Please connect your phone to your webinar platform by dialing #(participant ID)#.
Agenda

- Welcome
- Program Recap
- Learnings & Advice Reflection
- Sustainability Discussion
- Closing
You’ve got mail!

You should have received a Sunshine box in the mail. We hope you enjoy this token of appreciation for your partnership in MCU.

If you did not submit your address, we would still love to offer you a gift, so please submit this form: https://www.tfaforms.com/4904727
CCI Program Team

Diana Nguyen  
Program Manager  
she/her/hers

Briana Harris-Mills  
Senior Program Coordinator  
she/her/hers

Megan O’Brien  
Director  
she/her/hers

Lydia Zemmali  
Program Coordinator  
she/her/hers
Support Team

Natalie Martin
Coach

Deena Pourshaban
Coach

Sarah Henry
Journalist

Kristene Cristobal
Evaluator
Congratulations from Cedars-Sinai

Erin Jackson-Ward
Director
Community Benefit Giving Office
Icebreaker

Please chat in organization & one thing you’re looking forward to in the summer!
Program Recap
September 2019 - March 2020

- Assess strengths and opportunities
- Develop a better understanding of the problem by engaging patients & community members
- Strengthen systems for assessing SDOH
April 2020 - Present Day

• Address any gaps in referrals or partnerships
• Document internal workflows and protocols
• Document impact of targeted efforts on patients and staff
• Communicate & spread lessons learned within clinics and across the field
# MCU Cohort Overview

<table>
<thead>
<tr>
<th>Social Screening Characteristic</th>
<th>Participating Health Center (PHC) Approach</th>
</tr>
</thead>
</table>
| **Screening Tool**              | Six implemented Hunger Vital Sign Screening tool  
|                                 | Three implemented transportation screening questions 
|                                 | One implemented PRAPARE                     |
| **Sites**                       | Implementation of social screening work 1-7+ sites |
| **Patient Populations**         | All patients, high risk (HIV, diabetic, homeless, SUD, OB, mental health ), pediatrics, patients enrolled in case management, visit type (well person exams) |
| **Staffing**                    | Core Team: Providers, Case Manager, MA’s  
|                                 | Support Team: Clinic Manager, Research Analysts, AmeriCorps Volunteers, Nutritionists, Social Workers |
Overview of Food Security Resources

This tables shows which resources were most utilized among the food insecurity cohort.

This tables shows the extent to which each agency combined resources in their project.
Overview of Transportation Resources
Organizational Changes During COVID-19

• 100% of organizations successfully moved to providing *virtual care*.
• Several transportation teams pivoted vans for patient transportation to *delivering meals and/or medications*.
• Organizations also provided *necessary materials such as toilet paper and PPE* for patients.
• Organizations leveraged the *power of community volunteers* to ensure social needs efforts continued.
• Current technology was used creatively to support patients under social distance protocols.
• Organizations developed *stronger connections with community-based partners*. 
SDOH-Specific Changes During COVID-19

- **Adapt workflows** to virtual care (increased safety protocols, sanitation after each ride)
- Conduct **virtual screenings** over the phone
- Use of **volunteers** (AmeriCorps and Community)
- **Deliver medications** to patients
- Mail resources to patients (gift cards)
- Re-configuring workstations
- Staff **donating personal funds** when supplies run out (gift cards)
- Increase of **documented safety measures**
- Add additional metrics on whether social screenings are happening virtually (encounter type)
- Trend data by SPA to see community resource needs
- **Stronger partnerships** within the community
SDOH-Specific Changes During COVID-19

**Food Security**
- Provide food delivery to isolated patients
- Increase onsite emergency food supplies
- Adapting nutrition content to COVID-19

**Transportation**
- Focus transportation on clinic van and uber
- Deprioritize public transportation
Reflection Time
Reflection On...

What learnings are you walking away with after this program? 

What advice would you give to other clinics doing similar work?
### Cohort Takeaways

<table>
<thead>
<tr>
<th>Importance</th>
<th>Reimbursement doesn’t matter</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Reports</td>
<td>Screening tools in structured fields in EHR. Fundamental to success</td>
</tr>
<tr>
<td>Positive Screen</td>
<td>In house services when patient’s screen positive</td>
</tr>
<tr>
<td>Start Small</td>
<td>Start screening specialized populations</td>
</tr>
<tr>
<td>Executive Support</td>
<td>Critical but varied across health centers</td>
</tr>
<tr>
<td>Transportation</td>
<td>Mix of transportation services a best practice (uber-home, van-pick up)</td>
</tr>
<tr>
<td>Food Security</td>
<td>Critical to supporting patients during the pandemic. In-house services ensure success</td>
</tr>
</tbody>
</table>
1. In your breakout room, identify a scribe to document what is shared in your discussions.

2. Discuss as a group:
   a. What learnings are you walking away with after this program?
   b. What advice would you give to other clinics doing similar work?

3. Write one reflection per sticky note.
   ● To add your sticky note to the Reflection Wall, double click on the page and it will open a text box. First, type your name and organization. Then, type your learnings or advice in the text box.
Chat In:
What resonated with you from your discussions or the Reflection Wall?
Sustainability Discussion
## Sustainability Tips: Essential

<table>
<thead>
<tr>
<th>Data Metrics</th>
<th>Financial</th>
<th>Patient Engagement</th>
<th>Training/Workforce</th>
<th>Operational</th>
</tr>
</thead>
</table>
| • Evaluate data and reviewing project goals  
• Develop EHR reports for screening patients, positive screen and follow-up  
• Move away from excel tracking | • Seek funding (external and internal) to maintain social screening workflows  
• Understand the origins and sources of funding  
• Reach out to health plan community benefits program  
• ACEs, social screenings concerns will arise  
• CalAIM- ECM reimbursement  
• Quantify benefits: economics, patient retention, increases trust, enhance patience engagement, avoids a negative Yelp review | • Solicit patient feedback on social referrals and adapt based on patient needs, avoids a negative Yelp review | • Conduct staff training on impact of screening and highlight outcomes  
• Document protocols in the event there is staff turnover  
• Assign a main point of contact to lead and continue this work | • Expand screening to all patients  
• Develop nutritional workshops for patients  
• Partner with county/CBO (vaccine delivery, meal delivery, groceries)  
• Co-locate food resources in the clinic to enhance patient access  
• Align /link with existing with priorities. Ex: our mission is X and this work aligns with our mission |
What’s next?

- Thank you for submitting your Endline Assessments! Kristene Cristobal will be reviewing them and will reach out with any questions.
- We expect to have two more stories published on the program, so you may get an email from us or Sarah Henry over the next 3 months.
- CCI will be available via email through June 30.
- Please spend down any remaining grant funds by June 30, 2021. Plan to submit your final grant report to Cedars-Sinai by July 17, 2021, unless told otherwise.
Congratulations! Until next time!
Thank you!

For questions contact:

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**Lydia Zemmali**
Program Coordinator
Center for Care Innovations
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<table>
<thead>
<tr>
<th>Clinic</th>
<th>Program Name</th>
<th>Contact Person</th>
<th>Social Screening Focus</th>
<th>Screening Tool</th>
<th>Staff Involved in Implementation</th>
<th>Population of Focus</th>
<th>Follow-up for Positive Screen</th>
<th>PrEP Due to COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>AllMed</td>
<td>Food Resources for Kids (FRMK)</td>
<td>Amanda Dangle</td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>Provider’s Case Manager, MA’s, Clinic Manager, Research Analyst</td>
<td>All patients</td>
<td>Gift Cards, Food Bank Referrals, Emergency Food Supplies, Imperfect Produce program, CalFresh enrollment, Case Management, CalFresh and WIC enrollment and Grocery Delivery</td>
<td>Staff personally distributed to patients who purchase gift cards when none were available. Resistributed funds to increase the number of patients enrolled in Imperfect Produce program. Higher needed for stable groceries. Contacting food insecurity trainings virtually (not stopping due to the pandemic), and using the empathy skills training for communication with participants. Continue to screen, save manager and link patients to food resources, sending patients food resources (free cards) through the mail for patients who screen positive actively.</td>
</tr>
<tr>
<td>APLA</td>
<td>North Necessities of Life Program (NNLP)</td>
<td>Jeff Bailey, <a href="mailto:Ejlke@apla.org">Ejlke@apla.org</a></td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>dell, dell, dell</td>
<td>Change method of distribution of groceries, inclusion of PPE supplies. Provision of transportation. Modify use of volunteers: Rugging groceries, food parcells. Reconfigure work station.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHS</td>
<td>Eat for Your Health</td>
<td>Carolina Rodriguez, <a href="mailto:Carolina@bhs.org">Carolina@bhs.org</a></td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>MA’s, Providers, Core Coordinator, American Corp. fellows (volunteer on weekend)</td>
<td>Residents who are: high-risk patients (90 days, not for MA and CalFresh); October 2020: Expanded online order for food pantry and transportation</td>
<td>Oakland-Wide: Food Gifts Cards, CalFresh Enrollment, Food Resources, and other referrals</td>
<td>Resources shifted to developing COVID-19 safety protocol and transitioning to Telehealth to ensure clinics could continue to provide care to patients while maintaining empathy and patient safety. Due to staff shortages and the transition to Telehealth ITV screening is closer to the phone vs in-person. Sending Welcome-Home Gift cards through the mail.</td>
</tr>
<tr>
<td>Elmer</td>
<td>Utilizing Technology to Address Food Insecurity</td>
<td>Mark Jenkins, F咀<a href="mailto:itures@elmerhealth.org">itures@elmerhealth.org</a></td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>Providers and MA’s</td>
<td>Worked with Pediatrics that expanded to all patients</td>
<td>Food Bank and Other Programs Referrals, Uninsured, Atlas for Kids CHKD, LAPES, Case Management, Emergency Food Supplies, CalFresh and WIC</td>
<td>Tablets were put on hold and #CHW template used for virtual visits.</td>
</tr>
<tr>
<td>Kheir</td>
<td>Road to Wellness: Analyzing and Addressing Patient Transportation Needs</td>
<td>Kirby Feck, <a href="mailto:KFeck@kheir.org">KFeck@kheir.org</a></td>
<td>Transportation Insecurity</td>
<td>FRAPWR</td>
<td>Nurses, MA’s</td>
<td>General population (patients with an office visit)</td>
<td>Clinic, Visits, and Metro Referral to Patient Resource Dept. and Case Management, Arranging transportation to and from the medical center</td>
<td>Remotely transported workstations to include greater safety precautions (lower capacity per ride, sanitization after each ride, mask and PPE use).</td>
</tr>
<tr>
<td>LA LGBT</td>
<td>Nutrition Equity</td>
<td>Louis Guzman, <a href="mailto:lguzman@laglgbtcenter.org">lguzman@laglgbtcenter.org</a></td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>MA’s, Providers, Medical Social Worker, Nutritionist, VT</td>
<td>Patients identified for case management</td>
<td>Gift Cards, Food Bank, CalFresh and WIC enrollments, Emergency Nourishment, Other referrals (referral to Pride Pantry, Grocery Delivery</td>
<td>Use of tablets allowed staff to support patients with Cal Fresh enrollments while maintaining social distancing. Free delivery for isolated patients. Clinic meals delivery for isolated patients. Testing campaign to contact and refer any and all patients to Pride Pantry. Adapted nutrition content due to COVID-19.</td>
</tr>
<tr>
<td>Oscar Romero</td>
<td>Removing Barriers to Diabetes Wellness: Addressing Transportation Insecurity</td>
<td>Narciso <a href="mailto:Bueno-E-Ramos@oscarromerane.org">Bueno-E-Ramos@oscarromerane.org</a></td>
<td>Transportation Insecurity</td>
<td>Transportation Questions</td>
<td>MA’s, Providers, Van Drivers, Pharmacists, CL</td>
<td>Patients with an ERI ≥ 5</td>
<td>Clinic, Visits, and Transportation to medical appointments and or medication deliveries</td>
<td>Transportation support received from transportation support to medical visits, to medication delivery (COVID-19 vaccine delivery and administration.</td>
</tr>
<tr>
<td>IPPSIV</td>
<td>Mental Health &amp; Transportation Pilot</td>
<td>Ashley Leonard, <a href="mailto:aleonard@ippsiv.org">aleonard@ippsiv.org</a></td>
<td>Transportation Insecurity</td>
<td>Custom Questions: Transportation Questions</td>
<td>Screening recorded in EMR by MA, recorded and reviewed and addressed by provider as needed</td>
<td>All WFP (all patient groups) over 18</td>
<td>Pumpkins, Metro TAP cards</td>
<td>Need to confirm with IPPS: delivered nearly 13k tickets via emails, in-person visits are held during COVID-19 and connected to general resources (information pamphlets only).</td>
</tr>
<tr>
<td>St. John’s</td>
<td>Increasing Food Access for High-Risk Patients in South LA</td>
<td>Monica Cotrim, <a href="mailto:mcotrim@stjohns.org">mcotrim@stjohns.org</a></td>
<td>Food insecurity</td>
<td>Hunger Vital Signs</td>
<td>Case Managers</td>
<td>Homeless Health Services and Trauoealth Program patients</td>
<td>$20 Hunger Gift Cards, Emergency Food Supplies, Food Bank and Other programs referrals (Tertiary Coalition, APAH, Pride Pantry, IPPSIV Program, Case Management</td>
<td>Increased reliance on external food resources (strong partnerships within the community). Increased safety precautions (Mobile Clinic for Behavioral Health Services (MCHS), Trauoealth Program (THP). Adoption of a #DayInMyRole for in-person and video appointments.</td>
</tr>
<tr>
<td>THE</td>
<td>Leveraging Transportation Solutions to Address Opioid</td>
<td>Cheryl Treichel, <a href="mailto:etrichel@thepowernow.org">etrichel@thepowernow.org</a></td>
<td>Transportation Insecurity</td>
<td>Custom Questions: Transportation Questions</td>
<td>Call Center, Patient Retention Teams, MA’s</td>
<td>All patients screened</td>
<td>Clinic, Visits, Uber, Transportation to medical appointments and or medication deliveries, refer to patient retention</td>
<td>Implemented telehealth systems for virtual visits. Screened every patient over the phone for transportation barriers when scheduling appointments. Updated virtual formats and greater safety precautions for clinic care service. Managed staff trained and engaged, providing tools for efficient workflows, new COVID protocols.</td>
</tr>
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Appendix: Cohort Summary