

Moving Clinics Upstream

Transportation Share Out
December 9, 2019



CEDARS-SINAI®



CCI
CENTER FOR CARE
INNOVATIONS

Webinar Reminders

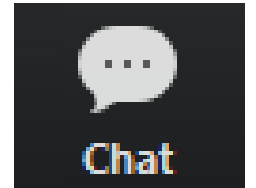
1. This is an interactive webinar! Everyone is unmuted.

2. Join us by video by clicking the



button.

3. Remember to chat in questions along the way! Use the chat window to ask/answer questions.



4. Webinar will be recorded, posted on CCI's website, and sent out via a follow up email.



Agenda

1. Welcome & Introductions
2. Transportation Team Presentations
 1. Kheir
 2. Clinica Romero
 3. Planned Parenthood
 4. T.H.E. Health and Wellness Centers
3. What's Next?
4. Wrap Up & Evaluations

CCI Team



Megan O'Brien,
Senior Program
Manager



Veenu Aulakh,
President



Diana Nguyen,
Senior Program
Coordinator

Also Joining Today!



**Laura
Blumenthal** CCI
Senior Program
Manager



Dr. Jill Rees
MCU Design Thinking
Mentor

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**.



Moving Clinics Upstream Timeline



Program Activities



Deliverables



Goals

Phase 1: Getting Started & Building Your Foundation

Sept 2019 – Dec 2019

In-Person
Sessions

Sept
26

Virtual
Learning

Weekly
Office
Hours
with Jill
Rees

Site Visits

NEVHC &
WCHC
Jan 2020

National
Site Visits
TBD

Coaching

Monthly

Coaching ends
by Oct 2020.
Coaches
available as
needed.

Project
Plan
Roadmap

By
Oct
15

Baseline
Assessment

By
Nov
1

December
Webinar
Presentation

Dec
9 &
16

- Clarify program team roles
- Assess your organization's strengths & opportunities
- Gather & synthesize patient & community input to inform strategies

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

Jan 2020 – Aug 2020

Mar
11,
2020

Aug
2020

Monthly
(except
Mar &
Aug)

Share &
Learn
Webinars

Feb
&
May

Roadmap
Update

By
Apr
2020

Y1 Program
Interviews

Aug
2020

- 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

Feb
2021

As
needed

Session
Presentation

Feb
2021

Endline
Assessment

By
Mar
31
2021

Final Case
Study

By
Apr
2021

- 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

Invitation

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



Design Thinking

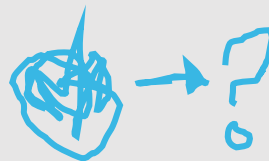
Human-centered design, also known as a “design thinking,” is an approach to problem solving that is collaborative, creative, and begins by understanding people’s needs and experiences.



collaboration



inclusion + empathy



show work early + often



make things tangible



start small + learn fast

Techniques That You Practiced



Open Ended
Interviews



Draw Your
Experience



Observation

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 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

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- 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



Kheir Clinic

Who We Are

- All Kheir sites located in Koreatown, Los Angeles
- Population Served:
 - UDS 2018: 11,519 Unique Patients Served
 - 90% of patients are low-income
 - 74% of patients are best served in a language other than English
- 4 Clinic Sites
- EHR: eClinicalWorks



Patient, Staff, & Community Voice

Who did you talk to?

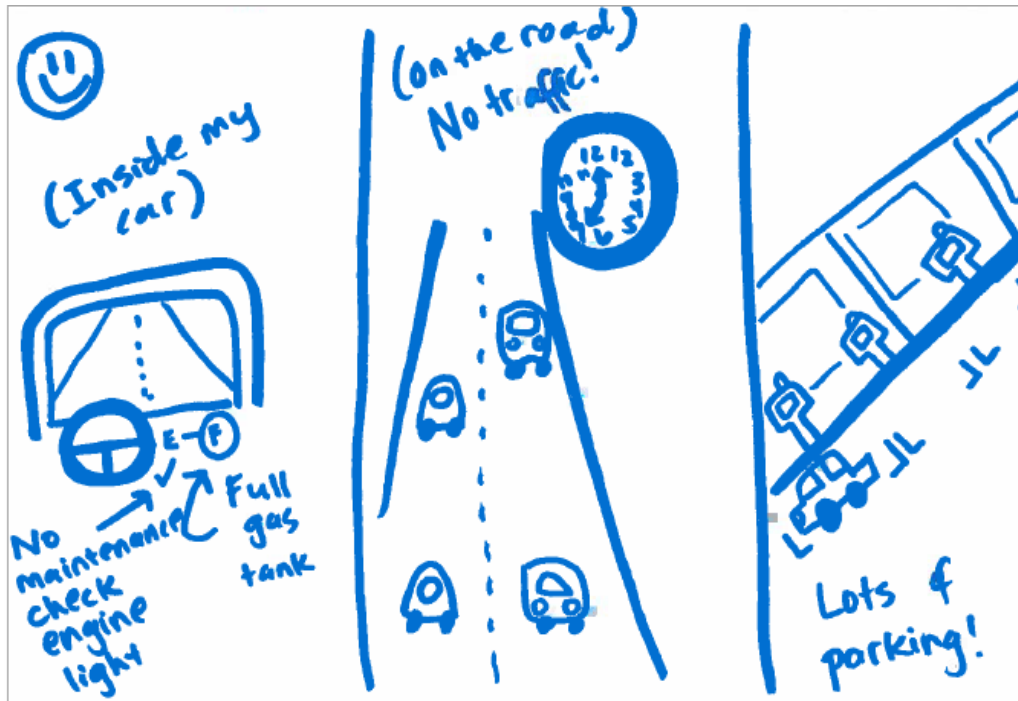
- One-on-one experiences with 4 Kheir patients
- More than 100 survey responses from patients



Methods

What methods did you use or try out? What worked & what didn't?

- Draw Your Experience



- Observation: Minivan Ride



Methods

What methods did you use or try out? What worked & what didn't?

- Transportation Survey



Patient Transportation Survey

1. In the last year, have you ever missed a medical appointment due to lack of transportation?

- ☐ YES
- ☐ NO (skip to question 2)

1A. If YES, what type of medical appointments have you missed due to lack of transportation?

Select all that apply:

- ☐ Kheir Clinic appointment
- ☐ Specialty care appointment or appointment at a non-Kheir medical office
- ☐ Hospital procedure/surgery
- ☐ Other (please explain below)

1B. Please explain why transportation was a problem. _____

2. What types of transportation do you CURRENTLY USE to get to your medical appointments?

Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Free Kheir van ride | <input type="checkbox"/> Bicycle/scooter |
| <input type="checkbox"/> Public transportation | <input type="checkbox"/> Personal vehicle |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Ride from family or friend |
| <input type="checkbox"/> Ride Share [Uber/Lyft] | <input type="checkbox"/> Other _____ |

3. Which of the following would be your PREFERRED METHOD of transportation to your medical appointments? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Free Kheir van ride | <input type="checkbox"/> Bicycle/scooter |
| <input type="checkbox"/> Public transportation | <input type="checkbox"/> Personal vehicle |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Ride from family or friend |
| <input type="checkbox"/> Ride Share [Uber/Lyft] | <input type="checkbox"/> Other _____ |

4. Did you know that Kheir currently offers FREE transportation services for those who qualify?

- ☐ YES
- ☐ NO

5. Would you be interested in participating in a focus group on transportation with other Kheir Clinic patients? If yes, please provide your information below.

Name: _____

Phone number: _____ Email: _____

11/8/19

Learnings

What did you learn from the patients, staff, and/or community?

Draw Your Experience

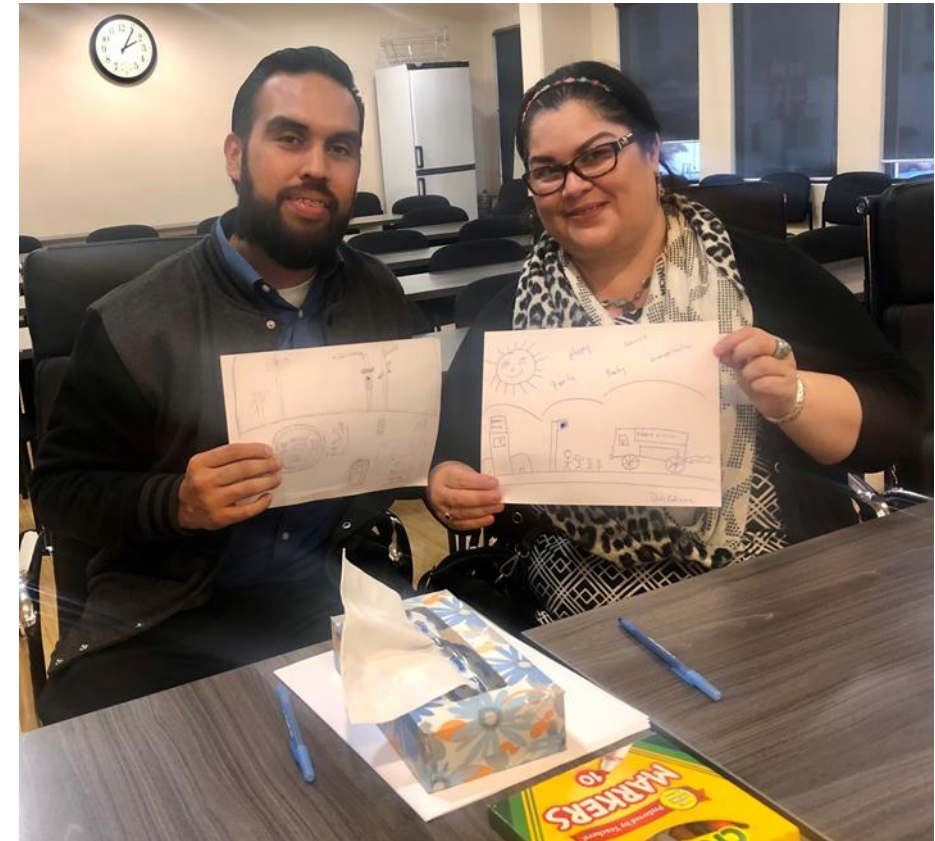
- Patients are eager to share their experiences
- Transportation is a critical determinant of patients' overall wellbeing and **stability**
- Their transportation service:
 - Is an integral component of overall patient resource network
 - Improves patients' compliance with appointments
 - Provides a level of attention, compassion, comfort, and SAFETY that Uber and other ride share apps do not offer.
- Some patients avoid Uber/other ride share apps:
 - Cost prohibitive
 - Drivers drive too fast/erratically
 - Carpool situations are physically uncomfortable (not enough space)
 - Poor customer service
- Some patients avoid public transportation:
 - Cost prohibitive
 - Physically restrictive

Learnings

What did you learn from the patients, staff, and/or community?

Draw Your Experience: Patient Quotes

- "We need a GPS in all aspects of our lives."
- "When it comes to transportation, many people assume that you have to be in a wheelchair or have a visual handicap to need help with your transportation. But you can look at the outside and not know the inside."
- "It's not just a van and it's not just a driver. He makes sure I am safe, and he makes sure that my needs are met."
- "Having transportation improves my mental stability, my physical condition, and helps me feel normal again."

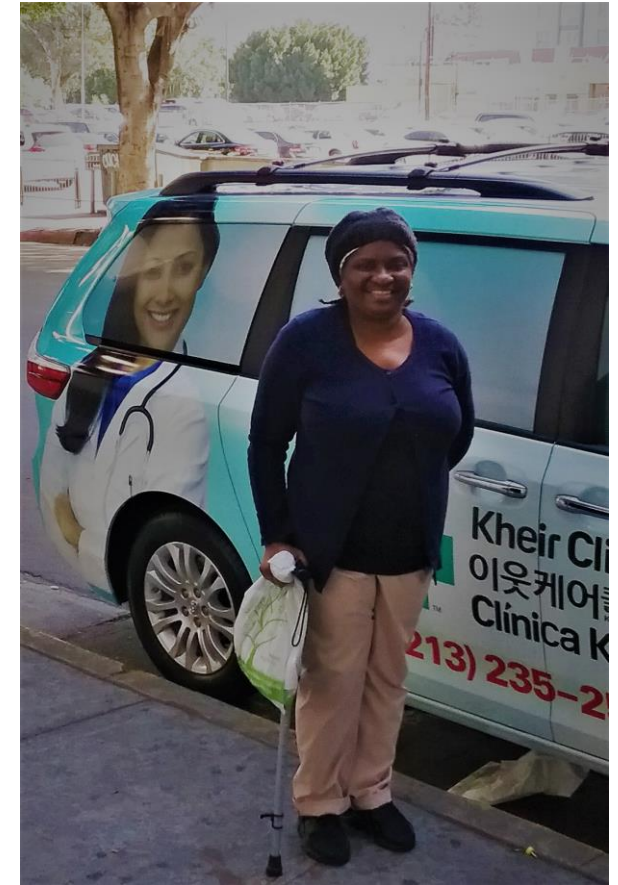


Learnings

What did you learn from the patients, staff, and/or community?

Minivan Ride Along

- Showed how transportation service is tailored to the needs of our patients:
 - Driver waits more than 5 min for one patient to come to van
 - Driver physically assists certain patients in and out of vehicle
 - Driver is a familiar face and part of the care team
- Revealed other clinic workflow issues:
 - Eligibility checks
 - Front desk check-in process from patient perspective



Learnings

What did you learn from the patients, staff, and/or community?

Survey

- More than 100 patients responded during their wait for their clinic or social services visit
- Few respondents identified transportation as a barrier (<10%)
 - Biased towards patients already in clinics
- 76% of respondents not familiar with our transportation service
- About 20 patients interested in a transportation focus group



Next Steps

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- Develop alternate strategies to hear about transportation barriers from patients who are not making their appointments
- Increase awareness of our existing transportation service
- Hold a focus group with interested patients



2032
CLINICA MRS. OSCAR A. ROMERO
COMMUNITY HEALTH CENTER

CLINICA ROMERO

Who We Are (1 min)

- Pico Union and Boyle Heights Areas
- Underserved Communities- Latino population of native born immigrants refugees, political asaylees and marginalized individuals

- 2 Clinic Sites

- Epic

Our mission is to provide quality, affordable, and culturally-sensitive health care and other services to the underserved communities of Greater Los Angeles, regardless of their ability to pay, by upholding the legacy and tradition of Monseñor Oscar A. Romero. We are driven to educate and empower Latino community members through community organizing, health education, social justice, and exchange programs.



Patient, Staff, & Community Voice (1 min)

Who did you talk to? *Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).**

PATIENT

- Type 2 diabetic patients who are uncontrolled with HBA1C greater than 8.5
- Insured and non insured patients
- Treatment medication oral glucose lowering agents and or insulin
- Ethnicity: Latino, Mexican, El Salvador, Guatemala, Honduras, Indigenous; African American; Asian and other

STAFF

- Front and Back Office-Medical Assistants
- Patient Navigators
- Pharmacy
- Behavioral Health-LCSW

COMMUNITY VOICE

Diabetes health education class
Board of Directors



Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

- Open ended questions
 - Clinical Medical History
 - Behavioral Screening
 - Focus groups
 - Formal presentation
-
- All of the above were successful in gathering preliminary information in order to develop a survey tool and method of administration

Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

Patients

- Access to appointment schedule due to transportation unavailability diabetes care by qualified practitioners
- Identification of a diabetes population of 3k patients mellitus care at an FQHC
- Dietary insecurity in order to follow an ADA recommended diet
- Lack of certified diabetes educator
- Lack of medication management and reconciliation
- Lack of quality of life intervention with exercise
- Diabetes resistance

Staff

- Call Center, Front and Back Office-Medical Assistants lack of knowledge with transportation resources
- Unavailability of pharmacy medication management and counseling
- Unviability of prediabetes evaluation and coaching
- Unviability of comprehensive diabetes care with multidisciplinary coordination

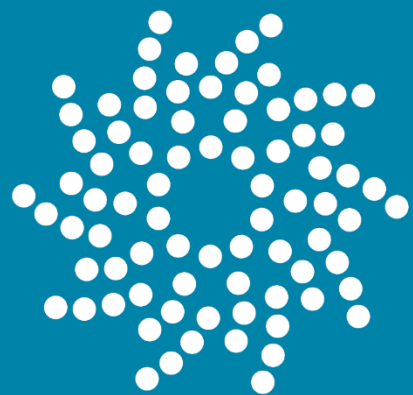
Community

- Lack of up to date clinical
- Lack of focus on best practices of diabetes

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- Develop a transportation and food survey questionnaire tool
- Assess the transportation programs which are accessible and non accessible to our FQHC population
- Administer the survey tool via by self person administer paper survey, self person computer survey, face to face administration of survey and telephonic administration of survey
- Determine the optimal method of surveying insecurity areas in a multicultural population with a predominant language, not of English, with low literacy rates or non existent literacy, with minimal to no survey participation experience, government sponsored insured and non insured, documented and undocumented marginalized patients of a FQHC from an urban environment
- Develop new logistics and strategies towards transportation and food insecurities
- Recognition as a Diabetes Prevention Program from the CDC
- Certification of our pharmacist as a certified diabetes educator
- Certification as a diabetes recognition program from the NCQA patient centered medical home



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Questions?

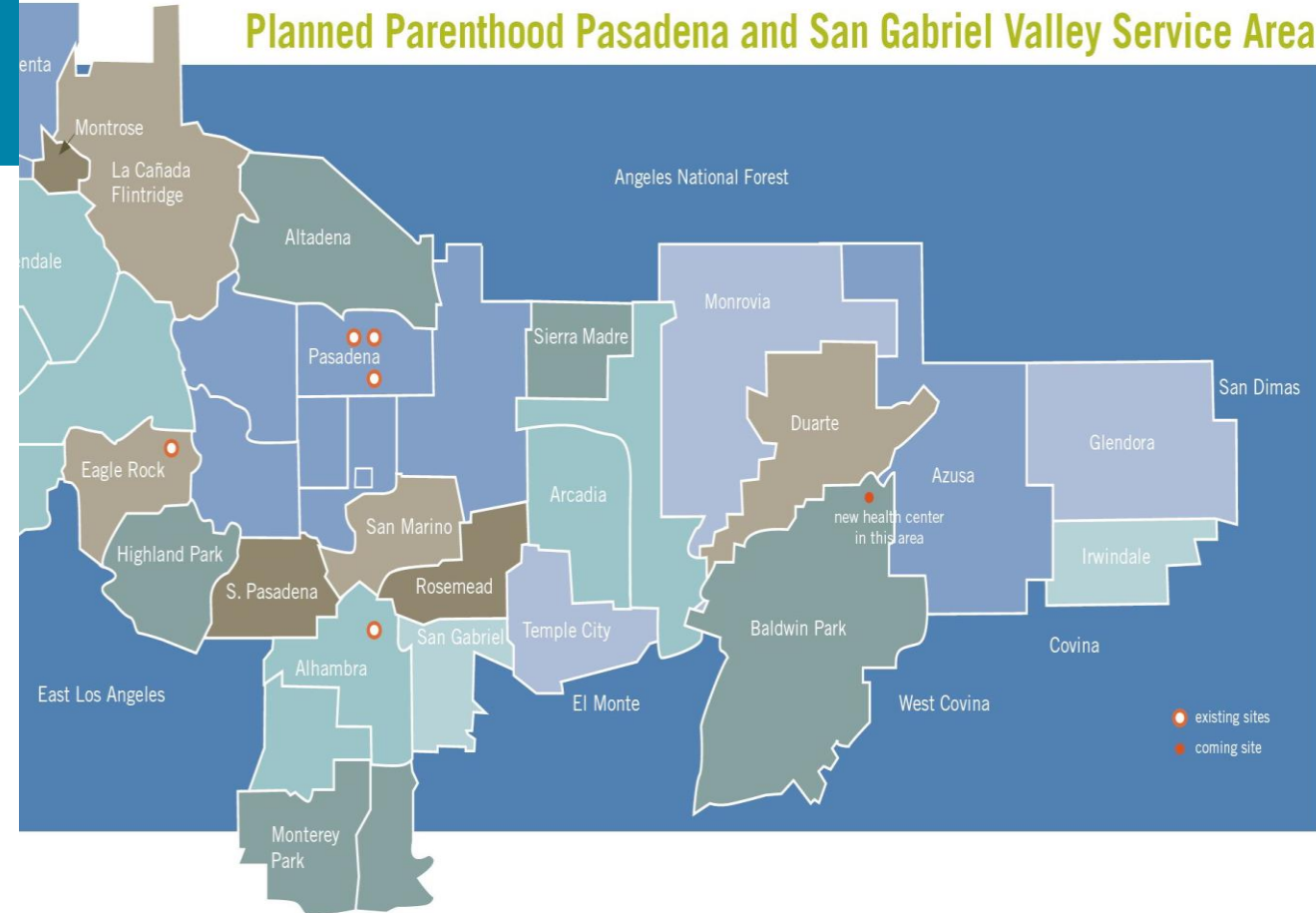




Planned Parenthood Pasadena & San Gabriel Valley

Who We Are (1 min)

- Location - Altadena
- Population Served - 24 communities across the San Gabriel Valley
- Clinic Sites - 4 Health Centers (Alhambra, Eagle Rock, Pasadena & Glendora) #5 opening early 2020 in Baldwin Park!
- EHR system - NextGen



Patient, Staff, & Community Voice (1 min)

Who did you talk to? ***Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).****

- Internal
 - VP of Patient Services – project flow and management
 - Sr. Dir. of Medical Services – all work related to PHQ-9/mental health screening
 - Dir. of Center Operations – workflow and implantation at pilot site
 - Sr. Mgr. of Business Development – connecting with external resources to find partners for referrals
 - Dir. of Business Strategy and Analytics – creating metrics for reporting back
- External
 - Board members
 - Mental Health resources and partners
 - External transportation resources (Metro TAP cards, Uber Health, Lyft corporate account)
 - Patient focus groups conducted early 2019

Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

- Survey
- Open-ended questions during visit with Clinician when patient screened for depression



Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

- Patients overall appreciative that we are offering mental health screenings and discussions
 - We were not seeing responses/engagement with addressing transportation as a barrier to care so we have shifted our approach to more direct survey questions / open-ended questions from Clinicians regarding transportation
- Inviting open communication about patients' experiences of birth control and its relationship to their mental health
- Staff has been receptive to the pilot program at their site and practitioners feel empowered to have dialogue regarding mental health as a way to address any barriers to care

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- We were not seeing responses regarding transportation in the first two weeks of the pilot and are addressing that moving forward.
 - We have expanded survey questions to focus directly on transportation as a barrier.
 - Questions ask about barriers to care and how patients arrived at their appointment.
- After our virtual coaching session with Jill, we want to expand the open dialogue happening on site with the Clinicians and have those direct transportation questions asked verbally vs. written survey.
- Affiliate is in beginning stages of launching a Telehealth program to further address transportation as a barrier; goal is to meet patients where they are to give them easy access to a provider.

A group of five women are standing in front of the entrance to T.H.E. Health and Wellness Centers. The entrance consists of glass doors with blue and green panels. The green panels feature a white logo of three stylized figures holding hands, and the blue panels feature a white logo of a heart with three stylized figures inside. To the right of the doors is a large green wall with the same white logo and the text "T.H.E. Health and Wellness Centers" and "Everyone" in white. The women are dressed in professional attire, including scrubs, blouses, and a blazer. They are all smiling and looking towards the camera.

T.H.E. Health and Wellness Centers

Who We Are (1 min)

- South Los Angeles
- Low-income, under-and-uninsured children, teens and adults
- Five clinic sites and one mobile clinic
- eClinical Works



Patient, Staff, & Community Voice (1 min)

Who did you talk to? ***Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).****

- T.H.E. is using the month of December to talk with our patients, staff, and providers about transportation to and from our clinics. Each person on our team, along with the support of the promotoras, and the medical and dental assistants, will focus on a five-question survey.
- T.H.E. is reaching out to fellow clinics to gain a deeper understanding of how their transportation programs began and they were implemented and sustained.



Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

T.H.E.'s is utilizing several methods.

- Surveys
- Open-ended Questions
- And, we are trying to have one focus group



Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

Our primary goal while gathering information is to remain open-minded and hear what our patient's needs and concerns are relating to transportation.

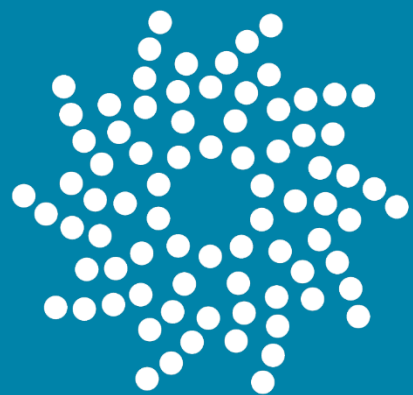


Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

Completing interviews, surveys, and focus groups. Compiling data and anecdotal information and organizing it by the end of January 2020.





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Asks & Next Steps

- ❑ **Site Visit:** Sign up for a site visit by EOD, December 23, 2019!
 - ❑ **January 27:** NEVHC – Food Insecurity - [Register here.](#)
 - ❑ **January 31:** West County – Transportation - [Register here.](#)
- ❑ **March 11th In-Person Convening:** [Register](#) for the convening by January 24, 20120.
- ❑ **Storytelling Interviews:** Project Leads will be connected with Sarah Henry in early January 2020 to begin documenting your team's progress.

Sarah Henry, MCU Reporter



Sarah Henry is a Bay Area-based writer who covers culture through the lens of food. She has written about food security, food justice, and other social and economic matters on the food beat for publications such as *The Washington Post*, NPR/*The Salt*, and *San Francisco Chronicle*. Sarah is the co-author of *The Juhu Beach Club Cookbook* and the author of *Farmsteads of the California Coast* and *Hungry for Change*, a project with UC Berkeley's Food Institute that showcased 20 food systems changemakers in the Golden State. She covered health issues while on staff at the Center for Investigative Reporting and *Hippocrates* magazine and has written about health and wellness for online outlets such as WebMD, Caring.com, and Consumer Health Interactive.

Thank You!

Please fill out
the post
webinar
survey!

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