The Social Determinants of Health: Integration into clinical practice

Session 4: SDOH program design and workplace management

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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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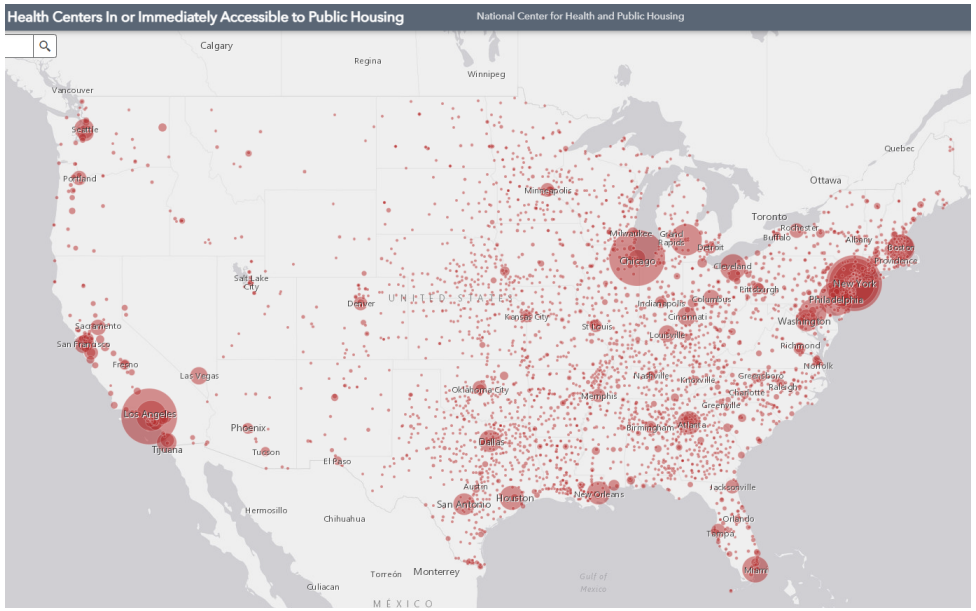
Housekeeping

- 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

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

Through an examination of the literature and engagement in case studies we will review the following:

1. **Discuss processes for institution of SDOH pilots.**
2. **Review the adaptation of SDOH Screeners to community needs.**
3. **Discuss the impact of SDOH policies on burnout and employee psychological wellbeing.**

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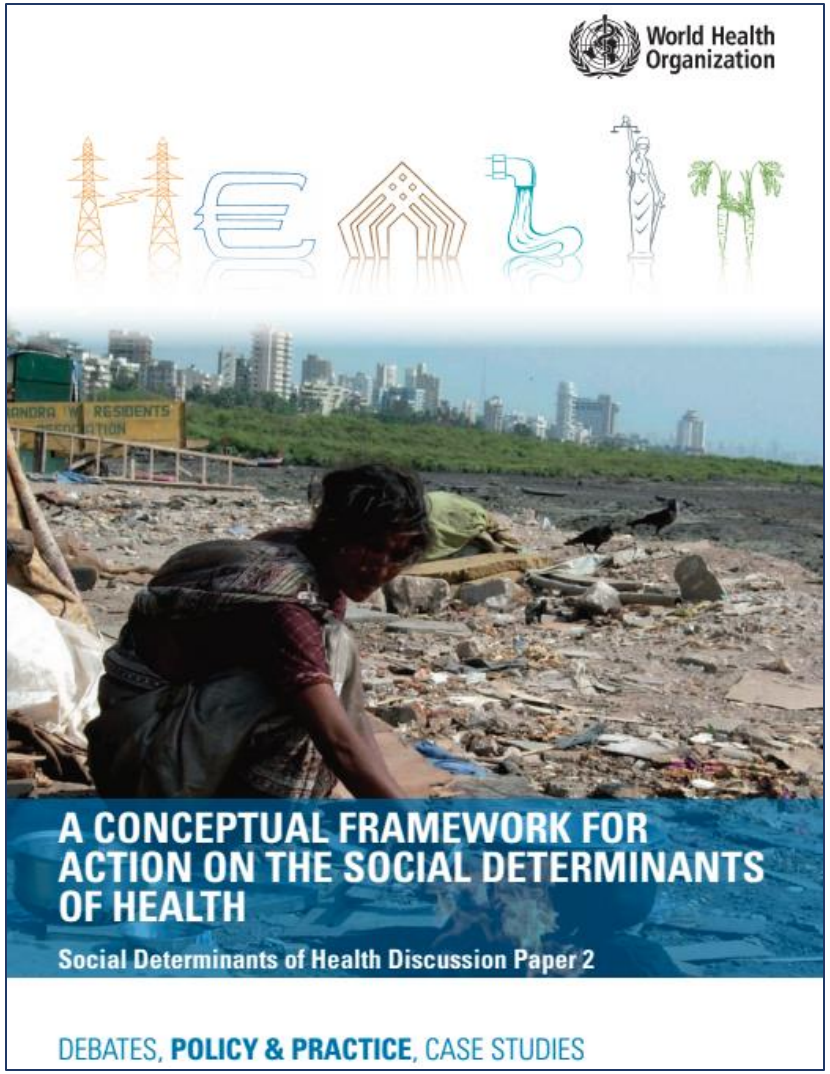
WHO Conceptual Framework



Human Rights → Policy Choices → More equitable outcomes

Link to Resource: [WHO Conceptual Framework]

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The SDOH: Conceptual Overview

Link to resource: [Healthy People 2030]

Case study – the impact of SDOH screeners on patient care and hospital management:

Mrs. Wilson is a 54 year-old female with a PMH significant for T2DM, CKD stage II and depression who presents in the ED with complaints of frequent falls.

When Mrs. Wilson enters the ED, she is processed by the intake nurse. Vitals and intake are performed along with an SDOH screener. She is sent to an an exam room and receives a complete physical and laboratory examination. Results indicate persistent low-grade tachycardia and mild hyponatremia.

Review of PMH indicates a similar occurrence in 2017.

She is diagnosed with syncope and told to follow-up with her PCP in 3 days.

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Case study – the impact of SDOH screeners on patient care and hospital management:

One week later, Mrs. Wilson is seen in the same ED for a head injury. During her physical examination, she mentions that she frequently feels dizzy, falls 2-3 times per month and that alterations to her medication have not altered this frequency. Due to scheduling conflicts, she was unable to see her PCP since her last visit to the ED.

On closer questioning, Mrs. Wilson mentions that when these instances occur, she feels overwhelmed and “looses control of her body”.

Mrs. Wilson is admitted to the hospital where she stays for 3 days as her electrolytes stabilize. She is seen by social services who again perform an SDOH screener.

Before discharge, Mrs. Wilson is again seen by social services who network her to services during a 20-minute consultation. The screener is performed again at this time.

Please consider the following question:

In her examination by hospital staff, Mrs. Wilson underwent multiple SDOH screeners. Considering the case, how do you think this impacted her?

Were there areas of hospital workflow that could be altered to ensure more judicious use of the SDOH screener?

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

Mrs. Wilson is a 54 year-old female with a PMH significant for T2DM, CKD stage II and depression who presents in the ED with complaints of frequent falls.

When Mrs. Wilson enters the ED, she is processed by the intake nurse. Vitals and intake are performed along with an SDOH screener. She is sent to an an exam room and receives a complete physical and laboratory examination. Results indicate persistent low-grade tachycardia and mild hyponatremia. Screener results indicate significant barriers to housing, employment and food resources.

Review of PMH indicates a similar occurrence in 2017.

She is diagnosed with syncope and told to follow-up with her PCP in 3 days.

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Before discharge, Mrs. Wilson is again seen by social services who network her to services during a 20-minute consultation. The screener is performed again at this time.

Structural limitations at this institution.

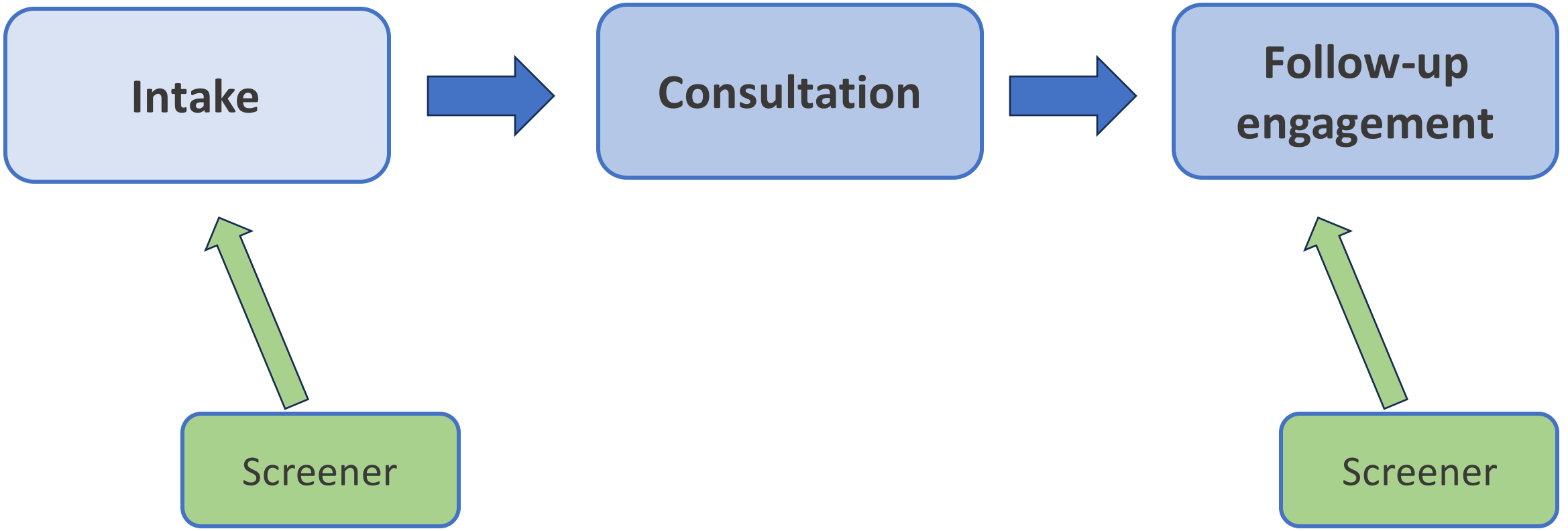
1. Lack of organized framework dictating when the SDOH screener is performed results in overuse of screeners.

2. Poor systems for tracking SDOH screeners result in duplication of efforts and limited ability to compare screening results.

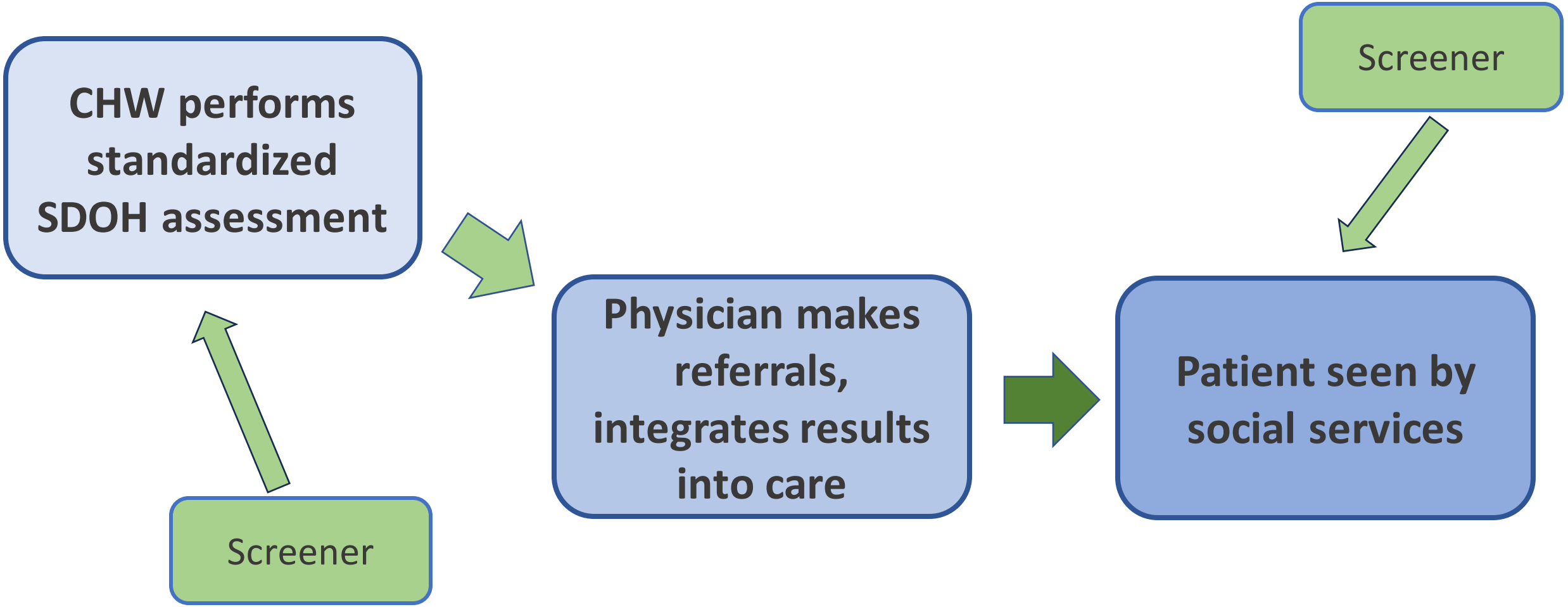
3. Multiple screeners results in fatigue in staff and patient, limiting resource navigation at key instances in the patient care continuum.

4. Significant organization resources are being spent without an appropriate impact on the community.

The use of SDOH Screening tools: Application



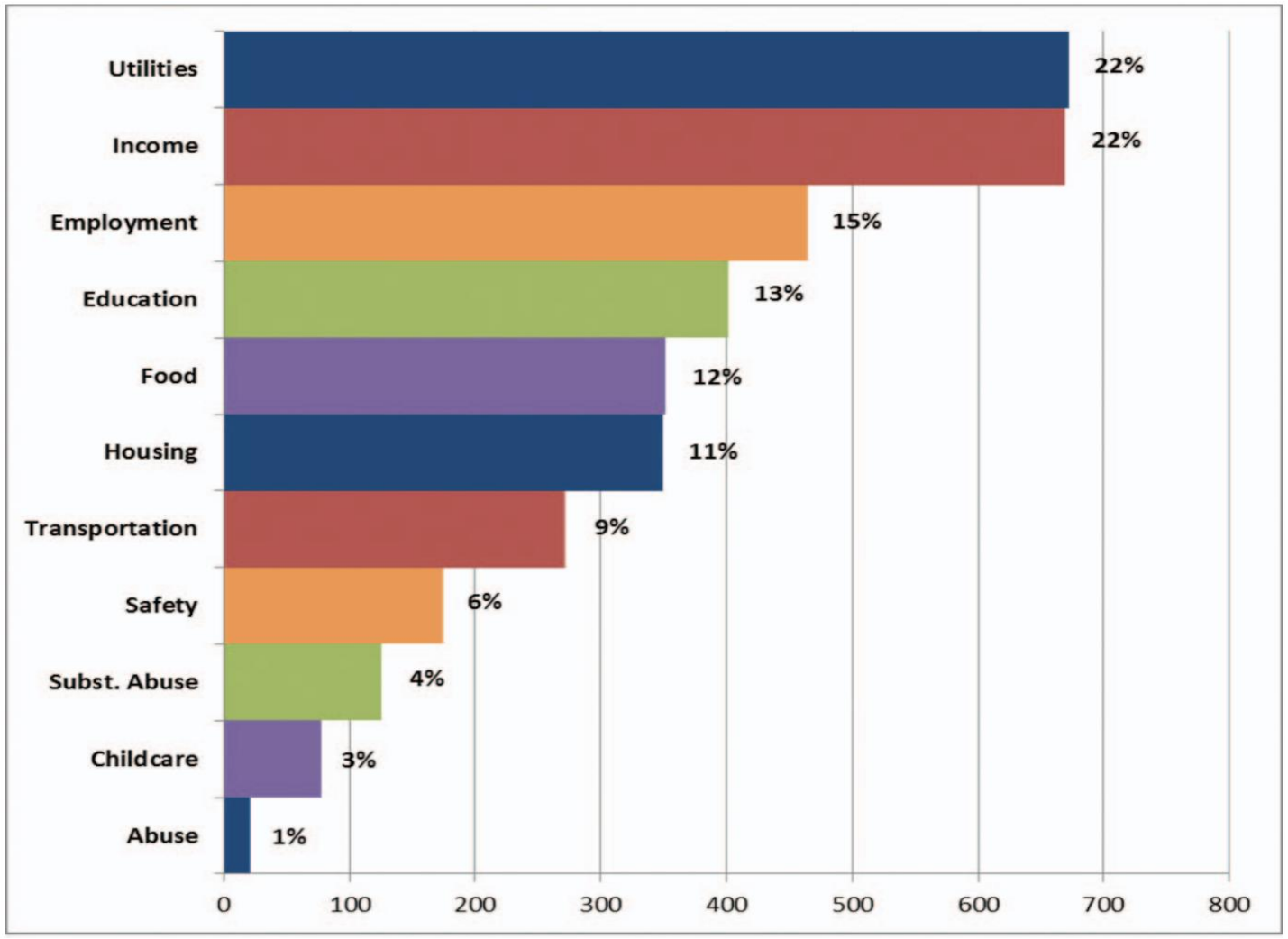
The use of SDOH Screening tools: Application



WellRx Pilot, University of New Mexico

[Link: To Publication]

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]

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

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1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

_____ Yes _____ No

2. Are you homeless or worried that you might be in the future?

_____ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

_____ Yes _____ No

4. Do you have trouble finding or paying for a ride?

_____ Yes _____ No

5. Do you need daycare, or better daycare, for your kids?

_____ Yes _____ No

Link: To Resource

_____ Yes _____ No

6. Are you unemployed or without regular income?

_____ Yes _____ No

7. Do you need help finding a better job?

_____ Yes _____ No

8. Do you need help getting more education?

_____ Yes _____ No

9. Are you concerned about someone in your home using drugs or alcohol?

_____ Yes _____ No

10. Do you feel unsafe in your daily life?

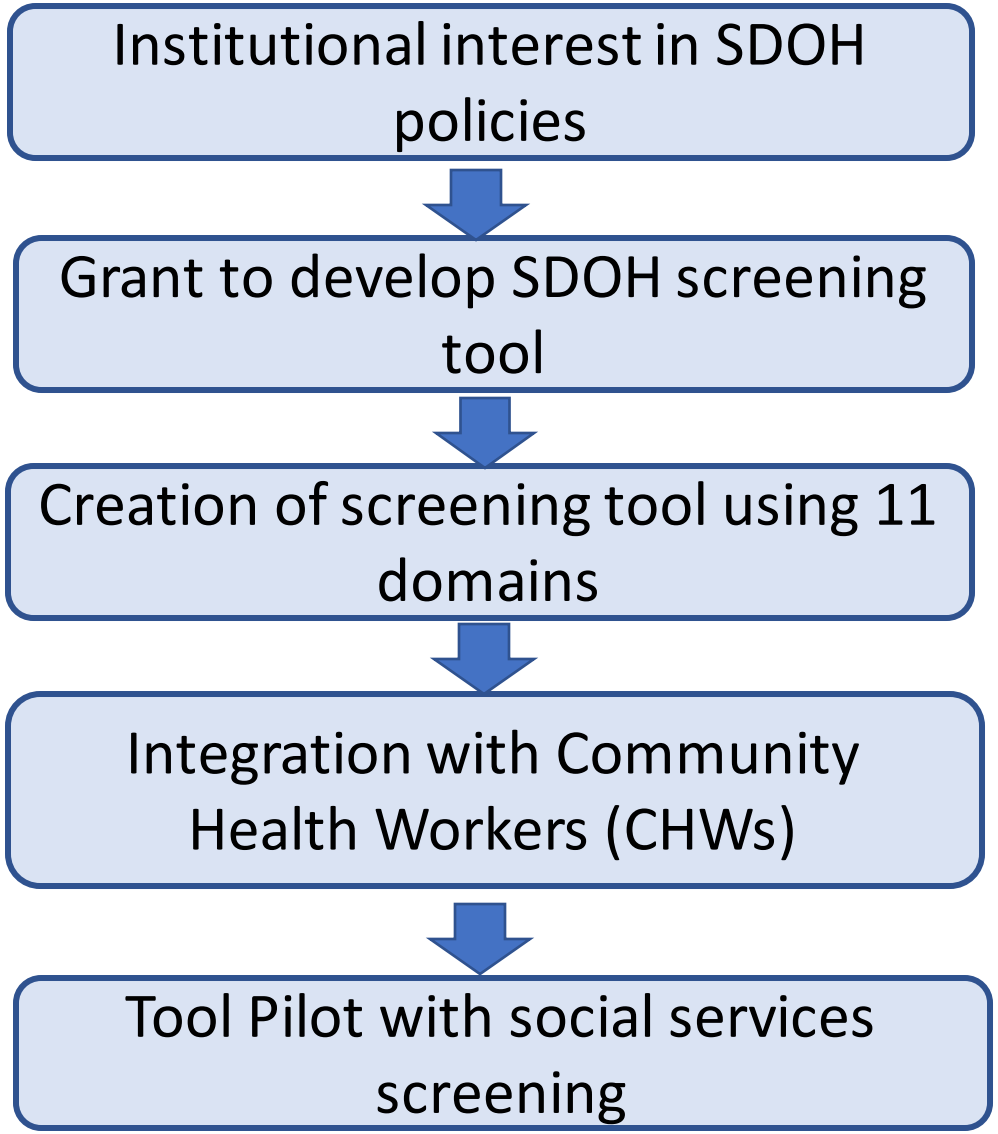
_____ Yes _____ No

11. Is anyone in your home threatening or abusing you?

_____ Yes _____ No

The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

Link: To Resource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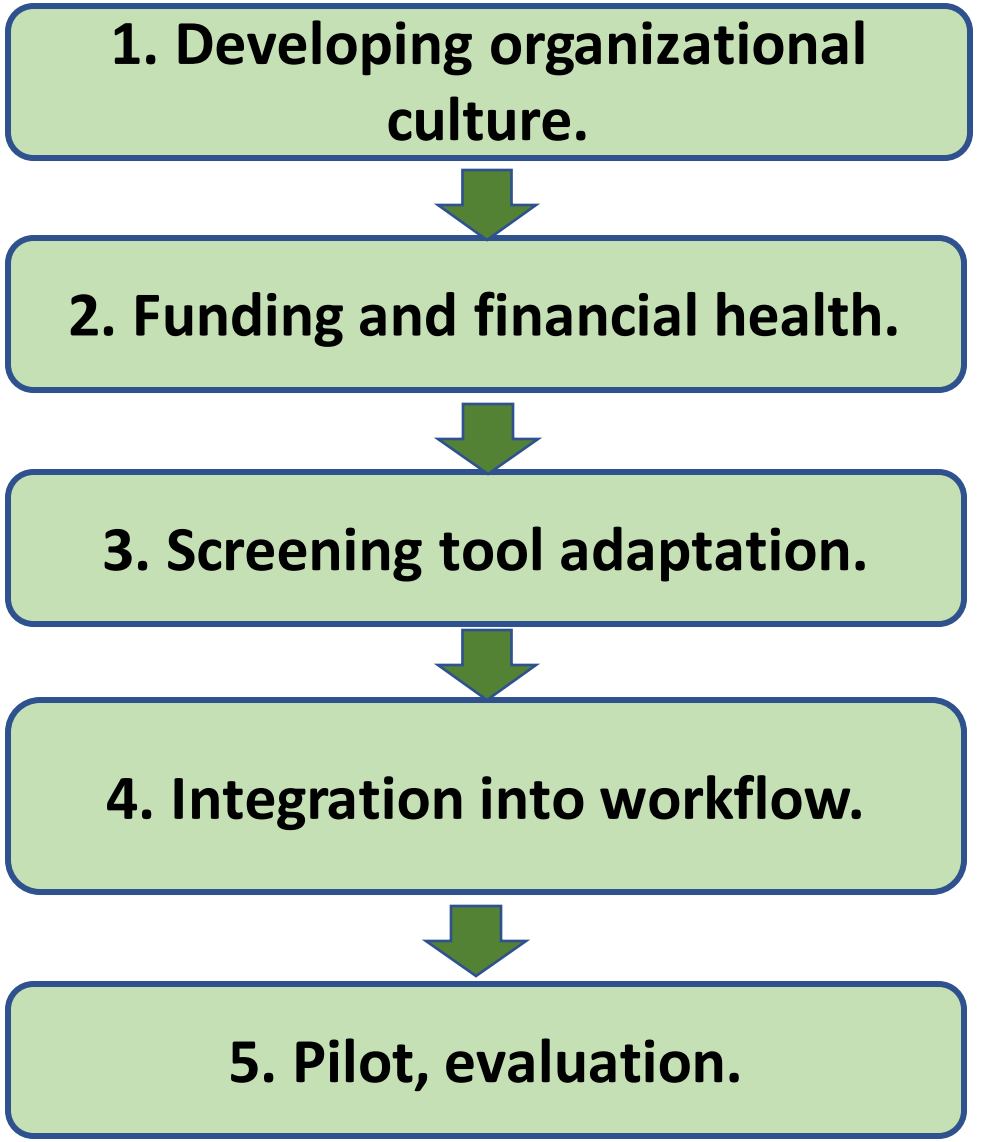
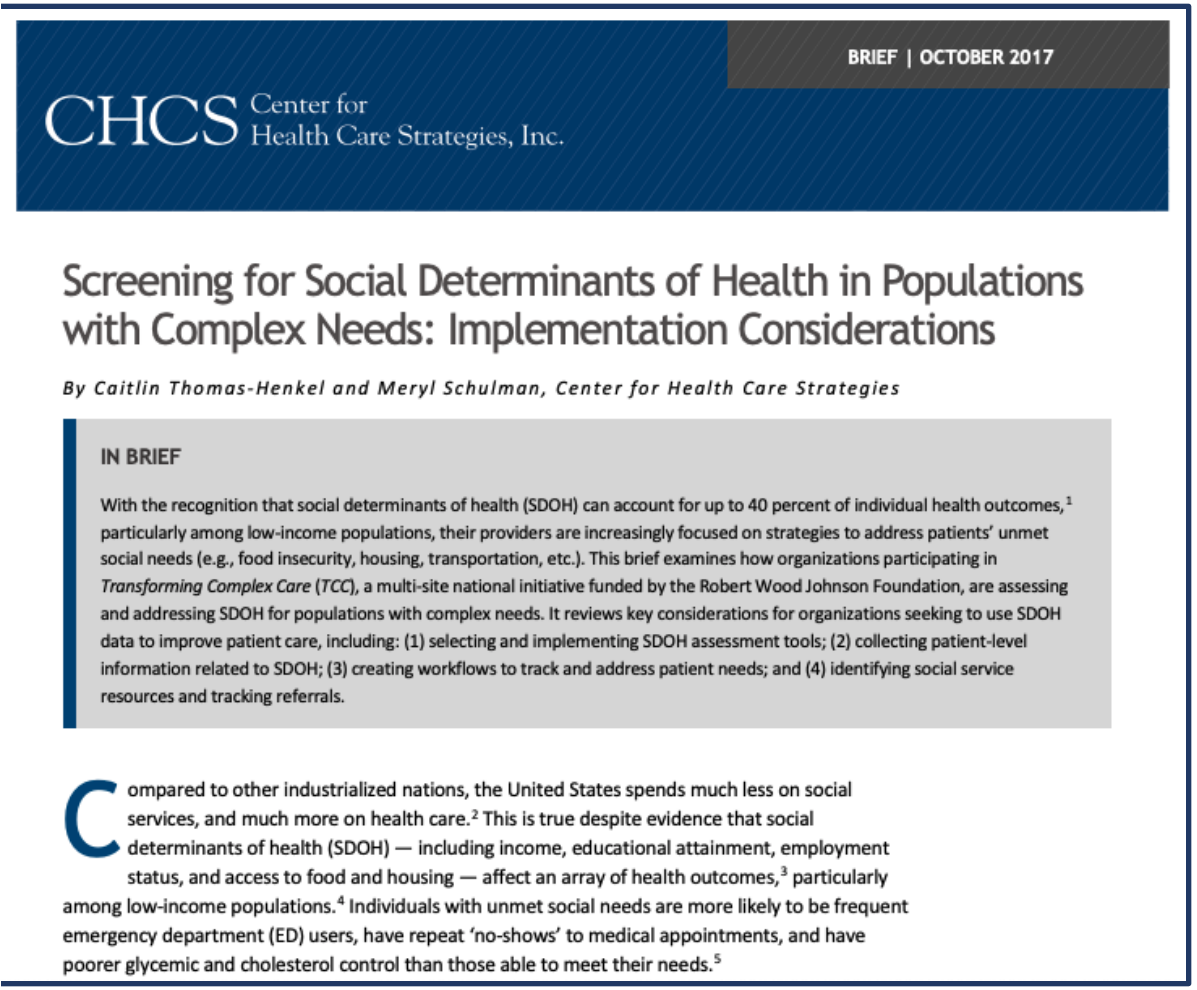

1. Developing organizational culture.
2. Funding and financial health.
3. Screening tool adaptation.
4. Integration into workflow.
5. Pilot, evaluation.



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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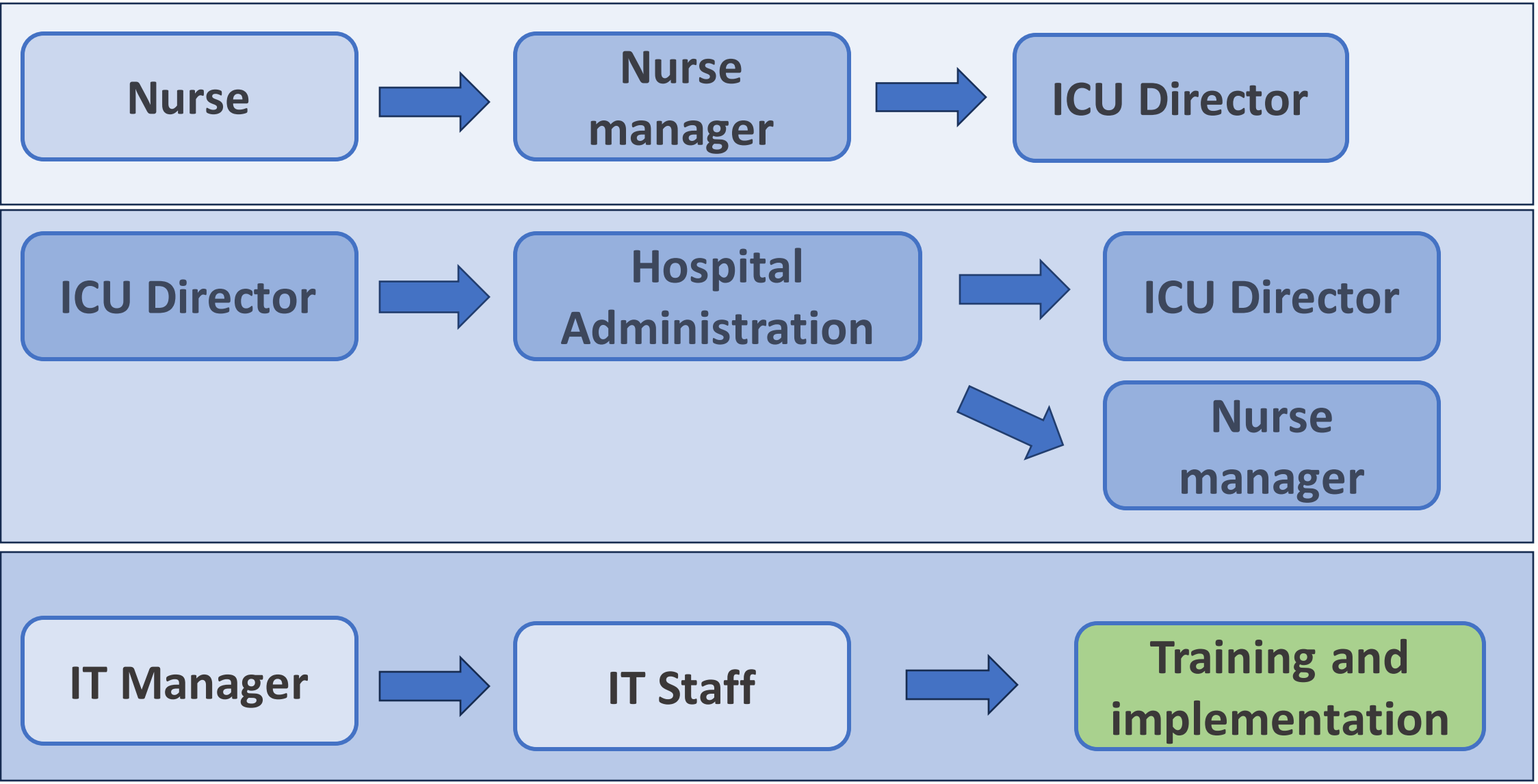
FY23 Omnibus Budget Bill (passed)

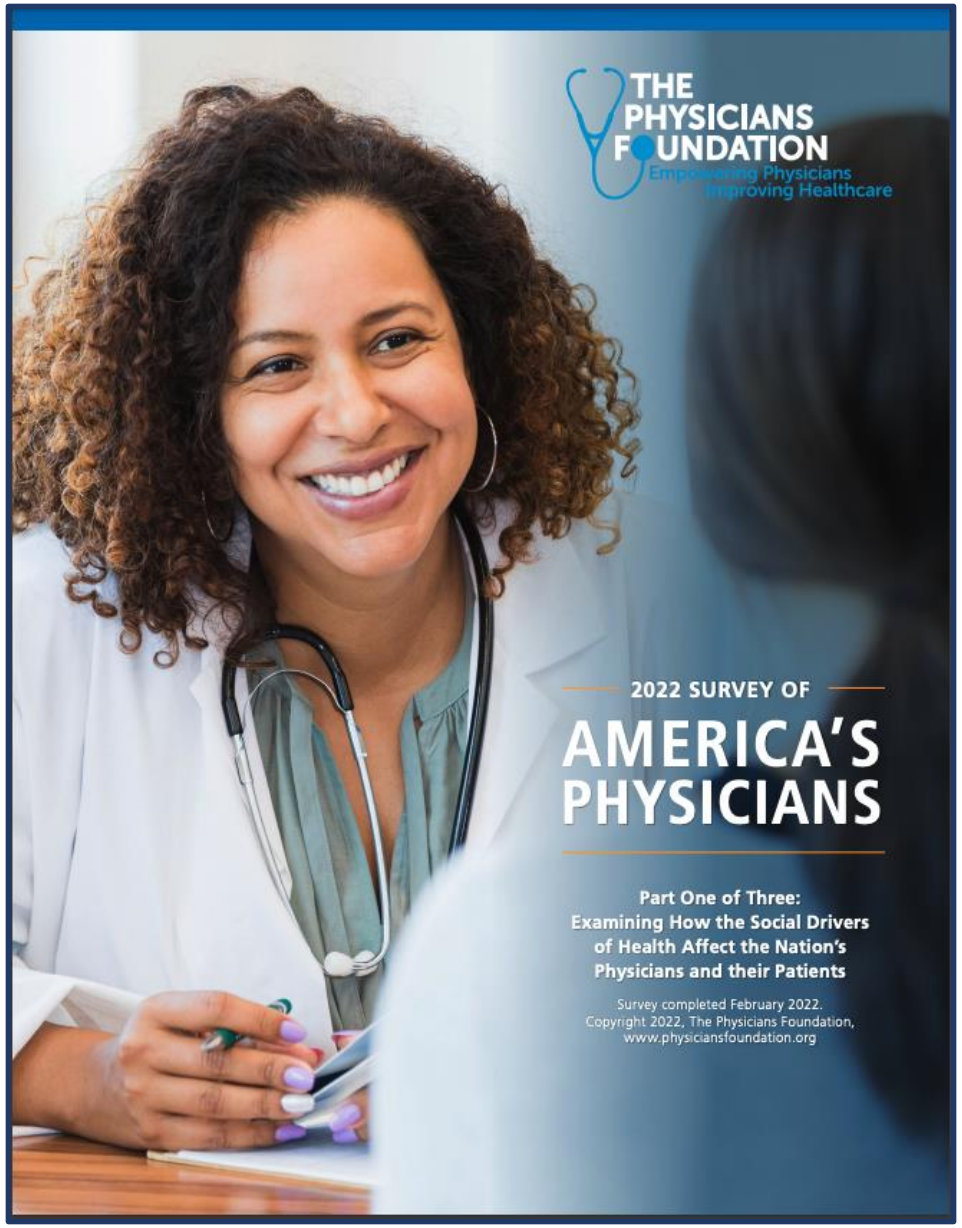
Sec. 1616. (1) By September 30 of the current fiscal year, **the department shall seek federal authority to formally enroll and recognize community health workers as providers and to utilize Medicaid matching funds for community health worker services, including the potential of leveraging of a Medicaid state plan amendment, waiver authorities, or other means to secure financing for community health worker services.** The appropriate federal approval must allow for community health worker services on a **statewide** basis and must not be a limited geography waiver. The authority should allow the application of community health worker services statewide and maximize their utility by providing financing that includes fee-for-service reimbursement, value-based payment, or a combination of both fee-for-service reimbursement and value-based payment for all services commensurate to their scope of training and abilities as provided by evidence-based research and programs.

(2) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the progress of meeting the requirements in subsection (1).

Link: To Resource

EHR intervention and remediation





[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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Capacity to Address Social Needs Affects Primary Care Clinician Burnout

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ABSTRACT

PURPOSE Primary care clinicians disproportionately report symptoms of burnout, threatening workforce sustainability and quality of care. Recent surveys report that these symptoms are greater when clinicians perceive fewer clinic resources to address patients' social needs. We undertook this study to better understand the relationship between burnout and clinic capacity to address social needs.

METHODS We completed semistructured, in-person interviews and brief surveys with 29 primary care clinicians serving low-income populations. Interview and survey topics included burnout and clinic capacity to address social needs. We analyzed interviews using a modified grounded theory approach to qualitative research and used survey responses to contextualize our qualitative findings.

RESULTS Four key themes emerged from the interview analyses: (1) burnout can affect how clinicians evaluate their clinic's resources to address social needs, with clinicians reporting high emotional exhaustion perceiving low efficacy even in when such resources are available; (2) unmet social needs affect practice by influencing clinic flow, treatment planning, and clinician emotional wellness; (3) social services embedded in primary care clinics buffer against burnout by increasing efficiency, restoring clinicians' medical roles, and improving morale; and (4) clinicians view clinic-level interventions to address patients' social needs as a necessary but insufficient strategy to address burnout.

CONCLUSIONS Primary care clinicians described multiple pathways whereby increased clinic capacity to address patients' social needs mitigates burnout symptoms. These findings may inform burnout prevention strategies that strengthen the capacity to address patients' social needs in primary care clinical settings.

Takeaways:

- SDOH burnout impacts clinicians' ability to meet patient needs.
- SDOH burnout has a severe impact on clinician emotional health and wellbeing.
- Social services in PCP clinics are protective against SDOH burnout.
- Clinicians see in-clinic social services as effective, but insufficient to meet patient needs.

[Link: To Publication]

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Q&A Session

Complete our Post Evaluation Survey

https://www.surveymonkey.com/r/FDLTK68

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Thank you!