Idea Sharing Webinar
#1:
Using Data to Understand SDOH Needs

Jim Meyers, DrPH
December 7, 2017
Welcome

CCI/ROOTS Faculty and Staff

Jim Meyers, DrPH
ROOTS Coach
jimmeyersdrph@gmail.com
Remembering Communities and Colleagues in Los Angeles Area
1. Everyone is unmuted.
   • Press *7 to unmute and *6 to mute yourself.

2. Remember to chat or e-mail in questions!

3. Webinar is being recorded and will be posted and sent out via email
Agenda

1. Overview of Idea Sharing Format
2. Team Leader Sharing
3. Questions and Answers
Idea Sharing Format
Idea Sharing Format

✓ Rapid Presentations – 3-5 minutes
✓ Simple Slides
  • Presenter Slide
  • Organization Slide
  • Story Slide
  • Screen Shot Slides
  • The Good, The Bad
  • A Question for the Group
✓ E-mail Follow-up
Team Leader Sharing
Asian Health Services

Thu Quach
Director of Community Health and Research
tquach@ahschc.org
Who We Are

- Oakland, California
- 5 medical clinics, 3 dental clinics, and 1 specialty mental health
- nearly 50 medical providers, 20 dental providers
- EHR Vendor: NextGen
- Target SDOH Population: Elderly, HIV+ and at-risk
- Target SDOH Need/Needs: housing and food security
**Our Story – Pilot test of PRAPARE**

<table>
<thead>
<tr>
<th>Organization</th>
<th>AHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teams</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Implementing Staff</td>
<td>case manager (2)</td>
</tr>
<tr>
<td>Patient population</td>
<td>Patients w/ mental health needs</td>
</tr>
</tbody>
</table>

404 data collected between 6/12 - 9/21
Housing Needs

A. What is your housing situation today? N=391
B. Are you worried about losing your housing? N=386

Almost 10% do not have housing.

28% are housing insecure.
Material Security (n=258)

- Food: 9%
- Clothing: 2%
- Utilities: 2%
- Child care: 2%
- Medical: 3%
- Phone: 2%
- Other: 43%
- Unassessed/Refused/Skipped: 37%
The Good…the Bad…the Question

The Good
• PRAPARE tool is applicable and feasible within our clinic flow
• Great team, leadership support, and timing to dive deep into this issue

The Bad
Do our current interventions have meaningful impact for patients?
  – Hard to track interventions
  – Are interventions addressing problems or just increasing workload?
  – Do we provide consistent resources across the teams?

One Question for the Group Today:
How do we measure success/outcomes in this project within short timeframe?
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 Story

• Brief Description of How Data Was Used or Is Used to Best Understand SDOH Need
  – Data Used:
    • Publicly reported data, staff survey data.
    • Starting collection in EMR using ICD10 codes December 2017.
  – Review Process:
    • Discussion of staff survey compared to public health data
    • Board of Supervisors memo

• Screen Shots
In July 2016, we asked staff how common they felt that the following problems were in our patient population.
The we compared and discussed staff responses with public health data.

Housing stress (percent)

The percent of housing defined as stressed in Los Angeles County, CA is:

54.7 %

http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/CA/Los%20Angeles
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:

1) Describe current efforts to screen for food insecurity in County health clinics, as well as best practices, challenges, and lessons learned from other jurisdictions;

2) 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,
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.
Subjective/History of Present Illness

Vital Signs

No results found

Consolidated Problems

Add new as: This Visit

Name: Tobacco use
Classification: Medical
Actions

Inadequate drinking water supply (Z59.4)

Historical

Intake Information

No results found
The Good… the Bad… the Question

• The Good:
  – Team is willing to collect level on our patient population
  – Will also begin collecting process metric data (number of referrals for food insecurity, housing insecurity)
  – This will start mid-December

• The Bad:
  – Our version of Cerner (ORCHID) does not have discrete data fields for food/housing
  – ICD 10 codes read out incorrectly (ie “Inadequate water supply”)
• One Question for the Group Today

– How are you collecting outcomes data given that most EMRs don’t link up with community organizations?
Lifelong Medical Care

Janelle Sauz
Population Health Program Manager
jsauz@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
Our Story

• Case Management Template developed in 2016 to track non-billable services that address SDOH
  – **Goal**: Integrate SDOH data into patient care not previously included in patient health record
  – **Data Used and Reviewed**: View report and dashboard of services and referrals on PowerBI
## Today's Services

<table>
<thead>
<tr>
<th>Staff Position:</th>
<th>Service Type:</th>
<th>Interpreter Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager</td>
<td>In-person (on-site)</td>
<td>☐ Yes ☑ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services/Referrals Provided:</th>
<th>External Referral:</th>
<th>Time Spent:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Food</td>
<td>☑</td>
<td>&lt;15 mi</td>
<td>Referred pt. to a food bank</td>
</tr>
<tr>
<td>2. Food</td>
<td>☐</td>
<td>30 min</td>
<td>Taught pt. basic cooking and meal prep techniques</td>
</tr>
</tbody>
</table>

### Additional Visit Notes:
(copied forward)

<table>
<thead>
<tr>
<th>Patient Providers</th>
<th>Telephone Call Summary</th>
</tr>
</thead>
</table>

### Follow-Up

<table>
<thead>
<tr>
<th>Date:</th>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/25/2016</td>
<td>Check in to ensure pt is getting correct nutrition and is practicing skills taught during today's visit</td>
</tr>
</tbody>
</table>
The Good...the Bad...the Question

• The Good: SDOH data recorded on patient chart; CM Template utilized by support staff and non-medical providers.

• The Bad: Challenge of integrating data to medical visit where providers are aware of patient priorities.

• One Question for the Group Today: How does your organization share SDOH data?
Northeast Valley Health Corporation

Debra Rosen
(for Jessica King)
Associate Director, Quality and Health Education
ejessicaking@nevhc.org
Who We Are

• Where We Are Located: Northeast San Fernando and Santa Clarita Valleys
• Number of Clinics in the Organization: 14 licensed health centers and 1 mobile
• Total Number of FTE Providers: 54.86 FTE (31.08 Physicians and 23.8 NP/PA/CNM)
• EHR Vendor: NextGen
• Target SDOH Population: Adolescents ages 12-17 at Pacoima and Santa Clarita Health Centers
• Target SDOH Need/Needs: Food Insecurity
Our Story

• Brief Description of How Data Was Used or Is Used to Best Understand SDOH Need
  – Data Used: Food Security Rates, SNAP Participation Rates, Childhood Obesity Rates, Staff’s Satisfaction with O-tech tablets, Staff Readiness to Address SDOH Needs
  – Review Process: Meeting with leadership to review top SDOH priorities, clinic capacity, and identify programs/services that can be leveraged.
### TABLE 1: Percent of Households <300% Federal Poverty Level That Have Food Insecurity and Very Low Food Security, LACHS 2015

<table>
<thead>
<tr>
<th></th>
<th>Food Insecurity</th>
<th>Very Low Food Security</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>95% CI</td>
</tr>
<tr>
<td>LA COUNTY HOUSEHOLDS</td>
<td>29.2%</td>
<td>27.1 - 31.3</td>
</tr>
<tr>
<td>FEDERAL POVERTY LEVEL§</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-99% FPL</td>
<td>41.1%</td>
<td>37.3 - 44.9</td>
</tr>
<tr>
<td>100%-199% FPL</td>
<td>25.4%</td>
<td>22.4 - 28.4</td>
</tr>
<tr>
<td>200%-299% FPL</td>
<td>13.7%</td>
<td>10.2 - 17.2</td>
</tr>
<tr>
<td>HOUSEHOLDS WITH CHILDREN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27.7%</td>
<td>24.3 - 31.1</td>
</tr>
<tr>
<td>No</td>
<td>30.4%</td>
<td>27.7 - 33.1</td>
</tr>
<tr>
<td>SERVICE PLANNING AREA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antelope Valley</td>
<td>34.4%</td>
<td>27.5 - 41.3</td>
</tr>
<tr>
<td>San Fernando</td>
<td>27.2%</td>
<td>22.7 - 31.6</td>
</tr>
<tr>
<td>San Gabriel</td>
<td>21.8%</td>
<td>17.2 - 26.4</td>
</tr>
<tr>
<td>Metro</td>
<td>32.0%</td>
<td>25.6 - 38.4</td>
</tr>
<tr>
<td>West</td>
<td>30.5%</td>
<td>18.5 - 42.5</td>
</tr>
<tr>
<td>South</td>
<td>32.4%</td>
<td>27.3 - 37.6</td>
</tr>
<tr>
<td>East</td>
<td>32.4%</td>
<td>26.2 - 38.6</td>
</tr>
<tr>
<td>South Bay</td>
<td>30.3%</td>
<td>24.7 - 36.0</td>
</tr>
</tbody>
</table>

*The estimate is statistically unstable and therefore may not be appropriate to use for planning or policy purposes.

§Based on U.S. Census 2013 Federal Poverty Level (FPL) thresholds which for a family of four (2 adults, 2 dependents) correspond to annual incomes of $23,624 (100% FPL), $47,248 (200% FPL), and $70,872 (300% FPL). [These thresholds were the values at the time of survey interviewing.]
US Total SNAP Participation

SNAP Participation

SNAP Participation

FY 2014  FY 2015  FY 2016  FY 2017
NEVHC WIC Total Participation

NEVHC WIC Participants

- 2011
- 2012
- 2013
- 2014
- 2015
- 2016
- 2017

NEVHC WIC Participants
The Good…the Bad…the Question

• The Good: Leveraging existing programs to connect patients to resources, build on current partnerships, and high patient participation and referrals from staff to nutrition education (SNAP-Ed) and additional resources (community gardens, food swaps, etc.).

• The Bad: Staff dissatisfaction with O-tech tablets.

• One Question for the Group Today: How do you convince staff to change their current processes to collect data effectively?
Petaluma Health Center

Jessica Moore
Director of Innovations
jessiccam@phealthcenter.org
Who We Are

- Where We Are Located: Petaluma, CA
- Number of Clinics in the Organization: 2
- Total Number of FTE Providers: 28
- EHR Vendor: eClinical Works
- Target SDOH Population: Unemployed Adults Seeking Employment
- Target SDOH Need/Needs: Employment
Our Story

• Brief Description of How Data Was Used or Is Used to Best Understand SDOH Need
  – Data Used: Analysis of PRAPARE responses as well as data from Purple Binder referrals.
  – Review Process: Reviewed responses for over 400 patients to identify the greatest areas of need and match those to areas where we have potential for community partnerships and impact. We broke down responses by demographic to identify subsets of the population.

• Screen Shots (use more than one page if necessary)
Our Story

Q4

What is your current work situation?

- Full time work: 13.14%
- Part time or temporary work: 15.23%
- Unemployed and seeking work: 14.37%
- Otherwise unemployed but not seeking work (ex. student, retired): 52.39%
- I choose not to answer this question: 4.91%

Referral by AIRS category since July 1st 2016, "rolled up" to top two levels
The Good…the Bad…the Question

• The Good: We were able to identify subsets of patients who may have somewhat different needs and target specific interventions and partners to meet those needs.

• The Bad: PRAPARE does not have enough information about specific drivers of unemployment so we had to try and collect that data separately.

• One Question for the Group Today: What kind of assessment of potential community partners do you do to ensure a good fit?
St John’s Well Child and Family Center

Elena Fernandez
Behavioral Health Services Director
efernandez@wellchild.org
Who We Are

• **Where We Are Located:** Service Planning Area (SPA) 6, serving the communities of South Central Los Angeles, Athens, Compton, Crenshaw, Florence, Hyde Park, Lynwood, Paramount, and Watts.

• **Number of Clinics in the Organization:** 9 Community Health Centers, 4 School Based Health Centers, 2 Mobile Clinics

• **Total Number of FTE Providers:** 88 FTE total (65 FTE medical, 17 dental, 11 FTE behavioral health)

• **EHR Vendor:** eClinicalWorks (eCW)

• **Target SDOH Population:** Justice-involved individuals (Reentry Community) with chronic illnesses

• **Target SDOH Need/Needs:** Primary medical, dental, and behavioral health care, case management, and community linkages as it pertains to patients’ needs.
• Brief Description of How Data Was Used or Is Used to Best Understand SDOH Need:
  – Determine areas of highest need (55-60% of released individuals from county jail return to SPA 6)
  – Determine program need and it is designed
  – Community reports
  – Weekly check-ins at staff meetings
  – Socioeconomic status (i.e., insured, uninsured, and demographics)

• Data Used:
  - DHS-LA County Health Disparities
  - LA County Sheriffs Release Rates
  - Anecdotal data from staff
  - New England Journal of Medicine
  - CPT codes

• Review Process:
  • Executive Team Discussion
  • Department of Health Services
  • Care Manager pulls data based on visits

• Screen Shots (see next 2 slides):
Billing Summary

No of encounters: 21
Total Charges: $0.00

Date range is limited to 30 days

Wednesday, November 1, 2017

Waikiki
Boomerang
Tel: Fax:

Billing Summary

Resource: IBH PCHW, Angel
Facility: Williams Behavioral Health

Service Date: 11/27/2017
Resource Name: IBH PCHW, Angel

PCP: Kelsey Bateman
Tel: 3235411600
UPIN: NPI: 1013463322

Responsible Party Name:
Provider No: Group No:
Tax Id: 954067758
Facility: Williams Behavioral Health

Insurance(s):
1. La Care Medi Cal HCLA, c/o Medpoint Management, PO Box 570590, Tarzana, CA 913570000

Copay: Subscriber No: 91805424C

Print Preview... Print... Print Report/Patient
The Good...the Bad...the Question

• The Good:
  – High Data Density
  – Formally Acknowledging the population is in our community and has complex needs

• The Bad:
  – Data Liquidity
  – Population is hard to reach (bureaucratic red tape & trust concerns)

• One Question for the Group Today:
  • How do we implement PRAPARE Toolkit for SDOH?
West County Health Centers

Dr. Jason Cunningham
Chief Medical Officer
jcunningham@wchealth.org

Kathleen Grenham
Innovation Project Manager
kgrenham@wchealth.org

Michael Heinle
Report Systems Manager
mheinle@wchealth.org
Who We Are

- **Where We Are Located:**
  Western Sonoma County

- **Number of Clinics 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 Number of FTE Providers:**
  26

- **EHR Vendor:**
  eClinical Works

- **Target SDOH Population:**
  Lower Russian River Area (Guerneville, CA)

- **Target SDOH Need/Needs:**
  Inadequate early Childhood Education & Community Partnerships
Our Story: **Self-Service Data Platform**
Our Story: Mapping as a data tool
Our Story: Systems Thinking & Human Centered Design

SYSTEMS PRACTICE JOURNEY MAP

PHASE 0: LAUNCH
Forming a team, acquiring systems practice fundamentals, and planning for the journey ahead.

PHASE 1: GAIN CLARITY
Developing a deep understanding of the system and then building a map that captures the key forces and patterns driving the system's behavior.

PHASE 2: FIND LEVERAGE
Exploring the most promising opportunities for engaging the system in ways that could help push it toward greater health.

PHASE 3: ACT STRATEGICALLY
Designing and implementing an approach that exploits opportunities for leverage to make sustainable social change.

PHASE 4: LEARN AND ADAPT
Continually sensing and learning from the system and adapting accordingly.

CCI CENTER FOR CARE INNOVATIONS

SEE & EXPERIENCE
DIMENSION & DIAGRAM
SIX PRINCIPLES for WORKING DIFFERENTLY
QUESTION & REFRAME
IMAGINE & MODEL
TEST & SHAPE
PITCH & COMMIT
THE OMIDYAR GROUP
The Good...the Bad...the Question

• The Good:
  – Creating data platform
  – Understanding the needs for collaborative data
  – Human Centered Design/ Systems Thinking

• The Bad:
  – Slower process
  – Complex initiative unique needs of partnership organizations

• One Question for the Group Today:
  – What are your strategies for engaging community partners?
Grantee Questions
The “One” Question

• **Asian Health**: How do we measure success/outcomes in this project within short timeframe?

• **Lifelong Medical Care**: How does your organization share SDOH data?

• **LAC+USC**: How are you collecting outcomes data given that most EMRs don’t link up with community organizations?
The “One” Question

• NEVHC: How do you convince staff to change their current processes to collect data effectively?

• Petaluma Health: What kind of assessment of potential community partners do you do to ensure a good fit?
The “One” Question

• **St John’s Well Child**: How do we implement PREPARE Toolkit for SDOH? Do we already have SDOH Data? How do we get it?
  – **Webinar Right Now**: Assessing and Addressing the Social Determinants of Health Using PRAPARE: Early Experiences in California (NACHC – It Will Be Recorded)

• **West County Health**: What are your strategies for engaging community partners?