

Moving Clinics Upstream

August 13, 2019 Kickoff Webinar



Webinar Reminders

1. Everyone is unmuted.

- Press *6 to mute yourself and *7 to unmute.

2. Remember to chat in questions!

3. Webinar is being recorded and slides will be sent out to those that attended.

CCI Team



Megan O'Brien,
Senior Program
Manager



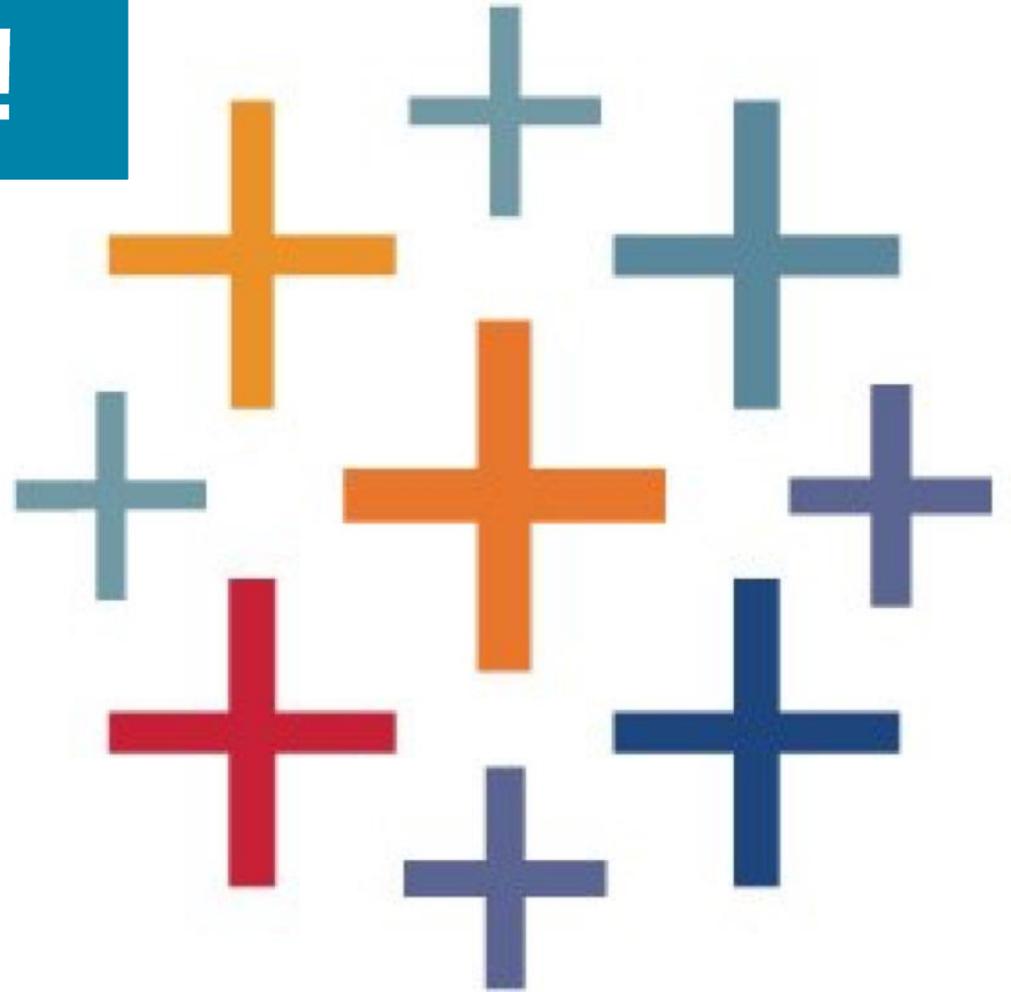
Veenu Aulakh,
President



Diana Nguyen,
Senior Program
Coordinator

We want to hear from you!

- Explain the **what we have in mind** for the Moving Clinics Upstream program;
- **Get your input** in order to tweak the curriculum and program activities based on what you needed to be successful.





Today's Agenda

- Welcome, Who is CCI?, and Intros (5 mins)
- Program Background (5 mins)
- Planned Overview & Highlights (15 mins)
- Guiding Questions & Feedback (25 minutes)
- Next Steps & Closing (10 mins)
 - **September 26 session**

Feedback Questions



What do you have **questions about** or **need clarifications**?



What are you **most excited** about & think would be **most helpful** to your organization? What would make this opportunity **even better**?



Who do you **want to hear from**? What's going on in LA that **we should know about**? What's the **biggest challenges** you are facing doing this work well?

Ways to Give Feedback

1

Jot down on **sticky notes** or on pieces of paper along the way

2

Wait until the feedback portion of the webinar and **unmute yourself** to ask a question

3

Chat your questions into the **chat box**

4

Email me at mobrien@careinnovations.org





About CCI



What We Do Today

CCI transforms care for underserved populations by inspiring, teaching, and spreading innovation among organizations serving patients.



Build Capabilities



Catalyze Innovation



Spread Solutions
That Work

Core Focus Areas

1

Population
Management

2

Innovation &
Design Thinking

3

Technology
Solutions

4

Community-
Centered Care



Core Focus Areas

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Population
Management

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Community-
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Introductions

Cedars-Sinai, Community Benefit Giving Office (CBGO)



Erin Jackson-Ward,
Senior Program
Officer



Nicholas Bloom,
Program Officer

MCU Cohort: Food Insecurity



Altamed:
Integrate learnings on practice of upstream clinical care into our health systems, incorporating social emotional determinants of health into every practice for our pediatric population.

APLA Health & Wellness:
Advance food security among low-income persons living with HIV.

Behavioral Health Services:
Gain more knowledge on food insecurity and how to eliminate this within the historically underserved community.

Clinica Ms. Oscar Romero:
Reduce mobility mortality type 2 diabetes in a high risk marginalized ethnic population and to reduce the disparity of a chronic illness compared to other community populations.

LA LGBT Center:
Address food insecurity for our patients by developing a sustainable intervention and providing staff the tools to implement the intervention

St. Johns:
Learn how to integrate this program into our various clinic sites.

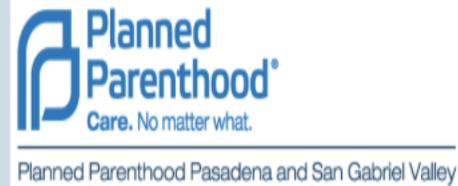
MCU Cohort: **Transportation**



Eisner Health:
Increase its capacity to collect and analyze SDOH data, while developing and piloting interventions to address food insecurity among our community in a strategic, patient-centric way.



Kheir Center:
Better understand the transit difficulties affecting our patients and use that knowledge to expand our transportation assistance programming.



Planned Parenthood Pasadena & San Gabriel Valley:
Pilot integrating mental screening, coordinated referral, and telehealth visits at one health center.



T.H.E. Clinic:
Create and implement transportation solutions for our patients.

What We Heard From You

- Learn from **other grantees & collaborate** with other organizations
- Increase my knowledge to **improve food security** and self management skills for clients
- Learn about **food insecurity in Los Angeles County**
- Learning how to address food insecurity at a **systems level**
- Learn how to **adopt upstream care into clinical practice**
- Learning more about **patients' transportation needs and barriers**, and addressing them through targeted interventions
- Learning new strategies for rolling out **organizational changes**
- Creating services to **support our patients**



Program Background





“Why not make medicine an instrument of social change?”

Changing Environment

1

Complex challenges require going beyond the walls of health centers (Social Needs, Trauma, Opioids)

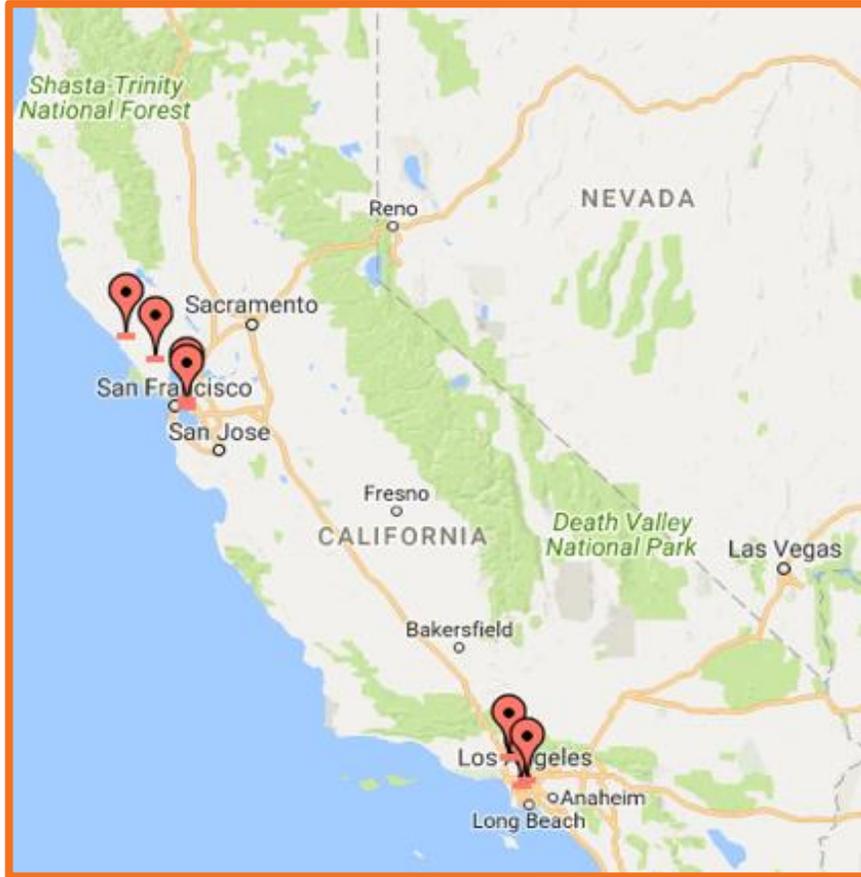
2

Understanding that “we” can’t do it alone. Partnerships are critical to address the wellbeing and whole health of patients.

3

Field is moving toward more systematic and data-driven approaches addressing individual patient social needs (PRAPARE, ERH Integration, Data Sharing)

ROOTS Program & Cohort



In 2017 & in partnership with BSCF, CCI ran a 12 month innovation collaborative focused on the role of clinics in addressing the social determinants of health.

1. Asian Health Services
2. LAC+USC Medical Center, Primary Care Adult Clinics
3. LifeLong Medical Care
4. Northeast Valley Health Corporation
5. Petaluma Health Center Inc.
6. St. John's Well Child and Family Center
7. West County Health Centers

Case Studies



COMMUNITY-CENTERED CARE

Case Study: Screening Youth for Food Insecurity at Northeast Valley Health Corporation

MAR 27, 2019 • CENTER FOR CARE INNOVATIONS

Northeast Valley Health Corporation focused on screening and referring for food insecurity, a top social risk for its patient population, in patients 12 through 17 years of age at two of its clinical...



Roles Outside Of Traditional Systems

In 2017, AHS joined a learning collaborative to help it gather the necessary data, build innovative partnerships, and develop long-term solutions to address the upstream factors harming the health of its community.

Asian Health Services

Asian Health Services (AHS) is a federally-qualified health center headquartered in Oakland, Calif., that provides medical, mental, and dental health care to more than 28,000 patients in English and more than 14 Asian languages. Addressing the social and environmental needs of patients and the wider Oakland community has been a core part of its mission and identity since its founding in 1974. Its **advocacy work**, for instance, contributed to safer crosswalks in the busy urban streets of Oakland Chinatown and the California Healthy Nail Salon Bill, which helps protect the health of nail salon workers.

Project Team

The ROOTS project team included the Director of Community Health and Research, the HIV Program Manager, the Community Services Manager, a Research Assistant, and a Research Intern.

<https://www.careinnovations.org/community-centered-care/>

What We Learned: Core Elements of This Work

Leadership
perspective on
social needs

Establishing
system for
assessing
social needs

Using data
from social
needs
assessments

Linking
patients to
social needs
resources

Closing the
loop on
referrals for
social needs

Strengthening
partnerships



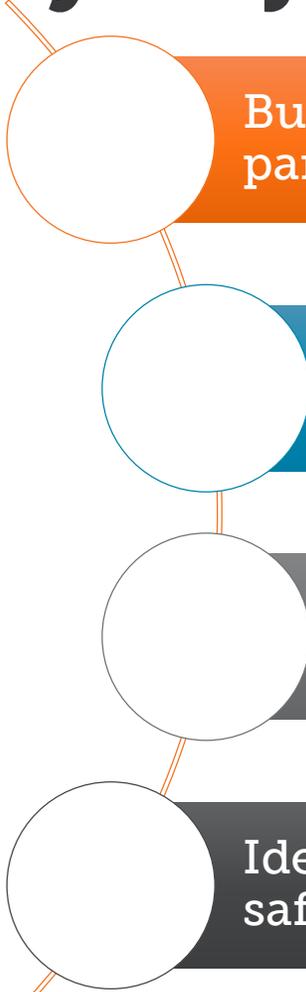
Program Overview

Moving Clinics Upstream

In partnership with Cedars-Sinai, CCI is launching an 18 month learning community to support **10 clinics in Los Angeles** in building capabilities needed to assess for and address **social needs**, with an emphasis on **food insecurity & transportation**.



Key Objectives



Build and sustain internal systems, referral processes, and effective partnerships to increase your capacity to assess for and address social needs

By using a human-centered design process, build mindsets & capabilities to address other social needs beyond food insecurity and transportation

Accelerate your individual progress by learning and sharing successes and challenges alongside your peers

Identify and develop resources, tools, and lessons to share with the larger safety net health care community

Program Support & Delivery

Grants of up to \$75,000 from Cedars-Sinai

Individual Priority Project

In-Person
Sessions &
Workshops

Site Visits

Coaching

Toolkits &
Resources

Access to
Technical
Experts

Virtual
learning

Metrics
Support

Peer
Learning
Community

Program Support

**\$75,000
over 2
years**

Can be used to:

- Offset staff time spent participating in this program & leading change efforts at your organization;
- Travel costs to attend the program's in-person convenings and site visits;
- Other associated project costs included in your budget proposal.

Program Support

4

In-Person
Sessions +
Virtual
Sessions

1. Session #1: September 26, 2019
2. Session #2: March 2020
3. Session #3: August 2020
4. Session #4: February 2021

***All sessions will most likely be held on Cedars-Sinai's campus.**

Webinars will be a mix of content & idea sharing

Program Support

Coaching Support

- Helps with **troubleshooting** and assists teams in advancing work
- Monitors your **experience** of the program
- Connects you with **additional resources** and informs CCI of additional needs
- Provide support & guidance on **implementing social needs programs**, based on experience

Program Support

Visits to
exemplar
orgs.

- Intended to **inspire** teams and provide **guidance** for work in the program
- Location pending; 1 will most likely occur in California & the other on the East Coast
- Expect to send up to 2 team members per site visit

Other Program Support

Individual Priority Project

Toolkits &
Resources

Access to
Technical
Experts

Metrics
Support

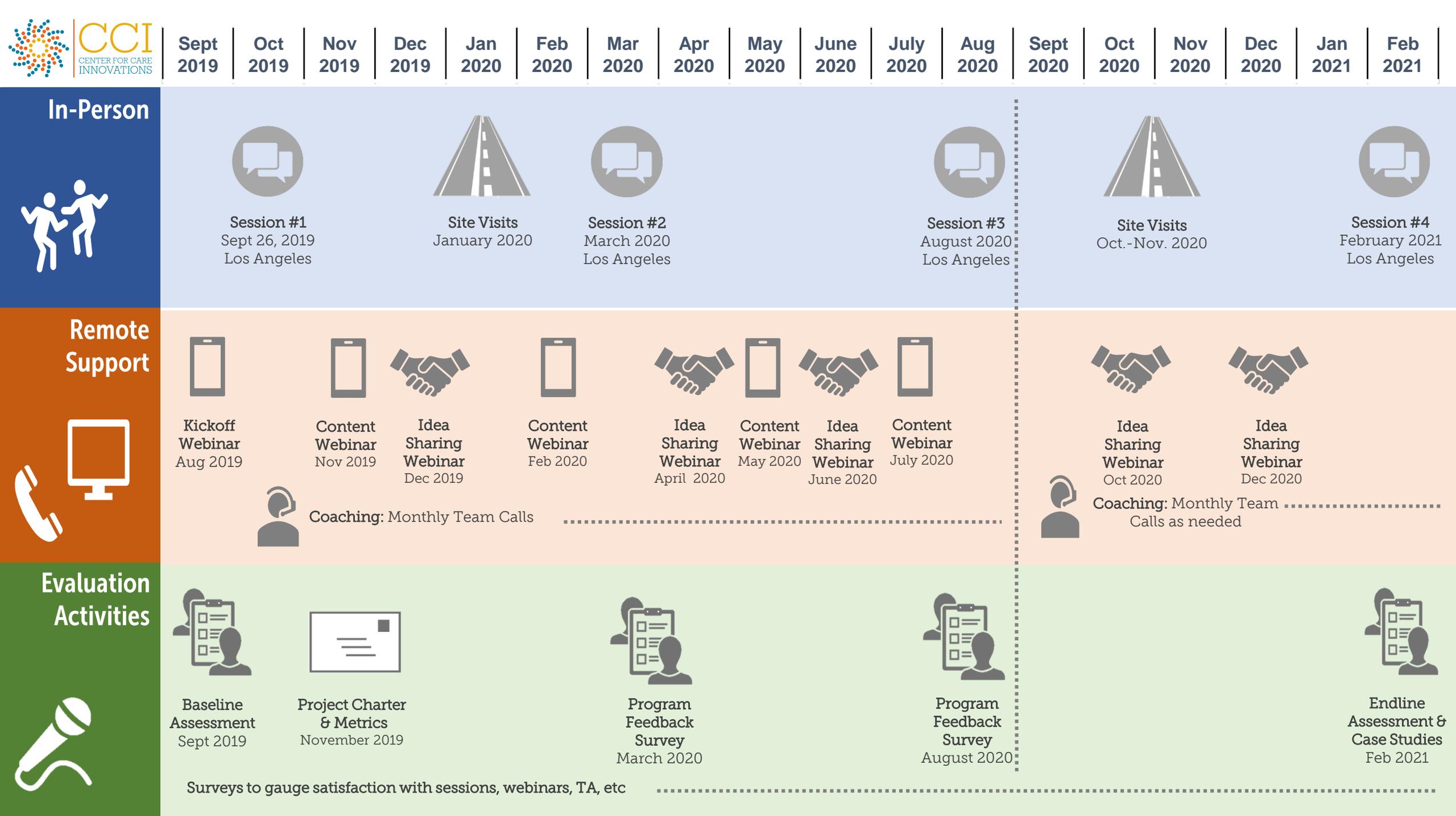
Peer
Learning
Community

Feedback Questions

Press *6 to mute
yourself and *7 to
unmute.



What do you have **questions**
about or **need clarifications?**



Sept 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 | Mar 2020 | Apr 2020 | May 2020 | June 2020 | July 2020 | Aug 2020 | Sept 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Jan 2021 | Feb 2021

In-Person



Session #1
Sept 26, 2019
Los Angeles



Site Visits
January 2020



Session #2
March 2020
Los Angeles



Session #3
August 2020
Los Angeles



Site Visits
Oct.-Nov. 2020



Session #4
February 2021
Los Angeles

Remote Support



Kickoff Webinar
Aug 2019



Content Webinar
Nov 2019



Idea Sharing Webinar
Dec 2019



Content Webinar
Feb 2020



Idea Sharing Webinar
April 2020



Content Webinar
May 2020



Idea Sharing Webinar
June 2020



Content Webinar
July 2020



Coaching: Monthly Team Calls



Idea Sharing Webinar
Oct 2020



Idea Sharing Webinar
Dec 2020



Coaching: Monthly Team Calls as needed

Evaluation Activities



Baseline Assessment
Sept 2019



Project Charter & Metrics
November 2019



Program Feedback Survey
March 2020



Program Feedback Survey
August 2020



Endline Assessment & Case Studies
Feb 2021

Surveys to gauge satisfaction with sessions, webinars, TA, etc

Feedback Questions

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What do you have **questions**
about or **need clarifications?**

Program Phases

Phase 1

September 2019-December 2019

- Build your **team**
- **Assess** your organizations' strengths and opportunities
- Develop a better understanding of the **problem**
- Make a plan to measure **what's working & your impact**
- Identify opportunities to strengthen **leadership and staff buy-in**
- **Assess** current partnerships and relationships to address food insecurity or transportation

Phase 2

January 2020-August 2020

- Engage **patients & community members**
- Establishing and/or strengthening your organizations **systems for assessing SDOH**
- **Using SDOH data** to inform both internal care decisions and linking patients to referrals and resources
- **Collecting data** needed to measure the impact of efforts
- **Closing the loop** on external referrals to address SDOH

Phase 3

September 2020-February 2021

- Work to address any **gaps in referrals or partnerships, and building new ones** where needed
- Document **internal workflows and protocols** to strengthen clinic infrastructure to respond to SDOH
- Document **impact of targeted efforts** on patients and their families
- **Communicate & spread lessons** within clinics and across the field

Phase 1: Building Your Foundation

September 2019-December 2019

- Build your **team**
- **Assess** your organizations' strengths and opportunities
- Develop a better understanding of the **problem**
- Make a plan to measure **what's working & your impact**
- Identify opportunities to strengthen **leadership and staff buy-in**
- **Assess** current partnerships and relationships to address food insecurity or transportation

Phase 2: Testing & Implementing Your Ideas

January 2020-August 2020

- Engage **patients & community members**
- Establishing and/or strengthening your organizations **systems for assessing SDOH**
- **Using SDOH data** to inform both internal care decisions and linking patients to referrals and resources
- **Collecting data** needed to measure the impact of efforts
- **Closing the loop** on external referrals to address SDOH

Phase 3: Deepening Capabilities & Expanding Partnerships

September 2020-February 2021

- Work to address any **gaps in referrals or partnerships, and building new ones** where needed
- Document **internal workflows and protocols** to strengthen clinic infrastructure to respond to SDOH
- Document **impact of targeted efforts** on patients and their families
- **Communicate & spread lessons** within clinics and across the field

Design Thinking

Human-centered design, also known as a “design thinking,” is an approach to problem solving that is collaborative, creative, and begins by understanding people’s needs and experiences.



collaboration



inclusion + empathy



show work early + often



make things tangible



start small + learn fast

Feedback Questions

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yourself and *7 to
unmute.



What do you have **questions**
about or **need clarifications?**

Ask & Expectations

Asks

- Come into the program **open-minded** & willing to **modify your proposed solution**.
- Be willing to **share your wins & challenges** with your peers & CCI.
- Be willing to **co-design** the program with us, sharing what's working & what could be better.
- **Don't ghost**: if something isn't working for your team, let us know. We want this program to work for you.

Expectations

- Establish a **core team** that will provide continuity throughout the 18-month program.
- Participate in the **in-person & virtual sessions**.
- Complete a baseline & endpoint **assessment**.
- Provide program feedback via **surveys and interviews** as needed.
- Develop **case studies** based on the evolution of your work.



Guiding Questions

Feedback Questions



What do you have **questions about** or **need clarifications**?



What are you **most excited** about & think would be **most helpful** to your organization? What would make this opportunity **even better**?



Who do you **want to hear from**? What's going on in LA that **we should know about**? What's the **biggest challenges** you are facing doing this work well?

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Who do you **want to hear from**? What's going on in LA that **we should know about**?
What's the **biggest challenges** you are facing doing this work well?



Next Steps & Closing

Location & Details

When/Where

- Thursday, September 26 from 9am-5pm
- Cedars-Sinai Accelerator
- **Register at:**
<https://www.eventbrite.com/e/moving-clinics-upstream-session-1-tickets-66388899987>

Who Should Attend

- Each organization should plan to send the core team participating in the MCU program
- Due to the size of the cohort, we are asking that each organization limit their attendance to 6 team members.

To-Do's

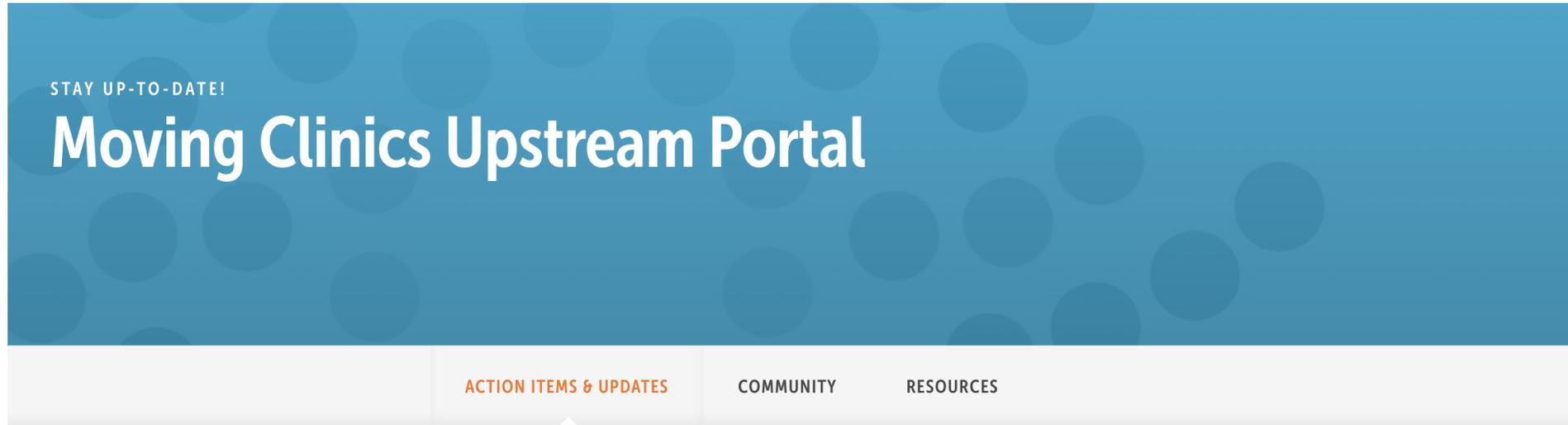
CCI

- Post the recording and webinar slides on CCI portal
- Send out a registration and agenda for the September meeting
- Send out link to the portal

MCU Teams

- Confirm team roster with Diana (if you haven't already!)
- Register to attend Sept session in [EventBrite](#) by August 23
- Send team selfie to Diana by September 9
- Bookmark the MCU portal page once you receive the link
- Be open and excited to share with your peers!

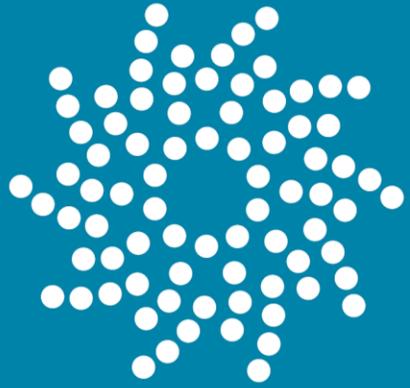
Portal



WELCOME, PARTICIPANTS!

This site is a support center for your team. Find program updates, resources, and community contact information. For more information about Moving Clinics Upstream, please visit the [program page](#).

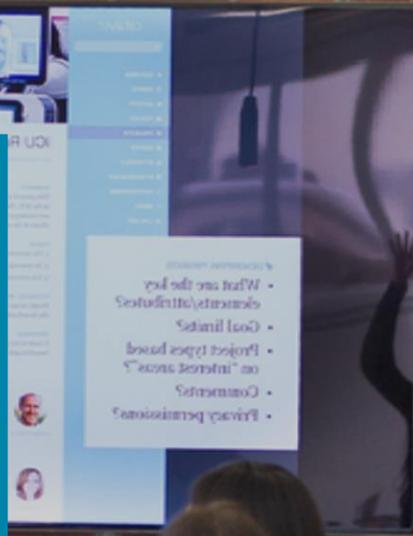
<https://www.careinnovations.org/moving-clinics-upstream-portal/>



CCI

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INNOVATIONS

Questions?



Thank You!

Please fill out
the post
webinar
survey!

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