neighborhood HEALTHCARE

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

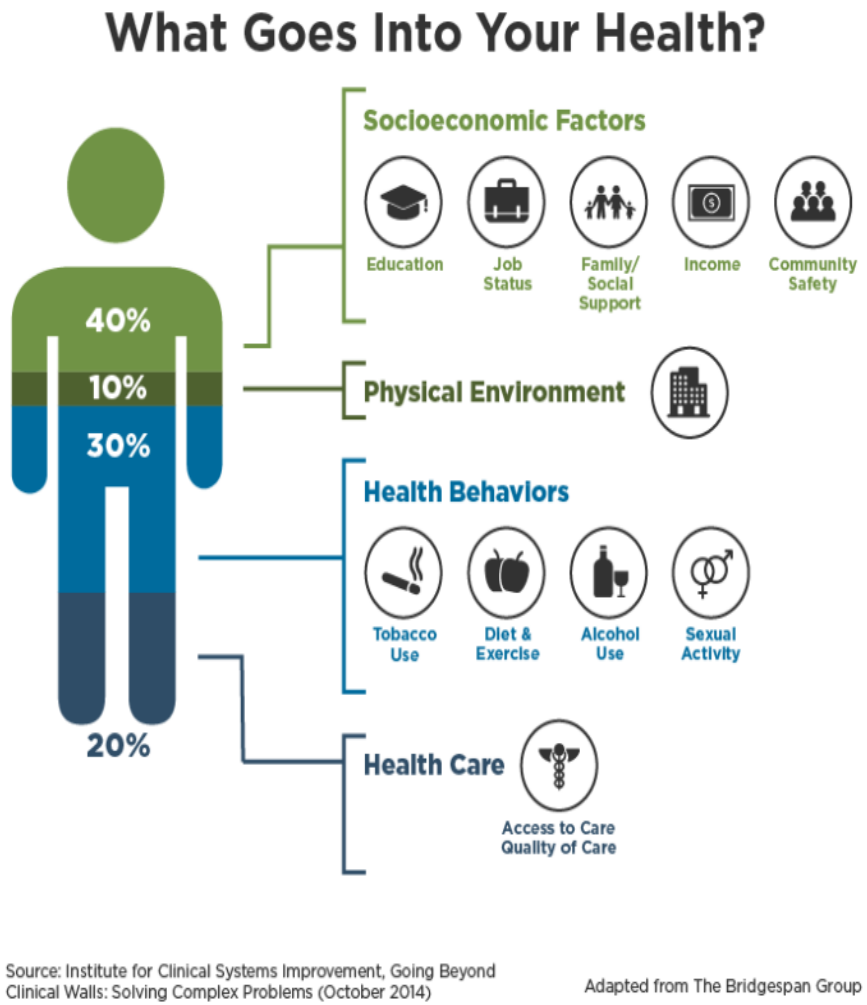
# of Clinic Sites: 16

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

Social Determinants of Health: Recognizing the Significance



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group

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

Low 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?

High Touch SDOH

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

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

NEIGHBORHOOD HEALTHCARE

Escondido/North County Social Service Resources:

Category/Need Type Field:	Program:	Address & Phone Number:
Physical Health:		
-Primary Care Provider:	• Neighborhood Health care	460 N. Elm St. Escondido, CA 92025 (760)520-8100
	• North County Health Services	150 Valpreda Rd. San Marcos, CA 92069 (760)736-6767
	• Vista Community Clinic	134 Grapevine Rd. Vista, CA 92083 (760)631-5000
-Urgent Care & ER:	• Neighborhood Health Care	460 N. Elm St. Escondido, CA 92025 (760)520-8100
	• Neighborhood Health Care (after hours)	728 E. Valley Pkwy. Escondido, CA 92025 (760)737-6900
	• Palomar Medical Center ER	2185 Citracado Pkwy. Escondido, CA 92029 (442) 281-5000
	• Rady Children's Urgent Care	625 W. Citracado Pkwy. Suite 100 Escondido, CA 92025 (760)739-1543
	• Urgent Care - Arch Health Medical Group, Ramona	211 13th St, Ramona, CA 92065 (858) 675-3100
-Dental Clinic:	• NHC- Dental Dept.	425 N. Date St. Escondido, CA 92025 Rm# 129 (760)520-8330
	• North County Health Services	150 Valpreda Rd. San Marcos, CA 92069 (760)736-6767
	• Bright Now! Dental	501 W Felicita Ave Suite 101, Escondido, CA 92025 (760) 705-3150

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

NEIGHBORHOOD HEALTHCARE
a california health center

interfaith community services

INTER-AGENCY CLIENT REFERRAL AND RELEASE OF INFORMATION FORM

Client Name: _____ Referral Date: _____

Client Phone: _____ Client DOB: _____

Referred By: _____ Phone: (___) _____

Agency: _____ Fax: (___) _____

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 HIV 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 ____ Problem List ____ Progress Notes ____ Lab / Radiology ____ Medication Records	◯ ____Treatment/Service Plan ◯ ____ Alcohol/Drug Information	◯ Mental Health Records ____ Psychiatric Progress Notes ____ Therapy Notes
◯ ____ History & Physical Exam	◯ ____ HIV/AIDS test Results	◯ ____ Other:

Reasons for referral:

◯ Basic Needs	◯ Mental Health	◯ Physical Health
◯ Substance Abuse	◯ Housing/Shelter/Motel	◯ Employment/Education
◯ Transportation	◯ Legal Aid	◯ Financial/Benefits
◯ Faith-Based Services	◯ Case Management	◯ Social Health
◯ Other:		

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

◯ Interfaith Community Services 425 Date Street #115 Escondido, CA 92025 760-520-8304 760-745-5467 (fax)	◯ Neighborhood Healthcare 425 N. Date Street #203 Escondido, CA 92025 760-520-8340 760-839-9459 (fax)	◯ Vista Community Clinic 1000 Vale Terrace Drive Vista, CA 92084 760-631-5000 760-414-3892 (fax)
◯ Community Housing Works 1820 S. Escondido Blvd. Escondido, CA 92025 760-755-5441 760-432-6883 (fax)	◯ Community Resource Center 650 2nd Street Encinitas, CA 92024 760-753-1156 760-753-0252 (fax)	◯ Mission Treatment Center 161 N. Date Street Escondido, CA 92025 760-745-7786 760-466-9347 (fax)
◯ Exodus Recovery, Inc. 1520 South Escondido Blvd. Escondido, CA 92025 760-796-7760 760-796-7758	◯ The Fellowship Center 737 Grand Avenue Escondido, CA 92025 760-745-8478 760-745-6852 (fax)	◯ North County Serenity House 240 S. Hickory St, Suite 210 Escondido, CA 92025 760-747-1015 ext. 2224
◯ North Inland Recovery 200 E. Washington Avenue Escondido, CA 92025 760-741-7708 760-741-5421 (fax)	◯ Other:	◯ Other:

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 it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

SDOH Navigation Assistance: My Success Plan

- 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

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

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

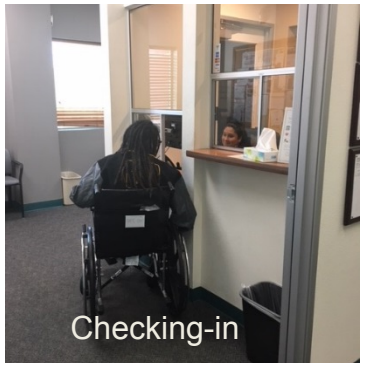
Our Biggest Surprise Was...

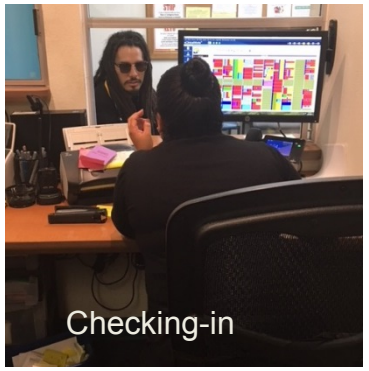
- Initial provider resistance
- Provider discomfort with questions

Solutions to Mitigate Challenges:

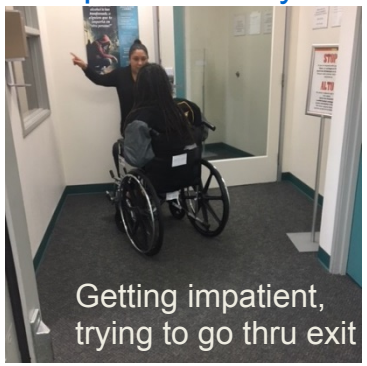
- SDOH Taskforce – get buy in!
- Don't try to be a social service agency
- Strengthen your partner!
- Do not underestimate the passion and compassion of staff
- PDSA's
- Mock patient simulations – be willing to be vulnerable
- Leverage resources

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.


Checking-in


Checking-in

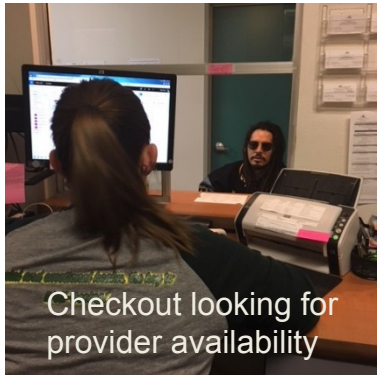

Waiting in lobby


Getting impatient, trying to go thru exit


Taken back by psychologist

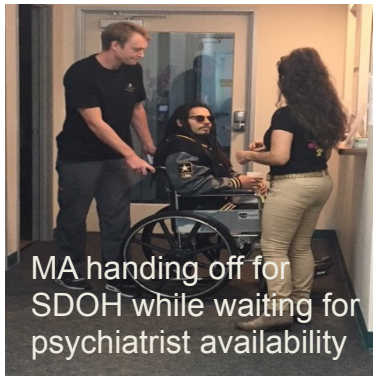

BH Assessment


BH checkout, request for urgent psychiatric & SDOH assessment


Checkout looking for provider availability


Waiting for MA to take vitals


MA taking vitals


MA handing off for SDOH while waiting for psychiatrist availability


SDOH Assessment & Referral to Interfaith


Told staff he was going for a smoke break and left

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?

Meet Melissa

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!”

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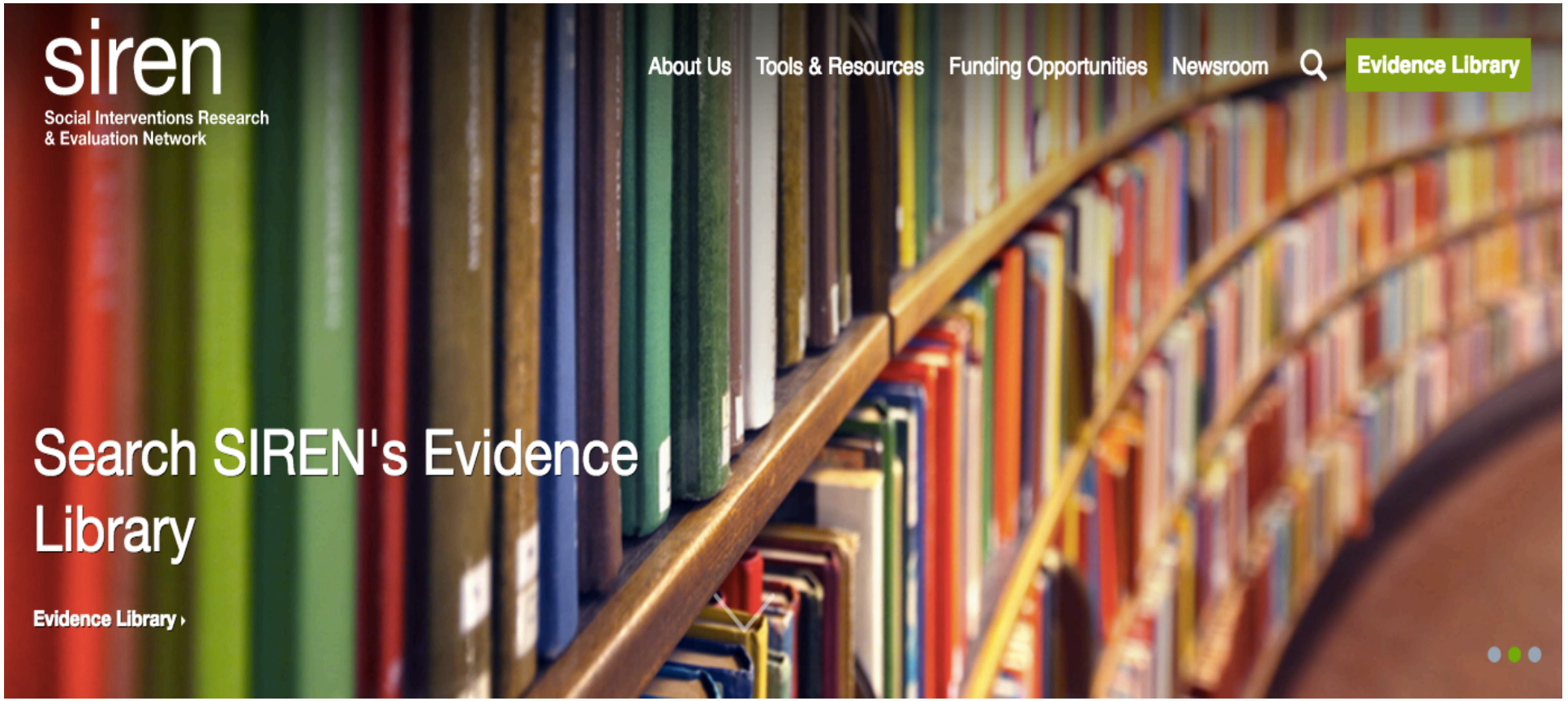
Searchable SDOH Evidence Library



https://SIRENetwork.ucsf.edu

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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?