CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Care Delivery Workshop: Better Screening for Improved Health

Pre-Workshop Webinar

Thursday, April 25, 2019
12:00 to 1:00pm

Play recording

Today's objectives

1. Share status of CAPH members in gathering and acting on information on a widening range of patient needs (from April 2019 survey)
2. Preview goals and plans for May 2 in-person meeting, and gather final needs and requests for how we spend that time

Intros & Logistics

Kristina Mody

Sr. Program Associate, SNI

Hunter Gatewood

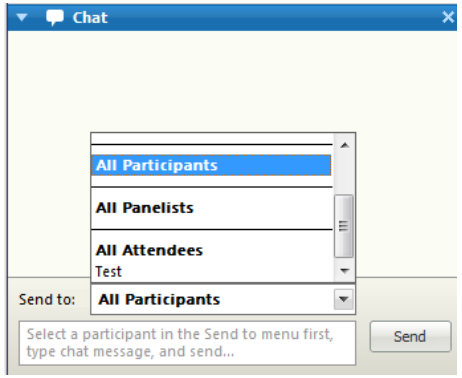
Owner, Signal Key Consulting

Feedback please! Please chime via chat **to all participants**

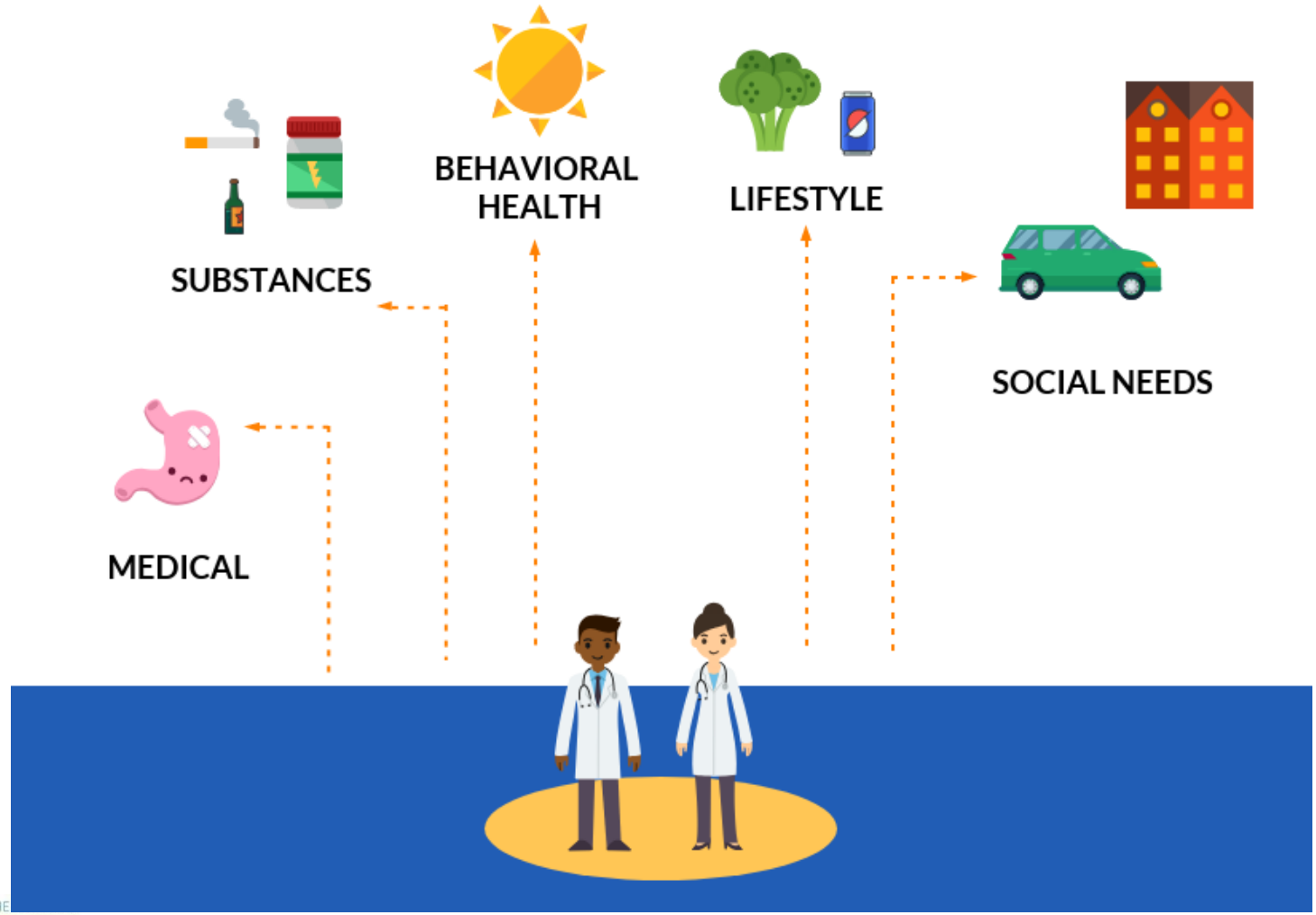
Lines are unmuted! Please mute locally when not speaking

If you have a question, chat & we will read out

Webinar will be recorded and saved on [SNI Link/Care Delivery]



Screening in PRIMARY CARE



Workshop Agenda May 2

8:30-9:00am	Breakfast, networking & registration
9:00-9:35am	Welcome, why we're here & introductions
9:35-10:30am	Effective modalities to screen and interview for multiple needs
10:30-10:45am	Break
10:45-11:15am	Our next steps: screening for multiple needs and conditions
11:15-12:00pm	After the screening: managing physical and mental health needs
12:00-1:00pm	Lunch & networking
1:00-2:15pm	Starting and scaling screenings for social needs
2:15-2:50pm	Launching social needs screening and building effective community partnerships
2:50 – 3:00pm	Best ideas & next steps
3:00 – 4:00pm	Informal collaboration

Survey

Screening and addressing multiple needs (medical, behavioral, social) in **primary care**

- Challenging screenings for medical conditions
- Which behavioral conditions, now and planned
- Social needs (social determinants) screenings, now and planned
- Screening/interview modalities for social needs, both in general primary care and WPC; now and planned
- Programs and partnerships to address social needs
- Questions for CAPH peers

Who completed survey?

14 systems completed
3 systems had 2 respondents

1. Alameda
2. Contra Costa
3. Kern
4. Los Angeles DHS
5. San Francisco
6. San Mateo
7. San Joaquin
8. Santa Clara
9. UC Davis
10. UC Irvine
11. UCLA
12. UCSF
13. UC San Diego
14. Ventura

Most challenging medical screenings

Top two (by a wide margin)

- Diabetic eye exams (10 of 17 individuals)
- Post-hospitalization follow-up for high-risk patients (the task of checking in, establishing needs)

At workshop, UCSF and Alameda to discuss screenings for multiple needs.

Now, any quick specific questions for each other on diabetes eye exams?

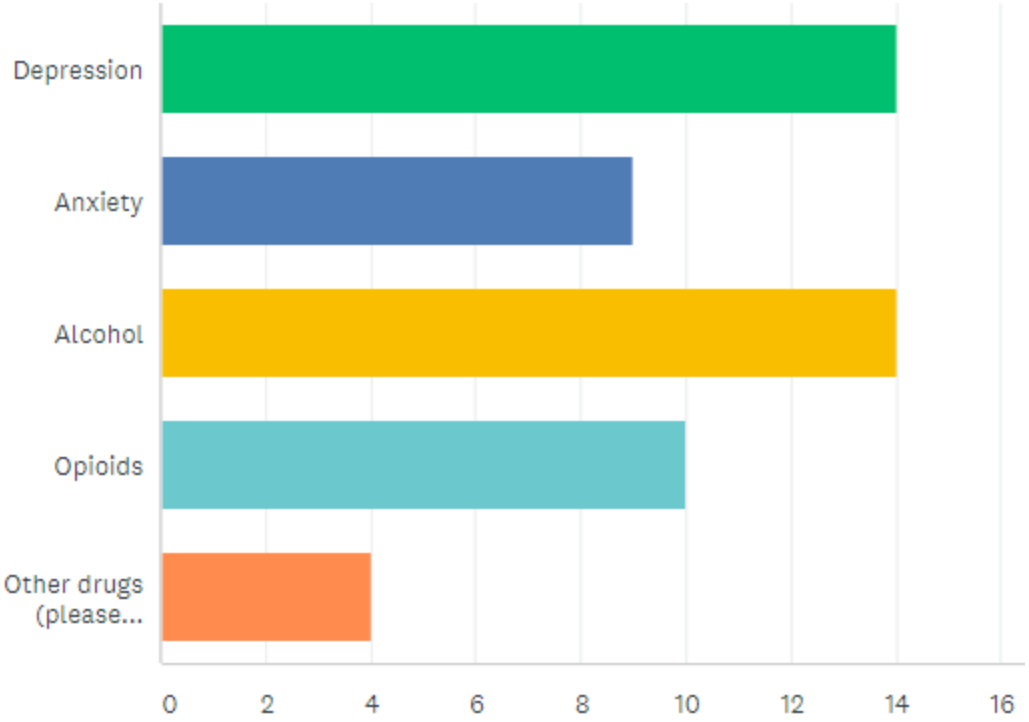
- Team roles
- Info management (e.g. getting records from telehealth vendor, health plans)
- Follow-up with patients

Is there anyone who is pleased with their system for eye exams?

Reminder: SNI webinar on diabetic eye exams (December 2018)

Behavioral health screenings

- All 14 systems – depression and alcohol
- 10 systems – opioids
- 9 systems – anxiety
- "Other" includes DAST-10 and other "other drugs" screenings



Changes planned for BH screening

- Alameda – add to MA role (with clerks), stop BH screenings in specialty
- Los Angeles – EHR workflows to capture behavioral + social needs
- San Francisco – EHR (Epic) workflows for depression, alcohol, SUD, IPV
- San Joaquin – more standard screening for opioids
- San Mateo – implementing SBIRT screening at 1 clinic, will spread next year
- Santa Clara – screen in obstetrics
- UC Davis – more SBIRT, AUDIT, DAST; add anxiety using GAD7
- UCLA – considering post-partum depression screening (Edinburgh tool)
- UC San Diego – considering PTSD/trauma and anxiety
- Ventura – tablet computers to collect info

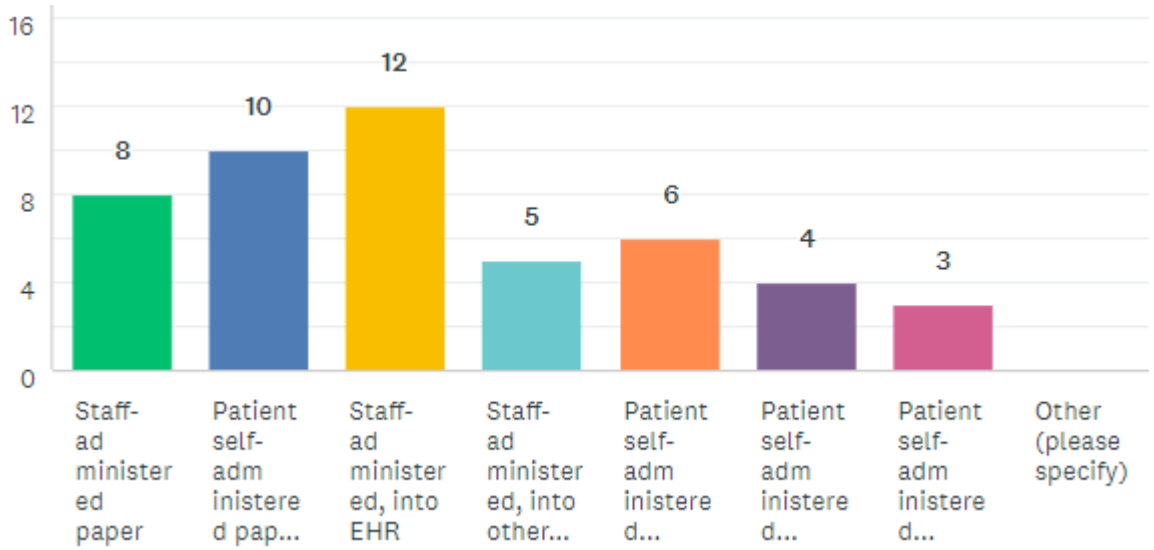
Feedback: Please use Chat to respond.

What tool is your system using to screen for opioid use or addiction?

Other questions about BH screenings?

Modalities to collect info on BH + social needs

- Asked about "all conditions and needs" and for all methods used
- Many members use **4 or more**
- Most common: Staff-admin into EHR (12), Self-admin on paper (10)
- Pre visit (apps/online) (4) = UCI, UCLA, UCSF, SCV
- Self-admin electronic, in clinic (6) = Kern, SF, UCI, UCLA, UCSD



At workshop, we will discuss next steps to get this info in the best way for patients and for staff.

Planning for workshop

10:45-11:15am	**Our next steps: screening for multiple needs and conditions**

Now, please Chat your response: Which topic(s) would you most value for a discussion among peers on your screening for multiple conditions? You may pick more than two.

1. Electronic self-administration (e.g. tablets)
2. Outreach to increase completion rates
3. Screening for specific substance use disorders (e.g. opioid)
4. Staff training
5. Other options?

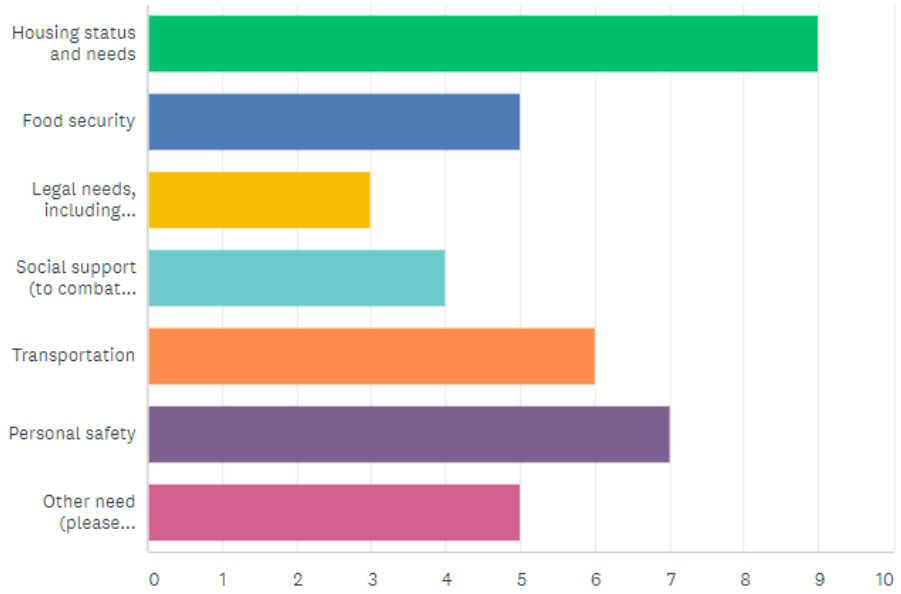
Social needs screenings

Most common: Housing status (9), personal safety (7), transportation (6)

4 of 14 systems are screening for 4 or more social needs.

2 systems noted that the screenings they reported here are not standard yet for all patients.

"Other": Kern screens for Education, Employment, Veterans Status, for total of 9 needs/categories



At workshop, LAC-USC's Jagruti Shukla will share their roadmap for initial roll-out and the county-wide progress with spread.

Now, please Chat: Which tool are you using for social needs screenings, if any? Accountable Health Communities, PRAPARE, homegrown, hybrid (of what?) etc.

SIREN – UCSF
Social needs tools comparison

	AHC-Tool	HealthBegins	Health Leads	MLP IHELLP	Medicare Total Health Assessment	NAM domains	PRAPARE	WellRx	Your Current Life Situation
# Social Needs Questions	19	24	10	10	7	12	17	10	19
# Non-Social Needs Questions	8	4	0	0	30	12	4	1	10
Patient or Clinic Population	Medicare & Medicaid	NS	NS	NS	Medicare	NS	CHCs	PC	NS
Reading Level*	8th grade	11th grade	6th grade	8th grade	College	6th grade	8th grade	2nd grade	9th grade
Reported Completion Time	NR	NR	NR	NR	10 - 20 min.	NR	NR	NR	NR
Languages							Spanish	Spanish	
Scoring	Y	Y	N	N	N	N	N	N	N
Cost	Free	Free	Free	Free	Free	Free	Free	Free	Free
Benefits				1					
Caregiver Responsibilities									1
Childcare Access & Affordability			1				1	1	1
Civic Engagement		1							
Clothing							1		
Disabilities	2								
Education	1	3		1		2	1	1	1
Employment	1	1		1			1	2	
Financial Strain	1	2				1			1

KEY Resource:
https://sirenetwork.ucsf.edu/tools-resources/screening-tools

Social needs interventions
Themes

- Screening for specific complex populations (like WPC) created new partnerships to meet patients' needs
- Range of approaches
- Consideration: collecting information, being able to act on it
- Most systems consider themselves in early days, figuring it all out

Social needs interventions
Partnerships & tracking services

- **Alameda**
  - Food insecurity with Dig Deep Pharmacy, track HbA1C for patients with diabetes
  - Health Advocates: social work students offer referral services in clinic
- **Kern**: Golden Empire Gleaners: food baskets for food insecurity
- **Los Angeles**: Recuperative care housing and homeless transitions from inpatient (through health homes)
- **San Francisco**
  - Food bank, YMCA, shelters, housing authority, police, IPV organizations, Homeless Connect.
  - Track progress for patients in complex care programs.

Social needs interventions
Partnerships & tracking services

- **San Mateo:** WPC Care Navigators track patients' progress and support for AOD, housing, suicide
- **San Joaquin**
  - WPC partnerships for mental health, transportation, health care access, shelters, recuperative care, and more.
  - Data-sharing through HIE starts April.
- **Santa Clara**: Second Harvest Food, Specialty Mental Health (Community Solutions), Institute of Aging, Roots Clinic, Community Health Partners, YMCA

Social needs screening
A selection of what's next

Screening spread

- **Alameda** – Add food insecurity to screenings in all sites
- **Los Angeles**– Integrate new "social behavioral determinants" screening into workflows
- **UC Davis** – ACES screenings; overall strategy
- **UCLA** – Collecting data from all patients (starting fall 2019)

Targeted Interventions / Partnerships

- **San Francisco** – Ride-sharing
- **Santa Clara** – CHWs will start post-discharge screenings on social needs, to help prevent readmissions
- **Ventura** – Spread from pilot on food insecurity for pre-diabetes patients

Changing EHRs

- **Alameda** – Standardize questions in Epic (new in fall) for social needs
- **San Francisco** – Screening on Epic

Planning for workshop

2:15-2:50pm	**Launching social needs screening and building effective community partnerships**

Please Chat a number or two from the list:

Which topic would you most value for a discussion among peers on your **next steps with social needs**?

SDOH Screenings

1. Doing more screenings in primary care, including spread from WPC
2. Putting info directly into EHR (perhaps Epic user group)
3. Other screening topic? *Chat in*

Community partnerships

4. Community partnerships: engaging new partners
5. Effective partnerships: goals, sharing info, sharing clients/patients,
6. Other partnership topic? *Chat in*

WRAP UP

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Workshop logistics
Thursday, May 2

- Location: **Ballrooms 1-3,** Oakland Airport Hilton

- Start/end time:
  - 8:30 breakfast
  - 9:00 start
  - 3:00 end
  - 3:00-4:00 optional networking with snacks

- Materials to be posted SNI Link/Care Delivery

- Questions?

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  Abby Gonzalez; agonzalez@caph.org; 510-874-3401

Upcoming Dates

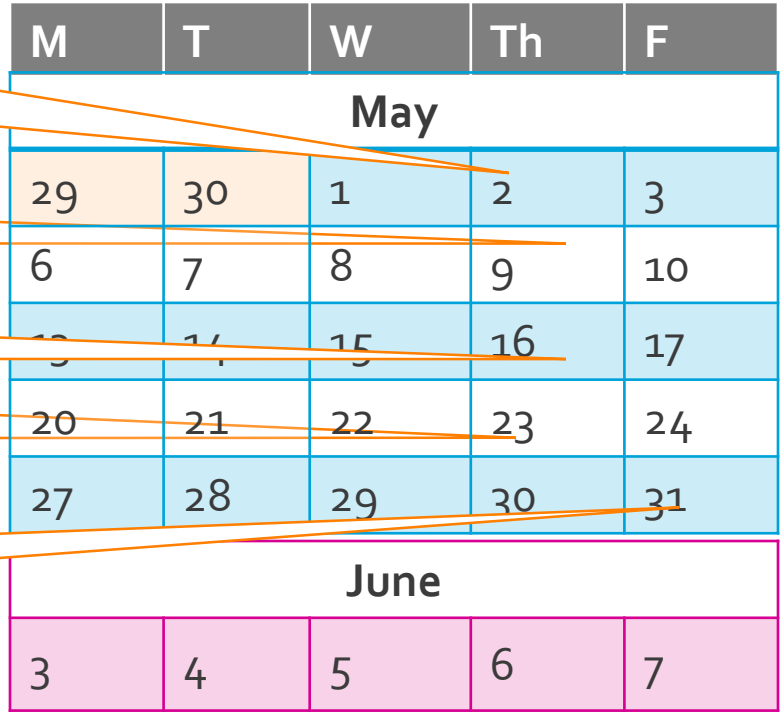
May 2 (Oakland, CA): Care Delivery Workshop – Better Screening for Improved Health (details here)

May 9 (12-1): PRIME/QIP Office Hours

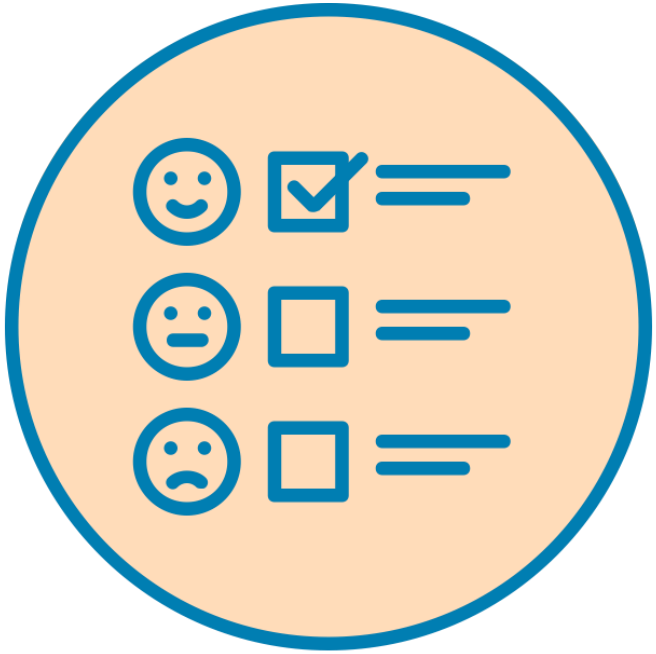
May 16 (12-1): PRIME DY14 Mid-Year Data webinar

May 23 (12-1): QIP Leads Webinar

May 31 (Sacramento, CA): DHCS PRIMEd Learning Collaborative Meeting



Share Your Feedback



How did we do?

What did you learn?

Do you have suggestions for future topics or content?

PLEASE COMPLETE OUR POP-UP SURVEY