Using SDOH Data to Screen for Social Vulnerability

April 27th 2:00pmET-3:00pmET

Housekeeping

- All participants muted upon entry
- Engage and submit questions 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 NCHPH website within a week after session

Welcome

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NCHPH
National Center for Health in Public Housing

HEALTH INFORMATION TECHNOLOGY, EVALUATION, AND QUALITY CENTER
HITEQ

National Center for Health in Public Housing

Strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees.

Training and Technical Assistance | Research and Evaluation | Outreach and Collaboration

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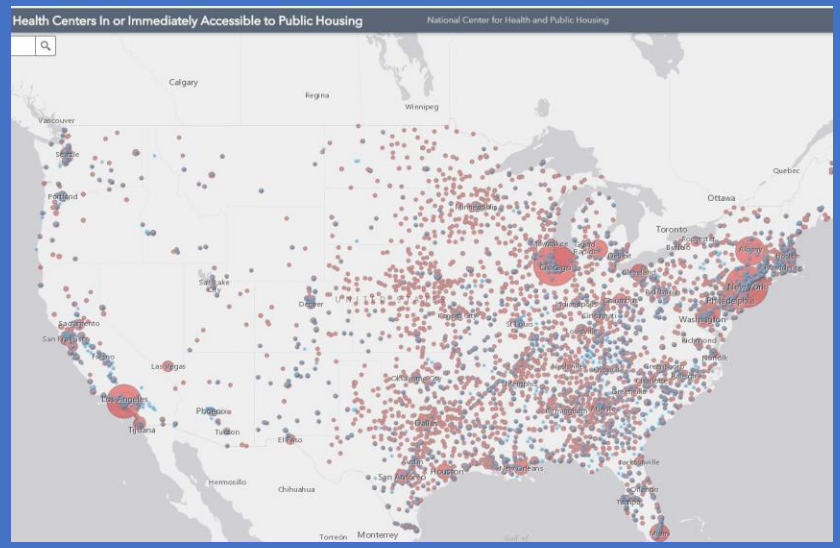


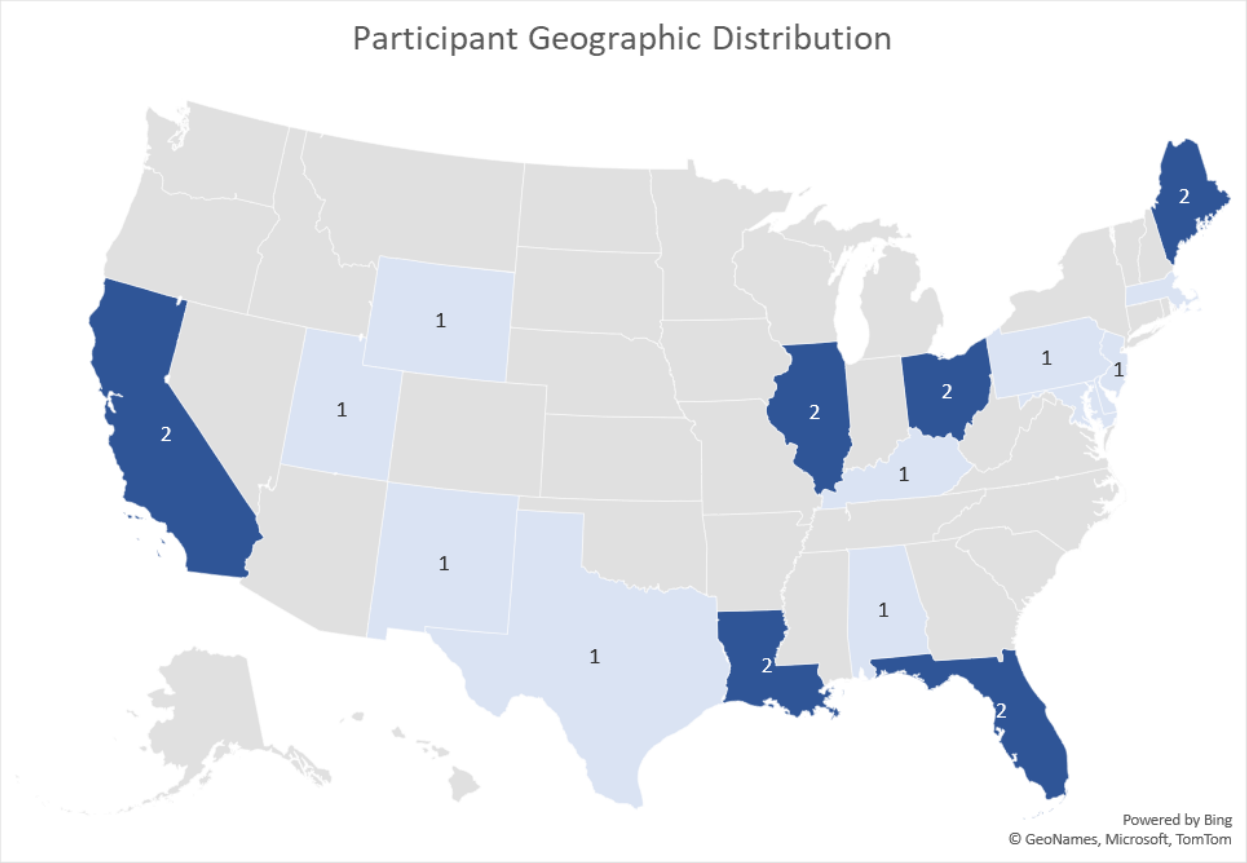
- Webinars
- Monographs
- Provider and Resident-Centered Factsheets
- Interactive Maps

- Training Manuals
- Newsletters
- Collaboration Guides
- One-on-One Matching

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $684,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

About You

Summary of Registration Data



Challenges

- A lot of times patient just won't tell you what is really going on in their life. That makes it very challenging for us to help.

Strategies

- Obtaining the information from the physician notes
- Translators
- Appropriate literacy levels
- Engaging patients at every encounter
- Providing consistent surveys

Expectations

- Learn new strategies
- Where to send people for help
- Learn what are the most pressing SDOH
- Practical uses and procedures

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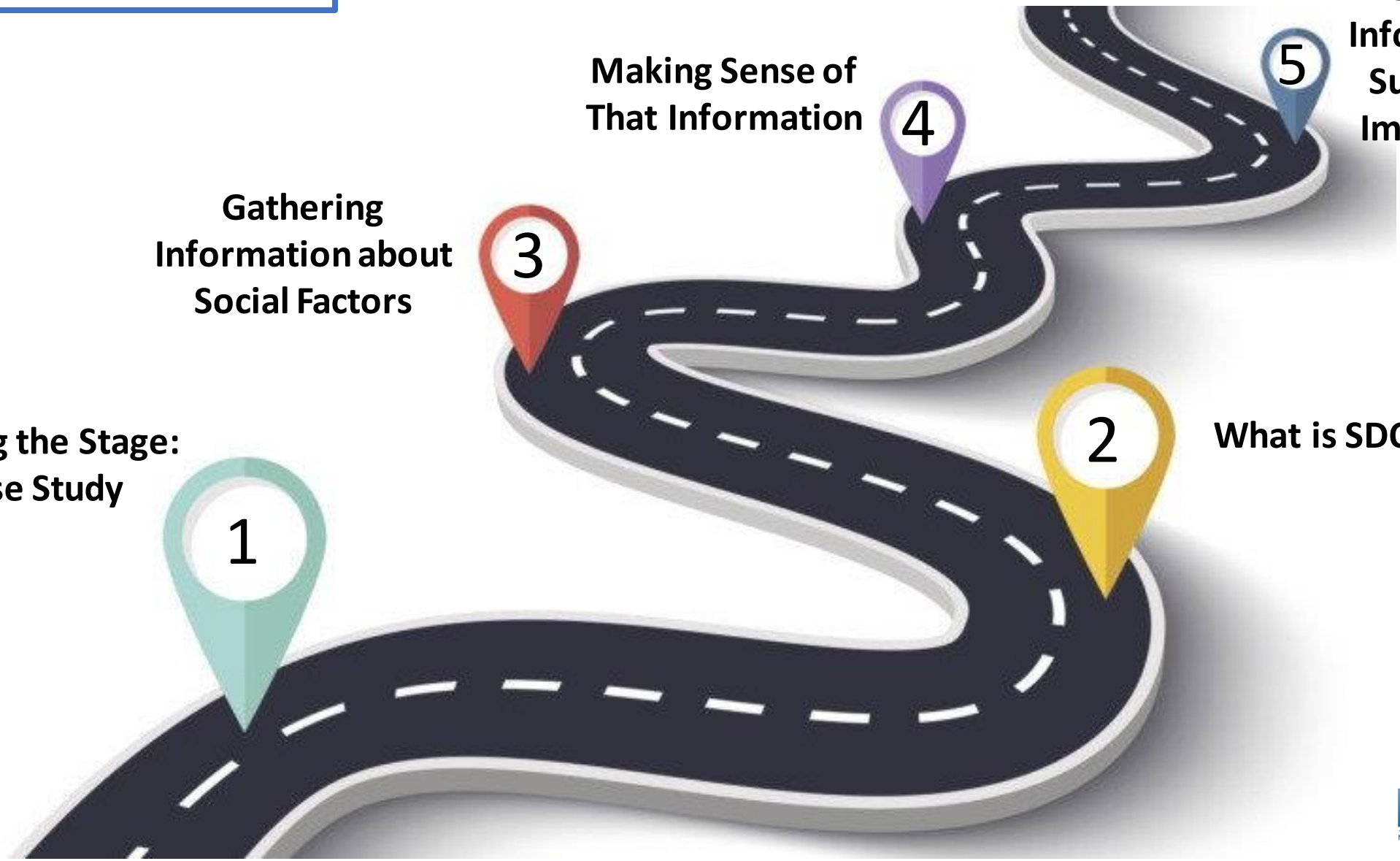
Agenda



1. Setting the Stage: Case Study
2. What is SDOH?
3. Gathering Information about Social Factors
4. Making Sense of That Information
5. Using that Information to Support and Improve care

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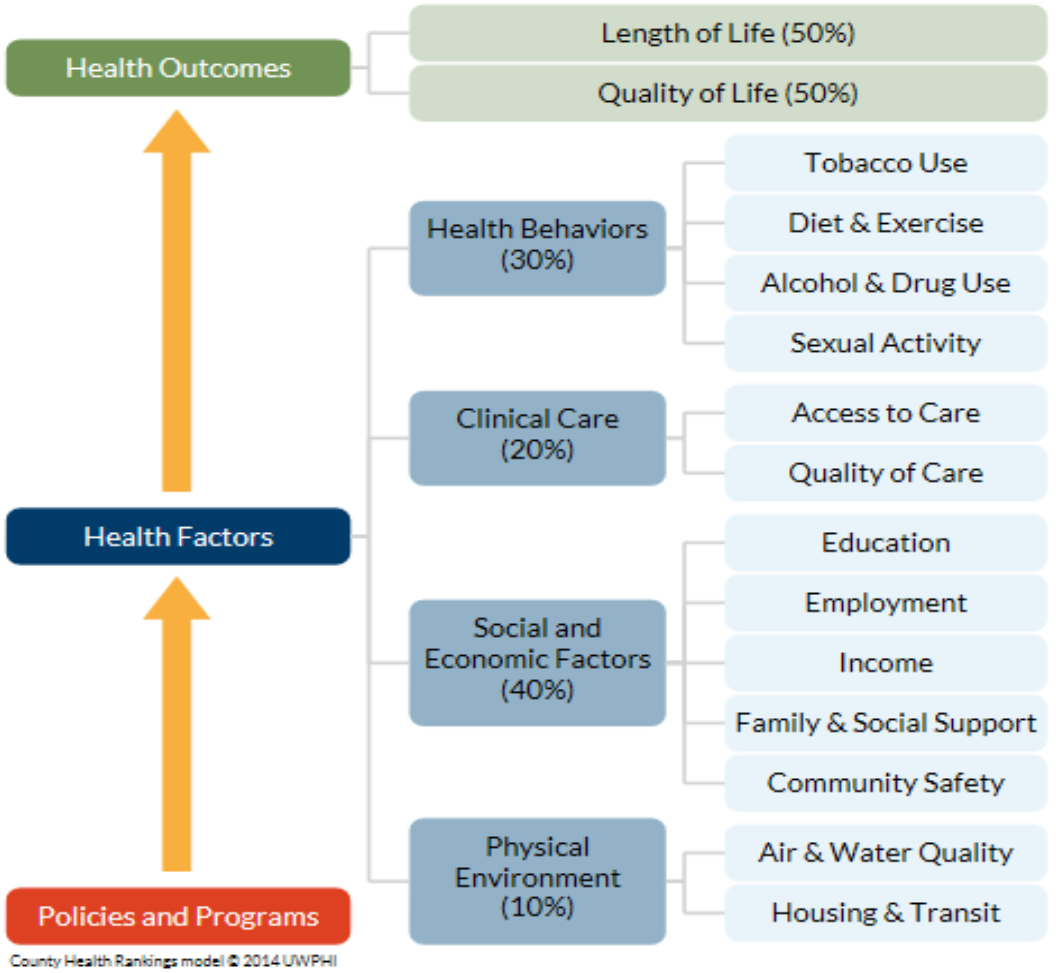
Social Determinants of Health

The Social Determinants of Health are the conditions that impact our health and well-being because where we live, work, learn, and play impact our health more than the medical care we receive.

Impacts of Housing on Health



Poll

- What are the social determinants of health impacting Lucy? (Choose all that apply.)
  - A. access to healthy food
  - B. access to health care services
  - C. access to transportation
  - D. safe environment
  - E. other (add to chat)

Introduction to HITEQ

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner (NTTAPs) that collaborates with HRSA partners including Health Center Controlled Networks, Primary Care Associations and other NTTAPs to engage health centers in the optimization of health IT to address key health center needs through:

- A **national website** with health center-focused resources, toolkits, training, and a calendar or related events.
- **Learning collaboratives, remote trainings,** and **on-demand technical assistance** on key content areas.

www.HITEQcenter.org | hiteqinfo@jsi.com | @HITEQcenter

HITEQ Topic Areas

Access to comprehensive care using health IT and telehealth

Privacy and security

Advancing interoperability

Electronic patient engagement

Readiness for value based care

Using health IT and telehealth to improve Clinical quality and Health equity

Using health IT or telehealth to address emerging issues: behavioral health, HIV prevention, and emergency preparedness

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Our Objectives

After participating in this session, attendees (that's you!) will be able to:

- → Describe how SDOH data can be used to advance population health, particularly for vulnerable and special populations.
- → Describe how to use SDOH data to tailor services for more timely, patient-centered care.
- → Describe the advantages and challenges of sharing SDOH data with partner organizations to provide comprehensive and holistic care.

Content for Today

Gathering Information about Social Factors

- SDoH Screening
- Other relevant information

Making Sense of That Information

- Aligning across purposes and requirements
- Risk Stratification

Using that Information to Support and Improve care

- Allocating resources
- Possible interventions
- Monitoring

SECTION 1

Gathering Information about Social Factors

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Gathering Information about Social Factors from Patients

Demographics

Long collected information, typically including ZIP code, age, sex, gender, race, ethnicity, language, etc.

Social Need Screening

Screening tool such as PRAPARE, Accountable Health Communities Screening Tools, Upstream Risks Screening Tool, or some amalgamation.

Other Information

Other information that the health center may have like any visit documentation noting SDoH; indication of lack of access such as use of transport vouchers; or lack of technology such as no cell on file or no portal access.

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Poll: Where is your health center with collecting social need information?

1. Yes, we are collecting all of the information mentioned, and are actively using that information across the patient population.
2. Yes, we are collecting all of the information mentioned.
3. We collect demographics, but are just getting a broader social screening approach in place.
4. We're not very far along on this yet, we are just considering how to approach it.

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Each patient's social needs and related risks are likely to change over time.

SECTION 2

Making Sense of That Information

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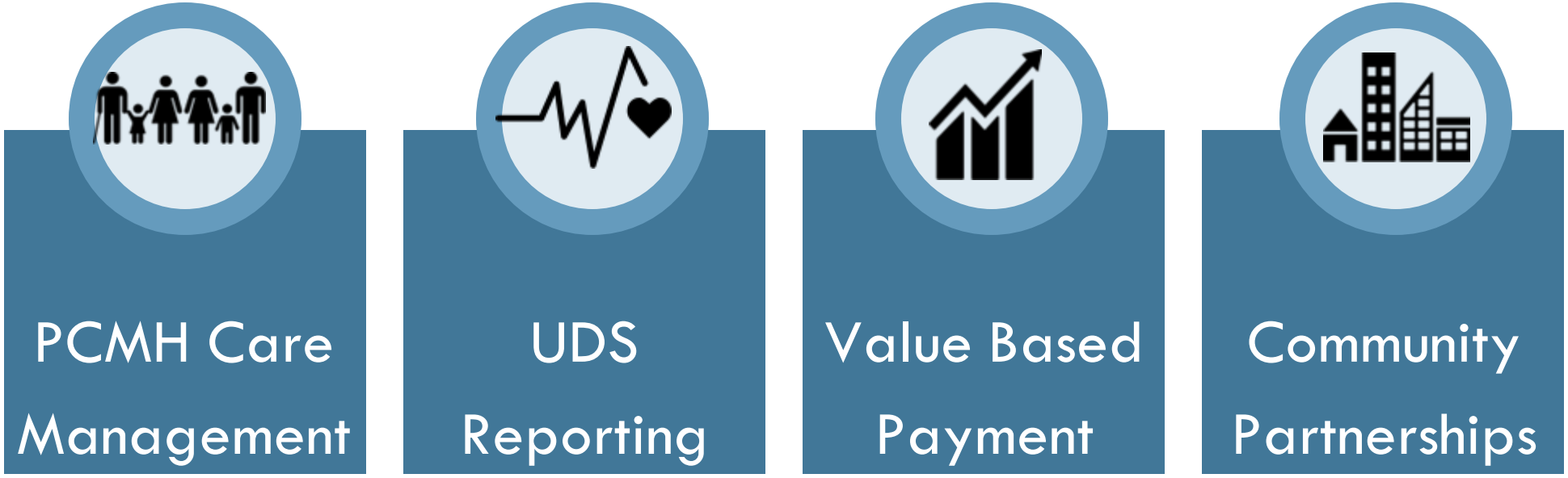
Social need screening is used in many health center initiatives.



Risk stratification is too!

Risk Stratification

Definition: Using information about patients to assign a risk status or risk score on an ongoing basis. Typically algorithmic, can also include clinician judgement.

Purpose: Used to optimize care, align practice with value-based care approaches

Identify patients and related data.

Establish risk stratification plan.

Assign patients into risk groups.

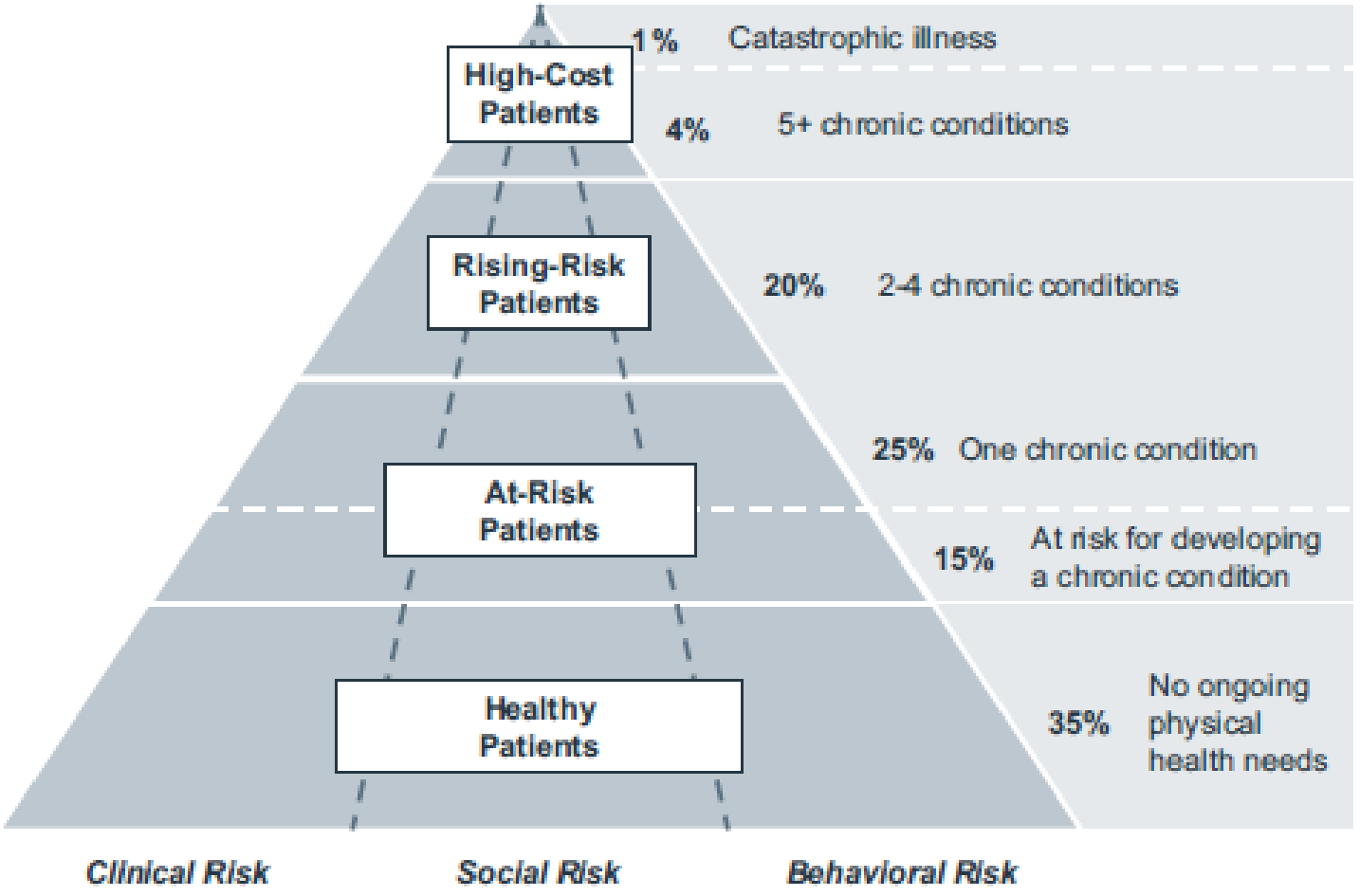
Tailor care pathways to groups.

SECTION 3

Using that Information to Support and Improve care

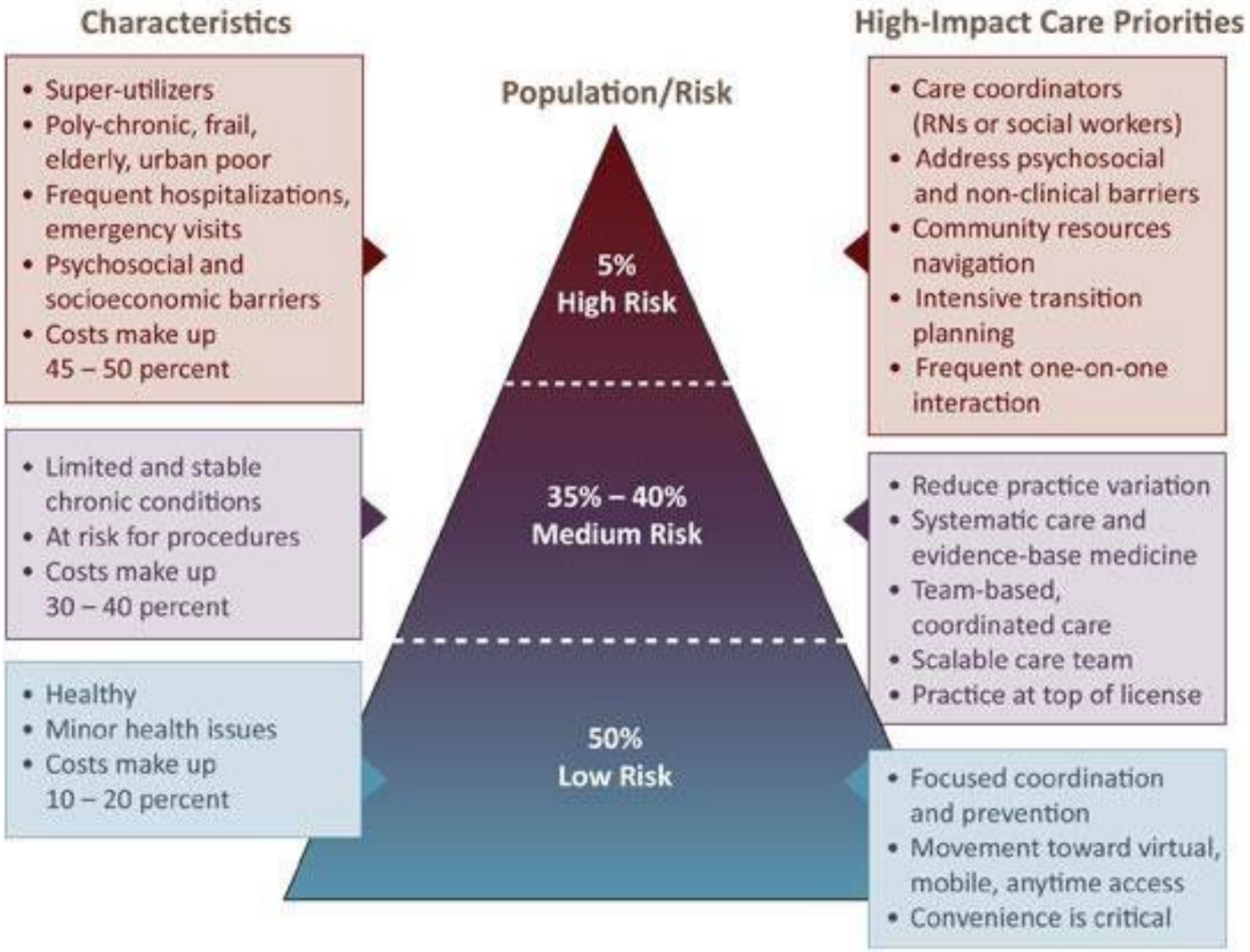
Risk Stratification Incorporates Key Information to Identify Groups

Clinical, social, and behavioral factors, combined with utilization and costs.



Risk Profiles Drive Care Priorities

Maximizing limited resources while also meeting all patients where they are is critical to high value care. Risk stratification drives these insights.



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Key: Can only respond to identified risk, so good information and access to that information is key!

- ➔ There may be an algorithm built into your EHR or health IT system; need to ensure that is mapped/ pulling correctly to the relevant information so its accurately representing patients.
- ➔ Care design across clinic designed with risk groups in mind. For example, timing of follow up or referral to care management.
- ➔ Actionable policies on how to use risk score at the point of care.
- ➔ Multidisciplinary care teams including patient engagement/ outreach beyond the walls of clinic.

Thank you!

WEBSITE

www.HITEQcenter.org

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Q&A

Please unmute or add questions to the chat.

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Please fill out Evaluation Poll!

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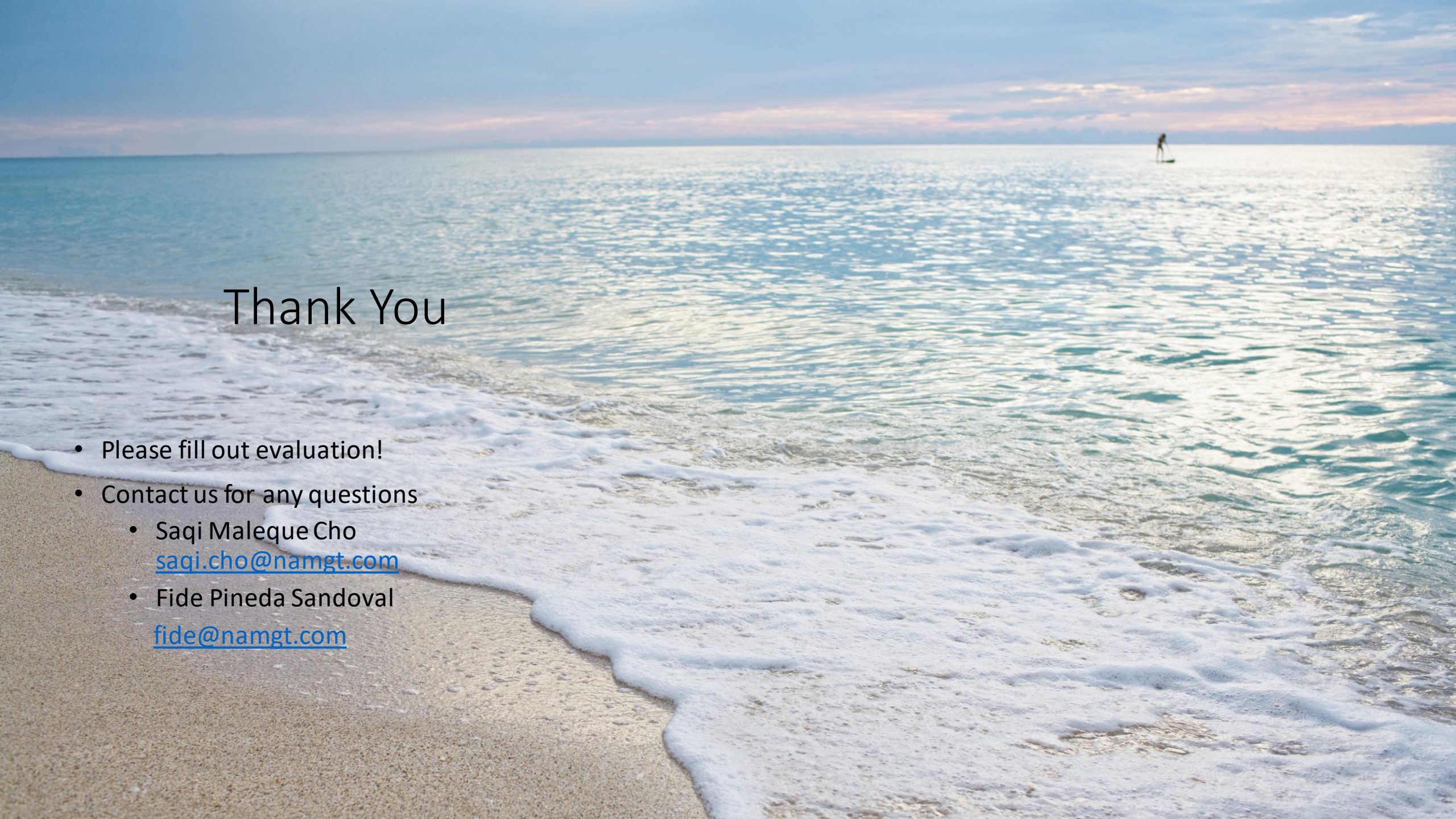

Thank You

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