ROOTS Program

June 7, 2018

Idea Sharing Webinar – Sharing Workflow Experiences

blue of california foundation

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Upcoming Events

Thurs., July 12, 2018 @ 12-1pm

Title: Early Lessons Learned from the ROOTS Program Webinar

- Faculty: CCI Staff + Others
- Focus:
  - Share the evaluation results & get reflections
  - Share agenda & prep needs for August in-person session
  - Have teams give a brief update on progress & challenges

Thursday, August 23

- What: Last In-Person Session
- What: Team sharing & sustainability

ROOTS Roadmap

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

In-Person

- **Session #1** 10/5/17 Bay Area
- **Site Visits** 1/31/2018: ROOTS Clinic; 2/22-23/18: KKV & WHC
- **Session #2** 3/8/18 Los Angeles
- **Session #3** 8/23/18 Bay Area

Remote Support

Coaching: Monthly Team Calls

- **Kickoff Webinar** 9/14/17
- **Content Webinar** 11/16/17
- **Idea Sharing Webinar** 12/7/17
- **Program Update Call** 1/10/18
- **Content Webinar** 2/8/18
- **Idea Sharing Webinar** 4/5/18
- **Content Webinar** 5/10/18
- **Idea Sharing Webinar** 6/7/18
- **Content Webinar** 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 Project Workflow and Marketing, Form Partnerships*

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

- **Project Charter** 11/17/17
- **Partners Agreements** 3/18
- **Share Lessons Learned** 8/18-10/18

Evaluation Activities

- **Interviews w/ Leads** 10/17-11/17
- **Provider/Patient Surveys** 12/17-1/18
- **Midpoint interviews (phone)** 4/18 *(instead of coaching call)*
- **Onsite Interviews, FUP surveys + project metrics** 9/18-10/18

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

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Empathic Inquiry: Additional Support

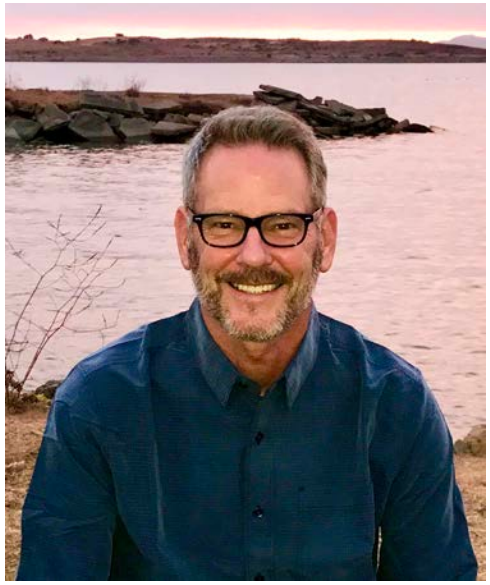
ELEVATION
HEALTH PARTNERS
ELEVATING HEALTH FOR ALL

- Customized **onsite training or group webinar** on empathic inquiry or empathic inquiry related training.
- Could be scheduled for the organization or held as part of the agenda of a provider, care team, quality improvement, quarterly or other existing meeting.

Idea Sharing on Partnerships

Facilitator:

Jim Meyers, DrPH



ASIAN HEALTH SERVICES

HEALTH CARE FOR ALL. ADVOCACY FOR THE UNDERSERVED.

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Asian Health Services

Linh Chuong

Who We Are

- Oakland, California
- Provide medical, dental, and mental health to >28,000 patients
- Serve in English and 12 Asian languages: Cantonese, Mandarin, Vietnamese, Korean, Cambodian, Mien, Hmong, Lao, Mongolian, Tagalog, Karen, and Burmese
- EHR Vendor: NextGen (anticipated changes)
- Target SDOH Pop.: Elderly, HIV
- Target SDOH Need(s): Housing and food security

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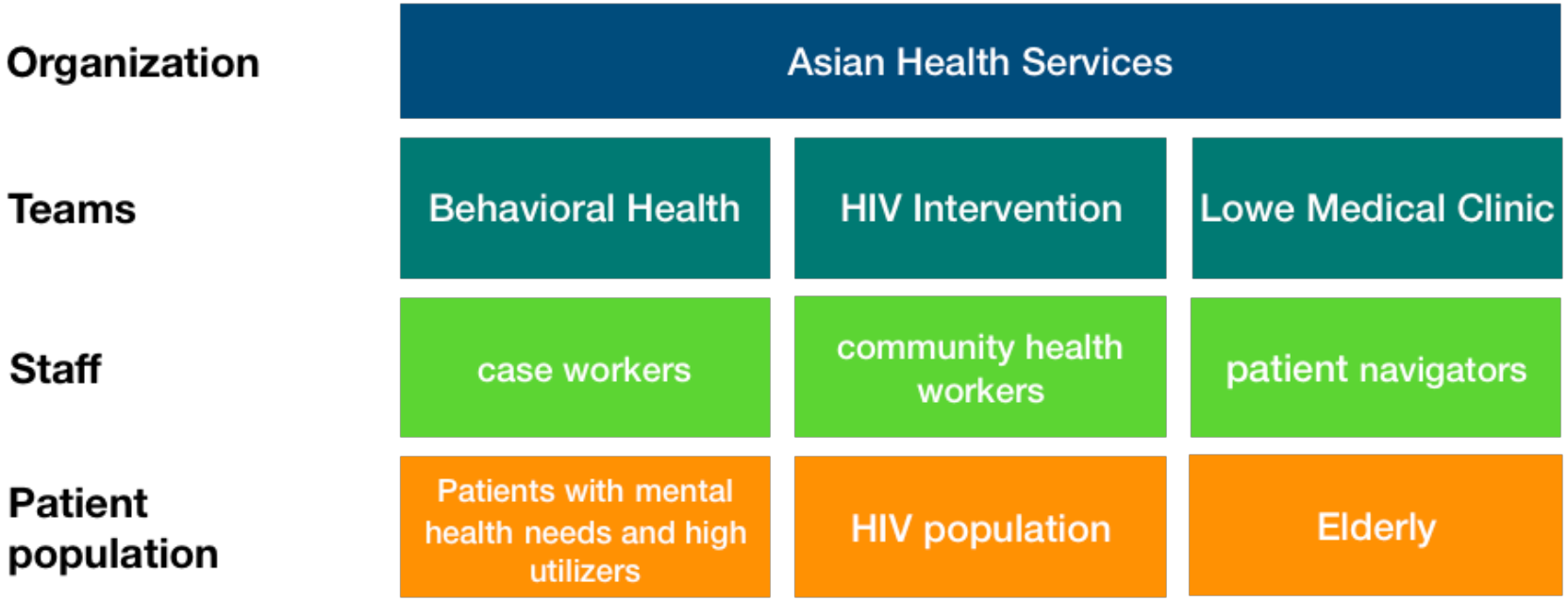
Implementation Teams



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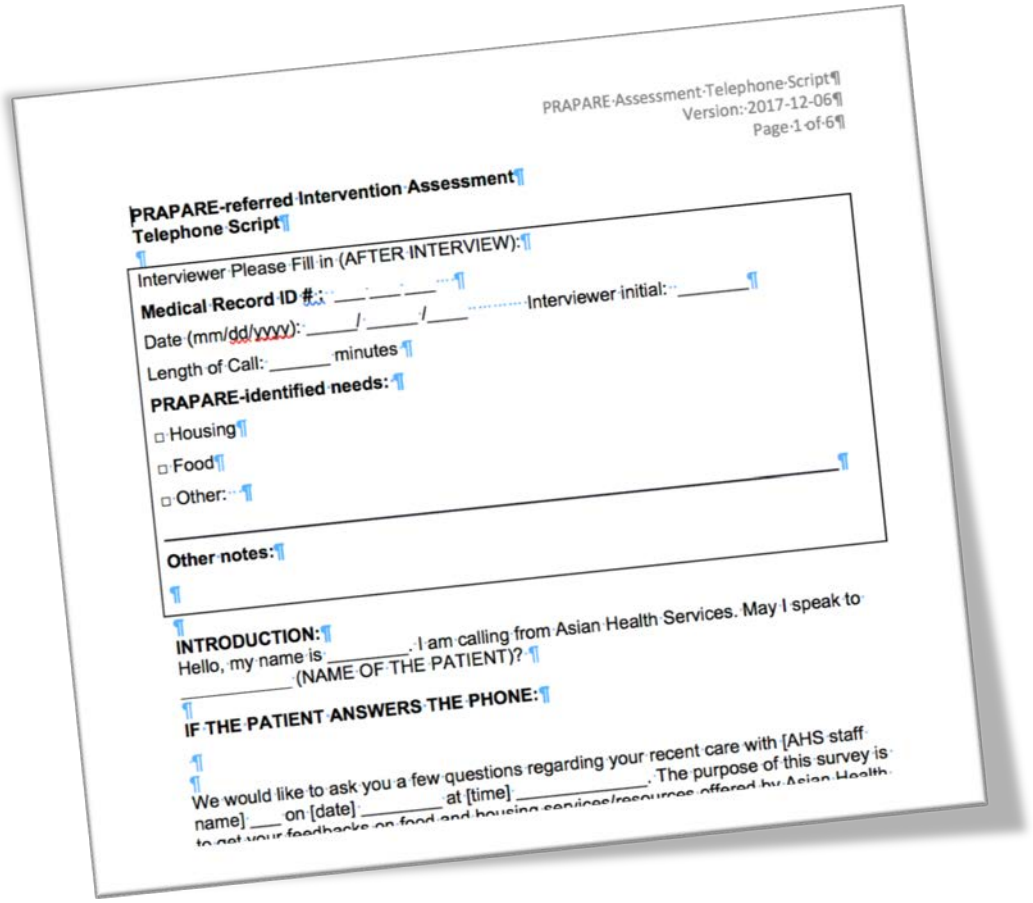
Measuring Impact through Informal Patient Interviews



PRAPARE Assessment Telephone Script
Version: 2017-12-06
Page 1 of 6

PRAPARE-referred Intervention Assessment Telephone Script

Interviewer Please Fill in (AFTER INTERVIEW):

Medical Record ID #: ___ ___ ___ Interviewer initial: _____

Date (mm/dd/yyyy): ____/____/____

Length of Call: _____ minutes

PRAPARE-identified needs:

- ☐ Housing
- ☐ Food
- ☐ Other: _____

Other notes:

INTRODUCTION:

Hello, my name is _____. I am calling from Asian Health Services. May I speak to _____ (NAME OF THE PATIENT)?

IF THE PATIENT ANSWERS THE PHONE:

We would like to ask you a few questions regarding your recent care with [AHS staff name] ___ on [date] _____ at [time] _____. The purpose of this survey is to get your feedbacks on food and housing services/resources offered by Asian Health

- 30 patients
- In-language: English, Vietnamese, Chinese (Mandarin, and Cantonese)
- Questions around:
  - Comfort level with questioning
  - Type and degree of support provided
  - Helpfulness of resources
  - Additional support needed

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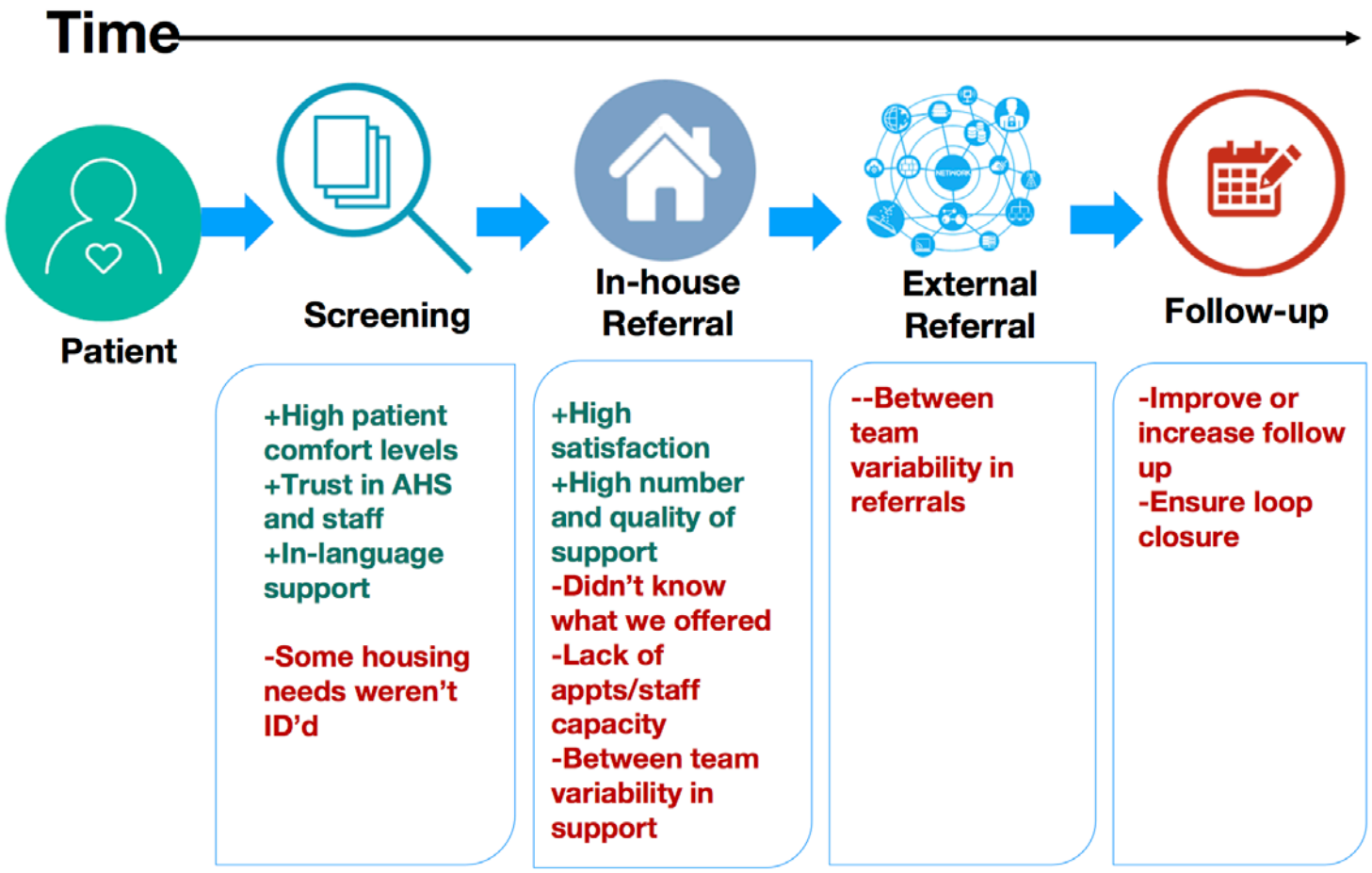
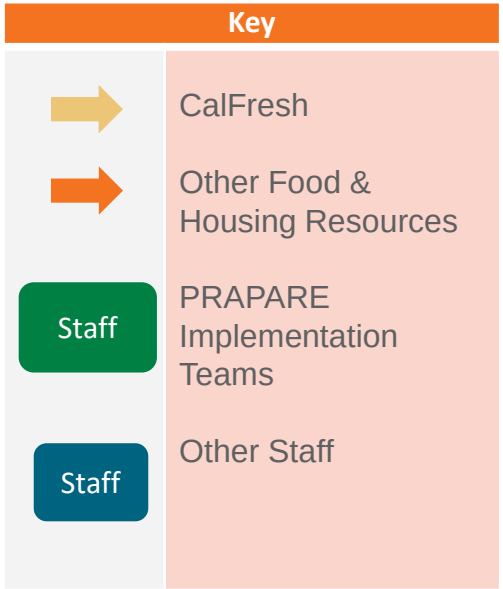
Results from Informal Patient Interviews



Original Referral Algorithm



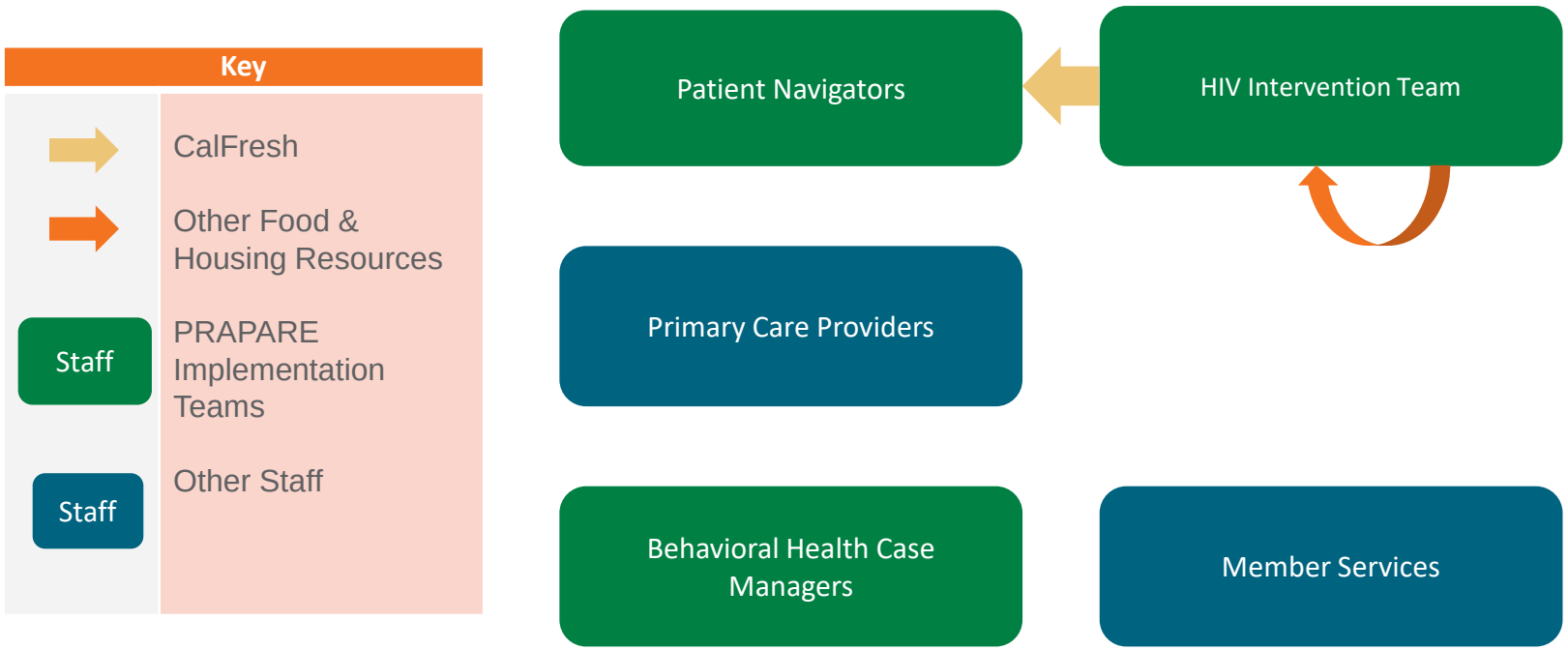
Patient Navigators

HIV Intervention Team

Behavioral Health Case Managers

Original Referral Algorithm

Original Referral Algorithm



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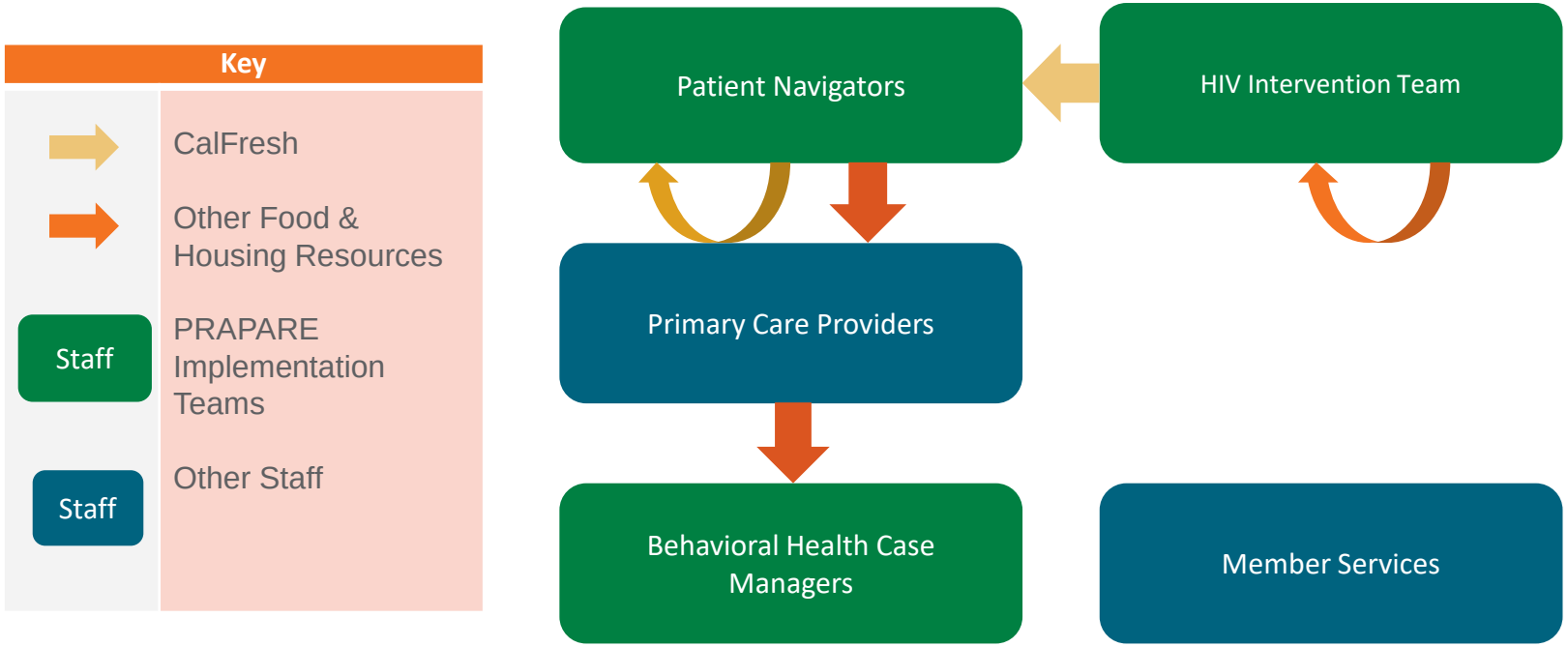

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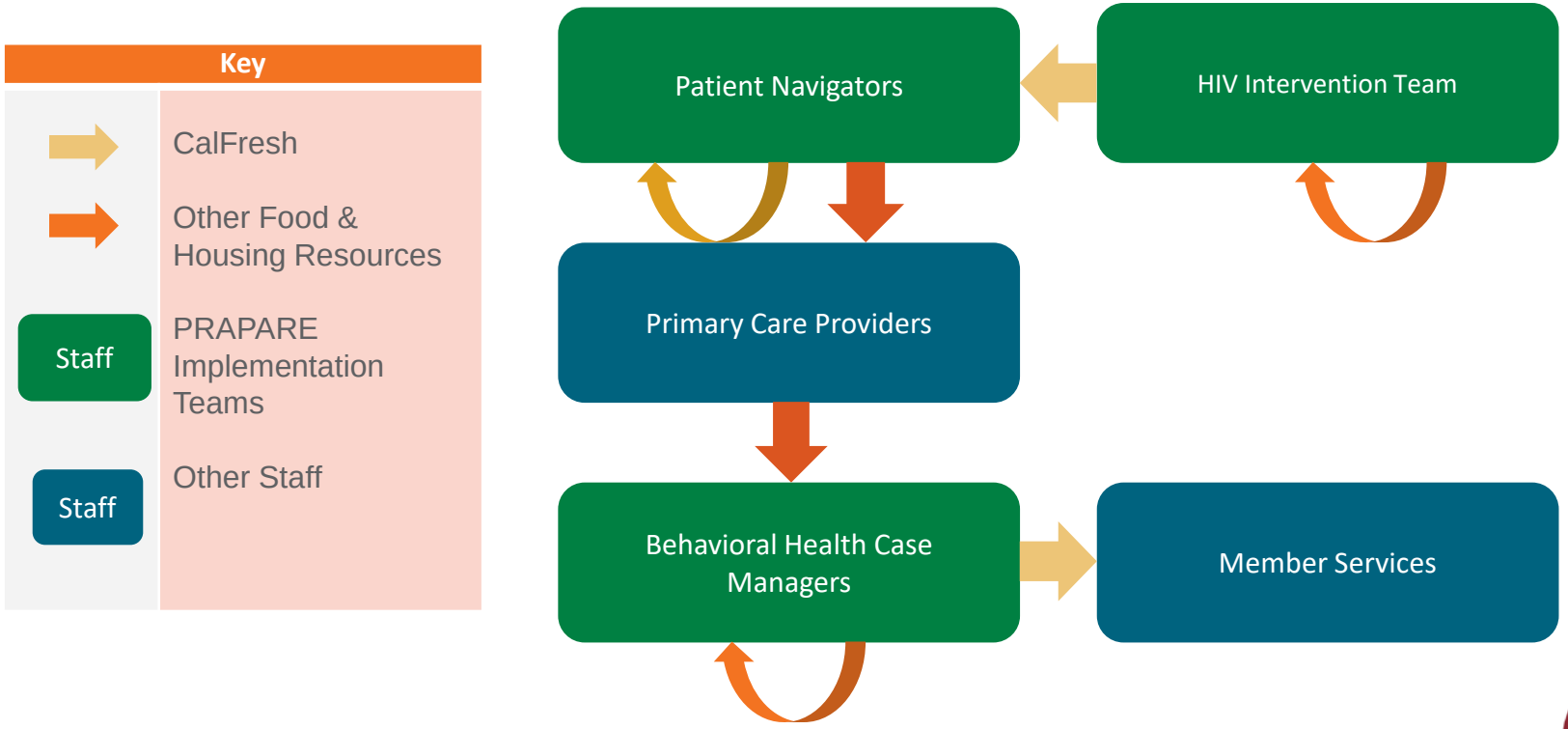

Risk-Stratified Referral Algorithm

ID social need:

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Risk-Stratified Referral Algorithm

ID social need:

Tiered Support Areas:

Food	Citizenship
Housing	IHSS
Transportation	Phone
Employment	Utilities

- Domestic Violence
- In-House Referrals (incl. mental health)
- Caregiver Support

Insurance

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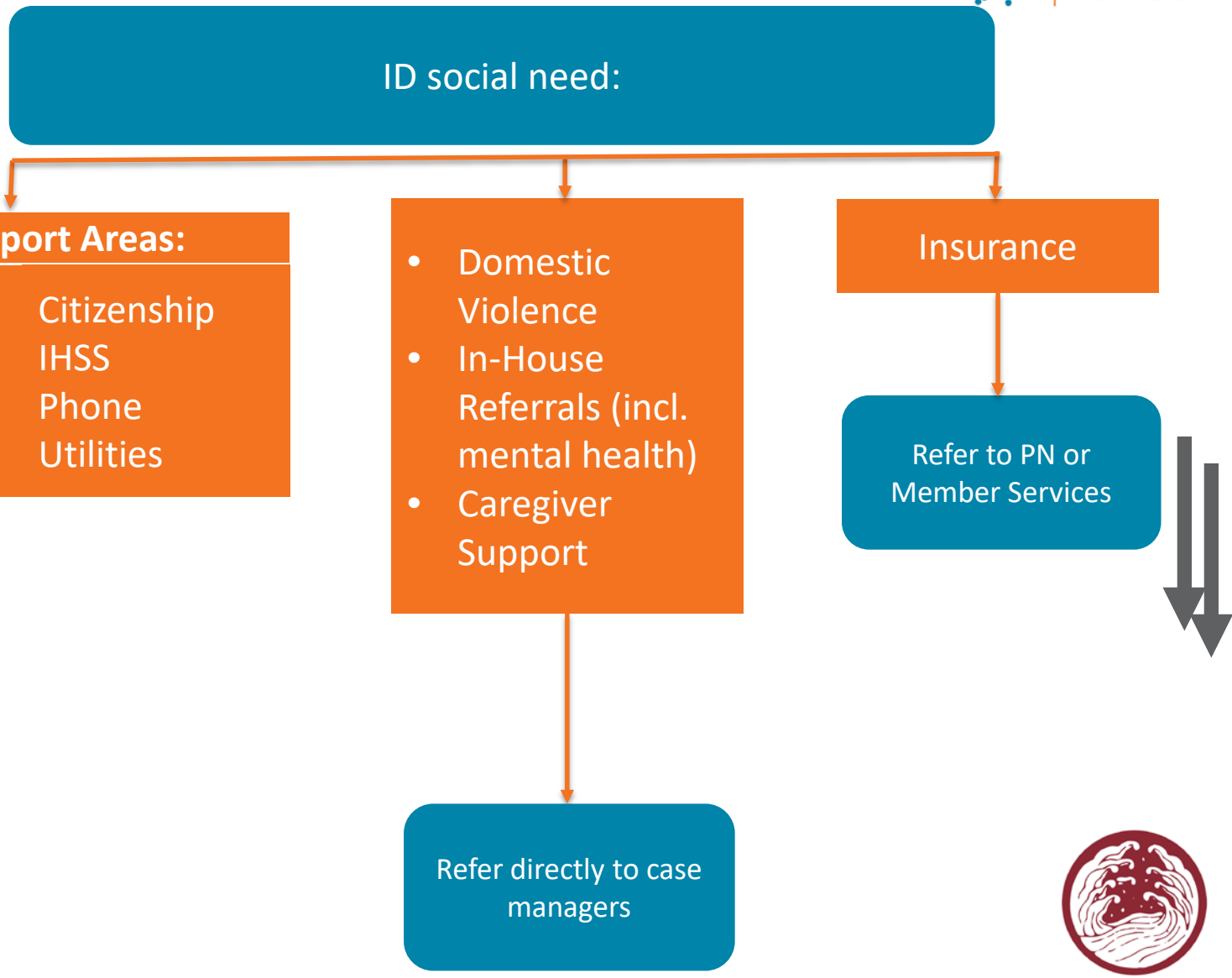
Risk-Stratified Referral Algorithm



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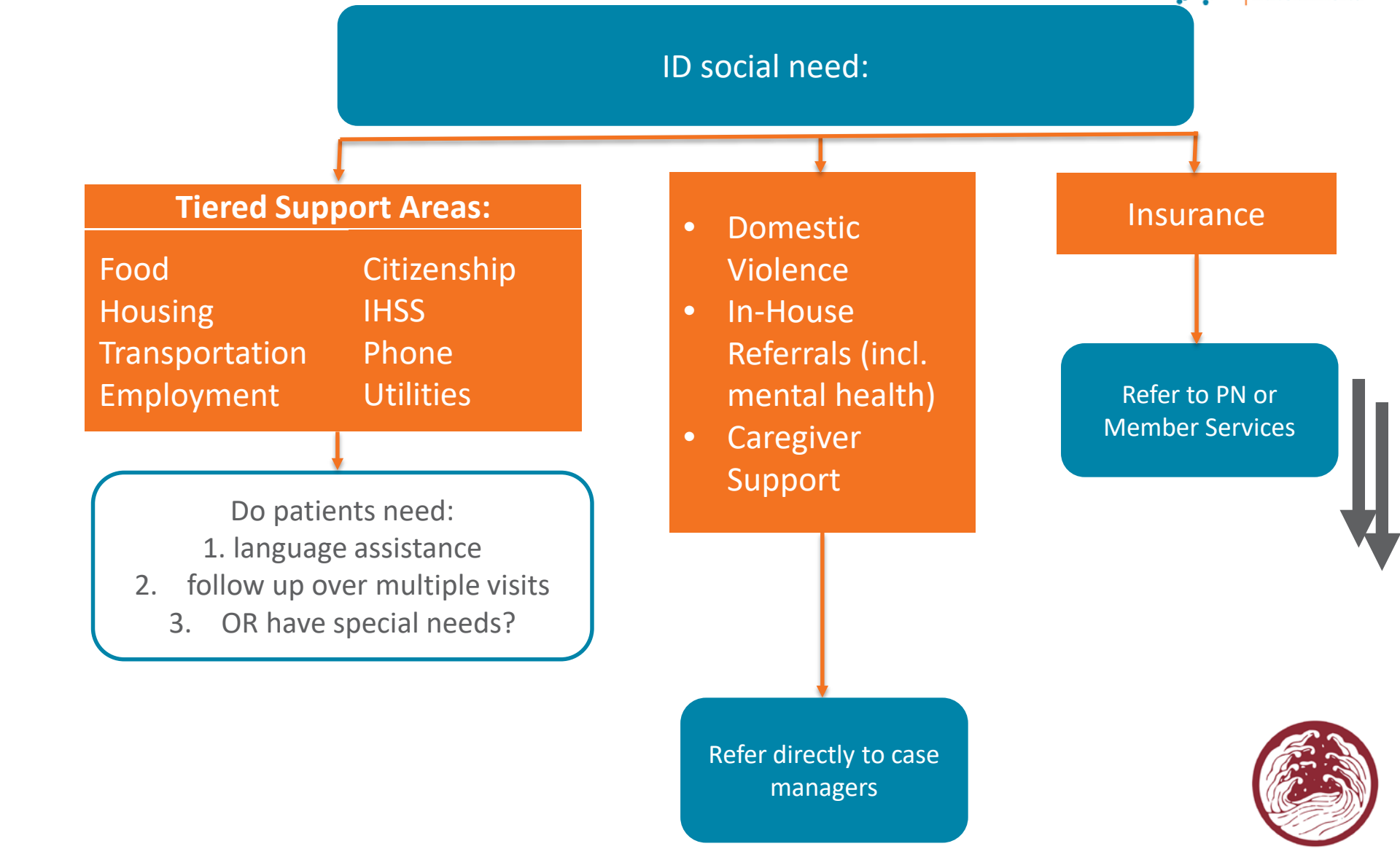

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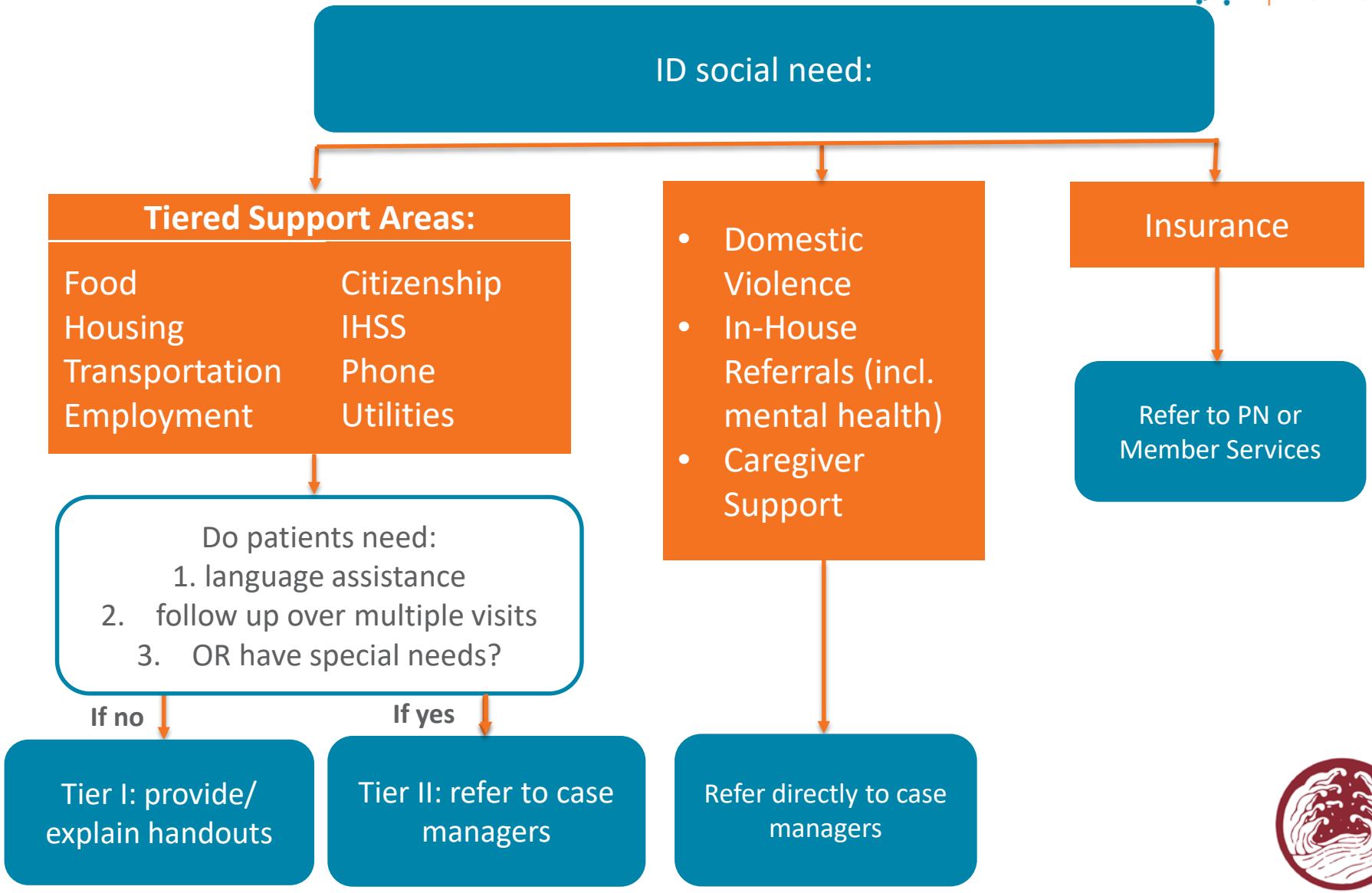

Our Story

- Where we started:
  - planned to develop new interventions
  - Planned to overhaul EHR (delayed by transition)
- Workflow changes along the way and why:
  - training up staff to offer consistent resources to patients
  - redeveloping referral algorithms to do tiered resource support

Not a question of how but when

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Our Story

- Why we ended up with this workflow:
  - listening to patients and staff
  - balancing with competing clinic demands
- Impact now and in the future on those who do the primary SDOH work:
  - reduce burden on case management team

...the Question

- One Question for the Group Today
  - –How have you captured loop closures?

Northeast Valley Health Corporation

Jessica King, MPH, RDN
Associate Director, Quality and Health Education
jessicaking@nevhc.org

Who We Are

- Where We Are Located: Northeast San Fernando and Santa Clarita Valleys
- Operates: 15 licensed health centers, 1 mobile, 4 dental clinics, and 13 WIC sites
- In 2017, NEVHC served 74,608 low-income patients
- EHR Vendor: NextGen
- Target SDOH Population: Adolescents ages 12-17 at Pacoima and Santa Clarita Health Centers
- Target SDOH Need/Needs: Food Insecurity

Addressing Food Insecurity

- NEVHC's ROOTS Food Insecurity Screening with Technology (FIST) project aims to:
  - Develop a process to identify pediatric patients ages 12 through 17 who are food insecure and link them to resources to address their needs
  - During a Well Child Exam visit, patients will be given an O-tech tablet to complete the *Hunger Vital Sign*, a 2-question validated food insecurity screening tool

Screening Process: Medical Assistant

MA Vitals the patient

↓

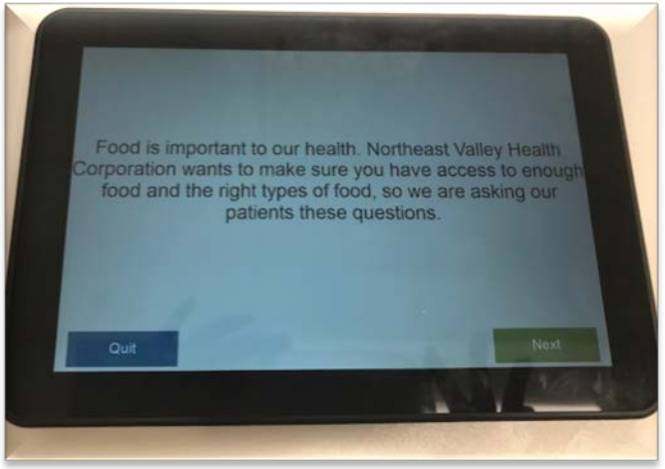
Distributes the tablet and introduces the PHQ-9 and Hunger Vital Sign

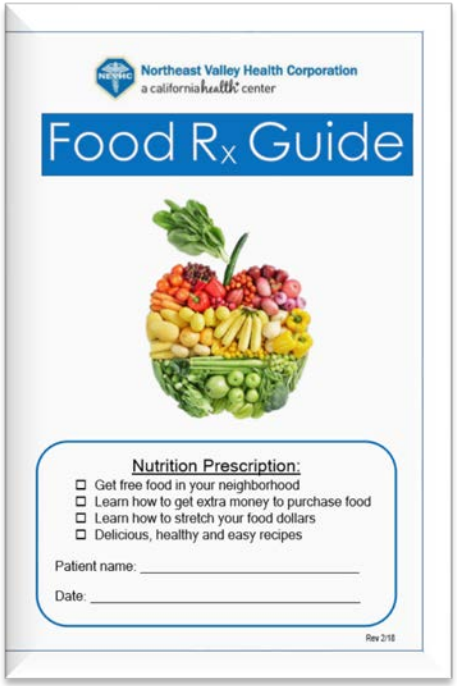
↓

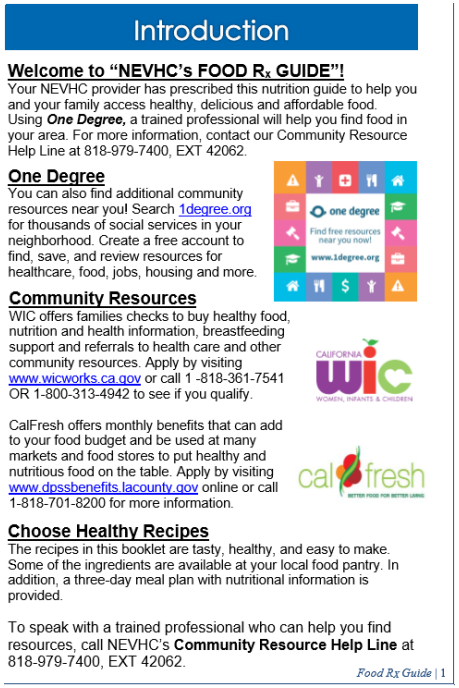
Generates template in EHR. Alert indicates positive screen.

↓

Places Food Rx Guide in provider's outbox as a "tickler".







Introduction

Welcome to "NEVHC's FOOD Rx GUIDE"!

Your NEVHC provider has prescribed this nutrition guide to help you and your family access healthy, delicious and affordable food. Using ***One Degree,*** a trained professional will help you find food in your area. For more information, contact our Community Resource Help Line at 818-979-7400, EXT 42062.

One Degree

You can also find additional community resources near you! Search 1degree.org for thousands of social services in your neighborhood. Create a free account to find, save, and review resources for healthcare, food, jobs, housing and more.

Community Resources

WIC offers families checks to buy healthy food, nutrition and health information, breastfeeding support and referrals to health care and other community resources. Apply by visiting www.wicworks.ca.gov or call 1 -818-361-7541 OR 1-800-313-4942 to see if you qualify.

CalFresh offers monthly benefits that can add to your food budget and be used at many markets and food stores to put healthy and nutritious food on the table. Apply by visiting www.dpssbenefits.lacounty.gov online or call 1-818-701-8200 for more information.

Choose Healthy Recipes

The recipes in this booklet are tasty, healthy, and easy to make. Some of the ingredients are available at your local food pantry. In addition, a three-day meal plan with nutritional information is provided.

To speak with a trained professional who can help you find resources, call NEVHC's **Community Resource Help Line** at 818-979-7400, EXT 42062.

Assessment and Referral: Provider

Positive Screen indicated by EHR alert and Food Rx Guide

↓

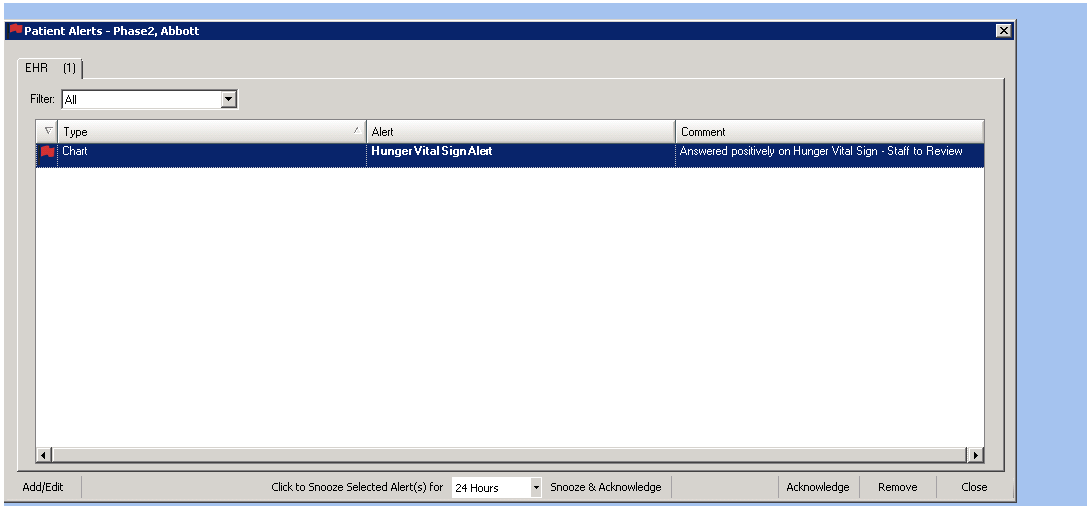
Discuss results, Food Rx Guide, and follow-up with nutrition. Assess and treat as indicated.

↓

Families in immediate need, ask MA to enroll and make referral to ER food bank using 1 Degree.

↓

Code Z59.4 and document standard phrase



Ordering Assessment:

#	Detail Type	Description
1.	Assessment	Lack of adequate food and safe drinking water (Z59.4).
	Patient Plan	1. NEVHC Nutrition Referral and Food Rx Guide given to the patient 2. Enroll in One Degree 3. Patient can also call the Community Resource Help Line 818-979-7400 extension 42062

Case Management:
Clinical Degreed Nutritionist (CDN)

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Generate i2i tracks report for patients who screen positive. Add patients to "registry" (tracking).

Call the family and document the encounter as a telephone visit. Make at least 3 attempts.

Review the Food Rx Guide, refer to SNAP and SNAP-Ed programs, enroll in 1 Degree and make additional referrals as necessary. Family receives resources via text or e-mail.

Refer and schedule patients at *high nutritional risk with a Registered Dietitian. (High nutritional risk = altered nutrition related lab values, FTT, and/or obesity with comorbidity). Nutritional Risk assigned by CDN and documented in encounter.

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Northeast Valley Health Corporation
a californiahealth+ center

1172 N. Maclay Avenue
San Fernando, CA 91340
(818) 898-1388 · www.nevhc.org

Departamento de Educación de Salud

CAMPEONES del CAMBIO™

Coma Saludable, Viva Saludable

¡ACOMPAÑENOS! APRENDA COMO PREPARAR COMIDA SALUDABLE Y NUTRITIVA PARA USTED Y SU FAMILIA.

Cada mes los talleres de nutrición ofreceran GRATIS demostraciónes de comida en vivo con recetas fáciles y saludables.

Día: Cada 2do Sabado del mes

Hora: 10:00 - 11:00 a.m.

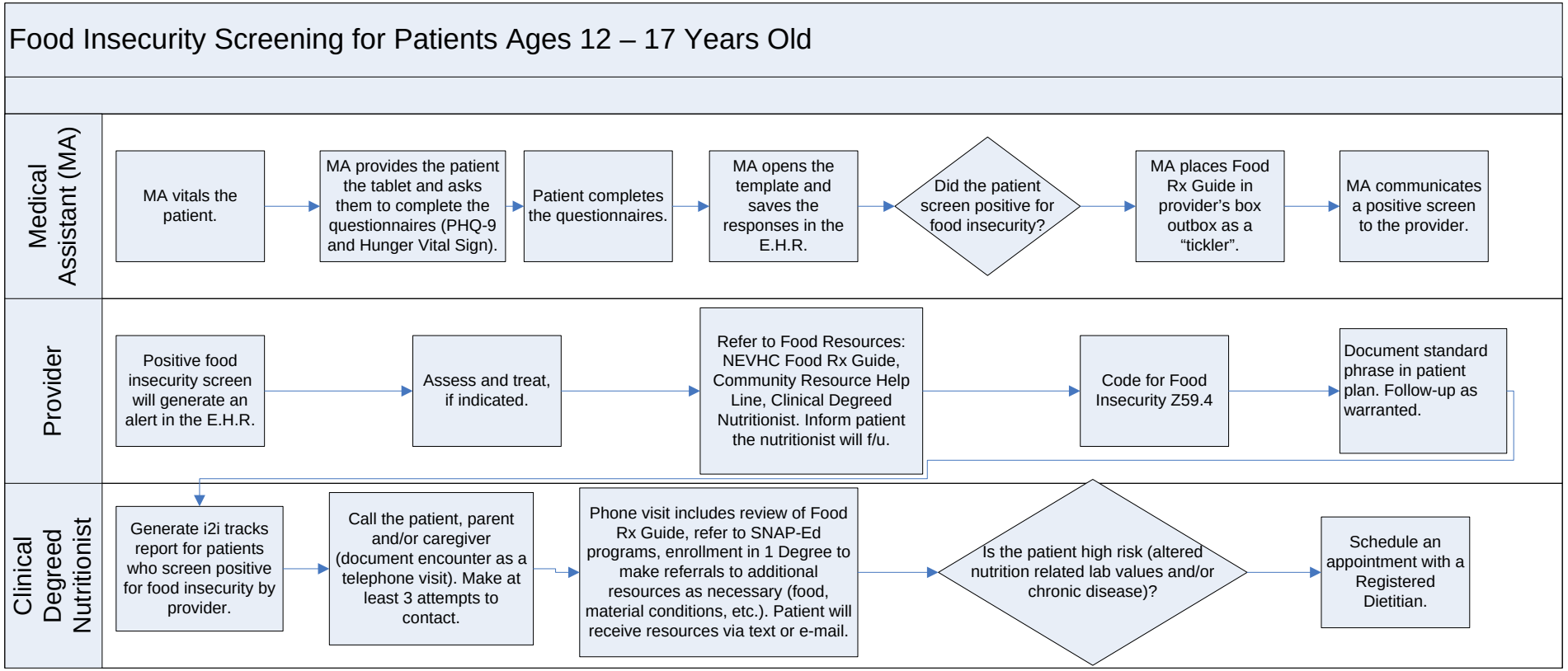
Locación: NEVHC Pacoima Health Center
12756 Van Nuys Blvd. Pacoima 91331

(La clase será eseñada en inglés.)

Fecha	Tema
Enero 13, 2018	Año Nuevo, Imagen Nueva: Metas Para su Salud
Febrero 10, 2018	Coma Saludable al Comer Afuera
Marzo 10, 2018	Comidas Saludables a su Alcance
Abril 14, 2018	Prepare un Plato Saludable
Mayo 12, 2018	Delicioso y Nutritivo: Preparando Platillos Saludables
Junio 9, 2018	Estire sus Dolares al Comprar la Comida
Julio 14, 2018	¿Que hay en las Etiquetas?
Agosto 11, 2018	Reconsidere su Bebida
Septiembre 8, 2018	Comidas Saludables a su Alcance
Octubre 13, 2018	Prepare un Plato Saludable
Noviembre 10, 2018	Delicioso y Nutritivo: Preparando Platillos Saludables
Diciembre 8, 2018	Mantengase Saludable Durante los Días de Fiesta

Para registrarse y más información, llame a la linea de mensajes de Northeast Valley Health Corporation al (818) 270-9508 ó DeniseTorres@NEVHC.org

Our Workflow



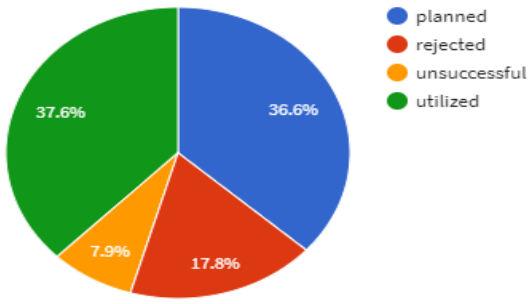
1 Degree Journey

- Contract initiated in October, 2017
- Used by Care Navigators/CHWs and staff as part of the Food Insecurity Screening Project
- Integrated into EHR, provide staff trainings, create goals and objectives on staff participation and status of referrals
- One Degree has been receptive to feedback based on staff and patient usage
- Platform does not allow for staff to share clients.
- Detailed reports on staff participation, referrals, and status are available to admin users.

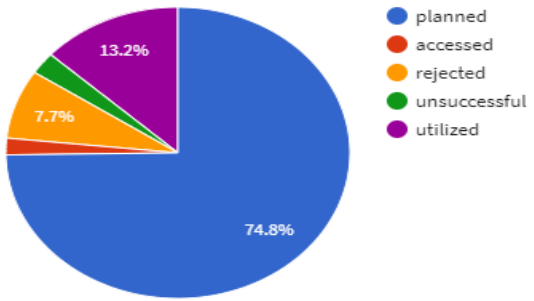
1 Degree Journey

Status of resources referred

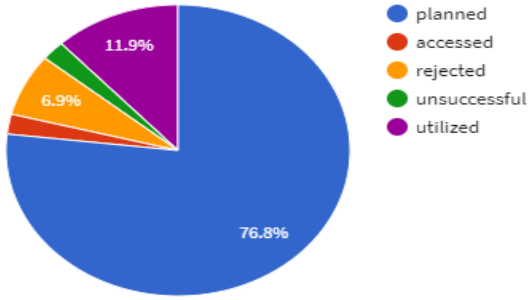
Past 30 days



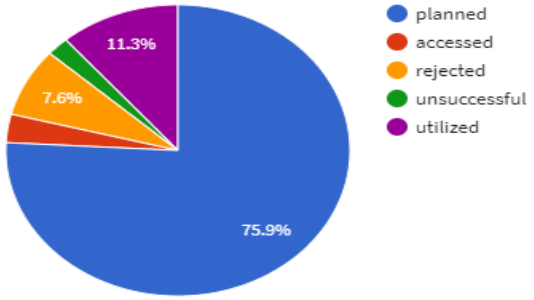
Past 90 days



Past 120 days

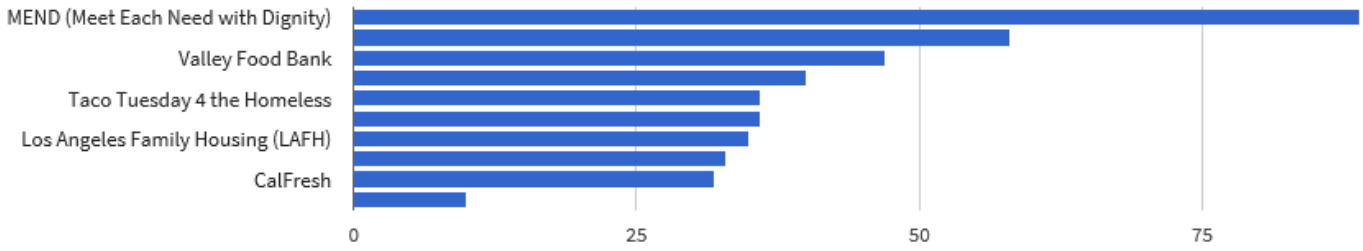


All time



1 Degree Journey

Top 10 most referred agencies (CBOs)



Our Story

- Pacoima Site
  - Original plan was to follow the roll out of Otech tablet use to administer the PHQ-9.
  - Technical difficulties = simultaneous roll out Otech tablet use for PHQ-9 and Hunger Vital Sign
  - Trained one provider at a time to make rapid changes to workflow as necessary.
  - Too much at once. Suspended MA enrolling patients in 1 Degree as there were staff frustrations with faulty tablet technology.

Our Story

- Valencia
  - Received all new tablets. No Wi-Fi or functionality issues have arisen!
  - Providers and MA(s) were trained on Otech tablet use to administer PHQ-9 prior to rolling out the Hunger Vital Sign screening.
  - MA(s) were also trained on 1 Degree Enrollment at Valencia for patients who are in need of immediate food assistance.

Our Story

- Original workflow: Enrollment in 1 Degree by Medical Assistants for all patients who screened positive for food insecurity.

- Revised workflow: Enrollment in 1 Degree by Medical Assistants for patients who are in immediate need of food.

  – 1 Degree does not support client sharing among staff.

  – Clinical Degreed Nutritionist is able to view patient referrals, but cannot update the status of the referral on the platform.

  – Future contract with One Degree will allow staff to update any NEVHC patient on the platform.

The Good…the Bad…

- The Good (what is going well):
  - Otech tablets are working!
  - Providers have positive feedback – "It's like social services packaged up into one intervention."
  - Plans to roll out to all pediatrics at all sites – supported by AAP recommendations for Hgb screening.
  - Able to identify at-risk families and offer additional support.

- The Bad (our continuing challenges):
  - "Patient screened false positive".
  - Staff need comprehensive training on empathy and communication skills. Limited time is available to offer these trainings.
  - Need to improve efficiency and accuracy of documentation

...the Question

- One Question for the Group Today
  - How are your staff introducing SDoH questions to adolescents and their parents/caregivers?
    - For example, do you encourage them to answer the questions together?

LifeLong Medical Care

Smriti Joneja
QI Coordinator
sjoneja@lifelongmedical.org

Who We Are

- **Northern California –** Alameda, Contra Costa and Marin Counties
  - Oakland, Berkeley, Richmond, San Pablo, Pinole, Rodeo, Novato
- **14 Primary Care Sites**
  - 1 Adult Day Health Center
  - 4 School-Based Sites
  - 2 Dental Clinics, 1 Dental Van
  - 10 Supportive Housing Program Sites
  - 2 Urgent/Immediate Care Sites
- **# FTE Medical Providers:** 70
- **EHR:** NextGen and eCW
- **Target:** East Oakland Location
- **SDOH:** Food Insecurity

Workflow of Patient Visit

Identify Food Insecure (FI) Patient

- Medical Assistant (MA) screens patient using 2-item Hunger Vital Sign™ survey

Determine Referral for FI Patient

- Provider (PCP) assesses FI and refers to
  - Social Worker
  - Food as Medicine Course (Wellness Center)
  - Nutritionist (TBD)

Complete Referral for FI Patient

- Social Worker or Wellness Center staff tracks referral to completion

Our Survey

2-item Hunger Vital Sign™ Scoring

1. "Within the past 12 months we worried whether our food would run out before we got money to buy more."
   - Often True (2) Sometimes True (1) Never True (0)
2. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."
   - Often True (2) Sometimes True (1) Never True (0)

SCORE COMBINATIONS

4 = 2 + 2

3 = 1 + 2

2 = 1 + 1 or 0 + 2

0 = 0

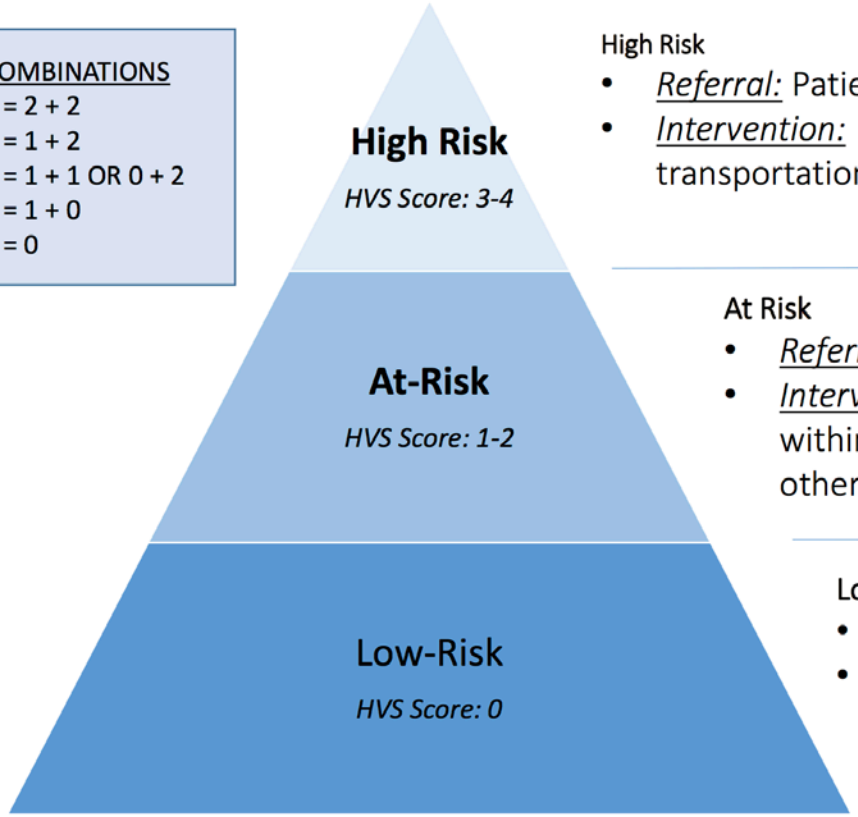
Moving forward, we will pilot:
- **'Sometimes'** = 1-2 times in a year
- **'Often'** = 3 or more times in a year

Rationale: experiencing food insecurity **3 or more times in a year** points to a pattern, which should be considered higher risk. Note that this is simply an educated guess and will be tested to see if it helps MAs to explain the questions to the patient

Our Risk Scoring

Risk Stratification – referrals and interventions

COMBINATIONS
4 = 2 + 2
3 = 1 + 2
2 = 1 + 1 OR 0 + 2
1 = 1 + 0
0 = 0

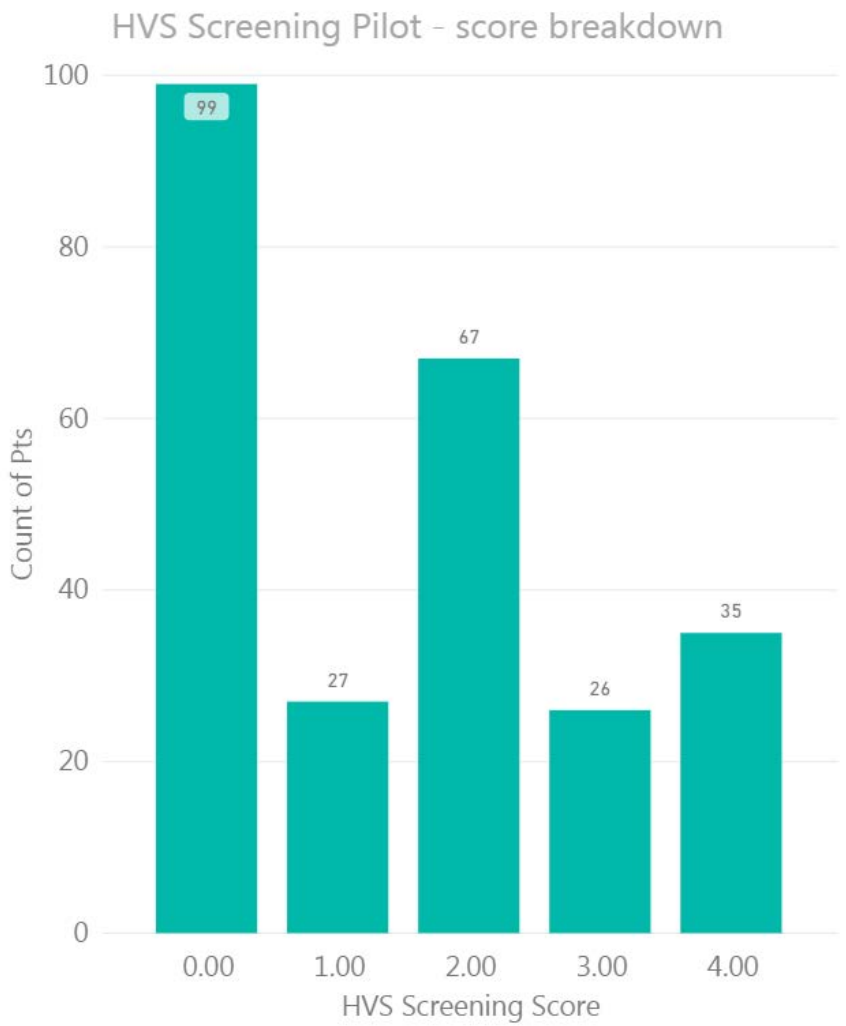


High Risk
- *Referral:* Patient referred to Social Worker (high need)
- *Intervention:* SW assesses food insecurity and other related SDOH (e.g. transportation), refers to appropriate services

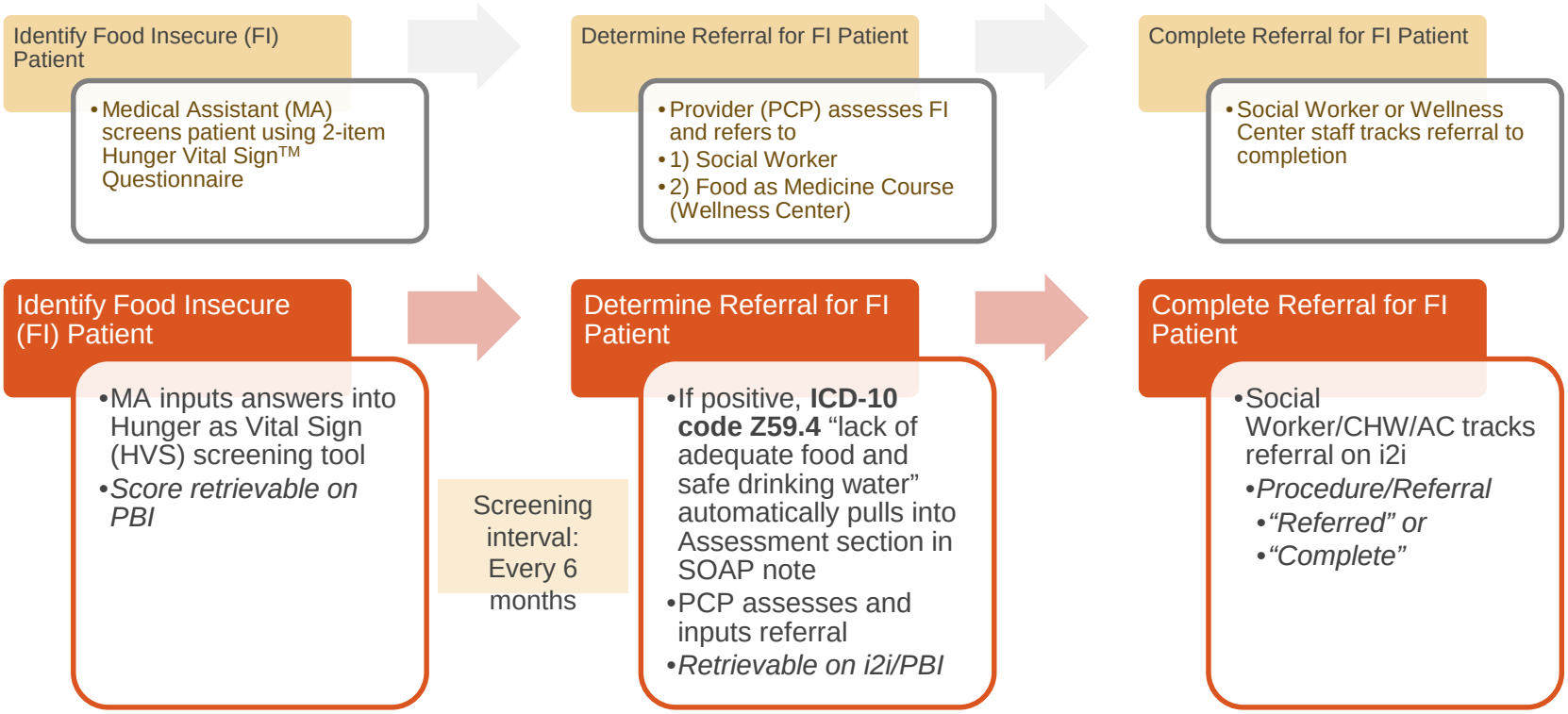
At Risk
- *Referral:* Patient referred to AmeriCorps (moderate need)
- *Intervention:* AmeriCorps assess food insecurity needs and refer within clinic to Shared Medical Visit series (FAM, DM, HTN) and other groups, or to Social Worker

Low Risk
- *Referral:* Patient referred within clinic (low/no need)
- *Intervention:* Patient education material (MA or Americorps)

Risk Score Breakdown



Workflow of the Tracking Process



Our Story

- Where we started
- Changes along the way and why
- Why we ended up with this workflow

The Good…the Bad…

- The Good (what is going well):
  - Strong pilot teams
  - Community partners seem invested thus far

- The Bad (our continuing challenges):
  - Which staff responsible for which step?
  - How to engage pts who may need extra hand-holding through the connection process?

...the Question

- One Question for the Group Today
  - How do you determine when to stop follow-up and/or outreach to a pt, connecting them with services?

Q&A

Fill out the post webinar survey!