neighborhood HEALTHCARE

Welcome CCI & ABHE Participants to Neighborhood Healthcare

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Who We Are

27 Locations: San Diego & Riverside Counties

Population Served since 1969:

- Low-income, medically underserved, uninsured, and underinsured
- 5% Homeless (approximately 3700)
- Behavioral Health integrated primary care

Approx. 112,000 unique patients: >410k visits/yr

- 61% Female, 39% Male
- 73% Medi-Cal, 5% Dual Elig, 7% Medicare
- 40% Monolingual Spanish

Neighborhood Healthcare Services

"Community health is about more than just vaccines and checkups. It's about giving people the resources they need to live their best lives. At Neighborhood, this is our vision. A community where everyone is healthy and happy. At Neighborhood Healthcare, we are Better Together."

- Primary Care
- Integrated Behavioral Health
  - Behavioral Health Counseling
  - Psychiatry
  - Harm Reduction Program
    - Medication Assisted Treatment
    - Naloxone Kits
  - Social Determinants of Health (High/Low)
- Dental Care - Pediatrics & Adults
- Pediatrics
- Pharmacy
- Women's Health
  - Birth control
  - Prenatal care
  - Cancer screenings
- Podiatry
- Chiropractic
- Acupuncture
- Labs
- Vision
- Certified Enrollment Specialists

Enrollment Services

Certified Enrollment Counselors

Medi-Cal

COVERED CALIFORNIA

Medicare

cal fresh
BETTER FOOD FOR BETTER LIVING

How do Access & Equity factor into Living our Best Life?

Living our best life means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

How do we get there?
We need to start leveling the field by removing visible and invisible access barriers!

Bigger Picture Access & Equity Issues

Understand the problem and speak the truth about it – educate yourself and your staff

-Identify your own implicit biases and work to address them

- NHC org-wide 4-part training series on Diversity & Inclusion
- JEDI (Justice, Equity, Diversity, Inclusion) Training Program

Live your Mission with the services you provide

-Hire staff that look like and speak the language of the population you serve

-Include people with lived experience in your programs

Identify Social Determinants of Health (SDOH) and address them

-Ask in a trauma informed manner

-Empower individuals to make decisions

-Provide resources and support as requested

-Identify access barriers and address them (transportation, daycare, language, literacy, mental illness, substance use, disability, etc.) – **Integrate Services!**

Neighborhood Healthcare BH Integration Model

Primary care providers (medical care and medication assisted treatment) provide warm hand offs (WHO) to Behavioral Health Consultants (Phd/PsyD, LCSW)
BH Medical Assistants – 1:Psychiatrist supports labs, injections, vitals, TE's
BH Patient Service Representatives – check in/out, optimize schedules, manage provider schedules, confirm insurance, provide confirmation calls
BH Call Center Representatives – manage phone calls for BH patients
Complex Care Resource Specialist (CCRS) – high touch SDOH assessment, referral, tracking, and linkage
Enhanced Care Management Team – care managers, community health workers, RN's
Harm Reduction Program – addictionologist, peer support specialist, CCRS, MA, and manager
STEPS – PTSD written exposure treatment vs. medication pilot with Univ of Washington
UCSD Fellows – provide medication assisted treatment and training for physicians for 1 yr
EUHSD – provide mobile healthcare center to high schools to reduce access barriers
Data Analytics – build out BH reporting and registries
Grants – co-author grants to improve coordination of care
Interfaith Senior Programs co-located at Date BH – provide inter-agency WHO's for senior social service programs and/or food pantry needs
Neighborhood Medical, BH, MAT, Harm Reduction co-located and integrated at Interfaith
Patient Feedback – patient satisfaction surveys incorporate feedback into systems change

Integrate Services to Reduce Access Barriers

- Universal Screenings – early detection & referral
  - Depression
  - Alcohol Use
  - Drug Use
  - SDOH and Access Barrier Assessment
- Integrated electronic medical record
- Care coordinators to effectively coordinate healthcare, specialty care, and social services
- Mobile Healthcare – homes, schools, group homes
- Telehealth Services – removes barriers, improves options for care
- Medication Assisted Treatment – Harm Reduction Program in Primary care

Social Determinants of Health - SDOH

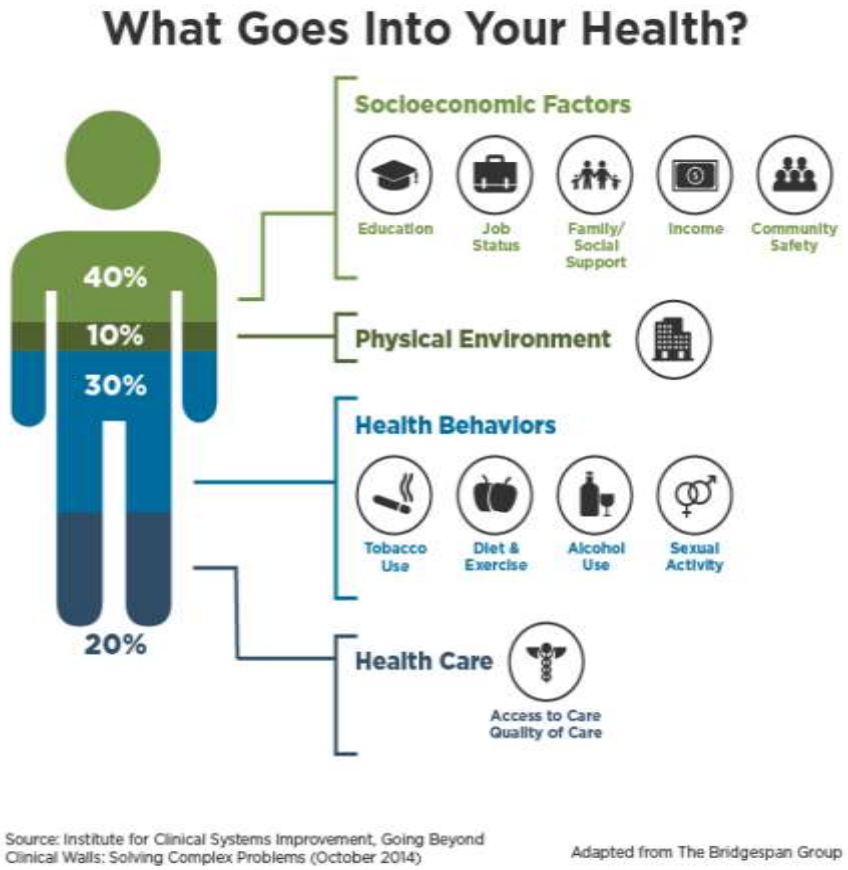
"SDOH are the conditions under which people are born, grow, live, work, and age, and include factors such as socioeconomic status, education, employment, social support networks, and neighborhood characteristics."

- Greater impact on health than factors like biology, behavior, and health care
- Poverty, structural racism, and discrimination are the primary drivers of health inequities

Why do they matter?

- No prescription can address every need
- Treatment plans need to consider all factors that influence a person's health with social needs-targeted care

Why Screen for SDOH?



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group

Social and Environmental Determinants explain 50%+ of health status!

If you don't screen and connect individuals with essential resources, they may spiral into poverty, or remain there, and have increased mortality rates

This is even MORE important during a pandemic to prevent individuals/families who have lost their financial stability to prevent them from spiraling

Mobile Healthcare

- Reducing Access Barriers
  - COVID Testing/Vaccination
  - Labs (blood, urine, stool)
  - Vital Signs
  - Medication Reconciliation
  - Remote Monitoring (HTN, DM)
- Telemedicine Visit
  - Health Coaching
  - Glucometer Review
  - Diabetic Foot Exam
  - PCP, Psychiatry, BH, MAT

Integrated Community Partnerships

We are Better Together!

Goal = Reduce access barriers and improve health equity

- Co-locate community partners
- Co-author grant funding opportunities
- Share space and resources
- Leverage partner expertise as extensions of care
- Inter-Agency warm hand offs
- Integrate coordination across agencies
  - Housing, Food, Job Assistance/Employment
  - Substance Use Treatment (detox, residential)
  - Medical, Mental Health, Harm Reduction, MAT
  - Integrate community-based organization into treatment plan

Meet Melissa

When we met Melissa, she had diagnoses of alcohol dependence, depression, anxiety, and PTSD. She was involved in an almost fatal car accident while drunk. She failed to follow through with treatment for her leg to heal, ultimately causing it to be amputated. She severely hurt others involved in the crash. Due to this, she was imprisoned and continued her addiction once released. She suffered years of homelessness, unstable income, and legal issues with the police. She had multiple suicide attempts.

Intervention: NHcare provided counseling and medication management

- Access to Independence for housing, medical equipment, and furniture
- Interfaith expedited housing application and case management services
- Legal Aid advocated for social security income
- Sobriety support group has been key to becoming and maintaining sobriety

Current Outcome and Growing: Stable disability income. Able to care of basic needs and be self-sufficient. Received housing and is off the streets. Sober 5+ years! Involved with her church. Melissa states, “I don’t think without you guys’ support all of this would have been possible. You always followed up with me, even when I didn’t. You always had other options and resources for me to get the help I needed. I have so much to thank you guys for!”

Meet Abigail

- Abigail is a 62-year-old Hispanic female, monolingual Spanish, who requested assistance for employment as she had just lost her job.
She was not computer literate and was unable to search for jobs. She was financially supporting she and her son, paying $600 each for two rooms they were renting. She was at risk for homelessness when she came to Neighborhood Healthcare (NHcare). Abigail was also challenged with obesity, hypertension, diabetes, and depression.
- NHcare provided healthcare and behavioral health counseling. Interfaith provided case management for employment services. Abigail received assistance updating her resume, applying for jobs online, and role-played to prepare her for interviews. Abigail was hired by Goodwill as a sorter. During this time Abigail's estranged spouse of 10 years returned. She and her spouse were referred to Interfaith's SOAR program to obtain assistance with benefits for her spouse.
- Family was able to move into their own apartment after a few months. Interfaith provided deposit, rental assistance, and furniture. Abigail was able to increase hours at Goodwill and obtained a second job through In Home Support Services. Her son became employed, and her spouse was able to obtain retirement benefits. The family continues to utilize the food pantry and other basic services to improve their stability. They reported they are extremely grateful for everything that Neighborhood Healthcare and Interfaith have done for them.

Thank You

better together

nhcare.org

Thank you for your time and attention. Any questions?

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