Food Resources for Kids (FORK)

AltaMed Health Services and Children's Hospital of Los Angeles
AltaMed: Joanna Garcia, Heydeh Khalili
CHLA: Amanda Daigle, Mona Patel, MD
12/18/20

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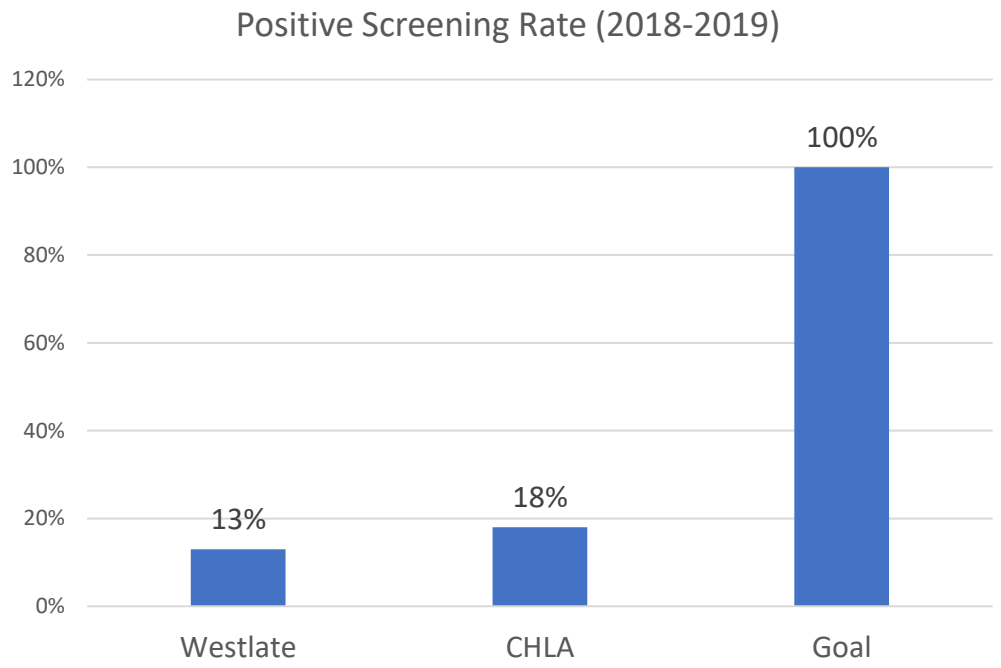
Our Problem

- Baseline data on food insecurity screening rate was very low. Goal was to screen everyone.
- Workflow not in a place. Screen, refer and follow-up. Not addressing food insecurity in a consistent way for our patients and their families
- Lack of dedicated staff resources to support patients and families with necessary resources



How You Explored the Problem (2019)

Activities

1. Patient Focus Groups
   - Partnership between CHLA, AltaMed and Best Start Metro Community Group.
   - Community members (from the metro and South LA) outlined social needs
   - **Dr. Rebecca Demaria:** Pediatric Resident leading patient focus groups on food insecurity
2. Pilot Testing
   - Focus groups informed implementation of Hunger Vital Sign (HVS) screener and Imperfect Produce program
   - HVS in paper form. Informed value of integrating screener into the EHR
3. Executive Buy-In
   - **Dr. Mona Patel** (Vice President of Operations at CHLA) was instrumental pushed for the screening in the clinic.

Food Resources for Kids (FORK)

Providing support and resources food insecure patients

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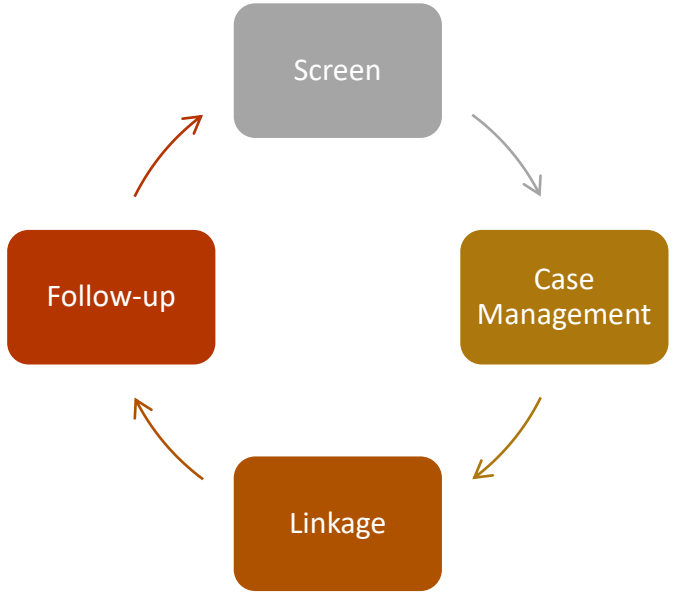
FORK

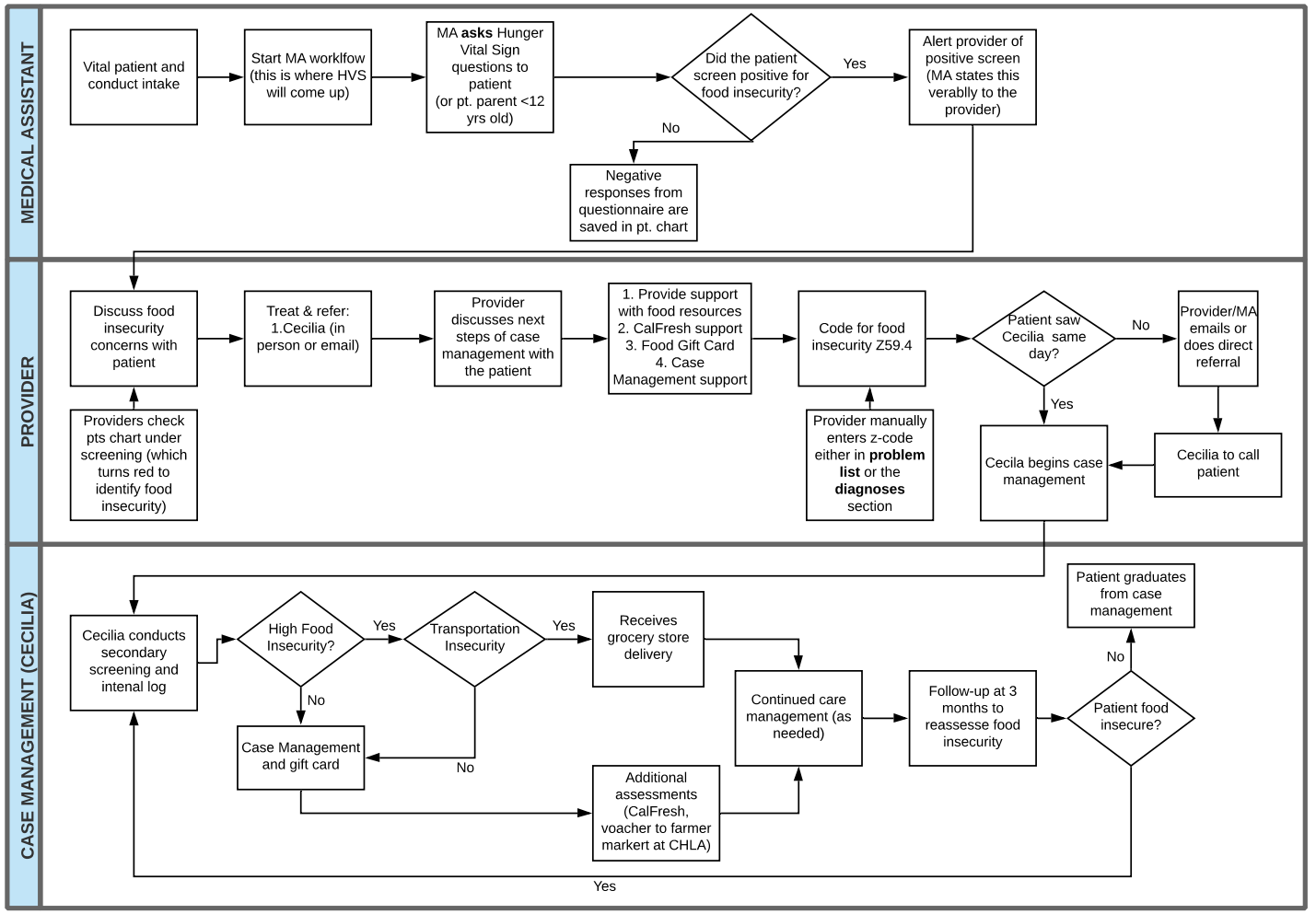
1. **Screen** all patients for food insecurity
2. Provide **case management** to all patients who screen for food insecurity
3. **Link** patients to necessary resources based on need
    1. Gift cards for emergency use
    2. Imperfect Foods delivery for 9 families over 6 months

4. **Follow-up** with patients three months after linkage and re-screen for food insecurity



Food Insecurity Workflow

FOOD INSECURITY SCREENING: ALL PATIENTS AT EVERY OFFICE



How We Pivoted During a Pandemic

1. Lack of gift cards for food insecure patients
2. More patients need food resources
3. Stigma- from patients (public charge) were afraid to get grocery gift cards MA's struggled that people didn't want to
4. Telehealth struggles, virtual trainings

1. Staff donating personal funds to purchase
2. Reallocate % of funding to Imperfect Produce program
3. The empathy and food insecurity training (reinforced the training, this helped training for staff)
4. Staff trained and now MA's are doing intake and asking FI questions when they are triaging and helping patients' login
5. CM sending gift cards through mail

Patient Story: Mom of Five

- 3-year-old patient
- Mom (completed interview)
- South Central (SPA 4)
- 1 year as an AltaMed patient

Screening for food insecurity shows that **AltaMed** not only **cares** for the physical wellbeing for the patients and the families, but also the general wellbeing of all their patients.

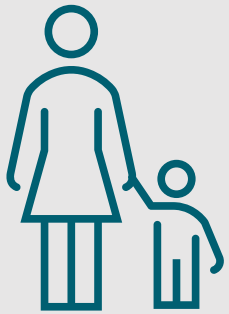
Having a **Case Manager** who calls after the appointment to give the **resources** and a **gift card** that be use for groceries, is so **valuable**. This is money that we didn't have before that can help our family.

If the **project stopped** to help families as a mother of five, I would feel **hopeless** because I would not know to whom to turn to because **AltaMed** has been able to help with a resources and a gift cards to continue to **feed my children**.

Without the help from AltaMed, we would not know where to look for any help in the community.

As a mother, I feel better to have support from Altamed.

Patient Story: Mom of Three



- 6-year-old patient
- Mom
- South Central (SPA 4)
- 6 years as an AltaMed Patient

"I am a mom with 3 children, and I **feel uncomfortable admitting that I need help**, but also knowing that I need to do what I have to, to **help my children.**

I feel relieved because **AltaMed is willing to help** me and families like mine.

AltaMed is providing the help that we all need especially in this time of year and while the pandemic is still on.

If **AltaMed stopped the project** and helping families with difficulties at home it would be hard because know we would have to look out and **seek for help somewhere** else and it is **not guaranteed** that we will receive help.

With **AltaMed**, I know that someone will reach out to help with resources to **help** us through the **hard times.**

COVID has made huge impact our lives. I lost my job due to COVID and that I have been struggling with paying my bills and providing food for my family. I assume that a lot of families have been coming to AltaMed to for help so the demand for help from AltaMed and this project must be high because there are a lot of families in need for help like ours.

Imperfect Foods: Patient Input

“The program was really good, I really liked it”

“The program was very useful, it brought food that I needed”

“The food box was great. I didn't have to go out and buy fruits and veggies anymore and I could buy other things”

“Thank you for bringing produce straight to my door, I’m very grateful. This program really helped me, and I really liked it”

“I knew that every Wednesday I would receive my box and knew I didn't have to buy produce so I could purchase other necessary groceries”

“Quality of produce was high quality”

“Program was perfect”

Staff Interview: Provider

- Dr. Mona Patel
- Vice President, Ambulatory Operations
- CHLA

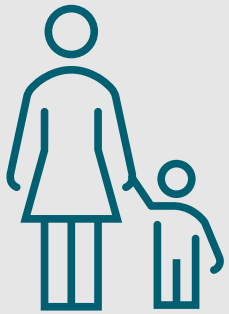
“**Food insecurity** screening is important because of how foundational **access** to **nutritious food** resources is and how critical that is to a **child’s outcomes** for the future”

Food security is the tenet and the **foundations** for a **child** to grow in a **healthy** way

When **families don’t have access** to nutrient rich **food**, we see **deleterious** effects on things like **child-growth** stature and medical diagnosis as they grow

It is **critical** for everyone to **ask** those basic questions (**food insecurity**). Food insecurity is wrapped up and challenging because you don’t want judgement, and it can be a **hard** one for people **to acknowledge they are struggling** with but is the **foundation of health.**

Staff Interview: Medical Assistant



- Karla
- Medical Assistant
- 1 year at AltaMed
- CHLA/AltaMed Clinic

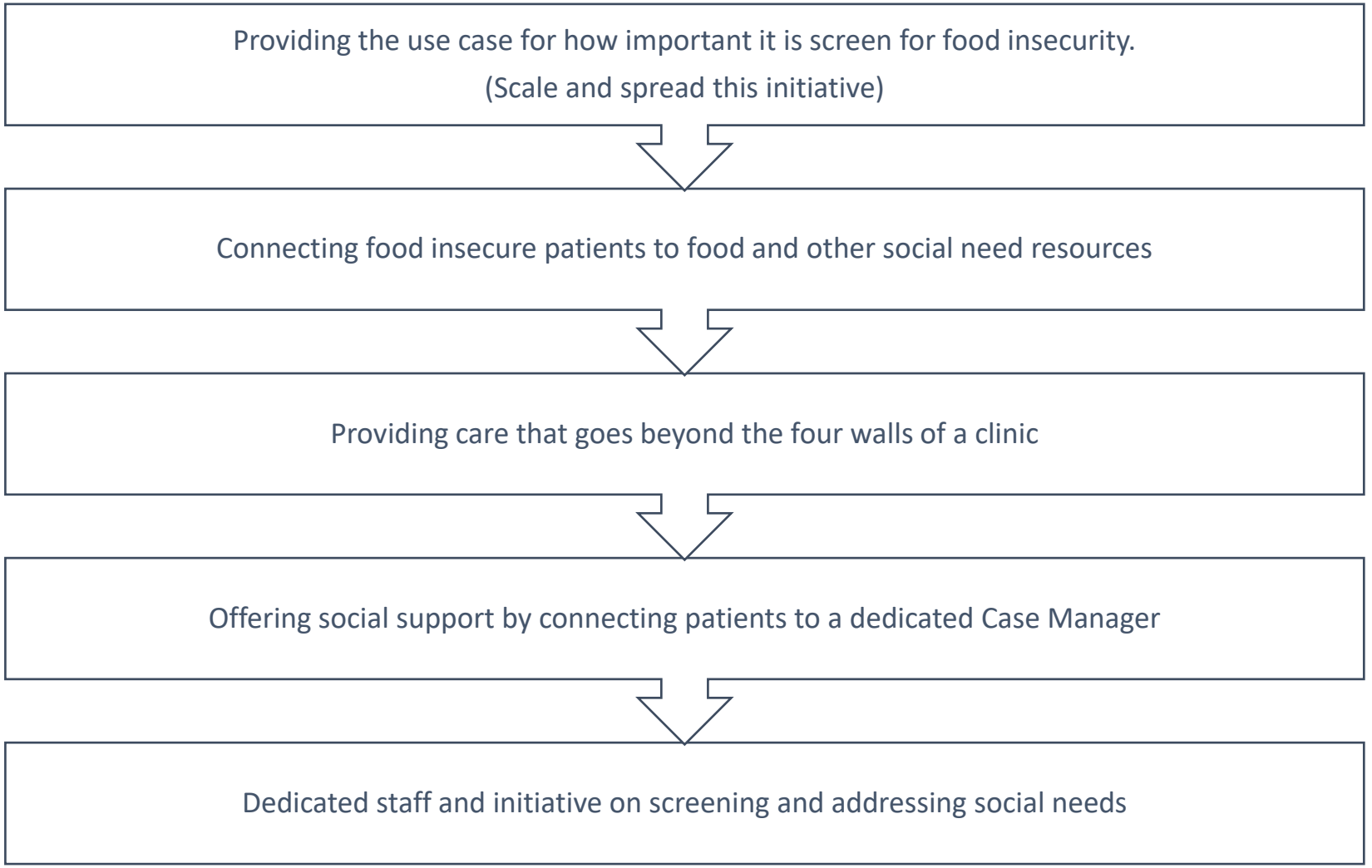
"Seeing the patient get the **services** that they **needed**, gave me a **sense of relief.** With everything going on right now there are lots of **people losing their jobs** and knowing that we can support patients in their time of need is a relief"

There is so much value to doing the **Hunger Vital Sign Questionnaire**. It's very **important**. It's a steppingstone for patients to get the **help** they need not only for their **body** but their **mind** as well"

One thing we can do to **improve** on our efforts is to have the **providers** helping/**emailing** the **Care Manager same day** and directly. Also, maybe a **newsletter** on how the team is doing. Keeping us in the loop and giving us tips/tricks on how to streamline our work.

I would absolutely **recommend continuing this work.** Knowing that the patient has support opens a door for them, especially because it's Christmas time, the **gift cards really help**. When the patients come back to the clinic, they are very **thankful**"

Summarize Benefits/Value of Your Project

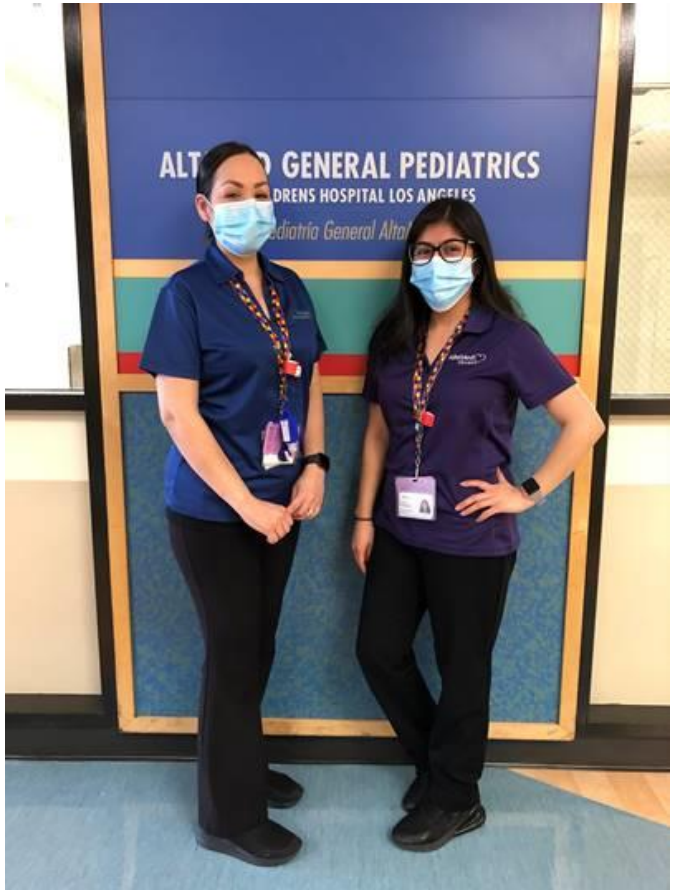


Consequences if You Discontinue The Project

- Decrease access to food resources for patients who need it.
- Patients will lose a platform where they feel they are being **cared** for and **listened** to.
- Patients will feel sad.
  - They look to AltaMed for support (outside of primary care) even if it's minimal.
- Clinic staff will feel disappointed.
  - They understand the value of screening and are willing to even "pitch-in."
  - This also supports staff job satisfaction and provides meaning to their work.

Project Next Steps

- Hoping to expand to other sites
- Find other grants and private donors to fund this initiative (see next slide on ask for support)
- Expand our intervention offerings



Your Ask for Specific Support

- Additional funding could help support navigating and providing infrastructure for nutritious food resources for all our patients and families
- Food could be relegated and given in an equitable manner, and we could begin to address food deserts in a meaningful way
  - Work with legislatures and look at benefits and how given to families in equitable fashion
  - Build access to gardens where our patients and families live, have markets and fresh markets where patients reside
  - Advocate for the costs of soda and chips cost more than fresh produce
  - Make it a basic sort of given, fresh fruits and vegetables are prioritized in a family's diet and build resources for education

Your Ask for Specific Support

- More focus groups of our families – what are the continued barrier and challenges to access and food insecurity in general
- Is it in their home environment, engaging with our populations to better understand food insecurity
  - Build stronger connections to community-based resource partners
  - Work with health plans – infrastructure is reimbursed
    - Food and nutrition is central
    - Costs should be covered

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Questions?

If you have any questions, please contact:

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Impact of Food Security on Health Outcomes Among Persons Living with HIV in Los Angeles County

Jeff Bailey MPH
Robert Milam MPHc
Tonya Washington Hendricks MA
APLA Health & Wellness

March 23, 2021

APLA Health

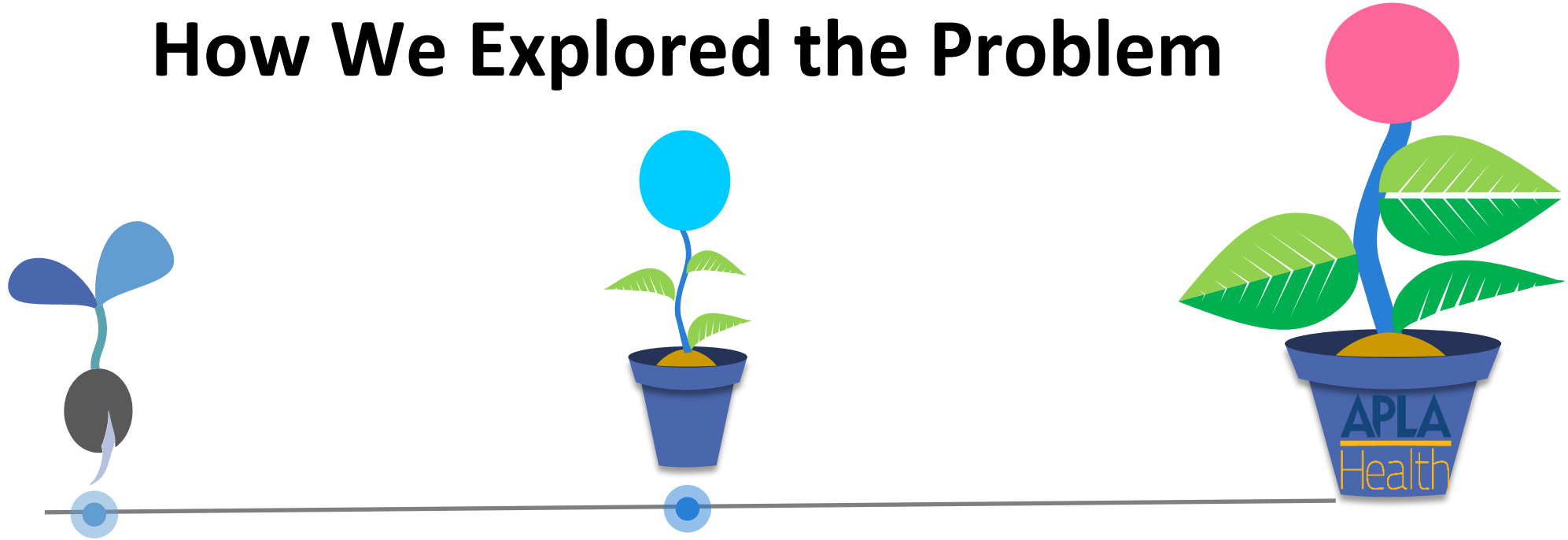
Background - Food Insecurity and HIV

Among persons living with HIV, food insecurity has been associated with:

- Lower CD4 counts
- Lack of viral suppression
- Poor medical adherence
- Poor retention in care
- Adverse mental health outcomes

McLinden, Taylor *et al.* "HIV and Food Insecurity: A syndemic Amid the COVID-19 Pandemic." AIDS and behavior, 1-4. 8 May. 2020

How We Explored the Problem



Recruitment

APLA Health recruited clients from each of the food pantries.

Baseline Assessment

- Engagement in HIV Care
- Experiences with food insecurity
- Frequency of food pantry utilization
- Frequency in the consumption of fruits and vegetables

Follow-Up at 6 & 12 months

- Retention in HIV care
- Changes in food insecurity
- Utilization of services

NOLP-Program Overview

NOLP is a food and nutrition program that provides free groceries, personal hygiene items, and nutritional supplements to low-income persons living with HIV (PLWH) and their immediate families throughout LAC.

APLA Health hosts food pantries at 14 locations across Los Angeles County. Clients can shop once each week, 52 weeks of the year.

Client Profile

"**NOLP** has impacted my life in a **positive manner** because in the past I didn't know how to eat. It has helped me balance and **eat better.**"

Alexxess, 46; Resident of South Los Angeles; Enrolled in NOLP for one (1) year and eight (8) months

Staff Profile

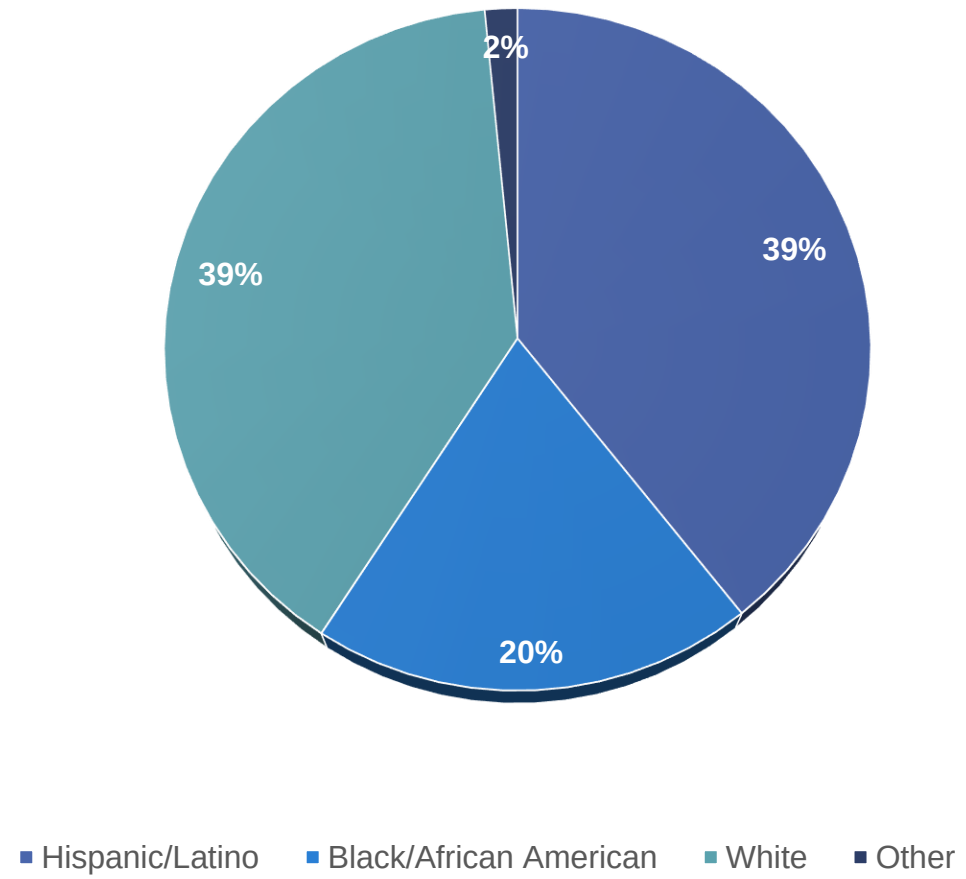
“**To hear that someone is hungry is heart-wrenching**… food is out of reach for so many people when we live in the presence of an abundance of food.”

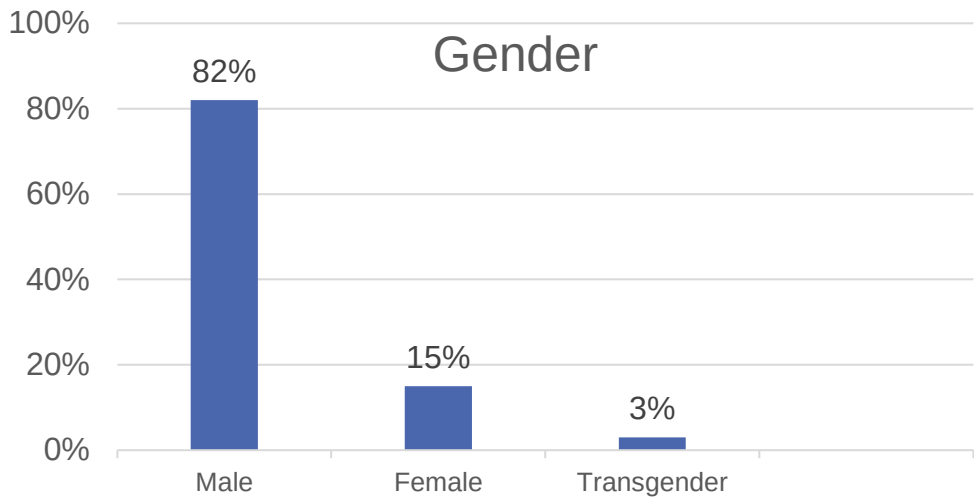
Janelle L’Heureux, Registered Dietician; employee of APLA Health for over 20 years; provides nutritional counseling to patients and hosts food demonstrations.

Value of NOLP

Value of NOLP

Figure 1: Race & Ethnicity





Main Finding

Food pantry services combined with nutrition education offer an opportunity to engage PLWH who may not be consistently engaged in HIV care and promote health literacy.

How APLA Health Pivoted During a Pandemic

- Change method of distribution of groceries
- Inclusion of PPE supplies
- Provision of transportation
- Modify use of volunteers
  - Bagging groceries
  - Food pantries
- Reconfigure work stations

Project Next Steps

- Implementation of a Kitchenless Bags program.
- Ongoing assessment of client satisfaction and health outcomes.
- Opening of new site in South Los Angeles, on the campus of Charles Drew University.
- Explore expansion of food pantry services for patients of APLA Health who are not HIV positive.
- Implementation of text messaging and social media platforms to alert clients about program changes, monthly special meal items, etc.

Project Support

- Client recruitment & engagement
- Expand distribution options
- Volunteer opportunities
- Expand research about food pantries and health outcomes

Acknowledgements

APLA Health would like to thank the clients, volunteers and staff who contribute to the ongoing success of NOLP.

Current NOLP Staff

- Tonya Washington-Hendricks, Program Manager
- Michael Landsman, Warehouse Supervisor
- Ben Enos, Food Pantry Supervisor
- Janelle L'Heureux, Registered Dietician
- Oscar Romero, Site Coordinator
- Jonathan Guzman, Site Coordinator
- Regina Padilla, Site Coordinator
- Michael Mariani, Warehouse Assistant
- Kevin Seanez, Warehouse Assistant
- Andres Villarreal, Warehouse Assistance
- Rene, Paredes, Nutrition Specialist
- Elizabeth Flores, Data Entry Coordinator

2019 APLA Health
FRIENDS IN DEED

Christopher Flynn Service Award

John Hands

John Hands first began volunteering at APLA Health in 2007. His dedication and hard work captured the eye of staff at AIDS Walk Los Angeles where devoted his time for the past 10 years in helping staff and assisting with the various AIDS Walk Los Angeles events. As the AIDS Walk Los Angeles team began to make transitions, John just couldn't be still so he reached out to staff at APLA Health to see how he could offer assistance to the Care Coordination Department. Since joining the Care Coordination team, John has gone out of his way to help organize a very busy department. John is always willing to help out wherever needed and has shown great dedication in serving the community, APLA Health staff and clients.

The staff and clients of APLA Health are tremendously grateful to have John as a member of the Care Coordination team.

Christopher Flynn Service Award:
Christopher Flynn was an outstanding volunteer with APLA Health for many years. He presented humanity and compassion to our clients and their loved ones.

Contact Information

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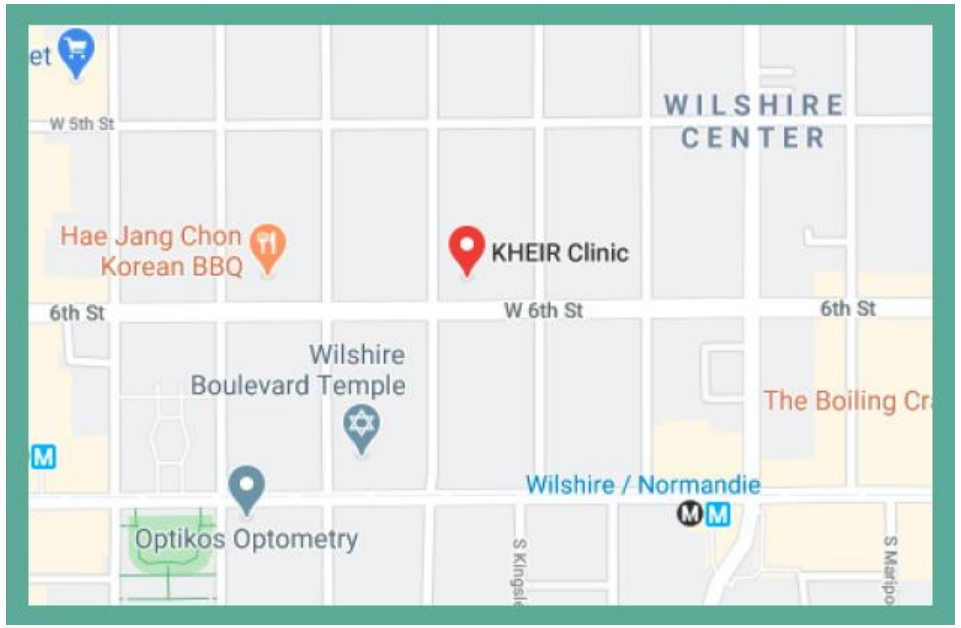
Road to Wellness:
Analyzing and Addressing Patient Transportation Needs

Kheir Clinic
Kirby Rock, Samantha McKee, Andrey Gordienko
Internal Reference Guide + Information for Supporters
March 2021

Kheir Clinic
이웃케어클리닉
Kheir Community Clinic
Clínica Kheir

Road to Wellness Patient Story

- Helen, 60-year-old patient
- Koreatown resident
- Visits Kheir Clinic at least once a month
- Multiple chronic health conditions renders her unable to drive herself to the clinic
- Public transportation was more difficult to navigate and less comfortable



Problem Statement

No-shows and cancellations often due to transportation and logistical difficulties

Lack of consistency in routine screening procedures for transportation barriers from clinical and care coordination staff

Not enough outreach to new and existing patients with transportation needs

How We Explored the Problem

01

Survey Data Collection

Developed and administered surveys in Survey Monkey

02

Patient Interviews

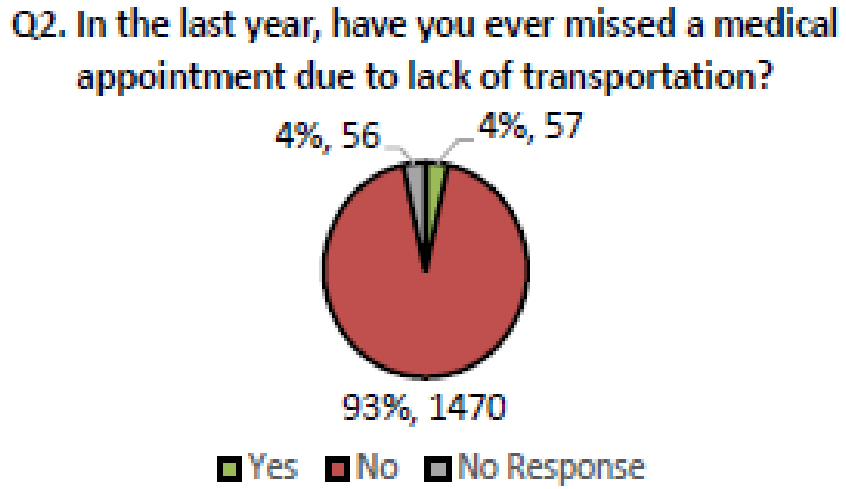
Met individually with patients to assess needs

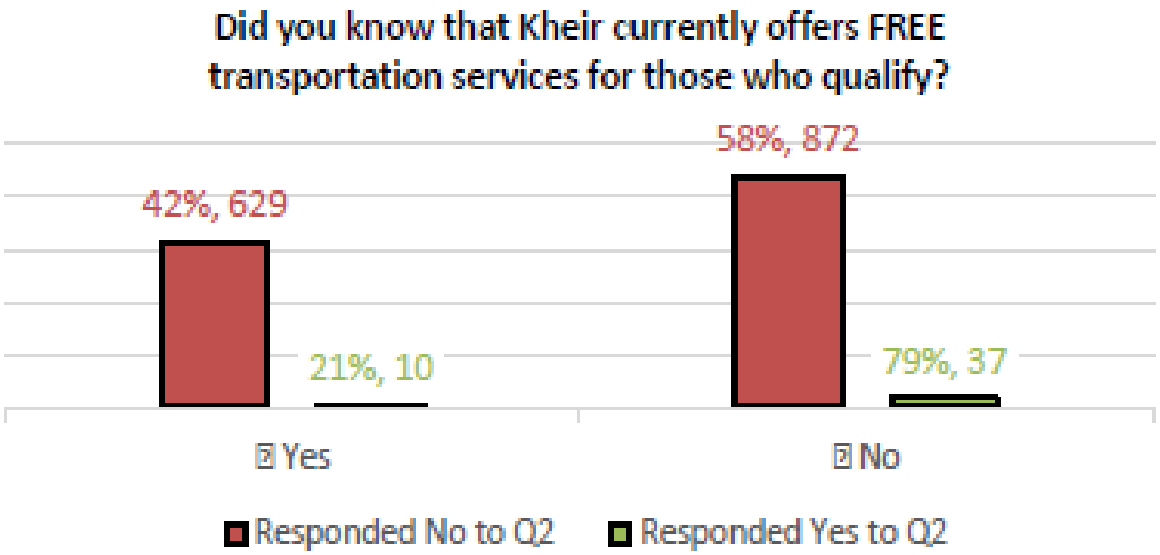
03

Observational Analysis

Conducted ride-alongs, noting workflow and gaps, documenting patient experience and ways to improve service

Transportation Survey





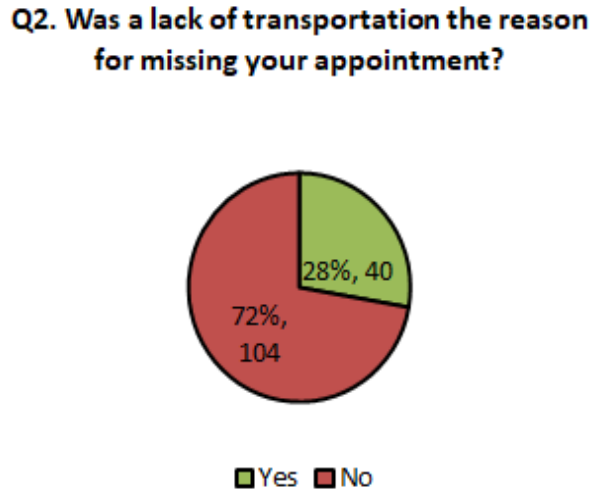
1,579 Survey Responses

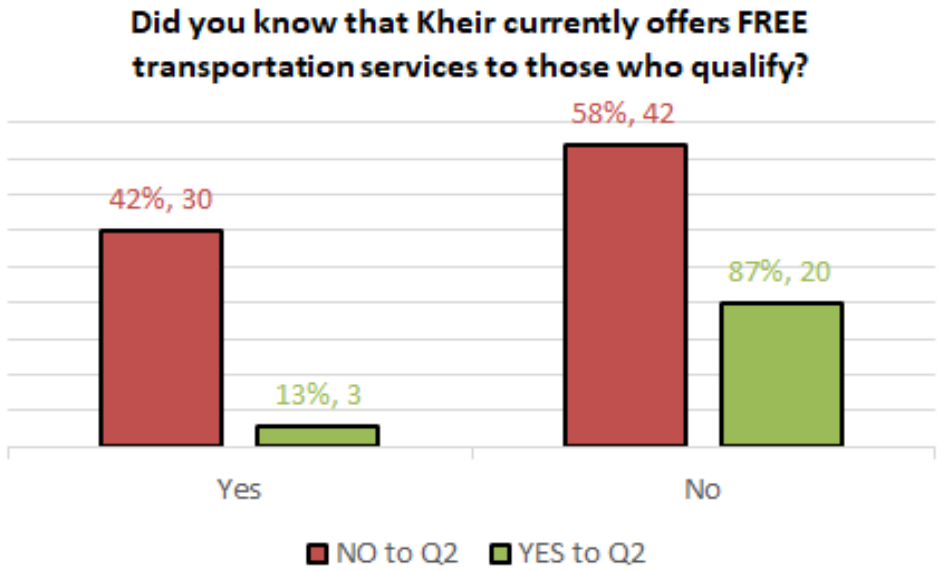
December 2019 - February 2020

- Provided to patients in the clinic waiting area
- 4% of respondents missed a medical appointment due to transportation barriers*
- Of those, 79% were not aware of Kheir's in-house transportation service

*led to further inquiry on data collection methods

No-Show Transportation Survey





144 Survey Responses, February 2020 - March 2020*

- Provided to patients who were no-shows to their appointment
- 28% of respondents said they missed the appointment due to transportation barriers
- Of those, 87% were not aware of Kheir's in-house transportation service

*Put on hold due to COVID-19 Pandemic

Our Insights from Exploring the Problem

- 90% of low-income adults in the service area (Koreatown) report transportation problems that hinder efforts to obtain medical care
- Patients experience both public transit and general transportation barriers
- Gaps in current Kheir’s Driver and Transportation Coordinator (DTC) workflow

How We Pivoted During the Pandemic

Implemented telehealth platform and processes

Leveraged EHR technology and screening tools (PRAPARE)

Revised transportation workflows to include greater safety precautions (lower capacity per ride, sanitation after each ride, mask and PPE use)

Road to Wellness

- Implement transportation survey and routine screening
- Create sustainable processes to connect patients to Patient Resource Department and case management
- Develop new and leverage existing transportation partnerships through clinic van, Uber, and Metro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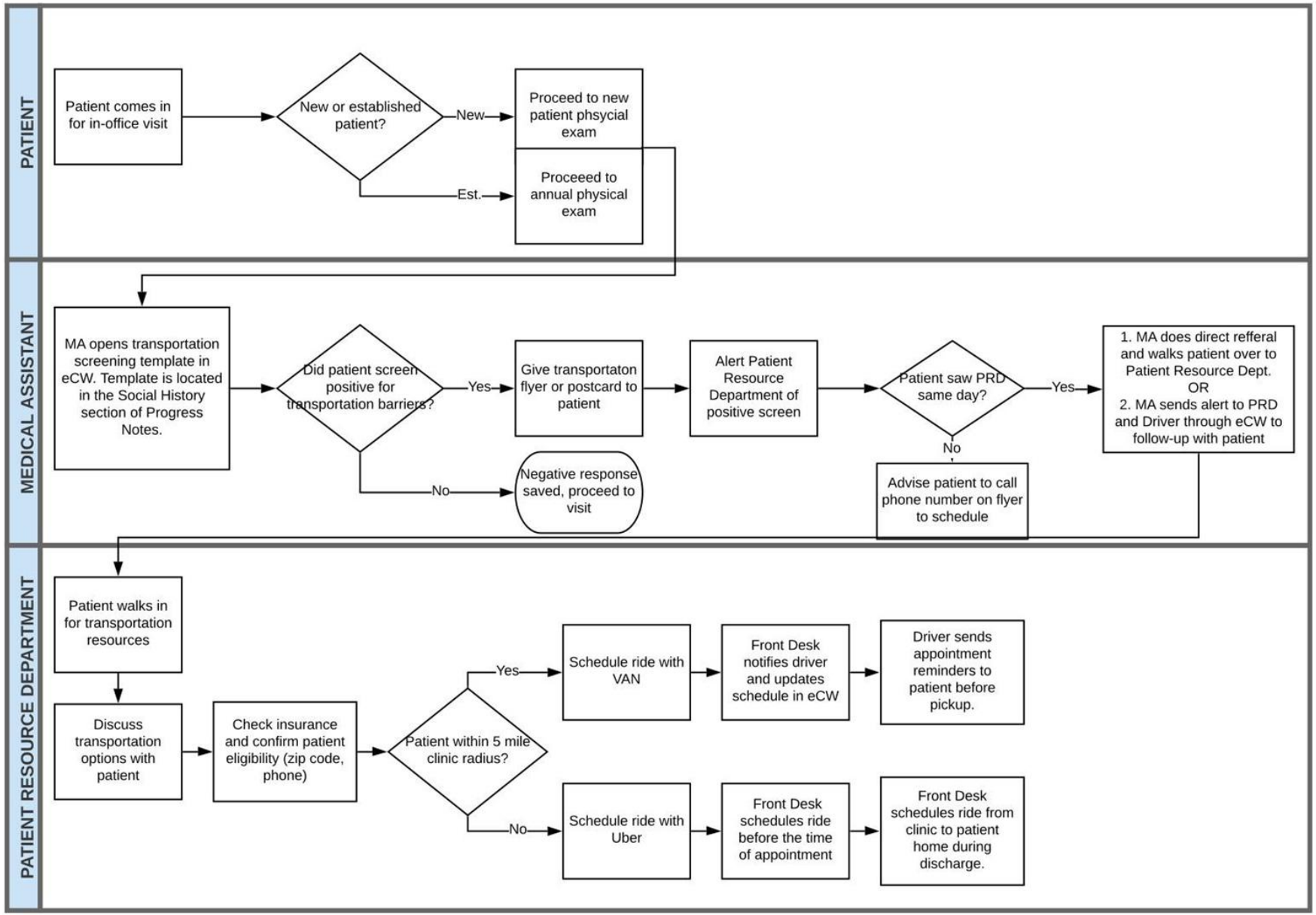
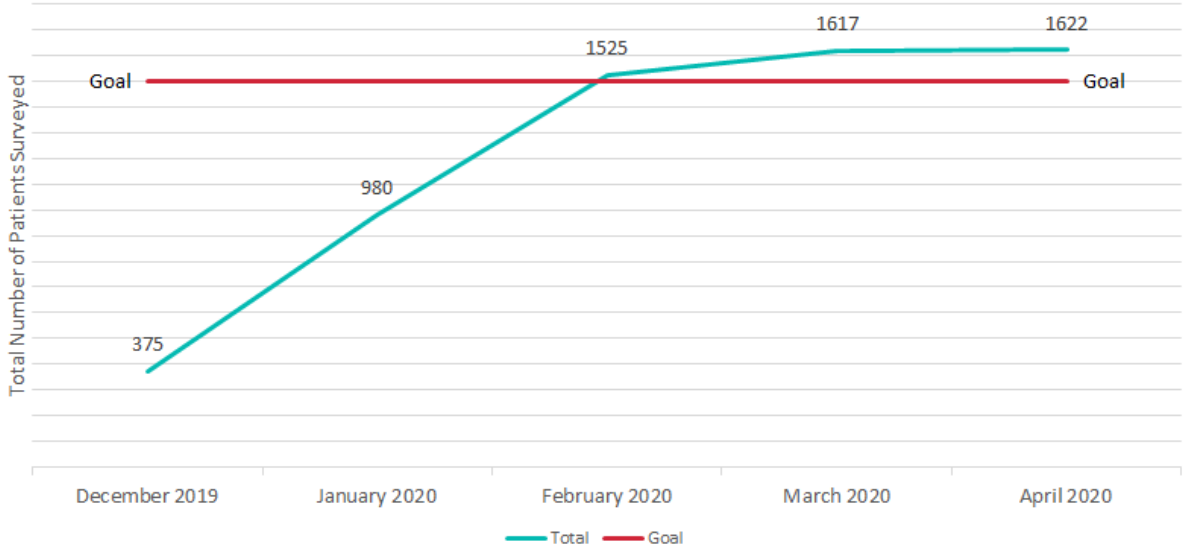
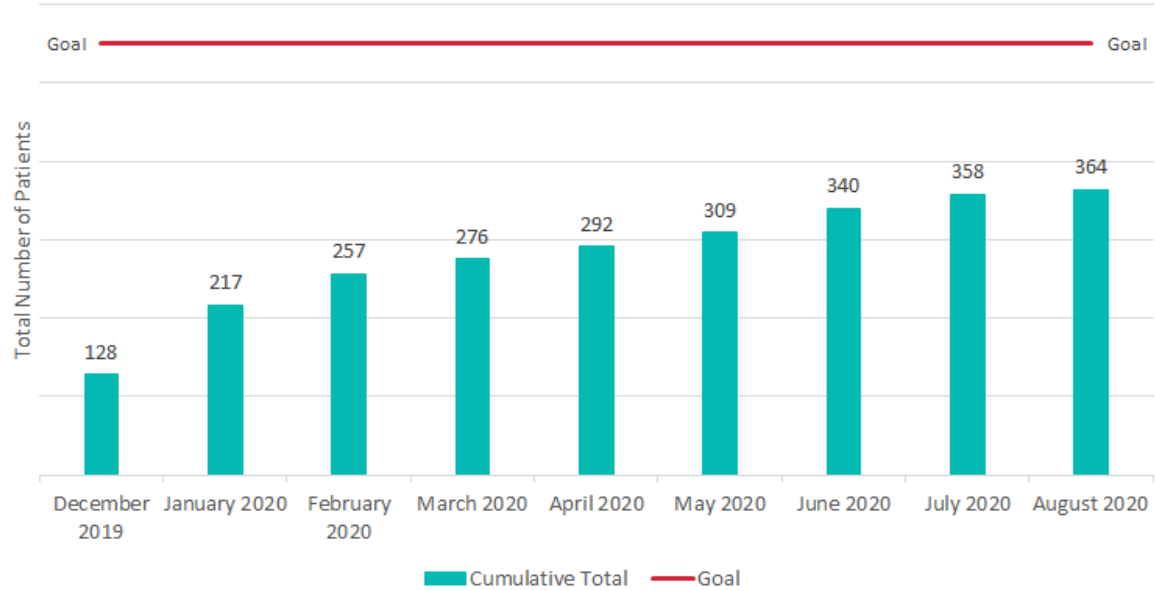
Transportation Screening Workflow: New and Established Patients



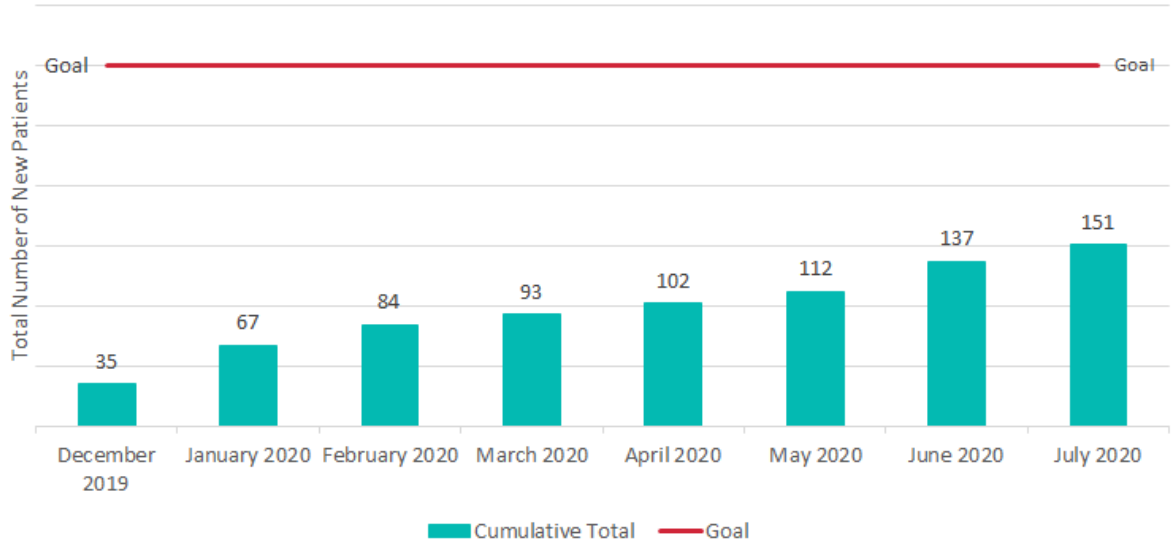
Objective 1: Total Number of Patients Surveyed



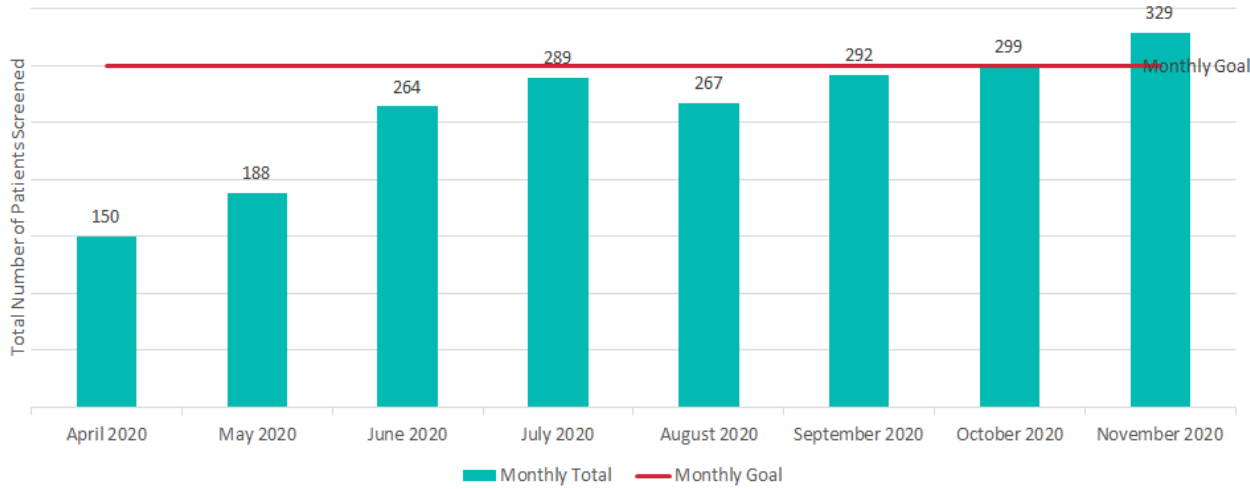
Objective 2: Total Number of Patients Utilizing Transportation Services



Objective 3: Total Number of New Patients Utilizing Transportation Services

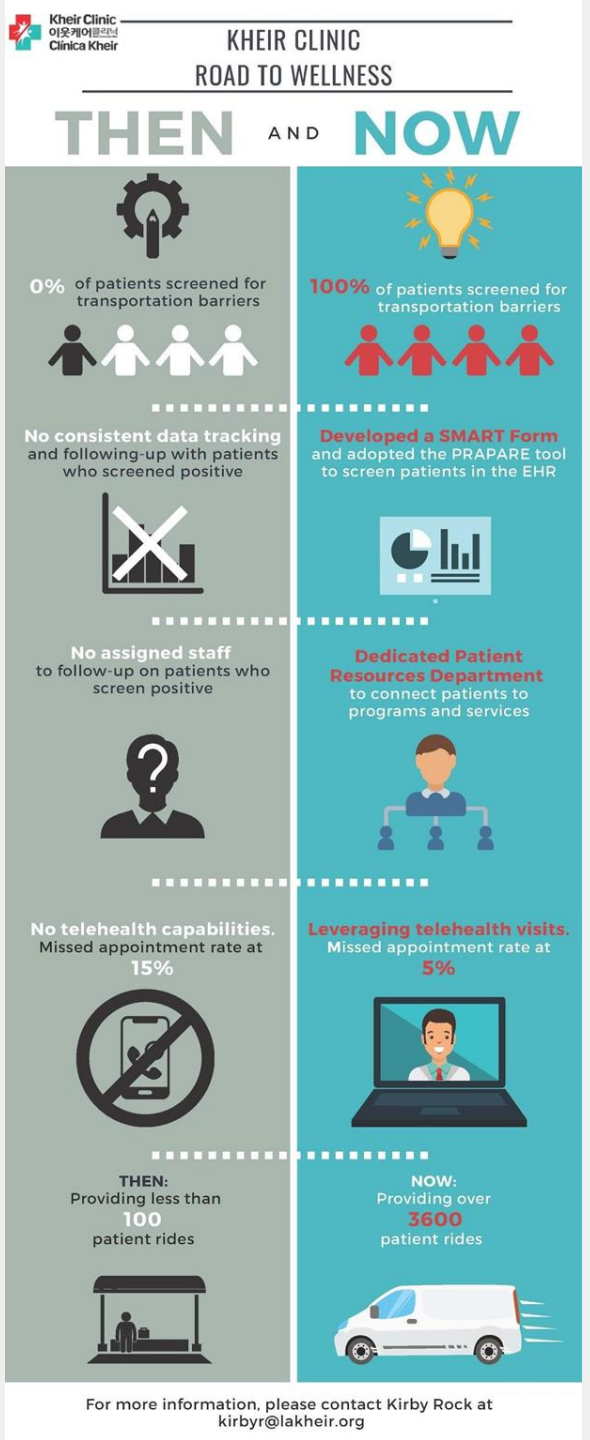


Objective 6: Number of Patients Screened for Transportation Barriers Using PRAPARE



THEN VS NOW

- **100%** of patients are screened for transportation barriers
- Increased data tracking, developed SMART Form in eClinicalWorks
- Dedicated Patient Resource Department staff to follow-up on transportation needs
- Implemented telehealth system, **reduced missed appointment rates by 10%.**
- **Over 3,600 rides** provided through the clinic van or Uber.



Helen

60 years

Koreatown Resident

Multiple chronic health issues

Patient at Kheir for 6 years

“**I didn’t even know that Kheir clinic had this! They came and picked me up because I don't have a ride [to the clinic]. Nelson, the driver, he is always on time. I have never met such a nice person!”**

Jorge

56 years

Koreatown Resident

Patient at Kheir for 15 years

“The transportation has helped me get home quicker. I usually take the bus and it's very inconvenient. The drivers are very patient with me since I walk very slowly and they are very nice and help me get in and out of the van.

Full interview at:
https://drive.google.com/file/d/1w0gmwOYTJPEcnyAONQbfaqtd2XlqpgR5/view?usp=sharing

Shadman Chowdhury

Driver and Enrollment & Outreach Specialist

Kheir Employee for 2 ½ years

“Having a car come and pick [patients] up at a set time and then drop them off after the appointment really helps them take care of their health better. It’s one less thing they have to worry about.

Full interview at:
https://drive.google.com/file/d/12ypSoBzRS2KsSAhqSU6kLiYcEVgUSxMu/view

Samantha McKee

Data Analyst

Kheir Employee for 2 years

> *For complex problems like transportation barriers, **we have to look at every piece of the puzzle** if we're going to make real changes. I've enjoyed working on this project because we've been analyzing human stories and quantitative data to get a full picture of the situation and improve our patients' access to resources.*

Benefits of Road To Wellness

- Eliminates transportation barriers for patients
- Decreases “no-show” rates
- Adds touchpoints and engagement with patients

- Transportation barriers resume
- No-show rates increase
- Lose opportunity for patient retention

Consequences
if we discontinue

Road To Wellness
Next Steps

- Continue to screen patients for transportation needs
- Continue to provide free van rides and Uber services to those patients who screen positive for transportation barriers
- Ensure that clients screening positive for transportation barriers are consistently referred to Patient Resource Department

- Ongoing feedback from patients on how to better address transportation needs given all the changes since the onset of the pandemic

- New Driver and Transportation Coordinator (DTC) as soon as possible

Support we need

Thank you!

Kheir Clinic
이웃케어클리닉
Kheir Community Clinic
Clínica Kheir

Kheir Clinic

Samantha McKee, Andrey Gordienko, and Kirby Rock

For more information, please contact:

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Mental Health & Transportation Pilot

Planned Parenthood Pasadena & San Gabriel Valley

Team: Cheri Pogue, Ashley Leonard, Grace Lin, Elizabeth Herrera, Mirella McCoy, Allyson Libao, Emylze Garcia, Christian Port, Noah Nattell, Casandra Quinonez

Audience: Internal and external stakeholders

Clinical staff were not yet screening for transportation or mental health

- Need for mental health screening during Well Person Exams to provide complete, rounded care for our patients with their physical and mental well-being in mind. Patients are linked with care via a referral list of providers who work with many incomes and insurances.

- Need for telehealth services to add to roster of services in order to expand compassionate, patient-centered, and culturally competent care for established patients from the comfort of their homes, creating critical access to sexual, reproductive and transgender health care for patients who could not otherwise attend traditional clinic visits.

Behavioral Health and Transportation in LA County

- Mental Health
  - 16.5% (1.3 million) in LA County reported suffering from mental illness
  - 49.2% not receiving treatment for condition

- Substance Abuse
  - 8% of CA population has SUDs & only 10% receive tx
  - 2013: alcohol & substance use accounted for 1,658 deaths in LA County

- Transportation
  - 7.4% of LA County population reported transportation as a barrier to receiving medical care
  - Barrier higher for age groups 18-24 and those identifying as African American

AskCHIS, 2017; California Department of Public Health: EpiCenter, 2013; California Health Care Foundation [CHCF], 2018a; CHCF, 2018b; Coffman, Bates, Geyn, & Spetz, 2018
Source: 2007, 2005, & 2002 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health
Source: 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Why Planned Parenthood?

Trusting and Accepted Provider

With 60 percent of PPPSGV patients using PP as their only source of medical care incorporating behavioral health services while screening for transportation needs helps to increase access to care for prevention and early detection of chronic disease, which is part of PPPSGV's mission.

How Will We Do This?

- ➔ Choose screening for one behavioral health issue
- ➔ Screen for transportation as a SDOH
- ➔ Learn how this can be incorporated into the workflow of family planning clinic
- ➔ Develop partnership with external behavioral health organizations
- ➔ Measure success and identify best practices
- ➔ Develop workflows to roll out to all health centers
- ➔ Explore Telehealth as an option

Research Methods

Screenings / Surveys

- PHQ-9 tool used to screen for depression
- Address transportation as SDOH via survey and providing resources
- Screen all WPE (well person exam) patients over 18

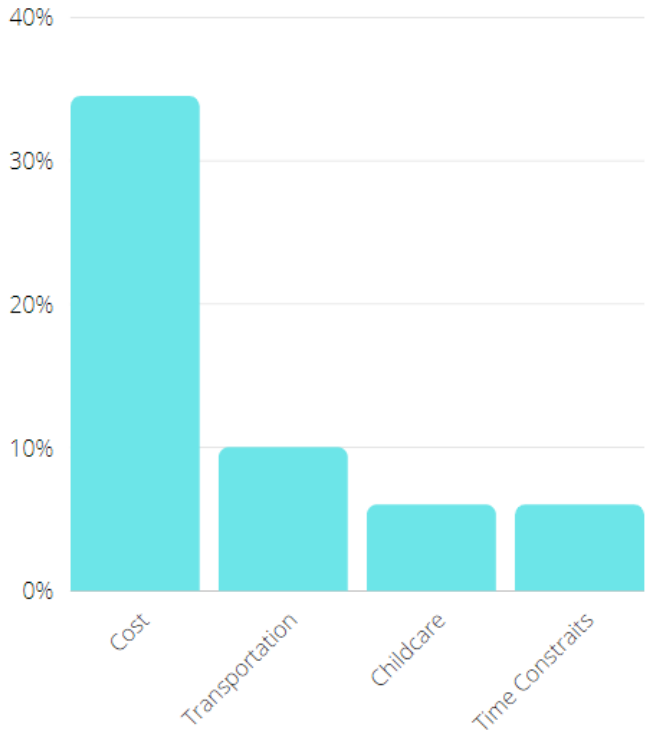
Clinical Conversations

- Screening recorded in EHR by MA, recorded in, reviewed and addressed by provider as needed
- Provider offers resources, referrals, and linkages to care as needed

Key Insights

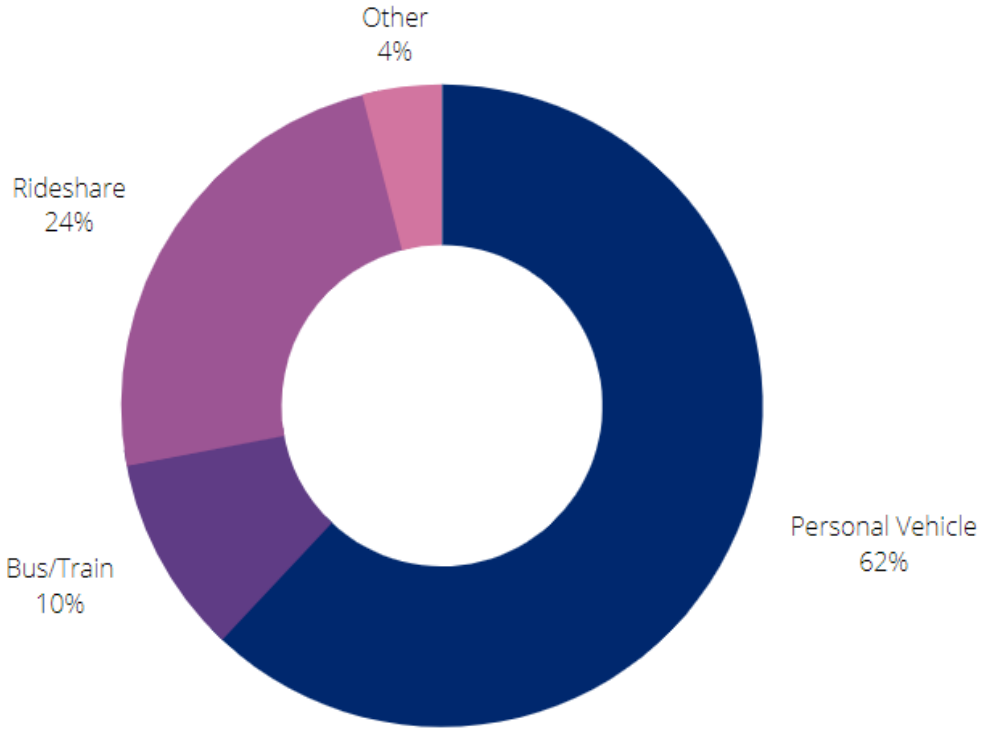
Mental Health

Out of over 100 patients surveyed on potential barriers to receiving care for mental health, patients identified Cost (35%) and Transportation (10%) as the biggest barriers



Transportation

Out of over 100 patients surveyed on how they arrived to their appointment Personal Vehicle was the most common.



Out of 35 patients surveyed, 6.7% of patients had missed a medical appointment due to transportation in the last year

“PPPSGV feels like a ‘home base’ where intimate questions are already being asked and it makes sense to talk about mental health - PPPSGV Patient

Planned Parenthood cares for you and mental health is so connected to everything PP already does - PPPSGV Patient”

Project:

Targeting transportation as a social determinant of health through Mental Health and Transportation Survey

We launched Telehealth!

PPPSGV Update on Telehealth

To help keep our staff and patients safe in the coronavirus era, we recently launched Telehealth, an online service that provides patients with "face-to-face" virtual appointments with one of our Planned Parenthood medical providers. Through Telehealth, we can continue to offer our community the essential sexual and reproductive health care they need from wherever they are.

We launched Telehealth because we know the important role we play in the communities we serve and that our patients rely on us to provide them with the health care they need. We've already seen hundreds of patients and have been able to provide them with the care they need via Telehealth appointments.

We've received countless words of appreciation that continue to remind us why we do the work we do. Thank you to everyone who has come to us for a Telehealth appointment, and to our community for supporting us. We are going to get through this together.

For more information or to make an appointment online:
Visit PPPSGV.org

Transportation SDOH through Mental Health and Transportation Survey

- Transportation resources are offered to all patients through public transportation information. Patients in need of direct assistance will receive a $10 TAP card.

- Telehealth directly addresses transportation barriers by meeting patients where they are and providing a visit when they would otherwise be unable to attend; either due to transportation or the pandemic.

FOS: Check in/confirm WPE and hand patient **PHQ9 and transportation survey** to complete and return, place in patient chart

MA: Transcribe the PHQ9 results into EHR, place completed paper into the patient's sleeve. Review Transportation survey and note any transportation needs. Place into patient's sleeve.

MA: Complete all other WPE indicated tasks

MA: Click "Other Code" box under the Finalize section of the Family Planning Template - select POSITIVE or NEGATIVE screen based on score

MA: Notify clinician verbally or by Spark about positive results or identified transportation barrier

Clinician: Review PHQ and address based on severity

Clinician: Refer as indicated (use mental health referral form)

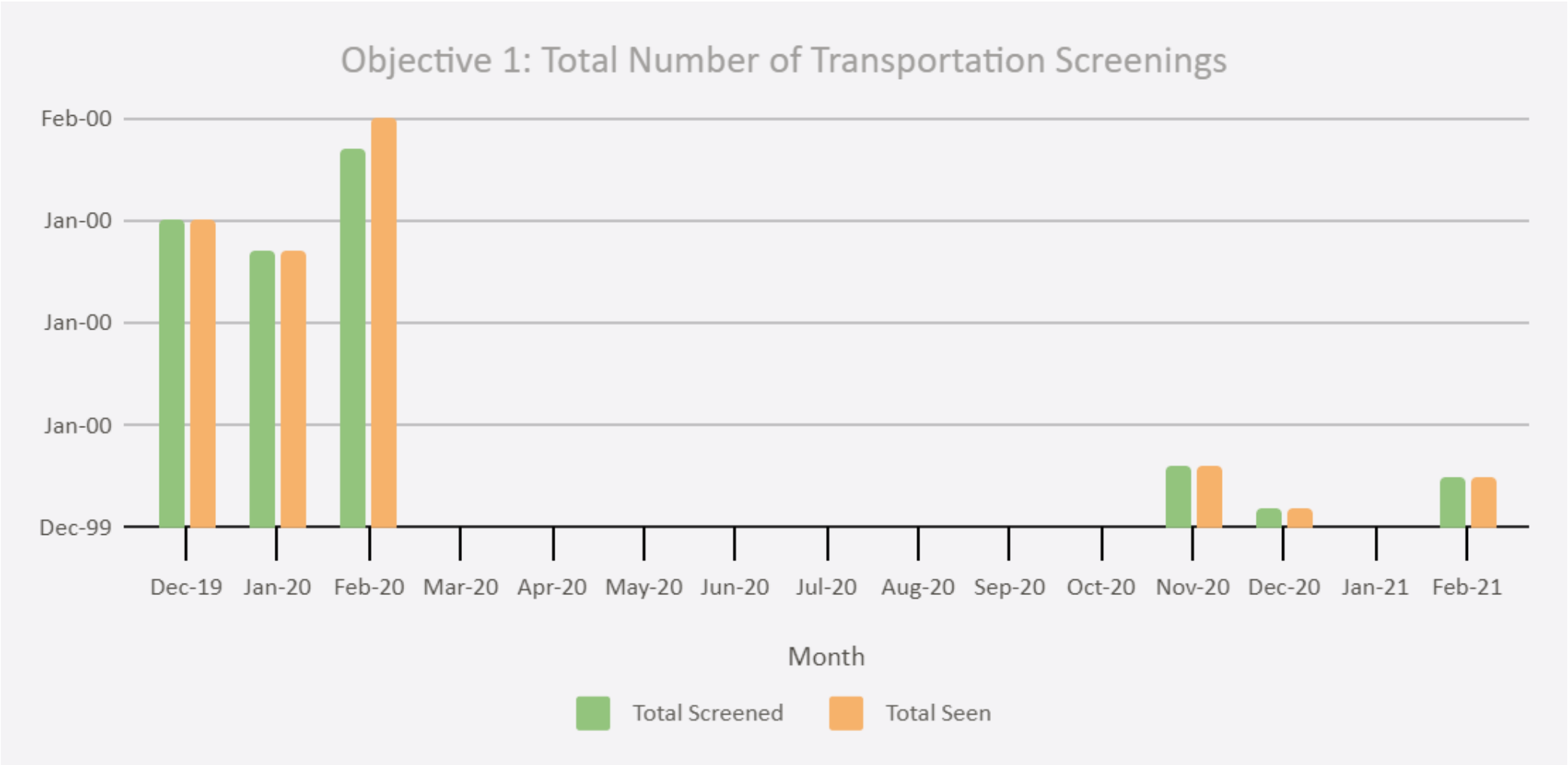
Clinician: Ask about Transportation barriers if giving referral, provide TAP/Gas Card if needed and note in Log book

Clinician: Complete Depression follow-up plan in EHR for scores 10+ and add ICD10 code in the primary care/SDOH list

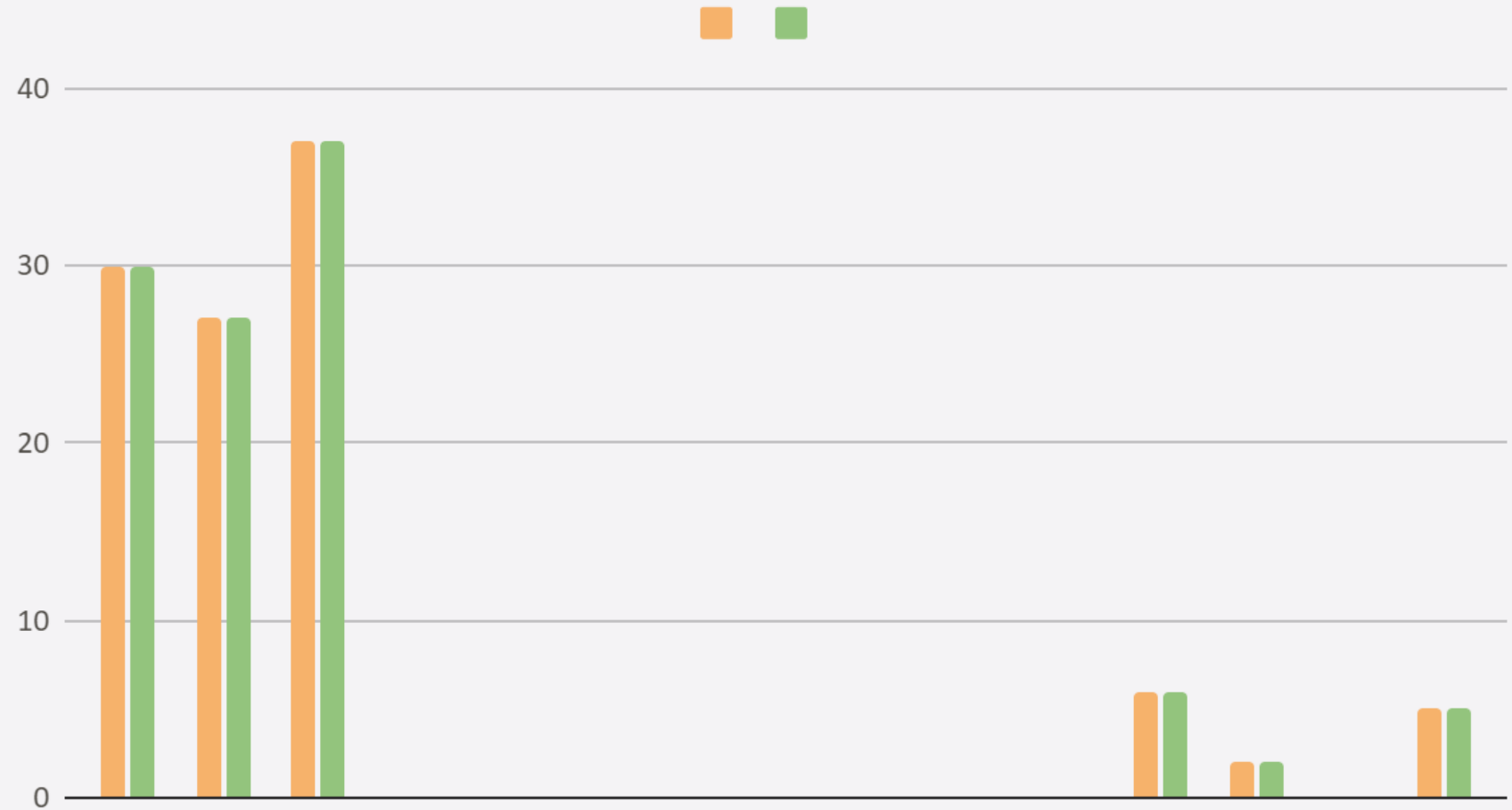
MA: Give completed transportation survey to Health Center Manager

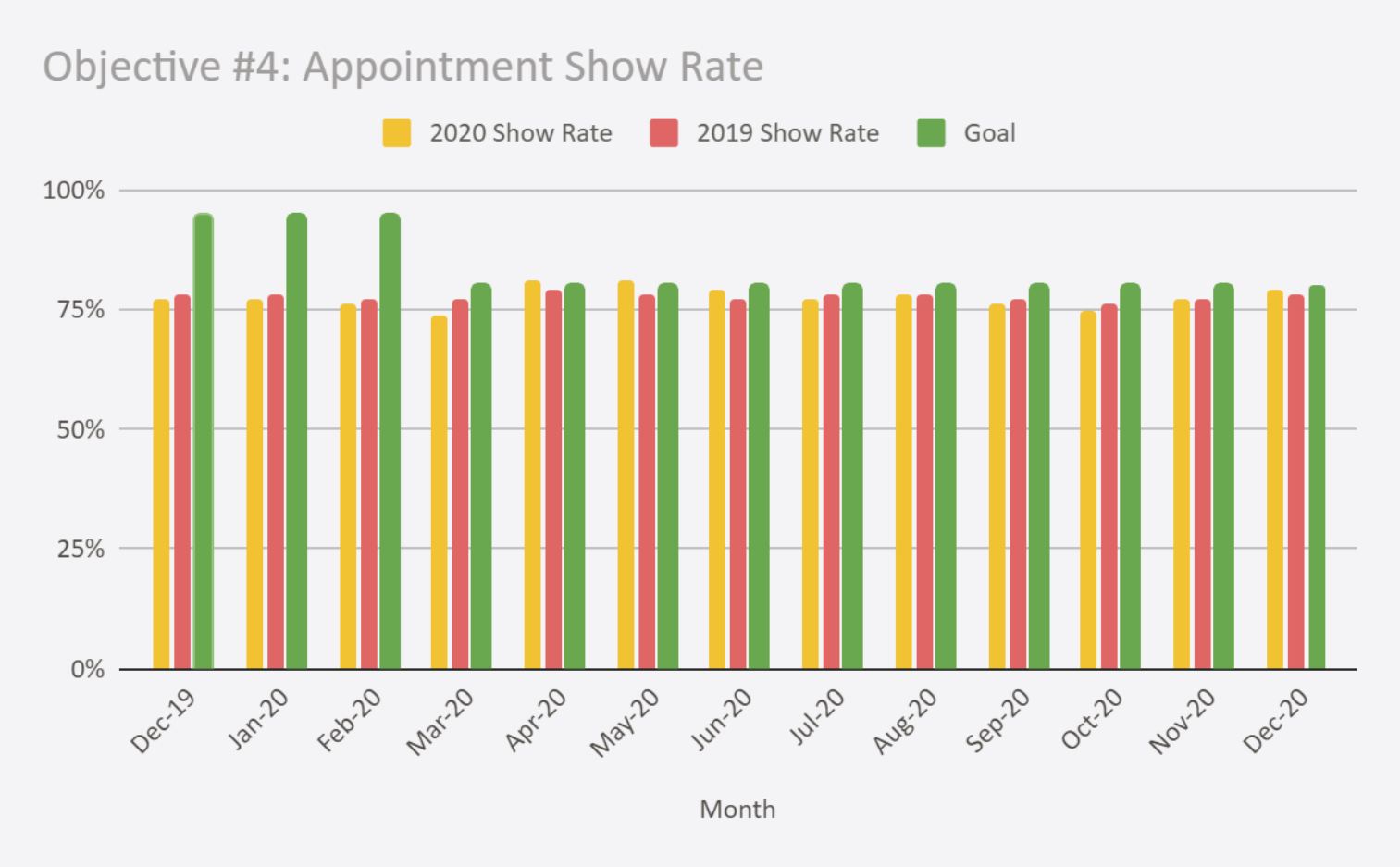
MA: Ensure that patient has referral and/or resource guide

FOS/FOS Biller: Check out Patient, Scan PHQ Questionnaire into EHR & shred paper copy. Return Transportation survey to Manager to keep and scan to Ashley 1x a week.


Objective 1: Total Number of Transportation Screenings
Feb-00
Jan-00
Jan-00
Jan-00
Dec-99
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Month
Total Screened
Total Seen

Objective #2: Patients Connected to Transportation Resources



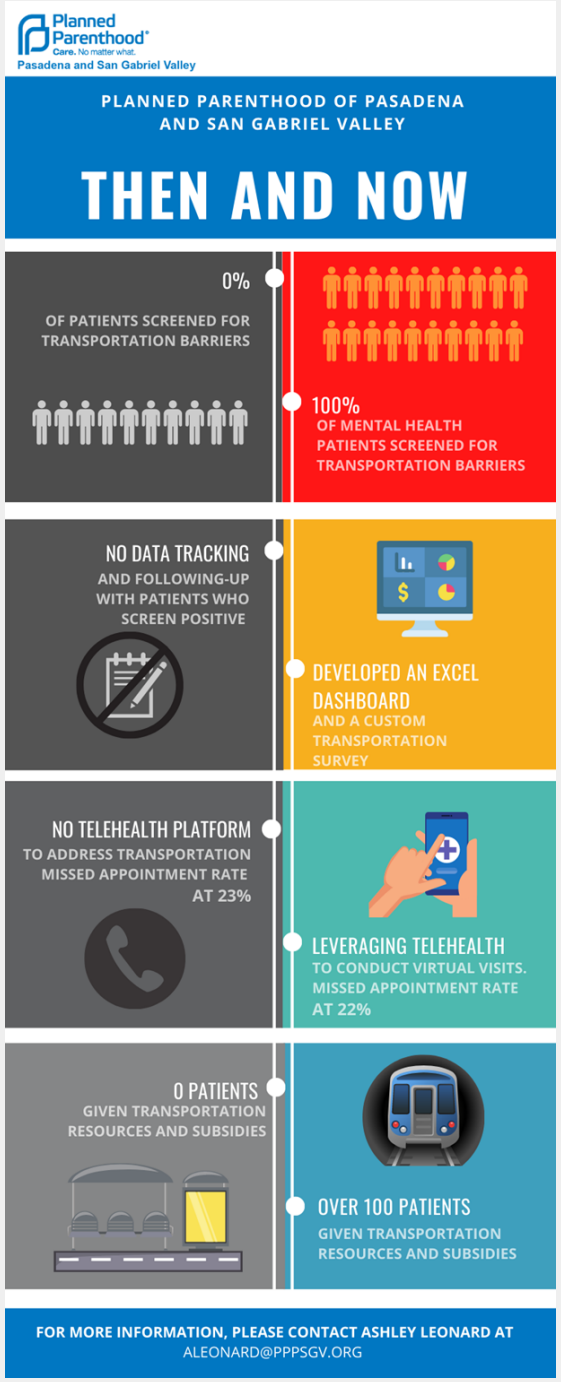


*17.7k+ to date

Objective	2019 Period	Show Rate	2020 Period	Show Rate	Change
4	4/1/2019-12/31/2019	76.80%	4/1/20-12/31/2020	77.90%	1.10%

THEN VS NOW

- 100% of mental health patients screened for transportation barriers
- Developed an Excel Data Dashboard to track patients
- Implemented a telehealth platform, reducing missed appointment rates to 22%
- Over 100 patients referral to transportation resources



- Female identifying patient, pronouns she/her
- Late 30s
- Eagle Rock
- New patient

"I don't have much support here, this actually might be the fastest way to get some. I wouldn’t have even known where to start."

Patient had just moved from Mexico to take care of their mother who was diagnosed with breast cancer last month and had an immediate double mastectomy. The patient’s family and entire support system is back in Mexico and told the provider that this transition has been very difficult.

- Female identifying patient, pronouns she/her
- Mid 20’s
- Eagle Rock
- Patient for 2 years

“This is actually really helpful because my therapist wasn’t sure about other sliding scale clinics or providers or other vital resources, so I was going to have to research that on my own, but now I at least have a place to start.”

- Sarah - Nurse Practitioner
- 1 year with PPPSGV
- Clinician - Highland Park Clinic

“Providing screening for mental health and transportation as a part of our WPE visit makes the visit feel even more comprehensive and shows the patient that we care about their mental health and wellbeing as much as their physical health. Especially during the Covid-19 crisis, many of our patients are struggling with mental health and appreciate the opportunity to speak with us about these struggles, even if just for a few minutes. This service provides an opportunity for me to check in with patients...and I believe that our new location helps increase access for those with transportation issues because of our proximity to the metro and bus stop, as well as being located in a more densely populated area.”

- Alex - Nurse Practitioner
- 4 years with PPPSGV
- Clinician - Highland Park Clinic

“It feels incredible to offer these screenings to patients. We are here to provide services for those who need them and to provide a basic Well Person Exam, as well to screen for depression and transportation feels like we are trying our best and providing outstanding care to our patients. Patient's absolutely feel as though this service made a difference. I think a lot of patients aren't aware of how important this is to their physical and mental health and were very appreciative the conversation was started.”

Creating Access/Opportunities

- Screening for transportation connects patients in need with resources in real-time
- Screening for mental health is caring for the whole person!
- Provides opportunities for Clinicians to meet more needs and bridge care for our patients

We Won’t Stop...

- COVID has increased mental health, and other SDOH for our patient population
- For 60% of patients, PP is their only source of healthcare, they need our services!
- Discontinuing this work could put vulnerable patients at risk

Keep Calm, Carry On!

- Re-introduce WPE screenings after current wave of COVID
- Have introduced at 2 sites, introduce to remaining 3
- Refine transportation screening and build stronger resource network

Planned Parenthood®
Care. No matter what.

Planned Parenthood Pasadena and San Gabriel Valley

Thank you!

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