SDOH SCREENING TOOLS FOR PUBLIC HOUSING RESIDENTS

LEARNING COLLABORATIVE

Screening 101:The Basics

April 20, 2021

National Center for Health in Public Housing

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The National Center for Health in Public Housing (NCHPH), a project of North American Management, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Cooperative Agreement (NCA) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Housekeeping

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email and posted to Moodle within a week after session

Moodle

- Materials related to LC will be available through this platform
- Visit Moodle.nchph.org select “Screening SDOH for Public Housing Residents”
- Create account
- Detailed instructions on how to access materials included in our “Welcome Packet”

Timeline and Commitment

- Attend all four 60-minute live Zoom learning sessions
- Engage in interactive dialogue during the live learning sessions
- Access Moodle for slides, recordings, resources, and continued conversation
- Complete “case presentation” challenges and solutions- send to saqi.cho@namgt.com

Welcome and Introductions

Saqi Maleque Cho, DrPH, MSPH
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Agenda

- Welcome and Introduction to the Learning Collaborative (15 min)
- Introduction to Session 1 (5 min)
- Why Screen for SDOH in public housing? (15 min)
- What to Screen (5 min)
- Example of a Screening Process (10 min)
- Handouts/Resources
- Q&A (10 min)

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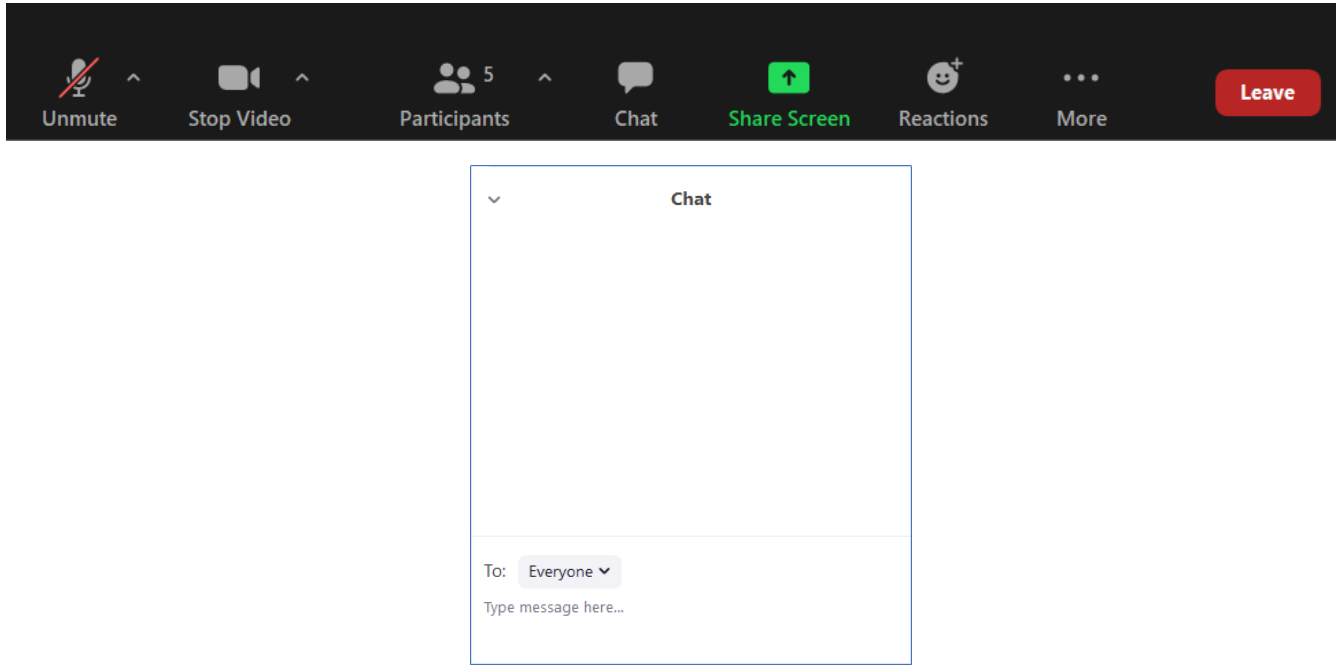
Icebreakers

In the Chat

- Name and role
- Health center name
- City and State

Answer the poll...



About You

Summary of Registration Data

Challenges	Strategies	Like to Get Out of LC
insufficient time	staff education	how to operationalize the data collected
stigma	dispelling stigma	resources; best practices for SDOH
lack of trust	standardized data gathering	new strategies
staffing		scripts to better discuss sensitive SDOH data
data utilization		
translation/Spanish		
standardization/inconsistent data gathering		
training		
workflow integration		

- Screening tools currently used: PRAPARE

What to Expect

- Session 1: April 20
  - Screening 101: The Basics
- Session 2: May 2
  - A Guided Tour of Screening Tools
- Session 3: May 18
  - Remembering the Goal: Implementing a Screening Process with Whole Families in Mind
- Session 4: June 1
  - In the Weeds: Integrating Screening Practices into EHRs and Managing Workflows
- Session 5: June 15
  - Accountability: Navigating Reimbursement and Evaluating Impacts

Add these dates to your calendar!

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Speakers

Joe Lee, MSHA

Director of Strategic Initiatives and Partnerships

Association of Asian Pacific Community Health Organizations

Christina Bethell, PhD, MBA, MPH

Director, Child and Adolescent Health Measurement Initiative

Johns Hopkins University

Zara Marsellian, PhD

Chief Executive Officer

La Maestra Health Center

Session 1
Screening 101: The Basics

Guiding Questions

- How did SDOH come about? How did it enter the field of health care?
- Why is SDOH important?
- How does SDOH assist clients and improve health outcomes?
- What is the role of screening tools? How is it helpful?
- What are best practices in the utilization of SDOH and screening tools?
- How can this series of webinars help your everyday practice and further improve health outcomes for your organization?

Screening 101: The Basics

- Learning Objectives
  - Understand SDOH in context and historical perspective.
  - Identify social risk factors that impact the health of public housing residents and their communities.
  - Describe the process of identifying and implementing an SDOH screening tool.
  - Explain a procedure for linking patients to community-based and other social services and programs that address SDOH.

Social Determinants of Health

- “Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.”
- Source: HealthyPeople 2020

SDOH and Historical Context

- SDOH model requires healthcare organizations address not only medical problems, but also environmental and social factors.
- For all societies, the social determinants of health have always related to health outcomes.
- In the U.S., however, while SDOH has always been present, it just recently entered as an important area of concentration and documentation near the start of the century.
- SDOH has grown very fast, increasing by nearly tenfold during the past decade alone.
- For many healthcare organizations, SDOH has grown faster than the capacity of many institutions to adequately respond.
- The impact of SDOH is felt more strongly among low-income and disenfranchised communities as well as in public housing.

The Context of SDOH

- The management of SDOH can be complex and multi-tiered.
- One research study (2019) has stated that …

"While it is heartening that health systems are now devoting attention to health's social determinants, they will need the same kind of discipline that has helped them develop biomedical therapies."[1]

- The SDOH process requires extreme care and multiple systems for their application.
- Viewed from an individual perspective, SDOH is more than just seeing a medical doctor.
- Bottom line is that other factors impact health that go beyond medication, proper diagnosis, and diet.

[1] Kangovi, S. "An effective way to tackle the social causes of poor health." *Harvard Business Review* (May 13, 2019).

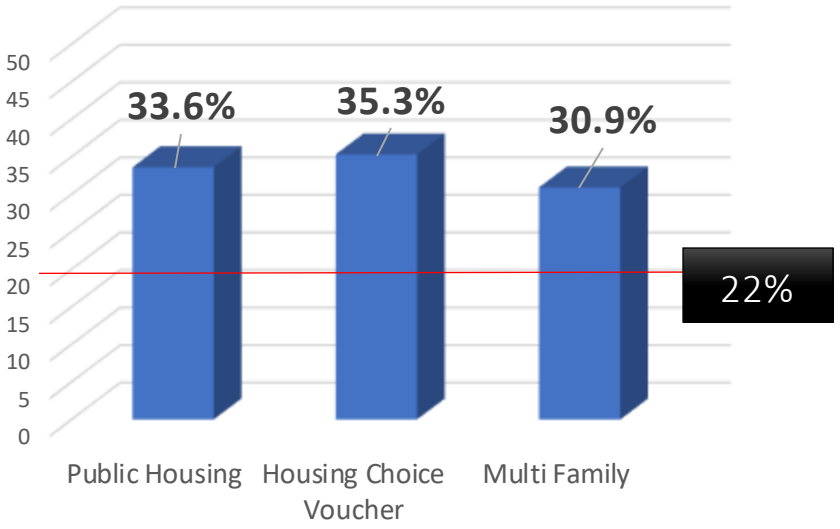
The Role of Race and Culture for SDOH

- **The role race and culture play are critical factors for SDOH.**
- **For this reason, healthcare organizations must engage the end-user in the planning process so as not to misdirect.**
- **A vivid example for SDOH is how racism can patients "sick," not just figuratively but physically.**
- **Racism, by itself, can foster a rigged system that systematically creates major disadvantages for certain groups.**
- **SDOH can help combat racism both at the individual level as well as at institutional level.**

A Health Picture of HUD-Assisted Adults (2006-2012)

Adults in HUD-assisted housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.

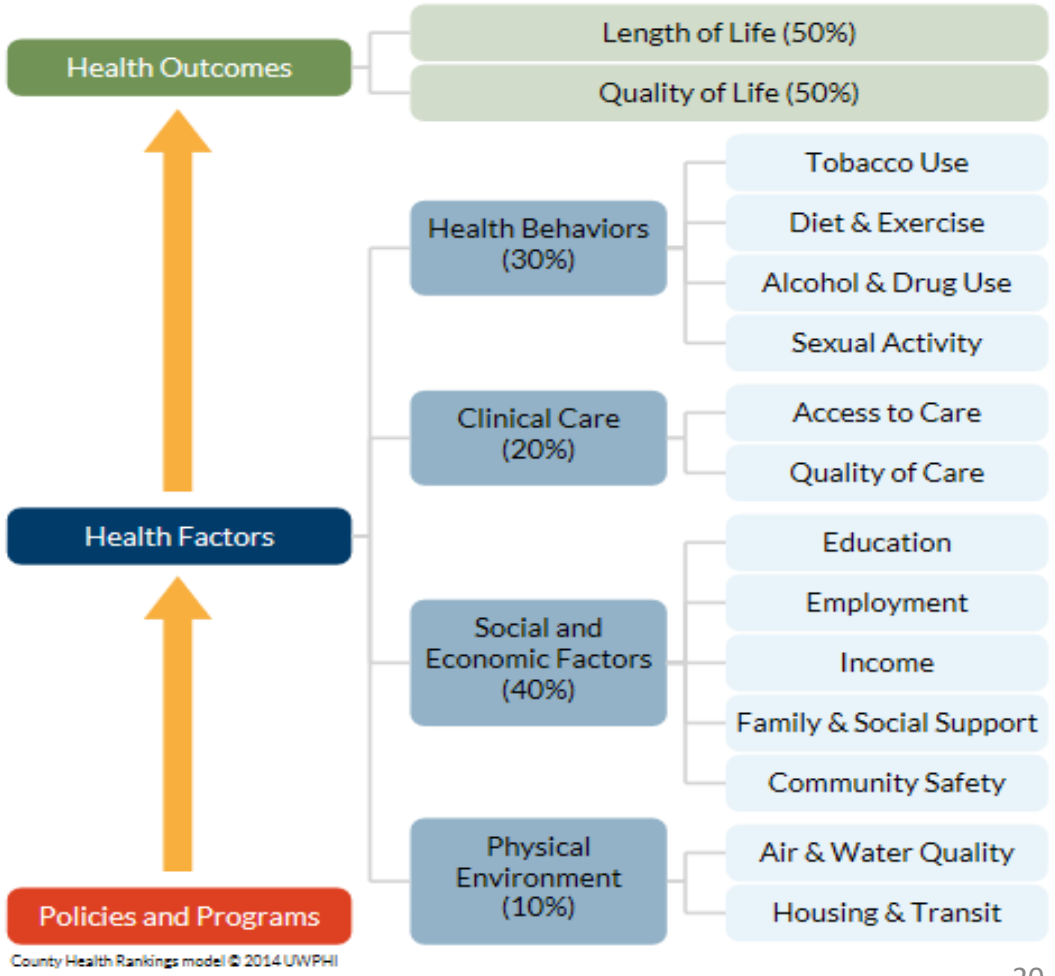
Adult Smokers with Housing Assistance



Source: Helms VE, 2017

	HUD-Assisted	Low-income renters	All Adults
Fair/Poor Health	35.8%	24%	13.8%
Overweight/ Obese	71%	60%	64%
Disability	61%	42.8%	35.4%
Diabetes	17.6%	8.8%	9.5%
COPD	13.6%	8.4%	6.3%
Asthma	16.3%	13.5%	8.7%

Impacts of Housing on Health



Social determinants of health have up to 6x the impact on health as compared to clinical care. Addressing social determinants requires collaboration across medical care, public health, and social service providers.

Key Factors in the Implementation of SDOH

- Patient **trust** in SDOH is key to the process of referral, going beyond traditional medical appointments.
- Understanding **differentiated** staff roles is also critical to the SDOH process. For example:
  - Those who perform the screening
  - Those who make the referrals
  - Others who follow-up
  - Those who track and create accountability within the system
  - Etc.
- Throughout there must be **integration** with different levels of needs that often occur concurrently.
- Staff must operate in lockstep fashion with **patient-staff relationships.**

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SDOH helps the patient by …

- Obtaining services that are related to patient *wellbeing* and better personal health
- Providing data that helps the agency and the care manager to better *assist* with the totality of patient needs.
- Improving the patient-provider *relationship*.
- Bolstering patient receptivity to better navigate and attain broader *service utilization*.

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How the Health Field Has Evolved

Using maternal health as a case in point, the field has changed considerably the past several decades:

It has moved from one of infectious disease and illness to that for the management of developmental and chronic health conditions.

More recently, the field has undergone additional transitions that now focus on:

Early and lifelong development of health; and	Whole-child wellbeing.

Current implications are that this now requires attending to both:

A medical model; and	A social determinants of health model.

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Poll question

Phase 1

1. Identify specific domains to be considered by the Office of the National Coordinator,

2. Specify criteria that should be used in deciding which domains should be included,

3. Identify core social and behavioral domains to be included in all EHRs, and

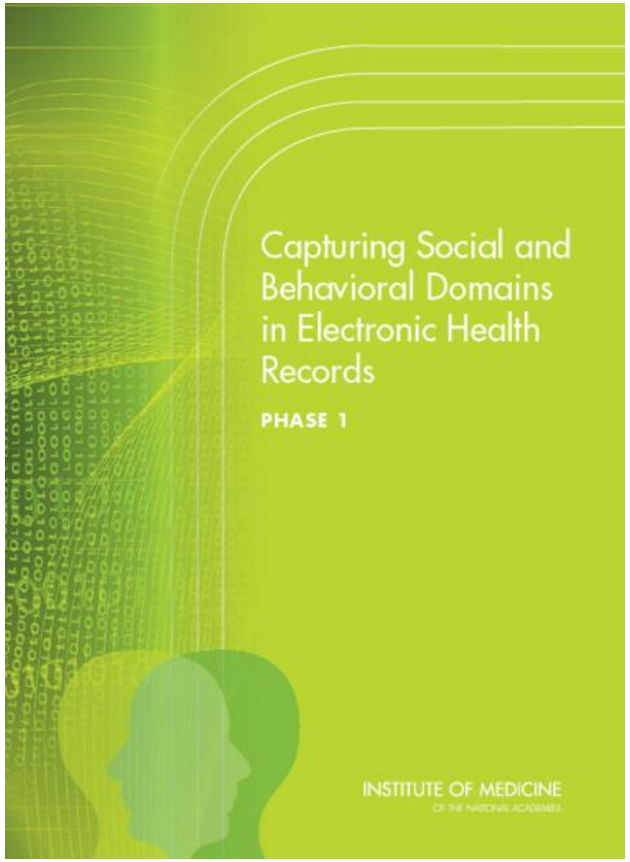
4. Identify any domains that should be included for specific populations or settings defined by age, socioeconomic status, race/ethnicity, disease, or other characteristics.

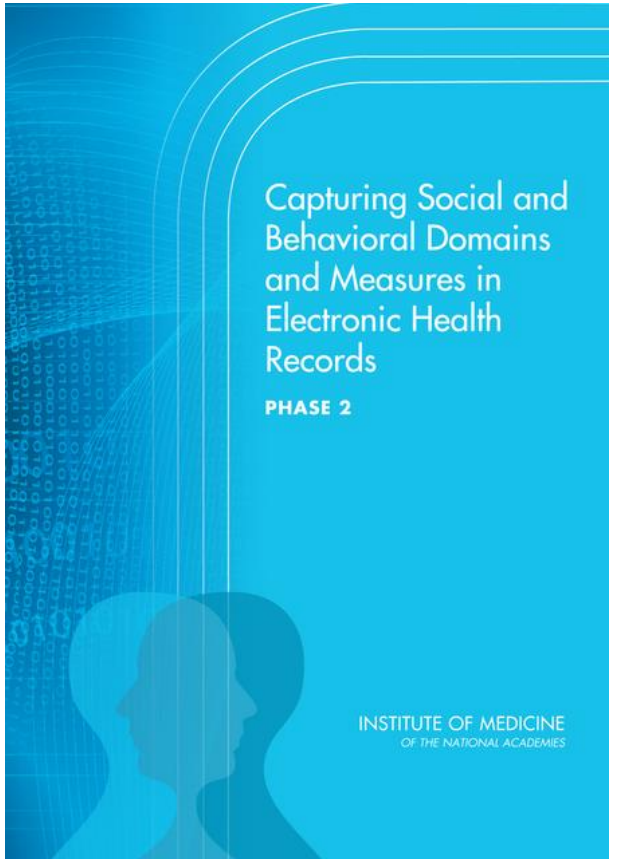
Phase 2

1. What specific measures under each domain specified in Phase 1 should be included in EHRs? The committee will examine both data elements and mechanisms for data collection.

2. What are the obstacles to adding these measures to the EHR, and how can these obstacles be overcome?

3. What are the possibilities for linking EHRs to public health departments, social service agencies, or other relevant non–health care organizations? Identify case studies, if possible, of where this has been done and how issues of privacy have been addressed.





Criteria:

1. Strength of the evidence
2. Usefulness of the domain
3. Availability of a reliable and valid measure(s) of the domain.
4. Feasibility
5. Sensitivity
6. Accessibility of data from another source.

Sociodemographic domains

- Sexual orientation
- Race/ethnicity
- Country of origin/U.S. born or non-U.S. born
- Education
- Employment
- Financial resource strain (Food and housing insecurity)

Psychological Domains

- Health literacy
- Stress
- Negative mood and affect (Depression, anxiety)
- Psychological assets (Conscientiousness, patient engagement/activation, optimism, self-efficacy)

Behavioral Domains

- Dietary patterns
- Physical activity
- Tobacco use and *exposure*
- Alcohol use

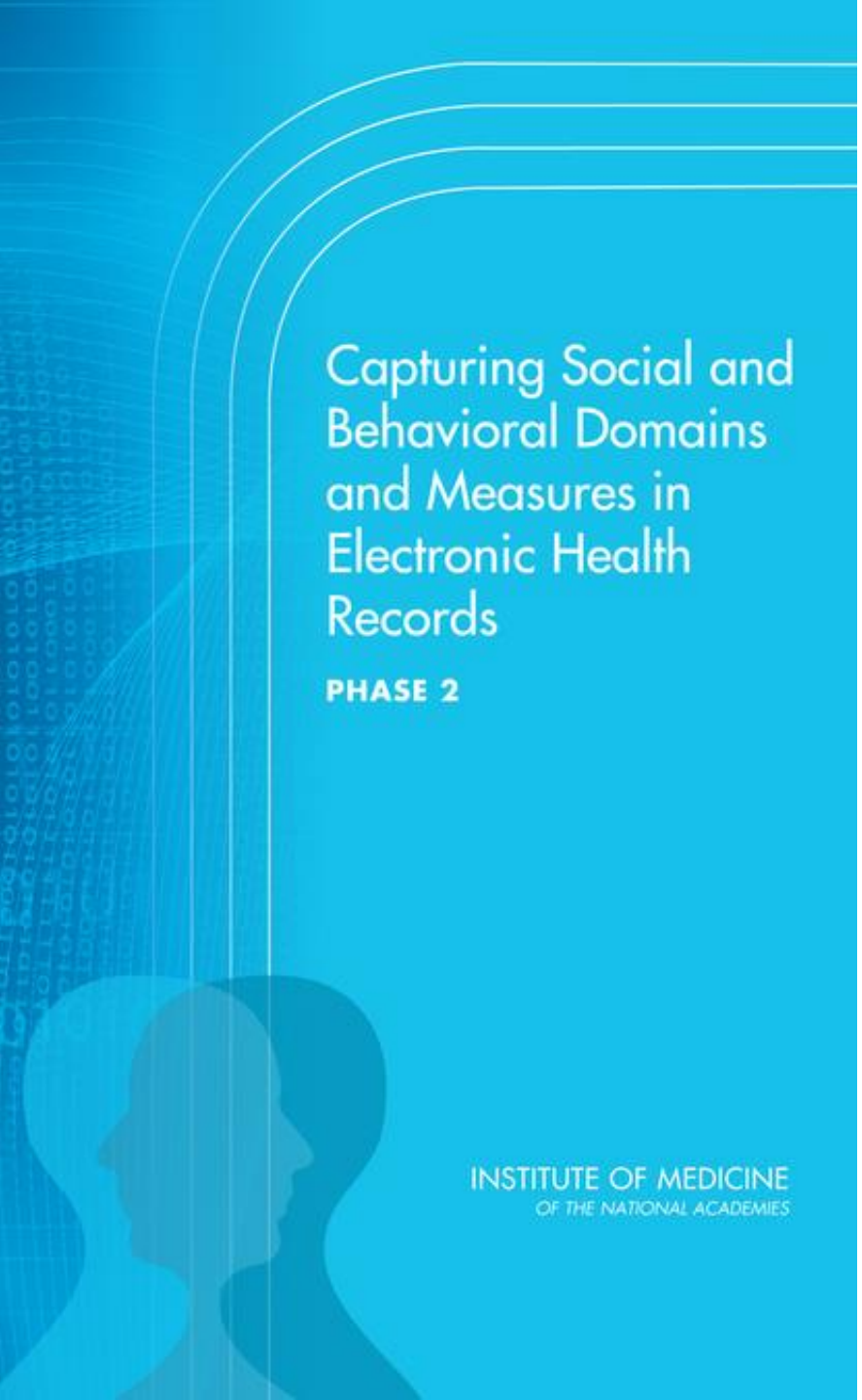
Individual-Level Social Relationships Domains

- Social connections and social isolation
- Exposure to violence

Neighborhoods and Communities

- Neighborhood and community compositional characteristics (Socioeconomic and racial/ethnic characteristics)

Capturing Social and Behavioral Domains in Electronic Health Records - NCBI Bookshelf (nih.gov)



- DOMAINS
  - Race/ethnicity
  - Education
  - Financial resource strain
  - Stress
  - Depression
  - Physical activity
  - Tobacco use and exposure
  - Alcohol use
  - Social connections and social isolation
  - Exposure to violence: Intimate partner violence
  - Neighborhood and community compositional characteristics
- IMPLEMENTATION CHALLENGES
  - Self-Reported Data
  - Privacy Protections
  - Linking Data
  - Resource Considerations
- NEXT STEPS/ RECOMMENDATIONS

Poll Question

- What domains do you currently screen? Choose all that apply.
  - Race/ethnicity
  - Education
  - Financial resource strain
  - Stress, Depression
  - Physical activity
  - Tobacco use and exposure, Alcohol use
  - Social connections and social isolation
  - Exposure to violence: Intimate partner violence
  - Neighborhood and community compositional characteristics
  - n/a

Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Principles:

- Domains linked to health outcomes
- Questions must be brief
- Validated questions
- Align with existing tools

Meet with Stakeholders

Meeting with key stakeholders that were interested in SDOH or already working on SDOH

Literature review

Examined best practices related to screening and identifying SDOH

Source:SDOH-Screening-Tool_Paper_FINAL_20180405.pdf (nc.gov)

North Carolina Standardized Screening Planning Process Cont'd

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Identify Appropriate Screening Tool

Review of screening tools

Identify priority SDOH domains

- food insecurity, housing instability, transportation, and interpersonal violence.

Compiled a list **of validated questions from various existing tools**

Convened a Technical Advisory Group

Advisory Group with diverse SME and stakeholders across the state.

TAG reviewed and refined questions over 4 working sessions.

Source:SDOH-Screening-Tool_Paper_FINAL_20180405.pdf (nc.gov)

North Carolina Standardized Screening Implementation Process

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

"Care Needs Screening" stage- one-time universal screening

- at least two contact attempts to screen all enrollees for their care needs within 90 days of enrolment.
- Results of Care Needs Screening sent to primary care provider within 7 days

Identify patients with "high unmet resource needs"

- individuals who are homeless,
- individuals experiencing domestic violence/lack of personal safety,
- and individuals screening positive on three of more of the four core SDOH domains on the standardized SDOH questions

Send to care management

- Additional deeper comprehensive assessment

Identify community resources

- securing health-related services that can improve health and family wellbeing (including assistance filling out and submitting applications);
- by having a housing specialist on staff or on contract who can assist individuals who are homeless in securing housing; and by providing access to medical legal partnership for legal issues adversely affecting health.

Translating into other languages

Source:SDOH-Screening-Tool_Paper_FINAL_20180405.pdf (nc.gov)

Resource Database and Social Service Integration Platform

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

"Screening for SDOH without an established pathway to help people meet their resource needs will not help meet the goal of improving the health, safety and well-being of all North Carolinians–and will deter health care providers from engaging patients on the full set of factors that impact their health. There must be a system and infrastructure to connect patients to community resources if they screen positive for an unmet resource need."

Source:SDOH-Screening-Tool_Paper_FINAL_20180405.pdf (nc.gov)

Q&A

Please unmute yourself to ask a question

Next Session

Session 2:

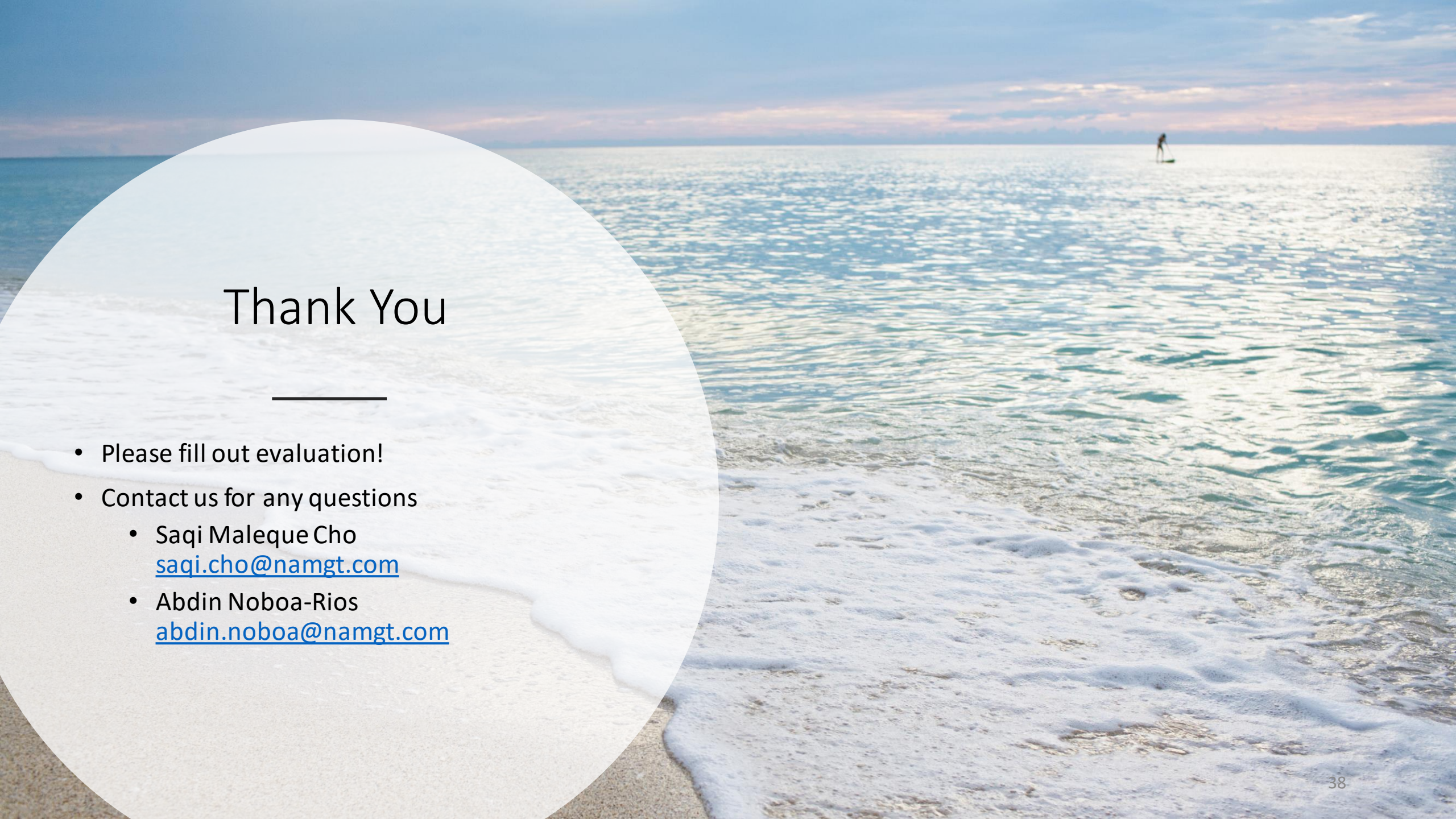
- May 2nd at 2pmET-3pmET
- A Guided Tour of Screening Tools
- Guest Speaker Joe Lee

Resources

- NCHPH Resources
  - **SDOH Community Violence**
  - **SDOH Diabetes**
  - **Access to Healthy Food and Exercise in Public Housing Communities**
  - **Social Determinants of Health for Public Housing Residents: Access to Healthy Food**
  - **Interactive Map- Socioeconomic Health Factors and Public Housing**
- Capturing Social and Behavioral Domains in Electronic Health Records: Phase 1 - PubMed (nih.gov)
- Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2 - PubMed (nih.gov)
- SDOH-Screening-Tool_Paper_FINAL_20180405.pdf (nc.gov)

Evaluation Poll

- Answer the poll…
- Add to the chat **to Organizer**
  - Which aspects of this learning collaborative session did you find most useful?
  - How could this learning collaborative session be improved in the future?



Thank You

- Please fill out evaluation!
- Contact us for any questions
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