Quality and Productivity Commission

31st Annual Productivity and Quality Awards Program

"Celebrating Quality Service"

2017 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: SOCIAL DETERMINANTS OF HEALTH IN PRIMARY CARE

DATE OF IMPLEMENTATION/ADOPTION: 7/1/2016
(Must have been implemented at least one year - on or before July 1, 2016)

PROJECT STATUS: X Ongoing ____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? ___ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

The Primary Care Adult Clinics at LAC+USC serve a population of over 40,000 unique patients and seek to provide accessible, coordinated and comprehensive health care that addresses the behavioral health, mental health, and social needs of our patients in the primary care clinic setting.

We developed an integrated behavioral health program to universally screen patients for social and behavioral conditions, improve patients' access to behavioral health and mental health providers, expand the medical home team, and deliver evidence-based interventions to manage social and behavioral conditions. We have integrated social workers, community health workers, psychiatrists, and pharmacists into the care team.

Our entire patient population now has access to behavioral health and social services provided within the primary care medical home.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$	$	$	X

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS LAC+USC Primary Care 2020 Zonal Avenue, OPD 4p41 Los Angeles, California 90033		**TELEPHONE NUMBER** 323 409 6349
PROGRAM MANAGER'S NAME Barbara Rubino, MD		**TELEPHONE NUMBER** 323 409 6349 **EMAIL** brubino@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Gerardo Pinedo	**DATE** 6/20/17	**TELEPHONE NUMBER** 213-240-8104 **EMAIL GPINEDO@DHS.LACOUNTY.GOV**
DEPARTMENT HEAD'S NAME AND SIGNATURE Mitchell H. Katz MD	**DATE** 6/20/17	**TELEPHONE NUMBER** 213-240-8101 Email: mkatz@dhs.lacounty.gov

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
NAME OF PROJECT: ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN PRIMARY CARE

1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What **quality and/or productivity-related outcome(s)** has the project achieved? Provide **measures of success**. Use Arial 12 point font.

Challenges:

The neighborhoods we live in influence our behaviors and affect our health in profound ways. Social and economic factors in our communities are linked to physical and mental health disorders, illiteracy, homelessness, substance abuse, and higher mortality rates. The population of Los Angeles County has tremendous social and behavioral needs based upon publicly reported survey data. On the 2015 Los Angeles County Health Survey, 16% of LA County adults admitted to binge drinking, 9% endorsed being depressed or having a medical diagnosis of depression, 29% of households <300% below the federal poverty level endorsed food insecurity, nearly 50% endorsed living in stressed housing conditions, and 15% of women endorsed physical intimate partner violence. Working in a safety net institution means that these issues are seen with a much higher prevalence than in the general population.

As a primary care team, we are responsible for the overall health of our patients. Often, this means delving deep into social and behavioral issues which so commonly affect our patients. After conducting a needs assessment of our core healthcare team (nursing, medical assistants, primary care providers) we found that our staff not only were unaware of the prevalence of the above issues, but also that they felt uncomfortable and ill-equipped to address them among our patient population.

Solutions:

The Patient Centered Behavioral Health model in our Primary Care Adult Clinics integrates social workers, psychiatrists, community health workers, and clinical pharmacists into the primary care medical home team. All nursing staff, medical assistants, and primary care providers are trained in their respective roles in screening, diagnosis, and referral for social and behavioral conditions. Our entire patient population has access to these services, and undergoes universal screening during every visit for behavioral and social determinants of health. Any member of the care team can refer a patient to any other member of the care team and all communication and documentation is shared within the electronic health record.

We based our integrated behavioral health model on the Impact Model and we use evidence-based screening tools for the social and behavioral health domains. We have worked closely with consultants and participated in webinars in order to learn about best-practices in behavioral health integration and to base our model on programs which have demonstrated success. Our program leaders also attended conferences on integrating behavioral health into the primary care clinic setting.

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We started in May of 2016 with a comprehensive needs assessment of our clinic staff awareness and comfort in addressing social and behavioral health issues. Together with the departments of social work and psychiatry, we developed staff workshops to prepare all line staff for their role in this program's implementation. Social workers and psychiatrists joined our team in June and July of 2016, and a substance abuse counselor became available to our team in December 2016. The departments of social work and psychiatry were integral partners in developing and assisting with the training sessions for our staff as we prepared for this work.

Universal screening and processes for addressing social and behavioral determinants of health was rolled out in two stages. Stage 1 began August 2016, is ongoing, and includes screens for tobacco, alcohol, drug use, depression, intimate partner violence (physical and sexual). We continued to educate staff and provide debriefing and educational sessions monthly related to one of the social or behavioral domains. Beginning March 2016, all patients are also screened for food and housing insecurity. We are currently training our staff to screen patients for immigration/legal issues, employment difficulty, and may be screened for social isolation. By July 2017, every single patient that presents to our clinic will be screened for each of these social determinants at every visit.

We have also focused on training and developing our core medical home team to be fully integrated with the new behavioral health staff. We have focused on improving their knowledge of the integrated care model and their respective roles in screening, assessing, and addressing the social and behavioral health domains. These trainings have been ongoing and have taken the form of workshops, lectures, role-play scenarios.

LAC+USC Departments of Social Work and Primary Care incurred no additional costs with the addition of full-time social work positions dedicated to the Primary Care Adult Clinics. By evaluating existing social work resources and reallocating three positions to primary care, we have maximized efficiency. We are currently working with one social worker for every 6-7 full time providers. Although our review of literature indicated that a more common ratio may be closer to one social worker for a group of 2-3 providers, this would significantly increase the cost of the program. We found that some of the work of addressing social and behavioral health can be distributed among other members of the healthcare team, such as medical assistants, nurses, and even clerical staff.

We incurred no additional costs in adding highly-demanded psychiatry consultants to our medical home team. In our innovative approach, we worked closely with the Department of Psychiatry and the Psychiatry Residency Program to bring resident physicians into the primary care clinic as the psychiatry consultant. This approach uses existing resources and is mutually beneficial since it provides psychiatry residents an experience in an integrated behavioral health model treating patients alongside the primary care provider. Psychiatry trainees working in the integrated model in primary care clinics saw twice as many patients in a 6 month period as their colleagues working in the psychiatry specialty clinic. This model has maximized their efficiency and productivity as they function as part of the primary care team.

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This collaboration also greatly benefits patients because their care is centralized in one place, and the great majority of mental illness is managed in the primary care clinic.

We leveraged our collaborators in the departments of social work and psychiatry to assist us in developing trainings for our clinic staff, nursing, and providers. Again, this training was no-cost but utilized personnel and experts across departments to do trainings and workshops. This inter-professional education was mutually beneficial as we learned about each other's traditional methods of care delivery and how integrated care combines pieces of each model.

Benefits:

Integration of social and behavioral health services into our primary care clinics has brought tremendous benefits to our entire patient population. All patients are now screened for social factors at every visit, which allows the healthcare team to detect and address these issues as peoples' lives evolve. All patients have access to mental health and social services on site, and are often seen immediately after their primary care provider visit at the time of referral.

Another significant benefit of this work is how it has expanded the role of our medical assistant, clerk, and nursing staff to be able to more effectively screen for and manage the drivers of health. We have leveraged each team member as part of the integrated behavioral health team.

Quality/Productivity Outcomes & Measures of Success:

The volume of patients accessing mental health and social services in our clinics continues to increase monthly as we improve our referral processes and workflows. Since September of 2016, we have seen a 418% increase in the number of patients seen monthly by our clinic social workers, and an 85% increase in the number of patients seen in clinic monthly by our team psychiatrists. Depression, anxiety, and other mental health conditions account for 40% of social work referrals. Currently, the median wait time to see a social worker in our primary care clinics is 1.2 days. All urgent referrals are seen immediately.

Preliminary data on our first cohort of patients shows that the majority of those referred to this program for moderate to severe depression had a reduction in their PHQ9 depression scale scores over the subsequent 6 months. Additionally, patients who had previously utilized the emergency room or urgent care did so less frequently after they had seen a social worker and/or psychiatrist.

Provider and patient experiences have been overwhelmingly positive based on survey results. 100% of primary care providers and 85% of patients surveyed said they were either "satisfied" or "very satisfied" with our integrated model. We have innumerable examples of patient cases who have accessed psychiatric care in our clinic which has changed the course of their health. Many have received housing through our screening and referral process in collaboration with social work, and have received treatment for alcohol and substance use disorders that we identified.

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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

Our project directly addresses the top goal for Los Angeles County DHS (2014-17) which is to transform from an episodic, hospital-based system to an integrated delivery system including community-based primary care and behavioral health providers focused on prevention, early interventions, and primary care with appropriate referrals to specialists.

By working collaboratively across multiple departments at the medical center, we have developed a model that crosses traditional cultural and interdepartmental barriers. Collaboration and close communication between the departments of primary care, psychiatry, and social work has allowed us to improve the quality of life and services that we offer to our patients.

We have developed and expanded the roles of our medical home team by educating and empowering them with the tools they need to care for issues that extend beyond the traditional acute or chronic physical illnesses we see in primary care. We have achieved a culture shift in the primary care adult clinics by engaging the entire medical home team in this program's development. We continuously work to get feedback from our staff, enhance buy-in, and hold ongoing workshops to continue to grow and expand their roles.

By integrating services that address the primary drivers of chronic disease - - the conditions in which patients live and their mental health –we are hoping to transform our patients' lives. We have made significant investments in developing educational curricula and adding new personnel to the clinic team. We took significant time out of our normal clinic schedule for training and developing new workflows. There is an up-front cost of adding new personnel to the clinic team, which we were able to offset by utilizing psychiatry trainees as part of their residency training. With all of this investment, we retrained and redesigned the primary care clinic team, which now includes social work, psychiatry services, substance use counselors, pharmacists and community health workers. We have been able to transform the lives of our patients by uncovering and addressing social needs ranging from housing, unsafe living environments, substance use issues, and providing mental health services in their primary care clinic.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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