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
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Remembering Communities and Colleagues in Los Angeles Area

Webinar Reminders

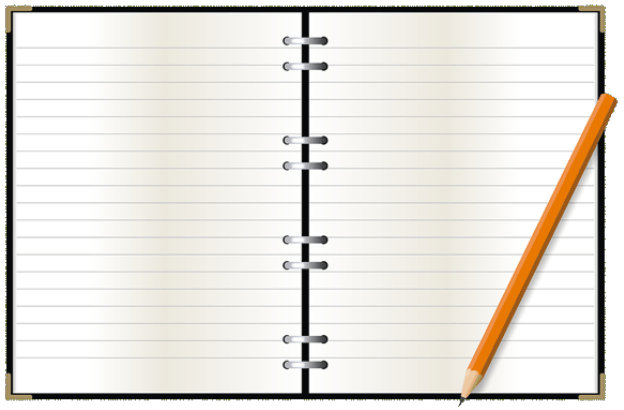
1. Everyone is unmuted.
   - Press *7 to **unmute** and *6 to **mute** yourself.

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

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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

ASIAN HEALTH SERVICES

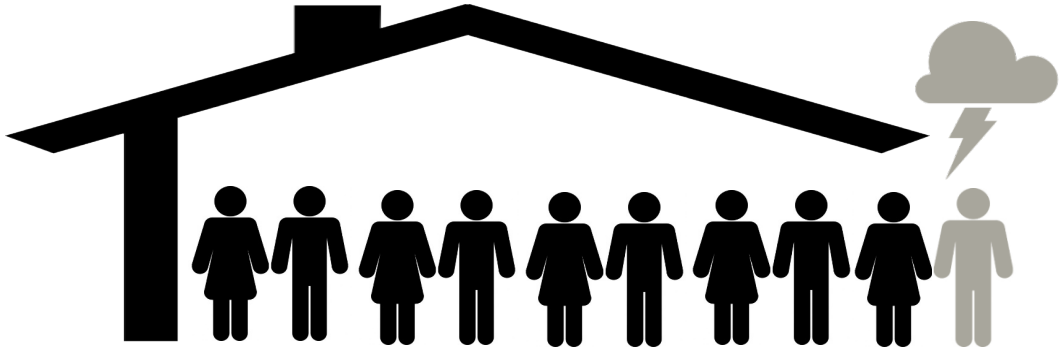
Our Story –Pilot test of PRAPARE

Organization	AHS			
Teams	Behavioral Health	Care Neighborhood	HIV Intervention	Lowe Medical Clinic
Implementing Staff	case manager (2)	case manager (1)	full team (5)	Patient Navigator (2)
Patient population	Patients w/ mental health needs	high utilizers	high-risk population	general patient population

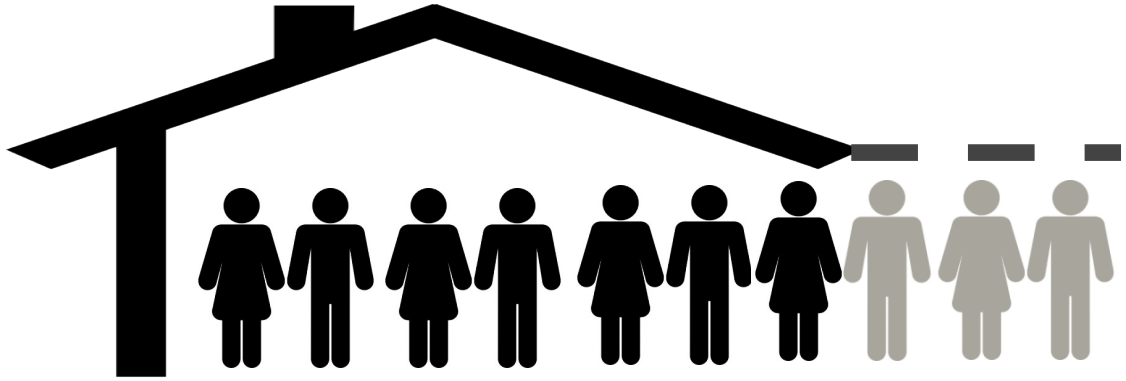
404 data collected between 6/12- 9/21

Housing Needs

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

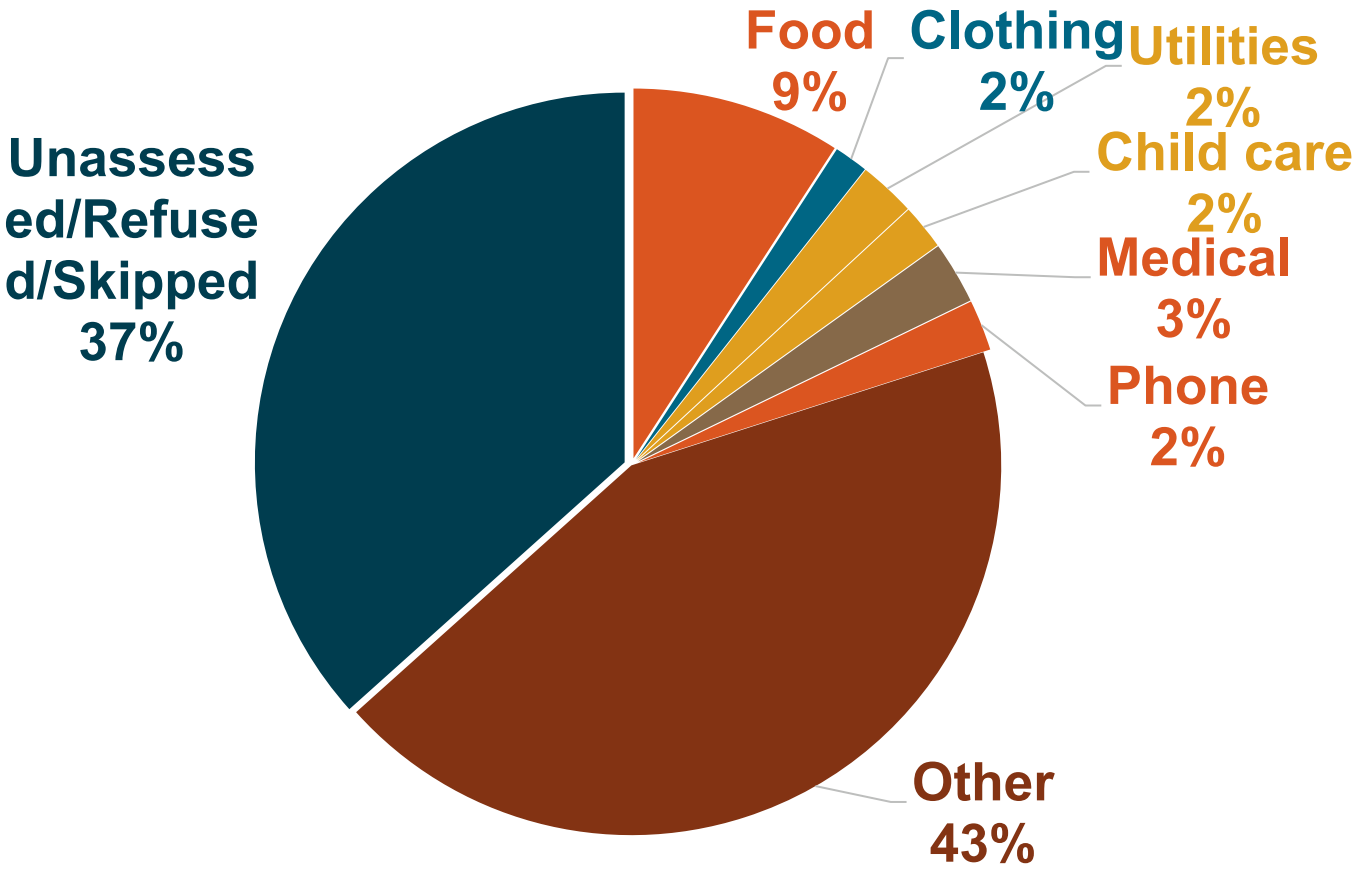


Almost 10% do not have housing.



28% are housing insecure.

Material Security (n=258)



The Good…the Bad…the Question

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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?

ASIAN HEALTH SERVICES

LAC+USC Medical Center Primary Care

Barbara Rubino

Director of Clinical Quality, LAC+USC Primary Care

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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.

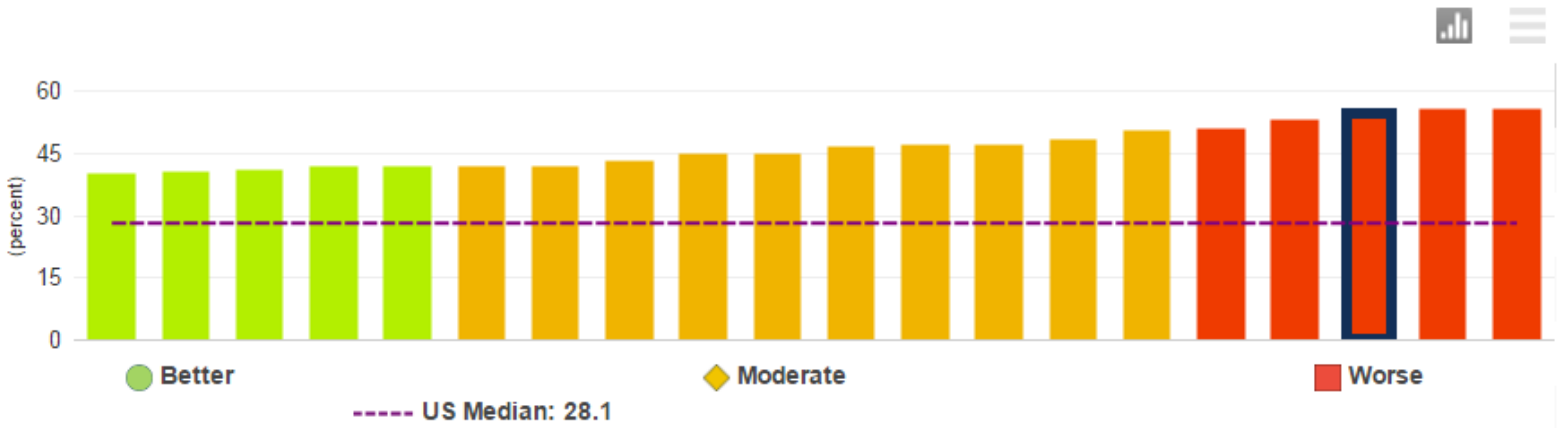
The we compared and discussed staff responses with public health data.

Housing stress (percent)

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

54.7 %

Distribution | Description | Populations | Census Tracts | Associated Indicators



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

Latest* | Last 7 days | Last 48 hours | More

No results found

Consolidated Problems

Classification: Medi

Add new as: **This Visit** z59.4

Inadequate drinking water supply (**Z59.4**)

Name	Classification	Actions
Tobacco use	Medical	This Visit

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)

The Good…the Bad…the Question

- **One Question for the Group Today**
  - How are you collecting outcomes data given that most EMRs don't link up with community organizations?

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Lifelong Medical Care

Janelle Sauz

Population Health Program Manager

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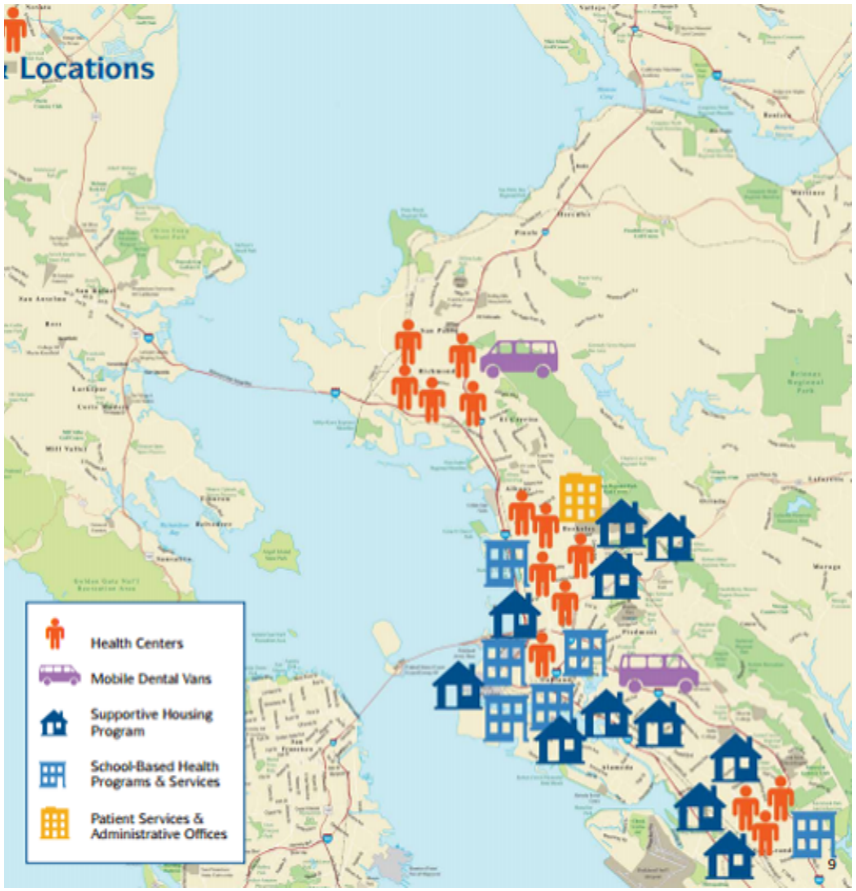
Who We Are



- **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

Case Management / Enabling Services Encounter

Case Management Status: ☑ Active ☐ Inactive **Referral from Outside LifeLong?** ◉ No ○ Yes

Attention !

☑ Ambulatory Disability*	☐ AOD Use/Abuse - History	☐ AOD Use/Abuse - Current	☐ Behavioral Health Dx	☐ Chronic Disease Dx
☐ Cognitive Disability*	☐ Complex Medical Needs	☐ Violence / Abuse - Current	☐ ED - High Utilizer	☐ Hearing Disability*
☑ Homelessness - Current	☑ Homelessness - History	☐ Independent Living Disability*	☐ Incarceration History	☐ Visual Disability*
☐ Self-Care Disability*	☐ Trauma / Abuse - History	☐ Migrant/Seasonal Worker	☐ Low Literacy	☐ Language Preferred Not English

Comments:

Pt currently livin

Self Care Disability
Having difficulty bathing or dressing

Care Guidelines | Screening Tools | Histories | Telephone Call Summary | Referral Manager | Panel Control: Toggle | Cycle

Patient Priorities/Action Plan

Priority Area: | Status: | Goal:

Service Date: 04/07/2016

Clear | Save to Grid

Date	Priority Area	Status	Goal	Completed Date	Last Modified By
04/07/2016	Transportation	Active	Wants a Ferrari	/ /	Smriti Joneja
04/04/2016	Jail/Prison Re-entry	Pt Declined Services	Pt wants mansion	/ /	Dustin Bainto
03/01/2016	Caregiver Issues (IHSS, Respite, etc)	Completed	Accepted to Respite program	03/01/2016	Lizeth Rodriguez
03/01/2016	Housing	Completed	Assist w/housing app to ABC Sr Complex Completed application 03/01/16	03/01/2016	Brigitte Peltekof
03/01/2016	Transportation	Completed	To complete ParaT application	03/01/2016	Brigitte Peltekof

Today's Services

Staff Position: | Service Type: | Interpreter Service: ○ Yes ◉ No

Services/Referrals Provided: | External | Time Spent: | Notes:

Today's Services

Staff Position: Case Manager

Service Type: In-person (on-site)

Interpreter Service: ○ Yes ◉ No

	Services/Referrals Provided:	External Referral:	Time Spent:	Notes:
1.	Food	☑	< 15 mi	Referred pt. to a food bank
2.	Food	☐	30 min	Taught pt. basic cooking and meal prep techniques
3.		☐		
4.		☐		
5.		☐		

CI Save to Grid

Additional Visit Notes: *(copy forward)* My Phrases Manage My Phrase (CM Plan)

Patient Providers Telephone Call Summary Appointments Send Task Patient Plan Generate Document

CPSP Billing

Follow-Up

Date: 05/25/2016

Reason: Check in to ensure pt is getting correct nutrition and is practicing skills taught during today's visit

History of Services

Community Contacts

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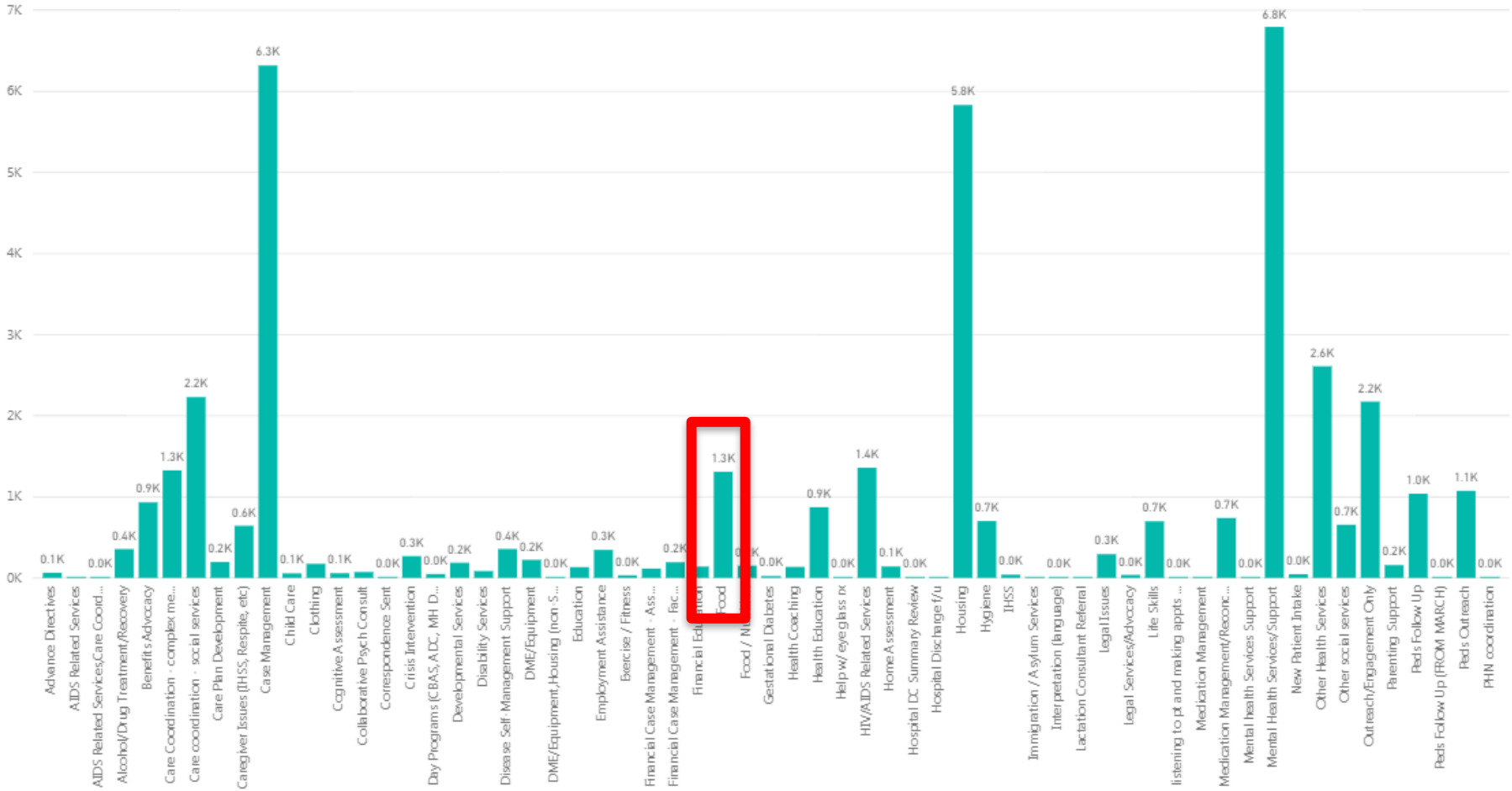
Services & Referrals Provided



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

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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.**

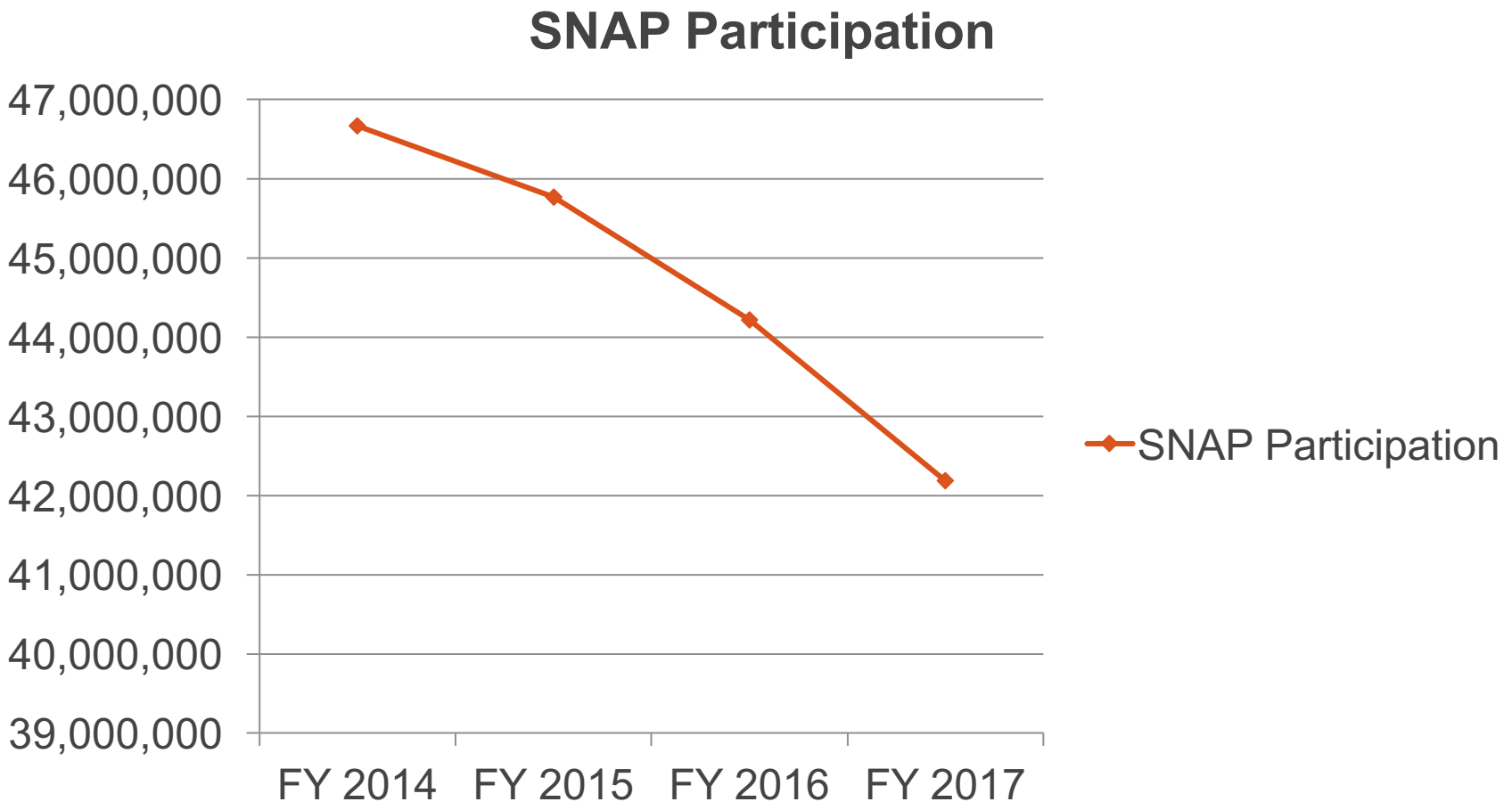
TABLE 1: Percent of Households <300% Federal Poverty Level That Have Food Insecurity and Very Low Food Security, LACHS 2015

	Food Insecurity			Very Low Food Security		
	Percent	95% CI	Estimated #	Percent	95% CI	Estimated #
LA COUNTY HOUSEHOLDS	29.2%	27.1 - 31.3	561,000	11.3%	9.8 - 12.8	217,000
FEDERAL POVERTY LEVEL[$]						
0-99% FPL	41.1%	37.3 -44.9	307,000	17.5%	14.5 – 20.5	131,000
100%-199% FPL	25.4%	22.4 – 28.4	203,000	9.2%	7.1 - 11.3	73,000
200%-299% FPL	13.7%	10.2 - 17.2	51,000	3.6%	2.0 - 5.2	14,000
HOUSEHOLDS WITH CHILDREN						
Yes	27.7%	24.3 - 31.1	223,000	9.6%	7.2 - 11.9	77,000
No	30.4%	27.7 - 33.1	338,000	12.6%	10.6 - 14.6	141,000
SERVICE PLANNING AREA						
Antelope Valley	34.4%	27.5 - 41.3	27,000	16.3%	9.9 - 22.6	13,000
San Fernando	27.2%	22.7 - 31.6	96,000	10.5%	7.7 - 13.2	37,000
San Gabriel	21.8%	17.2 - 26.4	72,000	6.1%	3.4 - 8.8	20,000
Metro	32.0%	25.6 - 38.4	93,000	16.9%	11.4 - 22.4	49,000
West	30.5%	18.5 - 42.5	26,000	6.4%*	1.8 - 11.0	5,000
South	32.4%	27.3 - 37.6	71,000	12.9%	9.2 - 16.6	28,000
East	32.4%	26.2 - 38.6	79,000	12.4%	7.3 - 17.4	30,000
South Bay	30.3%	24.7 - 36.0	97,000	10.7%	6.9 - 14.4	34,000

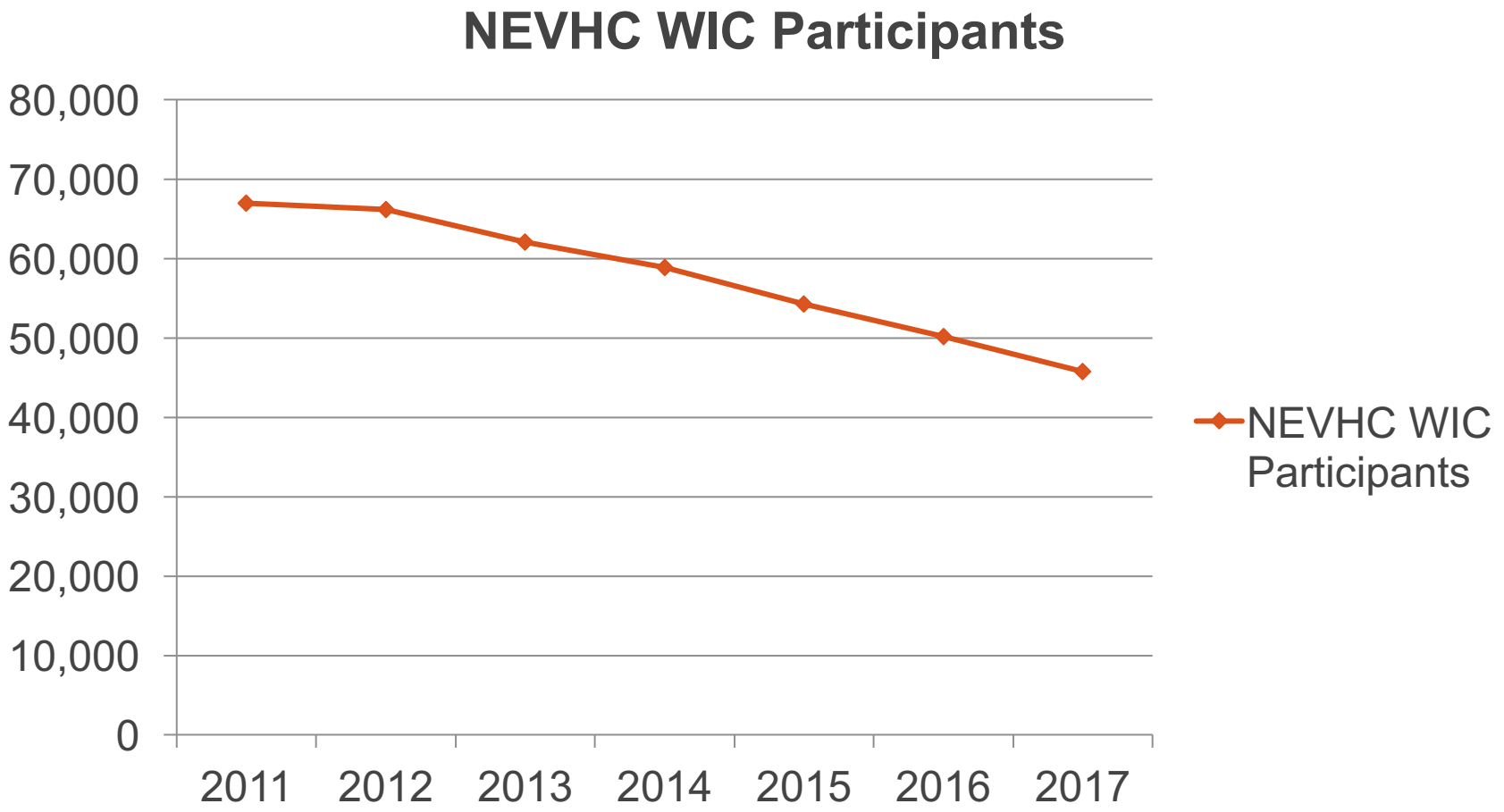
*The estimate is statistically unstable and therefore may not be appropriate to use for planning or policy purposes.

[$]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



NEVHC WIC Total Participation



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

Jessicca Moore

Director of Innovations

jessiccam@phealthcenter.org

Who We Are

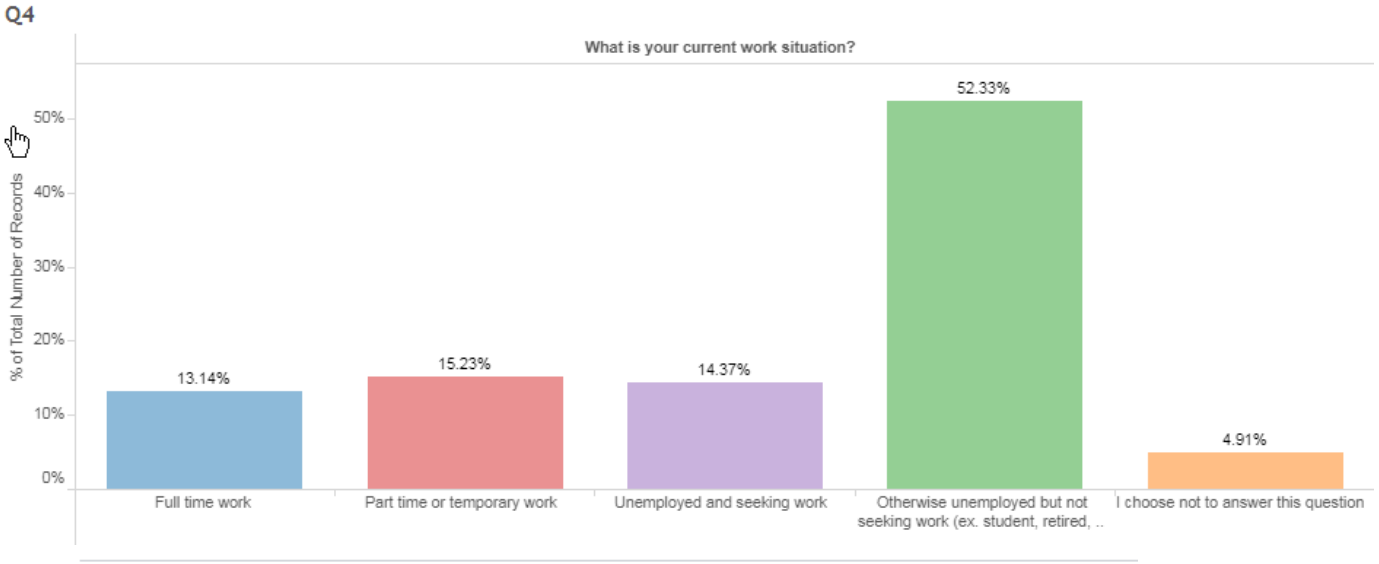
- Where We Are Located: Petaluma, CA
- Number of Clinics in the Organization: 2
- Total Number of FTE Providers: 28
- EHR Vendor: eClinical Works
- Target SDOH Population: Unemployed Adults Seeking Employment
- Target SDOH Need/Needs: Employment

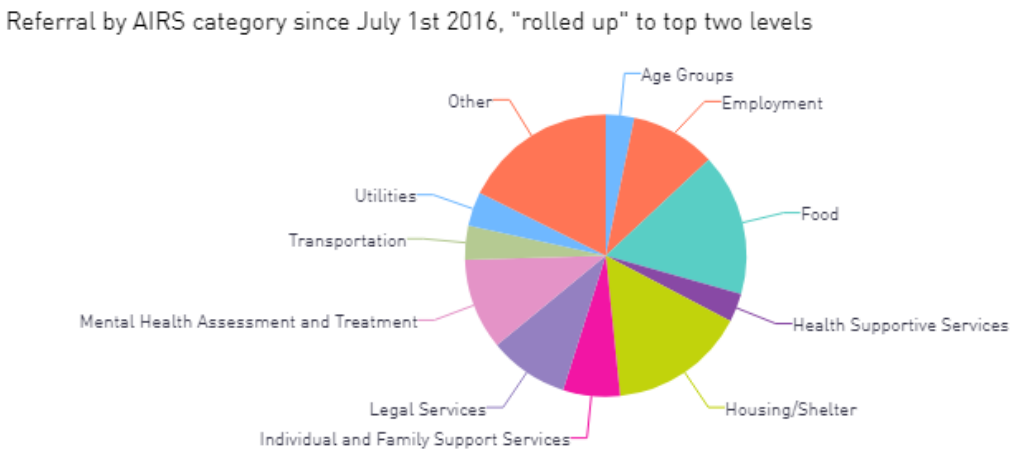
Petaluma Health Center
www.phealthcenter.org

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





www.phealthcenter.org

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?

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St John's Well Child and Family Center

St. John's Well Child & 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.

Our Story

- **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:**

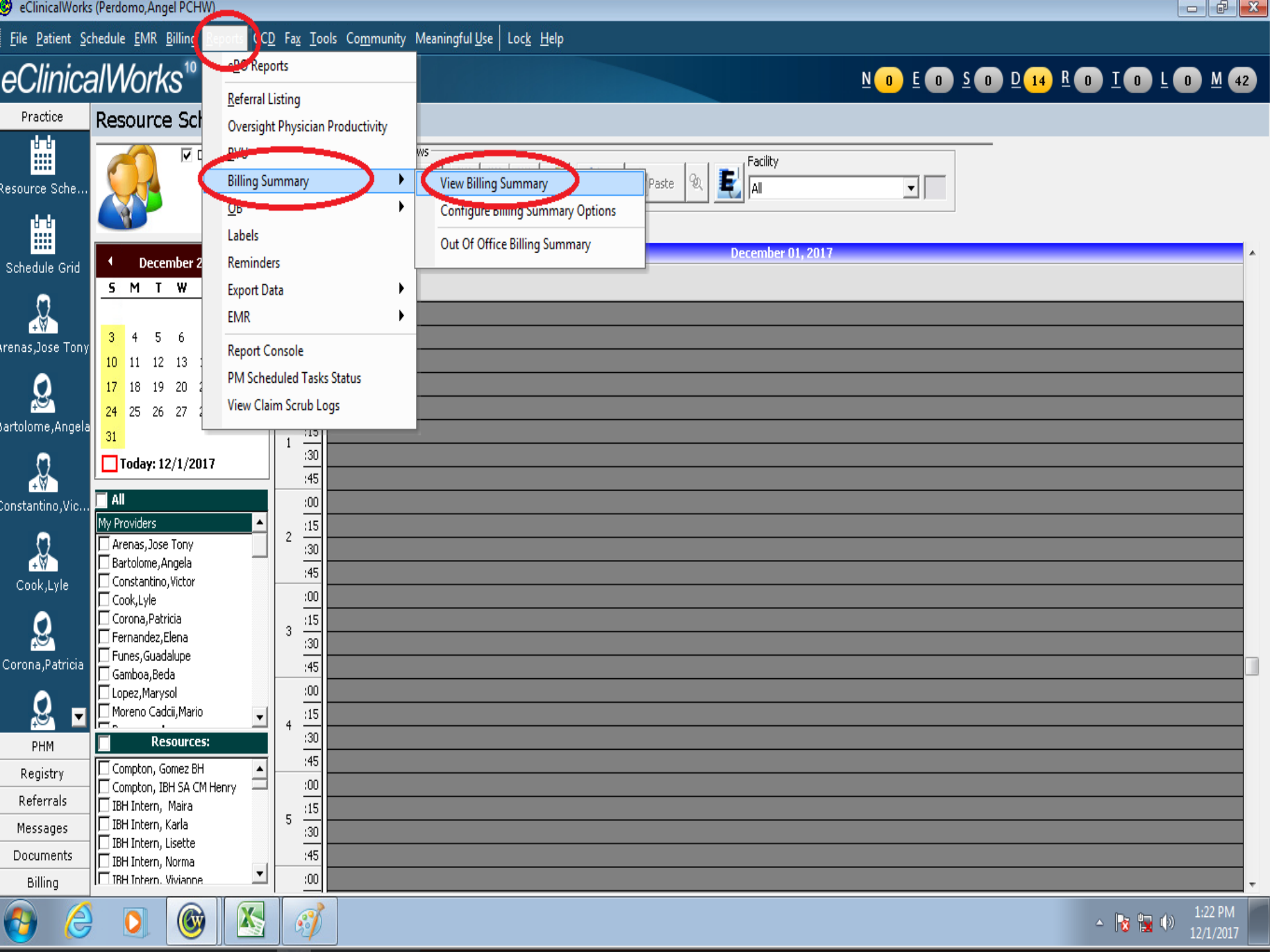
  -DHS-LA County Health Disparities

  -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):**


eClinicalWorks (Perdomo,Angel PCHW)
File Patient Schedule EMR Billing Reports CCD Fax Tools Community Meaningful Use Lock Help
eClinicalWorks 10
N 0 E 0 S 0 D 14 R 0 T 0 L 0 M 42
Practice
Resource Sch
Resource Sche...
Schedule Grid
Arenas,Jose Tony
Bartolome,Angela
Constantino,Vic...
Cook,Lyle
Corona,Patricia
PHM
Registry
Referrals
Messages
Documents
Billing
eRX Reports
Referral Listing
Oversight Physician Productivity
PWB
Billing Summary
Ob
Labels
Reminders
Export Data
EMR
Report Console
PM Scheduled Tasks Status
View Claim Scrub Logs
View Billing Summary
Configure Billing Summary Options
Out Of Office Billing Summary
Paste
Facility
All
December 01, 2017
December 2
S M T W
3 4 5 6
10 11 12 13
17 18 19 20
24 25 26 27
31
Today: 12/1/2017
All
My Providers
Arenas,Jose Tony
Bartolome,Angela
Constantino,Victor
Cook,Lyle
Corona,Patricia
Fernandez,Elena
Funes,Guadalupe
Gamboa,Beda
Lopez,Marysol
Moreno Cadcii,Mario
Resources:
Compton, Gomez BH
Compton, IBH SA CM Henry
IBH Intern, Maira
IBH Intern, Karla
IBH Intern, Lisette
IBH Intern, Norma
1:22 PM
12/1/2017

Practice

Resource Sche...

Schedule Grid

Arenas,Jose Tony

Bartolome,Angela

Constantino,Vic...

Cook,Lyle

Corona,Patricia

PHM

Registry

Referrals

Messages

Documents

Billing

Billing Summary

Resource | IBH PCHW, Angel | Encounter Status | All

Facility | Williams Behavioral He | Appt Date Range | 11/01/2017 | To | 12/01/2017 | Lookup

Date range is limited to 30 days

Waikiki
Boomerang
Tel: Fax:

Billing Summary **Wednesday, November 1, 2017**

No of encounters: 21

Total Charges: $0.00

[redacted] **DOB:**[redacted] **Tel:**[redacted] **SSN:**[redacted] **Sex:**[redacted] **Provider: Fernandez,Elena**

Address:[redacted]

Employer :Tel:

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

PCP: Kelsey Bateman **TEL:**3235411600 **UPIN:** **NPI:**1013463322

Responsible Party Name:[redacted]

Provider No: **Group No:**

Tax Id:954067758 **NPI:**

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 **Group No:**

Print Preview... | Print... | Print Report / Patient

1:43 PM
12/1/2017

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
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Kathleen Grenham
Innovation Project Manager
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Michael Heinle
Report Systems Manager
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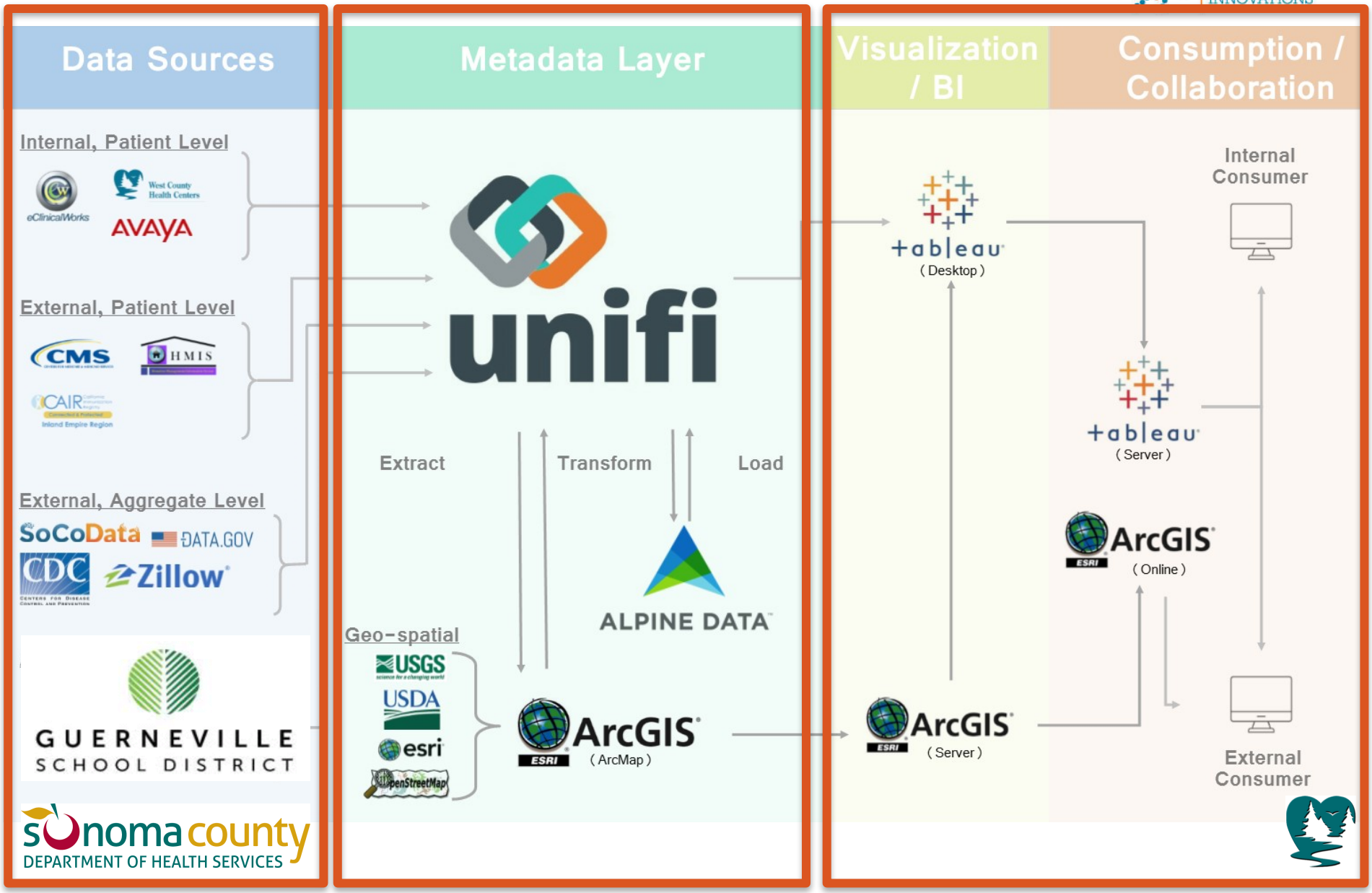
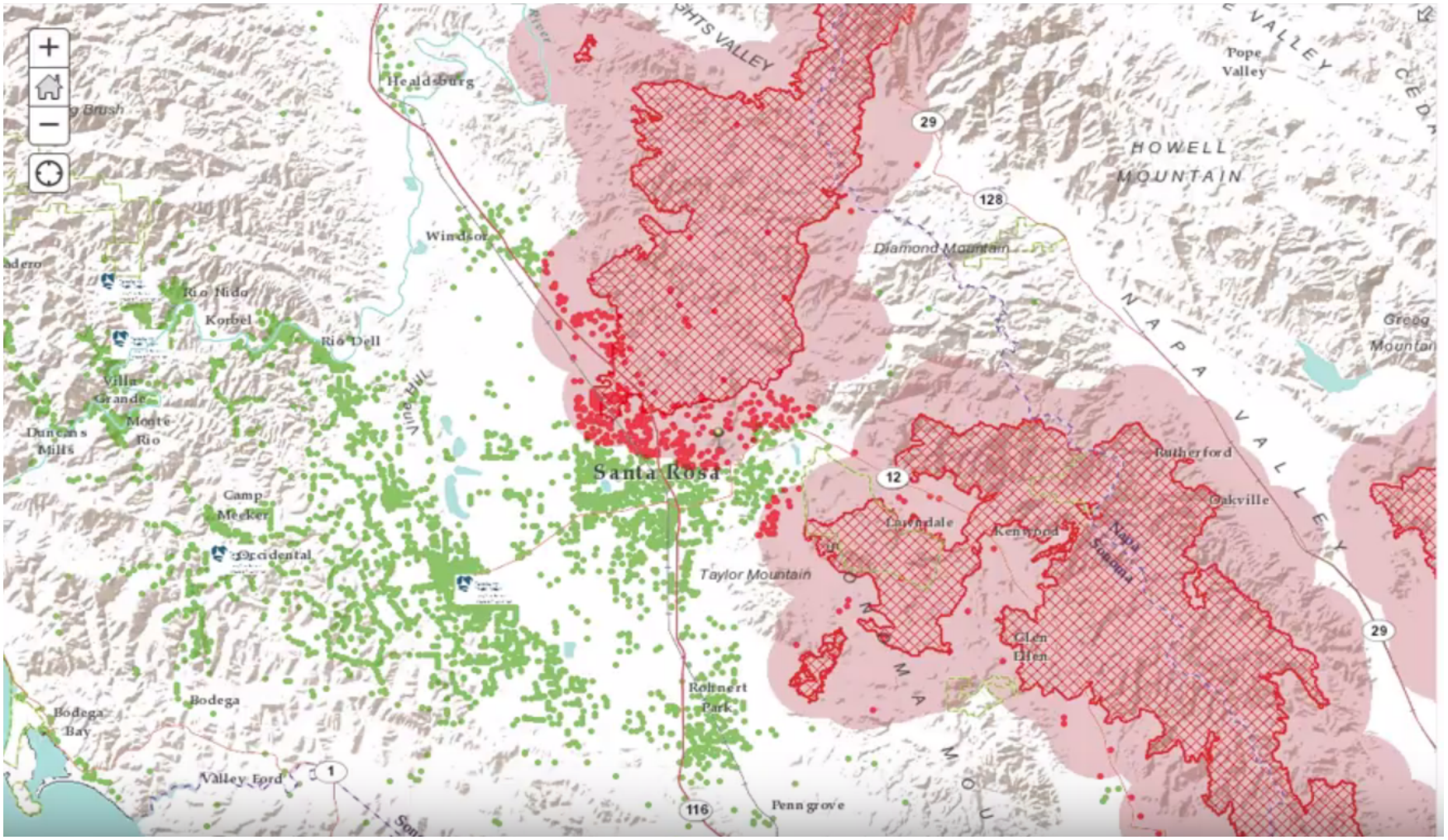
Who We Are

- **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

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?