







#### **Upcoming Events**

#### Monday, April 30, 2018 @ 12-1pm

Title: Closing the Loop on Referrals

- Faculty: Health Begins
- Learning Objectives:
- Describe best-practice methods to determine whether or not a referral was completed
- 2. Define roles and responsibilities for clinic staff in referral follow-up
- 3. Identify a change idea to test within their organization

#### Thursday, May 10 @ 12-1pm

- Title: Empathic Inquiry
- Faculty: Elevation Partners
- Learning Objectives: TBD







Sept Oct Nov

Session #1 10/5/17 Bay Area



Jan

1/31/2018: ROOTS Clinic 2/22-23/18: KKV & WHC

Feb

Mar

Session #2 3/8/18 Los Angeles



Aug

Sept-

Dec

Session #3 8/23/18 Bay Area

Remote Support

In-Person





Coaching: Monthly Team Calls



Content Webinar 11/16/17



Idea Sharing Webinar

12/7/17

Dec







4/5/18

Apr





5/10/18

May



6/7/18

June



July

Content Webinar 7/12/18

Milestones & Program Deliverables

\*\*Projects should have at least 9 monthsof implementation.



Milestone #1: Team Build, Data Review, Finalize Target Population & Need, Consider Staff & Partners, Initiate Metrics



**Project Charter** 11/ 17/ 17



1/10/18

Project Operations\*\* Design Project Workflow and Marketing, Form **Partnerships** 



Milestone #3: Analyze Progress, Redesign, Formalize Sustainable Operations



Partners Agreements 3/18



Share Lessons Learned 8/18-10/18

Evaluation **Activities** 



Interviews w/ Leads Provider/Patient 10/17-11/17 Surveys 12/17-1/18



Midpoint interviews (phone) 4/18 (instead of coaching call)



project metrics





Sept

Oct

Nov

Dec

Jan

Feb

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Apr

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June

July

Aug

Sept-Dec

In-Person



Session #1 10/5/17 Bay Area

**Kickoff** 

Webinar

9/14/17





Session #2 3/8/18 2/22-23/18; KKV & WHC Los Angeles



Session #3 8/23/18 Bay Area

Remote Support







11/16/17



Webinar

12/7/17



**Program** Content Webinar **Update Call** 2/8/18 1/10/18







Content Webinar 5/10/18



Webinar

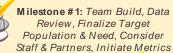
6/7/18

Webinar 7/12/18

Content

Milestones & Program Deliverables

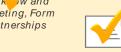
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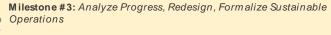


Milestone #2: Start Project Operations\*\*, Design / oject Work w and Marketing, Form Partnerships

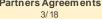














Share Lessons Learned 8/18-10/18

Evaluation **Activities** 



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Sept-Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Dec

In-Person









8/23/18 Bay Area

Remote Support





Coaching: Monthly Team Calls



11/16/17



12/7/17



1/10/18



2/8/18







7/12/18

**Milestones** & Program Deliverables

\*\*Projects should have at least 9 months of implementation.



Milestone #1: Team Build, Data Review, Finalize Target Population & Need, Consider Staff & Partners, Initiate Metrics



Milestone #2: Start Project Operations\*\*, Design / oject Work w and Marketing, Form **Partnerships** 



Milestone #3: Analyze Progress, Redesign, Formalize Sustainable Operations

Webinar

6/7/18



Partners Agreements 3/18



Share Lessons Learned 8/18-10/18

Evaluation **Activities** 











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





In-Person



Remote Support





\*Projects should have at least 9 monthsof implementation.







Oct

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May

Content Webinar 5/10/18



June

Idea Sharing Webinar 6/7/18



Content Webinar 7/12/18

July



Milestone #1: Team Build, Data Review, Finalize Target Population & Need, Consider Staff & Partners. Initiate Metrics



**Project Charter** 11/17/17

Milestone #2: Start Project Operations\*\*, Design Project Workflow and Marketing, Form Partnerships



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Partners Agreements 3/18



Share Lessons Learned 8/18-10/18





Interviews w/ Leads Provider/Patient 10/17-11/17 Surveys 12/17-1/18



Midpoint interviews (phone) 4/18 (instead of coaching call)



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



#### Changes

#### Final In-Person

• Date Change: Confirmed 8/23/18

• Location: Bay Area

#### **Evaluation Activities**

 Title: Onsite Visits/Interviews, FUP Staff Surveys, and Project Collection Metrics

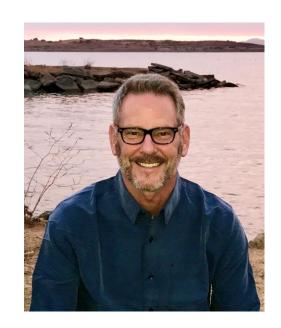
• Timeline: 9/18-10/18



### Idea Sharing on Partnerships

**Facilitator:** 

Jim Meyers, DrPH







### **West County Health Centers**

**Mary Szecsey** 

Chief Executive Officer mszecsey@wchealth.org

Kathleen Grenham

Innovation Project Manager kgrenham@wchealth.org

#### Who We Are



Where We Are Located:

Western Sonoma County

- Number of Sites in the Organization:
  - (4) Primary Care Locations with integrated Behavioral Health
  - (1) Wellness Center
  - (1) Healthcare for the Homeless
  - (1) Teen Clinic
  - (1) Dental Clinic
  - (1) Day Labor Center
- Total FTE Medical Providers:

12

EHR Vendor:

**eClinicalworks** 

Target SDOH Population:

Lower Russian River Area (Guerneville, CA)

Target SDOH Need/Needs:

Inadequate early Childhood Education & Community Partnerships















## **ROOTS Project Team**



We are a multidisciplinary team that uses leadership, data analytics and innovation to help empower our community to create transformative approaches to care

















## **Our ROOTS Project**



West County Health Centers recognizes that health happens outside the walls of our health centers and is committed to developing and approaching care in western Sonoma County in a new and transformative way.

Currently, WCHC is creating a collaborative delivery model that unites traditional and non-traditional health partners by using data as an exploration tool for community partners to identify barriers and using Human Centered Design to co-create action plans to transform our community.





#### **Our Partners**



#### Why is it important to address absenteeism?

- School success has a strong correlation with healthy development
- Students who miss more than 10% of school for any reason (chronic absenteeism) have less success in school

#### Our unique partners

- Ten years of collaboration through Health Action and Cradle to Career committee
- Community based school boards, relationships with board members
- Employees who have either graduated from or have children at Guerneville School
- Strong sense of community fostered through 40 years of working together







West County Health Centers

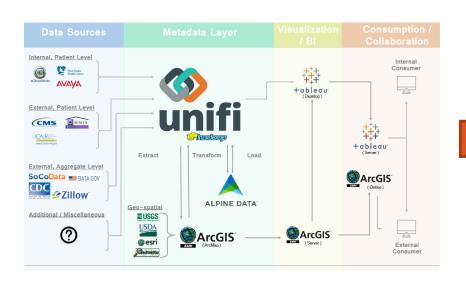
Caring for our Communities

a california health center

## **Our Approach**



#### **DATA**



## HUMAN CENTERED DESIGN (HCD)





## **Data Approach**



Build capacity to work collaboratively with community partners building a trusting relationship to share data ethically and legally to explore and inform SDOH





### **HCD Framework**



#### **Co-Designing with our Community Partners**

	$\sum$	Discovery		Ideation		Try & Test	>	Impact
	•	Understand experience	•	Generate concepts	•	Develop ideas	•	Pilot 'Super Users'
		СХРСПСПОС		Concepts	•	Test Ideas /		03013
<del>©</del>	•	Define problems/gaps	•	Design ideal experience		Solutions	•	Early adopters when
Value		_			•	Narrow &		operationalized
	•	Frame opportunities	•	Define / Prioritize		Shape Solutions		
		opportunities		Solutions		Solutions		
	•	Observations	•	Brainstorming / Affinity	•	Prototype	•	Pilot solution
Methods	•	Discovery Kit		Clustering	•	Rapid Experiments	•	Measurement
the	•	Interviews	•	Storyboarding		•		
Ž	•	Empathy	•	Enactments	•	PDSAs		
		Mapping			•	Simulations		
	•	Journey Mapping						







PURPOSE: The Discovery Kit facilitates a creative thinking process which leads to deeper understanding of community and actionable ideas.

"I call it the fun kit! It allowed for processing and thinking deeper. I was able to be creative and through this exploration I was able to reconsider projects. It really triggered my passions!" ~Community Organizer













#### **Continued**

PROCESS: Each participant gets 2-3 weeks to fill out their Discovery Kit. Each Discovery Kit is stocked with creative activities that help us creatively draw out and uncover the underlying needs of our community partners.

"It was cool to go through these activities and synthesize my thoughts. Getting to the journal at the end kind of made me think about what all this means. Where do I see gaps or opportunities?" ~Community Outreach Coordinator













#### **Interviews**

PROCESS: A one hour follow up interview is scheduled in the environment that is comfortable and familiar to the stakeholder.

"I like the idea that this kit was 3 dimensional. It really gave me the opportunity to explore things from a different perspective. While I don't consider myself creative I felt creative. And for those like me that don't consider themselves creative they will find that the interview provides them with every opportunity to communicate their perspective." ~Guerneville Resident









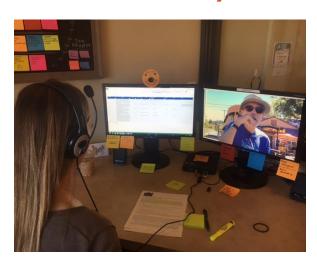




**Coding** 

#### PROCESS: Uncovering the narrative by coding each interview.

"Coding allowed us to organize, synthesize and interpret what is happening in the data. The interview provides a really rich data set that otherwise would be lost and the great thing about coding is that you get to analyze it, find themes and uncover the interviewee's story." ~ WCHC Administration Assistant



K Cut		Text General		Normal 2
Options 1	Fig. 1			ndtional Format as Neutral matting - Table -
- 1 2	√ f <sub>Z</sub> The world through my eyes.			
Α	D.	1	G	E H
Re_Clip Name	Quote	Start Time Code	End Time Code	Theme
ntendewee_1	"I think there has to be a better relationship with community and police difficers!! you know police officers then they word be brutil against you and vices versa, the community won't be aggressive toward the police."	201		WPs
deniewee_1	"I think we have to work a little bit more with the buses."	242	246	Community Collaboration
rilandewee_1	"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	Community Collaboration
nterviewee_1	"I would say more options different routes so I can for example go to Cazadero."	3.40	3.47	Ideal Community Collaboration
rteniewee_1	"More options. Creates a problem of how many people are gonns get on board at Cazadere. Is it really an issue if only 2 people can't ride the bus? How much is 8 gonna cost is, how much is 8 gonna benefit how many people."	3.50	4.06	Barter Busting







**Insights & Themes** 

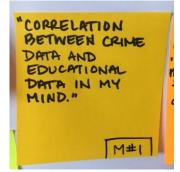
PROCESS: Using Human Center Design to translate coded quotes into insights. Understanding what truly matters most to your end users.

"Before this kit I was not really interested, but after I feel more 'inspired' and know I can help take these insights from insights and make some changes in my community." ~High School Student

















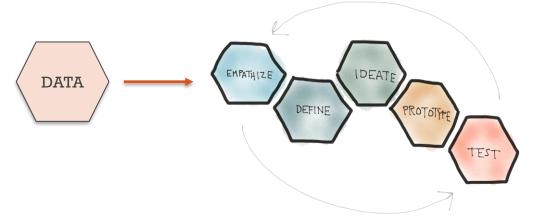
## **Next Steps**



Data Merge & HCD

Once Guerneville School's data has been merged with WCHC's data we hope to see some sort of trend, pattern, etc.

Together with Guerneville School's administration, board, teachers, parents and students we then plan on exploring these data sets and co-creating action plans for families based on the data trends identified. We will use Human Centered Design methods & techniques to create these action plans together.







#### **Petaluma Health Center**



#### Jessicca Moore

Director of Innovations jessiccam@phealthcenter.org

#### Who We Are



- Where We Are Located: Petaluma, CA
- Number of Patients Served: 29,000 across 2 sites
- Total Number of FTE Providers: 28
- EHR Vendor: eClinical Works
- Target SDOH Population: Unemployed Adults Seeking Employment
- Target SDOH Need/Needs: Employment



## Our Background to Partnerships



- SDOH Foundations:
   Food First ©
  - Redwood EmpireFoodbank
  - Petaluma Bounty"Farmacy"
  - -WIC In House

- What Next?
  - After food and
     Housing, Employment
     was the greatest need
     (via PRAPARE and
     Purple Binder data)
  - -Survey of Community Resources—What's out there?

## **Our Philosophy**



- Our organization's approach to connecting patients to services that support their SDOH needs is:
  - Holistic healthcare = understanding community needs beyond healthcare.
  - We do not have the internal resources to independently address these needs.
  - We seek to understand and connect to resources in the community with greater experience and infrastructure to address specific SDOH.
  - Patients know and trust us. Partnering in ways that bring outside resources in when possible is a good way to leverage that trust.
  - We value community relationships and demonstrate our connections to patients.
  - We believe in the autonomy of patients and will support patients in making their own decisions about when and how to access services.
  - We address systemic barriers to access and make the patient experience visible to our partner agencies.

## **Our Partner Story**



#### Partner 1: Petaluma Adult School

- I thought you were focused on employment?
  - We identified one barrier to employment to be computer skills and language (approx. 50% of our population is monolingual Spanish speaking).

#### Making a connection

 Sent a "cold e-mail" to Program Director and asked if we could come for a visit and learn more.

#### Shared Values

 Community education and advancement, especially for marginalized and vulnerable populations are values we share.

#### Program Contact

Catherine Crotty, Program Coordinator is our contact.

#### Informal contract includes the following:

- PAS will communicate with PHC about upcoming programs and classes at least 3 times a year to coincide with enrollment.
- PHC will host a PAS staff member to come to Patient Advisory Council meetings annually.
- PHC will include PAS as a community partner on our website and link to classes (exact location still in development).

## **Our Partner Story**

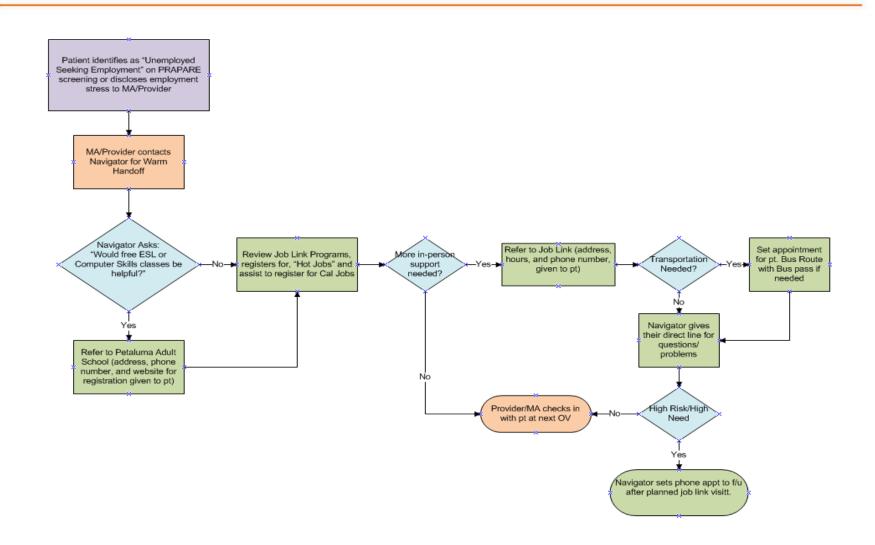


#### Partner 2: Job Link

- Job Link used to partner with Mary Isaac Center (local homeless shelter) where we have a small outpatient clinic.
  - Turnover in MIC staff and management negatively impacted the partnership
- Navigators at PHC/RPHC knew the name "Job Link" but weren't really familiar with their services.
  - Location was a perceived barrier (Santa Rosa site, 16 miles from PHC and 13 miles from RPHC)
- Let's Go and See!
  - Preliminary visit from project lead
  - Follow-up visit from navigators
  - Contact at Job Link: Patricia Andrews, Program Manager
- What can we offer each other?
  - PHC has space, access to 30K patients, facilities and relationships in Southern Sonoma County and free or low cost healthcare services to workers and application assistance
  - Job Link has navigation support for job seekers (including interview assistance and resume building) and access to job specific training programs
- Informal agreement to:
  - Collaborate on South County Job Fair (Hosted at PHC)
  - Collaborate to improve transportation options for South County residents
  - Communicate with PHC about upcoming programs and job fairs



## **Patient to Partner Workflow**



#### The Good...the Bad...



#### The Good:

- There are CBOs and Government Agencies doing great work to address SDOH, specifically employment.
- Staff and Providers see addressing SDOH as an important role of the health center and we have engaged leadership.

#### The Bad (Challenge):

- Meaningful partnerships take time to create, cultivate, and maintain.
- Creating a closed loop system requires a significant staff commitment for us and for the partner organization. Outcomes are hard to track outside of a closed loop system.

#### ...the Question



#### One Question for the Group Today

– How are you building trust with patients when referring out to other agencies so they go and access the service? How do you effectively engage patients in selfreporting the status/outcome of their CBO referrals?



## LAC+USC Medical Center Primary Care



#### **Barbara Rubino**

Director of Clinical Quality, LAC+USC Primary Care brubino@dhs.lacounty.gov

#### Who We Are



- Where We Are Located: East LA (Boyle Heights)
- Number of Clinics in the Organization: 10 Primary Care clinics, 3 in grant project
- Total Number of FTE Providers: 23, ~48,000 empaneled patients
- EHR Vendor: Cerner
- Target SDOH Population: All empaneled patients in the Adult East, West and Pediatrics Clinics
- Target SDOH Need/Needs: Food and housing insecurity



## Our Background to Partnerships



- Food Insecurity
  - The Wellness Center / community resource linkages
    - on campus
    - multiple organizations, produce distribution, community linkages by navigators
  - Social Work/DPSS
    - In clinic CalFresh enrollment
- Housing Insecurity social services
  - our social work department
  - already with integrated BH model in clinics
  - the most well-versed team member in housing issu





WE, THEREFORE, MOVE that the Board of Supervisors direct the Department of Public Health, the Department of Health Services, and the Department of Public Social Services to:

- Describe current efforts to screen for food insecurity in County health clinics, as well as best practices, challenges, and lessons learned from other jurisdictions;
- Report back in 90 days regarding the feasibility and costs of:
  - a) including a screening questionnaire in the County's electronic health records system(s) and training staff to use the tool,

#### MOTION BY SUPERVISOR HILDA L. SOLIS AND CHAIR SHEILA KUEHL December 5, 2017 PAGE 3

- b) implementing an action plan for establishing a referral process to onsite enrollment for CalFresh by County Health Clinic staff via the County's Your Benefits Now online application, WIC, and other food assistance resources, and,
- c) conducting nutrition education classes that focus on healthy eating and food resource management.

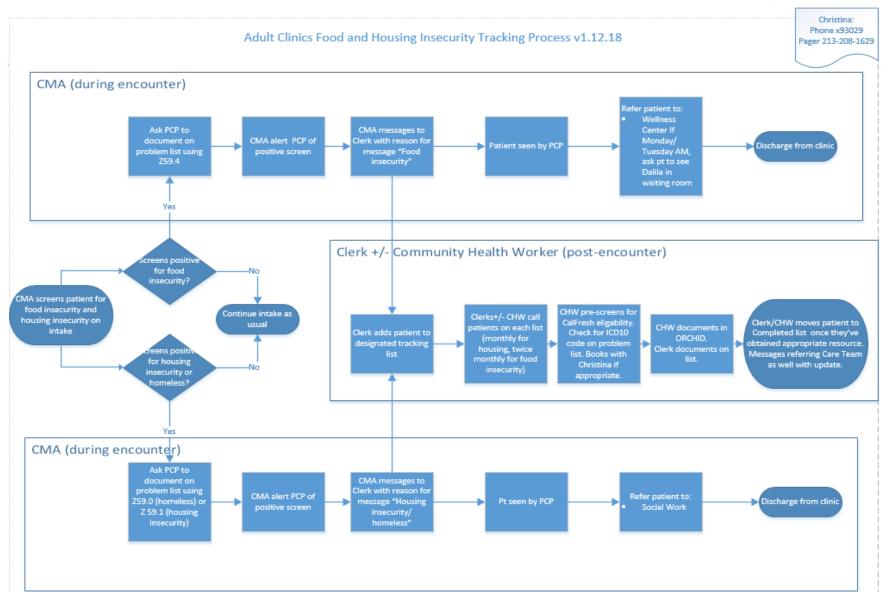




- Our organization's approach to connecting patients to services that support their SDOH needs is:
  - We see it as our role to provide our own services to address the need (dedicate clerk, CMA, RN time to addressing and following up patients' social needs)
  - We see it as our role to provide other partners space in our clinic to help address need (example: DPSS for CalFresh enrollment given an office in our clinic)
  - We see it as our role to refer patients to partners who provide services outside our clinic to help address need (example: warm handoff to Wellness Center Navigator)

### Patient to Partner Workflow





## **Our Partner Story**



- Partner 1:
  - The Wellness Center launched in 2014 on LAC+USC campus
  - Medical Director of TWC is a PCP in Adult West Clinic
  - Community orgs and services relevant and accessible to primary care patients
  - Yes! Medical Director of TWC (Dr. Janina Morrison)
  - Wellness Center Navigator located in Adult Clinics 2 days per week, working to have direct phone line all other clinic hours







- Partner 2:
  - Director of Primary Care + Director of Social Work
  - Bringing together two philosophies on social services: specialty/referral model + PCMH
  - We can't successfully address medical issues without addressing social needs
  - Yes! Social Work Director & Supervisor
  - 1 Social Worker in Adult East, 1 in Adult West
  - 1 DPSS Worker in Adult Clinics for ~2 hours per wee



#### The Good...the Bad...

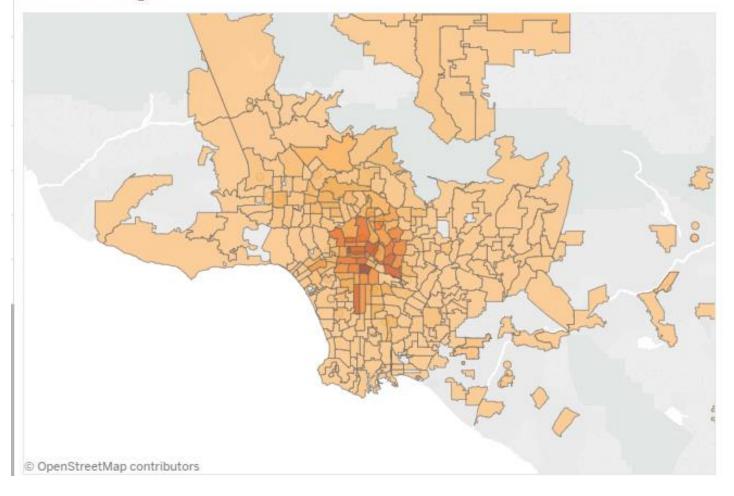


- The Good:
  - Patients like the one-stop-shop!
- The Bad:
  - Once they go home, which may be far away, we may not be connected with their community



## The Issue: Adult East, West, CCI and Peds (~46,000 pts)

#### Patient Origin

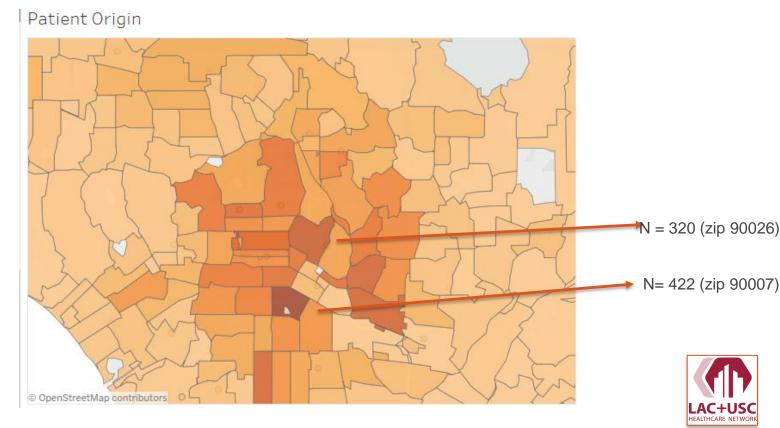




#### ...the Question



- One Question for the Group Today
  - -Ongoing struggle with wide geographic region



## Q&A



# Thank you to our Presenters Today!

