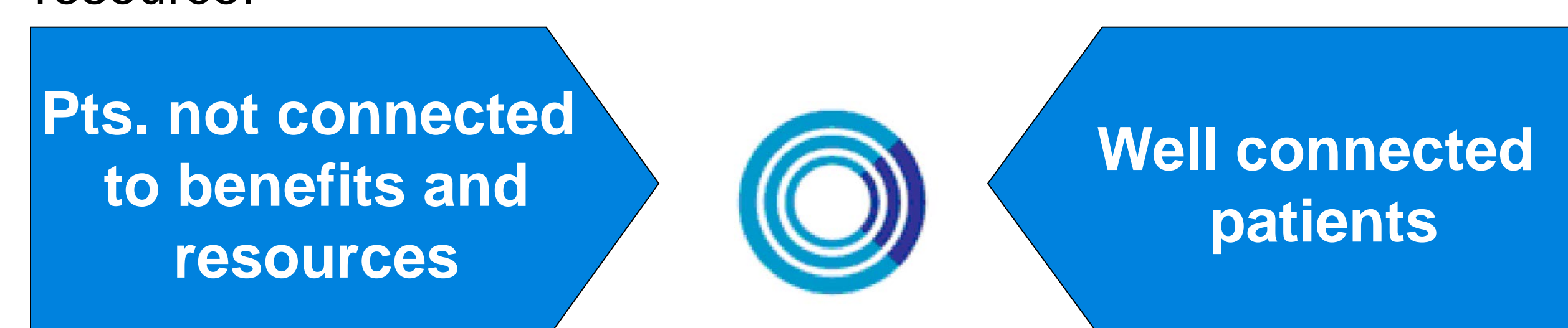


California Health Improvement Project (CHIP) Family Information Navigation Desk

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Problem Statement and Underlying Causes

The health care costs of treating disease that results from social determinants are huge. In the example of obesity, we can treat diabetes under the medical model. The prevention strategies (more exercise, better food, & basic benefits) are underutilized. Medical providers make practical community referrals but there are gaps in making the actual connection. The underlying causes are due to multiple factors relating to navigation to the specific resource.



Project Description

Volunteer navigators from local universities who make and case manage connections to community resources (e.g., CalFresh, local pools, parks and recreation and basic benefits such as housing and utility assistance) will staff a new family help desk located in the Primary Care clinic. This study compares tailored interventions with volunteers providing warm hand offs and biweekly follow up calls to a control group who receives similar information akin to 2-1-1. In Alameda County 2-1-1, connects families to vital services with a one-time informational referral.

Goal and Objectives

Goal: Improve the health of families we serve by enhancing their connections to basic community resources through increased navigation services.

Output-oriented Objective:

- Administer a screening tool to identify social needs to 200 families by December 30, 2014.
- Complete successful resource connection for 90% of families by April 30, 2015.

Outcome-oriented Objective:

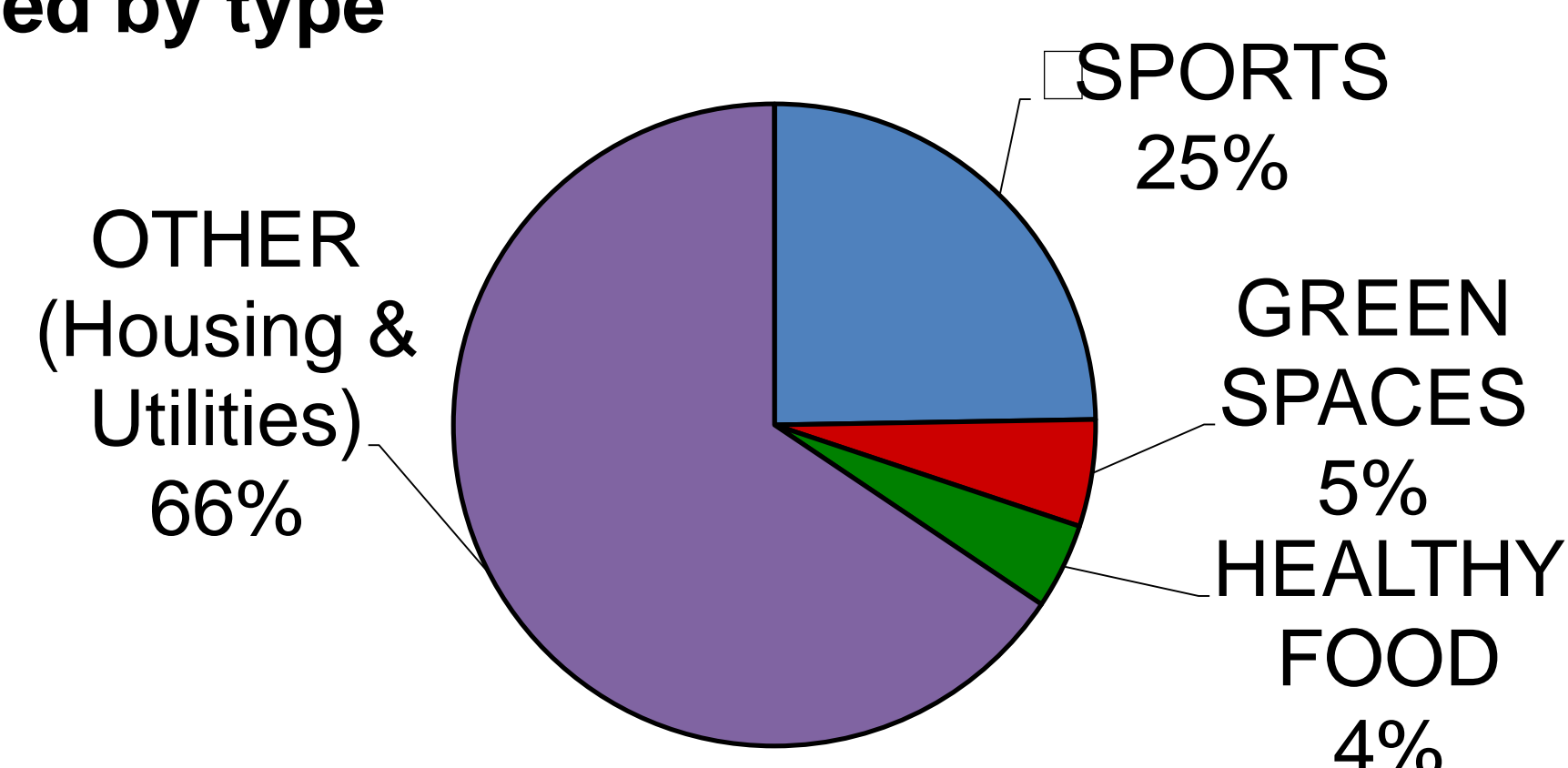
- The number of parents who rate their child's health status as Excellent or Very Good will increase by 20% at 6 weeks post intervention.
- The number of patients exercising more than 60 minutes per day will increase by 20%.
- The number of patients eating 4 or more portions of fruit and vegetables will increase by 20%.

Outputs & Outcomes

Outputs Achieved

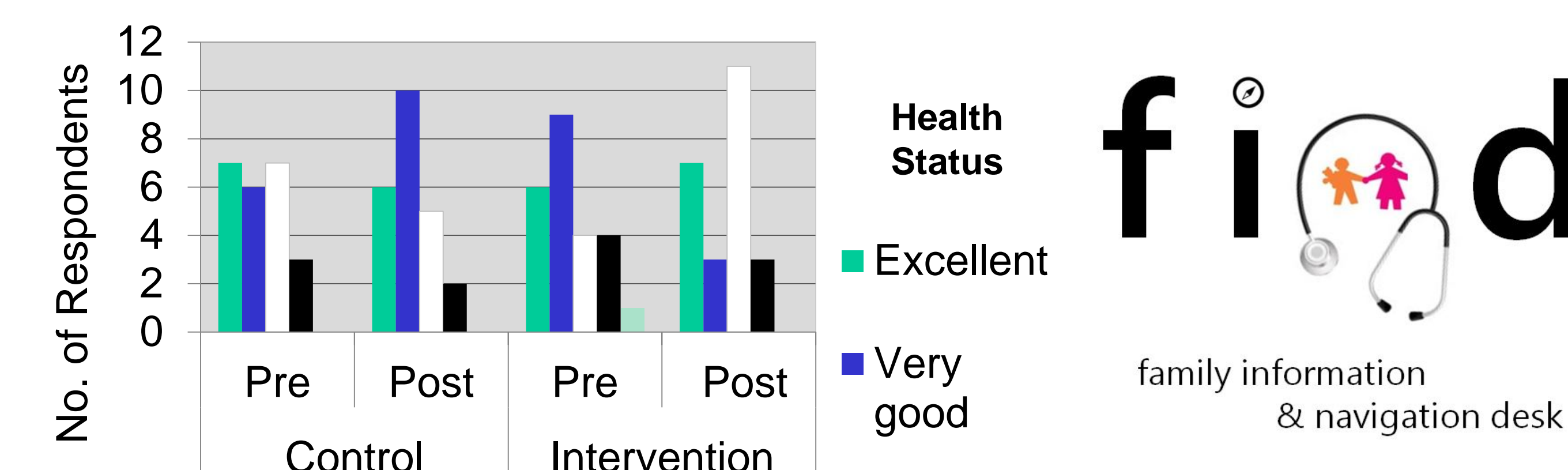
93 families enrolled March 31- July 15, 2014
47 families were retained in follow up at 6 week.
90% of retained families in the intervention made successful connections to source compared to 17% of controls.

Priority need by type

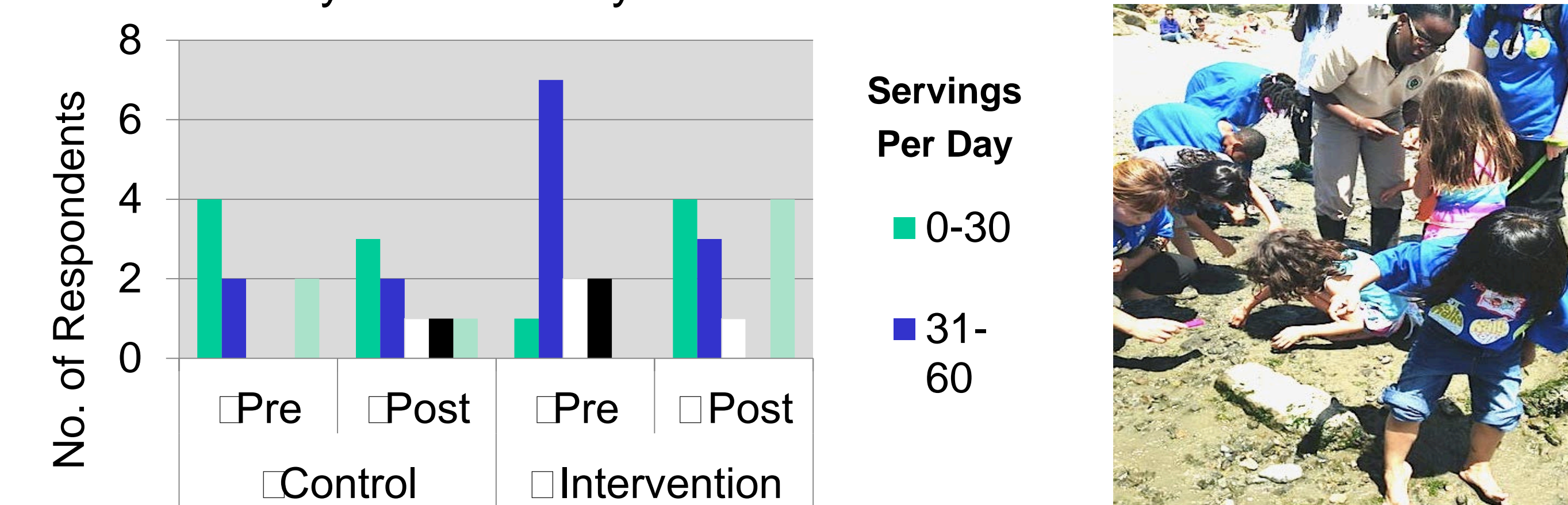


Outcomes Achieved (preliminary)

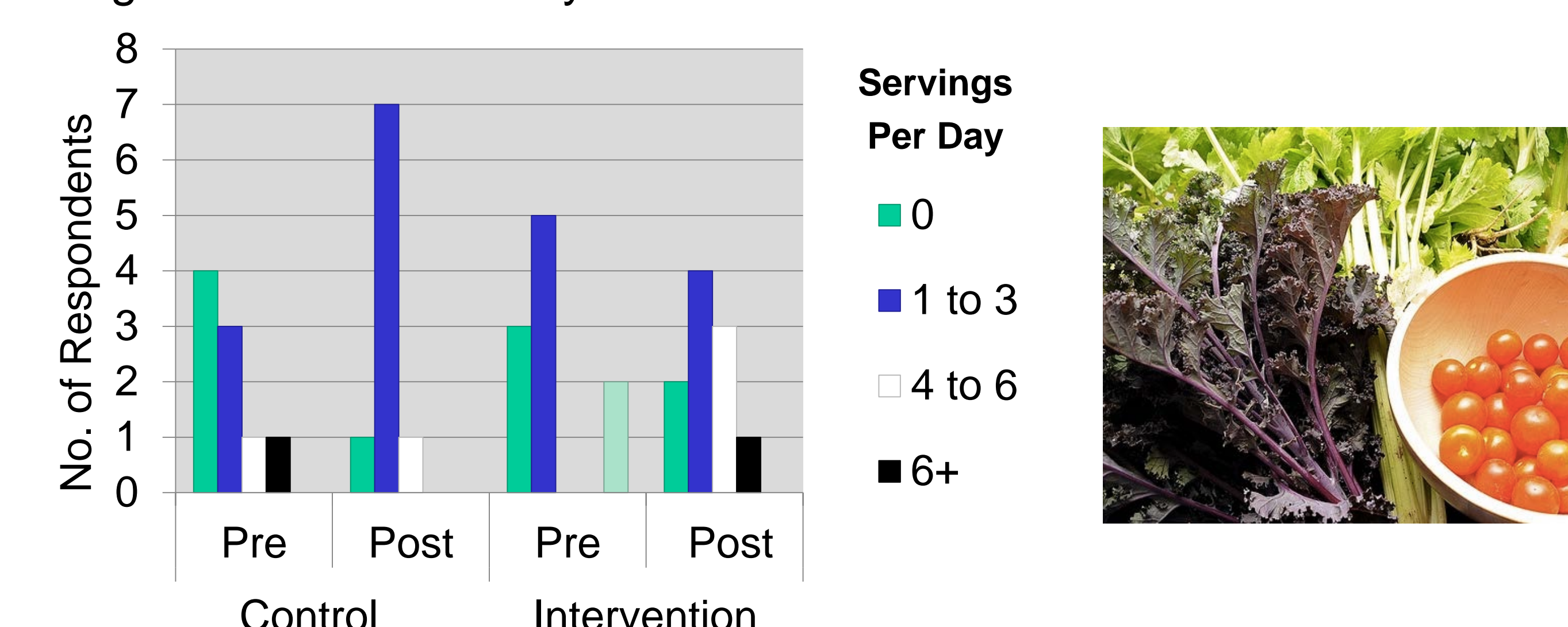
The number of parents who rate their child's health status as "Excellent" or "Very Good" did not significantly change.



The number of children who reported exercising more than 60 minutes daily increased by 20%.



The number of patients eating 4 or more portions of fruit and vegetables increased by 30%.



Lessons Learned

We struggled with our control days because it meant withholding needed resources from an at risk population in order to work within the confines of a clinical trial.



This project has readied us for healthcare reform because it uses a care coordination model that we can use for many new initiatives (embedded mental health, complex care coordination, educational and developmental interventions)



We could have used parent involvement earlier to direct the needs assessment.

Volunteers working on the frontline not only need training and supervision but also help debriefing.

About My Organization

UCSF Benioff Children's Hospital Oakland is the regional pediatric safety net hospital for Northern California. It houses a federally qualified health center that is uniquely pediatric, hospital based, and serves as the largest pediatric health center in the Bay Area. We are home to a large pediatric training program with a specific curriculum in advocacy and community pediatrics. We also have 15 (8.5 FTE) board certified pediatricians and 90 residents who serve and urban pediatric population. 95% of our patients are on public insurance.



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