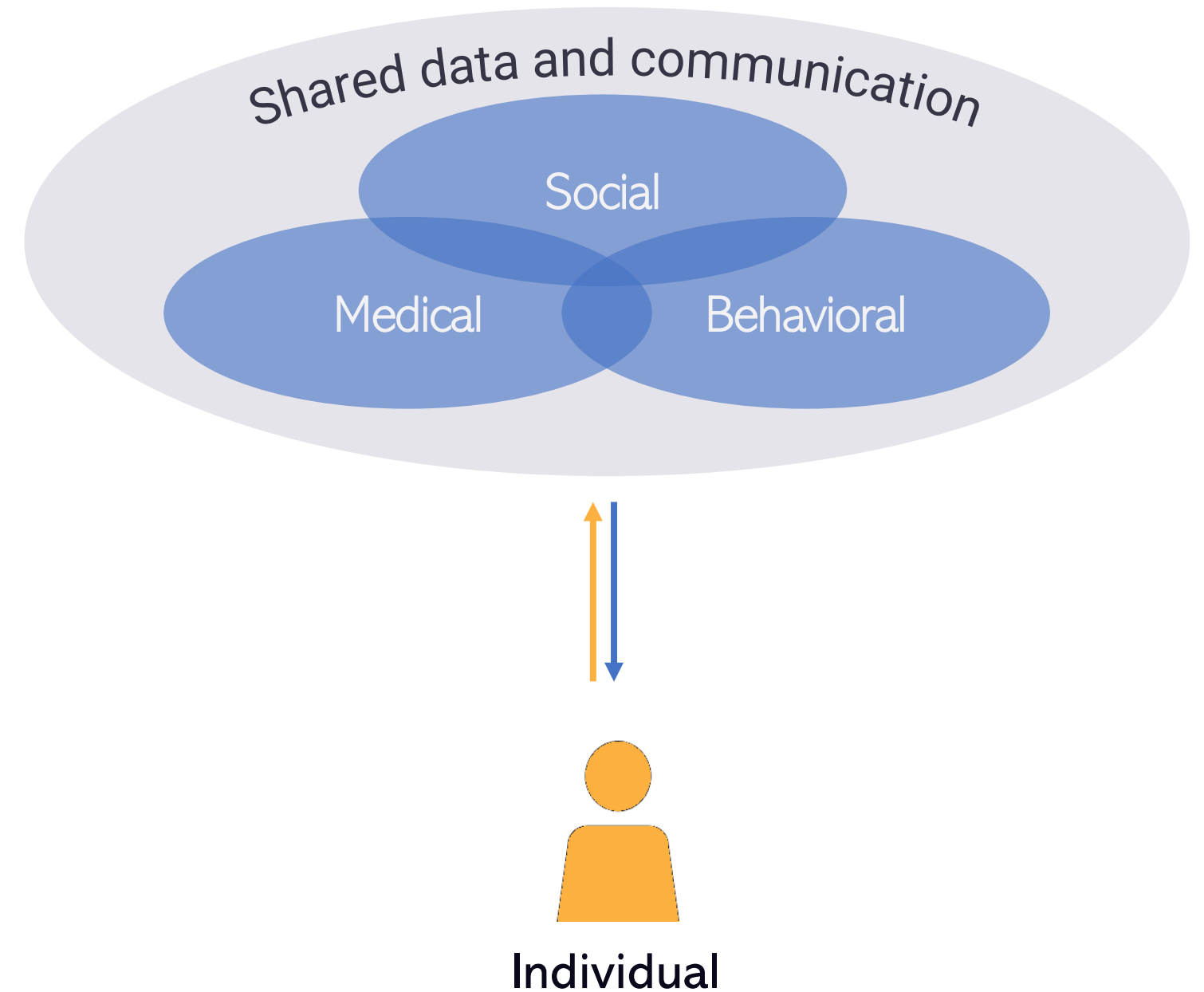
# How do we solve this?

## A collaborative model of care

Status Quo: Siloed systems yield siloed responses

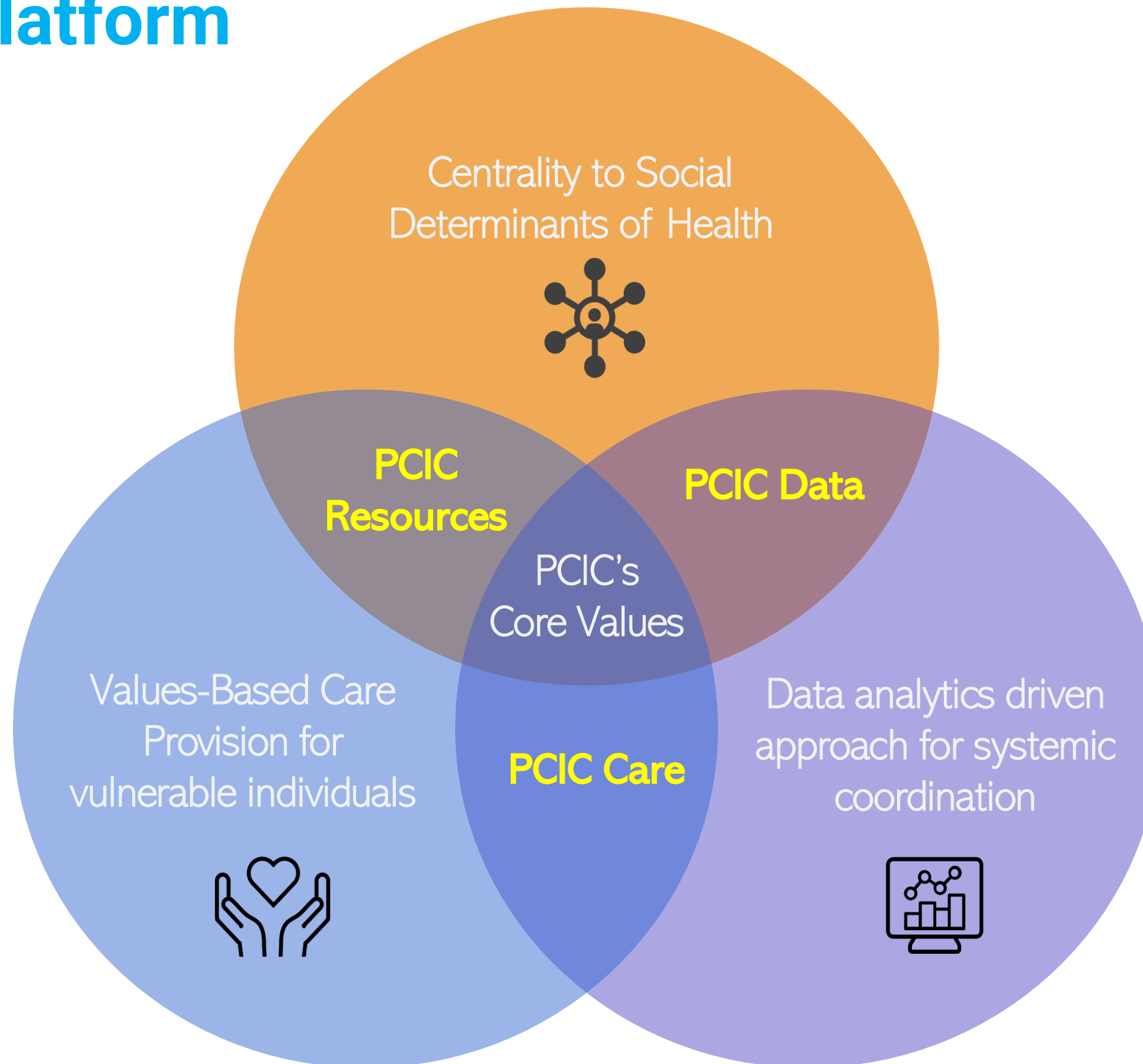


Interrelated needs require an integrated response



—→ Response  
—→ Need

# PCIC's core values towards in Integrated Platform







# Data Partners

- ✓ **500+** agencies sharing data
- ✓ **2.5M+** individuals
- ✓ **25M+** encounters
- ✓ **565** data points across different SDOH



houston**foodbank**  
**Vision, Mission and Values**

The Houston Food Bank is launching a new vision and mission this year to accurately represent what we do and where we want to go. Food banking has evolved over the years to further address root causes of hunger. Houston Food Bank provides programs and services aimed at helping families achieve long-term stability including nutrition education, job training, health management, and help with securing state-funded assistance.

### **Our Vision**

*(inspirational long-term desired change)*

**A world that doesn't need  
food banks**

### **Our Mission**

*(core purpose)*

**Food for better lives**

### **Our Values**

*(Behaviors expected to be upheld by all when interacting to accomplish work together)*

**Purpose:** Using our strengths passionately to contribute to our mission.

**Accountability:** Choosing to rise above one's circumstances and demonstrating ownership to achieve results. See it. Own it. Solve it. Do it.

**Courage:** Standing up for what's right and taking action.

**Transparency:** Doing things openly and honestly.

159 million  
nutritious meals were  
distributed in Fiscal  
Year '20!

Houston Food Bank is  
currently the **largest**  
food bank in the nation,  
in terms of distribution!





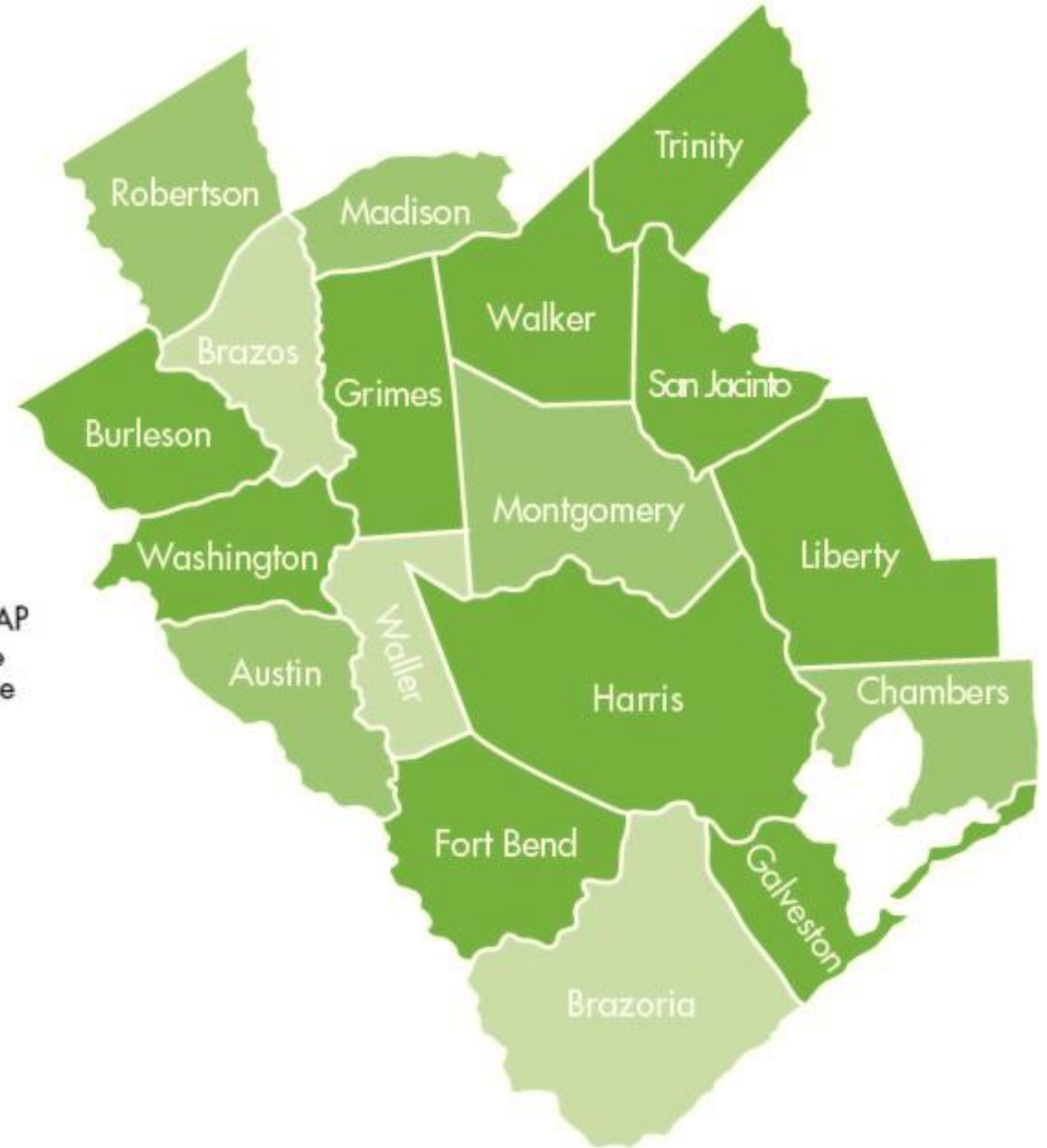
# 18 southeast Texas counties make up our service area

1,500

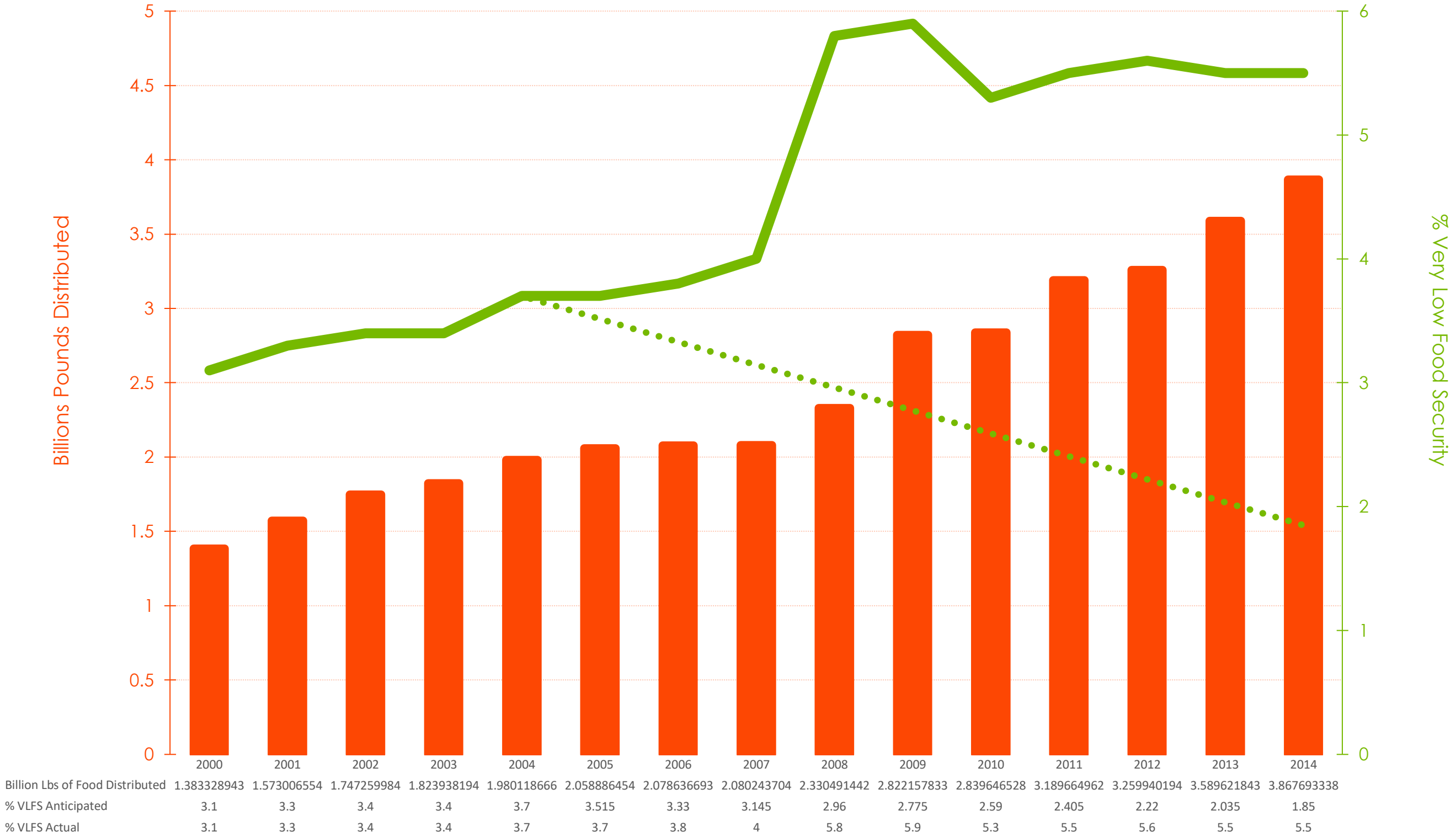
community partners

- Food Pantries
- Soup Kitchens
- Schools
- Social Service Providers
- Meal Sites

16 Million Meals  
made possible from HFB's SNAP  
(Supplemental Nutrition Assistance  
Program) application assistance

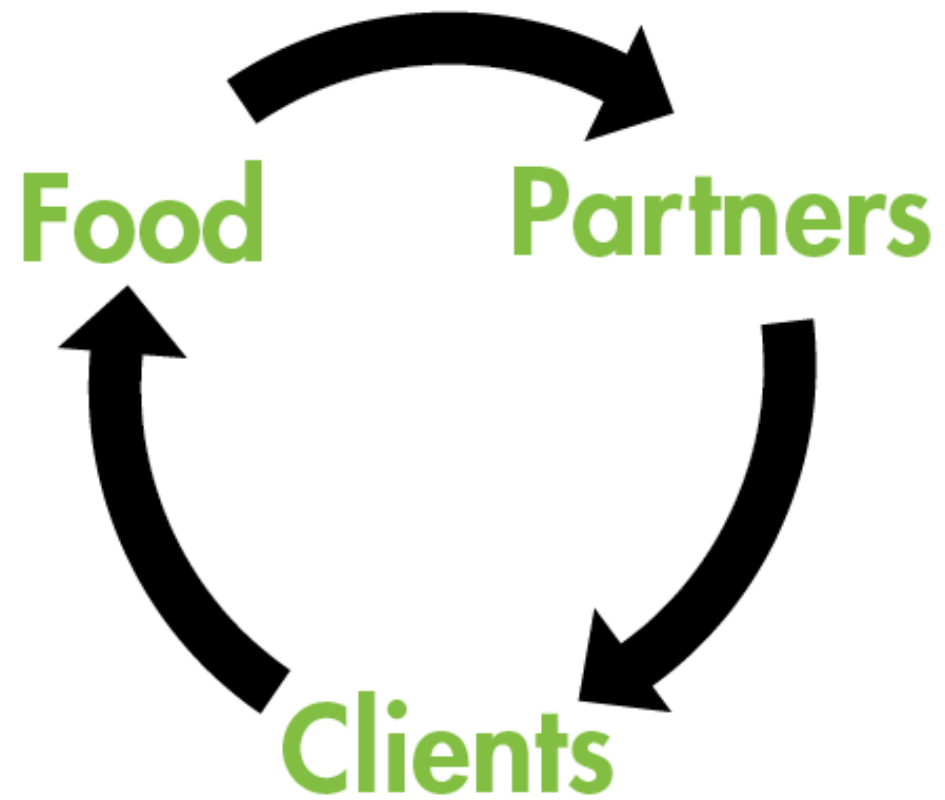


# Food Distribution to Clients vs. Hunger

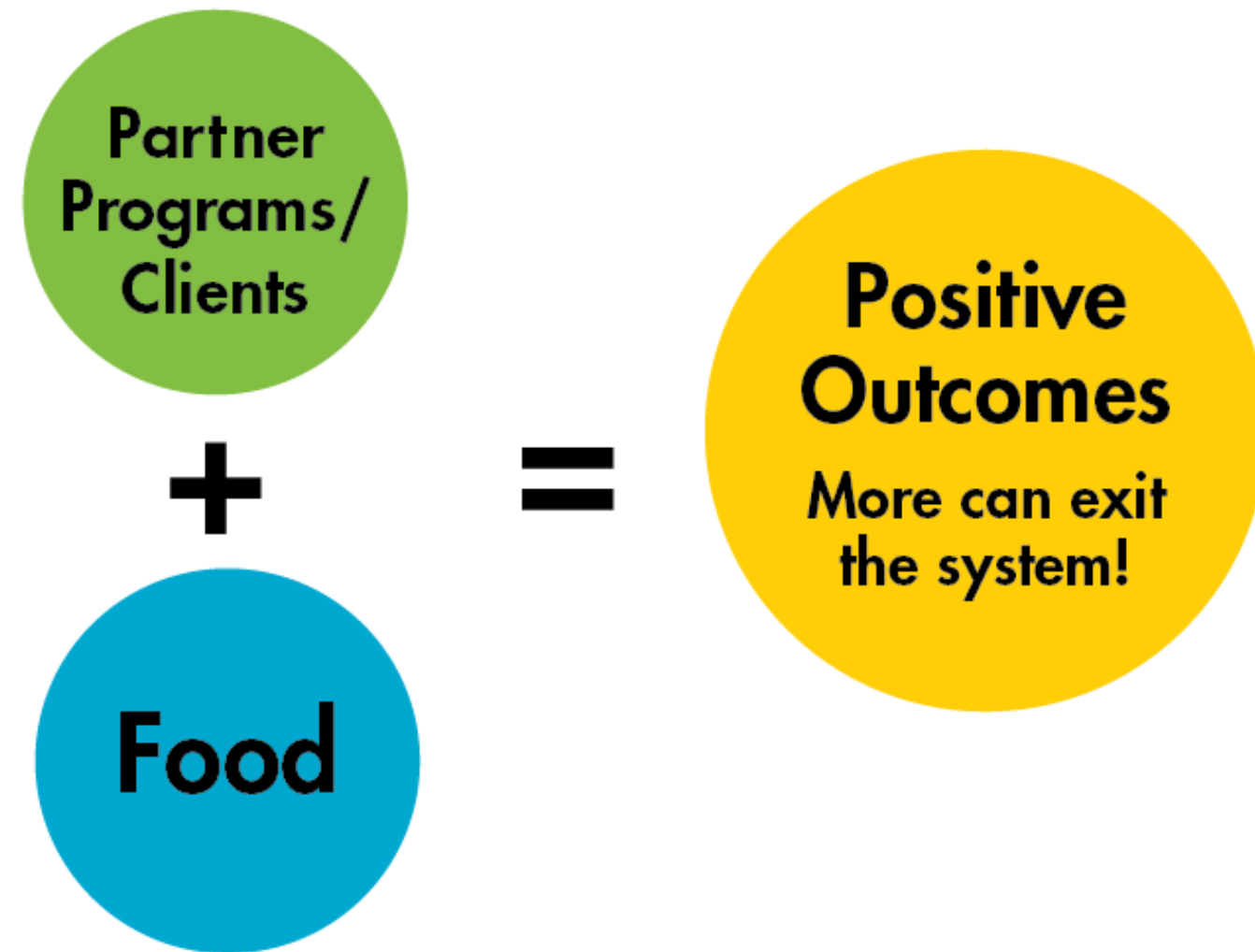


# Food For Change

Current System



Future System



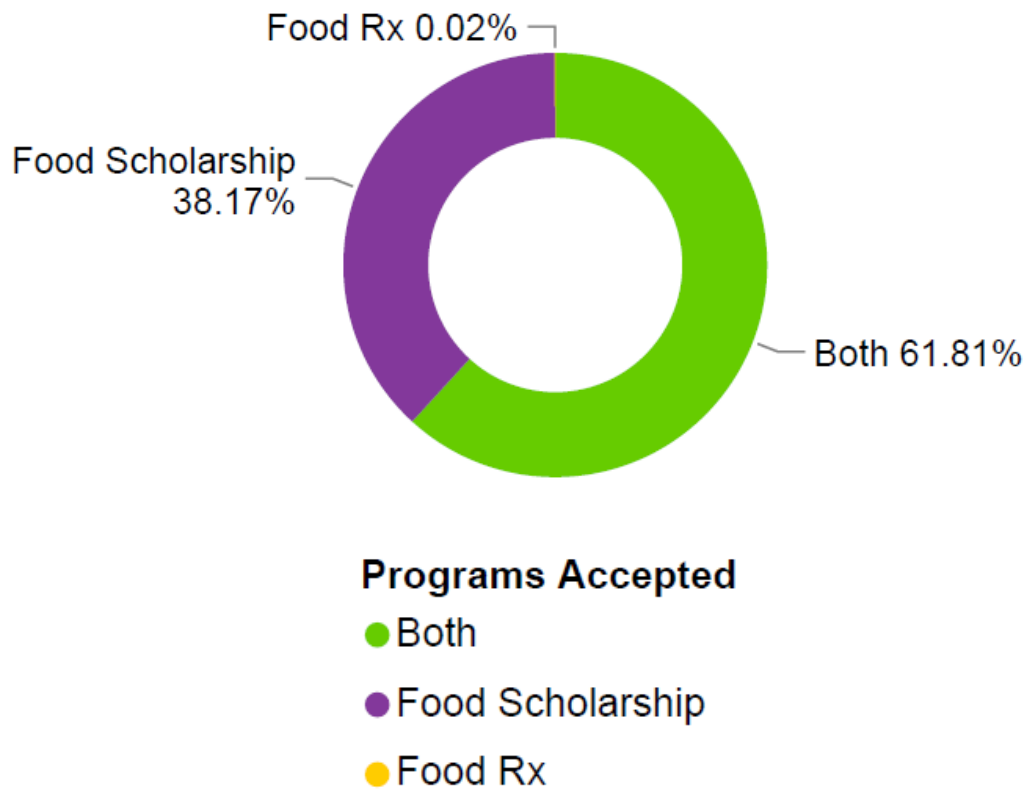
## Strategic distribution with outcomes

Address the upstream *causes* and downstream *effects* of food insecurity

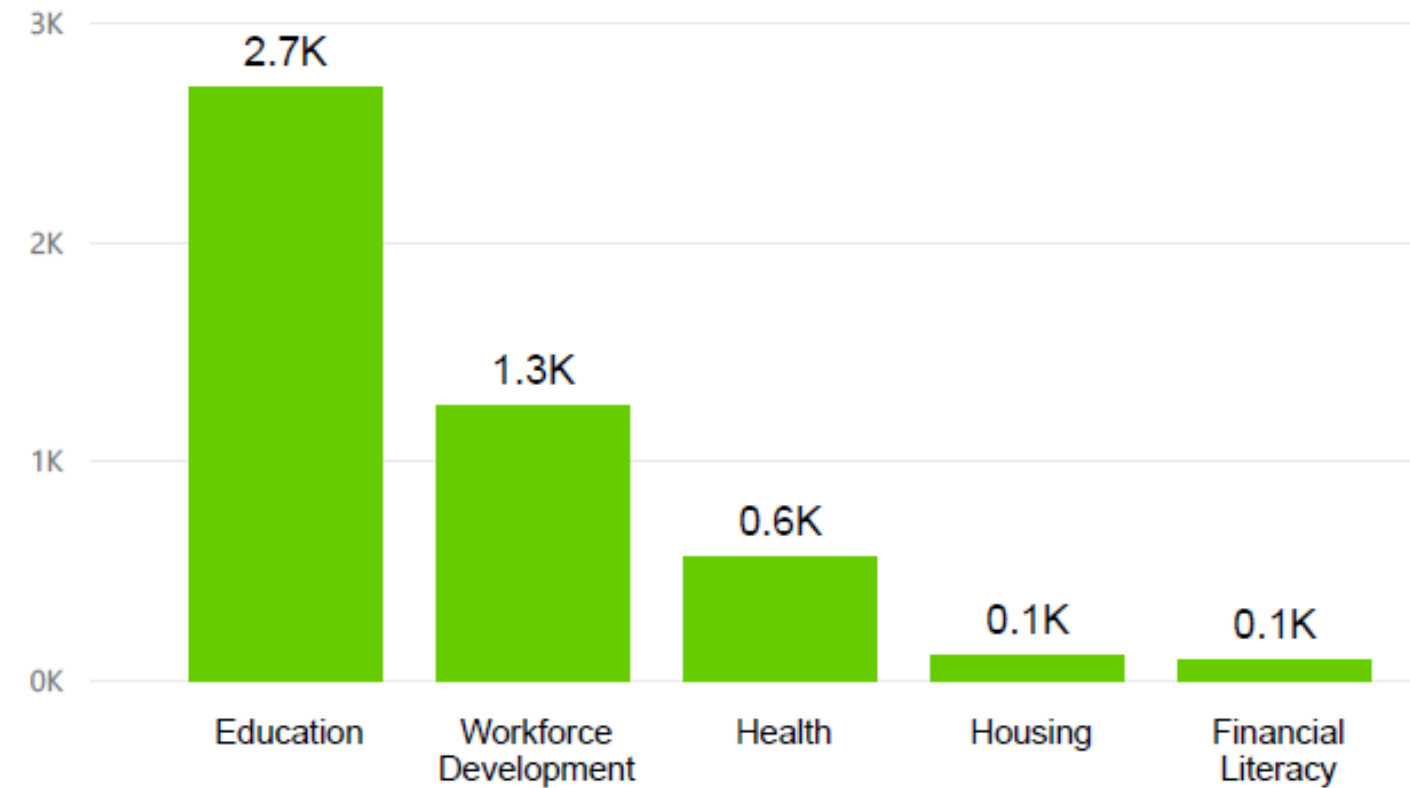
# Integrating Food For Change model across the organization

## Size

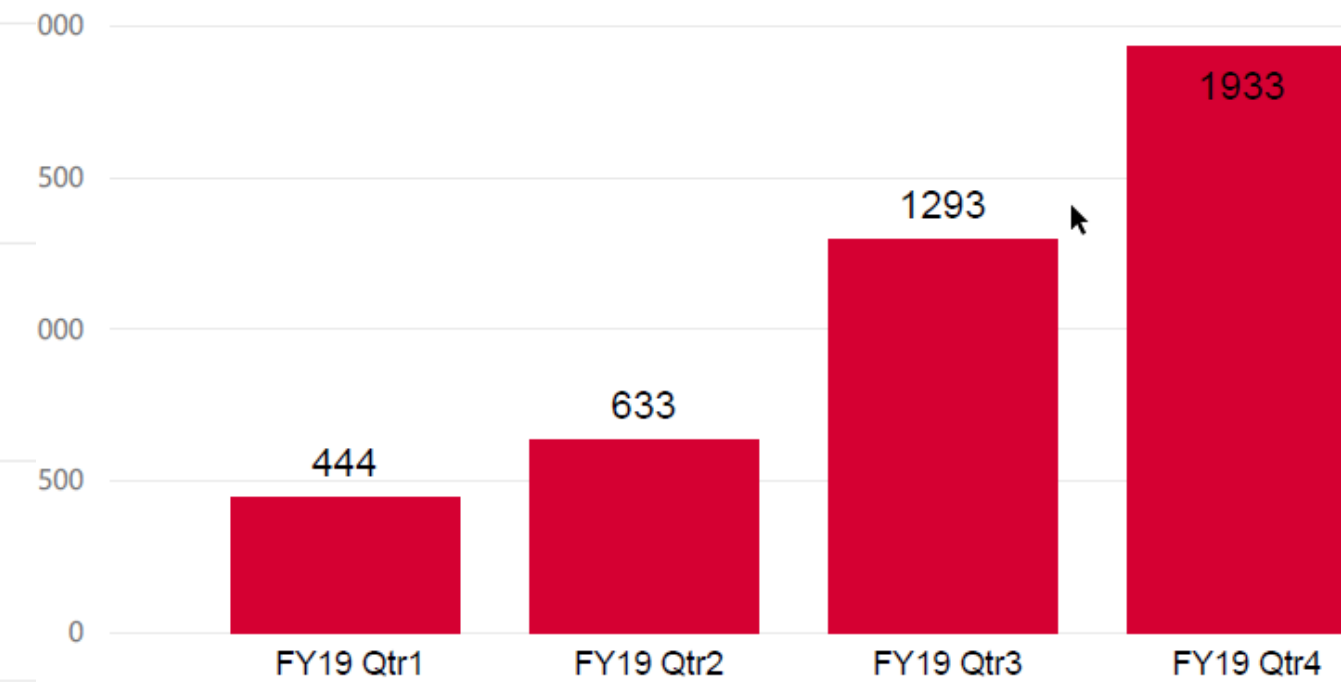
**FFC Markets by Number of Visits**



**Number of Clients Enrolled by Partner Type**



**Number of Visits to Markets by Fiscal Quarter**



4736

Number of Clients Enrolled

14

Number of FFC Markets

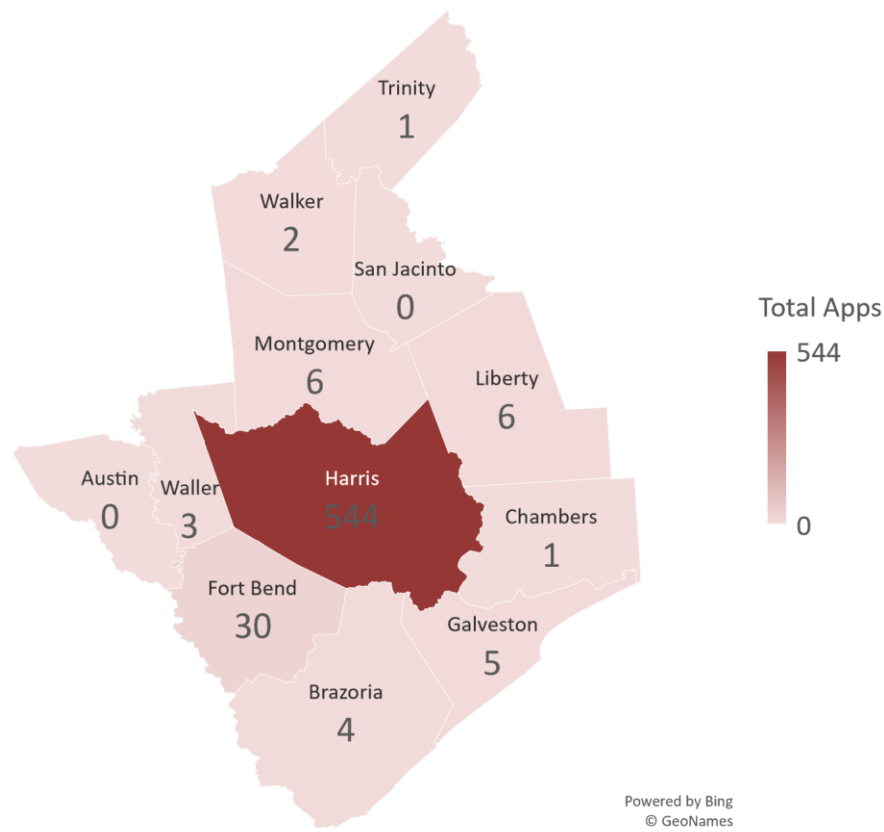
1342

Number of Unique Clients Served

4303

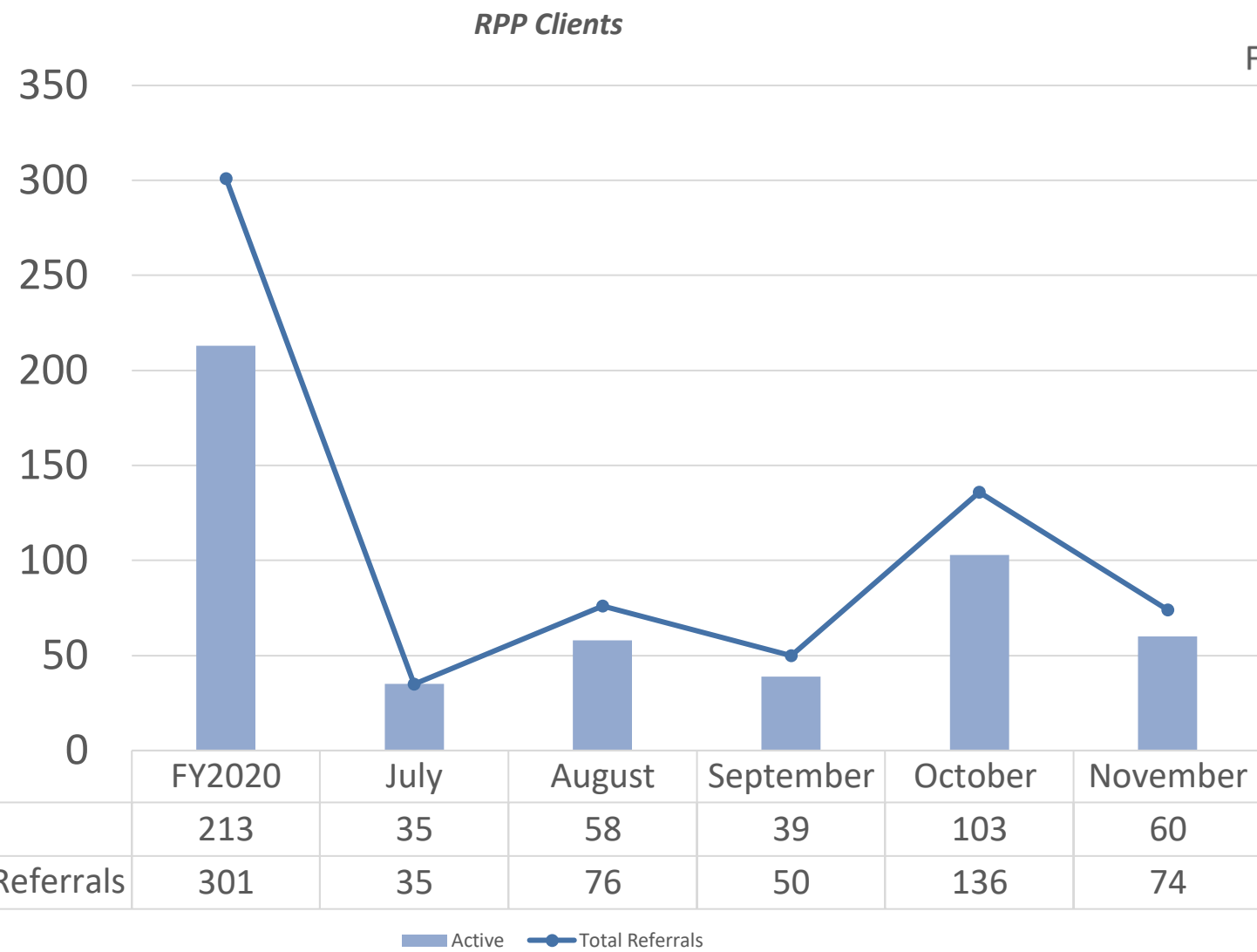
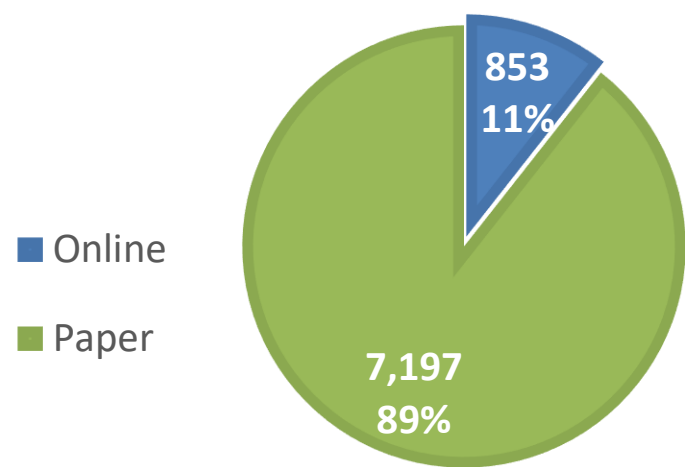
Total Number of Market Visits

### FY21 SNAP Apps by County

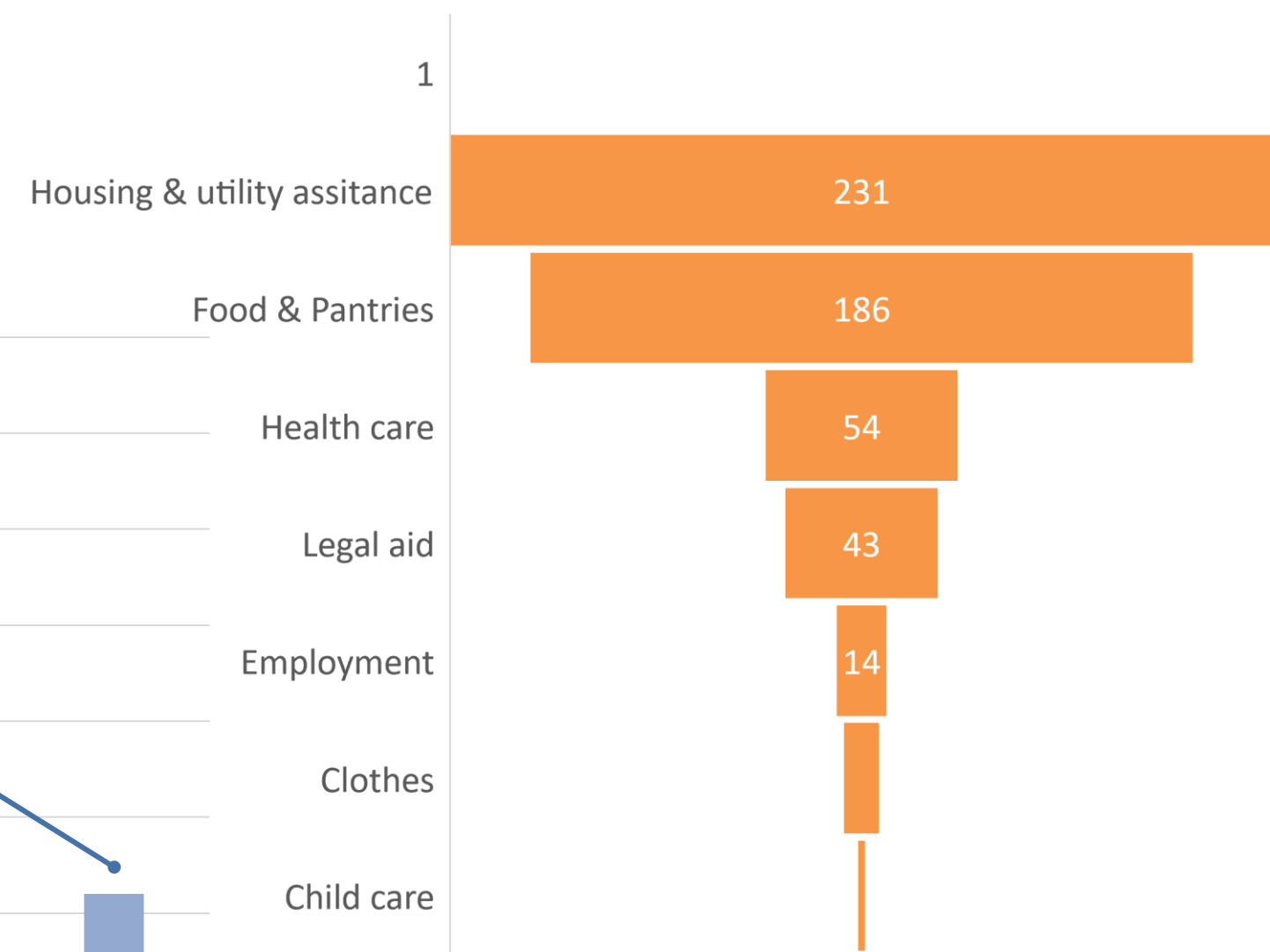


# Community Assistance Program Data Snapshot

### SNAP SUBMISSION FY21



### Client Needs FY21



# A collaborative model

## 1. Integrating cross-sector data

Data driven  
approach for  
systemic coordination

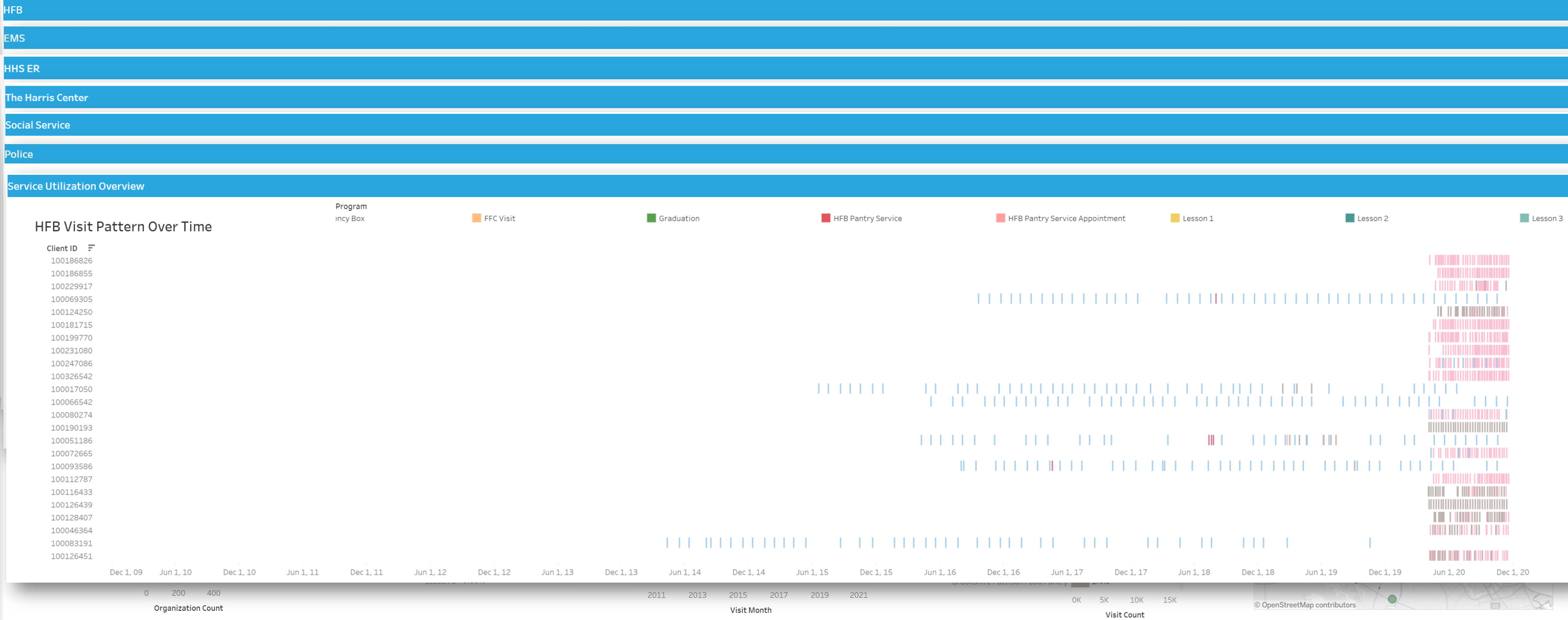


- Agency level utilization overlaps
- Community level, multi-layer data overlaps
- Community level resources



# A collaborative model

## 1. Integrating cross-sector data – Agency overlaps



# A collaborative model

## 2. Integrating patient values

Values-based care  
model for vulnerable  
individuals



### Integrating model and tracking

- Using CBT and MI
- Who or what is important to you?
- What gets in your way?



# A collaborative model

## 2. Integrating patient values



### Looking beyond Mr. T's:

- Homelessness
- Food insecure
- 12 ED visits and 2 hospitalizations
- Unemployed
- Multiple chronic conditions

**Striphe**  
**Mr. T's dog**



# A collaborative model


## 2. Integrating patient values

UCCP Unified Care Continuum Platform

Desktop Touch Enabled Welcome Kallol Mahata [Log Out]

Dashboard Calendar Demographics Assessments Planning Care Care Plan Visits and Tracking Forms and Documents Reports Actions

Monica > Planning Care

 **Monica Sanchez** 61Y, Hispanic, Female

**Who or what is important to Monica:** My Son; My Dog; My neighbor Sally; food security

**What would Monica like to be doing:** I like to take my pet on regular walks; Have dinner on Sunday with Sally; Take care of my son; eating 3 times a day

**What program is Monica enrolled in:** Unified Care Plan

**Monica's care team:** Victoria Bryant; [redacted]; Link; John Star; Markisa Holmes;

**Who or what is important to Monica (Values)**

**What would Monica like to be doing? (Aspirations)**

**What gets in Monica's way? (Barriers)** ⓘ

Add

Type: personal   Unmapped Lacks cell phone <input checked="" type="checkbox"/> Active? <input type="checkbox"/> Has been overcome? Readiness to change: 7 Edit Delete <a href="#">1 goal(s) created</a> Create Goal	Type: system   Unmapped Lacks access to reliable transportation <input checked="" type="checkbox"/> Active? <input type="checkbox"/> Has been overcome? Readiness to change: N/A Edit Delete <a href="#">1 goal(s) created</a> Create Goal	Type: system   Unmapped Difficulty accessing appropriate medical care <input checked="" type="checkbox"/> Active? <input type="checkbox"/> Has been overcome? Readiness to change: N/A Edit Delete <a href="#">4 goal(s) created</a> Create Goal	Type: system   Unmapped Limited financial resources <input checked="" type="checkbox"/> Active? <input type="checkbox"/> Has been overcome? Readiness to change: N/A Edit Delete <a href="#">1 goal(s) created</a> Create Goal
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# A collaborative model

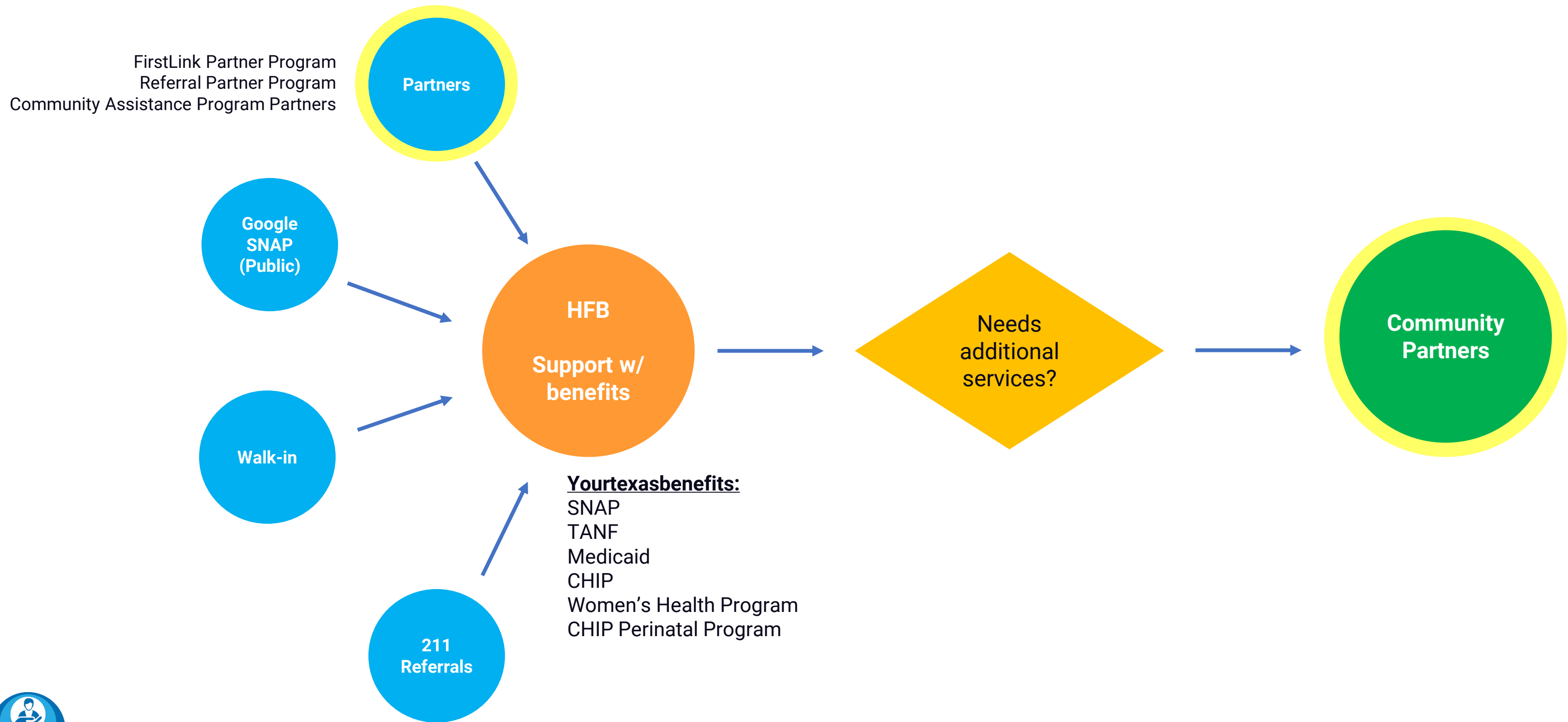
## 3. Collaborating with CBO partners

Centrality to  
Social Determinants  
of Health



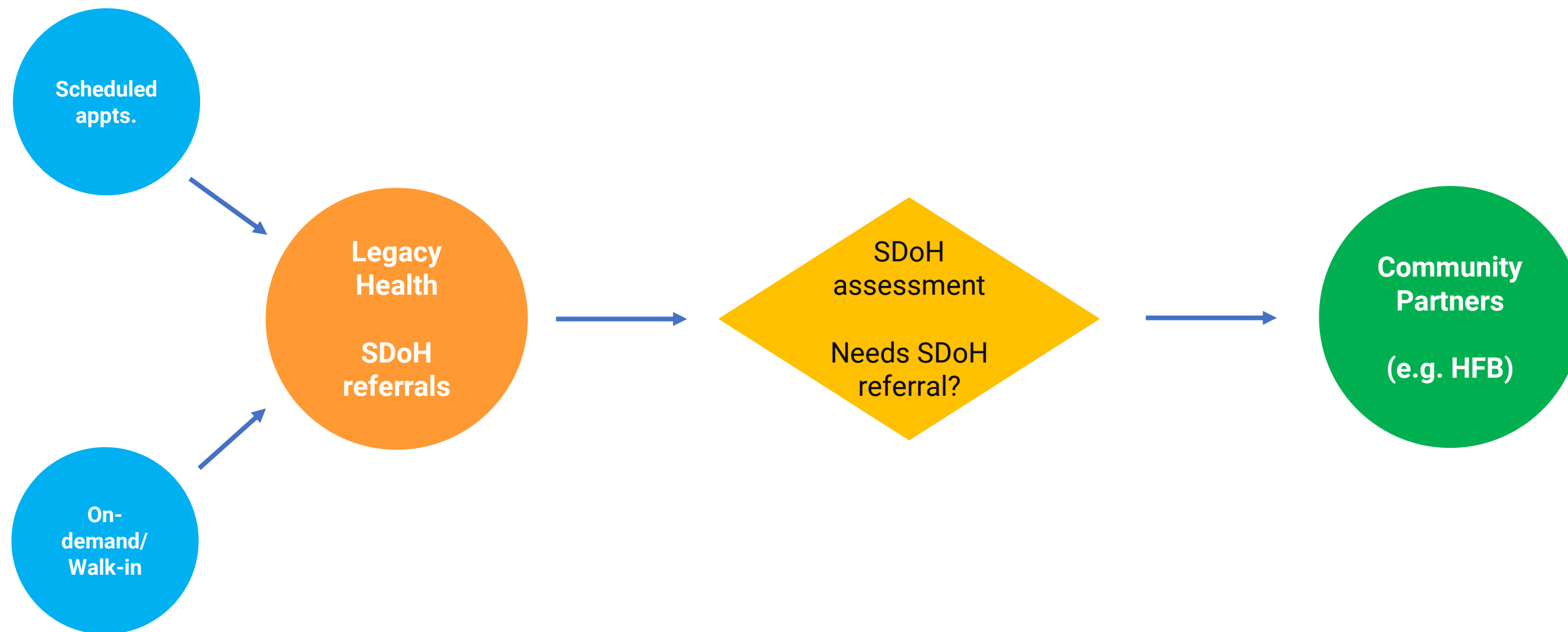
- Referral pathways
- Community Partnerships
- Federated directories

# Referral pathway from the Houston Food Bank



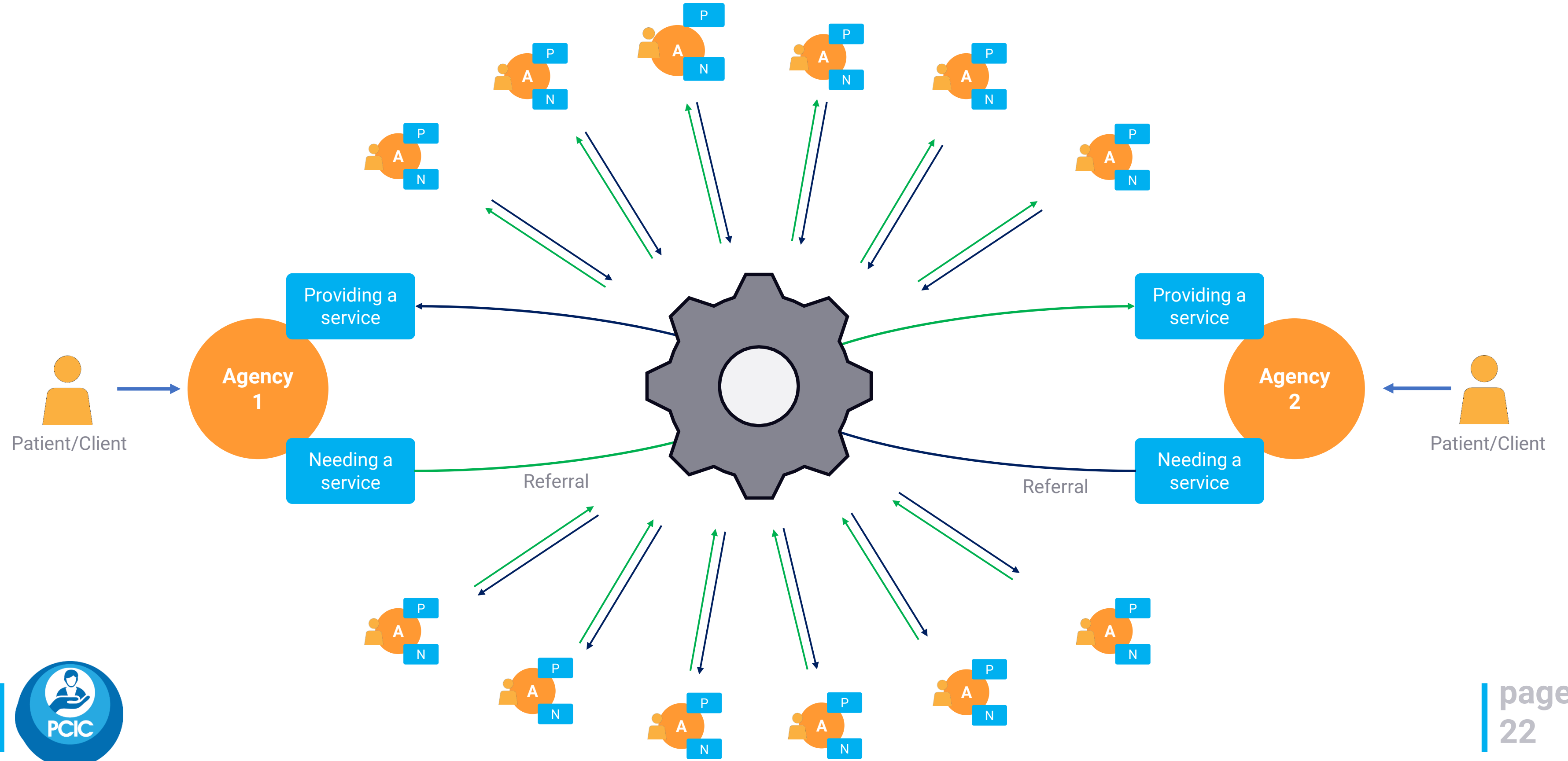


# Referral pathway to the Houston Food Bank (from an external partner)



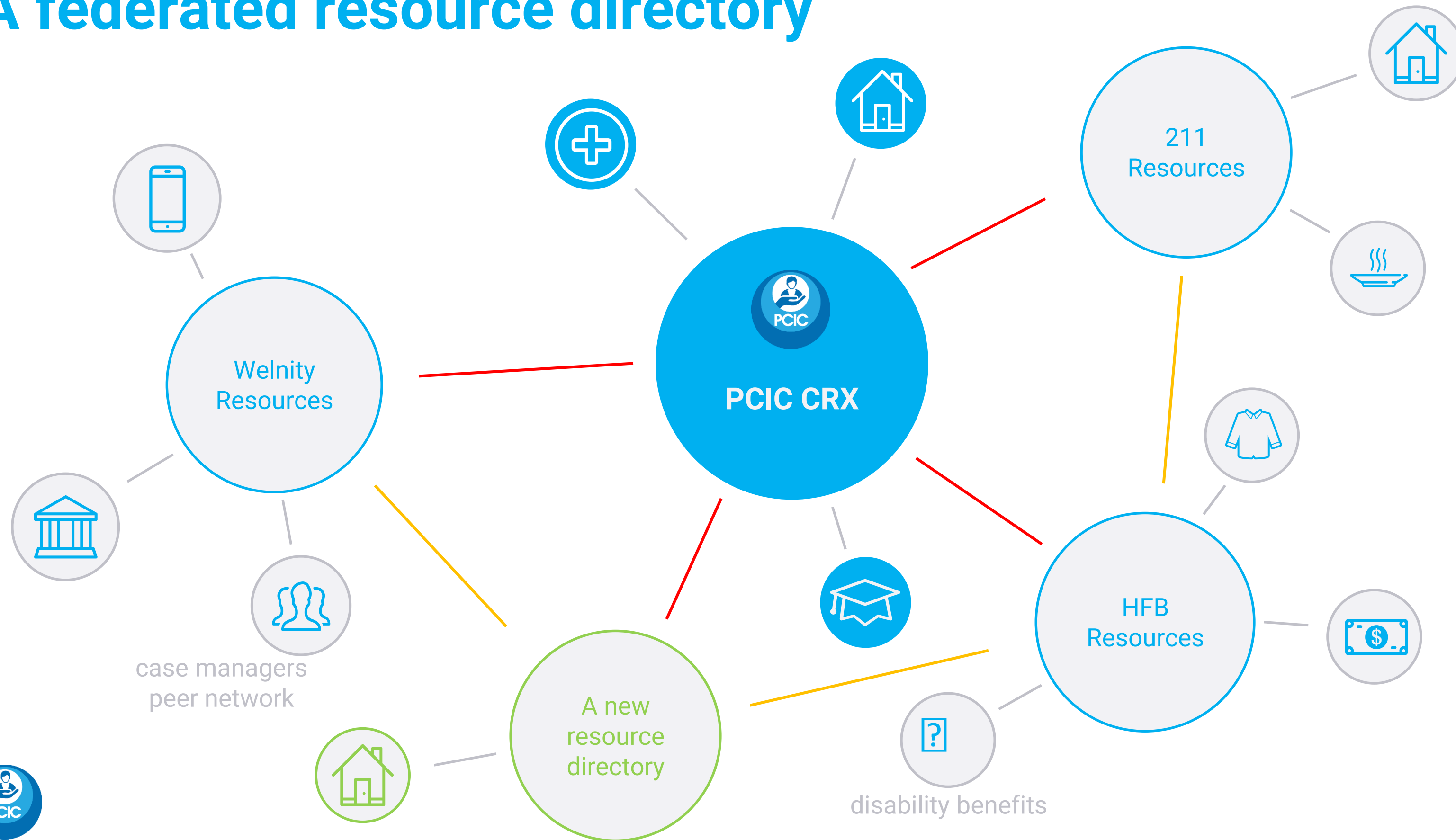
# A collaborative model

## Community Resource Exchange – Dedicated referral pathways



# A collaborative model

## A federated resource directory



# Connecting Patients To resources

UCCP > Resource Directory

Resource Directory - Search Filters

Search by agency:

Zip Code:

Please select the resource directory:  
 PCIC  Welnity

Limit search results to:  
Within 5 miles

**Age Groups**

- Children
- Youth
- Adults
- Senior

**Insurance Status**

- Insured population
- Accepts Medicaid

**Gender Groups**

- LGBTQI
- Men
- Women

**Health Conditions**

- Behavioral Health
- Diabetics
- HIV Positive

**Service Categories**

- Addiction
- Basic Needs
- Behavioral Health
- Case Management
- Education
- Employment
- Food
- Housing
- Health
- Transportation
- Utilities
- Legal
- Counsel Support

**Population Served**

- Homeless
- Low income
- Disabled
- Veteran
- Ex-offenders
- Pregnant
- Victims or Survivors of Domestic Violence
- Recently released from jail

**Services offered in language**

- English
- Spanish
- Vietnamese
- Limited English

Search





# Connecting Patients To resources

## UCCP Unified Care Continuum Platform

Program: UCCP - Care Coordination

Welcome Kallol Mahata

[\[Log Out\]](#)

Dashboard | Calendar | Demographics | Assessments | Planning Care | Care Plan | eReferrals | Visits and Tracking | Forms and Documents | Reports | Actions

Preferred Agencies

My Bookmarked Agencies

Search Agencies

### American Red Cross of Greater Houston

2700 Southwest Freeway HoustonTX77098  
Not applicable  
7133131631

### BakerRipley - Workforce Solutions - Astrodome

9315 Stella Link HoustonTX77025  
Not applicable  
7136613220

### Legacy Community Health - San Jacinto

4301 Garth, Suite 302 BaytownTX77521  
[info@legacycommunityhealth.org](mailto:info@legacycommunityhealth.org)  
2814208400

### Patient Care Intervention Center (PCIC)

3701 Kirby Dr. Suite 1133HoustonTX77098  
[support@pcictx.org](mailto:support@pcictx.org)  
2814042379

### Patient Care Intervention Center (PCIC)



Address: 3701 Kirby Dr. Suite 1133HoustonTX77098

Phone: 2814042379

Alternate Phone:

Email: [support@pcictx.org](mailto:support@pcictx.org)

Website: <https://pcictx.org>

Service available in: Not applicable

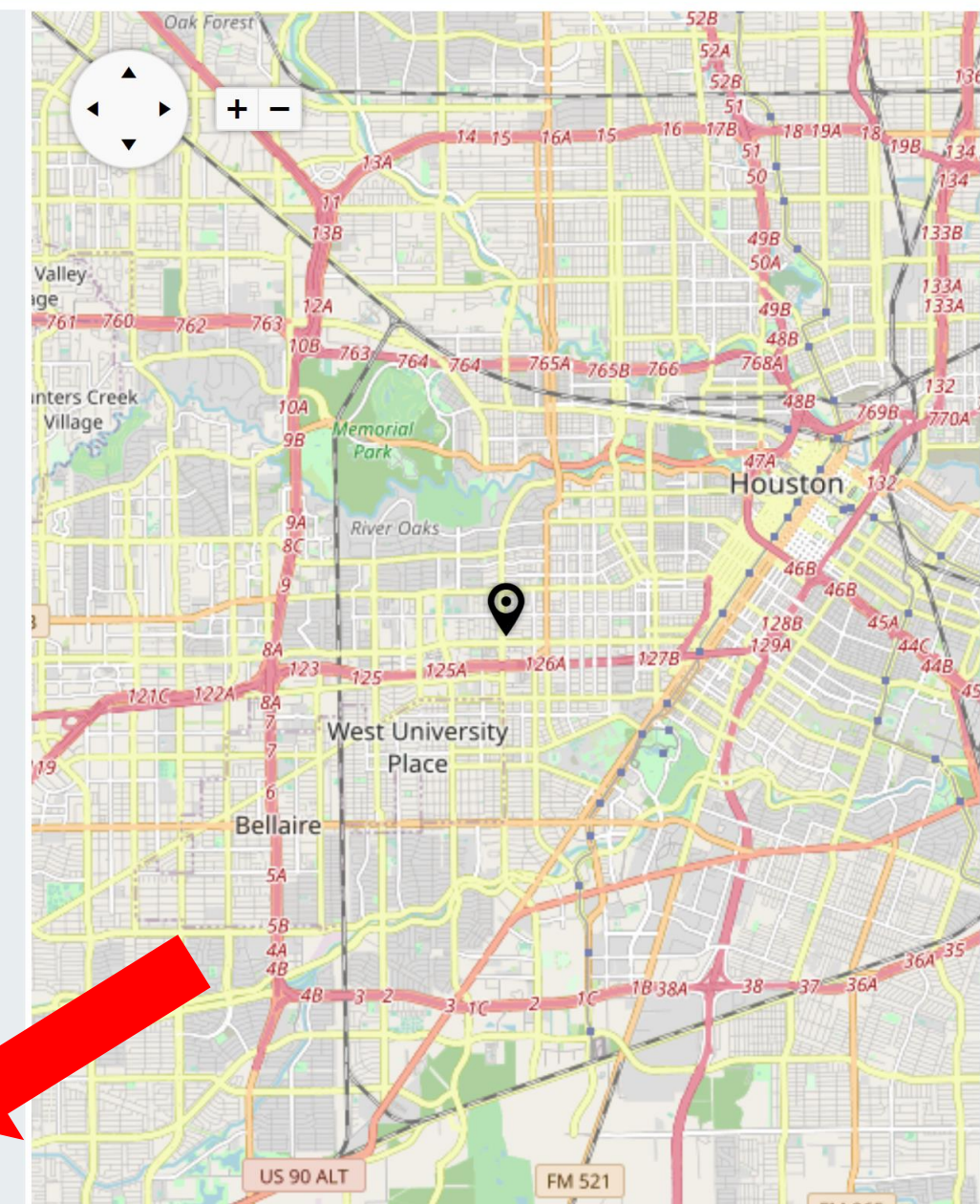
Serves: Not applicable

Speciality: Information and Referrals; Case Management; Family ; Medical Case Management; Adult Medicine ; Public Health or Welfare ; Self-sufficiency And Independence

#### Description:

PCIC is a nonprofit organization that leverages technology, health data sharing, and public health best practices to empower patients and providers to achieve enduring health outcomes and financial sustainability. They work with local governments, hospital systems, health plans, federally qualified health centers (FQHCs), health maintenance organizations (HMOs) and social service agencies to

Verified on : 5/5/2020



Submit eReferral



# Connecting Patients To resources

## UCCP Unified Care Continuum Platform

Program: UCCP - Care Coordination

Welcome **Kallol Mahata**

[\[Log Out\]](#)

Dashboard | Calendar | Demographics | Assessments | Planning Care | Care Plan | **eReferrals** | Visits and Tracking | Forms and Documents | Reports | Actions

Monica > eReferrals > eReferral



**Monica Sanchez** client ID: 2131 62Y, Race: Hispanic/Latino, Female

**Who or what is important to Monica:** My Dog; My neighbor Sally; Graduating from high school

**What would Monica like to be doing:** I like to take my pet on regular walks; Have dinner on Sunday with Sally; Take care of my son

**What program is Monica enrolled in:** UCCP - Care Coordination

**Monica's care team members:** Puneeth Bharadwaj;

### Sent eReferrals

Date range: The past three mo

+ Submit eReferral

Refresh

Actions	Sent To Agency	Sent By	Resources Requested	Status	Sent On	Contact Agency
<a href="#">Details</a>	A Social Service Agency	Swetha Kiledar	Information and Referrals		08/04/2020	✉ ☎ SMS
<a href="#">Details</a>	A Social Service Agency	Ellen Fiesinger			08/05/2020	✉ ☎ SMS
<a href="#">Details</a>	A Social Service Agency	Ellen Fiesinger			08/05/2020	✉ ☎ SMS
<a href="#">Details</a>	A Social Service Agency	Ellen Fiesinger			08/05/2020	✉ ☎ SMS
<a href="#">Details</a>	A Social Service Agency	Ellen Fiesinger			08/05/2020	✉ ☎ SMS

Page: 1 of 2 Go Page size: 5 Change

Item 1 to 5 of 10

### Received eReferrals

Date range: The past three mon...

Refresh

Actions	Sent From Agency	Sent By	Resources Requested	Status	Received On	Contact Referrer
<a href="#">Details</a>	PCIC	Elizabeth Henneke		In Progress	07/07/2020	✉ ☎ SMS





# Receiving direct client referrals

## Public interface



### We can help you apply for Texas SNAP benefits, formerly known as food stamps

We'll walk you through the entire application process and we are available to answer any questions you may have regarding Texas state benefits. We can also provide information about using the Texas Lone Star Card.

Complete the form below if you could like to be contacted to begin your SNAP application.


If you prefer to access the online SNAP application without assistance, you can do so here: [www.yourtexasbenefits.com](http://www.yourtexasbenefits.com)

First Name Enter first name	Middle Name Enter middle name	Last Name Enter last name
Phone Number ( ) - -	Alternate Phone ( ) - -	Email Address
Preferred Language Select language	Best time to contact	Preferred method of contact Select method of contact
Gender Select gender	Race Select race	Date of Birth
How did you hear about us? Select value		
Address Line 1		
Address Line 2		



# Community Assistance Program

## Tracking support with benefits



+ Track a benefit				
Benefit	Service	Submission Status	Approval Status	Tracked By
SNAP	Online app	Completed	Approved for \$1500 Duration: 3 months	Swetha Kiledar Siddaramappa
Healthy Texas Women	Online app	Mailed	Pending	Swetha Kiledar Siddaramappa
Parent & Caretaker Medicaid	Online redetermination	Completed	Denied Reason: other	Swetha Kiledar Siddaramappa

Navigation: Page: 1 of 1 Go Page size: 3 Change

UCCP > CAP assistance tracking > Benefits tracking

Benefits applied for SNAP	Submission Status Completed	Service Online app
Status of application Approved	Monthly amount approved (in \$) 1,500	Benefit approved for (in months) 3

# Social Needs Screeners

Dashboard | Calendar | Demographics | Assessments ▼ | Planning Care | Care Plan | eReferrals ▼ | Visits and Tracking ▼ | Forms and Documents ▼ | Reports ▼ | Actions ▼

### Referral Partner Program - Needs Assessment

Administered On : 11/23/2020 6:57 PM

*Directions: Read each statement to the client; then mark their response. Follow up with statements they disagree with in order to identify referral needs.*  
*Instrucciones: Lea cada instrucción al cliente y luego marque su respuesta. Haga un seguimiento de las declaraciones con las que no están de acuerdo para identificar necesidades de referencia.*

#### Housing / Shelter Vivienda / Refugio

1. My family and I have a safe place to sleep every night.  
1. Mi familia y yo tenemos un lugar seguro para dormir todas las noches.  N/A  Agree --Or-- de acuerdo  Disagree --Or-- desacuerdo

2. I can pay my electric, gas, utility, and/or phone bill(s) when due.  
2. Puedo pagar mi factura de electricidad, gas, servicios públicos y/o teléfono antes de la fecha de vencimiento.  N/A  Agree --Or-- de acuerdo  Disagree --Or-- desacuerdo

Comments/Needs --Or-- Comentarios:

#### Employment Empleo

3. I have a job that pays me enough to pay my bills.  
3. Tengo un trabajo que me paga suficiente para pagar mis cuentas.  N/A  Agree --Or-- de acuerdo  Disagree --Or-- desacuerdo

Comments/Needs --Or-- Comentarios:

#### Food / Nutrition Alimentos / Nutrición

4. I can access food that meets my family's nutritional requirements.  
4. Puedo acceder a alimentos que cumplen con los requisitos nutricionales de mi familia.  N/A  Agree --Or-- de acuerdo  Disagree --Or-- desacuerdo

Comments/Needs --Or-- Comentarios:

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# Unified tracking

## Receiving referrals

**UCCP Unified Care Continuum Platform**  
Program: Community Assistance Program

Welcome Swetha Kiledar Siddaramappa [\[Log Out\]](#)

My Dashboard My Calendar Clients **eReferrals** My Settings My Assessments Administration Help

eReferrals > Received eReferrals

### Open eReferrals (Unlinked)

Date range: The past one year

Actions	Client Name	Sent From Agency	Sent By	Sent On	Resources Requested	Status	Contact Referrer
<a href="#">[Link a client]</a> <a href="#">[View Details]</a>	Jane Doe	Legacy Community Health	Swetha Kiledar Siddaramappa	10/21/2020	Information and Referrals	Pending	

Page: 6 of 6 Go Page size: 5 Change Item 26 to 26 of 26

### Open eReferrals (Linked)

Date range: This week

Actions	Client Name	Sent From Agency	Sent By	Sent On	Resources Requested	Status	Contact Referrer
No eReferrals received in the selected date range.							

### Closed eReferrals

Date range: This week

Actions	Client Name	Sent From Agency	Sent By	Sent On	Resources Requested	Status	Contact Referrer
No eReferrals received in the selected date range.							

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# Outcomes



# Outcomes

## Beyond Process Metrics

### Process Outputs

- Volume of clients supported
- Volume of e-referrals by source
- Success rate (paper vs. electronic)
- Decline rates (+ reason)
- Duplication of services
- Interdependencies between referral types (Pathways)
- Tracking top needs

### Program/Agency Outcomes

- Improved quality of life
- Improved health outcomes
- Needs closure
- Long-term food insecurity and SDoH tracking
- Reduction in ED visits
- Cost avoidance

### Community Outcomes

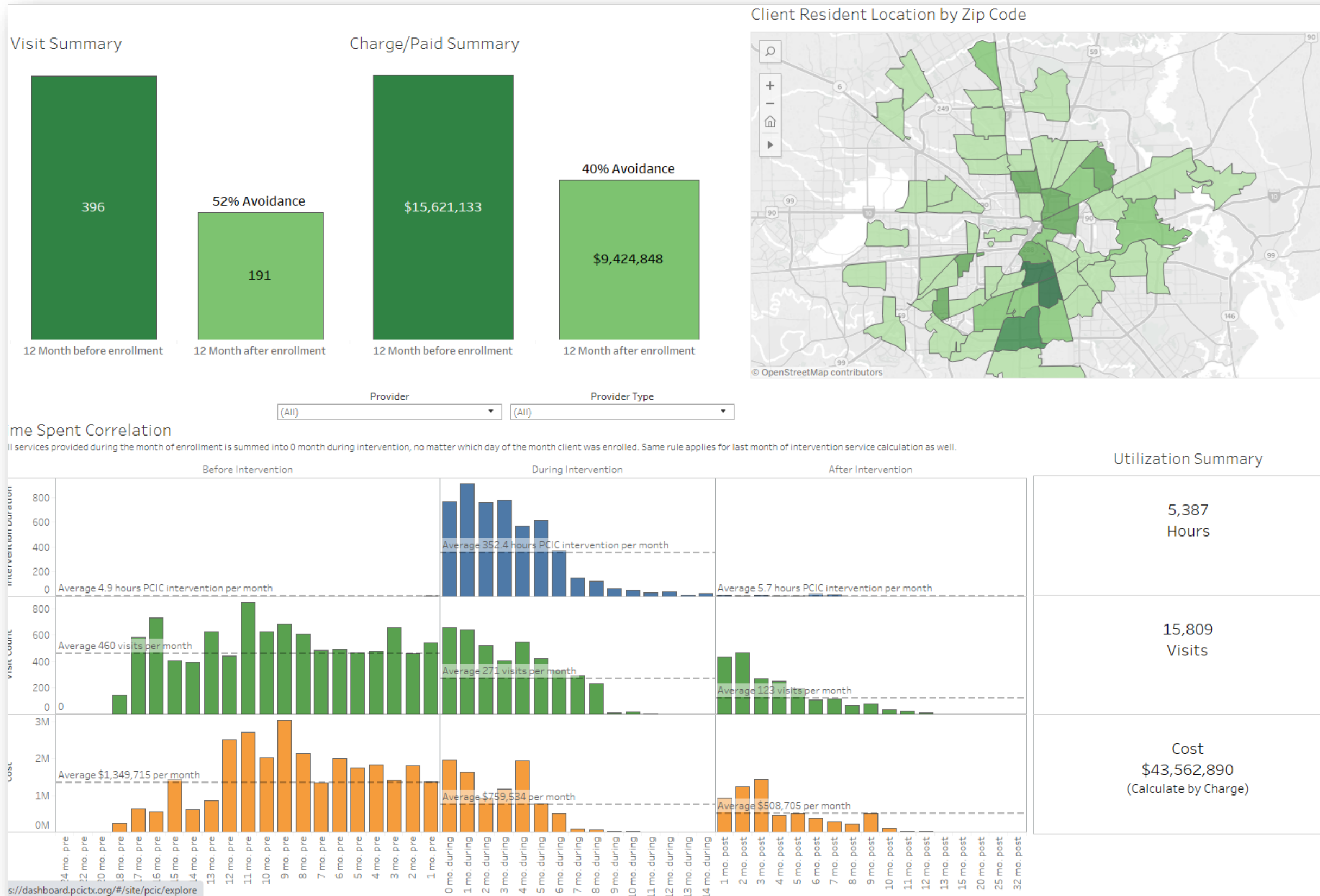
- Community level reduced SDoH risk
- Impact on broader community health outcomes
- Community standard of living
- Improved access to health
- Security and crime rates



## Community Assistance Program:

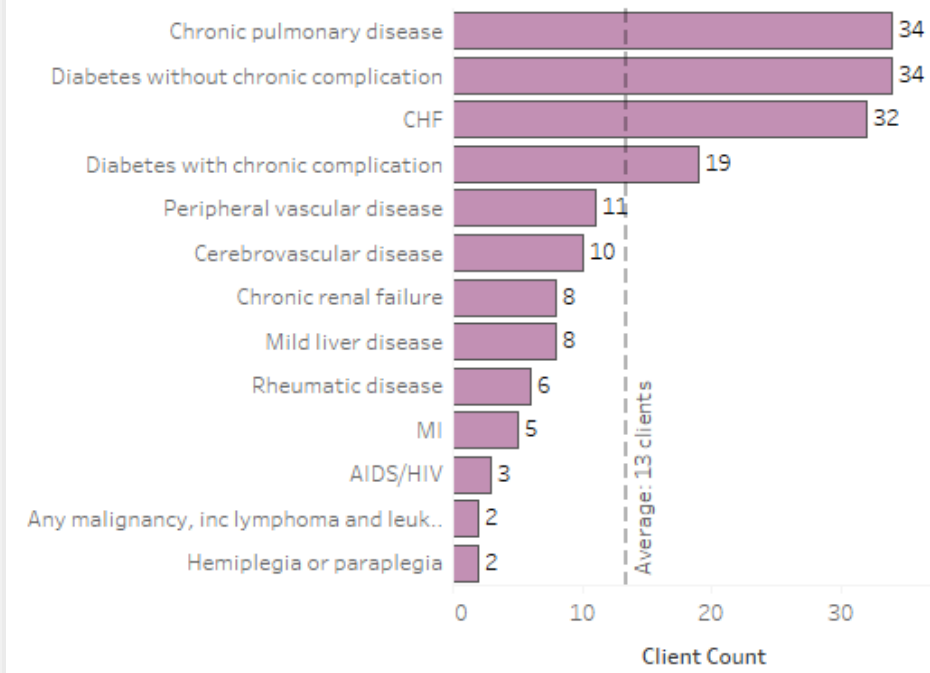
- ~1800 client outreached/month
- ~1600 state benefit application or inquiry/month (90% SNAP & TANF)
- ~300 clients screened for food insecurity/month
- ~120 clients screened for SDoH needs/month
- ~8 clients e-referred for community services/month (outside of HFB)

# Program/Agency Outcomes

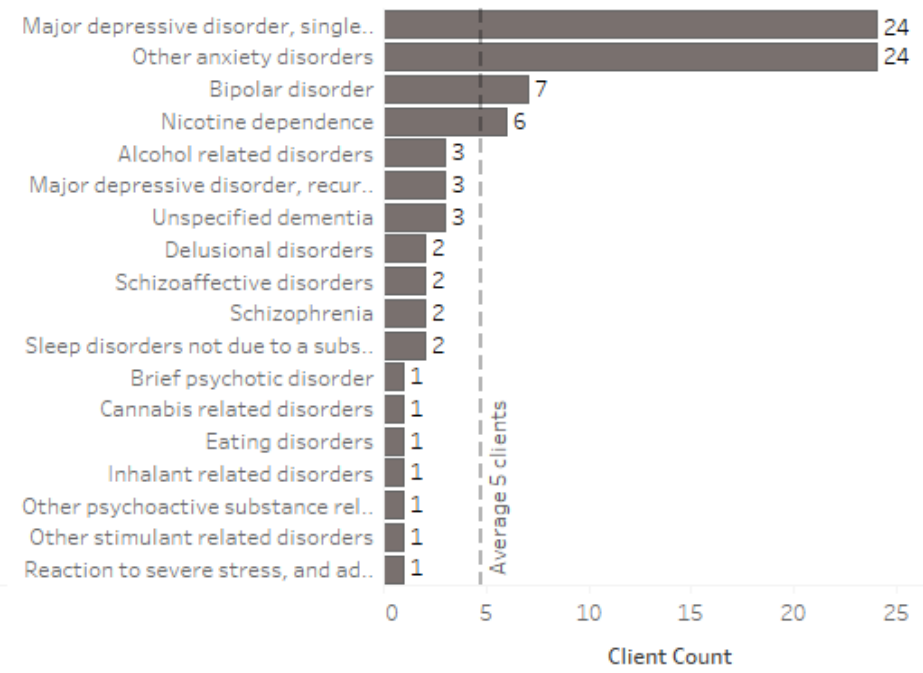


# Program/Agency Outcomes

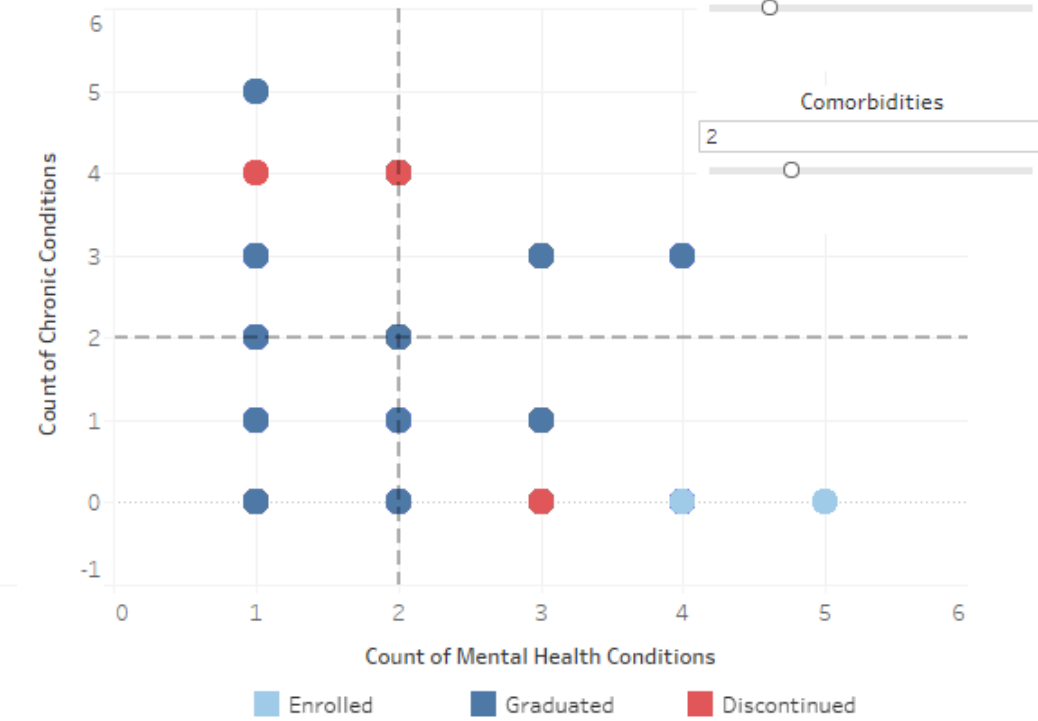
Chronic Condition Analysis



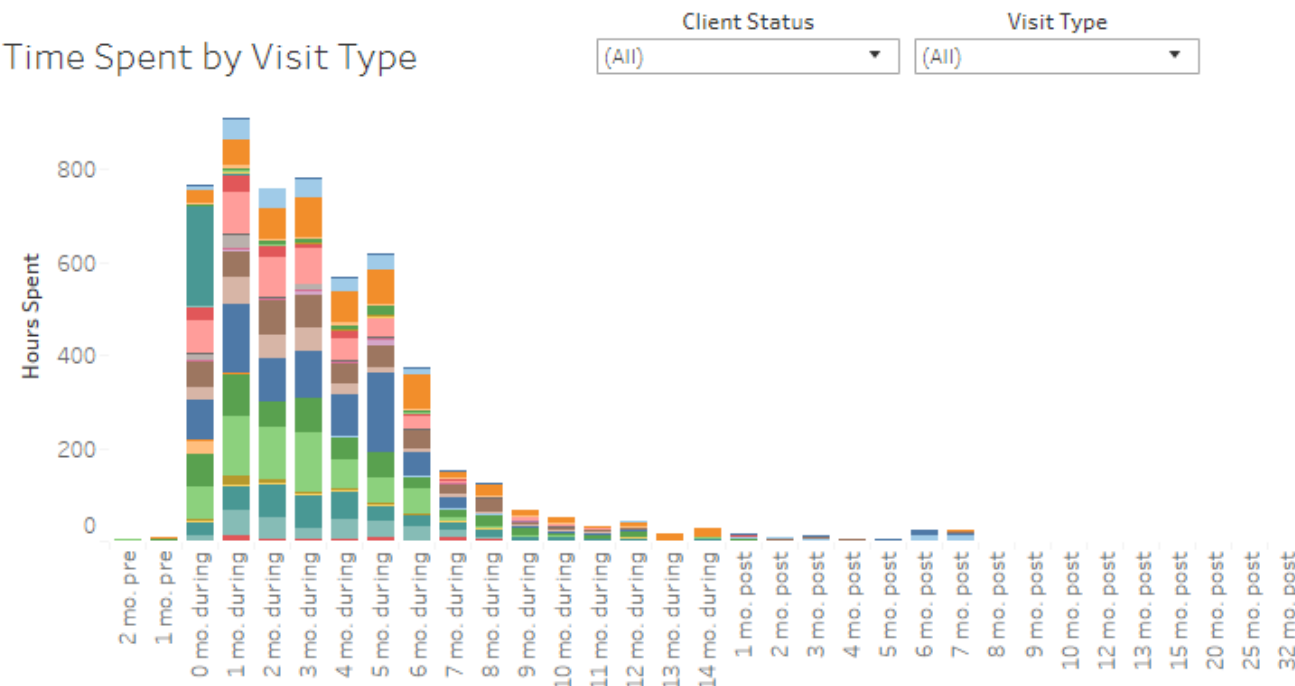
Mental Health/Substance Abuse Analysis



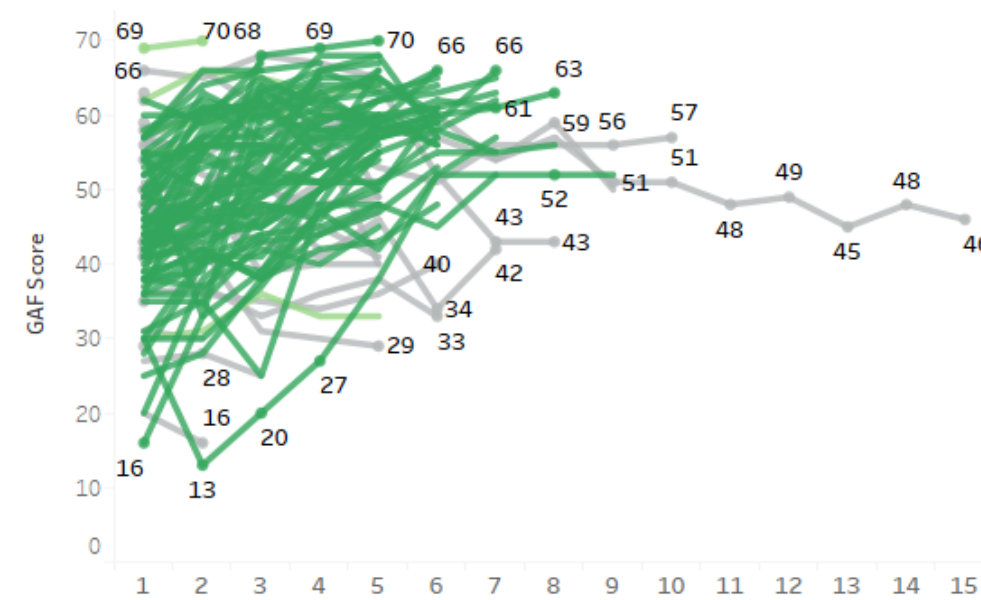
Diagnosis Complexity



Time Spent by Visit Type



Daily Living Activities



Number of Clients who have 1+ DLA administrated : 96

Average GAF changes on selected clients: 8

Average improvement in the quality of life : 20%

- Significant Impact (GAF Changes > 3)
- Minor Impact (0 < GAF Changes <= 3)
- No Impact (GAF Changes <= 0)



# Questions & Discussion

