Neighborhood Healthcare SDOH 101

WENDI VIERRA, PHD
DECEMBER 6, 2018

Neighborhood Healthcare

- Federally Qualified Health Center
- 13 Integrated Behavioral Health Clinics in San Diego & Riverside counties
  - Serve low-income, medically underserved, uninsured, and under-insured
  - 5% Homeless (approx. 3700)
  - Behavioral Health Consultants (LCSW, PhD) in each clinic
  - 1 Behavioral Health Department
- Approximately 65k unique patients, 290k visits/yr
  - 61% Female, 39% Male
  - 73% Medi-Cal, 5% Dual Elig, 7% Medicare
  - 40% Monolingual Spanish
- EMR: eCW

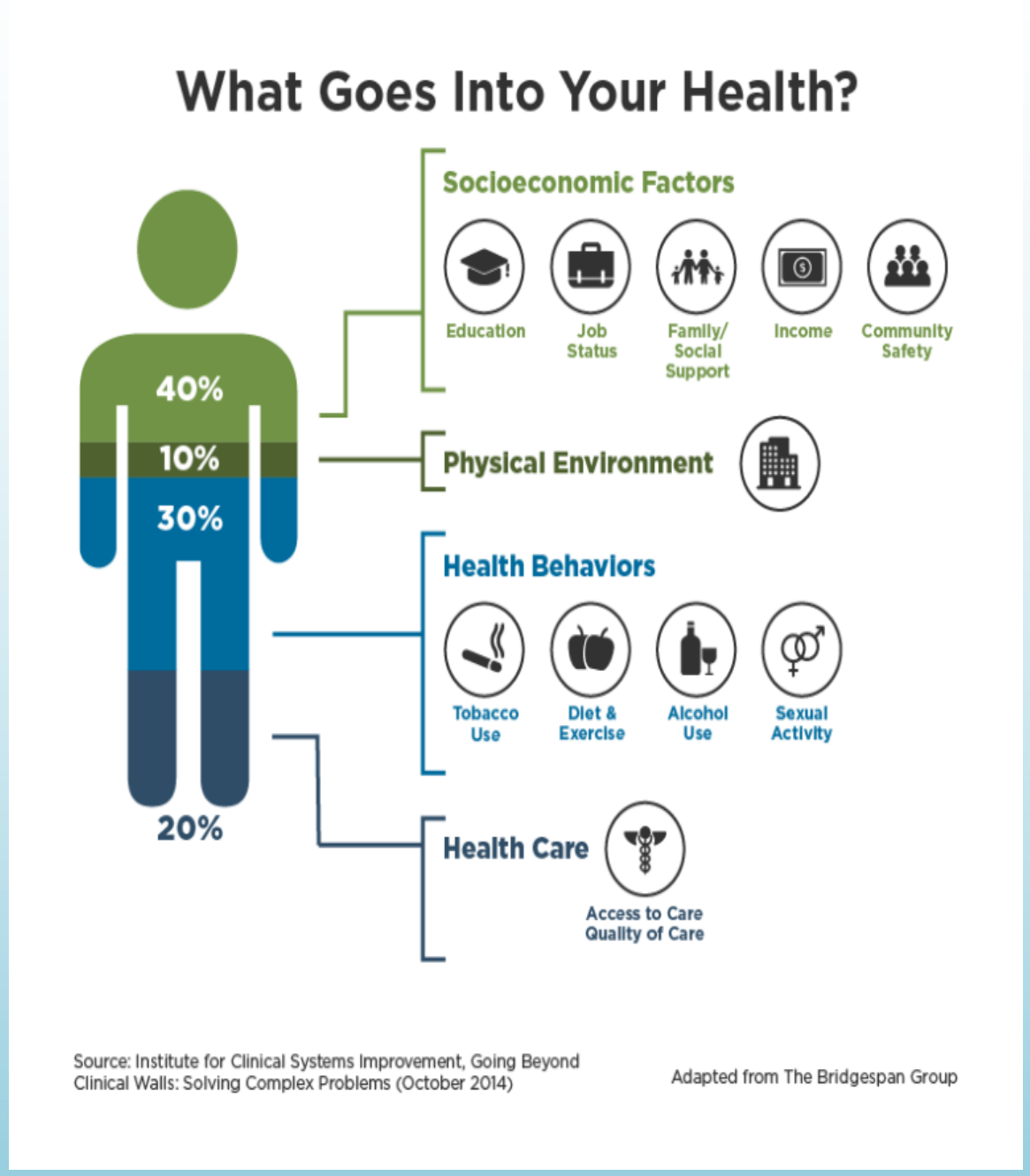
SDOH 101 Objectives

- Learn
  - What Social Determinants of Health (SDOH) are
  - Why are SDOH important
  - Where your focus is will drive your success
  - How to screen, When to screen, Who to screen
  - Lessons Learned
  - What do you do with the information

What are SDoH?

According to the Word Health Organization, SDoH are, “The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.”

Determinants include: Income, Education, Employment, Food Insecurity, Housing Stability, Social Exclusion/Inclusion, Substance Abuse, Transportation, Legal, etc.



Why are SDOH important?

- Collaborate with patient where they are at
- Address potential access barriers:
  - Food, housing, safety, transportation, legal, daycare, literacy, employment, etc.
- Develop a comprehensive treatment plan:
  - Broaden treatment/care team to include CBO's – SDOH 201 will discuss this in more detail!

The best treatment plan in the world can fall apart as soon as the patient walks out the door if you miss this!

What are you focused on?

Quicksand

- SDOH needs in vulnerable populations can be complex
- Assessment, navigation, and tracking SDOH are costly
- We lack the resources to fund this service
- Sometimes needed services are not available
- Isn't this someone else's job to do this?
- I don't get paid any differently to take care of a patient that is homeless versus one that has housing

Opportunity

- Doing something, no matter how small helps to ease moral distress and burnout
- Manage what is possible vs. what is not
  - Perception is reality! Do you believe you can make a difference? If you don't, you won't. Our identity drives us!
- Do not underestimate your staff capacity
  - Ordinary people can accomplish extraordinary things!
  - If you were to change your focus from the sand to the horizon imagine how would that impact your ability to create something new?

Still…it's difficult to not get overwhelmed

With limited resources, do we focus our efforts on all of the shells on the beach to cast a wide net or focus on the complex needs of the starfish?

The Beach Challenge: Create a program that does not negatively impact staffing resources or patient flow, while positively impacting gaps in essential resource needs for all of the shells on the beach

- First challenge thinking to not let perfection get in the way of trying something new to do good
- Identify an easy to use and understandable screening method
- Embed screening tool into existing workflows and protocols
- Identify existing community resources and a develop community resource guide
- Document data to utilize for needs assessment
- Use data to build a business case model

Low Touch SDOH Program for all of the shells

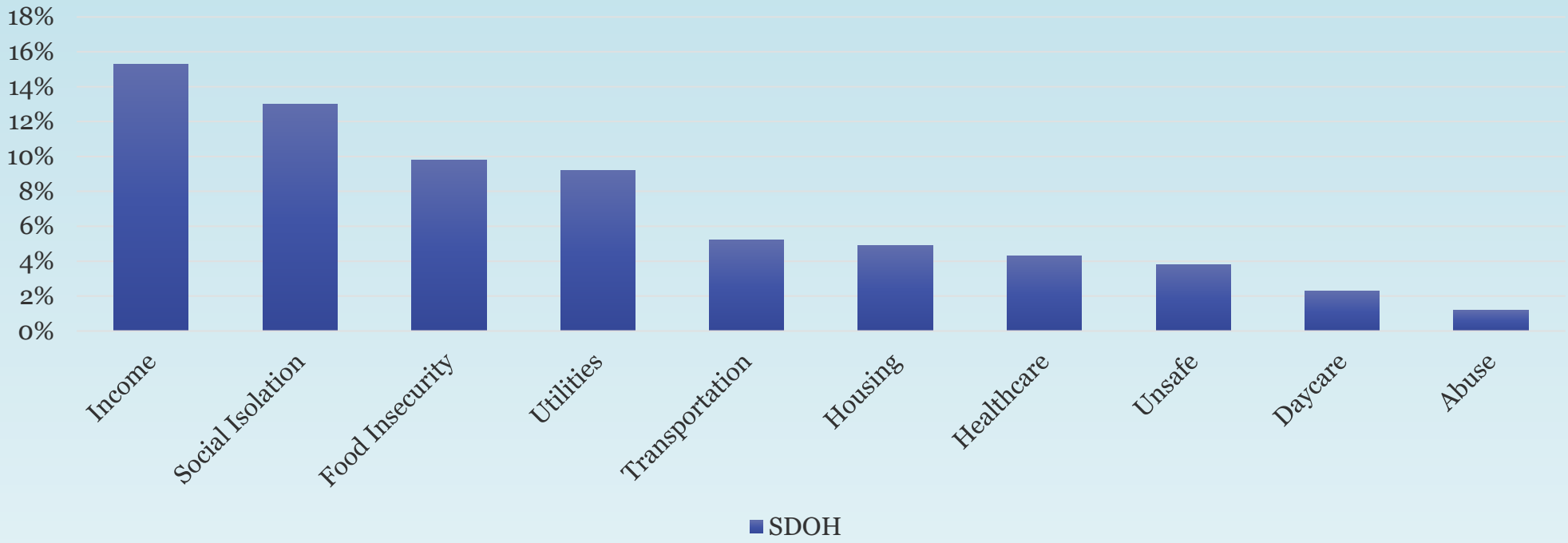
Assess at intake and annually thereafter the following Y/N questions:

1. We were worried whether our food would run out before we got money to buy more.
2. The food we bought just didn't last and we didn't have money to get more.
3. Are you homeless or worried that you might be in the future?
4. Do you have trouble paying for utilities?
5. Do you have trouble finding or paying for a ride?
6. Do you need daycare, or better daycare, for your kids?
7. Are you unemployed or without regular income?
8. Do you feel unsafe in your daily life?
9. Is anyone in your home threatening or abusing you?
10. Do you see or talk to people you care about less than twice a week?
11. Have you or your child needed to see a doctor, but didn't have healthcare or could not afford the cost?

Social Needs Screening Toolkit – Health Leads

Low Touch SDOH

- Positive responses elicit community resource guide that Patient's are expected to self-navigate
- Implemented 4/1/18 with 25,060 assessments completed to date!



Lessons Learned with Implementation

- Challenge thinking that is focused on barriers instead of solutions
- Think outside the box: If patient's cannot get to a resource, consider how you might bring the resource to your clinic; you don't have staff, utilize volunteers; you don't have space, consider teledeterminants; you don't have funds, consider mini grants
- Don't try to be a social service agency – partner with CBO's!
- Change, even desired change is difficult! Be compassionate when your patient doesn't follow through with much needed resources ("Don't give up on me!")
- Meet patients where they are at. Your goals may not be theirs. Address your discomfort with this so it does not become a barrier for your patient. It is difficult to watch others suffer.
- Identify barriers and remove them (i.e., transportation, daycare, language, literacy)
- Don't underestimate the passion and compassion of your staff and their desire to be part of the solution!
- Take care of yourself! This work can be emotionally draining and burn you out. Maintain good boundaries and balance in your life to provide the best care possible to those you serve!

What about the Starfish?

They have complex needs that prohibit them from effectively self-navigating community resources

Targeted high touch navigation for 2% of patients with complex needs can be provided within existing job duties, small mini-grants, and volunteers

High Touch SDOH Program for the Starfish

Welcome to Neighborhood Healthcare. Please indicate if you would like information for any of the following services. If you have any questions about any of the listed services, please direct them to a member of our staff.

FOR IMMEDIATE ASSISTANCE, YOU MAY ALSO CALL 2-1-1. PROVIDE YOUR ZIP CODE AND THE 2-1-1 OPERATOR WILL PROVIDE YOU WITH THE RESOURCE INFORMATION IN YOUR AREA.

- **Physical Health:**
  - Primary Care Provider
  - Urgent Care Clinic
  - Dental Clinic
  - Vision Care Center
  - Support Groups
  - Health & Wellness Groups
  - Exercise groups/classes
- **Occupation/Education:**
  - Employment program
  - Job readiness program
  - Adult education
  - Community college
  - Vocational/trade school
- **Mental Health:**
  - Psychiatrist (Med. Management)
  - Counselor/Therapist
  - Specialty mental health clinic
  - Intensive outpatient/day treatment
  - Inpatient Treatment
  - Crisis Centers
  - Support Groups & Self-Help
  - Clubhouse
- **Financial Advocacy/Benefits:**
  - Money Management class or group
  - Medi-Cal Enrollment Assistance
  - Medicare Enrollment Assistance
  - Affordable care/covered California
  - CalFresh (food stamps)
  - SSI/SSDI/SDI Enrollment Assistance
- **Social Health:**
  - Case management
  - Socialization & Advocacy
  - Educational class/workshops
  - Faith based organizations
  - Volunteer opportunity
  - Family support groups
  - Parenting classes
- **Housing:**
  - Homeless shelter
  - Affordable Housing
  - Board and care
  - Skilled Nursing Facility
  - Independent Living Facility (ILF)
  - Senior housing
- **Substance Abuse:**
  - Outpatient services
  - Inpatient services
  - Self-help Recovery Groups
  - Sober living
  - Faith based
  - SMART recovery
- **Legal Aid:**
  - SSI application advocacy
  - Family law
  - Restraining order
  - Children & youth law
  - Tenant/landlord disputes
  - HIV/Aids law
- **Transportation:**
  - North County Transit District
  - ADA Ride
  - LIFT services
  - Manage care plan transportation
- **Basic Needs:**
  - Clothing
  - Hygiene products
  - Food
  - Showers

Warm Hand-Off's & SDOH Navigation Assistance

- At NHcare we believe inter-agency warm hand off's will improve likelihood of patients connecting with resources
- Supportive health navigation
  - Identify barriers (i.e., transportation, support, daycare, literacy, language)
  - Collaborate with individual and make appts with them, not for them
  - Provide summary appointment reminder sheet with contact information
    - My Success Plan
  - Follow up with individuals and community partners until linkage is confirmed

Inter-Agency Referral & Release of Information

NEIGHBORHOOD HEALTHCARE
a california health center

interfaith community services

INTER-AGENCY CLIENT REFERRAL AND RELEASE OF INFORMATION FORM

Client Name: _____ Referral Date: _____

Client Phone: _____ Client DOB: _____

Referred By: _____ Phone: (___) _____

Agency: _____ Fax: (___) _____

I do hereby consent to the exchange and/or disclosure of information contained in my medical record between the agencies checked off below. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol treatment, and may also contain confidential HIV (AIDS) related information, including HIV results.

The disclosure of information and records authorized herein is required for Treatment Planning and Coordination of Care only.

I specifically request that the following information be released (patient should give permission for release of the below information by initialing each of the circles that apply):

○ Medical Records ____ Problem List ____ Progress Notes ____ Lab / Radiology ____ Medication Records	○ ____Treatment/Service Plan ○ ____ Alcohol/Drug Information	○ Mental Health Records ____ Psychiatric Progress Notes ____ Therapy Notes
○ ____ History & Physical Exam	○ ____ HIV/AIDS test Results	○ ____ Other:

Reasons for referral:

○ Basic Needs	○ Mental Health	○ Physical Health
○ Substance Abuse	○ Housing/Shelter/Motel	○ Employment/Education
○ Transportation	○ Legal Aid	○ Financial/Benefits
○ Faith-Based Services	○ Case Management	○ Social Health
○ Other:		

I understand information will only be shared with the agencies I have selected below:

○ Interfaith Community Services 425 Date Street #115 Escondido, CA 92025 760-520-8304 760-745-5467 (fax)	○ Neighborhood Healthcare 425 N. Date Street #203 Escondido, CA 92025 760-520-8340 760-839-9459 (fax)	○ Vista Community Clinic 1000 Vale Terrace Drive Vista, CA 92084 760-631-5000 760-414-3892 (fax)
○ Community Housing Works 1820 S. Escondido Blvd. Escondido, CA 92025 760-755-5441 760-432-6883 (fax)	○ Community Resource Center 650 2nd Street Encinitas, CA 92024 760-753-1156 760-753-0252 (fax)	○ Mission Treatment Center 161 N. Date Street Escondido, CA 92025 760-745-7786 760-466-9347 (fax)
○ Exodus Recovery, Inc. 1520 South Escondido Blvd. Escondido, CA 92025 760-796-7760 760-796-7758	○ The Fellowship Center 737 Grand Avenue Escondido, CA 92025 760-745-8478 760-745-6852 (fax)	○ North County Serenity House 240 S. Hickory St, Suite 210 Escondido, CA 92025 760-747-1015 ext. 2224
○ North Inland Recovery 200 E. Washington Avenue Escondido, CA 92025 760-741-7708 760-741-5421 (fax)	○ Other:	○ Other:

I may revoke this authorization at any time before the information has been released. This consent will expire in one year on: _____

I may retain a copy of this authorization. Initial here if you desire a copy: _____

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Parent, Guardian, Conservator or Probation Office if minor is a ward) (Date)

_____ _____
(Signature of Health Care Provider) & Employer (Date)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

NEIGHBORHOOD HEALTHCARE
a california health center

My Success Plan

_____

1. **Appointment With:** _____
   Address: _____
   Date: _____ **Time:** _____
   Reason: _____

2. **Appointment With:** _____
   Address: _____
   Date: _____ **Time:** _____
   Reason: _____

3. **Appointment With:** _____
   Address: _____
   Date: _____ **Time:** _____
   Reason: _____

Thank you for the opportunity to connect you to local resources. If I can be of further service, please contact me:

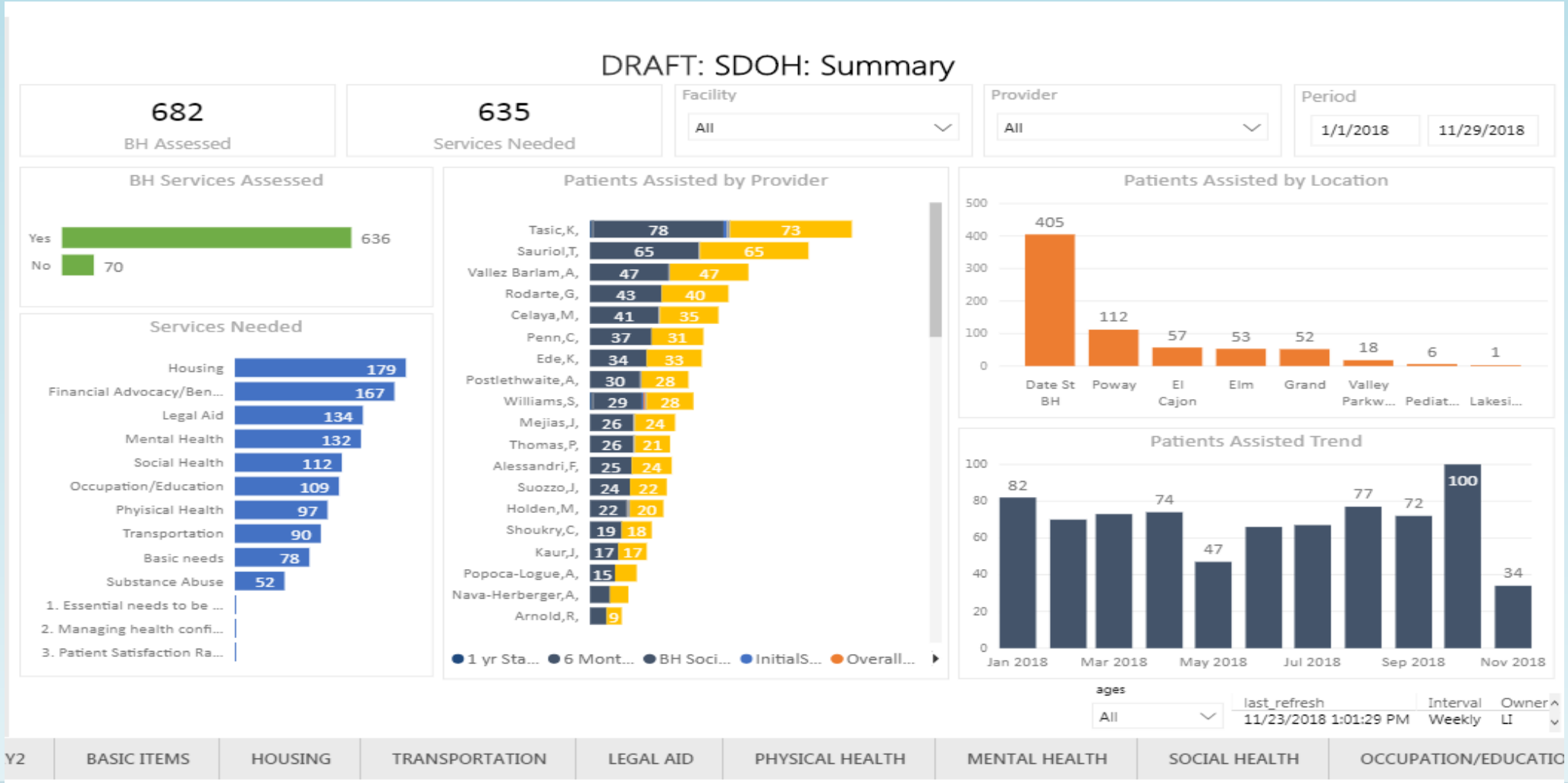
_____

SDOH Tracking & Outcomes

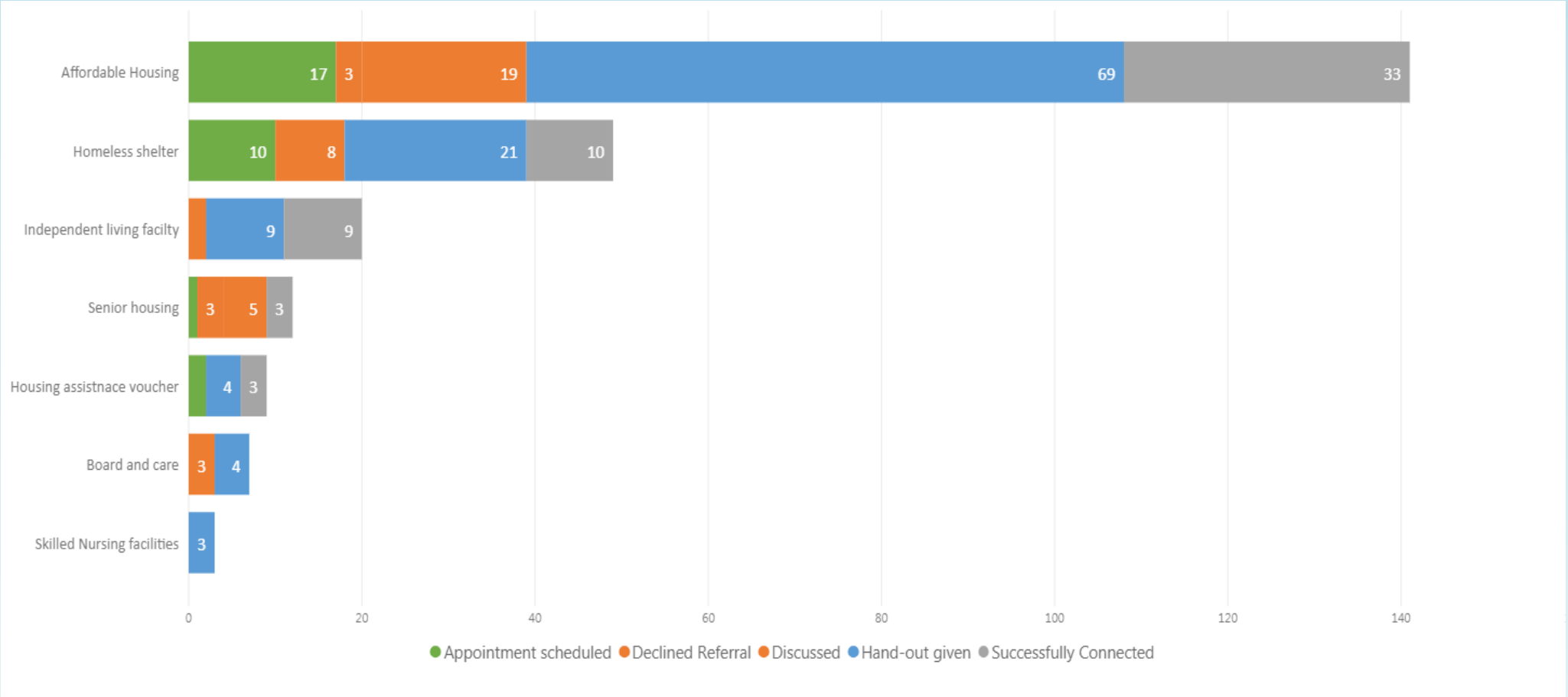
EMR tracking process:

- Assessment of Need
  - Filter by site, region, date range, age
- Referral Outcome
  - Discussed
  - Education provided/handout given
  - Scheduled appointment
  - Successfully connected/linked to service
  - Declined referral

High Touch SDOH Analytics



High Touch SDOH Referral Outcomes



2017 High Touch SDOH Referral Outcomes

Outcome	Basic Items	Housing	Trans.	Legal	Physical Health	Mental Health	Social Health	Occ / Educ	Financial	Substance Abuse
Decline	0%	3%	0%	1%	1%	1%	5%	2%	0%	2%
Discussed	7%	7%	20%	5%	18%	10%	5%	5%	8%	4%
Hand-Out	3%	23%	10%	38%	32%	15%	27%	33%	19%	55%
Appt Sch	2%	10%	4%	11%	8%	17%	11%	14%	21%	17%
Successfully Connected	88%	57%	66%	45%	41%	57%	52%	46%	52%	22%

What do we do with all of this data?

- Use data to drive partnership opportunities, think creatively, and create a business case model – more to come in SDOH 201 ☺
- Utilize data for funding opportunities (grants, donors, success stories)
- Correlate SDOH referral outcomes to health related outcomes
  - Top 100 high risk diabetic patient pilot
    - 50 randomly selected to receive Low Touch SDOH
    - 50 randomly selected to receive High Touch SDOH
  - SDOH "successfully connected" vs. "referrals provided" will be assessed at baseline, 6 months, and 1 year
    - A1c, Bp, LDL
    - Appointment Compliance (n/s, r/s, canc)
    - Patient Satisfaction (feel heard, understood, satisfied with the process)

Lessons Learned with SDOH Program

- Continually use PDSA's (plan, do, study, act) to monitor your effectiveness: Are you doing what you say you are? Be flexible and adaptable with feedback!
  - Mock patient simulations – be willing to be vulnerable
  - Assess at different touch points to determine best fit
- Assess staff level of comfort with asking these questions
- Ask your patients what the SDOH experience was from their perspective and how you could improve your service
- Be careful that warm, compassionate, staff do not overwhelm patients with their good intentions to be helpful
  - Ask what is the most important issue for you today that I can assist you with?
  - Ask what is your time commitment/availability today to address these issues?
  - Ask how best can we assist you today? Take a moment to explain options to establish a collaborative relationship from the beginning

Still believe you can't make a difference?

Focus on what's important. Don't get lost with all of the things you are not able to do. Start small and make a difference one starfish at a time!

MAKE A DIFFERENCE

One day a man was walking along the beach when he noticed a boy picking something up and gently throwing it into the ocean. Approaching the boy, he asked, "What are you doing?"

The youth replied, "Throwing starfish back into the ocean. The surf is up and the tide is going out. If I don't throw them back, they'll die."

"Son," the man said, "Don't you realize there is miles and miles of beach and hundreds of starfish? You can't possibly make a difference!"

After listening politely, the boy bent down, picked up another starfish, and threw it back into the surf. Then, smiling at the man, he said…

"I made a difference for that one."

Meet Melissa – one of our “Star”fish

When we met Melissa, she had diagnoses of alcohol dependence, depression, anxiety, and PTSD. She was involved in an almost fatal car accident while drunk. She failed to follow through with treatment for her leg to heal, ultimately causing it to be amputated. She severely hurt others involved in the crash. Due to this she was imprisoned and continued her addiction once released. She suffered through years of homelessness, unstable income, and legal issues with the police. She had multiple suicide attempts.

Intervention:

- NHcare provided behavioral health counseling and medication management
- Referral to Access to Independence for transitional housing, medical equipment, and furniture
- Referral to Interfaith Community Services (ICS) to expedite her HUD application and wrap around case management services
- Referral to Legal Aid for advocacy with her SSI
- Referral to sobriety support group which has been key to becoming sober

Current Outcome and Growing: Melissa is now has stable disability income and is able to take care of her basic needs, increasing her self-sufficiency. She currently has HUD housing and is off the streets. She received her 1 year sobriety token in 6/2018! She is involved in her church and is now seeking custody of her granddaughter to improve her life as well. She states, “I don’t think without you guys’ support, all of this would have been possible. You always followed up with me, even when I didn’t. You always had other options and resources for me to get the help I needed. I have so much to thank you guys for!”

Next Steps

- Develop prospective patient model to stratify patients to match level of service with need
  - Complex Needs – complex care resource specialist, social worker, case manager
  - Resource Needs – volunteer, intern, front or back office staff, enrollment specialist
  - Social Screening – rolled into intake packet with other standard screening surveys
- Improve patient portal opportunities to self-assess and provide resources
- Develop standardized training protocol for addressing complex needs
  - SDOH, Workflows, Cultural Humility, Motivational Interviewing, Understanding Trauma Informed Care, HIPAA
- Develop community partnerships to support/facilitate connection and reduce access barriers for patients

Searchable SDOH Evidence Library

https://SIRENetwork.ucsf.edu

Thank you for your time and attention.

Questions?

Wendi.vierra@Nhcare.org

760-520-8342