The Social Determinants of Health: Integration into clinical practice

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The National Center for Health in Public Housing

Session 2: SDOH program creation

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

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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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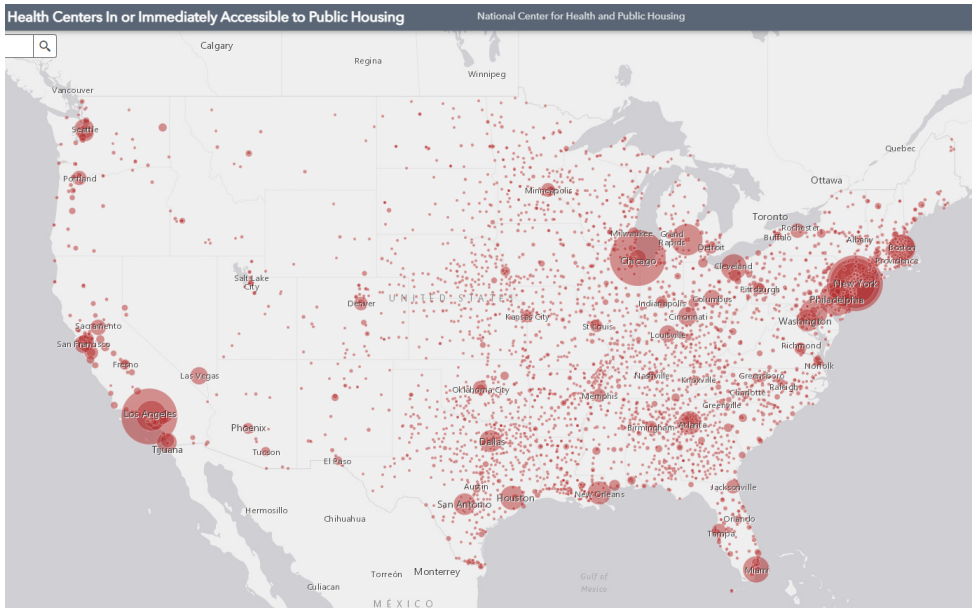
Health Centers Close to Public Housing

- 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. Examine the planning and integration efforts that support SDOH policy success.
2. Describe workflow frameworks that support SDOH policy success.
3. Examine and critique examples of SDOH program design and implementation.

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NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

A Nebraska Community Proactively Addresses Social Drivers of Health

Jessica Sattler, RN, MS, WHNP, Matthew Goudreau, John Loughnane, MD, Linda Dunbar, PhD, RN

Vol. 4 No. 6 | June 2023

DOI: 10.1056/CAT.22.0383

Activate Care, a for-profit company and leader in social risk management solutions, partnered with a direct health care company and a Nebraska managed care organization to fund a pilot program focused on affecting social determinants of health in a Medicaid population in the Omaha area. They began with a community assessment that identified the resources available, barriers to obtaining care, root causes of disparities, and assets within the community. Leveraging the Activate Care application to streamline care and resource navigation processes, they launched the evidence-informed intervention,

Case Study: SDOH Program Intervention

In this study, a Nebraska-based consortium implemented a SDOH community assessment and a community-based SDOH intervention.

We will review the following:

1. Pre-intervention Assessment.
2. A model for outreach and screening.
3. The role of CHW's in SDOH program implementation.
4. Key takeaways of program implementation.

Your attention and participation is appreciated.

Case Study: SDOH Program Intervention

A Nebraska-based healthcare consortium seeks to better address their SDOH patient supports. To do so, they perform a review of the literature and decide to expand their existing CHW workforce to better meet patient needs. No other program creation preparation has been performed.

Which of the following is an appropriate next step:

A. Perform an assessment of the needs and demographics in their community.
B. Design a program based on patient needs identified by staff.
C. Design a program based on the interests and skills of health center staff.
D. Hire and train additional CHW staff

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Case Study: SDOH Program Intervention

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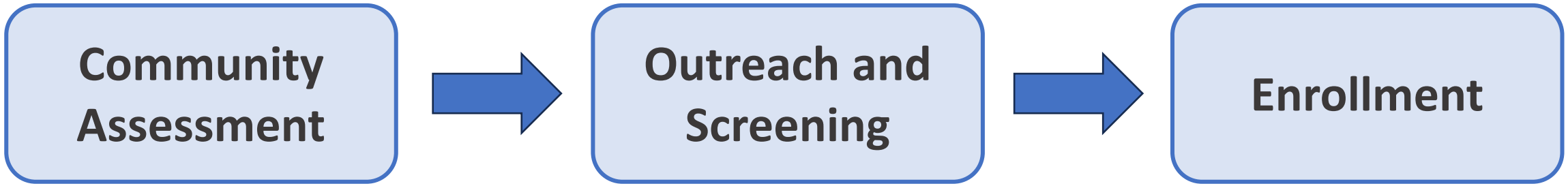
Case Study: Outreach and Screening



- 30,000 residents prioritized based on location.
- 7,000 prioritized due to SDOH vulnerability

- Multichannel outreach efforts.
- Screening performed to identify SDOH vulnerability.

- Coaching regarding key resources.
- Goal setting.
- Positive reinforcement.

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Case Study: Benefits and limitations of corporate partnerships.

In the Nebraska-based study, a healthcare consortium worked with Active Care, a Boston-based healthcare organization to use their digital platform for enrollment and resource navigation.

This resource was used by CHWs during patient encounters.

Please take 2 minutes to consider the following:

“What are the benefits and limitations of partnering with private, for-profit corporations in these circumstances?”

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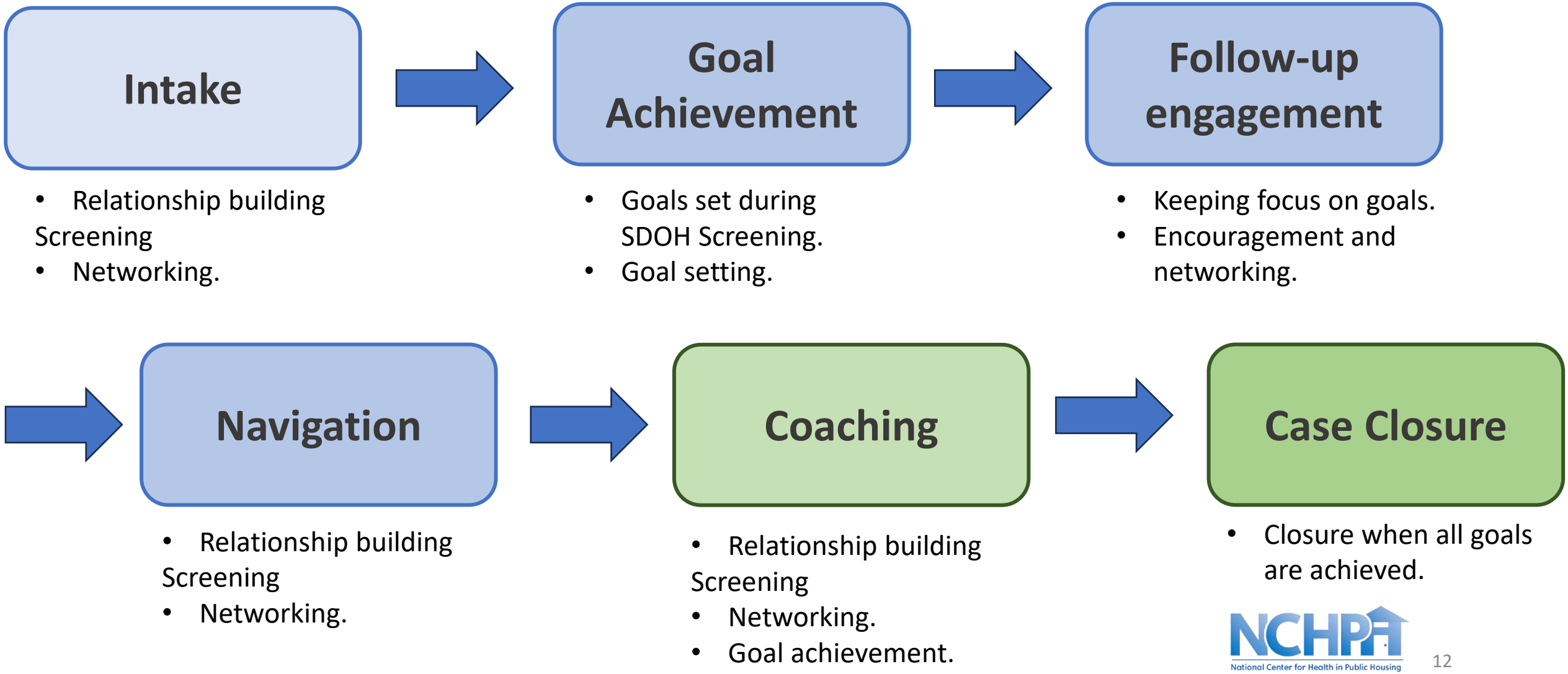
Case Study: The Role of CHWs



- Relationship building Screening
- Networking.

- Goals set during SDOH Screening.
- Goal setting.

- Keeping focus on goals.
- Encouragement and networking.

- Relationship building Screening
- Networking.

- Relationship building Screening
- Networking.
- Goal achievement.

- Closure when all goals are achieved.

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Model 1: Integration of CHW and Social-Services into outpatient 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

Discussion Question:

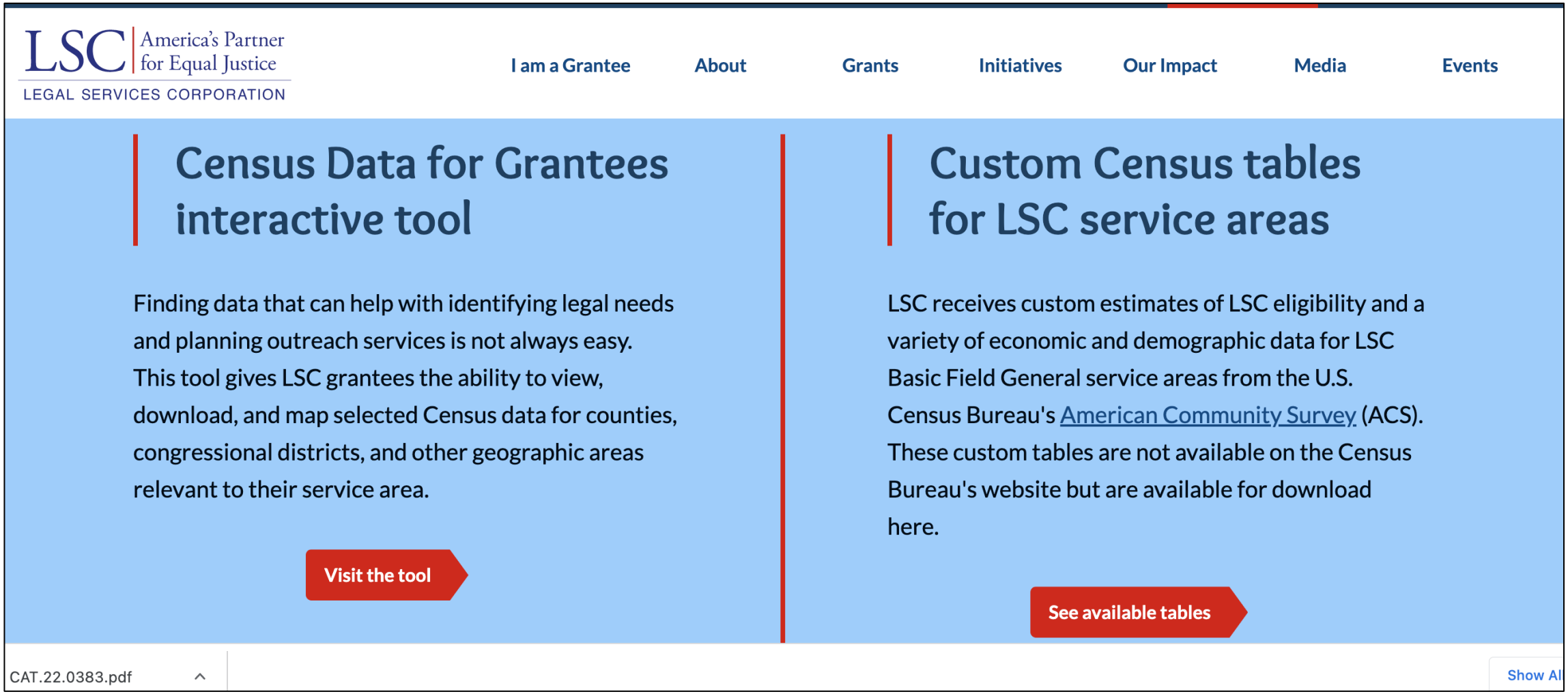
Community Health workers are an indispensable aspect of health center service provision and efficient management.

However, CHWs are a relatively new profession. As a result, the frameworks and recommendations for their effective use are less clear than other professions such as nurses and case workers.

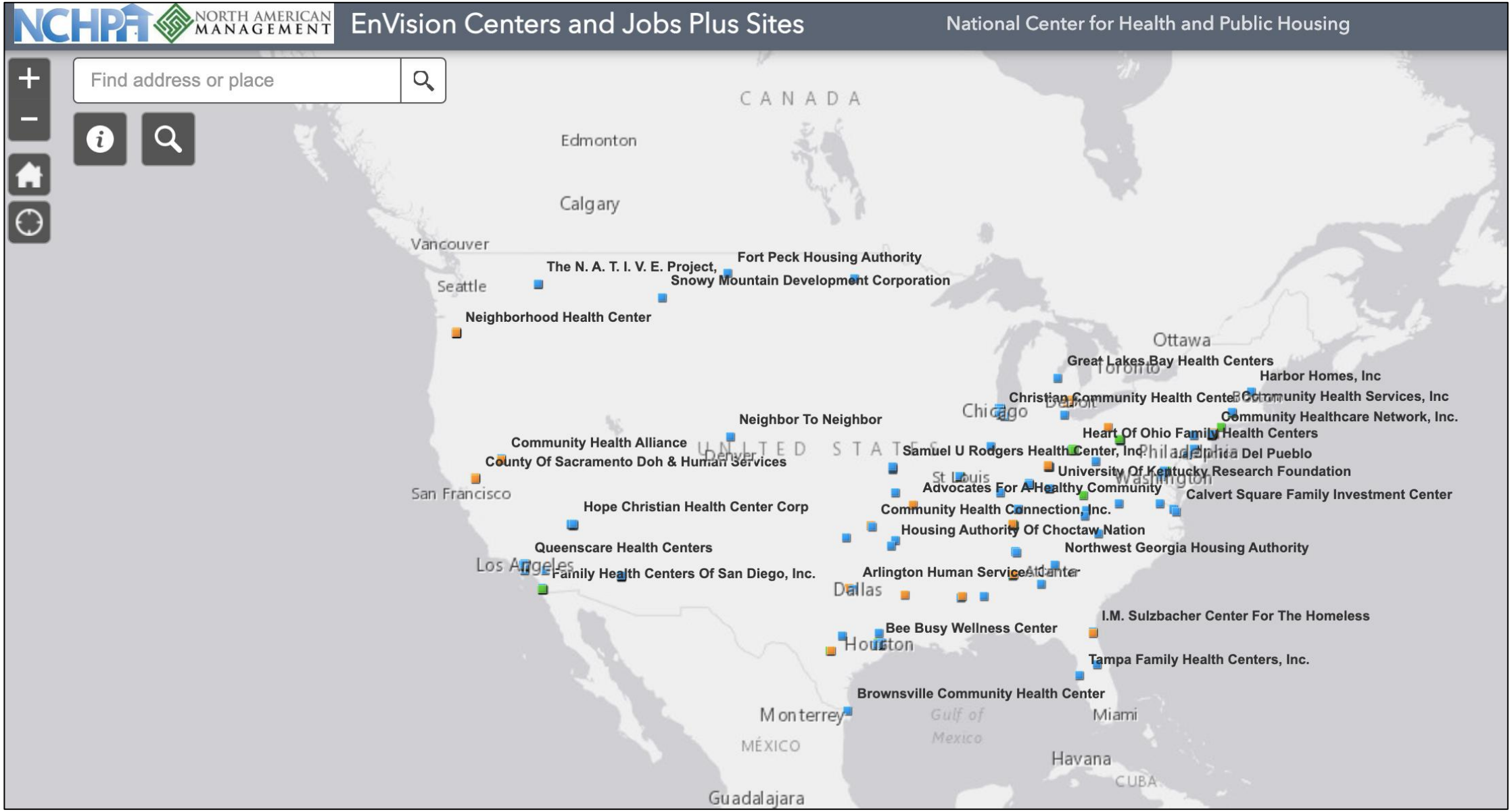
Please take 3 minutes to answer the following questions:

1. **What have been the main challenges in maximizing the use of CHWs at your organization or organizations you have partnered with?**
2. **How have you or your organization navigated this?**

Your participation, insight and thoughtfulness is appreciated.



Resource Link: [LSC Website]



Resource Link: [LSC Website]

RESOURCES

Filter Resources by:

TYPE

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- NCMLP-Authored Reports & Fact Sheets
- Peer-Reviewed Research
- Stories & Case Studies
- Tools
- Webinars & Podcasts

POPULATION / SETTINGS

- Complex Care
- COVID-19
- Health Centers

Tool: Screening for Disability Discrimination

By Katie Hathaway, JD

National Center for Medical-Legal Partnership, Health Outreach Partners

TUESDAY, AUGUST 23, 2022

As part of Tips to Help Health Centers Address Disability & Chronic Disease Discrimination, consultant Katie Hathaway created two brand new screening tools to determine if your patient is experiencing discrimination based on a disability or chronic disease. There is one tool for adults and another for children and young adults (including those attending college)....
Read more »...Read More

Tools

Tips to Help Health Centers Address Disability & Chronic Disease Discrimination

By Katie Hathaway, JD; Bethany Hamilton, JD

National Center for Medical-Legal Partnership, Health Outreach Partners

FRIDAY, JULY 22, 2022

In 2020, approximately 30 million adults and children in medically underserved communities received comprehensive, primary and preventative health care and enabling services from 1,462 HRSA Health

Resource Link: [NCMLP resources]

Key takeaways:

1. A local-well trained Community Health Navigator workforce that serves as a liaison between persons and services.

2. A care coordination technology platform that eases documentation of acre activities and promotes data collection and information sharing can. Be an effective tool for organizing workforce.

3. An evidence-informed intervention model that fosters self-efficacy, health confidence and client-centered care to promote lasting skills can help support program success..

4. Integration with local, trusted community-based organizations is key to SDOH program success.

The SDOH: Conceptual Overview

Link to resource: [Healthy People 2030]

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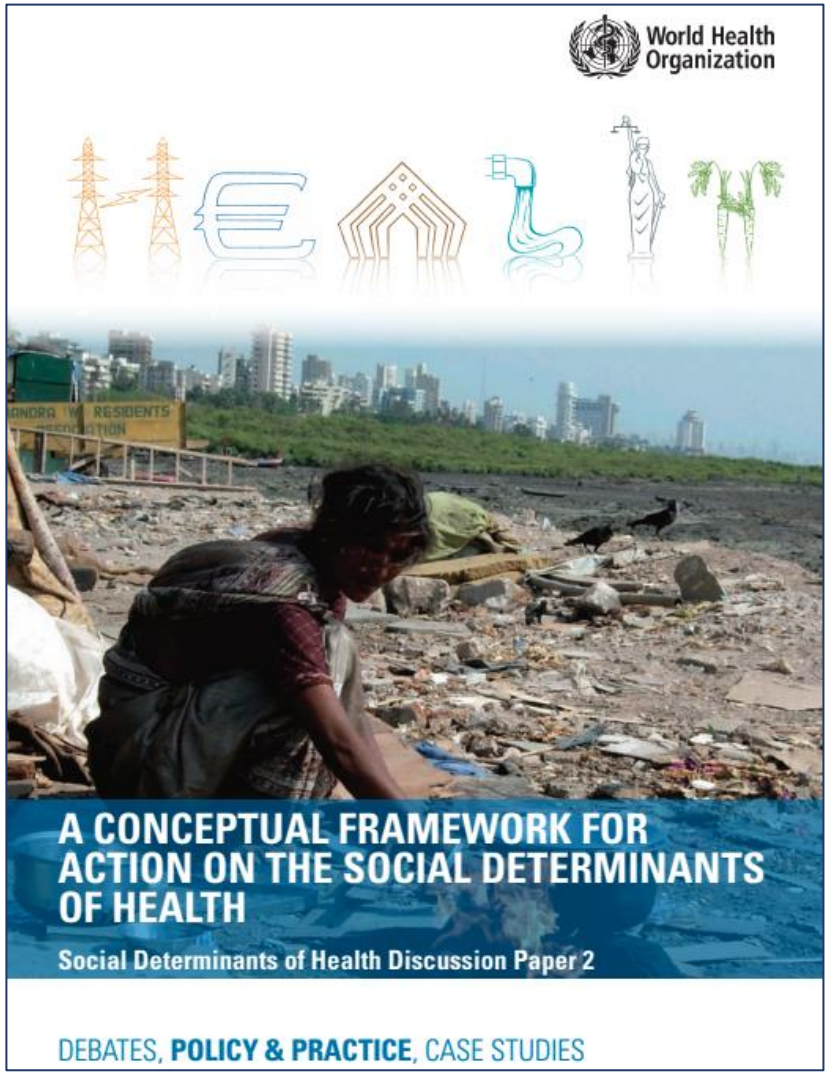
WHO Conceptual Framework



Human Rights → Policy Choices → More equitable outcomes

Link to Resource: [WHO Conceptual Framework]

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Link: To Publication

ACP Policy Recommendations:

1. Increased efforts to evaluate and implement public policy recommendations.
2. The SDOH should 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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Link: To Publication

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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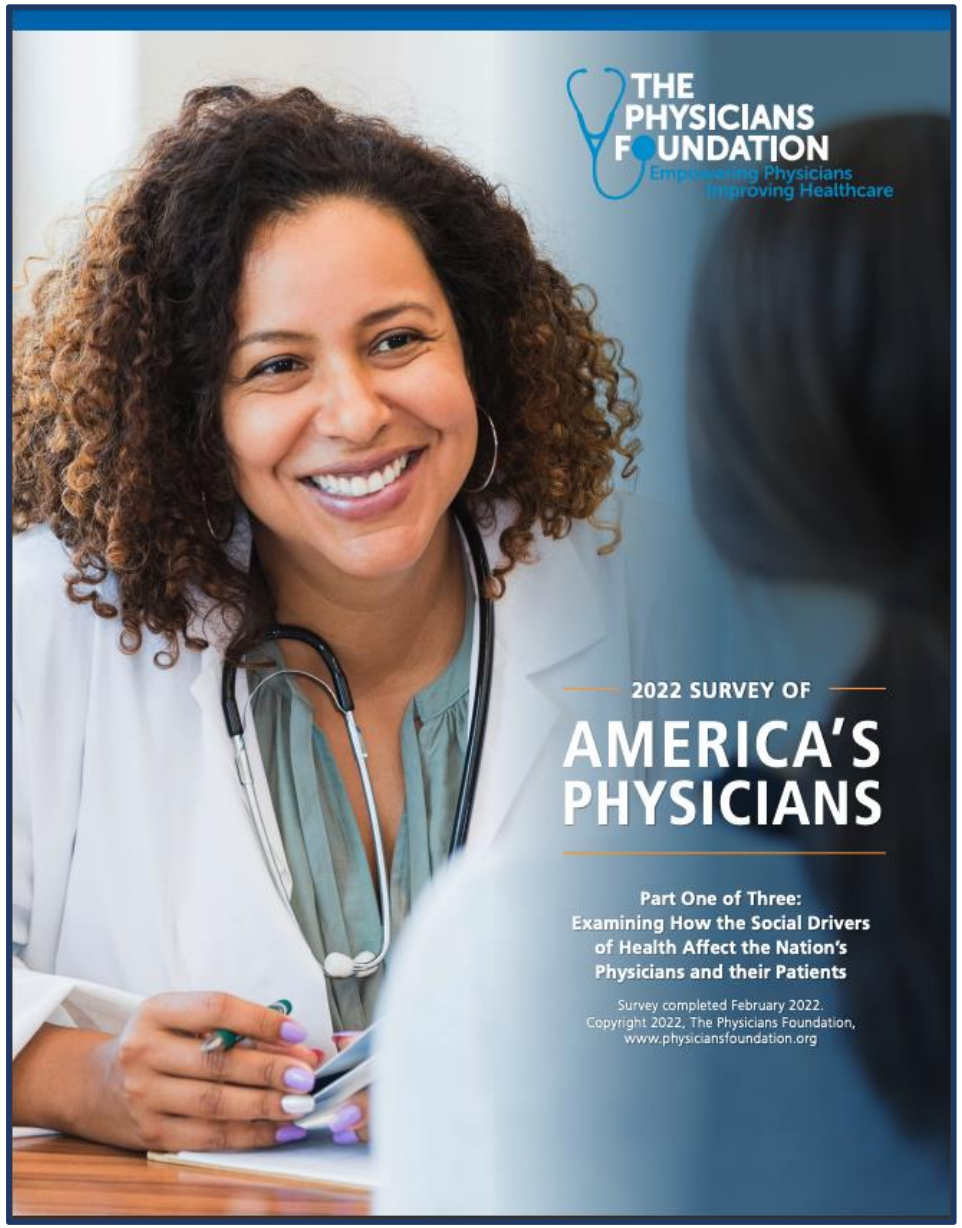

[Link: To Publication]

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

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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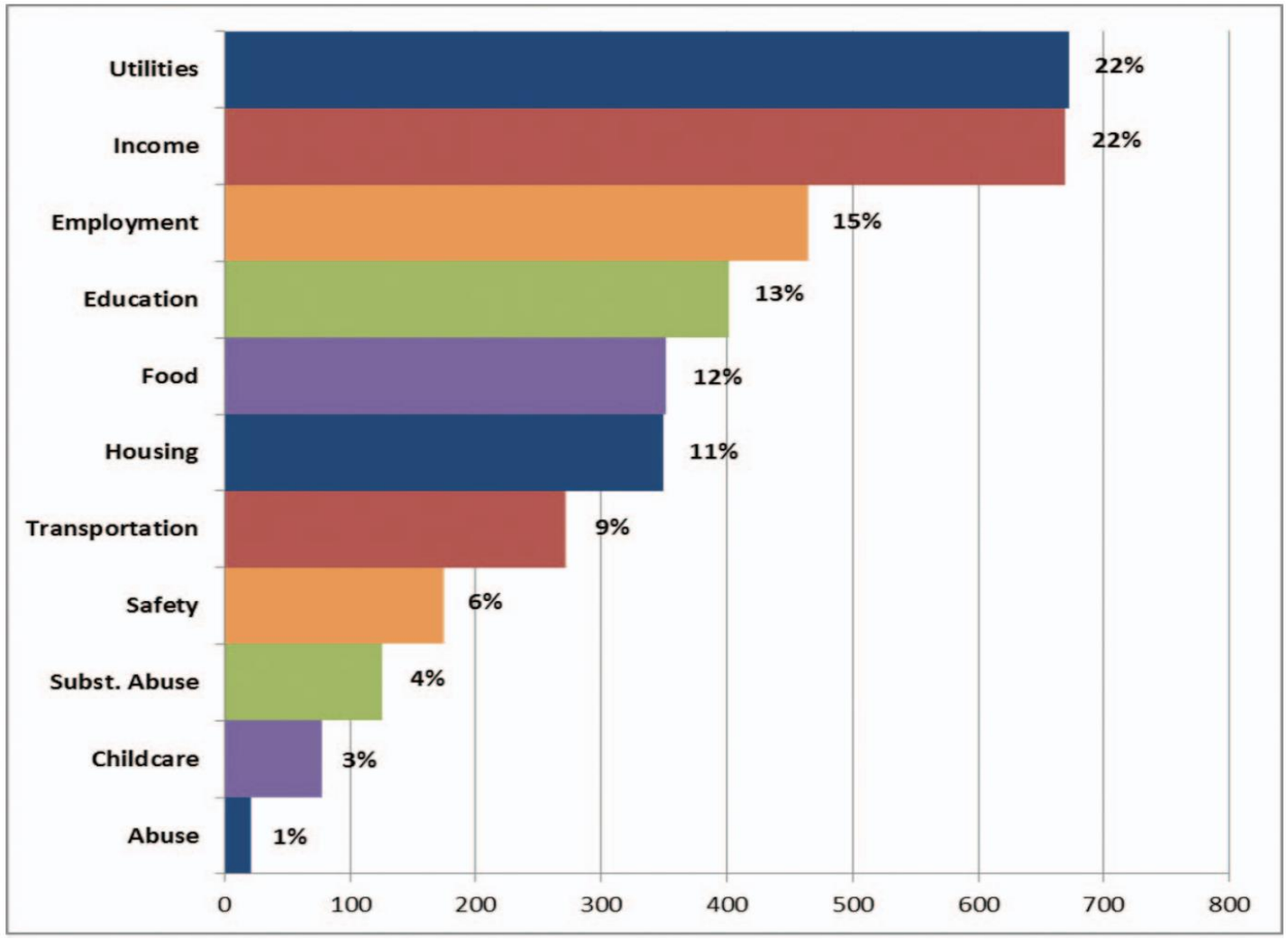
WellRx Pilot, University of New Mexico



Institutional interest in SDOH policies

↓

Grant to develop SDOH screening tool

↓

Creation of screening tool using 11 domains

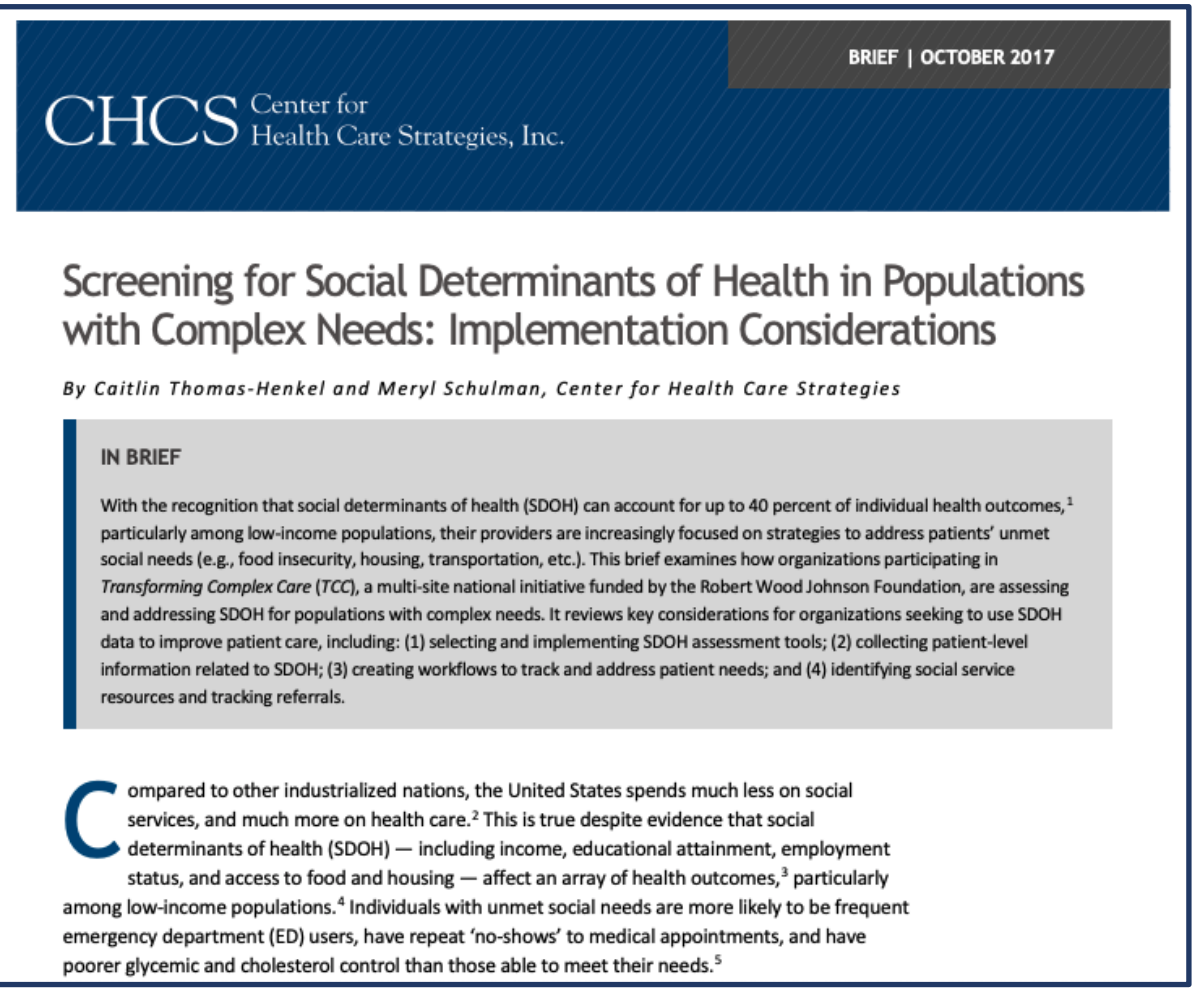
↓

Integration with Community Health Workers (CHWs)

↓

Tool Pilot with social services screening

[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]

[Link: To Publication]

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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Integration of SDOH policies and frameworks into health center management, workflow and patient care is complex and difficult.

A body of research has indicated that evolving workplace culture to place greater value on the SDOH can lead to more comprehensive care of patients, and less burnout in our workforce.

Please take 3 minutes to consider the following:

How has your organization, or individuals in your organization helped to aid this evolution?

How can workplace culture be altered to further advance the SDOH in your community?

Your participation and opinion are greatly appreciated.

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.
- Training and patient-facing materials for Haitian Creole speaking patients/workforce.

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Wrap-up:

Please take this time to mention anything you would like to address further related to the SDOH, clinical practice and health center management.

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Next Session Reminder

- **Session 3: Next Wednesday, June 14th at 1:00 pm EDT.**
- **Use the same registration link for today's session.**
- **Registration link:** https://us06web.zoom.us/meeting/register/tZwodeyprTwsH9Sn6Dcc5wd6H2AcaZ9u4sno#/registration

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Q&A Session

Complete our Post Evaluation Survey

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Thank you!