



## Social Determinants of Health (SDoH)

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17<sup>th</sup> Annual Healthcare Symposium  
March 2, 2018  
Long Beach, CA

## Learning Objectives

- Share how Venice Family Clinic is using SDoH data for patient level, population level, and organizational level needs
- Learn successes and challenges in developing a comprehensive approach to address SDoH among patients and community members

# Venice Family Clinic

## Mission:

To provide quality primary health care to people in need.

## Vision:

To improve the health of people and communities through accessible, quality care.



## We Serve

### 26,000 served each year

- 73% live below the Federal Poverty Level
- 77% are minority group members
  - 61% Latino
  - 11% African-American
  - 3% Asian
- 15% are homeless
- 29% children; 71% Adults



Services are provided at 12 locations across West Los Angeles.



## Comprehensive Services

- Primary Medical Care
- Pediatrics & Teen Services
- Chronic Disease Management
- Reproductive Health
- Homeless Health Care
- Specialty Care
- Dental
- Vision
- Behavioral Health
- Health Education & Wellness
- Prenatal Care
- Laboratory
- Pharmacy
- Children First Early Head Start
- Integrative Medicine
- Common Ground HIV/AIDS
- Substance Use Services



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## Partnerships and Training

Significant partnerships with:

- Quest Diagnostics
- Cedars-Sinai Medical Center
- Kaiser Permanente of Southern California
- Providence Saint John's Health Center
- David Geffen School of Medicine at the University of California, Los Angeles (UCLA)

These partnerships provide vital in-kind services, residents in training and operating funds.



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## Our History of Addressing SDoH

- Screening
- Enhanced Care Team with Care Managers
- Trauma Informed Care
- Community Partnerships
- Homeless Services
  - Street Medicine
  - Medical care at Shelters and Homeless Access Centers
  - Simplified access at our clinic sites with high homeless numbers with additional support like clothing closet, showers, hygiene kits, food cards, transportation assistance
  - Tailoring specific services like dental, vision, HIV and Health Insurance Enrollment



## More About Street Medicine

- Started with backpack and a provider on a bike
- Morphed into different programs
  - Hot List
  - Engage and Connect
  - Hybrid
- All programs work together with social services/case management agencies to provide comprehensive, integrative services



## SDoH Screening

- Screening Tools Used
  - PRAPARE
  - Household Food Security Survey (question 1-2)
- Developed screening template in NextGen
- Target Population
  - Pediatrics
  - Adult
- Workflow
  - Patient Navigator interviews patient/family
  - Inform patients about behavioral health & other programs
  - Warm handoff to PCP for DV & housing issues



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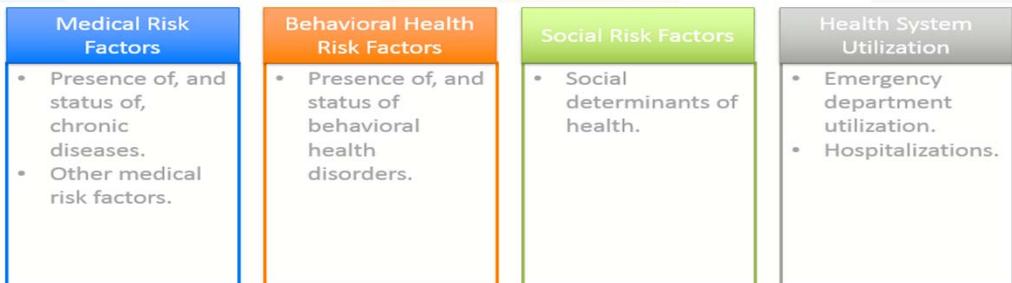
## SDoH Screening: Future Plans

- Working to create reports in Azara DRVS
- Modify screening tool
  - Determine core needs to screen for and shorten to screen for those needs
  - Might consider adding or replacing questions from other screening tools
- Staffing
  - Care Navigator
  - Other Staff or Volunteers



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## Risk Stratification Model

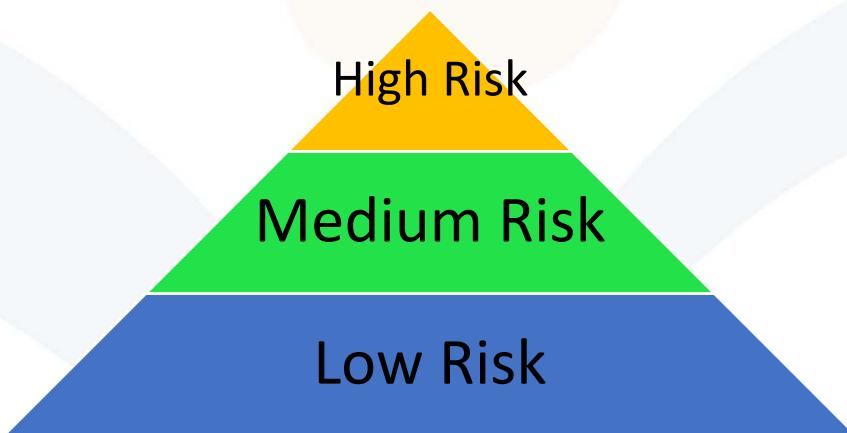


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## Risk Stratification Model (cont'd)

- Developing Care Management Framework to Address Patients in Different Risk Tiers



# SDoH Workgroup Approach



<http://www.hustleandgroove.com/dream-big-set-goals-take-action>

## SDoH Workgroup Goals

- Goal 1: Improve Services and/or Partnerships to Better Address SDoH Needs of Patients
  - Use data to recommend 3 priority areas to focus on
  - Create inventory of current work in priority areas
  - Recommend how to address gaps in programming and/or partnerships



## SDoH Workgroup Goals (cont'd)

- Goal 2: Advocate for SDoH issues in the community we serve
  - Raise awareness on SDOH/ Health Equity among board, staff, patients, community members, etc.
  - Recommend how to influence SDOH policy changes at the community level



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## Identifying Priority Areas

- Data
  - Which SDoH affects our patients and community the most?
- Pathway to health
  - Which SDoH impact health the most?
- Capitalize on opportunities/partnerships
- Patient input



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## Successes

- Engaged Leadership
- Staff buy-in and champions
- Data to help understand patient and community needs
  - SDoH screening data
  - Other patient level data
  - County level data
- Ability to build on existing work
- Existing and new partnerships
- Technical assistance opportunities



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## Challenges

- Staffing to screen and address SDoH needs
- Need for data to fully understand patient needs
  - ED and Hospitalization usage
- Insufficient community resources such as affordable housing
- Need to strengthen inter-agency communication and tracking

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## Next Steps



## Neighborhood Healthcare's SDoH Program

Presented By: Wendi Vierra, PhD

March 2, 2018

## NHcare's Mission and Values

- ▶ **Mission Statement:**
  - ▶ Neighborhood Healthcare is committed to providing quality health care and promoting wellness to everyone in our communities, focusing on those most in need regardless of ability to pay.
- ▶ **Vision Statement:**
  - ▶ We believe health care is a right, not a privilege.
  - ▶ We believe in patient centered and patient focused care that involves the patient, significant others and family in shared decision making.
  - ▶ All patients and staff are treated with dignity, respect, and compassion, and courtesy.
- ▶ **NHcare:**
  - ▶ NHcare operates 12 integrated health centers in San Diego and Riverside counties. In 2016 we served approximately 67,000 individuals through over 271,000 visits. Ninety-seven percent of our patients live 200% below the Federal Poverty Level. Our primary target population are those who are low-income, medically underserved, uninsured, and under-insured.

## NHcare's Social Determinants of Health (SDoH) Program

**Goal:** to develop systems-level screening and referral process to improve the lives of the patients we serve by connecting them with community resources to improve their self-sufficiency and health outcomes

### ▶ **Objectives**

- ▶ Understand the difference between high and light touch SDoH processes
- ▶ Be able to identify barriers to patients accessing community services
- ▶ Understand the importance of tracking needs and outcomes
- ▶ Be able to identify lessons learned to set your program up for success

## Light Touch SDoH Screening & Referral

- Challenge – Identify a screening tool that is easily understandable to our patient population, that can be compared across agencies, and does not negatively impact staffing resources, patient flow, or performance.
  - PREPARE – too complex, too long, and not easy to follow for patients. It had redundant information we were already capturing in EMR demographics
  - We opted for a short simple screening tool through Health Leads with 11 questions piloted at two sites 11/1/17 with org-wide implementation 4/1/18. Community referrals are provided for any positive response, with the expectation patient will follow-up with resources.
- 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 your utilities (gas, electricity, phone)?  
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/adolescent needed to see a doctor, but did not have healthcare or could not afford the cost?

## High Touch SDoH Program Overview

- Provider requests social service assessment and provides warm hand off to Referral Specialist
- Referral Specialist provides assessment in English/Spanish
- Patient signs inter-agency referral and release of information form (improves access, reduces barriers, and redundancy)
- Appointments are made in collaboration with patient and community resource during assessment
- Referral Specialist follows up with patient and resource until patient is connected with resource
- All activity and outcomes are documented in EMR

## High Touch SDoH program

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.**

<ul style="list-style-type: none"> <li><b>Physical Health:</b> <ul style="list-style-type: none"> <li>Primary Care Provider</li> <li>Urgent Care Clinic</li> <li>Dental Clinic</li> <li>Vision Care Center</li> <li>Support Groups</li> <li>Health &amp; Wellness Groups</li> <li>Exercise groups/classes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Occupation/Education:</b> <ul style="list-style-type: none"> <li>Employment program</li> <li>Job readiness program</li> <li>Adult education</li> <li>Community college</li> <li>Vocational/trade school</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li><b>Mental Health:</b> <ul style="list-style-type: none"> <li>Psychiatrist (Med. Management)</li> <li>Counselor/therapist</li> <li>Specialty mental health clinic</li> <li>Intensive outpatient/day treatment</li> <li>Inpatient Treatment</li> <li>Crisis Centers</li> <li>Support Groups &amp; Self-Help</li> <li>Clubhouse</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Financial Advocacy/Benefits:</b> <ul style="list-style-type: none"> <li>Money Management class or group</li> <li>Medi-Cal Enrollment Assistance</li> <li>Medicare Enrollment Assistance</li> <li>Affordable care/covered California</li> <li>CalFresh (food stamps)</li> <li>SSI/SSDI/SDI Enrollment Assistance</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li><b>Social Health:</b> <ul style="list-style-type: none"> <li>Case management</li> <li>Socialization &amp; Advocacy</li> <li>Educational support workshops</li> <li>Faith based organizations</li> <li>Volunteer opportunity</li> <li>Family support groups</li> <li>Parenting classes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Housing:</b> <ul style="list-style-type: none"> <li>Homeless shelter</li> <li>Affordable Housing</li> <li>Domestic Violence</li> <li>Skilled Nursing Facility</li> <li>Independent Living Facility (ILF)</li> <li>Senior housing</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li><b>Substance Abuse:</b> <ul style="list-style-type: none"> <li>Outpatient services</li> <li>Inpatient services</li> <li>Self-help Recovery Groups</li> <li>Sober living</li> <li>Faith based</li> <li>SMART recovery</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Legal Aid:</b> <ul style="list-style-type: none"> <li>SSI application advocacy</li> <li>Family law</li> <li>Restraining order</li> <li>Children &amp; youth law</li> <li>Tenant/landlord disputes</li> <li>HIV/Aids law</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li><b>Transportation:</b> <ul style="list-style-type: none"> <li>Community Transit District</li> <li>ADA Recs</li> <li>LIFT services</li> <li>Manage care plan transportation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Basic Needs:</b> <ul style="list-style-type: none"> <li>Clothing</li> <li>Hygiene products</li> <li>Food</li> <li>Showers</li> </ul> </li> </ul>

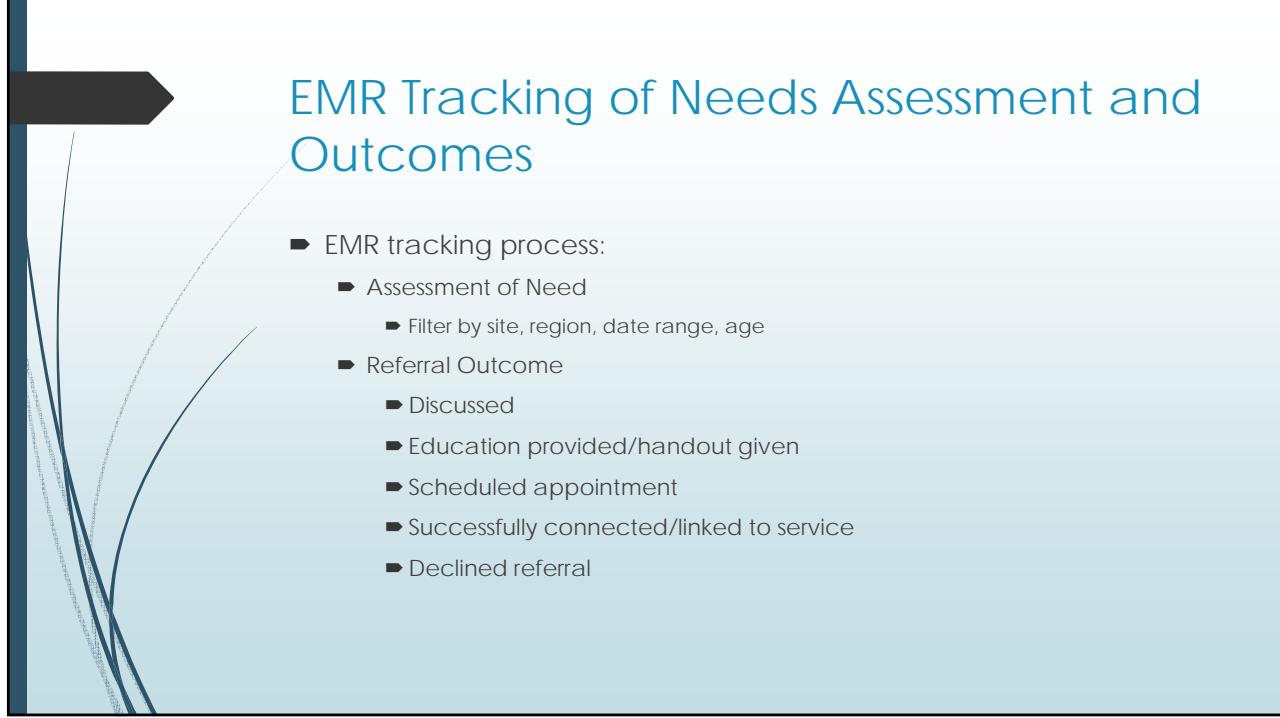
## Warm Hand-Off's & Health Navigation

- 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)
  - Collaborate with individual and make appts with them
  - Provide summary appointment reminder sheet with contact information
  - Follow up with individuals and community partners until linkage is confirmed

# Inter-Agency Client Referral & Release of Information Form

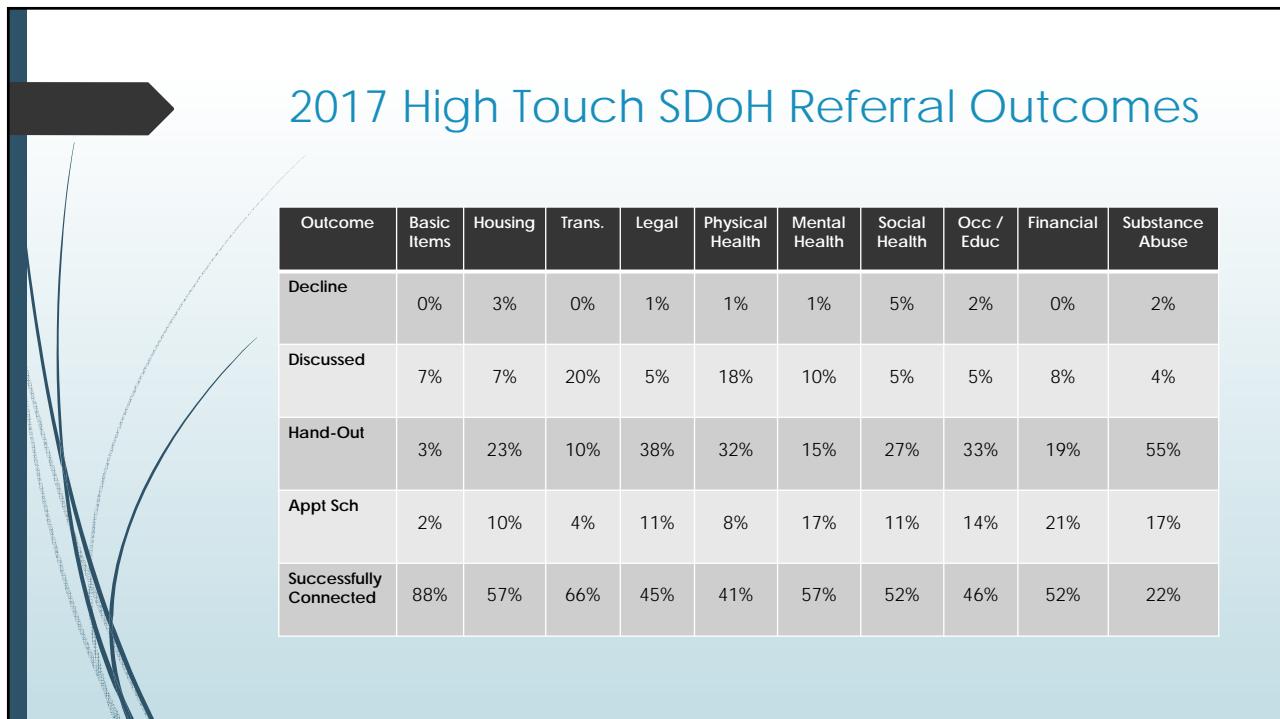
1. Appointment With: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Reason: \_\_\_\_\_
2. Appointment With: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Reason: \_\_\_\_\_
3. Appointment With: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Reason: \_\_\_\_\_

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



## EMR Tracking of Needs Assessment and Outcomes

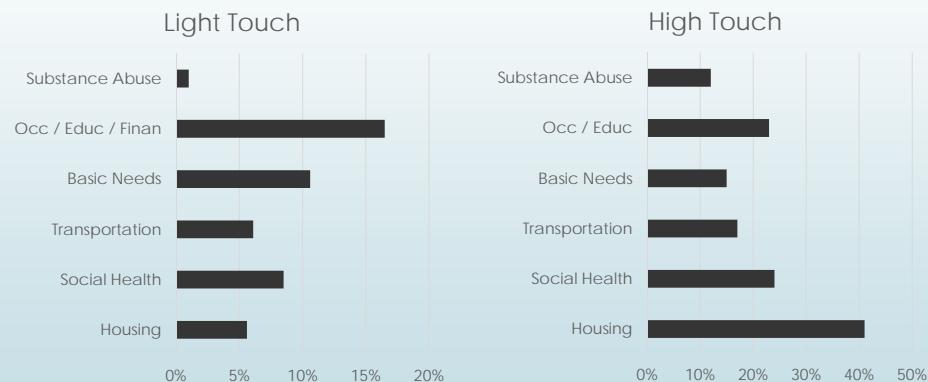
- ▶ EMR tracking process:
  - ▶ Assessment of Need
    - ▶ Filter by site, region, date range, age
  - ▶ Referral Outcome
    - ▶ Discussed
    - ▶ Education provided/handout given
    - ▶ Scheduled appointment
    - ▶ Successfully connected/linked to service
    - ▶ Declined referral



## 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%

## Light Touch (Fam Med) versus High Touch (Behavioral Health)



## Lessons Learned

- Flexibility, flexibility, flexibility and lots of patience!
- Need to 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.
- Change, even desired change, is difficult! Be patient and compassionate when your patient does not follow through with much needed resources.
- Identify and remove barriers.
- Think widely – if patients cannot get to resources how do you bring resources to them?
- Let data drive decisions, not emotions regarding where to put your resources and interventions.
- Drill down data to explain variance within similar populations (i.e., low income).
- Take care of yourself! This work can be emotionally draining and burn you out. Be sure to maintain good boundaries with patients and balance in your life to provide the best care possible to those you serve!

## Success Story



Female patient with 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.

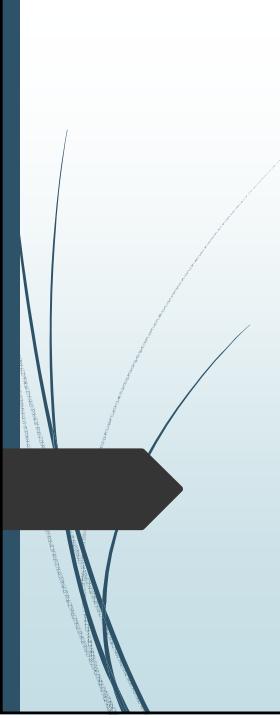
### Intervention:

- 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: She 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 6 month sobriety token in 1/2018! 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

- Correlate SDoH referral outcomes to health related outcomes
  - Top 100 high risk diabetic patients
  - SDoH "successfully connected" vs. "referrals provided" will be correlated to lab values and appointment compliance at baseline, 6 months post assessment, and 1 year post assessment
    - 50 randomly selected to receive Low Touch SDoH intervention
    - 50 randomly selected to receive High Touch SDoH intervention



Thank you for your time  
and attention

Questions?  
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