Better Together: Building Community Partnerships to Address SDOH

September 18, 2019
Who We Are

Location: San Diego & Riverside Counties

Population Served:
- Low-income, medically underserved, uninsured, and underinsured
- 5% Homeless (approximately 3700)
- Behavioral Health integrated in all primary care clinics

Approximately 67k unique patients, 290k visits/year
- 61% Female, 39% Male
- 73% Medi-Cal, 5% Dual Elig, 7% Medicare
- 40% Monolingual Spanish

# of Clinic Sites: 16

EHR System: eCW
Changes at Neighborhood Healthcare Since Learning Session 1

• Hired two additional MAT waivered providers – 13 total, with 2 more in process
• Scheduled Quarterly MAT consultation meetings
• Awarded MAT Access Points grant to create MAT video to raise awareness and reduce stigma internally and externally
• Awarded HRSA Integrated Behavioral Health Services grant to improve SA & Trauma Informed Care knowledge, skillset, and organization transformation and add high touch Social Determinants of Health (SDOH) program to two regions
• Awarded SBIRT grant, providing GPRA assessments for enhanced treatment planning
• Rebranded to “Neighborhood Healthcare…Better Together”
  • Launch new website with section on MAT services in September
• Opened new integrated satellite clinic in Interfaith Community Services main hub to reach complex mentally ill and medically fragile homeless patients
The concept of SDOH is not new – how we are learning to manage population health is now being driven from a resource perspective.

So why are SDOH so important?

The best treatment plans will fall apart if we are not willing or able to address SDOH essential needs.

In response, NHcare developed SDOH program, tailored to meet high and low touch community resource navigation needs of patients to build a solid foundation for recovery and wellness.

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Adapted from The Bridgespan Group
Low Touch SDOH

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<thead>
<tr>
<th>Physical Health:</th>
<th>Occupation/Education:</th>
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<tbody>
<tr>
<td>Primary Care Provider</td>
<td>Employment program</td>
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<tr>
<td>Urgent Care Clinic</td>
<td>Job readiness program</td>
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<tr>
<td>Dental Clinic</td>
<td>Adult education</td>
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<tr>
<td>Vision Care Center</td>
<td>Community college</td>
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<td>Support Groups</td>
<td>Vocational/trade school</td>
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<td>Health &amp; Wellness Groups</td>
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<td>Exercise groups/classes</td>
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<tr>
<th>Mental Health:</th>
<th>Financial Advocacy/Benefits:</th>
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<tr>
<td>Psychiatrist (Med. Management)</td>
<td>Money Management class or group</td>
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<tr>
<td>Counselor/Therapist</td>
<td>Medi-Cal Enrollment Assistance</td>
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<td>Specialty mental health clinic</td>
<td>Medicare Enrollment Assistance</td>
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<tr>
<td>Intensive outpatient/day treatment</td>
<td>Affordable care/covered California</td>
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<tr>
<td>Inpatient Treatment</td>
<td>CalFresh (food stamps)</td>
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<tr>
<td>Crisis Centers</td>
<td>SS/SSI/SDI Enrollment Assistance</td>
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<tr>
<td>Support Groups &amp; Self-Help</td>
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<td>Clubhouse</td>
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<th>Social Health:</th>
<th>Housing:</th>
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<tr>
<td>Case management</td>
<td>Homeless shelter</td>
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<tr>
<td>Socialization &amp; Advocacy</td>
<td>Affordable Housing</td>
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<tr>
<td>Educational class/workshops</td>
<td>Board and care</td>
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<td>Faith based organizations</td>
<td>Skilled Nursing Facility</td>
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<td>Volunteer opportunity</td>
<td>Independent Living Facility (ILF)</td>
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<td>Family support groups</td>
<td>Senior housing</td>
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<td>Parenting classes</td>
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<th>Substance Abuse:</th>
<th>Legal Aid:</th>
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<tr>
<td>Outpatient services</td>
<td>SSI application advocacy</td>
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<tr>
<td>Inpatient services</td>
<td>Family law</td>
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<tr>
<td>Self-help Recovery Groups</td>
<td>Restraining order</td>
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<td>Sober living</td>
<td>Children &amp; youth law</td>
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<tr>
<td>Faith based</td>
<td>Tenant/landlord disputes</td>
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<td>SMART recovery</td>
<td>HIV/Aids law</td>
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<th>Transportation:</th>
<th>Basic Needs:</th>
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<tr>
<td>North County Transit District</td>
<td>Clothing</td>
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<tr>
<td>ADA Ride</td>
<td>Hygiene products</td>
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<td>UFT services</td>
<td>Food</td>
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<tr>
<td>Manage care plan transportation</td>
<td>Showers</td>
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High Touch SDOH

In the last six months... (Y/N questions):
1. We were worried whether our food would run out before we got money to buy more.
2. The food we bought just didn’t last and we didn’t have money to get more.
3. Are you homeless or worried that you might be in the future?
4. Do you have trouble paying for utilities?
5. Do you have trouble finding or paying for a ride?
6. Do you need daycare, or better daycare, for your kids?
7. Are you unemployed or without regular income?
8. Do you feel unsafe in your daily life?
9. Is anyone in your home threatening or abusing you?
10. Do you see or talk to people you care about less than twice a week?
11. Have you or your child needed to see a doctor, but didn’t have healthcare or could not afford the cost?
Low Touch vs. High Touch SDOH

**Low Touch SDOH**
- 11 Questions
- Positive response elicits resource guide
- Patient self-navigates community referrals
- Assessment only is tracked in EMR

**High Touch SDOH**
- For all complex care and MAT patients
- Conversational style discussion
- Positive responses lead to collaboration to develop a success plan – meeting them where they are at
- Appointments scheduled during visit
- Strong coordination of care with community based organizations
- Inter-agency Referral & ROI
- Assessment, referrals, and outcomes are tracked in EMR
  - Discussed; Handout Given; Sched Appt; Successfully Connected; Declined
Inter-Agency Warm Hand Offs: Communication and Coordination of Care is Key

UNDER-AGENCY CLIENT REFERRAL AND RELEASE OF INFORMATION FORM

client name: ____________________________ referral source: ____________________________

Client ID: ____________________________ Client DOB: ____________________________

Referral By: ____________________________ Phone: ____________________________

Agency: ____________________________

I do hereby consent to the exchange and/or disclosure of information contained in my medical record between the agencies checked off below. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol treatment, and may also contain confidential HIV/AIDS related information, including AIDS results.

The disclosure of information and records authorized herein is required for treatment planning and Coordination of Care only.

I specifically request that the following information be released (patient should give permission for release of the below information by initialing each of the circles that apply):

[ ] Medical Records
[ ] Laboratory / Radiology
[ ] History & Physical Exam
[ ] Substance Abuse
[ ] Mental Health
[ ] Employment/Education
[ ] Transportation
[ ] Financial
[ ] Faith-Based Services
[ ] Other:

reasons for referral:

[ ] Basic Needs
[ ] Mental Health
[ ] Physical Health
[ ] Substance Abuse
[ ] Housing/Shelter/Income
[ ] Employment/Education
[ ] Transportation
[ ] Legal
[ ] Financial
[ ] Faith-Based Services
[ ] Case Management
[ ] Social Health
[ ] Other:

This information will only be shared with the agencies I have selected below:

| Neighborhood Community Services 420 Locust Street #188 San Diego, CA 92103 619-353-3571 | Neighborhood Health Services 421 N. Date Street #200 Escondido, CA 92025 760-350-8284 99999@neighborhood.com |
| Community Housing Services 11920 L. Allston Street San Diego, CA 92130 858-575-4551 858-575-4552 | Neighborhood Health Services 421 N. Date Street #200 Escondido, CA 92025 760-350-8284 99999@neighborhood.com |
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I may revoke this authorization at any time before the information has been released. This consent will expire in one year on: __________.

I may retain a copy of this authorization, initial here if you desire a copy: __________.

I agree that a photocopy or fax of this authorization is to be considered as effective as the original:

(Signature of Client) ____________________________ (Date) __________

(Signature of Parent, Guardian, Conservator or Probation Office (If minor is a ward): ____________________________ (Date) __________

(Signature of Health Care Provider & Employer) ____________________________ (Date) __________

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of confidential written summaries of the information to whom exception, or to otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.
• At NHcare we believe inter-agency warm hand offs will improve the likelihood of patients connecting with resources
• Supportive health navigation
  • Identify barriers (i.e., transportation, support, daycare, literacy, language)
  • Collaborate with individual and make appts with them, not for them
  • Provide “My Success Plan”
  • Follow up with individuals and community partners until linkage is confirmed

SDOH Navigation Assistance: My Success Plan

My Success Plan

1. Appointment With: ________________________________
   Address: ___________________________________________
   Date: _________________    Time: ___________________
   Reason: ___________________________________________

2. Appointment With: ________________________________
   Address: __________________________________________
   Date: _________________    Time: __________________
   Reason: __________________________________________

3. Appointment With: ________________________________
   Address: __________________________________________
   Date: _________________    Time: __________________
   Reason: __________________________________________

Thank you for the opportunity to connect you to local resources. If I can be of further service, please contact me:
**What do we do with all of this SDOH data?**

**Indicators of Value-Based Care**
- Correlate SDOH with health-related outcomes, treatment plan adherence, and patient satisfaction
- Develop more comprehensive treatment plans to include CBO’s
- Address access barriers that impact health and wellness
  - Work with local city, county, and CBO partners to create services where there are gaps
- Influence policy and programs to support equity
- Track trends over time

**Drive Strategic Partnerships**
- Build business case model
- Identify SDOH of most concern to stakeholders
- Identify SDOH that have the greatest impact
- Drive multisector cross-organization partnerships
  - Build personal relationships!
  - Requires trust to exchange information/data, collaborate, and share resources, funding, and power
    - PATH (Partnership Assessment Tool for Health)
  - Requires executive leadership support, open/honest dialogue, and willingness to explore uncharted territory
Key Learnings

Our Biggest Surprise Was...
- Initial provider resistance
- Provider discomfort with questions

Solutions to Mitigate Challenges:
- SDOH Taskforce – get buy in!
- Don’t try to be a social service agency
- Strengthen your partner!
- Do not underestimate the passion and compassion of staff
- PDSA’s
- Mock patient simulations – be willing to be vulnerable
- Leverage resources

Early Wins or Successes:
- Strong CBO partnership
- Grant funding opportunities

Challenges:
- Lack of resources
- Change, even when desired is difficult (“Don’t give up on me”)
- Need to meet patients where they are at
- Identify and address access barriers
- Compassion fatigue
Meet our Mock Patient Roger Jones. He is a 65 year old Hispanic male. Roger is a paraplegic Vet. He is diagnosed with Bipolar Disorder, Anxiety, and PTSD. He is unhappy with his services with the VA and is seeking services at NHcare because it is closer to his home. He currently resides in an apartment complex that is run down and being destroyed. He has been given 5 months to relocate. He cannot find affordable housing because he requires living space with ramps and other disability features. Due to his severe back pain, he has been taking more than recommended doses of his pain medications. He is not able to complete ADL’s, chores, or shopping and is need of assistance. Throughout his experience, he consistently complains of pain to every staff he interacts with.

Ultimately Roger left before seeing the psychiatrist due to frustration with waiting, his level of pain, and being touched by so many staff he felt overwhelmed. What did we learn?
When we met Melissa, she had diagnoses of alcohol dependence, depression, anxiety, and PTSD. She was involved in an almost fatal car accident while drunk. She failed to follow through with treatment for her leg to heal, ultimately causing it to be amputated. She severely hurt others involved in the crash. Due to this, she was imprisoned and continued her addiction once released. She suffered years of homelessness, unstable income, and legal issues with the police. She had multiple suicide attempts.

**Intervention:**
- NHcare provided BH counseling and medication management
- Access to Independence for housing, medical equipment, and furniture
- Interfaith to expedite HUD application and case management services
- Legal Aid for advocacy with her SSI
- Sobriety support group which has been key to becoming sober

**Current Outcome and Growing:** Has stable disability income. Able to take care of basic needs, increasing self-sufficiency. Currently has HUD housing and is off the streets. Received her 2 year sobriety token in 6/2018! She is involved in her church and is seeking custody of her granddaughter. Melissa states, “I don’t think without you guys’ support, all of this would have been possible. You always followed up with me, even when I didn’t. You always had other options and resources for me to get the help I needed. I have so much to thank you guys for!”
Searchable SDOH Evidence Library

https://SIRENNetwork.ucsf.edu
Q&A and Discussion Questions

1. How are other clinics exchanging information related to SDOH and coordination of care?
2. Are other clinics billing for coordination of care activities?