Neighborhood Healthcare SDOH 201

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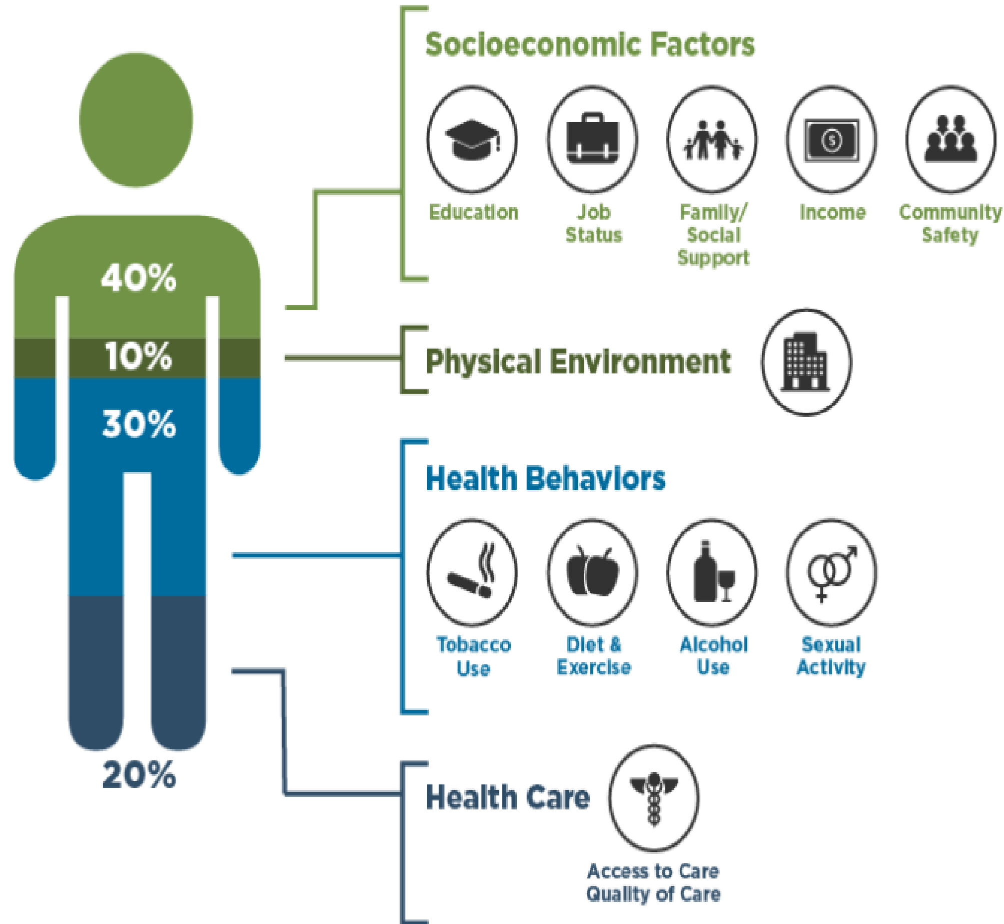
Neighborhood Healthcare

- 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 201 Objectives

- Learn Opportunities to Utilize SDOH Information to:
  - Improve patient care
  - Identify community needs and gaps in service
  - Strategically develop community partnerships



The concept of SDOH is not new – how we are learning to manage population health is now being driven from a resource perspective.

So why are SDOH so important?

The best treatment plans will fall apart if you are not willing or able to address SDOH essential needs.

SDOH as Indicators of Value-Based Care

SDOH information improves health related outcomes by:

- Collaborating with patient where they are at
- Providing patient-centered “true” whole person care
- Identifying which patients can benefit most from intervention
- Correlate SDOH data with health-related outcomes, treatment plan compliance, and patient satisfaction
- Addressing potential access barriers that impact health and wellness
  - Food, housing, safety, transportation, legal, daycare, literacy, employment, etc.
- Developing a comprehensive treatment plan
  - Broaden treatment/care team to include CBO’s

SDOH as Indicators of Community Needs

- Assessing for SDOH provides an instant community needs assessment when data is aggregated
  - Data can be used to work with local city, county, and CBO partners to develop services where there are identified gaps
    - Demonstrate need for seed funding opportunities
  - Data can be used to influence policy and programs, restore equity
  - Data can be used as evidence for best practice interventions and to track trends over time

SDOH to Drive Strategic Partnerships

- Use data to build a business case model – need to analyze the financial costs relative to impact and outcomes
  - Which SDOH are of most concern to community stakeholders?
  - Which SDOH have the greatest effect on health, health equity, well-being, and health care costs?
    - Ultimately we want to address these more upstream to prevent health disparities, inequities, and high costs
- SDOH can drive multisector cross-organization partnerships
  - Requires trust to exchange information, collaborate, and share resources, funding, and power

IMAGINE what you could do if you removed the "yes, but…"

- What would your ideal state for whole person care look like?
- Who might be able to help with those needs?
- Are there opportunities available you may not be accessing today?
  - Volunteers, Interns, Grants, Donations, In-Kind Support, New Partnerships
  - Reassessing job duties and resources for maximum impact
- What kind of collaboration would you like to see happen?
- How would all of this improve the lives of those you serve and the health and well-being of our communities?

Let’s Build Strategic Partnerships!

- Identify the social needs for the population you are serving
- Identify key stakeholders in the community that address those needs
- Build relationships through meet and greets: site/program tours
  - Doors open when there is personal investment!
  - Utilize the Partnership Assessment Tool for Health as a guide to maximize the impact of the partnership
    - Requires dedicated time, executive leadership support, open and honest dialogue, and willingness to explore uncharted territory
    - Assess partnership strengths, gaps, challenges, and opportunities

Partnership Assessment Tool for Health

Developed by Partnership for Healthy Outcomes: Bridging Community-Based Human Services and Healthcare

- Step 1: Share tool with CEO to gain buy-in to pursue a partnership
- Step 2: Complete the tool
- Step 2: Share tool with CEO's of both organizations
- Step 3: Set up regular, at least monthly meetings to sustain momentum
- Step 4: Strategize and prioritize changes – where is there low hanging fruit?
- Step 5: Continuously remain creative, thinking outside the box, and focus dialogue on how you can make something happen - there is always "something" that can be done to do more, do better! You have to believe it first!

"If you believe, all things are possible" – Walt Disney

PATH Check-Up Summary

Partnership Check-Up Summary

Using your responses in the Partnership Check-Up, complete the summary chart below.

Internal & External Relationships	
Benchmark	**Score (1-5)**
Shared Goals: *My partner and I share an understanding of the goals our partnership seeks to achieve.*	
Maximizing Partner Value: *My partner and I bring complementary expertise to the partnership and maximize the unique value we each bring.*	
Leveraging External Relationships: *We fully leverage our relationships with the community, funders, and other professional networks to advance our partnership's goals.*	
Internal Buy-in: *Leadership and key staff at each partner organization are supportive of the partnership and the organization's participation in it.*	

Service Delivery & Workflow	
Benchmark	**Score (1-5)**
Service Alignment: *The services our partnership provides enable us to achieve our goals.*	
Workflow Processes: *Our workflow processes allow the partnership to deliver services effectively and efficiently.*	
Service Delivery Capacity: *We have the necessary time, people, and expertise to deliver effective services to our target population.*	
Engaging the Target Community: *We engage our target population to inform and improve service delivery.*	

Partnership Check-Up Summary, cont.

Funding & Finance	
Benchmark	**Score (1-5)**
Covering Full Cost: *We understand the full cost of partnership and incorporate this into our funding model.*	
Securing Revenue: *We have reliable revenue streams sufficient to cover the full cost of partnership.*	
Financial Goals & Priorities: *My partner and I are aligned on the financial goals of our partnership, and understand each others' financial priorities.*	

Data & Outcomes	
Benchmark	**Score (1-5)**
Data Collection: *The data our partnership collects accurately conveys progress toward our shared goals.*	
Data Usage: *Our partnership uses the data we collect to improve the way we deliver our services.*	
Demonstrating Outcomes: *We are able to demonstrate and articulate our outcomes using the data we collect.*	

NHcare & Interfaith Community Services

- Completed PATH in 8/2018 – imagined what we could do if we both leveraged our resources to support the expansion and growth of our partner
  - Intermittent clinic to provide medical, behavioral health, and enrollment services to our communities must vulnerable population inside Interfaith's main campus
  - Co-author multiple grants to increase funding opportunities to build collaborative programs and expand care coordination
  - Co-locate Interfaith in multiple NHcare clinics
  - Relocate/house Interfaith programs within NHcare to meet population needs
  - Bringing psychiatry to Recuperative Care and Recovery & Wellness Programs
  - Bring in 2-1-1 for CIE pilot
  - Exploring partners to build Legal Medical Partnership
  - Train Interfaith staff to administer PHQ9, AUDIT, DAST for early identification and referral for services
  - Exchange collaborative care information through shared registry

Thank you for your time and attention.

Questions?

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