In-Person Session #3
August 23, 2018

ROOTS Program

ROOTS Program Team

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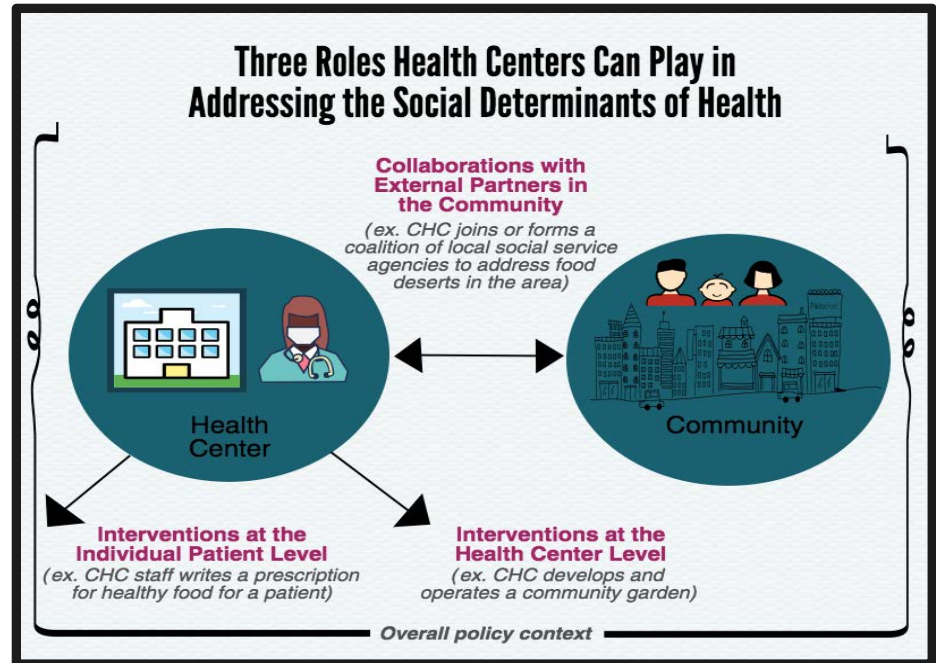& UCSF SIREN Team,
Evaluation Partners

Dr. Jim Meyers,
Program Coach

ROOTS Program

- Meant to be a year of testing & innovating

- Our intention is to share lessons learned with our clinics and the field as a whole.

- What role should clinics play in assessing & addressing social needs?

Three Roles Health Centers Can Play in Addressing the Social Determinants of Health

Collaborations with External Partners in the Community
(ex. CHC joins or forms a coalition of local social service agencies to address food deserts in the area)

Health Center

Community

Interventions at the Individual Patient Level
(ex. CHC staff writes a prescription for healthy food for a patient)

Interventions at the Health Center Level
(ex. CHC develops and operates a community garden)

Overall policy context

Key Questions

Questions for the Field

- Where can clinics really make a difference and **be best positioned** to contribute to addressing social needs?

- **Which social needs** make sense for clinics to address?

- How best can clinics use **individual and community level data** to address social needs?

- What are the steps or key considerations when forming new **partnerships** to address social needs?

Questions for ROOTS/CCI

- What **types of projects** were easiest to implement and why?

- What **challenges** did you face in implementing your projects and how did you address them?

- What ROOTS program activities were **most helpful**?

- Did participation in this program **increase your clinic's capacity** to address patients' social needs?

Goals for the Day

 Learn what your colleagues have been working on, the challenges, and the wins, and explore the impact your work has had on patients, staff, and/or partners

 Hear about trends in sustainability & financing social needs, and think through next steps for your work at your organizations

 Help CCI & the larger field think about where to go next

Today's Agenda

- **9:30 – 9:45:** Welcome & Overview
- **9:45 – 11:10:** ROOTS Sharing & Learning Part 1
- **11:10–11:25: Break**
- **11:25 – 12:35:** ROOTS Sharing & Learning Part 2
- **12:35 – 1:20: Lunch**
- **1:20 – 2:00:** ROOTS Art Project
- **2:00 – 2:45:** Sustainability & Financing
- **2:45 – 3:00: Break & Stretch**
- **3:00 – 4:15pm:** World Cafe
- **4:15 – 4:30pm:** Evaluation & Wrap Up
- **4:30 – 5:30pm: Celebration**

Morning Introductions at Your Table

1) Name
2) Organization & Role
3) Summer Time Memory
4) Share your answer on www.menti.com. Code: 97 04 84.

Housekeeping Reminders

Sharing & Learning Part #1:
Assessing for & Addressing Food Insecurity

1. **Asian Health Services:** Developing infrastructure and community linkages to address housing and food insecurity.
2. **LAC-USC:** Incorporating community partners into an integrated social and behavioral health model to address food insecurity.
3. **LifeLong Medical Center:** Improving data integration to assess and address food insecurity at the care team level.
4. **NEVHC:** Developing strong referrals to assist pediatric patients and families experiencing food insecurity.

ASIAN HEALTH SERVICES

ROOTS Program
August 23, 2018

ASIAN HEALTH SERVICES
HEALTH CARE FOR ALL. ADVOCACY FOR THE UNDERSERVED.

Who We Are and Social Needs Nuts & Bolts

- **Location**: Oakland Chinatown

- **EHR Used**: NextGen (anticipated changes to EPIC)

- **Social Needs Focus**: food and housing

- **Population Focus**: Elderly, HIV

- **Screening Tool Used (if any)**: PRAPARE

- **Partnerships (if any)**: Alameda County Food Bank, Asian Prison Support Committee

Project Recap

Where did you start with your ROOTS project, and where are you now?
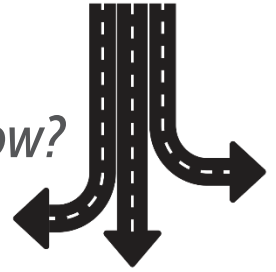
September 2017

- Original Project Goal:

  - To explore usefulness of PRAPARE screening and interventions

  - To expand to new teams

  - To identify/develop new interventions in food and housing

August 2018

- Project Update:

  - ID'd strengths and deltas in PRAPARE

  - Focusing on training up staff, expansion slowed because of capacity for referrals

  - Standardized existing best practice interventions across teams w/ resource referral algorithm

  - Establishing strong partnership with Alameda County Food Bank

  - Promoting a culture of sharing resources throughout departments

Project Roadblocks, Challenges, & A-ha's

Roadblocks	Overcoming Challenges	A-ha's & Successes
Stalled expansion: wanted to see impact, staff capacity issues	Conducted informal audit in 3 primary languages	lots of insights on where to make changes
Variability between teams in workflow and referrals	flexibility in workflows, cross training, & develop referral algorithm	Koji's story
Low Asian American turnout at Alameda County Community Food Banks	Madison Park Survey: Determined the gap between patients/community and accessing ACCFB food resources	Oakland Chinatown First Wednesdays galvanized our partnership with
Implementing two surveys (PRAPARE and Ryan White)	Team meeting to ID duplicates & implement	Realized importance of loop closures.

Top 3 Takeaways

What were your top three takeaways or learnings from ROOTS?

Screening has to go hand in hand with **culturally responsive**, and **consistent** interventions
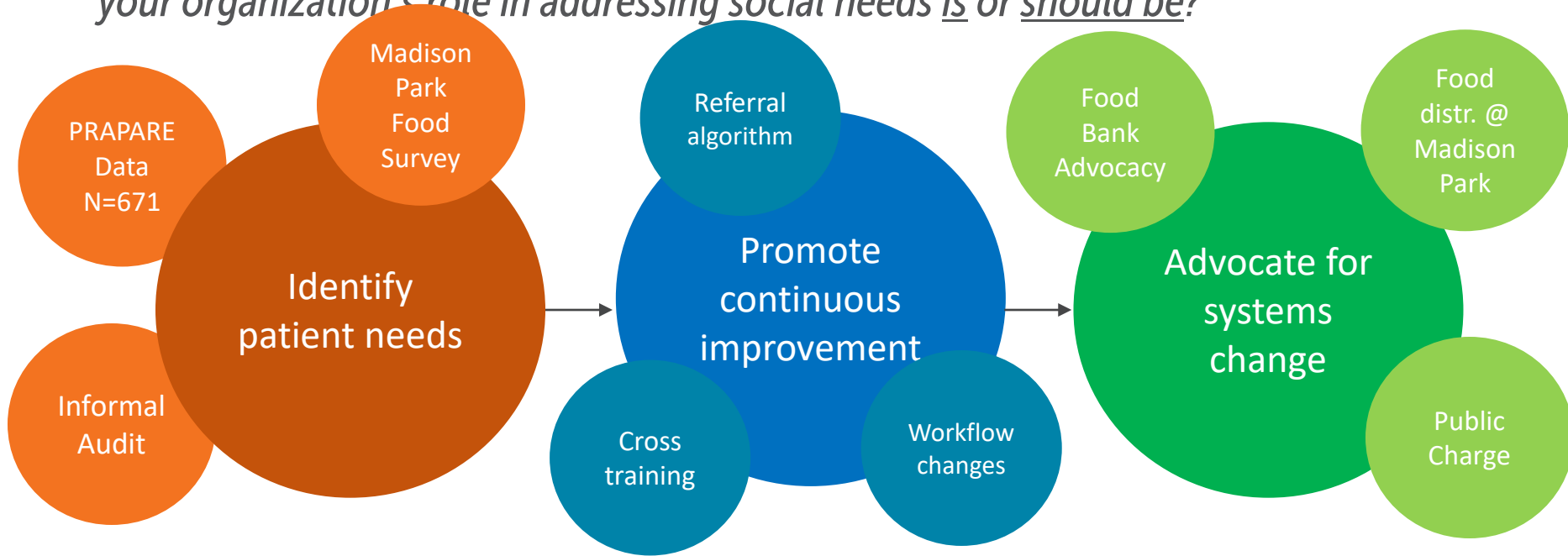
Structural equity issues require structural interventions at all levels

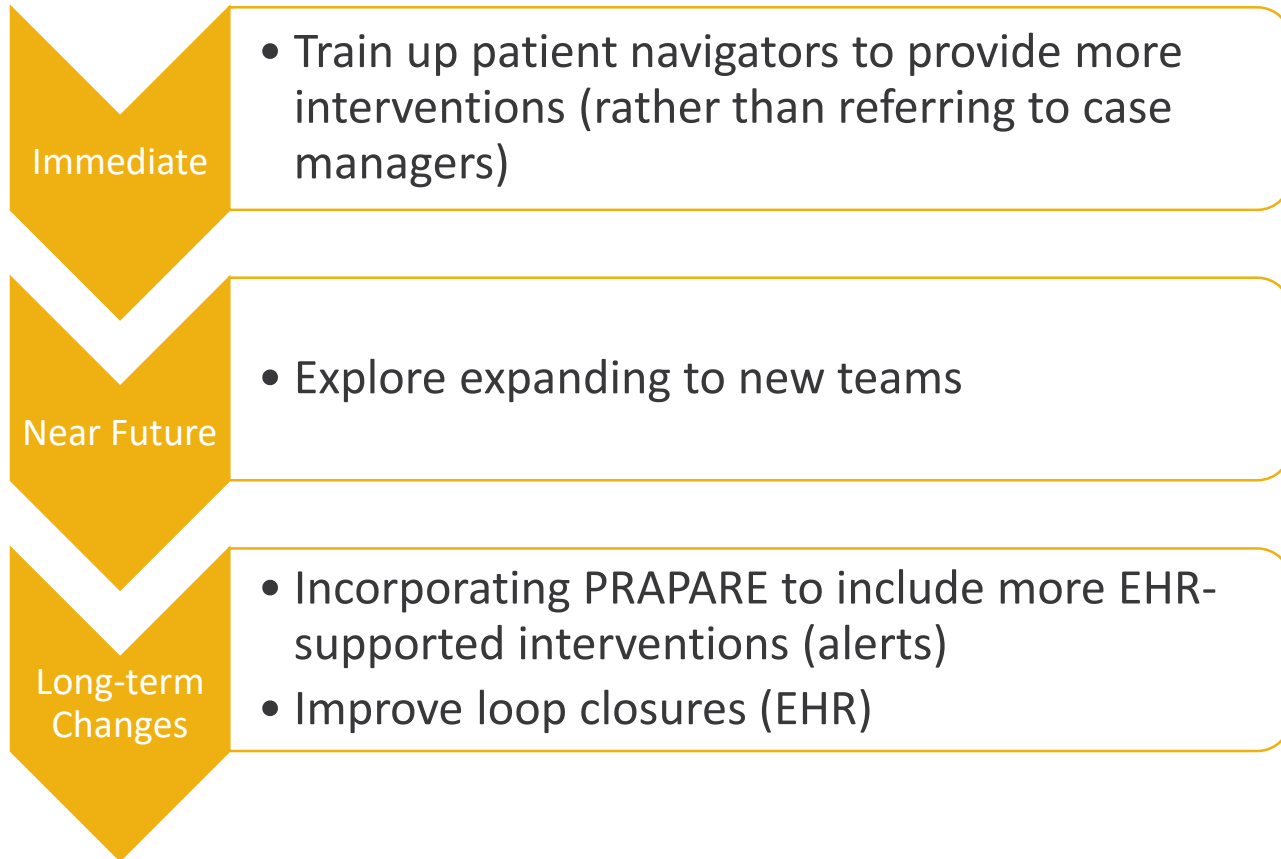Partnerships take a lot of time

Impact & Role

How has addressing social needs impacted your organization? What do you think your organization's role in addressing social needs is or should be?

PRAPARE Data N=671

Madison Park Food Survey

Informal Audit

Identify patient needs

Referral algorithm

Promote continuous improvement

Cross training

Workflow changes

Food Bank Advocacy

Advocate for systems change
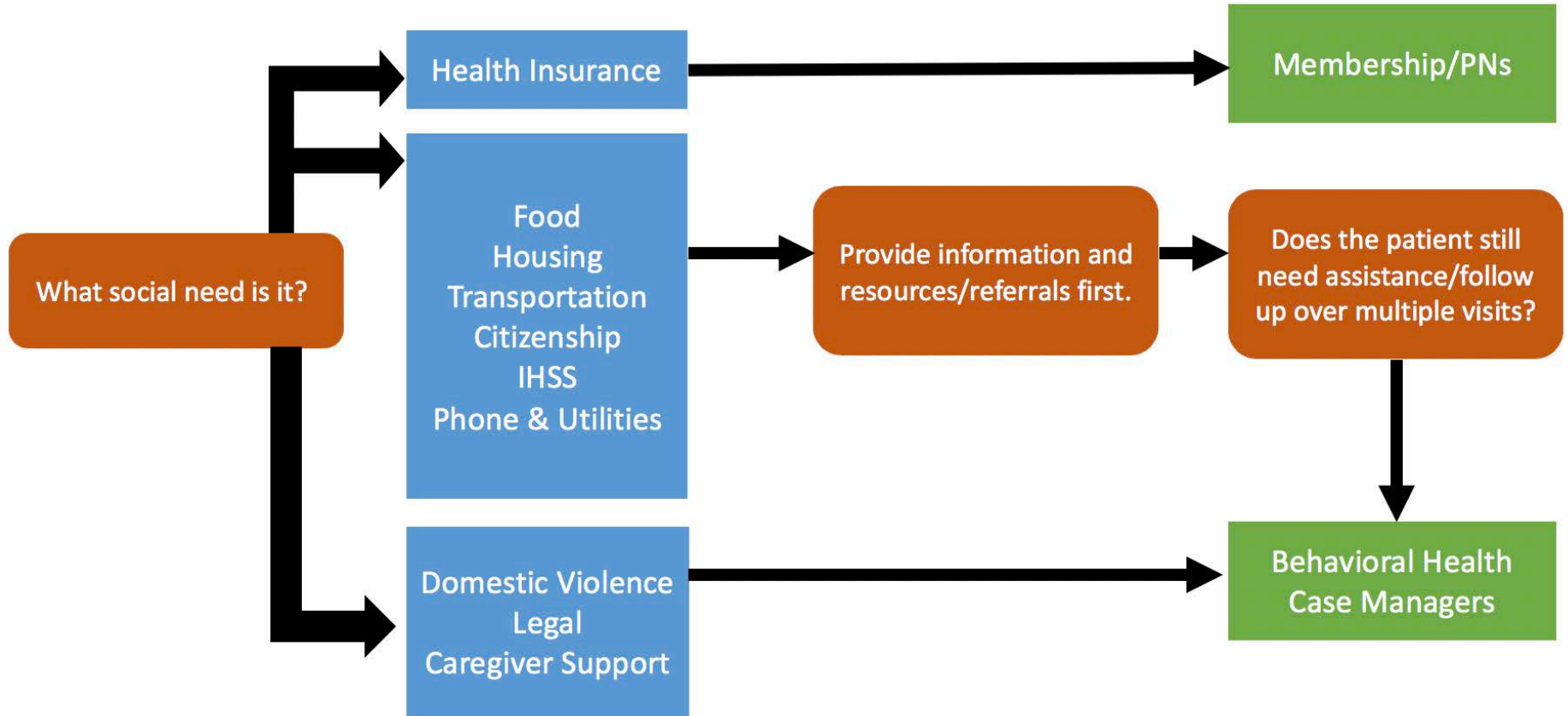
Food distr. @ Madison Park

Public Charge

Our patients, their experiences, and their data tell us a story that AHS then uses to deliver culturally competent services and advocacy to address systemic inequities.

What's Next?

What is next in your organizations journey to assess & address social needs? What are you planning for the rest of 2018 & beyond?

Immediate
- Train up patient navigators to provide more interventions (rather than referring to case managers)

Near Future
- Explore expanding to new teams

Long-term Changes
- Incorporating PRAPARE to include more EHR-supported interventions (alerts)
- Improve loop closures (EHR)

Social Needs Referral Algorithm 8.1.2018

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LAC+USC Primary Care

LAC+USC Primary Care

- **Location**: Boyle Heights (East LA)

- **EHR Used**: Cerner

- **Social Needs Focus**: Food and housing insecurity

- **Population Focus**: All empaneled adult (and now, Peds) primary care patients

- **Screening Tool Used (if any)**: As part of CMA intake: 1 question food insecurity screener (combo of Hunger Vital Sign), 1 question on housing needs

- **Partnerships (if any)**: On campus- Dept of Social Work, The Wellness Center

Project Recap

September 2017
- Original Project Goal:

- Assure that 30% of patients who screen positive for food insecurity obtain resources needed to address this within 3 months of positive screen

- Connect 25% of patients who screen positive for homelessness or housing insecurity to resources (submit application for Housing for Health, etc) within 6 months of positive screen

August 2018
- Project Update:

- Enroll 20% of patients who screen positive for food insecurity in CalFresh within 3 months of a positive screen

- Assure 15% of patients who screen positive for homelessness have Housing for Health application in process within 6 months of positive screen
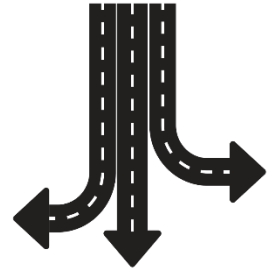
Project Roadblocks, Challenges, & A-ha's

Roadblocks & Overcoming Challenges

- Addition of multiple new team members

- Different leadership & organizational structure, and priorities between primary care, Wellness Center, social work dept

- Competing priorities for time and energy

A-ha's & Successes

- Implementation of new workflows

- Our ability to enroll patients in clinic for CalFresh

- Our ability to collect (a small amount) of data on this work

- Engaged staff as leaders among their peers

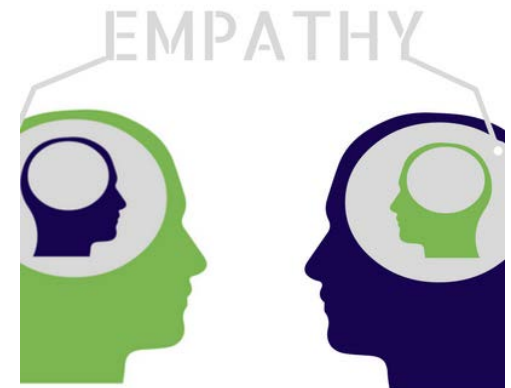- Consultants and outside experts conducting trainings

Top 3 Takeaways

Staff training and engagement is a pre-requisite for success. Engage front-line staff as leaders and champions.

Utilize partners that make sense for your patient population and clinic setting. Look outside and inside.

Use evidence to guide you but don't let scripts or screeners constrain the conversation.

Impact & Role

Impact:

- LAC+USC Adult Clinics have experienced culture change through this work

- No questions on the "why" of doing this work, no challenges to "job scope"

Role:

- Primary Care Adult Clinics can inform larger discussions across DHS, DPH on overall strategy

- Start to consider role in spread and sustainment

What's Next?

LAC+USC Primary Care

- Refining and redesigning workflows and referral pathways

- Care teams as owners of this work

- Spread to Pediatrics, Geriatrics clinics

Dept of Health Services

- Development and roll out of social needs screener across all of DHS primary care (65+ clinics)

- Addition of behavioral health team members to all staffing packages

- Potential collaboration with Dept of Public Health

ROOTS Program

August 23, 2018

LifeLong Medical Care

LifeLong Medical Care

Who We Are and Social Needs Nuts & Bolts

- **Location**: LifeLong East Oakland (LMC EO)

- **EHR Used**: NextGen

- **Social Needs Focus**: Food Insecurity in East Oakland

- **Population Focus**: Adults at LMC EO; East Oakland community

- **Screening Tool Used (if any)**: Hunger as Vital Sign® 2-item screening tool

- **Partnerships (if any)**: Alameda County Community Food Bank; SunBasket; Leah's Pantry

  - (Imperfect Produce, DaVita Dialysis, Farmer's Markets)

Project Recap

Where did you start with your ROOTS project, and where are you now?
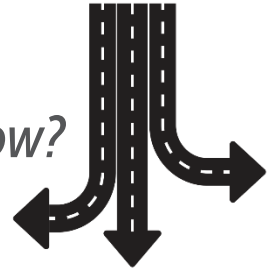
September 2017

Original Project Goal:

Screen all patients seen in primary care for food security, and ensure that all patients identified as food insecure receive follow-up that addresses their food insecurity.

Build partnerships that will support the services, referrals and resources most commonly needed by our patients and community

August 2018

Project Update:

Screen all patients seen by one clinical dyad (and by the Americorps) for the pilot period (1/31-7/31), and ensure that the food insecurity issue(s) identified are followed –up and closed out by the end of the ROOTS program (8/31)

Project Roadblocks, Challenges, & A-ha's

What roadblocks or challenges forced you to change direction? How did you overcome those challenges? What "a-ha" or moments of success did you have, and why?

Roadblocks & Overcoming Challenges

- HVS Screening tool is inadequate/inefficient -

- Too many providers/not enough staff time to do follow-up services

- How often to rescreen?

- How do you ensure that you get what you want/need in the partnership, and that your partners do as well

A-ha's & Successes

- Patients don't know public health lingo – important to break it down for them

- Necessary to have enough staff time to complete follow-ups. Necessary to take into account that patients need hand-holding in this process

- Connecting with SDOH resources in the community is not easy or intuitive – process is complicated, and often need support from health professionals

Top 3 Takeaways

What were your top three takeaways or learnings from ROOTS?

Appropriately assessing Social Determinants of Health is key

Addressing Social Determinants of Health requires dedicated staff time and resources

Strategic and efficient partnerships require a clear understanding of the population's needs and organizational intention

Impact & Role

How has addressing social needs impacted your organization? What do you think your organization's role in addressing social needs is or should be?

Addressing social determinants of health REQUIRES time and dedication

- Necessary to ensure dedicated staff time towards BOTH the assessment of food insecurity and corresponding follow-up services and referrals
  - Connecting with patients and resources takes time and often several attempts before it sticks
  - Without adequate time dedicated to follow-up services and referrals, patients will fall through the cracks and SDOHs remain unaddressed
- Easier to split the work up and assign different tasks to different roles; not possible to assess and address everything all at once
  - Each step of the workflow requires a different amount of time

Position your organization according to the amount of resources and staff time you have available:

- Acknowledge/Engage: highlight the role of social determinants of health in your patient's lives, engage with them on the SDOH endorsed as needing support with

- Assess: ask the right questions with a culturally sensitive and trauma-informed approach, to get all the information needed to identify root causes

- Address: once the root cause(s) have been identified, working with the patient to address factors affecting food insecurity; this may involve multiple simultaneous approaches including providing services, referrals to agencies/ community resources, and light case management

What's Next?

What is next in your organization's journey to assess & address social needs? What are you planning for the rest of 2018 & beyond?

What capacity do we have? What capacity *could* we have?

- LifeLong is in the process of refining clinical roles, specifically non-licensed roles

- What roles are best for which step of the workflow process?

    - Long- vs. short-term step of workflow AND long- vs. short-term staff

- Which space in the clinic is best for which step of the workflow?

    - Clinic sees high volume of unique pts; v short visits

    - Wellness Center holds many social services and patients more likely to engage with staff AND other patients here

When building partnerships (which require energy, time and intention) ensure that the partnership is truly fruitful for you

- Important to be able to explicitly state your objective, goals and deliverables/outcomes for the partnership

- What are the key things that 'make or break' the partnership for your organization?

    - Services

    - Referrals

    - Resources

    - Feedback loop

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August 23, 2018

**Northeast Valley Health Corporation**

Northeast Valley Health Corporation

Who We Are and Social Needs Nuts & Bolts

- **Location**: Pacoima and Valencia

- **EHR Used**: NextGen® EHR

- **Social Needs Focus**: Food Insecurity

- **Population Focus**: 12-17 Age Group

- **Screening Tool Used (if any)**: The Hunger Vital Sign™

- **Partnerships (if any)**: LA Care Family Resource Center, Montague Charter Academy, Vaughn Charter Next Century Learning Centers, Youth Speak Collective

Project Recap

Where did you start with your ROOTS project, and where are you now?
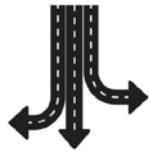
September 2017
Original Project Goal:

- At least 9 care teams will be trained on how to use the Otech tablets to screen for food insecurity and respond to positive responses using 1 degree.

- At least 75% of patients ages 12-17 will have been screened for food insecurity during their Well Child Exam.

  - ➢ Of those who screen positive for food insecurity, 80% will be referred to NEVHC Nutrition Services

  - ➢ Of those who screen positive for food insecurity and enroll in 1 degree, 60% will have closed resource referrals on 1 degree.

August 2018 Project Update:

- Trained 7 care teams at 2 sites.

- Screening Rate (July): All Providers (55%) and trained providers (69%)

- As of 8/19

- All providers screened 429 patients, 13% (56) responded positive

- Trained providers screened 262 patients, 15% (39) patients responded positive

  - ➢ 74% (29) of the total patients who responded positive to the questions were contacted by Nutritionist

  - ➢ 53% (21) of patients who responded positive had documentation included in EHR (NEVHC Nutrition Services, Food Rx Guide, Community Resource Line)

    - ➢ 48% (10) were enrolled in 1 Degree

Project Roadblocks, Challenges, & A-ha's

What roadblocks or challenges forced you to change direction? How did you overcome those challenges? What "a-ha" or moments of success did you have, and why?

Roadblocks & Overcoming Challenges

- Technology: OTECH and One Degree

- Buy- in (false positives)

- Communication, Empathy, and SDOH

- Efficiency & Spread

A-ha's & Successes

- Patients are open to their care team addressing non-medical needs

- Raised awareness about food insecurity

- Food Insecurity is not about food

- Training approach needs to be tactful and ongoing - staff may be experiencing food insecurity, burnout, etc.

Top 3 Takeaways

What were your top three takeaways or learnings from ROOTS?

Technology allows for efficiency, but personal connection is the key to success.

We cannot address food insecurity without also addressing other SDOH needs.

We need to develop an efficient follow-up plan in order to scale and spread.

Impact & Role

How has addressing social needs impacted your organization? What do you think your organization's role in addressing social needs is or should be?

- We have an increased awareness of SDOH and how our patients are impacted. However, we still need funding or ROI data.

- Through this data collection we are identifying top needs and taking a closer look at internal/external resources and ways to increase connections/usage.

- We realize we need to do more to increase empathy among staff.

What's Next?

What is next in your organizations journey to assess & address social needs? What are you planning for the rest of 2018 & beyond?

- We are identifying individuals who can collect and respond to data

  - PARENT Coaches

  - Behavioral Health Care Coordinators

  - 4 Community Health Workers

- Developing an organizational spread plan

- Increase efficiency of follow-up

  - "High Touch" follow-up

  - "Low Touch" follow-up

Table Discussion

1 What did you hear that you could apply to the work at your organization?

2 How did the challenges relate to challenges you've encountered?

3 What did you hear that you were excited about?

1 minute: Self reflection/jot down notes

14 minutes: Table discussion

5 minutes: Report out top highlights

BREAK (15 minutes)

Sharing & Learning Part #2:
New Approaches to Data & Partnerships

1. **West County Health Centers**: Developing a shared data platform with community partners to inform and address school absenteeism.
2. **Petaluma Health Centers**: Cultivating new partnerships to address unemployment and underemployment.
3. **St. John's:** Supporting the reentry population to stabilize and improve health and prevent recidivism.

ROOTS Program

August 23, 2018

West County Health Centers

West County Health Centers

Who We Are and Social Needs Nuts & Bolts

- **Location**: Western Sonoma County

- **EHR Used**: eClincal Works

- **Social Needs Focus**: Education

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

- **Screening Tool Used (if any)**:

- **Partnerships (if any)**: Guerneville School District

Project Recap

September 2017

Original Project Goal

The goal was to **work outside our four walls with a critical community partner** to create something that either organization could not do alone.

We wanted to **practice the use of shared data and the application of human centered design and systems thinking** in the collaboration process.

We planned to **partner with the Guerneville School District** to create successful data sharing and use Human Centered Design and Systems Thinking to **understand the factors that influence absenteeism** and to **create successful solutions together**.

August 2018

Project Update

We **partnered with Guerneville School District** and we were able to create a **legal agreement** to **ingest pupil level data and to create joins with patient identified data and successfully uploaded began analysis with joined data sets.**

We also used **Human Centered Design to understand factors outside of the data**.

We have gained insights into **successfully managing a key stakeholder and ethical implications of cross-sector data sharing.**
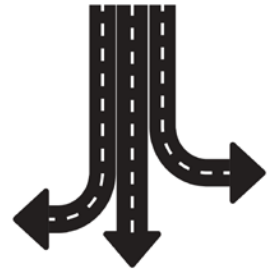
Project Roadblocks, Challenges, & A-ha's

Roadblocks & Overcoming Challenges

- Legal implications of sharing protected data

- Timing – pace working with partner's timeline

- Relationship building – discovery kits, building trust

- Ethical thought process needed to be safe

- IT hiccups

A-ha's & Successes

- Being part of community matters – KG story

- Partnership is better than being in silos

- Data is interesting

- Using data relationally provides a unique perspective

- Process of HCD and community partnership

Top 3 Takeaways

Partnership

Each one of us can make a difference. Together we make change. Community informed interventions are guided by key partnerships with a shared vision. Lastly, timing can be hard.

Data

As we begin to enter the realms outside of the traditional healthcare model and adopt new analytical tools and data sets, we find that the moral, ethical, and at times, legal boundaries of these new landscapes have yet to be defined.

Discovery Kit

Data can inform and provide great insight but using Human Centered Design can help us uncover the narrative by moving beyond the obvious and understanding the underlying needs and causes.

Impact & Role

WCHC recognizes that we must improve population health and broaden our focus from providing health care services to **addressing overall health and equity of our communities**.

We think that **non traditional community partnerships** are critical to make meaningful impact on the social determinants of health.

The role of healthcare and particularly FQHCs, with long history of community trust and relationships, is uniquely positioned to be a **driver in this new area of focus**.

This grant allowed us to practice strategic use of data in a collaborative way. Because of the unique restrictions on healthcare data sharing, we think that **healthcare is the best partner to receive and hold data for other participating organizations**.

Lastly, Human Centered Design allowed us to work toward creative actionable projects, across systems and **uncover the narrative behind the data**. We think this was important.

What's Next?

Continue to share and analyze data including:

- Social network analysis

- Geospatial analysis

- Using data to identify at risk families for increased support

Expanding the role of community health to do a joint teaching around trauma informed care

Joint care management and support for students and families with high risk for absenteeism

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Petaluma Health Center

Petaluma Health Center

Who We Are and Social Needs Nuts & Bolts

- **Location**: Petaluma & Rohnert Park, CA (Southern Sonoma County)

- **EHR Used**: eCW

- **Social Needs Focus**: Employment

- **Population Focus**: Currently unemployed adults seeking employment

- **Screening Tool Used (if any)**: PRAPARE

- **Partnerships (if any)**: Sonoma County Job Link & Petaluma Adult School

Project Recap

Where did you start with your ROOTS project, and where are you now?
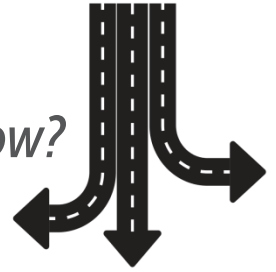
September 2017

- Original Project Goal:
  - Improve patient health and overall well being by connecting unemployed and underemployed adults with opportunities for job training and employment.

August 2018

- Project Update:
  - Evolving Partnership with Sonoma County Job Link
    - Transportation
    - On Site Support
    - Online Resources
    - Future Job Fair
    - Aunt Bertha

Project Roadblocks, Challenges, & A-ha's

- ## Roadblocks & Overcoming Challenges

  - Initial attempts to narrow our target population didn't work for our project because the resource was unlimited (Job Link) and we needed to get more volume to test our process.

  - Not all partners are created equal. Some move slowly (especially County systems) and funding and priorities shift.

  - When people have pressing needs in terms of food and housing, employment is sometimes hard to engage them around employment.

- ## A-ha's & Successes

  - You don't know until you ask. Sometimes priorities align and funding is available (Job Link and Lyft).

  - Front line staff who are doing the work need to be at the table from the beginning.

  - You need conversations and collaborations across both organizations to create a process and a partnership that works.

  - Survey existing internal relationships and partnerships to leverage them for new projects.

Top 3 Takeaways

What were your top three takeaways or learnings from ROOTS?

Partnerships take time and attention.

There are agencies and organizations who want to help. They don't all have the resources or band width to commit.

Go and see. It's hard to know what your patients will experience if you've never seen it yourself.

Impact & Role

How has addressing social needs impacted your organization? What do you think your organization's role in addressing social needs is or should be?

- Having community partnerships has allowed us to move beyond the "medical" role we play and have a more far reaching impact.

- Staff and providers can feel confident assessing for social needs knowing that we have or can develop partnerships and resources to address a variety of needs.

- Our role is to be able to connect clients either on site or off to reliable organizations that can support their social wellbeing.

- We will develop internal resources when there are insufficient resources in the community or there is demand that exceeds the supply of community resource.

What's Next?

What is next in your organizations journey to assess & address social needs? What are you planning for the rest of 2018 & beyond?

- Aunt Bertha Implementation

- Center for Well Being Community Health Worker Program

- Re-visit Petaluma Adult School

- Explore Job Fair Options

- Consider Staffing Agency Partnerships

- Continue to collect and analyze data collected from PRAPARE to inform new partnerships

- Work with Regional Consortia Members to share learnings

ROOTS Program

Sara Wilshinsky
Jack Morris
Elena Fernandez
Opulence Abundance

St. John's | Well Child & Family Center

LEADING CHANGE THROUGH HEALTH

- 15 locations in South Central LA and 2 mobile units

- Electronic Health Record: E-ClinicalWorks

- Social Needs Focus: Connect formerly incarcerated individuals to integrated health services and peer support

- Population Focus: Formerly incarcerated individuals with barriers to care (housing, food, employment) living in South Central Los Angeles

- Screening Tool Used (if any): PRAPARE, PQH9, LA County CHAMP comprehensive assessment

- Partnerships (if any): Anti-Recidivism Coalition, Tarzana Treatment Center, DHS, Whole Person Care, Partners for Children Los Angeles, Office of Diversion & ReEntry, Black Aids Institute, LA County Parole & Probation, First to Serve, Volunteers of America, Shields for Families, HOPICS, Housing for Health, CCI, TCN, Homeboy Industries, Beit T'Shuvah

Project Recap:

September 2017
:
- In Oct 2017, St. John's entered into a contract with LA County for one community Health worker to provide intensive case management services

- SJWCFC is the first FQHC in Los Angeles to develop a re-entry program

- Services limited to individuals with chronic illness who were recently released

August 2018
:
- SJWCFC has 4 case managers and a supervising LCSW.

- Services expanded to anyone with hx of Justice involvement and undocumented individuals

- Expanding into youth diversion and Juvenile after care services

- Part of a vibrant network of partnerships specific to re-entry

Project Roadblocks, Challenges, & A-ha's

- Large portion of individuals who request services while incarcerated do not follow up post-release.

- Hard to accommodate immediate placements in shelters or residential treatment centers.

- Mental Health and Substance Abuse

- Comprehensive Assessments determining SDOH insecurities, but not enough effective resources.

- Expanded network : Accompanying clients to court – advocate for release, reduce fees, dismiss cases and get clients discharged from supervision.

- Making linkages to appropriate integrated health services and specialty care.

- Stepping back as clients begin to succeed on their own and watching them grow.
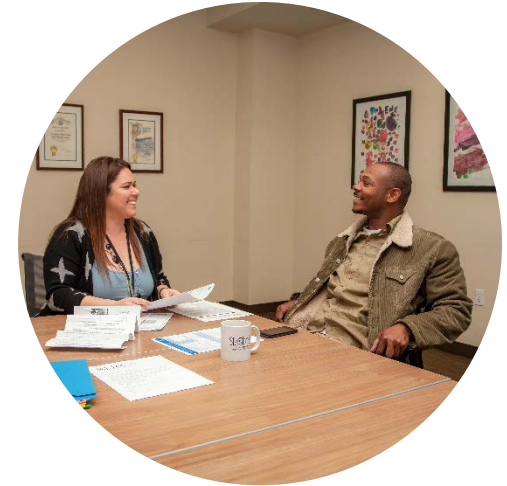
Top 3 Takeaways

It's Important to Have strong Roots; and to examine the Roots of each issue

You have to be aware of project barriers in order to solve them

Take time to learn the history and stories of your team members

Impact & Role

- Improved our ability to offer comprehensive services and understand the holistic needs of the client

- As a health center addressing social needs, utilizing the PRAPARE screening has allowed us to not only assess current needs but patient vulnerabilities

- It has allowed us to offer more effective care

- It is the responsibility of our organization to address social needs

What's Next?

- Providing Trans competent services

- Developing services specific to youth

- Increasing substance use treatment for individuals exiting incarceration

- Developing professional development, paid internships for recently released individuals

- Creating a model of best practices for other FQHC's to offer integrated intensive case management.

Table Discussion

1 What did you hear that you could apply to the work at your organization?

2 How did the challenges relate to challenges you've encountered?

3 What did you hear that you were excited about?

1 minute: Self reflection/jot down notes

14 minutes: Table discussion

5 minutes: Report out top highlights

LUNCH (45 minutes)

Depicting the Impact:
ROOTS Art Project (40 minutes)

Art Project

1. Get a flip chart paper.
2. Discuss in your group: who do you want to show impact on?
   - Patient
   - Staff
   - Community Partner
3. Think of this "person" and how your social needs work has impacted them in the head, heart, and hands. Provide one example of each.
4. Create & decorate person with your team. You have 20 minutes.
5. Pair up and share with another team. You'll have 15 minutes.

Head: Changes in Mindset or Perspective

Heart: Changes in Emotions/Feelings

Hands: What is the practical difference now?

Art Project: Group Up & Share

Team Groupings:

- LifeLong & LAC+USC

- NEVHC & Asian Health

- Petaluma, St. John's & West County

15 minutes to share!

Sustainability & Financing (45 minutes)

Exploring models to finance CHC activities related to social determinants of health
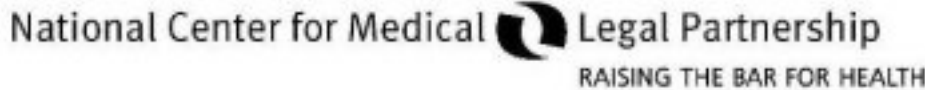
Laura Gottlieb, MD, MPH

Social Interventions Research and Evaluation Network
University of California, San Francisco

August 23, 2018

Appreciations to Hugh Alderwick, Blue Shield of CA Foundation, and Center for Care Innovations

SIRENetwork.ucsf.edu

Ways CHCs "scramble and make crazy" to finance upstream work

Background and rationale

Health Leads

U.S. Department of Veterans Affairs

AAPCHO

one degree

NATIONAL ASSOCIATION OF Community Health Centers

THE COMMONWEALTH FUND

ALAMEDA HEALTH SYSTEM

KAISER PERMANENTE.

OCHIN

UnitedHealthcare®

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Epic

THE AMERICAN ACADEMY OF PEDIATRICS

HelpSteps.com

Humana.

Cerner

NATIONAL QUALITY FORUM

ROBERT GRAHAM CENTER

Robert Wood Johnson Foundation

National Center for Medical Legal Partnership
RAISING THE BAR FOR HEALTH

Cincinnati Children's® Hospital Medical Center

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES

PROMEDICA TOLEDO HOSPITAL

BOSTON MEDICAL CENTER Graduate Medical Education EXCEPTIONAL CARE WITHOUT EXCEPTION

Healthify

Children's Hospital of Philadelphia℠

SDH on the health care innovation curve

Peak of Inflated Expectations

Plateau of Productivity

Slope of Enlightenment

Trough of Disillusionment

Time
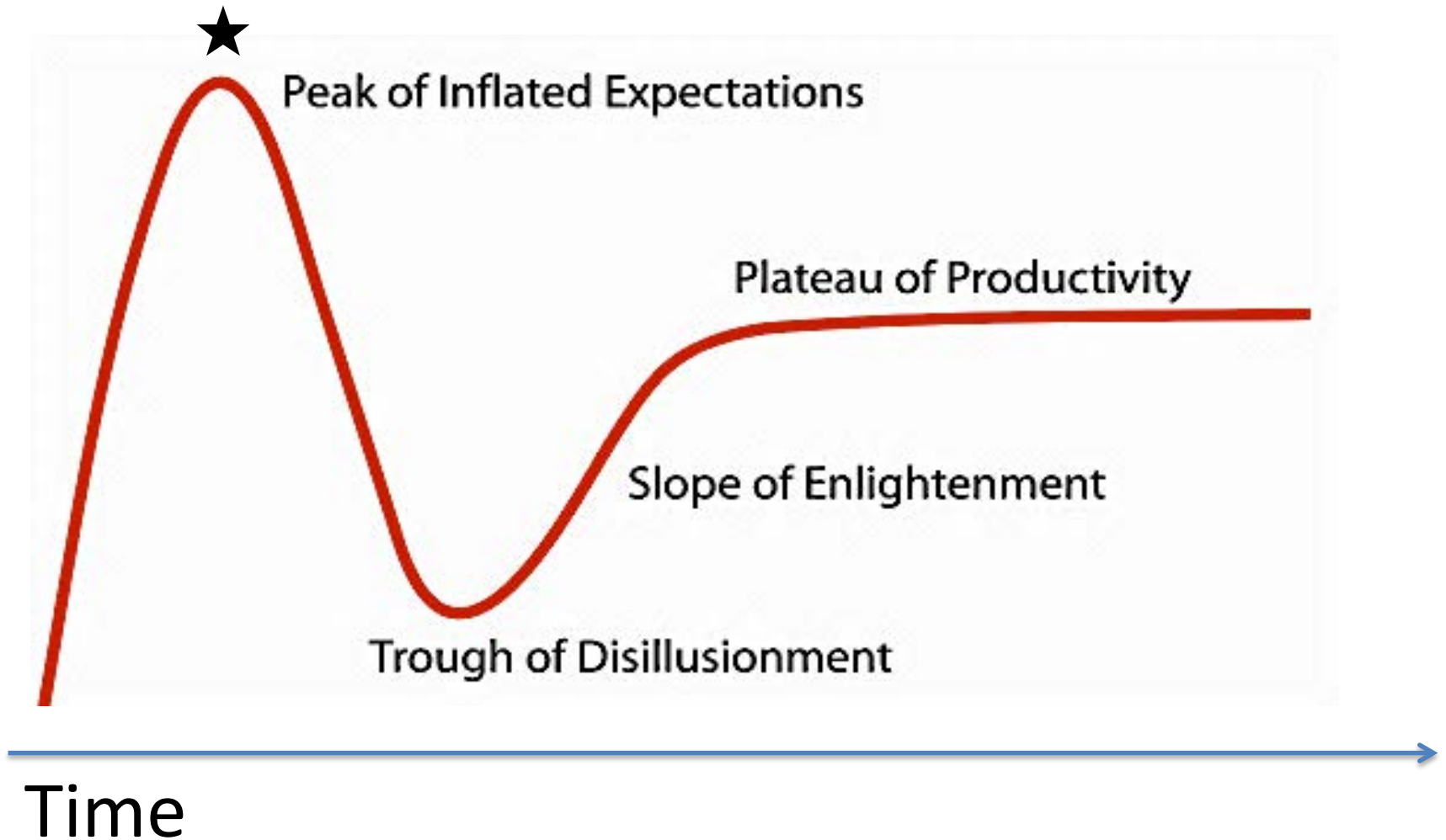
Various policy initiatives are creating new opportunities to fund social interventions

› **Payment reforms**—Accountable Care Organizations (ACOs) and other value-based payment models

› **National initiatives**—e.g. Accountable Health Communities

› **State-level reforms**—e.g. Medicaid 1115 waivers, State Innovation Models (SIMs), etc.

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Tale of two studies

First study: Medicaid

› **Objective**: To understand how Medicaid funding is being used to identify and help address patients' social needs under state-level reforms in OR and CA—not specific to CHCs.

Oregon

Coordinated care organizations (CCOs) established in 2012 with responsibility for improving care and reducing costs for patients in geographically-defined areas

Alternative payment models being used for providers—including capitation for Federally Qualified Health Centers (FQHCs)

California

Whole Person Care (WPC) pilots launched in 2016 to coordinate health care, behavioral health and social services for CA's most vulnerable Medicaid beneficiaries

County partnerships of health departments, managed care plans, providers and community based organizations (CBOs)

Second study: Community Health Centers

> **Objective**: Describe range of financing strategies exemplar CHCs (not exclusive to FQs) employ to support their upstream work.
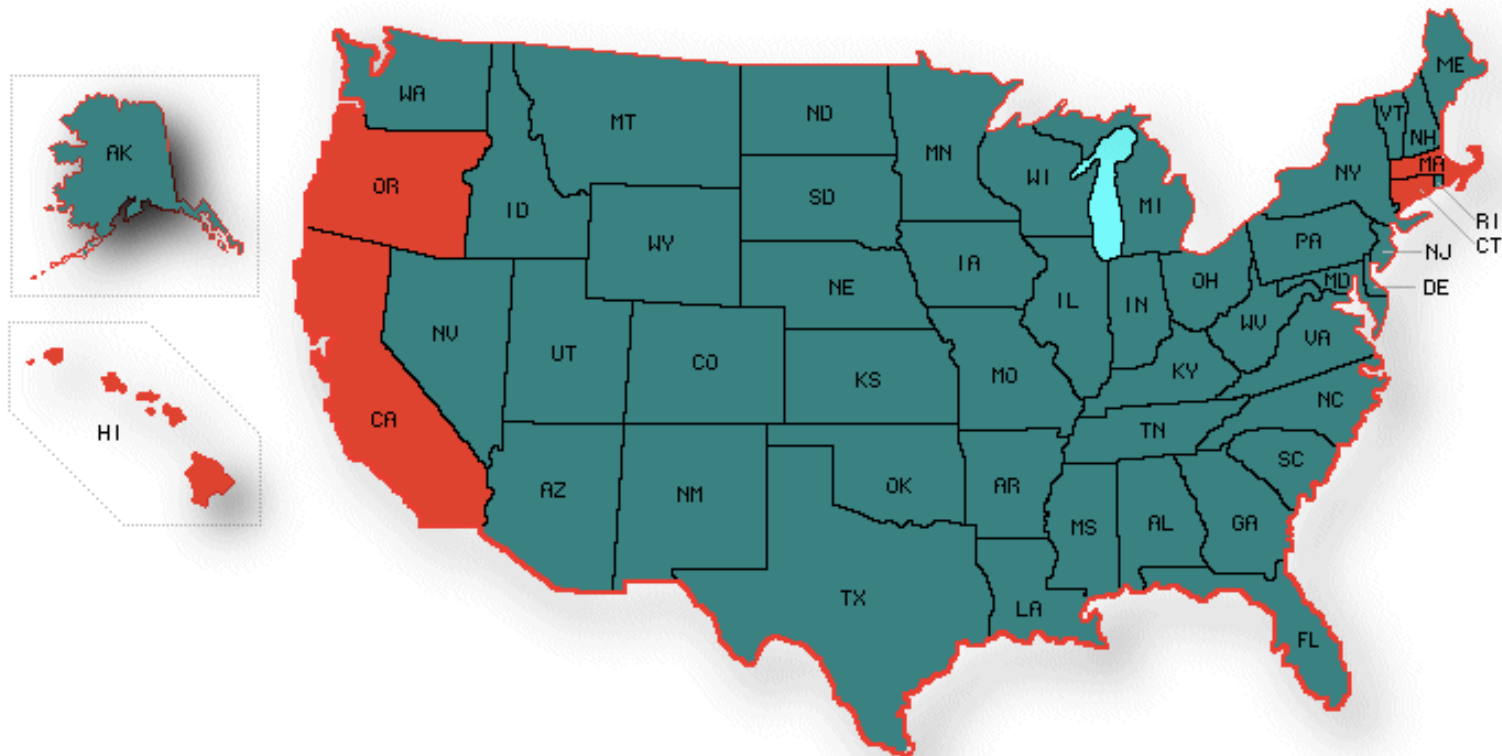
Preliminary Findings

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Study 1: Medicaid dollars are being used to support....

Service-level interventions

- Housing/housing supports
- Food insecurity
- Income and benefits
- Transportation
- Legal needs
- Criminal justice and re-entry
- Education and employment
- IPV

Capacity-building interventions

- Data sharing and analysis
- Building CBO capacity
- Staff training New roles (e.g. CHWs)
- Community engagement
- New facilities and capital costs (e.g. medical respite)

Different types of **Medicaid $s** are used in different ways

Traditional Medicaid

- Provider rates
- Medicaid Administrative Activities (MAA)
- Targeted Case Management (TCM)
- And many more...

Alternative Medicaid

- FQHC APM (OR)
- Whole Person Care $s (CA)
- Flex $s (OR)
- Incentive $s (OR)

Medicaid savings

- Coordinated Care Organization (CCO) or managed care contracts (OR and CA)
- From WPC $s/contracts (CA)

Less flexibility ⟶ *More flexibility*

Example: WPC county in CA

Activity	Funding
Care coordination for high risk patients	MCO benefit
Housing navigator outreach with homeless clients and landlords	1115 $s (PPM)
Permanent supportive housing, including onsite support and rental costs(!)	1115 $s (PPM)
Additional units purchased to boost community housing supply (for supportive housing)	County funds—savings from 1115

siren

UCSF

But all faced *major* barriers to addressing patients' social needs, too

Social needs continue to outstrip resources—lack of social supports/access

"We're doing our best to piece together interventions that are just scratching the surface."

Funding boundaries—complexity, ambiguity, lines in the sand

"it's just like, none of this would be necessary if CMS would get over itself and allow us to spend Medicaid dollars to buy housing."

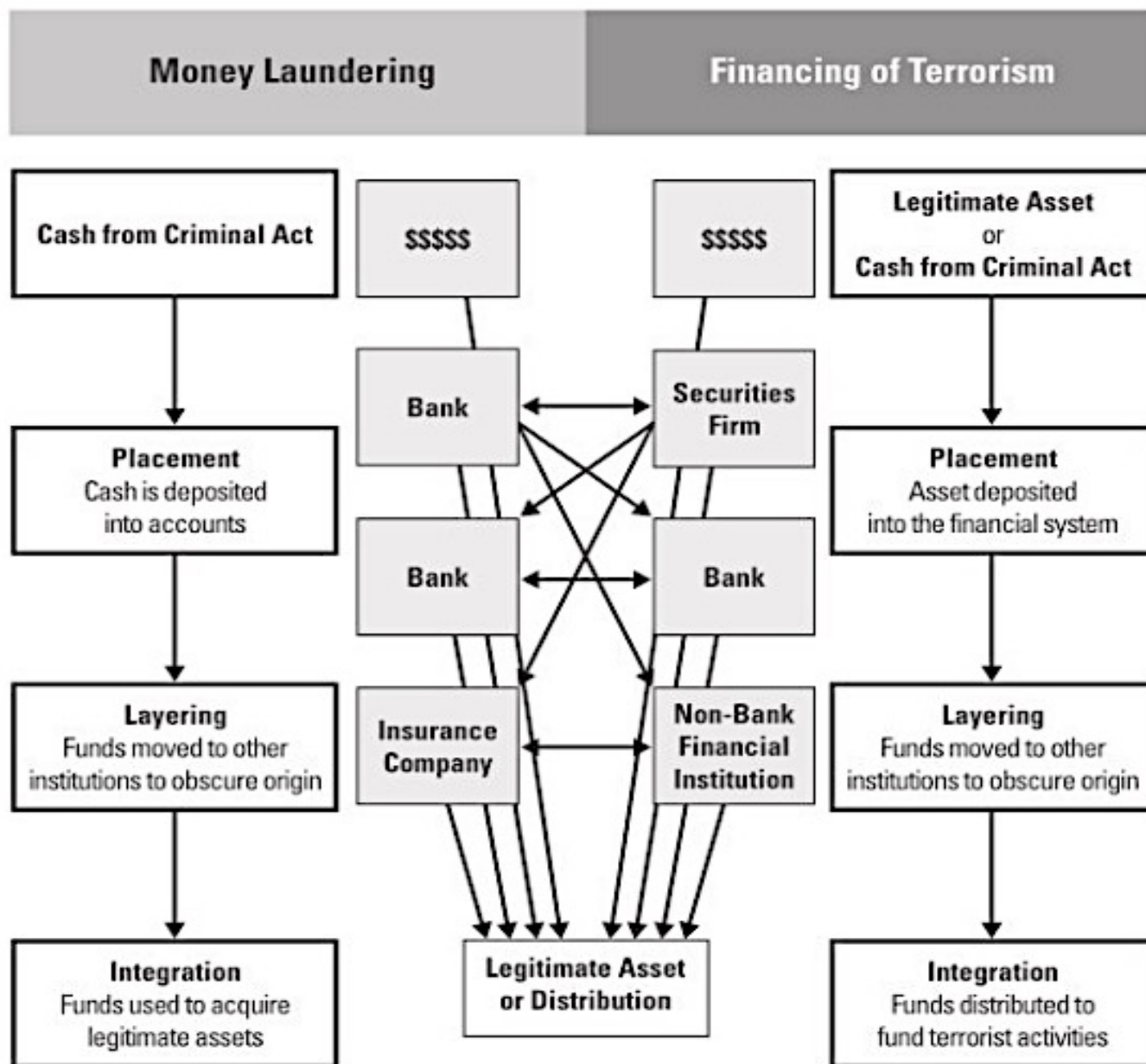**Sustainability**—limitations of using savings, waiver timelines, rates

"I don't think we have a specific plan on how these services will continue after 2020."

Findings: Study 2 (CHCs)

We heard CHC leaders describe those same funding sources being used to support their upstream work:

- Traditional federal sources (e.g. FQ RAP rates and HRSA enabling services grants, MAA/TCM)
- Alternative Medicaid sources (waivers)
- Medicaid Shared Savings programs (PCMH+)

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The Processes of Money Laundering and Financing of Terrorism

Money Laundering	Financing of Terrorism

Cash from Criminal Act

$$$$$

$$$$$

Legitimate Asset
or
Cash from Criminal Act

Bank

Securities Firm

Placement
Cash is deposited
into accounts

Placement
Asset deposited
into the financial system

Bank

Bank

Layering
Funds moved to other
institutions to obscure origin

Layering
Funds moved to other
institutions to obscure origin

Insurance Company

Non-Bank Financial Institution

Legitimate Asset or Distribution

Integration
Funds used to acquire
legitimate assets

Integration
Funds distributed to
fund terrorist activities

Range of mechanisms used to support CHWs

Medicaid Administrative Activities/TCM		
FQHC rates and HRSA grants		
Whole Person Care waiver		
Medicaid Shared Savings (PCMH+)		

Range of mechanisms used to support CHWs

Medicaid Administrative Activities/TCM	Department of Probation	County Social Service Agency grants
FQHC rates and HRSA grants	Department of Agriculture (SNAP E&T)	ACO Program Infrastructure Investment
Whole Person Care waiver	City and county bond measures	Social enterprise
Medicaid Shared Savings (PCMH+)	Accountable Health Communities	State Preventive Service Initiative for partnerships w/ CBOs

Plus volunteers and philanthropy….

Study 2

"We submit 120 grants per year and get about 80 of them."

Well, the funding has been different every year. Well...the funding has been stable, but the source has changed....

"We've clearly grown in the last eight years from 0 to 9, but...(because they're funded through many different programs) the 9 CHWs are doing 9 different things."

"Without reliable yearly funding, one cannot guarantee that there isn't a six-month gap in between where it's hard to sustain a position.."

Study 2

"[How do we fund the positions?] With paper clips, baling wire, and gray hair. So I have a board in my office and it's covered with orange sticky notes that are the funding streams."

It's a hodgepodge...but it's a hodgepodge that we've been able to historically pull together, featuring volunteers and different grants...and then increasingly we're hopefully going to be having it funded through these value-based payment models.

Discussion questions

- Do you know your SDH program costs?
- What Medicaid and more non-traditional sources are you currently using to support your program?
- How are you planning to support your program in months/years to come?
- Who needs to be engaged in your organization to take advantage of different funding opportunities?
- What do <u>you</u> think the policy solutions should be to enable CHCs to do upstream work?

BREAK (15 minutes)

World Café
(75 minutes)

World Café

1. Color dot on your name tag (red, blue, yellow, and green).
2. Go to table with your color dot.
3. Your facilitator will have a question for your table.
4. There will be two rounds. For each round, you'll have 25 minutes to discuss a question.
   - After Round 1, you'll rotate to the left.
   - After Round 2, you'll appoint a pointperson to report out the main points of the discussion. Your group will have 5 minutes to report out.

Question #1: **What would be helpful to spread this work to other organizations?**

Question #2: **What would be helpful to sustain & scale at your own organization?**

Wrap Up & Evaluation

Wisdom

One piece of advice for clinics when getting started **or** expanding work on social needs.

Go to www.menti.com. Code: 53 79 21.

Next Steps

- **Evaluation Onsite Interviews**: Sep-Oct 2018
  - Project Leads & Teams
  - Clinic Leadership
  - Partners

- **Final Grant Budget Report:** End of October
  - We'll send out a link in the follow up email to a template & instructions about how to submit it.

ROOTS Portal

- Access past newsletters, SDOH resources, webinar recordings, & program documents

- Link to monthly milestone updates

www.careinnovations.org/roots-portal

Upcoming CCI Webinar & Workshop

Leading Profound Change

*A workshop that leverages quality improvement
and human centered design tools to lead and manage change*

- **Pre-Workshop Webinar:** September 20, 12:00 pm – 1:00 pm
- **Workshop:** October 18 (Oakland) & November 8 (Los Angeles), 9:30 am – 5:00 pm

> **Early Bird Registration until Sept. 7
> Register separately:**
>
> **Webinar:** Register **here**
> **Workshop:** Register **here**

Objective: Review a framework to capture what Lean, Improvement Science, Social Movements and Human Centered Design have in common and highlight the best of what they have to offer in creating and leading change

Suggested Attendees: Individuals leading change efforts (senior level management) and individuals managing the staff and resources for making change (directors and managers).

Upcoming CCI Webinar

Value Proposition Webinar Series
Hosted by Nonprofit Finance Fund, as part of CCI's Spreading Solutions

- **Webinar Part 1:** September 26, 1:30 pm – 2:30 pm (Tentative)
- **Webinar Part 2:** October 30, 1:30 pm – 2:30 pm (Tentative)

> **More information to come
> via email & ROOTS portal!**

Objective: Provide an overview of the key components of an effective value proposition for sustaining solutions after your grant ends, including:

- fresh insights on how to approach the financial and mission impact of your solutions on their organization
- guidance on how your team can refine your own value proposition.

Upcoming Social Needs Webinar

Addressing Social Determinants of Health:
Connecting People with Complex Needs to Community Resources
Hosted by Center for Health Care Strategies

Webinar: September 10, 2018, 2:00 – 3:30 pm ET

Register here!

Objective: Hear from speakers from AccessHealth Spartanburg in South Carolina and Petaluma Health Center in Northern California who will share strategies for addressing SDOH through screening approaches, innovative technologies that track social service referrals, and development of strong connections with community partners.

Celebrate with us!