“Community Based Opportunities to Address Health and Social Determinants: What’s an FQHC?”

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Disclosures

I have no disclosures that have exerted any control over his presentation.

- Blue Shield of California – Board of Directors
- St. John’s Well Child and Family Center - CMO
Educational Objectives

• Define SDOH and describe at least 4 Social Determinants that can affect health and health promoting behaviors
• Understand 3 key defining elements that distinguish an FQHC from other health care practice settings
• Be able to describe the unique role FQHCs can play in addressing Social Determinants of Health
• Understand the various components of cultural diversities (i.e., gender, age, race, religion, ethnicity, language, sexual orientation, socio-economics, etc.) that relate to demographics, diagnosis and treatment.
Case 1: Refractory Persistent Asthma

A 12 year male with **longstanding uncontrolled asthma** presents for the first time to a St. John’s clinic for care. The patient has had persistent wheezing, **reduced exercise tolerance** and limitations in **unable to participate** in intramural sports activities with his same agenda peers. The patient and his mother report he has an asthma action plan and has been maintained on **appropriate controller meds and reliever medications** for several years, and are demonstrate to you appropriate administration of inhaled medications. The only time the patient has **some relief from his symptoms is when he visits relatives in Texas.**
What is the explanation for his persistent symptoms?

A. Patient is non-compliant with medication regimen

B. Patient has outgrown the doses of his asthma medication and is not receiving therapeutic effect

C. Unrecognized/unaddressed asthma triggers

D. The diagnosis of asthma is incorrect and the patient should be worked up for other conditions (e.g., alpha 1 antitrypsin deficiency, cystic fibrosis)
Case 2: Abnormal PAP and Broken Appointments

A 37 yo female has been followed at St. John’s for 4 years, through 3 pregnancies, for all of her primary care, and for management of her depression. A PAP smear 3 months ago was interpreted as ASC-US with positive HPV. The patient failed two appointments for colposcopy. The MA spoke with the patient after the 1st broken appointment, and she promised she would show for the next appointment, but did not. She picked up the phone when the MA called after the 2nd broken appointment but hung up when she knew the call was from St John’s.
What are acceptable next steps with this patient?

A. Send the patient a letter via certified mail and if she does not respond, you have made a good faith effort

B. Make a referral for the patient to be seen by another GYN specialist.

C. Call the Sheriff’s office and request a welfare visit

D. Secure an outreach worker to visit the patient’s home and encourage her to keep her next appointment
Basic Determinants of Health

- Biology and Genetics
- Individual Behaviors
- Social Environment
- Physical Environment
- Policy Making
- Health Services
Social Determinants of Health (SDOH)

Definitions

• Conditions in which people are born, grow, live, work play and age – WHO,

• Life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life – CDC

• The social determinants of health (SDOH) are the economic and social conditions and their distribution among the population that influence individual and group differences in health status - Canadian Government
Why Focus on SDOH?

<table>
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<tr>
<th>SODH</th>
<th>HEALTH OUTCOMES</th>
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<tr>
<td>Education</td>
<td>Mortality, chronic disease</td>
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<td>Geography</td>
<td>Disease, Access to Resources, Life Expectancy, Economic Mobility, Inf Mortality</td>
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<td>Income</td>
<td>Premature Death</td>
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<td>Stress/Social Supports</td>
<td>Premature Death, MH Conditions, Cardiac Ds</td>
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• Social Determinants are responsible for most health inequities - WHO
• Social Determinants account for about 1/3 of the deaths in the US Annually – Galea et al, 2010
CORE DETERMINANTS OF HEALTH

- health services
- employment/working conditions
- education and literacy
- physical environments
- social support networks
- personal health practices and coping skills
- social environments
- healthy child development
- biology and genetic endowment
- culture
- financial and social status
- gender
What’s an FQHC?

• Safety net provider delivering comprehensive primary care services in outpatient setting
• Develop systems of integrated care responding to the unique needs of diverse medically served population
  • Legal mandate for open door policy
  • Significant Medicaid and low income population
• Recipient of 300B Grants Under Public Health Services Act

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<tr>
<th>Community Health Center</th>
<th>Migrant Health Workers</th>
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<td>Public Housing</td>
<td>Homeless</td>
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• Meet (19) stringent program requirements
FQHCs in California

- 813 FQHCs with 1237 sites
- 6.2 Million Californians served
- 19 million visits

1 IN 7 CA RESIDENTS SERVED
St. John’s Well Child and Family Center

• Network of Federally Qualified Health Centers in Central and South L.A.
• Serve patients of all ages through 13 independent health centers and 2 mobile vans
• Provide primary medical, dental, mental health, and “social support/enabling services”
• In 2016, we served >76,000 patients through >296,000 visits
• Eleven sites PCMH Certified thru NCQA (Level 3)
• National Health Services Corps Member and OSHPD LRP participant (PC HPSA = 19)
Distinguishing Features of St. John’s

- Longevity – 53 years and counting
- Of, by and for the community
- PCMH Certified → Moving to team-based care
- Consistently committed to the (residually) uninsured
- Walking the walk

*Health care is necessary but not sufficient for health and well-being*
South L.A.

- 26.7% of the target population has no usual source of health care vs. 22% (LACDPH, 2017)
- 32.5% of adults report difficulty accessing health care vs. 23.6% (LACDPH, 2017)
- 30.6% of adults report their health to be fair or poor vs. 21.5%
- The population to Primary Care Physician Ratio in South LA area is 8,948:1 (11,000 Peds:1)
- Almost 45% of the target population has Medicaid, while 30.8% are uninsured (compared to 15.7% Medicaid and 22.8% uninsured LA County) (US Census, 2011)
### Physical Determinants of Health

#### Neighborhood
- Percent of adults who believe their neighborhood is safe from crime
  - N/A N/A 84.0 86.0 **95.2** 90.1 74.3 **97.4** 40.3 85.0 87.8
- Percent of children ages 1-17 years who can easily get to a park, playground, or other safe place to play
  - N/A N/A 86.8 87.1 86.3 **91.5** 81.9 90.2 **78.5** 90.8 87.7
- Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood
  - N/A N/A 47.5 35.3 **50.4** 47.4 48.4 54.9 **39.4** 48.6 46.4
- Percent of adults whose neighborhoods do not have walking paths, parks, playgrounds, or sports fields
  - N/A N/A 15.2 27.9 **12.9** 12.5 **19.2** 13.2 21.7 13.5 14.1

#### Air Quality
- Number of days in the year when AQI (Air Quality Index) was unhealthy
  - N/A N/A 37.0 N/A N/A N/A N/A N/A N/A N/A N/A
- Percent of households with children ages 0-17 years regularly exposed to tobacco smoke at home (one or more days in the past week)
  - N/A N/A 14.9 **23.9** 11.2 16.2 17.1 **6.0** 23.7 13.6 12.8

#### Climate Change
- Percent of adults who are concerned about more heat waves due to climate change
  - N/A N/A 78.3 74.8 73.7 76.3 **95.6** 81.0 72.2 78.6 77.0
- Percent of adults who are concerned about droughts and water shortages due to climate change
  - N/A N/A 90.5 90.9 87.8 92.1 **95.6** 96.2 **81.8** 94.3 88.1
- Percent of adults who are concerned about worse air pollution due to climate change
  - N/A N/A 86.4 85.8 84.4 87.4 88.0 89.0 85.1 87.3 85.9

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**User’s Guide**
- SPA fares better
- SPA fares worse
- Data not statistically tested

* Data are unstable (see technical notes p. 5)
Perinatal Data – South L.A.

- Rate of births to women age 15-19: 44.3 per 1,000 (vs. 22 in LAC) – highest in L.A. County (LACDPH, 2017)
- Los Angeles neighborhoods of concentrated poverty experience
  - 34% greater maternal health risks than the rest of Los Angeles. (Matsunaga, Economic Roundtable, 2008)
  - 24% increase in babies born with health complications. (Matsunaga, Economic Roundtable, 2008)
  - A higher rate of preterm births (12.6%) and low birth weight (7.9%) than in L.A. County as a whole (11.4% and 7.3%, respectively) (State of California DPH, 2007/2008)
  - Infant mortality rates as high as 12.9/1000 for certain populations (6.4/1000 vs 4.4/1000 overall) (LACDPH, 2017)
  - Increased rates of gestational diabetes from 10.3% in 2005 to 12.4% in 2010 (LAMB survey, 2010)
About Our Patients ➔ Informing Services

General

• Race/ethnicity
  • 75% Hispanic
  • 17% African American

• Poverty: 87% <100% FPL

• Coverage
  • 52% “Uninsured”
  • 47% Medi-Cal

• >10% Homeless

Children

• Children with special health care needs 12.5%
  • Race/ethnicity is a heavier burden

• More children in poverty but better coverage (>80% Medi-cal)

• Growing Unaccompanied Minor population
Dental Health

Challenge

- Dental pain is leading cause of absenteeism in LA Schools
- 40% Adults and 60% patients have obvious oral health disease

Support/Enabling Services

- Dental service in 8 sites
- Dental home project in 3 sites
Challenge
South LA has the highest density of children (0-5 yrs.) living with relatives or foster parents “out-of-home” (26,000 DCFS referrals annually in SPA 6).

Support/Enabling Services
PCSLA is a collaborative of 7 partner agencies who provide services for young children at risk for poor developmental outcomes and involvement with the child welfare system, with a special emphasis on children in kinship care and those born to pregnant/parenting teens.
Nuestra Promessa: Unaccompanied Minors

Challenge
St. John’s has seen >1500 unaccompanied minors in need support services in the past year.

Support/Enabling Services
• Case management
• Behavioral health services for support psychological support, treatment, as well as assessments in support of asylum hearings
• Health services
• Connection with legal system thru partnerships with 6 public interest firms
Chronic Diseases
Chronic Disease Prevention

Challenges
• Thirty-four percent (34%) of South LA residents are diagnosed with obesity (vs. 24% in LA County)
• > 9000 patients have diabetes
• > 8500 patients have hypertension

Support/Enabling Services
• Kids ‘N Fitness program
• Free weekly physical activity classes: yoga; Zumba; Hip Hop; walking groups, and conditioning classes
• Group Diabetes Classes
Asthma, COPD and Environmental Toxins

Healthy Homes, Health Families Program

Program Design
- Partnership between St. John’s Esperanza Community Housing, SAJE
- Trained Promotoras/CHW provide home visits, assessments and education to minimize toxins/triggers in the home
- SAJE steps in with tenant’s rights support

Outcomes
- ER Visits ↓ by 80%
- Hospitalizations for asthma ↓ by 67%
- Missing school/work will ↓ by 69%
- South LA Declaration of Human Rights served as model for policy change in several states,
- LACDHS partnership shared “access” strategies in Trinity Park
**Challenge**
- Nearly 15% of our patients have at least 1 mental illness diagnosis and nearly 1500 more have alcohol/substance abuse issues.
- Stigma is huge on our populations.

**Support/Enabling Services**
- Integrated Behavioral Health Program co-located at 10 sites
- Alcohol/Substance Abuse Counseling
- Psychiatry and medication management
- Medical Assisted Therapy and SA Counselling
Challenge
Twelve-15% of children have special needs. Nearly 1:68 children has ASD.

Support/Enabling Services
• Comprehensive psycho-developmental assessments and treatment
• ABA Services – In home and center-based
• Parent training and support
• Parent advocacy training
• Partnership with Special Needs Network
Transgender Health Program

**Challenge**
Health and support services for the Trans* health population are nearly.

**Support/Enabling Services**
- Trans* primary care provider
- Psychiatric/psychological Counseling as needed
- Managing referral authorizations for hormones and surgery
- Support with name change
- Trans Empower – employment, education, risk reduction
Center for Autism and Development Delays

Challenge
One in 65 children have ASD. Minority children are diagnosed later, and have less access to ABA and medical therapy.

Support/Enabling Services
• Routine devel. screening
• Comprehensive developmental evaluations and Functional Behavioral Assessments
• Advocacy training and Support groups for parents, siblings, patients
• Applied behavioral Analysis
• Kids ‘N Fitness for ASD
Additional Support
Additional Support: Health Services

- Homeless Services program (>5000)
- HIV/AIDS PRIME Program (n=\sim 100)
- Podiatry
- Retinal Screening
- Nutrition services
- OB/GYN and reproductive health services
- Health services for public housing beneficiaries
Benefit counselors can enroll and verify eligibility. Thirty (30%) of the adult and 11% of the child population in South LA are uninsured.

- Onsite MLCP partnership (NLS)
- Right to Health Community Action Groups
Challenges and Opportunities

- Building culture of health/wellbeing
- Plethora of regulatory/contractual requirements/”required incentives”
- Maintaining skilled workforce: Dynamic provider environment
- Building more value and population health strategies
- Affordable Care Act
- Community cache
Challenge
Health and support services for the Trans* health population are nearly.

Support/Enabling Services
- Trans* primary care provider
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On the Horizon

Whole Person Care
• Recuperative Housing for re-entry population

Expansion of CADD

Expansion of Clinic Sites

Boys and Girls Club Dental Partnership
Answers to Case 1: Refractory Asthma

What is the explanation for his persistent symptoms

A. Patient is non-compliant with medication regimen
B. Patient has outgrown the doses of his asthma medication and is not receiving therapeutic effect
C. Unrecognized/unaddressed asthma triggers
D. The diagnosis of asthma is incorrect and the patient should be worked up for other conditions (e.g., alpha 1 antitrypsin deficiency, cystic fibrosis)

The correct answer is C
Answer to Case 1, Q2: Refractory Asthma

After additional history taking, and despite the parents’ assurance that their apartment is sparkling clean, you determine the patient is subjected to asthma triggers. Interventions to consider:

A. Advise parent to use plastic pillow covers and a vacuum cleaner with a HEPA filter
B. Refer patient to home visiting program to assess the presence of asthma triggers
C. Encourage parents to move to a new apartment building
D. Add a LABA to his current regimen

The correct answer is B
The correct answer is D
References


• LA County Department of Public Health, Office of Health Assessment and Epidemiology, *Key Indicators of Health by Service Planning Area, January, 2017*