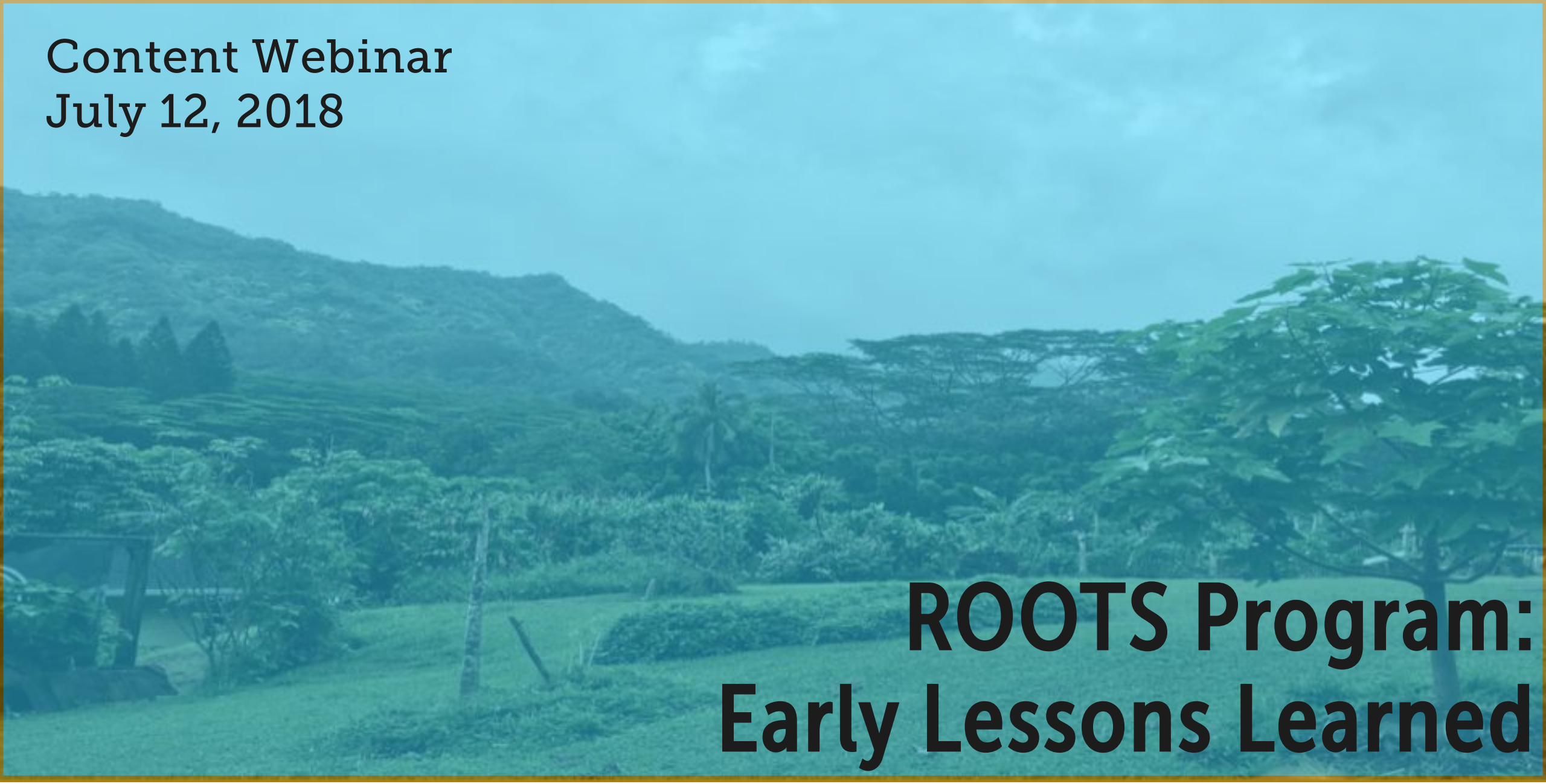
Content Webinar
July 12, 2018



ROOTS Program: Early Lessons Learned

blue of california foundation

CCI CENTER FOR CARE INNOVATIONS

Our Program Team

Megan O'Brien

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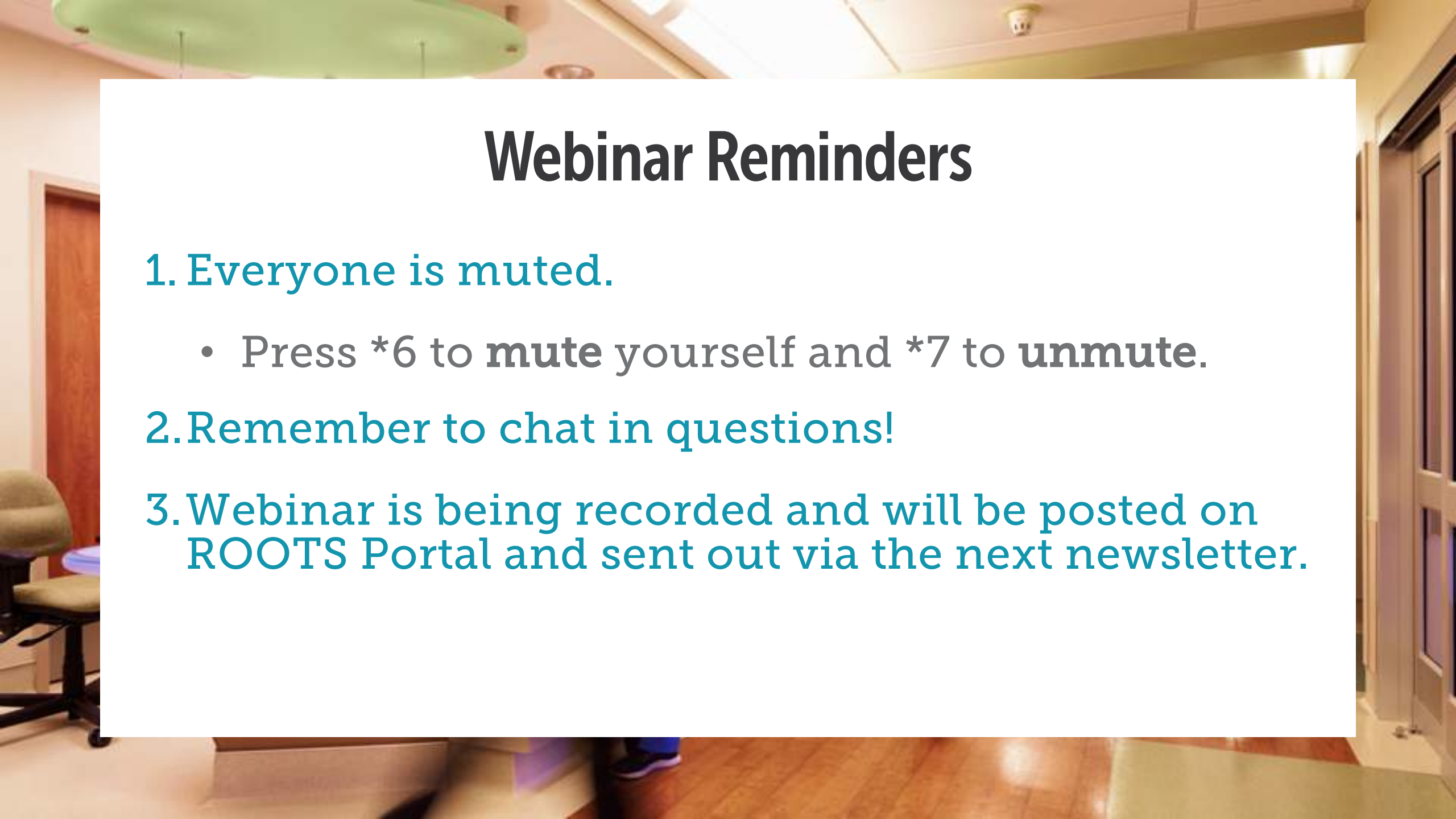


Webinar Reminders

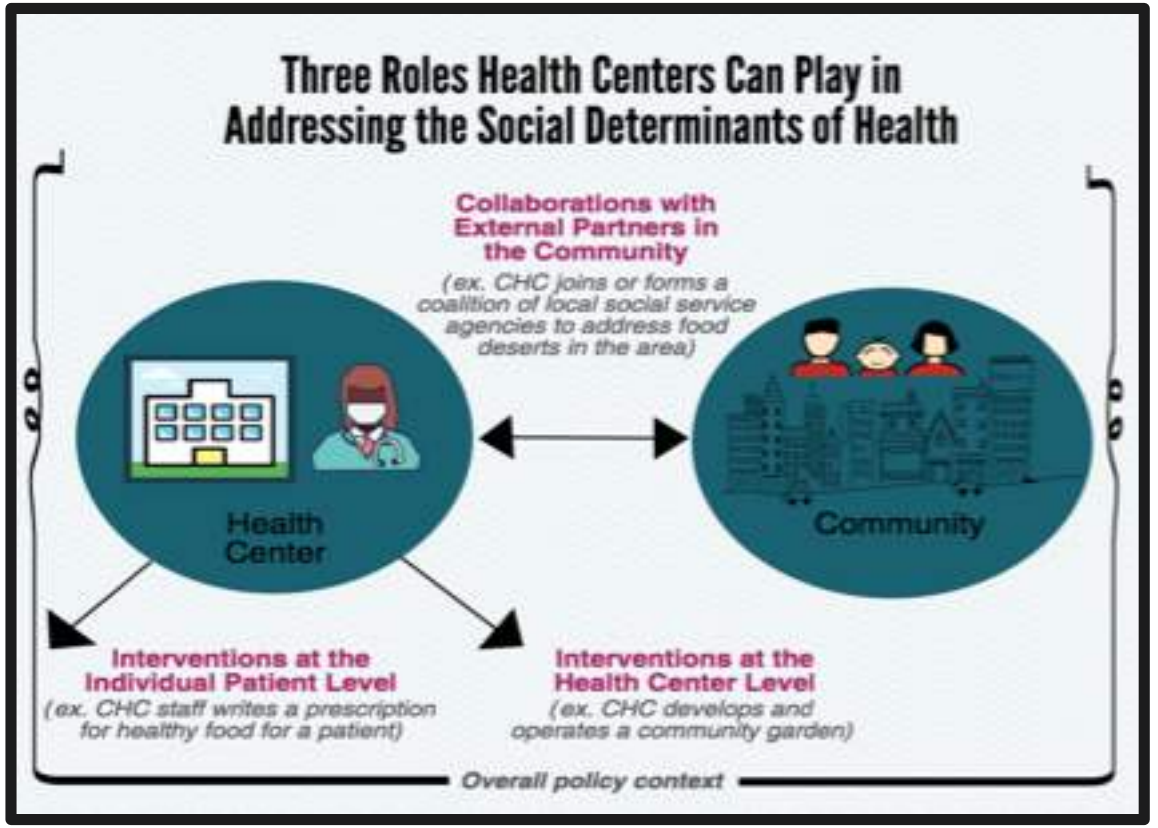
1. Everyone is muted.
    - Press *6 to **mute** yourself and *7 to **unmute**.
2. Remember to chat in questions!
3. Webinar is being recorded and will be posted on ROOTS Portal and sent out via the next newsletter.

Today's Agenda

- **12:00 – 12:05:** Welcome & Housekeeping
- **12:05 – 12:15:** Team Go Around: What do you wish you knew?
- **12:15 – 12:50:** Program Lessons Learned & Reflections
- **12:50 – 1:00pm:** Looking toward August 23rd

Webinar Goal

- In the **spirit of co-design**: are these the right lessons learned?
- We want to move toward a **change package** or resource to support other clinics and move the field forward.
- Invitation to **reflect & share**.



Key Questions

Questions for the Field

- Where can clinics really make a difference and **be best positioned** to contribute to addressing social needs?
- **Which social needs** make sense for clinics to address?
- How best can clinics use **individual and community level data** to address social needs?
- What are the steps or key considerations when forming new **partnerships** to address social needs?

Questions for ROOTS/CCI

- What **types of projects** were easiest to implement and why?
- What **challenges** did you face in implementing your projects and how did you address them?
- What ROOTS program activities were **most helpful**?
- Did participation in this program **increase your clinic's capacity** to address patients' social needs?

Team Sharing

What do you **know now** that you wish you would have known at the beginning of the ROOTS program to guide your work?

ROOTS Cohort

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

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Early Learnings

Conversation

Which of the lessons **resonate** with you and your work?

Which lessons **don't resonate** with your work and why? What is missing?

What stories do you have that add value or bring life to the lessons?

Early Lessons

1. It's the "How" Not the "Why"
2. Listen & Learn
3. Tailor Resources
4. This Work Takes Time
5. Invest in Partnerships

Lesson#1:
It's The "How" not The "Why"

- Challenges in addressing social needs will vary depending on individual clinics. 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.

"We're moving to a health framework where people are always talking about social determinants of health...that's something that health centers have been designed to address since our inception.... **That's why health centers are there**."

Key "How" Questions

- How to **screen**? What are the best **tools**? How **to ask these questions** in ways that don't stigmatize patients?
- How to integrate screening data into the **EHR**?
- What to do to help patients with non-medical needs? **What assistance actually helps**?
- How to identify effective **partners**? How to build effective partnerships?
- How to **track referrals** to outside organizations?
- How to measure **success**?
- How to **motivate teams** to do things differently and to add new work to already stretched workflows?

Addressing the "How"

Optimizing the Flow of Information and Work for Social Needs

(December 14 Webinar)

- How to **map out workflows,** and how to identify opportunities to enhance workflow to **incorporate social needs** screening & referrals.
- Upstream Medicine **Workflow Canvas**.
- Dr. Steven Chen from **Hayward Wellness:** how they improved the flow of information and work in order to **integrate food insecurity screening.**

Closing the Loop on Referrals

(April 30 Webinar)

- **Improving the Referral Process** through direct connections with CBOs, teaching back with patients, and engaging families
- **Developing & Formalizing Partnerships**
- **Using Technology Solutions** like Healthify, One Degree, etc.
- **Patient Follow-Up**

Sharing Workflow Experiences

(June 7 Webinar)

- **Asian Health Services**: Using patient interviews to revamp the referral algorithm to do tiered resource support & process for training staff to offer consistent resources
- **NEVHC: J**ourney with 1 Degree, and the differences of rolling out Otech tablets at two sites with regard to who screens and enrolls patients into 1 Degree
- **LifeLong Medical Care**: Shared 2-item Hunger Vital Sign & risk stratification for referrals and interventions

Lesson #2:
Listen & Learn

- 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.

"I looked at some of the questions and I thought [...] it's not really necessary to ask [...] something like that. But it really **opened my eyes to understand** all the different variables that a person can have affect them..."

Evolution of Program Focus

- We went into the program thinking that systematically screening patients with a standard tool was the right way to do this work.
- Heavy emphasis during the design and at the beginning off the program on **collecting individual patient data** and **aggregating it with outside data.** **BUT** some ROOTS clinics were using PRAPARE, others not. No one was really look at data sharing/aggregating outside data.

The Role of Data in Addressing Social Needs (September 14 Session)

- How to identify data that informs the most pressing issues in your area
- Strategies for data-informed prioritization of social needs interventions and for integrating data sets with external data sets
- Got a look into external data sets that exist

Using Data to Drive SDOH Priorities: Lessons Learned from Cincinnati Children's Hospital (November 16 Webinar)

- Screening patients SDOHs is important, but what really matters is **how you use screening data to drive action** to improve health outcomes & narrow inequities.
- **Data is critical** (both quantitative and qualitative) at each step along the way of addressing SDOH.
- Collecting SDOH data can **open opportunities** for innovative **outreach & new partnerships.**

ROOTS Teams & Using Data

Using Data to Understand SDOH Needs (December 7 Webinar)

Asian Health Services: Shared # of PRAPARE surveys collected (404), data on housing insecurity, and challenges related to tracking interventions

LAC-USC: Shared how publicly reported data, staff survey data, and ICD10 codes were collected and used, and challenges of entering ICD10 codes into Cerner

LifeLong Medical Care: Shared Care Management Template developed to track non-billable SDOH services & the challenge integrating data into a medical visit

NEVHC: Discussed data used to drive meeting with leadership to identify top SDOH priorities, capacity, and programs that can be leveraged

Petaluma Health Center: Used data from 400 PRAPARE surveys to identify subsets of patients and target interventions & shared how PRAPARE doesn't assess for the root case of unemployment

St. John's: Used external data and staff stories, and reviewed with leadership and external partners

WCHC: Shared story of self-service data platform & process for using mapping as a data tool

From Data to….Listening?

- Our site visits focused on **patient stories and building connections** through CHWs, navigators and community-based programs. Even without the formal data, they know what their patients need.

- Should we focus on a **blended approach to assess needs,** by capturing individual-level data when possible to ensure patients are not slipping through the cracks and helps us start quantifying needs **AND** get more creative in how we listen?

- And **what do we do** once we get information and stories from patients?

Role of Empathic Listening

Empathic Inquiry

(May 10 Webinar)

Empathic inquiry requires one to **listen without judgement.** Consider your:

1) sensitivity to information that is shared by the patient 2) body language 3) voice inflection.

When utilizing empathic inquiry to solicit SDOH info consider:

1) the room/setting/patient privacy concerns

2) what the patients thoughts may be

3) taking a pause to assess the situation and continue discussion or connecting the patient to a resource.

It's important to stress **to staff that they are not responsible for how a patient feels. It's important to set boundaries.**

Lesson #3:
Tailor Resources

- Resources should be well **matched to patient needs**. Staff should understand the referral criteria and ensure the resource is accessible and culturally appropriate before making a referral. **Not all patients require the same level of assistance.** The intensity of the assistance should be tailored to match the complexity of their need.

"**Keep looking** for something that really fits and benefits our clients [...] [Stay] on **top of our game** so that the clients get the best most efficient service"

Lesson #4:
This Work Takes Time

- Finding time to meet as a team, training staff on new processes and workflows and cultivating partnerships can be time intensive. **Start small** with screening for social needs, linking patients with resources and building interventions. Its important to **understand if the changes** work well for staff and patients **before spreading it clinic wide**.

"Start small and don't rush it because it's **not about the numbers that you screen**, but it's about your ability to respond [to those needs]."

Lesson #5:
Invest in Partnerships

- Identify what resources, knowledge and connections **already exist in your organization** before forging new partnerships. As you enter into new partnerships, it is essential to **build trust** by meeting in-person and clearly understand each other's goals and intentions.

"[B]uilding a partnership is very much like dating. You need time to kind of **court the other partner** and see where they're at and what they're looking for and does that align with that you're looking for. And what **scope** is there for developing a partnership"

Focusing on Partnerships

- Understanding **risks and incentives** among multiple entities
- Key elements to **designing and sustaining** partnerships
- Understanding progress toward **benchmarks** of effective partnerships

Partnership Design, Tools, and Best Practices

(March 8 Session)

- **West County**: Co-design with local **schools** using human centered design and **discovery kits**
- **Petaluma Health Center**: Work partnering with the **Petaluma Day School & Job Link** to address unemployment
- **LAC-USC**: Connecting with the Wellness Center on **their own campus**

Sharing Community Partnerships

(April 5 Webinar)

Early Lessons

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Conversation

Which of the lessons **resonate** with you and your work?

Which lessons **don't resonate** with your work and why? What is missing?

What stories do you have that add value or bring life to the lessons?

So What Did We Learn?

There's No One Clear Right Role

- Most clinics focused on the **role of screening and referring patients**. However, we've learned through ROOTS and other CCI programs that there are additional roles to play, like:
  - Community convener
  - Data owner
  - Creator of economic opportunity
  - Operator of a social enterprise and job creator
  - Advocate
- Role might depend on organizational philosophy, leadership priorities, clinic history, other available community services, location, and size.

More Support & Examples Are Needed

- There is **no one faculty, technical assistance provider, or change package** to do this work that we've found has all the answers or is the perfect fit.
- Building capacity to do this work is a heavy lift, and there are many outstanding questions and technical assistance needs. There is a great need to **provide and lift up examples of clinics** doing this work well, and to connect clinics with each other.
- The knowledge to answer some of these questions exists. There is a big need for information sharing and technical assistance about how to **implement screening and referral.**

ROOTS 2.0?

- **Site visits** were the most useful program element. They provided inspiration, motivation, concrete ideas and time to connect with other teams.

  *"...envisioning **the potential** of our organizations."*

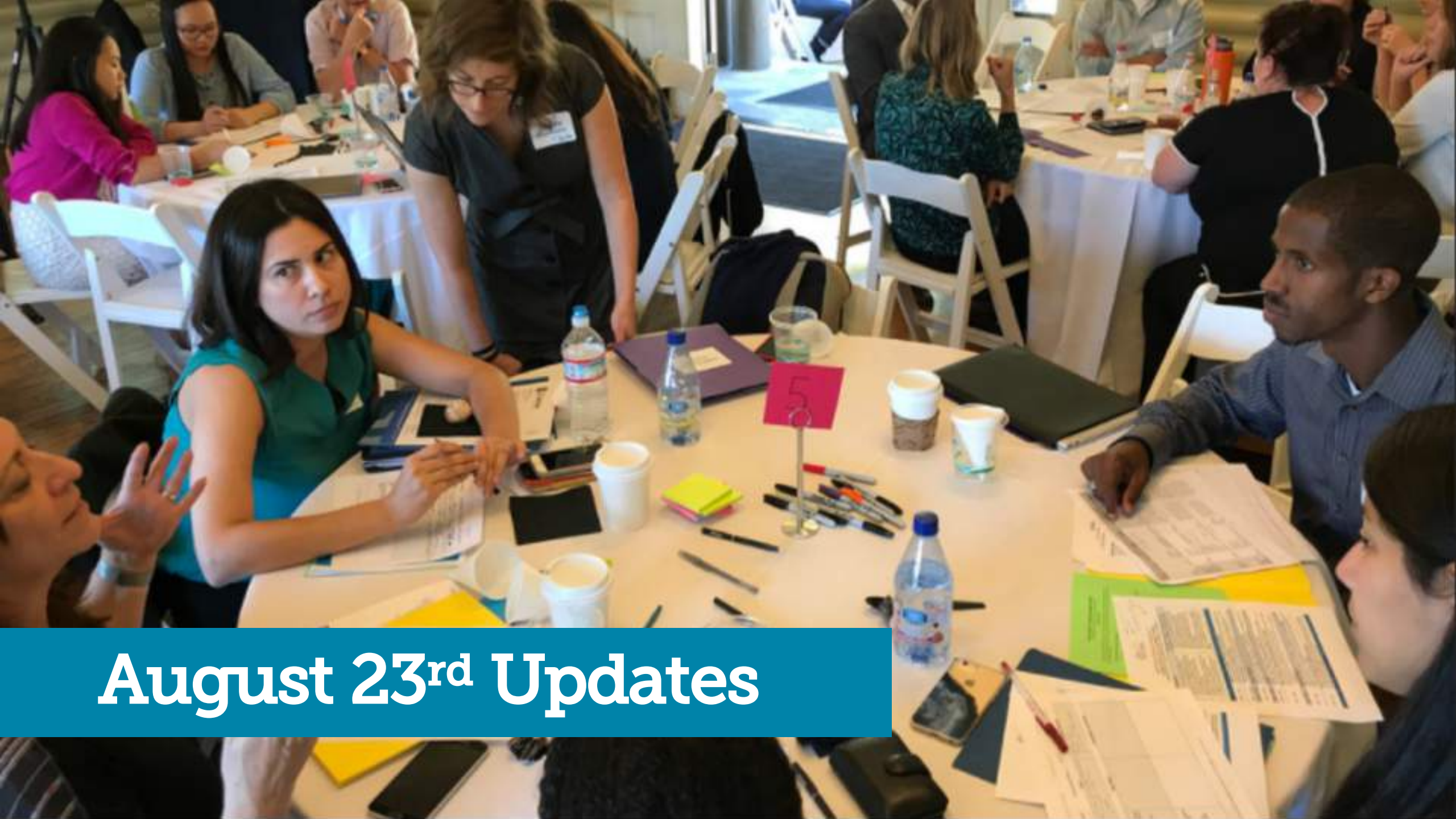
  *"...it kind of forces you to think about what are the **realm of possibilities**. And sometimes we think so much in a box that being able to see examples, it's not about replicating exactly what people do, but being able to say, hey, I never thought about that."*

- Add more time at in-person convenings for teams to connect & share, **less didactic presentations**.
- More **guidance or a roadmap** at the beginning & emphasis on partnerships earlier in the program.
- More **time** than a year.

  *"...doing this work in addressing social determinants of health is not like a one-time project. **What we're building is a program.** It's not a project."*

- Focus on **one core** social determinant?

Questions?



August 23rd Updates

August 23rd Session & Draft Agenda

When/Where:

- Thursday, August 23, 2018 from 9:00am-5:30pm
- DoubleTree Berkeley Marina Hotel
- **You should bring 4 teams members**

15 Minutes of ROOTS Talk Story

Sharing & Learning, Part 1: Food Insecurity

Sustainability & Financing

Sharing & Learning, Part 2: Data & Partnerships

World Café: What's Next?

Celebration

Asks

- ❑ Register your team in EventBrite by August 1
- ❑ **Pre-work:** Create a 10 minute presentation & email it to **Diana by 8/20** (using the suggested slide deck or your own), making sure to address the following:
  - **Organizational Info:** *Location, EHR, Social Needs Focus, Population Focus, Screening Tool, Partnerships*
  - **Project Recap:** *Where did you start with your ROOTS project, and where are you now?*
  - **Project Roadblocks, Challenges, and A-ha's:** *What roadblocks or challenges forced you to change direction? How did you overcome those challenges? What "a-ha" or moments of success did you have?*
  - **Top 3 Takeaways**: *What were your top three takeaways or learnings from ROOTS?*
  - **Impact & Role:** *How has addressing social needs impacted your organization? What do you think your organization's role in addressing social needs is or should be?*
  - **What's Next**: *What is next in your organizations journey to assess & address social needs? What are you planning for the rest of 2018 & beyond?*
- ❑ **Got a patient or staff story to share? We'll support you!**

Evaluation

- **Follow-up staff surveys**: Sep-Oct 2018
- **Onsite Interviews**: Sep-Oct 2018
  - Project Leads & Teams
  - Clinic Leadership
  - Partners

Questions?

Thank you!

For questions contact:

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