The Social Determinants of Health: Integration into clinical practice

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06/01/2023

Housekeeping

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email

zoom

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National Center for Health in Public Housing (NCHPH)

- The National Center for Health in Public Housing (NCHPH) 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 Partner (NTTAP) 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.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

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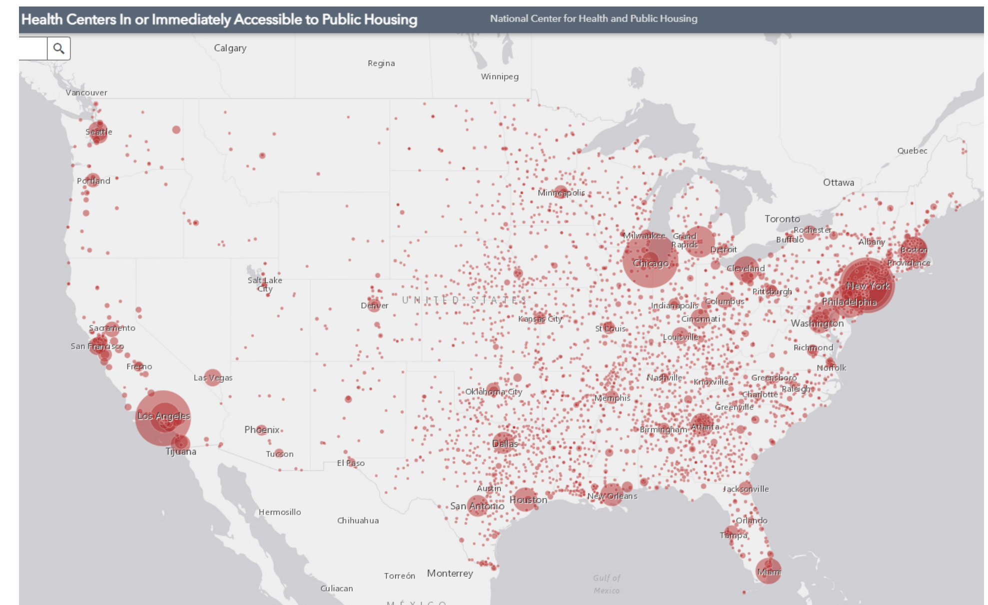
Health Centers Close to Public Housing

- 1,373 Federally Qualified Health Centers (FQHC) = **30 million patients**
- 458 FQHCs In or Immediately Accessible to Public Housing = **5.7 million patients**
- 108 Public Housing Primary Care (PHPC) = **911,683 patients**

Source: 2021 Health Center Data



Source: Health Centers in or Immediately Accessible to Public Housing Map

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Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

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Session content objectives

1. Present and discuss the SDOH as an epidemiological framework.
2. Review research regarding the implementation of SDOH policies/protocols.
3.Examine the implications of this framework on clinical and practice.
4.Examine frameworks for implementation of SDOH policies/protocols.

The SDOH: Conceptual Overview

Link to resource: Healthy People 2030

- ***"How has addressing the SDOH at your institution positively impacted the working lives of you and your staff/colleagues?"***

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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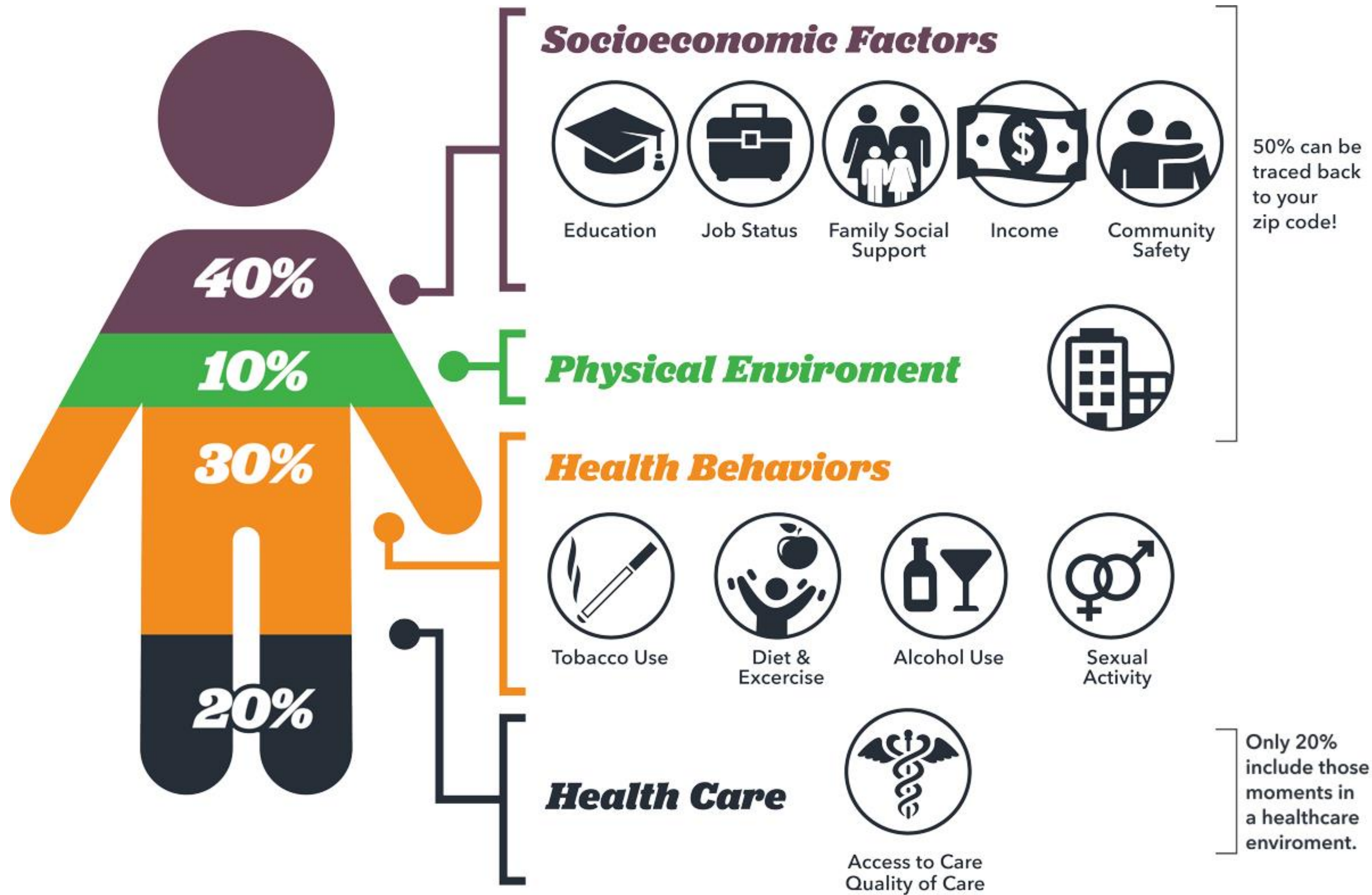
[Link to resource]



Link to resource

- **Case Study:**

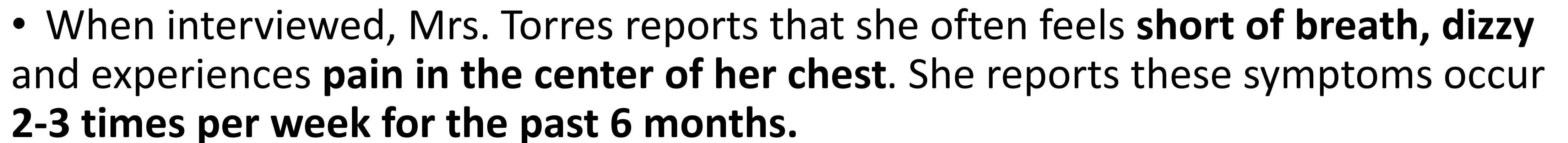
- Mrs. Torres is a 45 y/o female who presents to her Primary Care office with complaints of chest pain, fatigue and general malaise. Vitals indicate a heart rate of 75 bpm, BP of 170/85. Physical exam is unremarkable aside from slight shaking of the hands and feet while sitting.

- When interviewed, Mrs. Torres reports that she often feels short of breath, dizzy and experiences pain in the center of her chest. She reports these symptoms occur 2-3 times per week for the past 6 months.

- She has a PMH significant for: Depression, T2DM and hypertension.

- **Case Study:**

- Mrs. Torres is a **45 y/o female** who presents to her Primary Care office with complaints of **chest pain, fatigue and general malaise**. Vitals indicate a **heart rate of 75 bpm, BP of 170/85**. Physical exam is unremarkable aside from slight shaking of the hands and feet while sitting. Labs have been drawn and are pending.



- When interviewed, Mrs. Torres reports that she often feels **short of breath, dizzy** and experiences **pain in the center of her chest**. She reports these symptoms occur **2-3 times per week for the past 6 months.**

- **She has a PMH significant for: Depression, T2DM and hypertension.**

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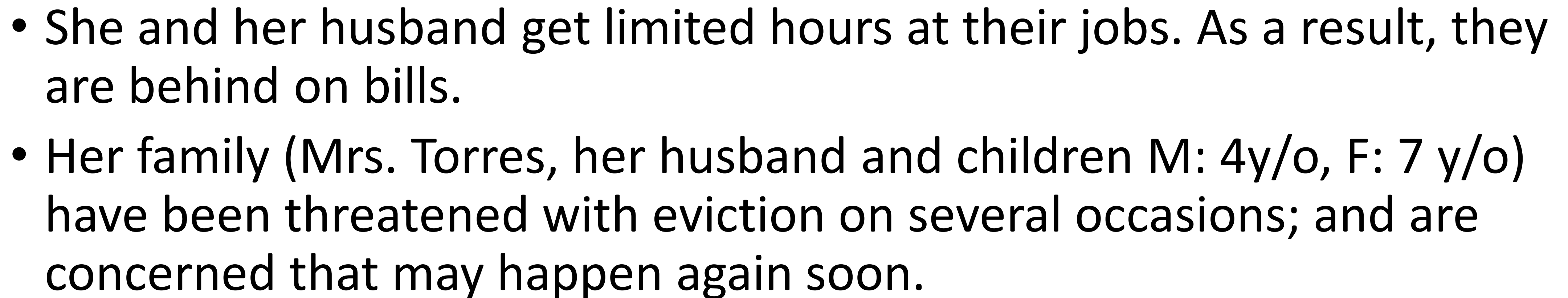
- **Case Study:**



- Mrs. Torres is experiencing symptoms **concerning for anxiety and PTSD**. When questioned further regarding stressors in her life. Mrs. Torres mentions the following:
  - She and her husband get limited hours at their jobs. As a result, they are behind on bills.
  - Her family (Mrs. Torres, her husband and children M: 4y/o, F: 7 y/o) have been threatened with eviction on several occasions; and are concerned that may happen again soon.

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- **Questions: Please take 3 minutes to consider the following.**
  - How do the stressors in Mrs. Torres's life impact her physical symptoms?
  - What are some ways that Mrs. Torres and her family can be networked to resources which can reduce her anxiety and improve her overall wellbeing?

  - What are the implications of not networking Mrs. Torres to services?

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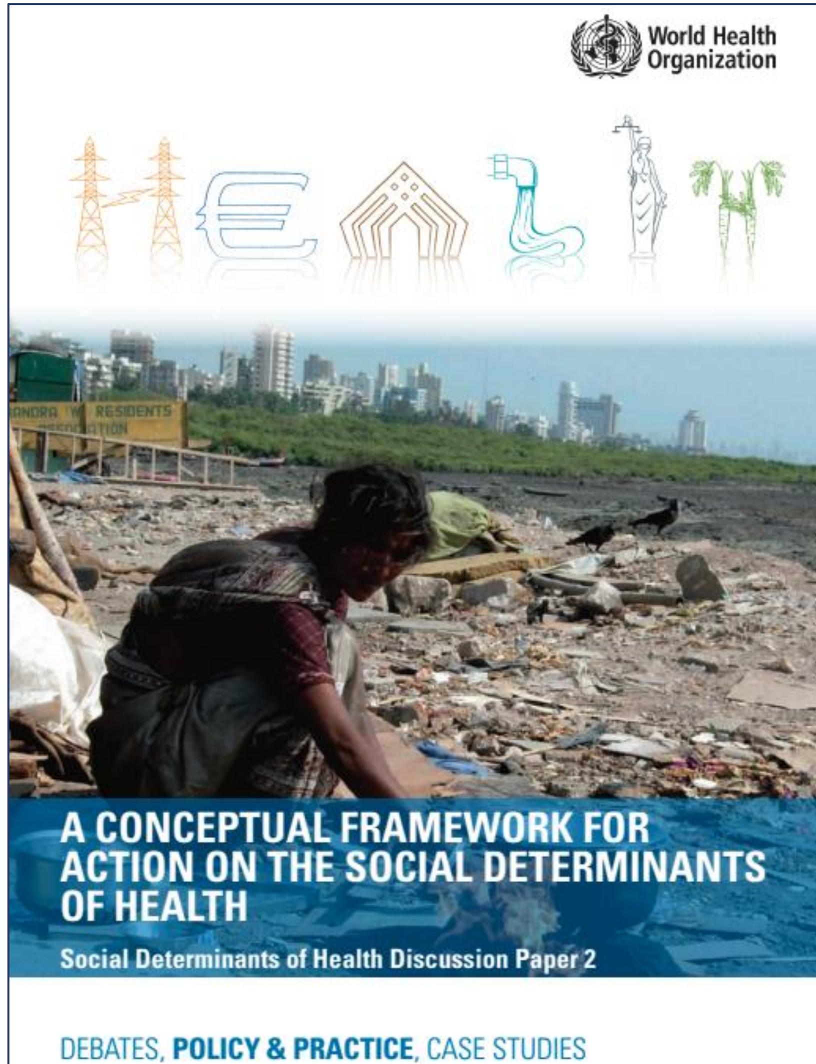
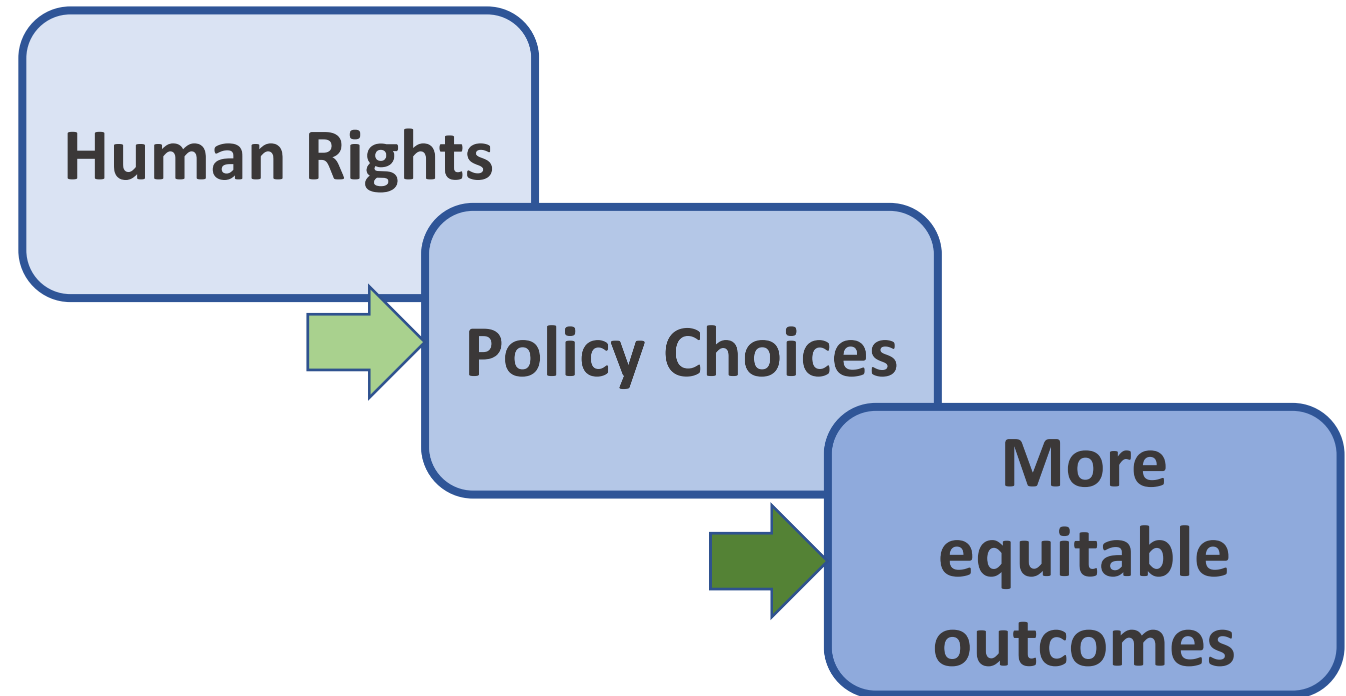
WHO Conceptual Framework





Link to Resource: [WHO Conceptual Framework]

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Author, Article, and Disclosure Information

https://doi.org/10.7326/M17-2441

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ACP Policy Recommendations:

1. Increased efforts to evaluate and implement public policy recommendations.
2. The SDOH be integrated into medical education at all levels.
3. Increased use of interprofessional and collaborative models that encourage a team-based approach to patient care.
4. Investment in SDOH-focused programs.

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Author, Article, and Disclosure Information

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ACP Policy Recommendations:

5. Increased SDOH research.
6. Integration of health considerations into community planning.
7. Best practices for using EHR's to improve individual and population heath.
8. Adjusting quality payment models and performance measurement assessments to reflect increased risk associated with caring for disadvantaged populations.
9. Increased screening and collection of SDOH data to aid in health impact assessments and support.

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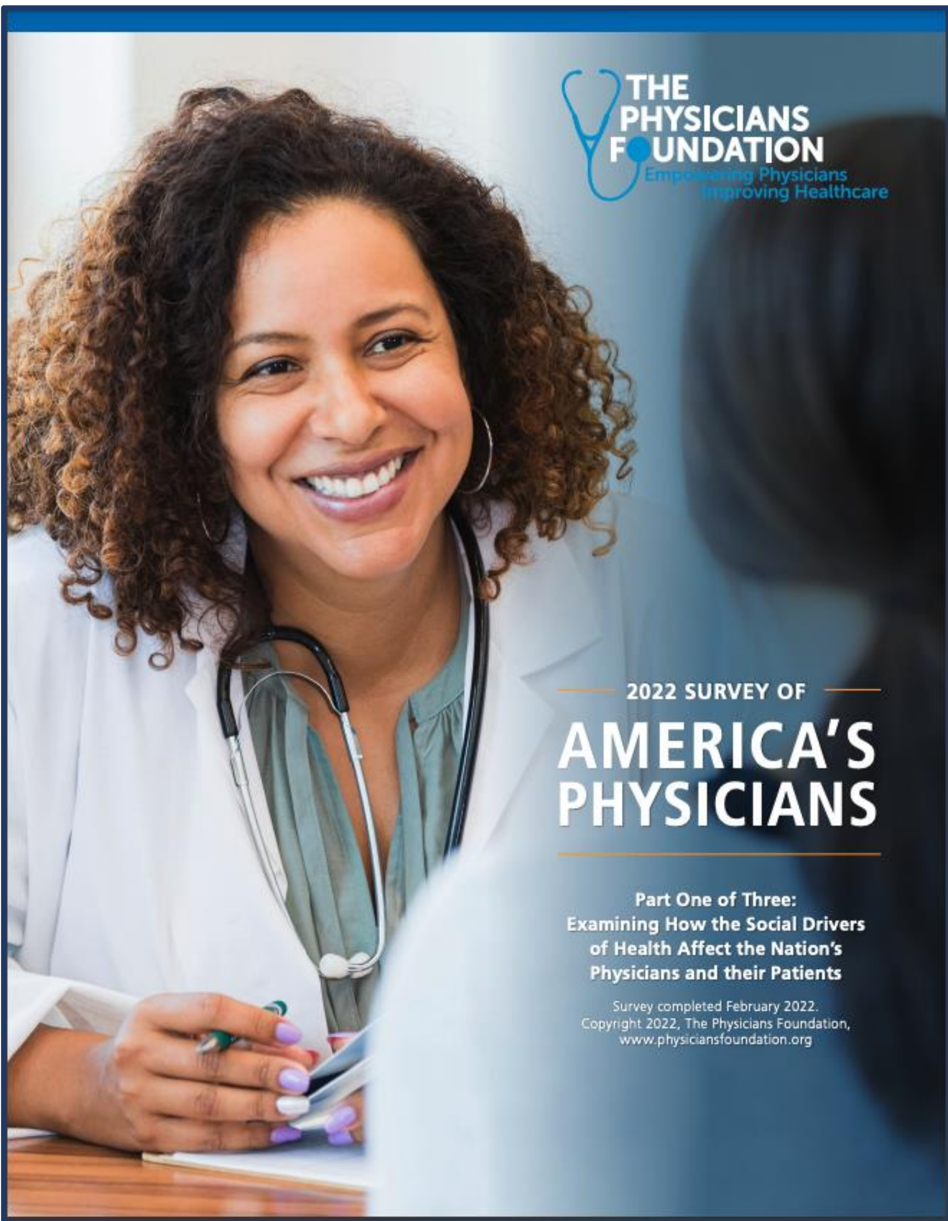

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Takeaways:

- 6 in 10 physicians have little to no time to address the SDOH in the exam room.
- 89% indicated lack of staff to address the SDOH.
- 8 in 10 physicians believe not integrating SDOH into care contributes to burnout.
- 6 in 10 report burnout when addressing SDOH.

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How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care

An Overview

Kate LaForge, MPH, Rachel Gold, PhD, MPH, Erika Cottrell, PhD, MPP, Arwen E. Bunce, MA, Michelle Proser, PhD, MPP, Celine Hollombe, MPH, Katie Dambrun, MPH, Deborah J. Cohen, PhD, and Khaya D. Clark, PhD, MA

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Abstract

Go to:

Little is known about how health care organizations are developing tools for identifying/addressing patients' social determinants of health (SDH). We describe the processes recently used by 6 organizations to develop SDH screening tools for ambulatory care and the barriers they faced during those efforts. Common processes included reviewing literature and consulting primary care staff. The organizations prioritized avoiding redundant data collection, integrating SDH screening into existing workflows, and addressing diverse clinic needs. This article provides suggestions for others hoping to develop similar tools/strategies for identifying patients' SDH needs in ambulatory care settings, with recommendations for further research.

Keywords: ambulatory care, community health centers, data collection, electronic health records, patient-reported outcome measures, primary care, screening, social determinants of health

Link: To Publication

Takeaways:

1. Institutions have wide breadth to improve on existing tools.
2. Customizability of tools to local SDOH concerns is key to program strength.
3. Organizational culture is a key component of promoting SDOH policies.

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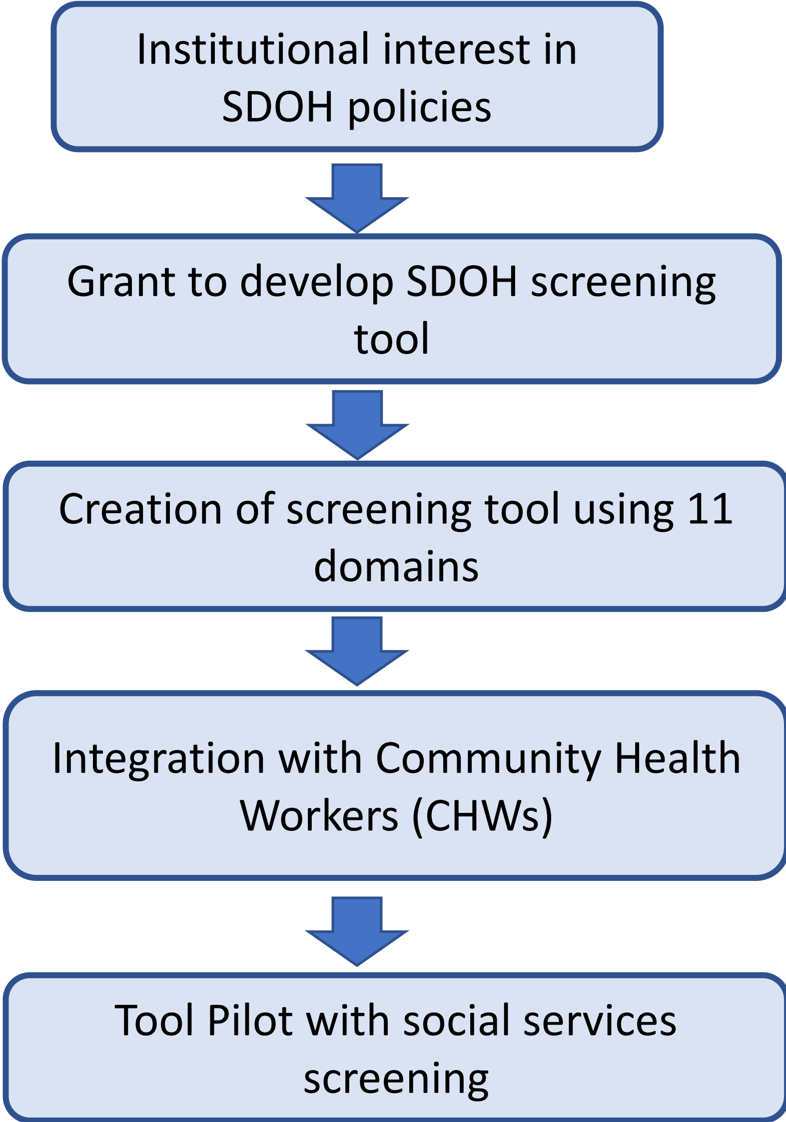
WellRx Pilot, University of New Mexico

Domain	%
Utilities	22%
Income	22%
Employment	15%
Education	13%
Food	12%
Housing	11%
Transportation	9%
Safety	6%
Subst. Abuse	4%
Childcare	3%
Abuse	1%

Axis: 0, 100, 200, 300, 400, 500, 600, 700, 800

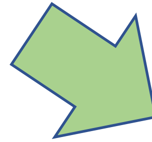


Link: To Publication

Model 1: Integration of CHW and Social-Services into workflow.

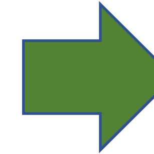
CHW performs standardized SDOH assessment

- Assessment performed using standardized tool.
- Tool results added to patient's file or entered directly into EHR.
- Patient educated regarding resources and access.



Physician makes referrals, integrates results into care

- Using form data, physician integrates data into patient care.
- Physician approves referral to social services.



Patient seen by social services

- Patient consulted regarding available resources they qualify for.
- Patient assisted in resource application process.

Link: To Publication

BRIEF | OCTOBER 2017

CHCS Center for Health Care Strategies, Inc.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

By Caitlin Thomas-Henkel and Meryl Schulman, Center for Health Care Strategies

IN BRIEF

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes,[1] particularly among low-income populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). This brief examines how organizations participating in *Transforming Complex Care* (TCC), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Compared to other industrialized nations, the United States spends much less on social services, and much more on health care.[2] This is true despite evidence that social determinants of health (SDOH) — including income, educational attainment, employment status, and access to food and housing — affect an array of health outcomes,[3] particularly among low-income populations.[4] Individuals with unmet social needs are more likely to be frequent emergency department (ED) users, have repeat 'no-shows' to medical appointments, and have poorer glycemic and cholesterol control than those able to meet their needs.[5]

Takeaways:

Screening tools should be adapted to meet the following:

- Capacity to address specific SDOH needs.
- Availability of local resources and referral networks.
- Ease of use within clinical setting (workflow).
- Ability of tool to capture needs the organization can realistically address.

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Please contact us if you are interested in any of the following:

- Improving access to legal services through person-centered delivery models.
- Integrating the SDOH into health center management and workflow.
- The impact of the SDOH on FQHC workforce retention.

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Next Session Reminder

- **Session 2: Next Wednesday, June 7th at 1:00 pm EDT.**
- **Use the same registration link for today's session.**
- **Registration link:** https://us06web.zoom.us/meeting/register/tZwodeyprTwsH9Sn6Dcc5wd6H2AcaZ9u4sno#/registration

Q&A Session

Complete our Post Evaluation Survey

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Thank you!