Moving Clinics Upstream

In-Person Session #1
September 26, 2019

CEDARS-SINAI

CCI
CENTER FOR CARE INNOVATIONS


GREETINGS
HI
WELCOME
HELLO
HOWDY
GLAD YOU'RE HERE

CCI Team

Megan O'Brien,
Senior Program Manager

Veenu Aulakh,
President

Diana Nguyen,
Senior Program Coordinator

Cedars-Sinai, Community Benefit Giving Office (CBGO)

Erin Jackson-Ward,
Senior Program Officer

Nicholas Bloom,
Program Officer

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

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1. Population Management
2. Innovation & Design Thinking
3. Technology Solutions
4. Community-Centered Care

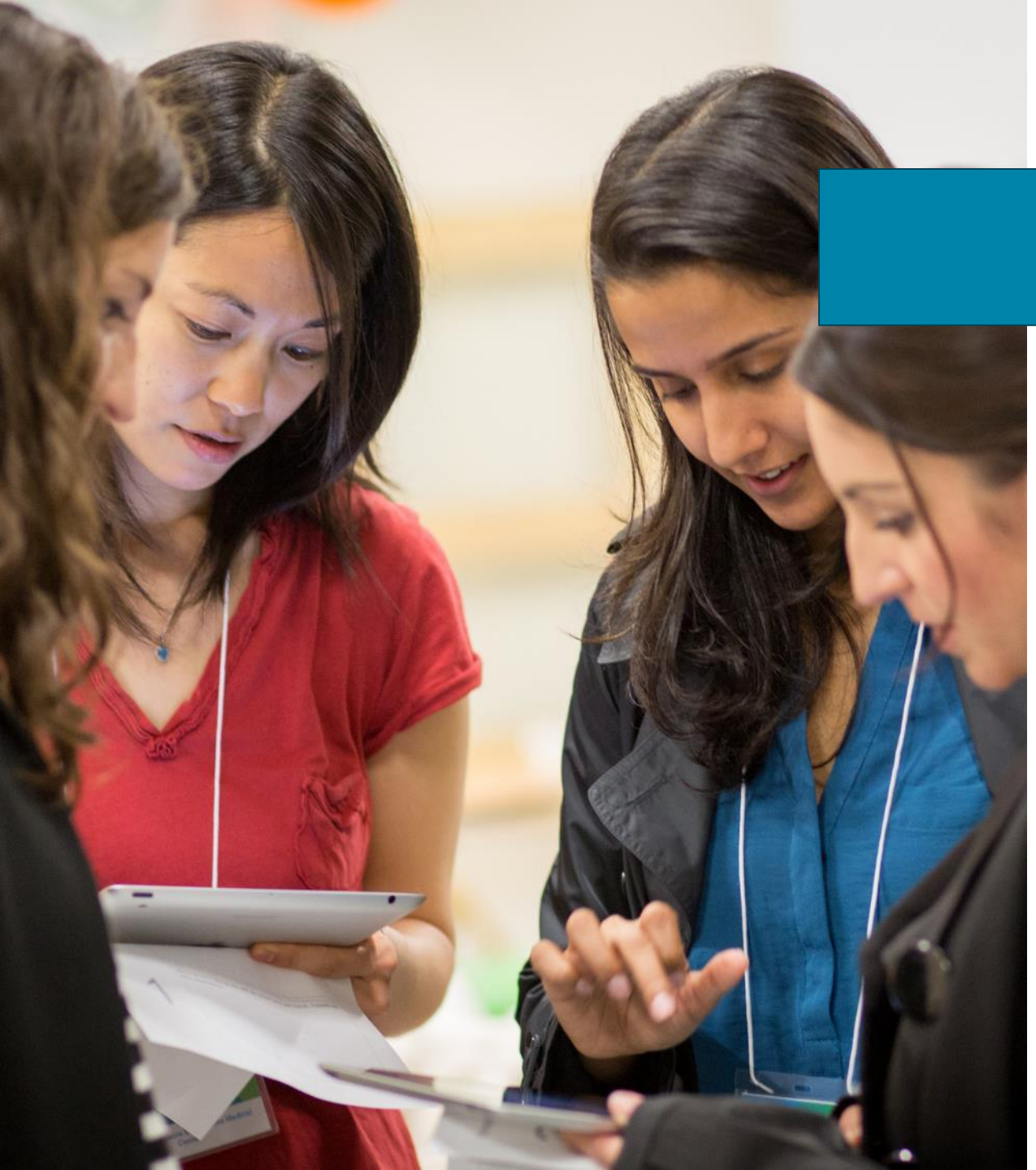
Grassroots volunteer & lay health worker model of care

shanti PROJECT
shanti.org

Care navigation & peer emotional and practical support

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

Bringing enabling & clinical services into the community



Today's Agenda

1. Welcome! & Program Reminders
2. Why Social Needs & Why Now?
3. Hearing from NEVHC & WCHC
4. Lunch
5. Breakout Sessions
6. Team Time
7. MCU Program Co-Design

Housekeeping

Bathroom

Wi-Fi

Take Breaks!

Program Overview

Moving Clinics Upstream

In partnership with Cedars-Sinai, CCI launched 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.

Program Support & Delivery

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

Individual Priority Project

In-Person Sessions

Site Visits

Coaching

Toolkits & Resources

Access to Technical Experts

Virtual learning

Metrics Support as needed

Peer Learning Community

Moving Clinics Upstream Timeline

Phase 1: Getting Started & Building Your Foundation

Sept 2019 – Dec 2019

Program Activities

- In-Person Sessions: Sept 26
- Virtual Learning: Weekly Office Hours with Jill Rees
- Site Visits: Site Visits: NEVHC & WCHC Nov. 2019
- Coaching: Monthly

Deliverables

- Project Plan Roadmap: By Oct 15
- Baseline Assessment: By Nov 1
- December Webinar Presentation: Dec 9 & 16

Goals

- Build & clarify program team
- Assess your organization's strengths & opportunities
- Gather & synthesize staff, patient & community input to inform strategies
- Inventory current partnerships

Phase 2: Testing & Implementing Your Project & Developing Core SDOH Capabilities & Infrastructure

Jan 2020 – Aug 2020

Program Activities

- In-Person Sessions: Mar 2020; Aug 2020
- Virtual Learning: Monthly (except Mar & Aug)
- Site Visits: National Site Visits Feb. 2020
- Coaching: Monthly

Deliverables

- Share & Learn Webinars: Feb & May
- Roadmap Update: By Apr 2020
- Y1 Program Interviews: Aug 2020

Goals

- Develop or refine a plan for how to identify food insecurity or transportation, via a screening tool or other mechanism
- Start testing approaches to identify & address food insecurity or transportation at least one clinical site
- Assess your partnerships and referrals

Phase 3: Spreading & Sustaining Your Work

Sept 2020 – Feb 2021

Program Activities

- In-Person Sessions: Feb 2021
- Virtual Learning: As needed
- Coaching: Coaching ends by Oct 2020. Coaches available as needed.

Deliverables

- Session Presentation: Feb 2021
- Endline Assessment: By Mar 31 2021
- Final Case Study: By Apr 2021

Goals

- Address gaps in referrals or partnerships
- Document internal workflows and protocols
- Document impact of efforts
- Spread lessons within organization and to other work to address social needs

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
- Coaching will occur **monthly between October 2019-October 2020**, and as needed after that. Vanessa is available to meet both **by phone & on site**.

Site Visits

- Intended to **inspire** you and provide **guidance** for work in the program
- Expect to send up to 2 team members per site visit

  First round: **November 2019!**
  - NEVHC: **Nov. 6**
  - West County : **Nov. 20**

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Phase 1: Building Your Foundation

September 2019-December 2019

Build your team & clarify roles	❑Establish a regular meeting schedule with your team ❑Clarify who is your team lead and other important roles ❑Set up a monthly time to meet with your coach Vanessa
Assess your organizations' strengths and opportunities, including leadership and staff buy-in	❑Take the baseline assessment as a team within the next month
Gather & synthesize staff, patient & community input to inform strategies	❑Use today to develop a 3-month plan to gather input ❑Sign up to meet with our HCD mentor Jill ❑Report back your findings in December during a virtual session
Inventory current partnerships and relationships to address food insecurity or transportation	❑Start some of this work together during our breakout sessions ❑Continue it through your research

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.

Invitation

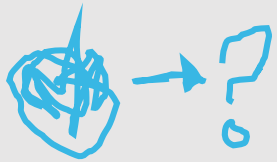
Come into the program **open-minded** & willing to **modify your proposed solution**

Design Thinking

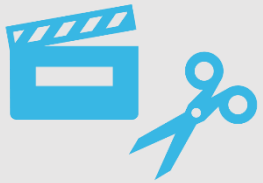
Human-centered design, also known as a "design thinking," is an approach to problem solving that is collaborative, creative, and begins by understanding people's needs and experiences.

collaboration

inclusion + empathy



show work early + often



make things tangible

start small + learn fast

Virtual HCD Mentor

- Dr. Jill Rees, Licensed Clinical Psychologist & Coach, West County Health Centers
- CCI Catalyst Program Alumni
- Helps with **troubleshooting** and assists your team with gathering end user input and synthesizing themes
- Available October-December 2019
  - Mondays 11am-1pm
  - By appointment outside office hours

Warm Up Time!

Show & Tell About Your Wallet!

- Break into groups of three and assign a "participant", an "interviewer" and a "observer."
- Interviewer: Ask the participant to share about their wallet. Use the prompts on the next page to start.
- Practice: listening, waiting through participant pauses, asking open-ended questions.
- Be curious and respond authentically to what the participant shares.
- Rotate roles when you hear the signal.

Some Starting Prompts...

- **Story behind the wallet.** "Tell me about how you acquired the wallet." "What do you like about it?" "What don't you like?"
- **Overall use of the wallet.** "Tell me about how you use the wallet." Where you carry it, when you use it.
- **Inventory.** Share with me some of what is in your wallet and what you use them for.
- Probe interesting details.
- Switch when you hear the signal.

Reflection

- How did the exercise feel?
- What was challenging about the exercise?
- Did you learn something interesting or surprising during the exercise?

Why Social Needs & Why Now


Health Leads


Aunt
BERTHA
.COM
CONNECTING PEOPLE AND PROGRAMS


THE
COMMONWEALTH
FUND


AAPCHO


one degree


NATIONAL ASSOCIATION OF
Community Health Centers


UnitedHealthcare


KAISER PERMANENTE


OCHIN


HealthBegins


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION


Cerner


Humana.


THE
ROOTCAUSE
COALITION™


Epic


siren
Social Interventions Research
& Evaluation Network


THE AMERICAN ACADEMY OF PEDIATRICS


UNITE US


Robert Wood Johnson
Foundation

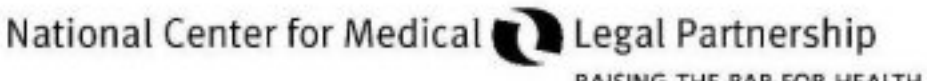

Cincinnati
Children's®
Hospital Medical Center


PRAPARE
Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences


PROMEDICA
TOLEDO HOSPITAL


BOSTON MEDICAL CENTER
Graduate Medical Education
EXCEPTIONAL CARE WITHOUT EXCEPTION


Healthify


National Center for Medical Legal Partnership
RAISING THE BAR FOR HEALTH

Social Determinants of Health= Buzzword of 2019

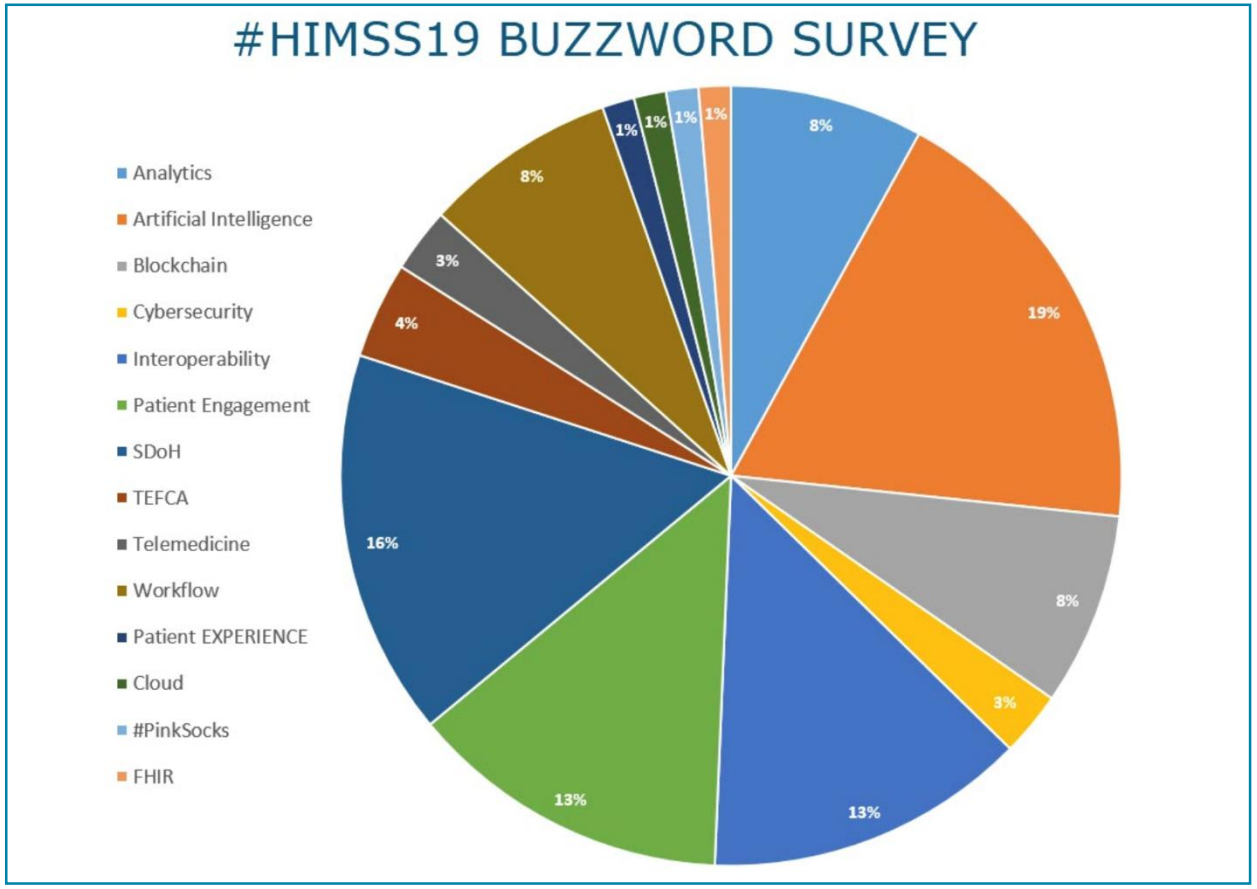
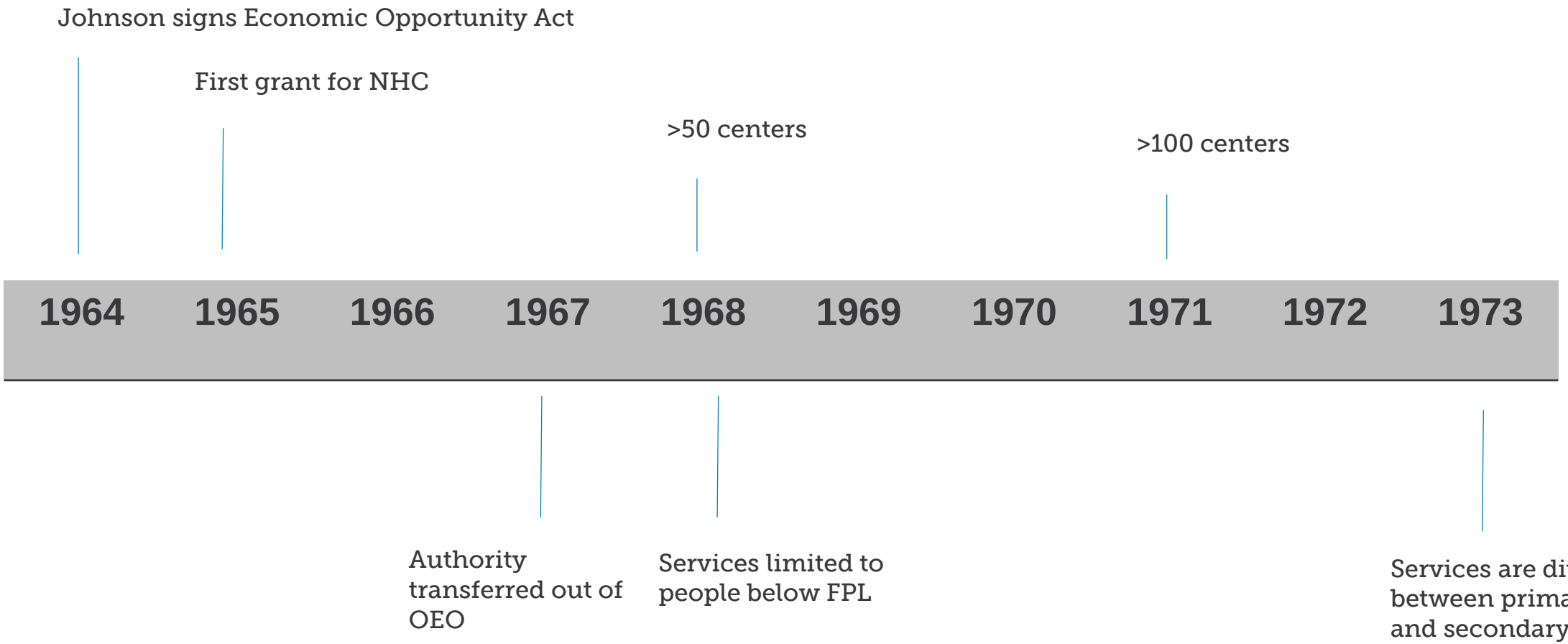


FIGURE 1: WHAT DETERMINES HEALTH?
(ADAPTED FROM MCGINNIS ET AL., 2002)

"Why not make medicine an instrument of social change?"

Funding Changed Focus



*Courtesy of Lauren Taylor

Changing Environment & Trends

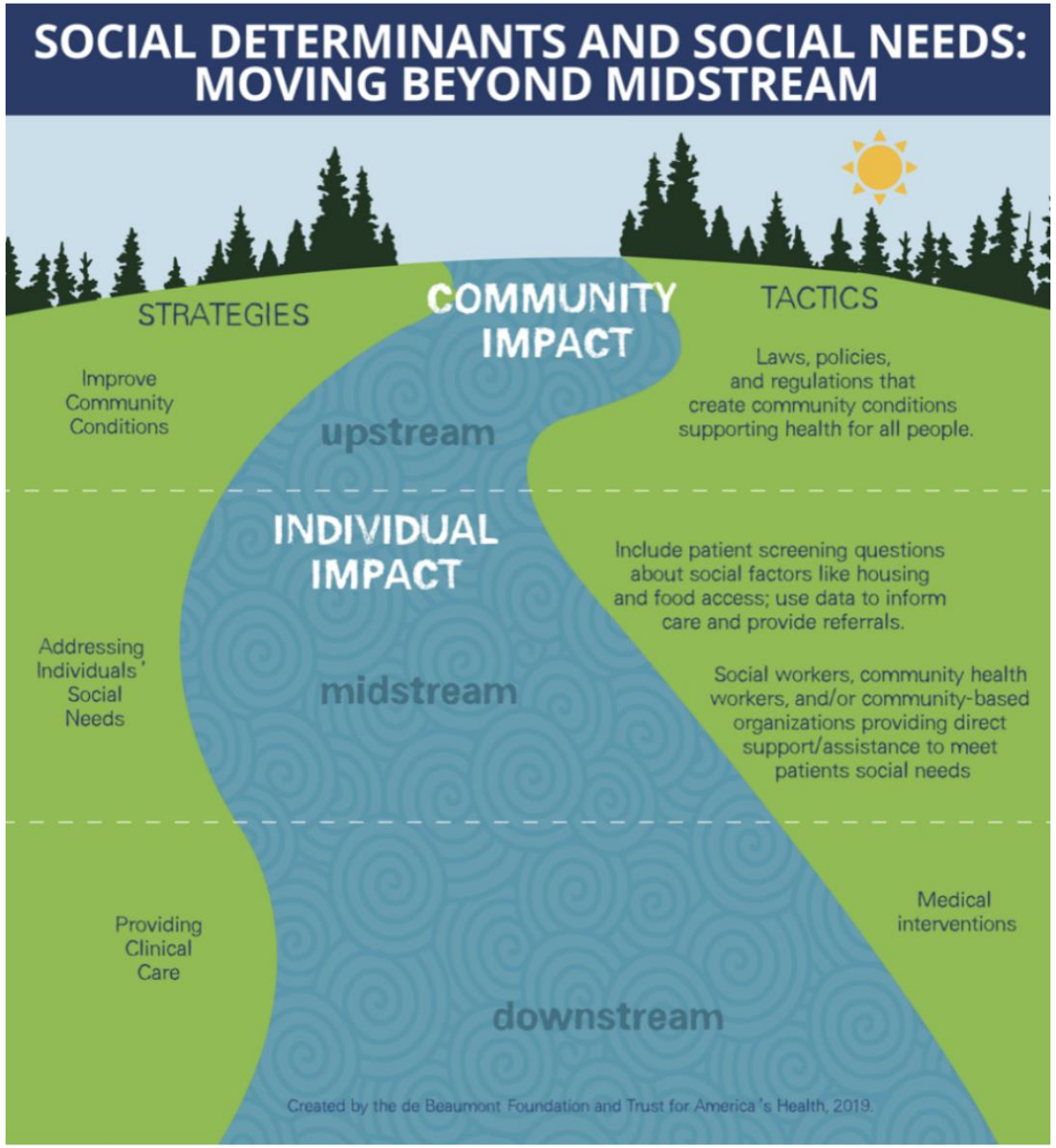
1. Complex challenges require going beyond the walls of health centers (Social Needs, Trauma, Opioids)

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, EHR Integration, Data Sharing)

What are we talking about?

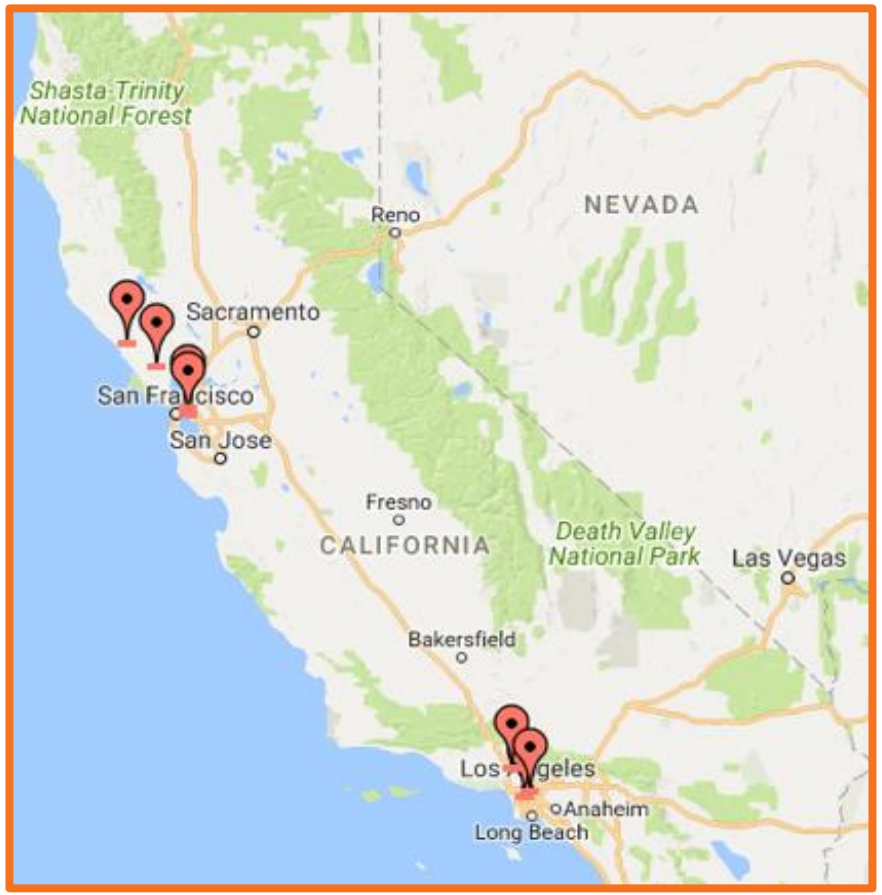
- WHO: "...the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices."
- CDC: "...the complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services and structural and societal factors."
- RWJF: "Health starts where we live, learn, work and play."



Social Determinants of Health?

Social Needs?

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/

Lesson #1: Win Buy in at Every Level	It's important to include everyone — nurses, providers, community health workers, executives, etc. — in this process. Frontline staff are often the best leaders and champions of this work. When strong leadership support and organizational buy-in exists, the main challenge becomes "the how." Figuring out how to best screen, track referrals, and integrate data becomes more important than making a case for doing the work.
Lesson #2: There's Value in Screening	Staff may feel uncomfortable asking patients about their social needs. However, using a screening tool or integrating questions into regular visits can be valuable to better understanding the overall needs of a patient. Some clinics are using PRAPARE, some are using other validated or homegrown tools. Others are combing tools and approaches.
Lesson #3: And There's Value in Focusing on Patient Stories	During site visits in Hawai'i, our teams were introduced to the island concept of "talk-story." We learned to hear patient stories and build connections through community health workers, navigators, and community leaders. Even without formal data, these roles know what patients really need. While protocols, like screening processes and tools, are important, so is coming together to eat food and cultivate relationships. Take the practice of understanding people's personal narratives very seriously. Listen, listen, listen.
Lesson #4: Vet your Referral and Partners	Before you make a referral, be sure to develop some personal knowledge about that intervention. Build relationships to facilitate "warm handoffs" between the clinic and the community. At the same time, realize that not all patients require the same level of assistance. The intensity of the assistance should be tailored to match the complexity of their needs.

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

Reflection & Team Sharing

- Reflect on Sticky Notes (5 minutes):
    - What do you think are the biggest problems related to food security or transportation at the community level? Why do you think these exist?
    - And what do you think is the role your clinic should play in addressing food insecurity or transportation?
- Team Sharing (10 minutes)
- 1-2 takeaways to share with the group


BREAK

Bringing in Patient & Community Input to Address Social Needs

WEST COUNTY HEALTH CENTERS
PRESENTS

Responding to Transportation using Hitch Health

Lessons learned from rural Western Sonoma County

Understanding the Problem

Prepared by: Kathleen Figoni & Eve Harstad

MAIN DISCUSSION POINTS

- What problem are we trying to solve?
- What is Hitch Health?
- Using Human Centered Design to understand our problem
- Lessons Learned from PHASE 1
- Engaging staff & patients throughout our Project PHASEs
- Recommendations

AGENDA

THE PROBLEM

When our patients do not have reliable transportation, we see an increase in no-show rates, lost clinic revenue and patient health risk. We believe that a patient's lack of access to reliable transportation directly and adversely effects their health by increasing their risk of preventable conditions, emergency departments visits, and hospitalization.

SOLUTION

WHAT IS HITCH HEALTH?

A proprietary technology that automatically initiates a patient ride offer through SMS text using a ride-share service like Lyft when an appointment is scheduled.

WCHC QM Department safely & securely transmits scheduled clinic appointments to Hitch Health

Hitch Health offers a patient ride via a SMS Text Message for their upcoming appointment

Patient replies "YES" to the text message

Text message reminder is sent the day before the visit

The Lyft ride arrives the day of their scheduled appointment

After the patients visit they reply "READY" and Lyft comes & picks them up and takes them home

HITCH HEALTH

TIMELINE

We are here

PHASE 1

Understanding the Problem

PHASE 2

Vet Technology & Project Planning

PHASE 3

Technology Implementation

PHASE 4

Pilot Testing & Data Collection Review

PHASE 5

Sustain & Spread

PHASE 1

UNDERSTANDING THE PROBLEM

OCTOBER - DECEMBER 2016

- Project Lead & Administration Assistant conducted interviews with Community Members & Community Leaders.

JANUARY - MARCH 2017

- Interviews are transcribed, coded & Qualitative Analysis is underway

APRIL 2017

- Transportation is identified as a pressing issue for our community

MAY 2017

- Transportation is identified as the #2 resource referral on Purple Binder (social services referral platform).
- Hitch Health is a technology vendor at CCI's SNIN Conference

JUNE 2017

- To understand the problem more the Project Lead interviews staff & patients to learn more about transportation issues experienced by our communities.

PHASE 1

DATA BREAKDOWN

UNDERSTANDING THE PROBLEM

(12) Stakeholder Interviews
(3) WCHC Interview Team Members
Equipment included: (1) iPad & (1) Microphone

DISCOVERY KIT

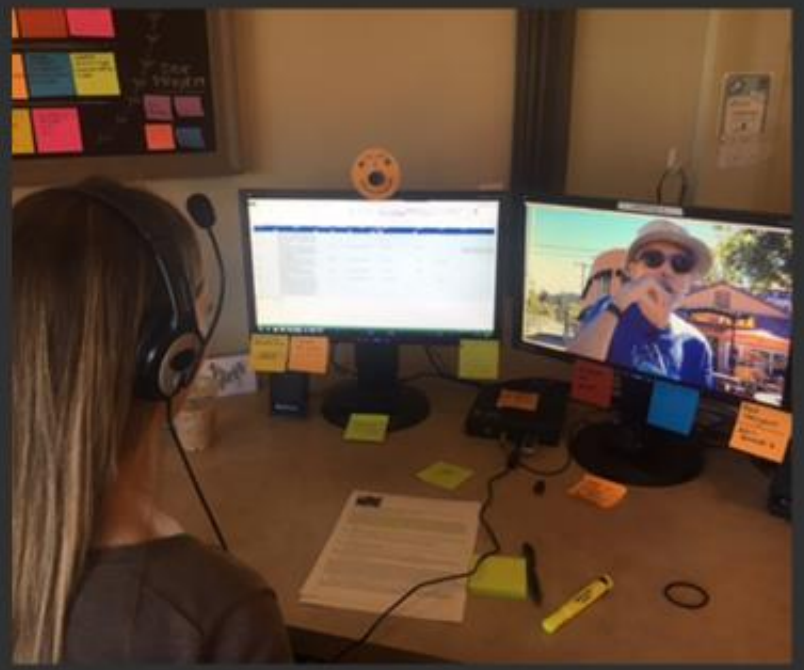
COMMUNITY INTERVIEWS

WORD CLOUD

PHASE 1

UNDERSTANDING THE PROBLEM

Qualitative Analysis



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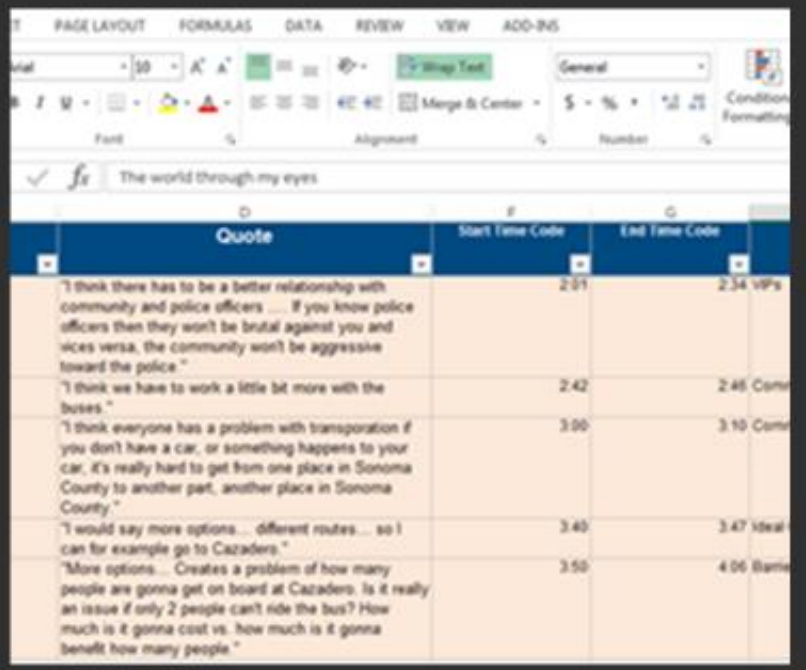


Quote	Start Time Code	End Time Code	
"I think there has to be a better relationship with community and police officers ..... If you know police officers then they won't be brutal against you and vices versa, the community won't be aggressive toward the police."	2:01	2:34	VIPs
"I think we have to work a little bit more with the buses."	2:42	2:46	Comm
"I think everyone has a problem with transporation if you don't have a car, or something happens to your car, it's really hard to get from one place in Sonoma County to another part, another place in Sonoma County."	3:00	3:10	Comm
"I would say more options... different routes... so I can for example go to Cazadero."	3:40	3:47	Ideal
"More options... Creates a problem of how many people are gonna get on board at Cazadero. Is it really an issue if only 2 people can't ride the bus? How much is it gonna cost vs. how much is it gonna benefit how many people."	3:50	4:06	Barrie

CODING

THEMES & INSIGHTS

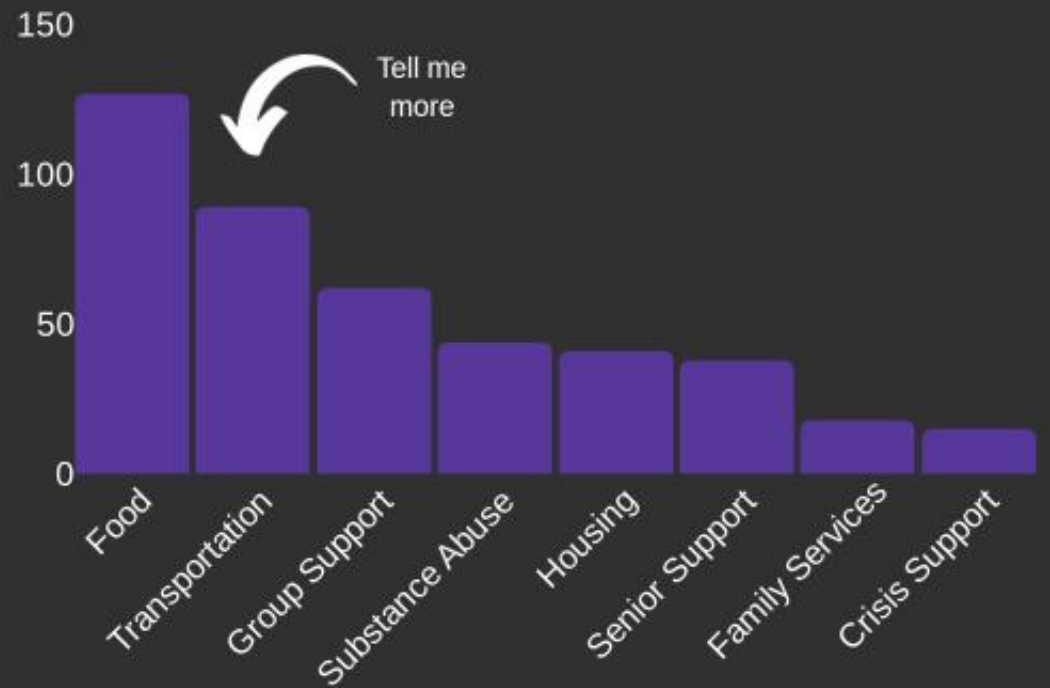
PHASE 1

UNDERSTANDING THE PROBLEM

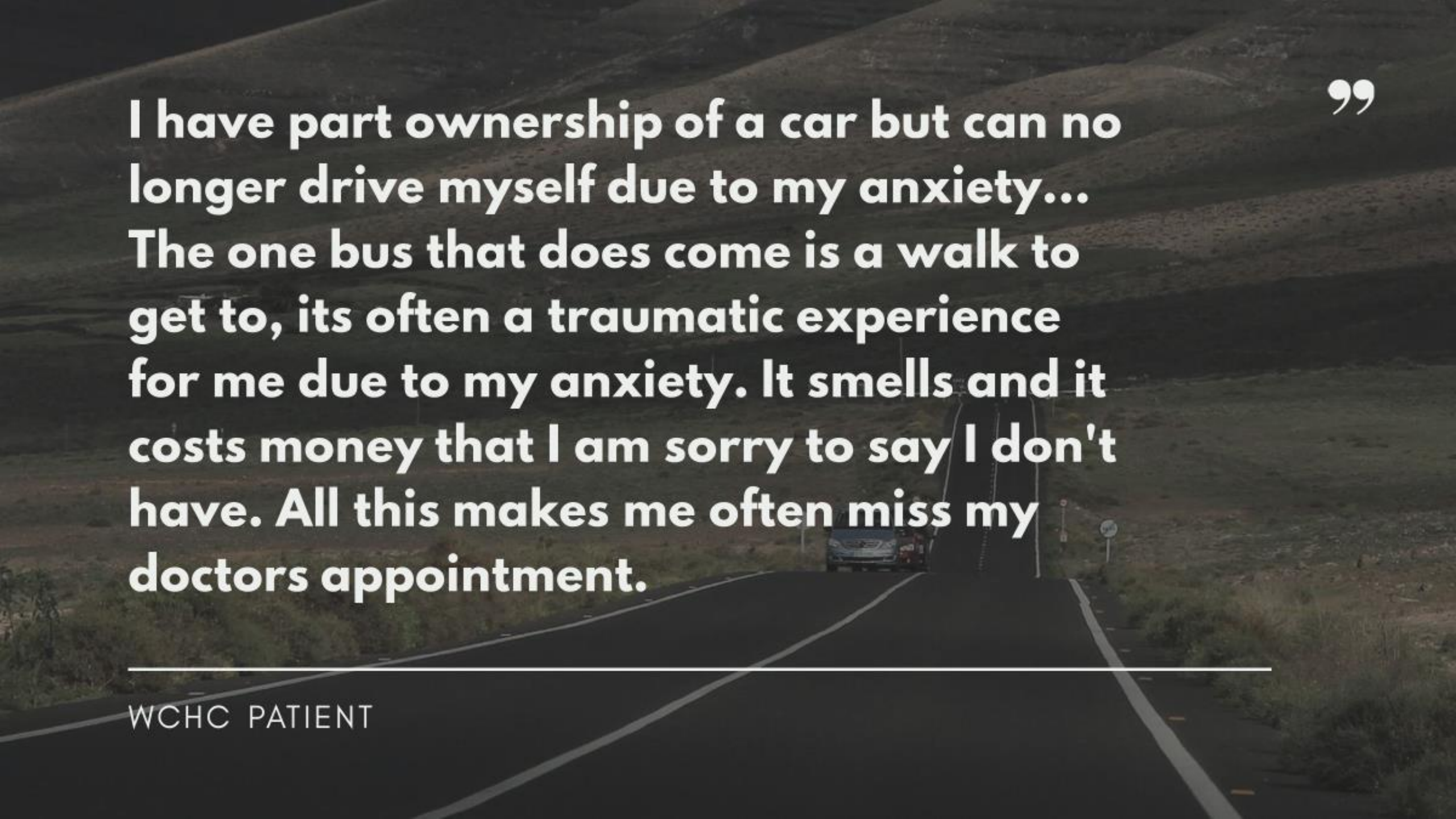
Purple Binder

A web-based platform that helps health care providers connect patients to up-to-date, local social service information and support.

ACCESS COORDINATOR REFERRAL



RESOURCE REFERRALS



I have part ownership of a car but can no longer drive myself due to my anxiety... The one bus that does come is a walk to get to, its often a traumatic experience for me due to my anxiety. It smells and it costs money that I am sorry to say I don't have. All this makes me often miss my doctors appointment.

WCHC PATIENT

”

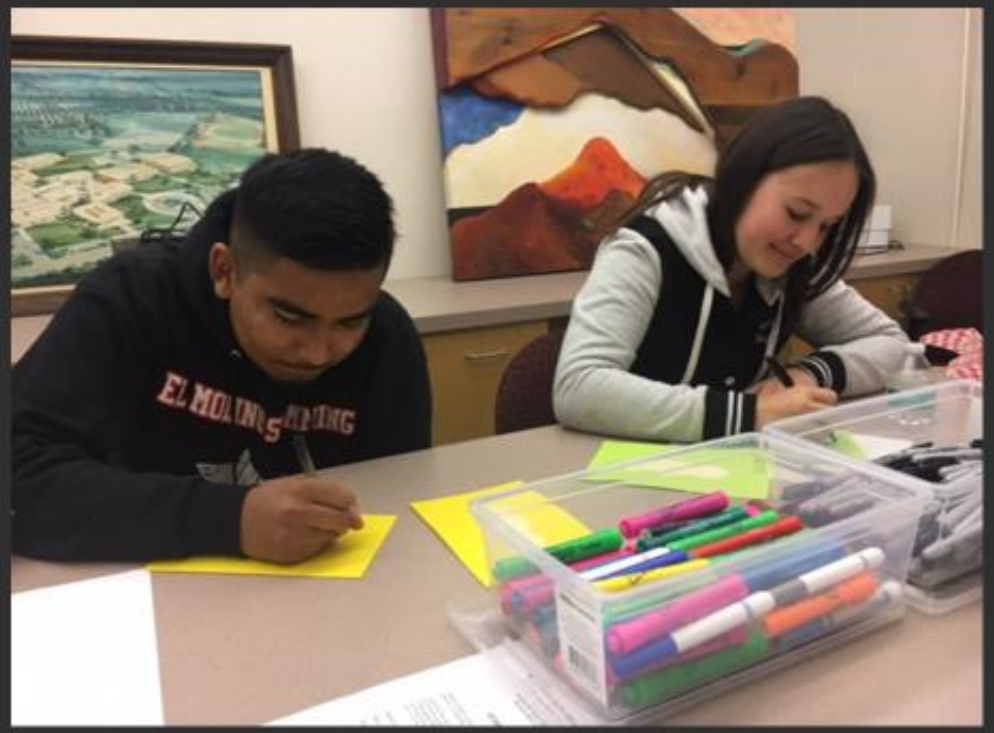
I spend hours on the phone with patients trying to find them rides. Our managed care insurer often cancels the day of the appointment so we scramble trying to get our patients here.

WCHC REGISTERED NURSE

PHASE 1

UNDERSTANDING THE PROBLEM

Draw your experience - The Teen Experience



> The closer you get to the ocean the less likely you have access to the bus and the more likely my peers experiment with drugs because well...we are bored.

LESSONS LEARNED

PHASE 1

Reach out to an array of individuals to understand the problem.

Interview patients, staff, community partners - anyone that you have determined is a stakeholder.

It's okay to interview again.

Our first set of interviewees gave us great insight but we had more questions.

Thematic saturation will determine when the interview process has ended.

We kept hearing the same thing over & over and that's when we knew we were done collecting data in PHASE 1.

This work takes time but if your project team carries out a research plan it can be completed in 3 - 4 months.

It's important to be curious and let the end user guide you throughout the interview process HOWEVER, it's okay to stop the interview if their is a critical patient care or staff need that has been identified that you can help them with or redirect them to.

STAFF & PATIENT ENGAGEMENT


TUBBS FIRE |OCTOBER 2017

PHASE 2

VET TECHNOLOGY & PROJECT PLANNING

OCTOBER - DECEMBER 2017

- Tubbs Fire
  - Listening Sessions at Sonoma County Department of Public Health - Health Action Council

West County Health Centers

APPROVED BY patient family council

PHASE 3

TECHNOLOGY IMPLEMENTATION

FEBRUARY 2018

- Patient & Family Council Listening Session
  - Hitch Health standardized text messages
    - Low literacy language addressed

MARCH 2018

- Pilot #1: Technology Implementation
- Pilot #2: RELAUNCH Technology Implementation
  - Patient Experience Simulation with Patient & Family Council & Staff

PATIENT & STAFF INTERVIEWS

We are here

PHASE 4

PILOT TESTING & DATA COLLECTION REVIEW

JULY 2018

- Pilot #3: One week of scheduled appointments at GCHC - Primary Care Visit Only
  - QM Department listening session about hypothesis & results

SEPTEMBER 2018

- Pilot #4: Rolling data with scheduled primary care appts at GCHC
  - Patients & Staff interviewed

OCTOBER 2018

- Pilot #5: On Demand Rides with Healthcare for the Homeless Program
  - Staff interviewed
- Pilot #6: Rolling data with scheduled primary care appts at RRHC
  - Staff & patients interviewed

NOVEMBER 2018 - PRESENT

- Pilot #7: Expand visit types at GCHC
  - Staff & patients interviewed

RECOMMENDATIONS

INTERVIEW, OBSERVE & IMMERSE

UNCOVER THE PROBLEM

To effectively design solutions for the people you are designing for you must first understand and uncover their needs.

Remember these people are your experts. Don't make assumptions about what they need allow them to tell or better yet show you.

UNCOVER THE INSIGHTS

THEMES & CONCEPTS

Gather data from across many dimensions (observations, interviews, draw your experience).

Identify concepts & themes in the data.

Categorize the themes and illustrate with examples from the data.

REFINE THE PROBLEM

FRAME PROBLEM STATEMENT

Your data will uncover many themes.

Together with your project team determine your area of focus.

Developing a How Might We statement will help turn those challenges into opportunities for design.

CONTACT INFORMATION

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a california health+ center

Northeast Valley Health Corporation

Understanding Food Insecurity

Presented by

Debra Rosen, RN, MPH
Director,
Quality & Health Education

Jessica King, MPH, RDN
Associate Director,
Health Education

Contents

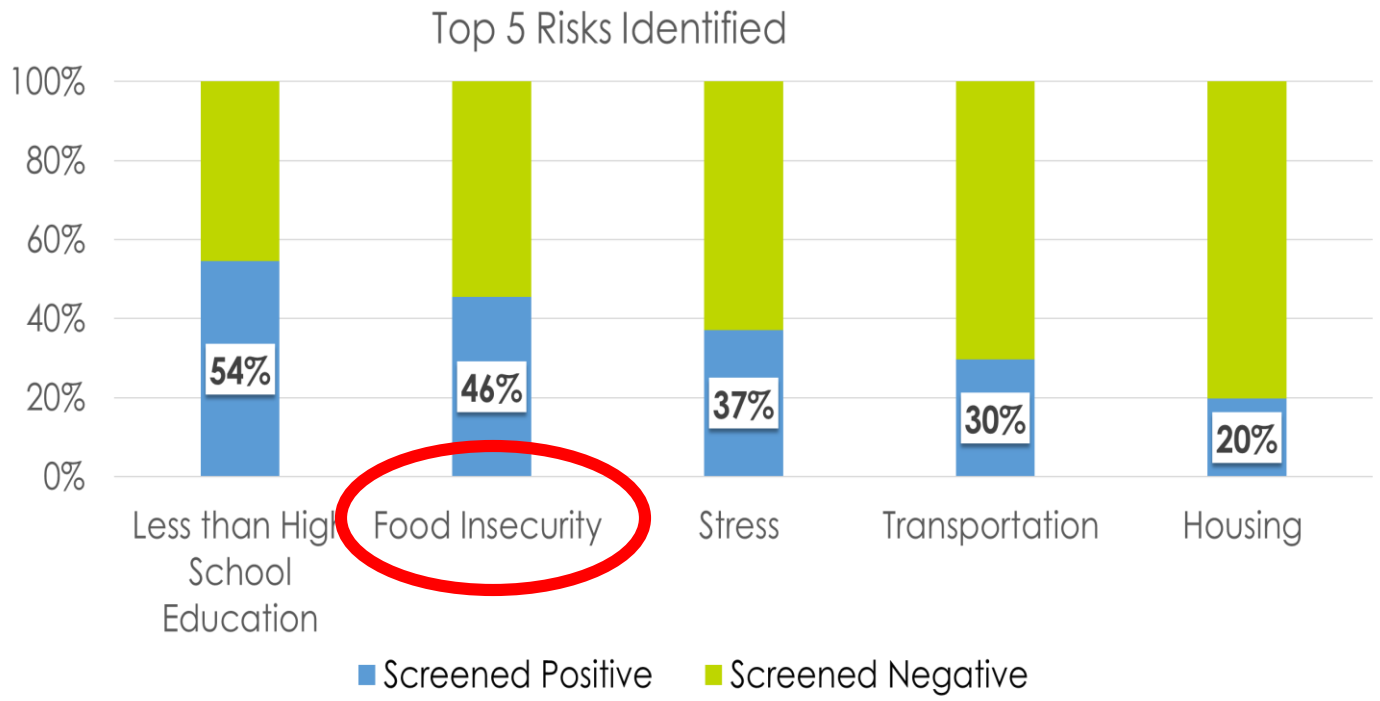
- NEVHC Overview
  - Who we are
  - Population Served
  - Services
- Our Journey
  - Needs Assessment
  - Food Insecurity Screening During Well Child Exams
  - Internal and External Resources
  - Next Steps

Northeast Valley Health Corporation (NEVHC)

- FQHC - PCMH recognized by Joint Commission
- Los Angeles County: SPA 2
  - SF and SC Valleys
- 15 licensed health centers, (2 under construction) 1 mobile, 4 dental clinics, and 13 WIC sites
- 326,441 visits in 2018
- 75,924 users/patients in 2018
- 84.1% Latino
- 93% < 200% of FPL ; 77% < 100% of FPL
- 51% ages 0-17; 49% 18 & up
- 19% uninsured

Social Determinant of Health: Needs Assessment

PRAPARE PILOT (11/18-4/18): 202 Patients Surveyed

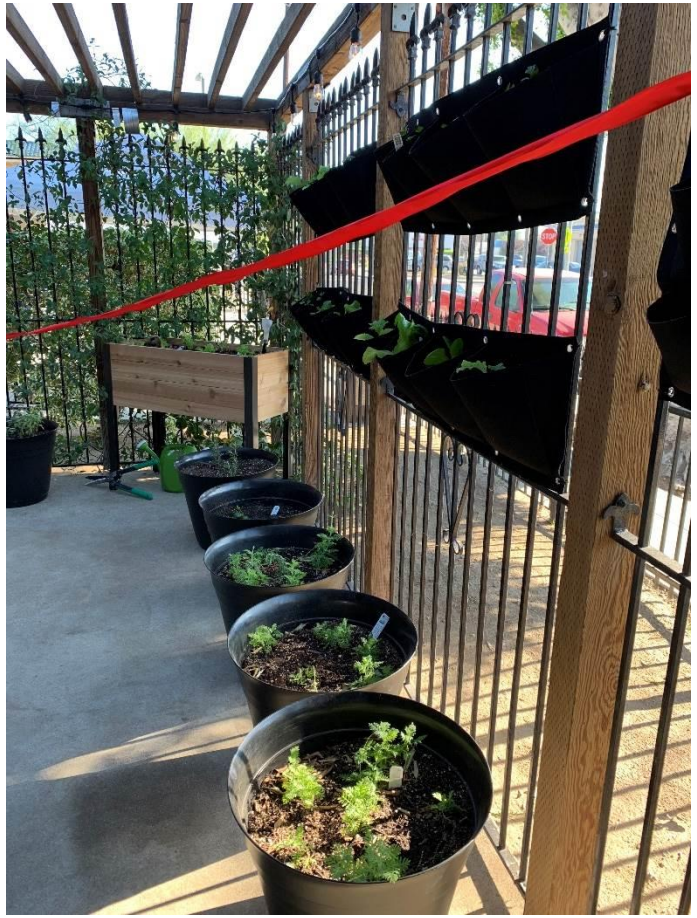


Understanding the Problem

Understanding the Problem: Healthy Food Access

Healthy Food Access: Gave the Stakeholders a Voice.

Vaughn High School Students

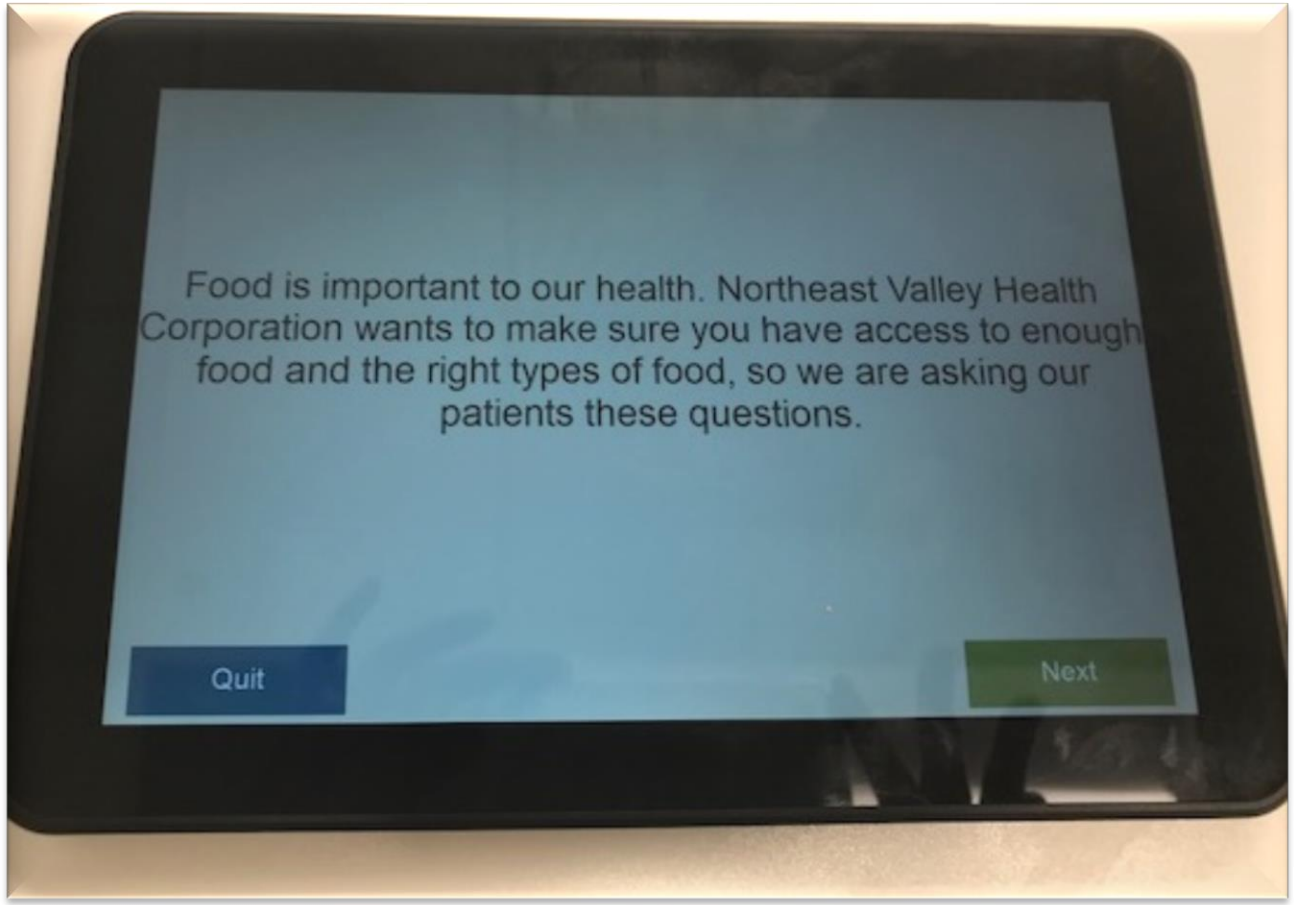


Garden Task Force

Our work within the 4 walls…

Began Food Insecurity Screening during Well Child Exams in February 2018.

Screening Process: Medical Assistant

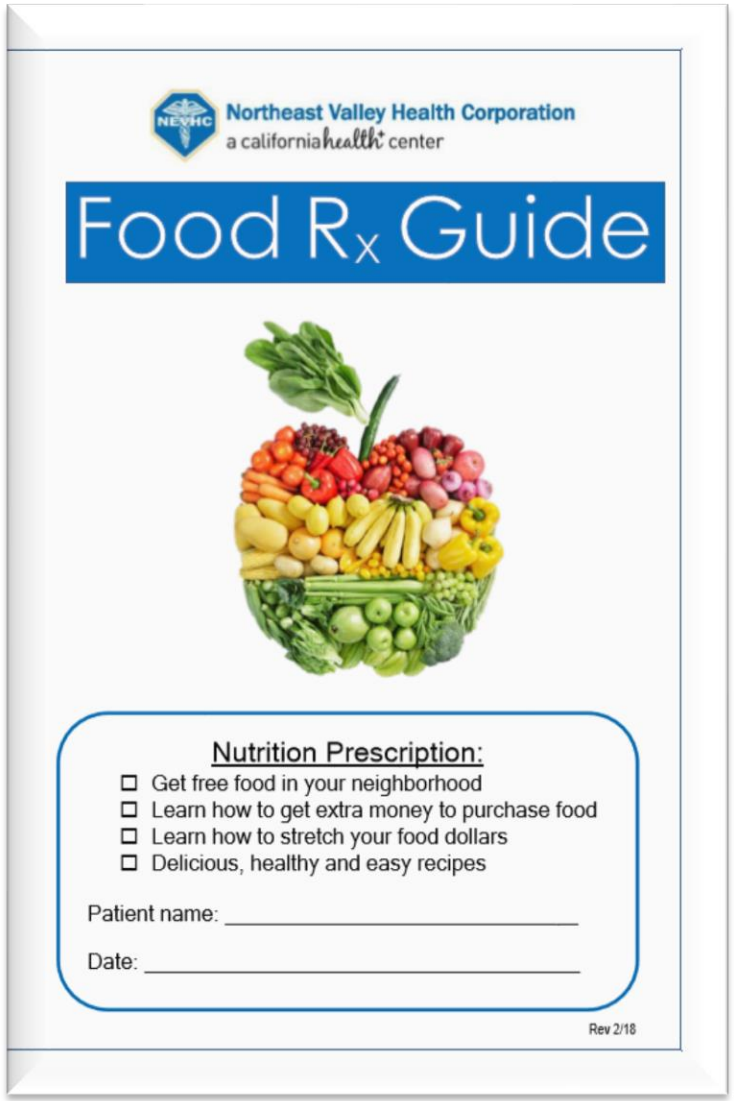


Assessment and Referral: Provider

Ordering Assessment:

#	Detail Type	Description
1.	Assessment	Lack of adequate food and safe drinking water (Z59.4).
	Patient Plan	1. NEVHC Nutrition Referral and Food Rx Guide given to the patient 2. Enroll in One Degree 3. Patient can also call the Community Resource Help Line 818-979-7400 extension 42062

Patient Education and Resources



Northeast Valley Health Corporation
a californiahealth+ center

Food Rx Guide

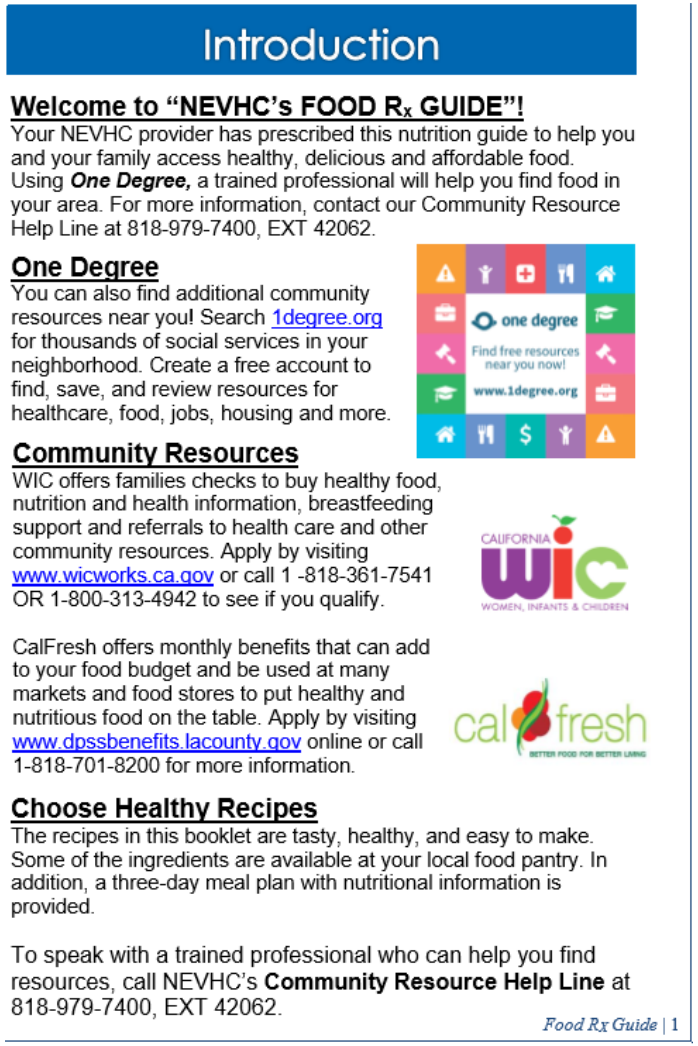
Nutrition Prescription:

- ☐ Get free food in your neighborhood
- ☐ Learn how to get extra money to purchase food
- ☐ Learn how to stretch your food dollars
- ☐ Delicious, healthy and easy recipes

Patient name: _____

Date: _____

Rev 2/18



Introduction

Welcome to "NEVHC's FOOD Rx GUIDE"!

Your NEVHC provider has prescribed this nutrition guide to help you and your family access healthy, delicious and affordable food. Using ***One Degree,*** a trained professional will help you find food in your area. For more information, contact our Community Resource Help Line at 818-979-7400, EXT 42062.

One Degree

You can also find additional community resources near you! Search 1degree.org for thousands of social services in your neighborhood. Create a free account to find, save, and review resources for healthcare, food, jobs, housing and more.

Community Resources

WIC offers families checks to buy healthy food, nutrition and health information, breastfeeding support and referrals to health care and other community resources. Apply by visiting www.wicworks.ca.gov or call 1 -818-361-7541 OR 1-800-313-4942 to see if you qualify.

CalFresh offers monthly benefits that can add to your food budget and be used at many markets and food stores to put healthy and nutritious food on the table. Apply by visiting www.dpssbenefits.lacounty.gov online or call 1-818-701-8200 for more information.

Choose Healthy Recipes

The recipes in this booklet are tasty, healthy, and easy to make. Some of the ingredients are available at your local food pantry. In addition, a three-day meal plan with nutritional information is provided.

To speak with a trained professional who can help you find resources, call NEVHC's **Community Resource Help Line** at 818-979-7400, EXT 42062.

Food Rx Guide | 1

Case Management: Clinical Degreed Nutritionist (CDN)

- Phone follow-up
- Interest in resource linkage
- Text Messaging

Developed Partnerships

- Vaughn School and parents help build the community gardens

Developed Interventions

- Food Swap at Vaughn Family Resource Center

Enhanced Interventions: “Pop-up Produce Markets”

THANK YOU, MEND!

Shared our successes with elected officials, community, and leadership

Looking Forward: Future Spread Goals…

- Screen all pediatric patients for food insecurity at ALL sites
- Create a competent workforce and a culture of empathy within our organization
- Monthly “Pop-up Produce Markets” at 4 sites
- Edible gardens at a minimum of 3 health center sites
- Establish Food Rx Voucher and volunteer program
- Integrate garden activities in care delivery (health education classes, medical nutrition therapy sessions, shared medical visits, etc.)
- Strengthen our Garden Task Force, engage elected officials in strategic planning efforts, serve as a model for health centers across the nation.

Thank you!

- DebraRosen@nevhc.org
- JessicaKing@nevhc.org

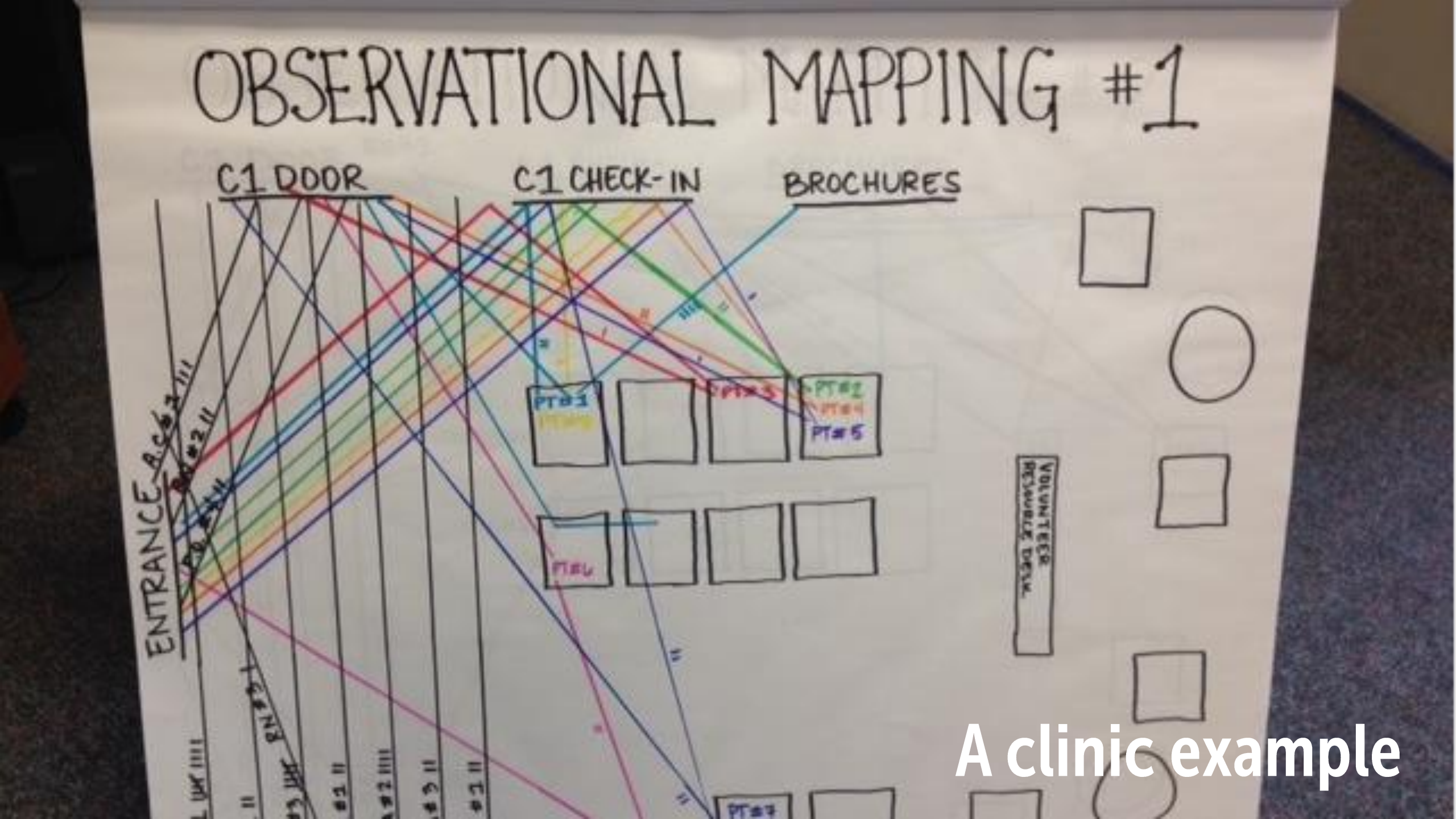
Resources

- Food Insecurity Algorithm for staff
- HVS Workflow
- Food Rx Guide

More Ways of Gaining Input:

Observations & Draw Your Experience

Observations: What do you notice?


OBSERVATIONAL MAPPING #1
C1 DOOR
C1 CHECK-IN
BROCHURES
ENTRANCE
VOLUNTEER RESOURCE DESK
A clinic example

Benefits of doing observations

- See the existing context with fresh, curious eyes
- Understand what really happens
- Develop empathy and insight
- Identify specific pain points or challenges
- Observe the real-world context

Try it yourself!

1. In your same partner pairs, stand facing each other. Identify one person as Partner A & B.
2. Partner A: Take 2 minutes to observe your partner B's appearance.
3. When prompted, spin around and stand with your backs facing each other. Partner B change 2 items on yourselves.
4. When prompted, turn around and face each other again. Partner A attempt to identify the 2 items that changed.
5. Switch!

Draw Your Experience: What is it?

When you're trying to learn about people's experiences, a visual exercise like drawing is a more engaging way to help people articulate what they're feeling, doing, thinking, and saying.

A picture is worth a thousand words, right?

Draw Your Experience: Why it's helpful

- Way to gather more rich information from your stakeholders than a standard survey or interview.
- Conversation between you and a person who is involved in the experience you are trying to make better.
- Will help you in identifying patterns across various stakeholders.

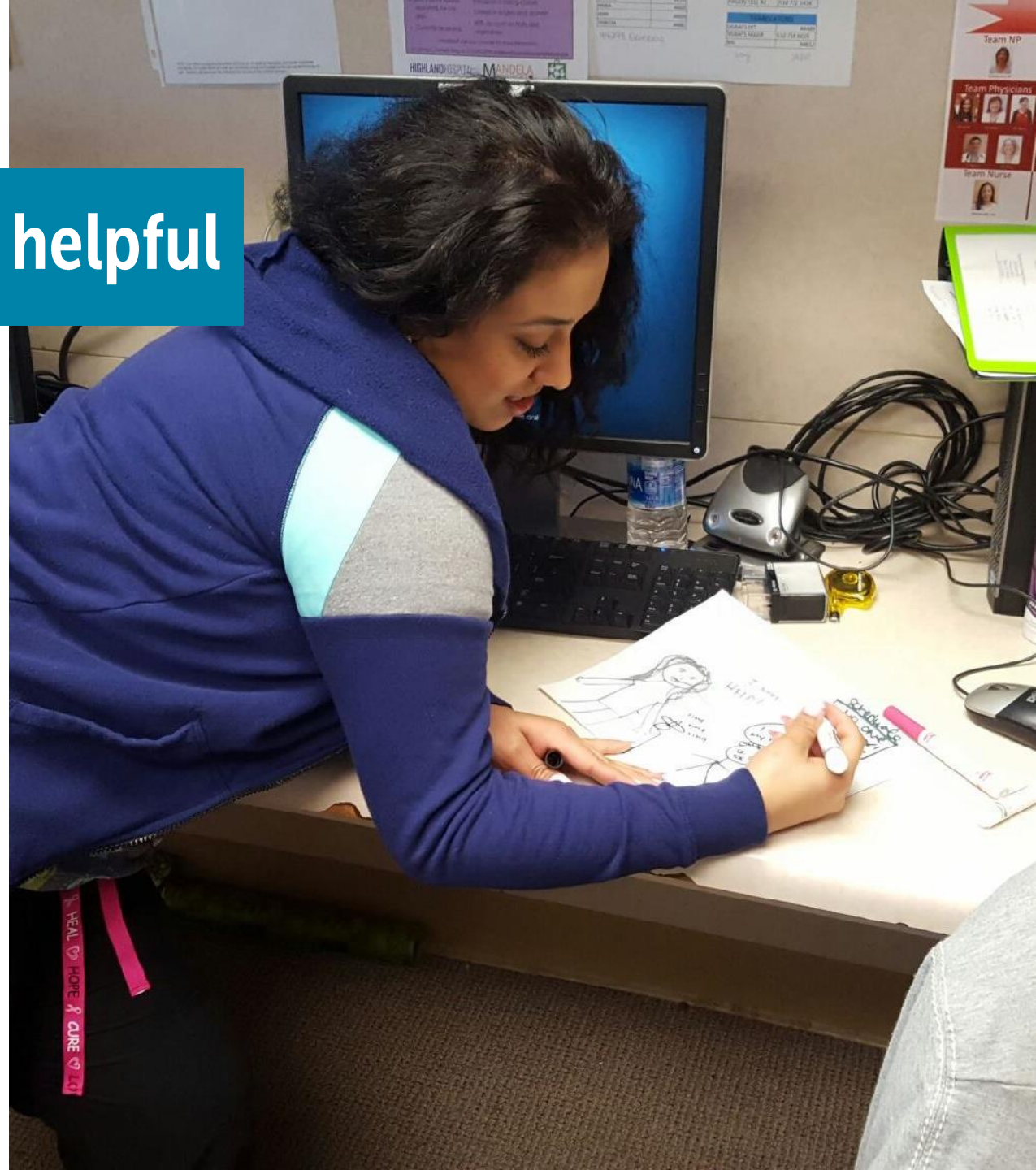


Photo Credit: Alameda Health System

Draw Your Experience: The Basics

1. Think about a person's experience that you want to learn more about.
2. Provide them with two sheets of paper and a colorful marker or two.
3. Write a prompt at the top of each sheet:

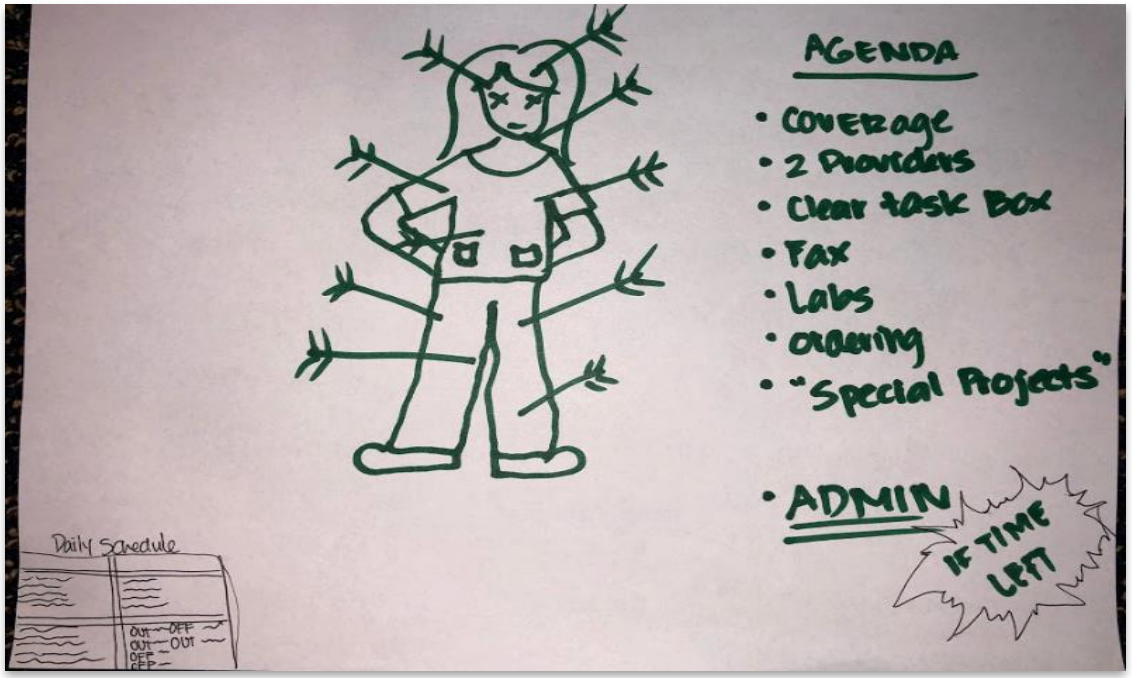
Draw your experience with _____ that was _____ [positive extreme: helpful, great, effective, inspiring].

Draw your experience with _____ that was _____ [negative extreme: tiring, bad, discouraging, unhelpful].

4. Ask them to spend 5-10 minutes drawing individually.
5. Schedule 20 minutes to walk through their drawing. During this time, ask questions & note your observations & any patterns.

Two Drawings

Positive (+) Extreme:
A workday that felt productive.



Negative (-) Extreme:
A workday that felt chaotic.

Try it yourself!

1. **5 min**: Individually, draw your experience on a **great day at work.**

2. **10 min**: Pair up with someone you don't know. Take 5 minutes each to share your drawings. Practice asking open-ended questions! Note your observations during the activity.

3. **5 min**: Large group share-out. What realizations came from doing this exercise with your partner? What would you like to learn more about now?


Out to
LUNCH!

Breakout Sessions

Breakout Session Instructions

- Break out the teams into the 2 focus areas: food insecurity & transportation.
- 10 minutes: Brainstorm on sticky notes who are external organizations/partners:
    1. That you are working with currently,
    2. That you have heard of or would like to work with that are in the field.
- 20-30 minutes: Teams share out and start to cluster.
- Discussion:
    - *Is there anything as a collaborative that we should focus our efforts on together?*
    - *What have been your experiences working with certain partners?*


BREAK

Team Time

Techniques That You've Learned

Open Ended Interviews

Draw Your Experience

Observation

Why use these Techniques & Others?

- To understand what is really going on and why
- To make your project tangible by having lots of visual evidence, examples & references
- To broaden your capacity for designing a better solution

The Attitude to Bring to the Work

Curiosity and learning → Investigator, explorer → No assumptions -- leave what you think you know behind for now

What do you want to learn?

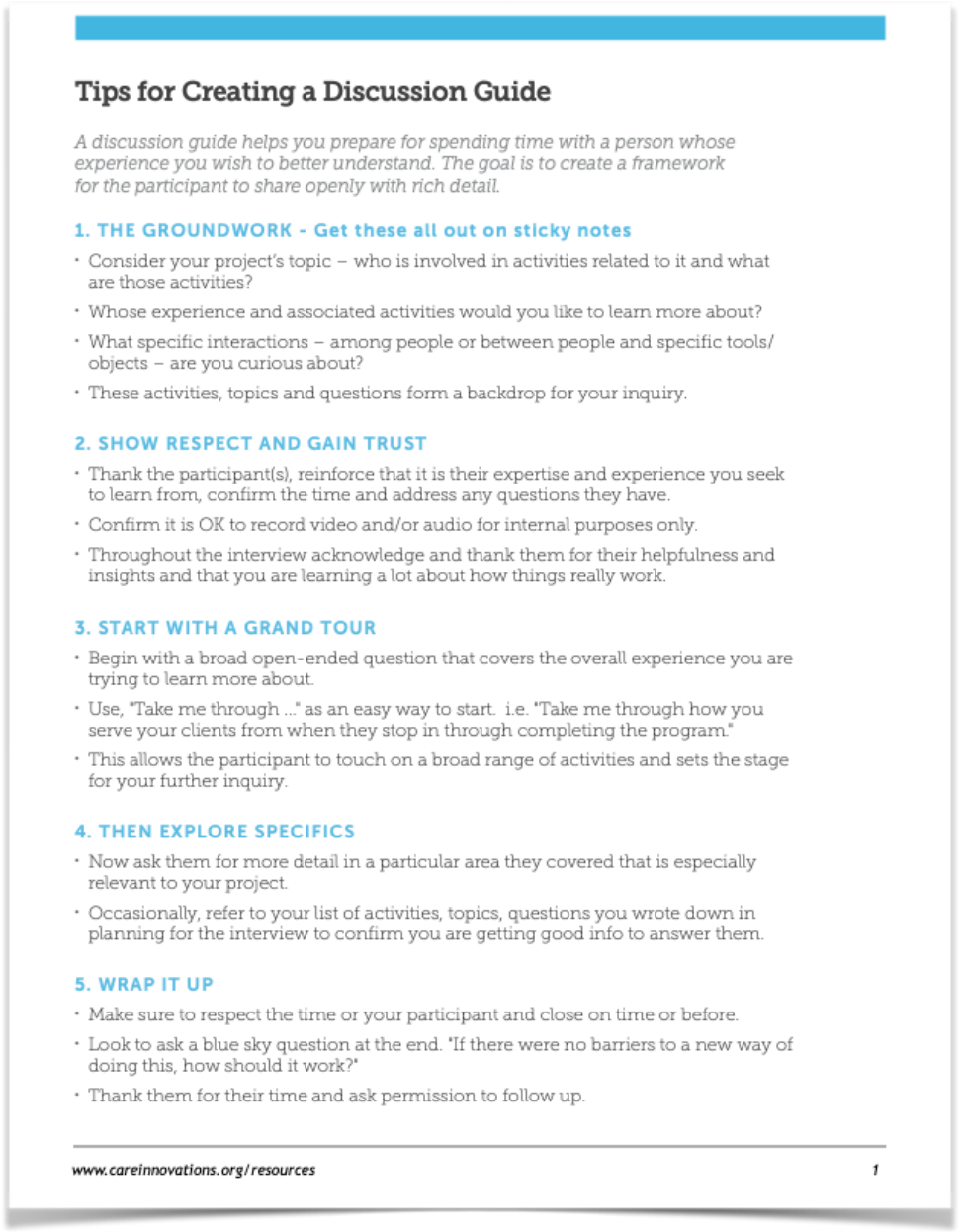
Who can you learn from?

How can you recruit people?

What do you want to learn?

- Clarify activities or experiences you wish to better understand. Identify topics or questions that you'd like to know about.
- Cover pre-discussion logistics. Patient/ community is expert, want to know what really happens, timing, etc.
- Open with a "grand tour" question. "Tell me about a typical day..."
- Follow with open-ended questions focused on what participant is sharing with you and relates to your planned topics and questions.
- Listen, don't talk. Use "Tell me about..." more than direct questions.

Tip Sheet for Creating a Discussion Guide



Tips for Creating a Discussion Guide

A discussion guide helps you prepare for spending time with a person whose experience you wish to better understand. The goal is to create a framework for the participant to share openly with rich detail.

1. THE GROUNDWORK - Get these all out on sticky notes

- Consider your project's topic – who is involved in activities related to it and what are those activities?
- Whose experience and associated activities would you like to learn more about?
- What specific interactions – among people or between people and specific tools/objects – are you curious about?
- These activities, topics and questions form a backdrop for your inquiry.

2. SHOW RESPECT AND GAIN TRUST

- Thank the participant(s), reinforce that it is their expertise and experience you seek to learn from, confirm the time and address any questions they have.
- Confirm it is OK to record video and/or audio for internal purposes only.
- Throughout the interview acknowledge and thank them for their helpfulness and insights and that you are learning a lot about how things really work.

3. START WITH A GRAND TOUR

- Begin with a broad open-ended question that covers the overall experience you are trying to learn more about.
- Use, "Take me through ..." as an easy way to start. i.e. "Take me through how you serve your clients from when they stop in through completing the program."
- This allows the participant to touch on a broad range of activities and sets the stage for your further inquiry.

4. THEN EXPLORE SPECIFICS

- Now ask them for more detail in a particular area they covered that is especially relevant to your project.
- Occasionally, refer to your list of activities, topics, questions you wrote down in planning for the interview to confirm you are getting good info to answer them.

5. WRAP IT UP

- Make sure to respect the time or your participant and close on time or before.
- Look to ask a blue sky question at the end. "If there were no barriers to a new way of doing this, how should it work?"
- Thank them for their time and ask permission to follow up.

Who Can you Learn From?

1. Who can we learn from?
2. Where can we go to learn more?
3. What processes should we use to better understand?
4. How many people should we talk to?
5. Who will lead this work?

WHO TO RECRUIT:

- Patients & Families
- Colleagues & Staff
- Community Partners
- People inside and outside the organization for new inspiration

How Can You Recruit People?

1. Share the goal of your project
2. Consider planned or opportunistic encounters
3. Invite them to participate and share their experiences in an environment comfortable to them
4. Identify a time that works for them to talk and/or observe them

Remember: People want to help, getting people to interview and observe may be easier than you think 😊

Helpful Tips!

- Treat this just like you would hosting a gathering in your home - be aware, empathetic, helpful!
- Plan the event, invite participants, host the event, follow up from the event
- Have positive energy throughout - learning from others is a gift and builds community
- Find simple ways to appreciate and thank participants
- Recruit obvious and not-so-obvious participants

Team Team

Instructions

- With your team, use the project planning worksheet to prepare:
  - Which **stakeholders** will you research after this session?
  - Which **staff** will lead your working gathering end user input ?
  - What **method(s)** will you use?
  - What **questions** will you ask?

Next Steps

- ❑ Office Hours with Jill
  - ❑ Mondays 11am-1pm between October & early December
- ❑ Project Planning Worksheet
- ❑ December Sharing Webinars

Help Us Co-Design MCU

I Like, I Wish, I Wonder

Spend 5 minutes *individually* capturing your thoughts on sticky notes.

What I like about the program

What I wish could be different about the program

What I wonder about and still need to better understand about the program

Next Steps & Closing

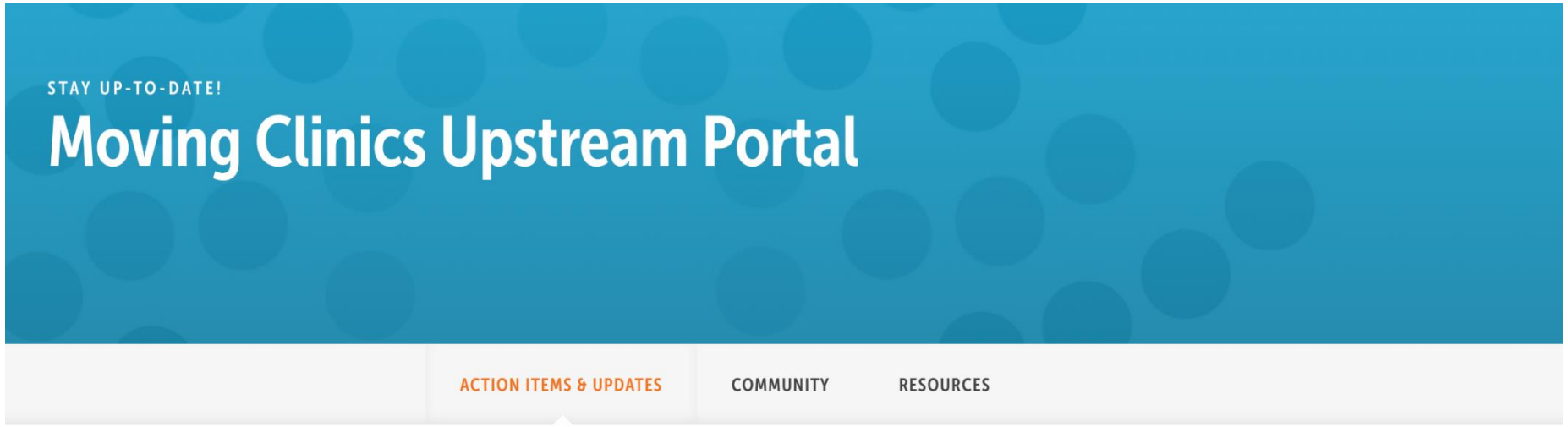
Communication Tools

Monthly Newsletter

Calendar invites for big events

CCI Program Portal Page

Portal

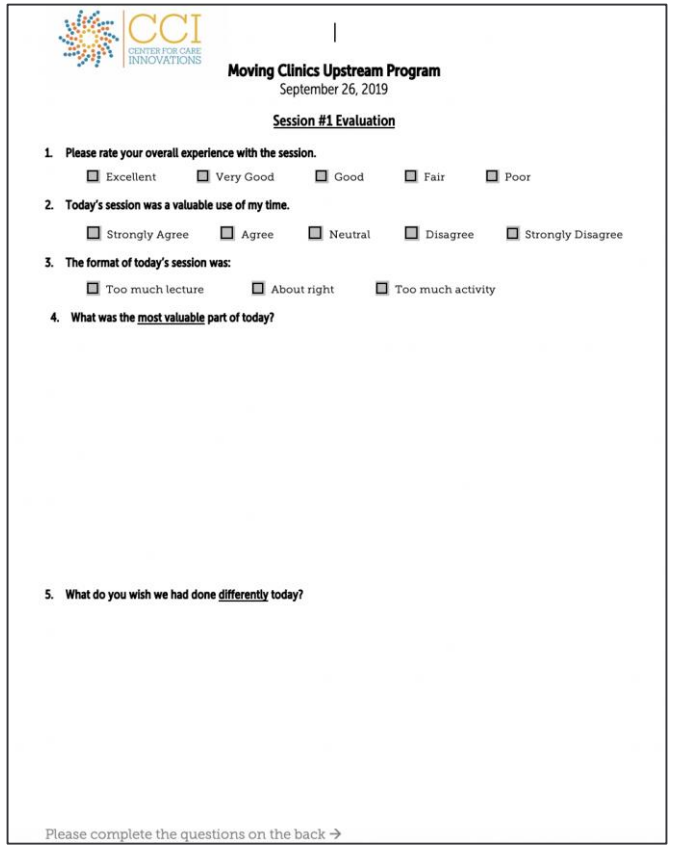


https://www.careinnovations.org/moving-clinics-upstream-portal/

Ask & Next Steps

- ❑ **Coach:** Find a monthly time to meet with your coach Vanessa.
- ❑ **HCD Mentor:** Schedule a time to meet with Jill.
- ❑ **Project Planning Worksheet:** Turn your worksheet into action & start gathering end user input!
  - ❑ **October 15:** Send it to Diana (diana@careinnovations.org).
- ❑ **Baseline Assessment:** With your team, complete the baseline assessment.
  - ❑ **November 1:** Send it to your coach Vanessa.
- ❑ **Site Visit:** Sign up for a site visit!
  - ❑ **November 6:** NEVHC
  - ❑ **November 20**: West County
- ❑ **Webinars:** Save the dates for the December sharing webinars:
  - ❑ **December 9:** Transportation
  - ❑ **December 16:** Food Insecurity

Evaluation



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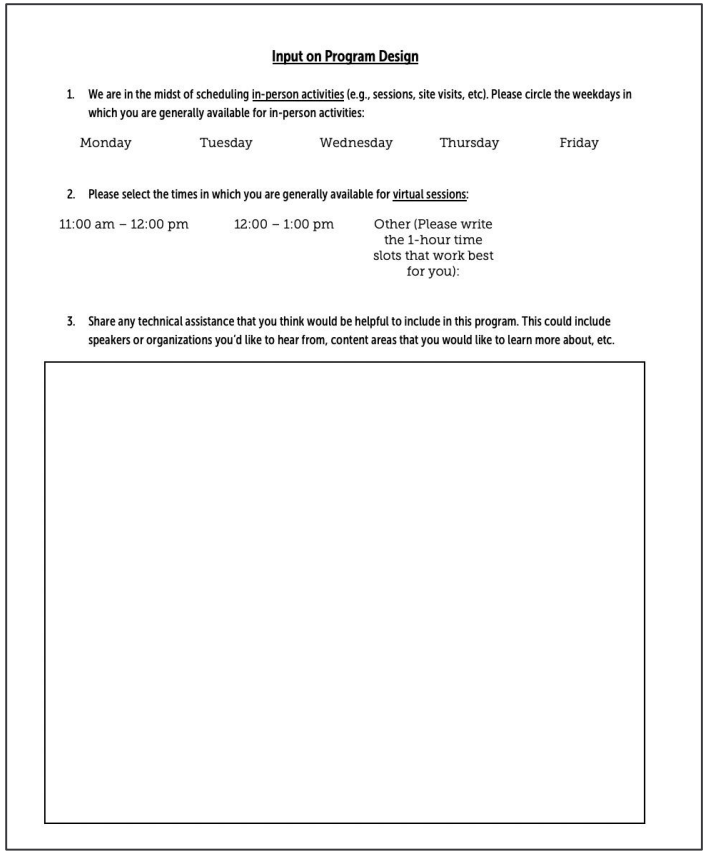
CENTER FOR CARE INNOVATIONS

Moving Clinics Upstream Program
September 26, 2019

Session #1 Evaluation

1. **Please rate your overall experience with the session.**
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. **Today's session was a valuable use of my time.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
3. **The format of today's session was:**
   ☐ Too much lecture ☐ About right ☐ Too much activity
4. **What was the most valuable part of today?**
5. **What do you wish we had done differently today?**

Please complete the questions on the back →



Input on Program Design

1. We are in the midst of scheduling in-person activities (e.g., sessions, site visits, etc). Please circle the weekdays in which you are generally available for in-person activities:

   Monday Tuesday Wednesday Thursday Friday

2. Please select the times in which you are generally available for virtual sessions:

   11:00 am – 12:00 pm 12:00 – 1:00 pm Other (Please write the 1-hour time slots that work best for you):

3. Share any technical assistance that you think would be helpful to include in this program. This could include speakers or organizations you'd like to hear from, content areas that you would like to learn more about, etc.


CCI
CENTER FOR CARE
INNOVATIONS
Questions?

Thank You!

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Senior Program Coordinator
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CEDARS-SINAI

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