Health for all -Increasing inclusion for people with disabilities

Learning collaborative session 4:

Kevin Lombardi MD, MPH
Manager of Health Research, Policy and Advocacy
The National Center for Health in Public Housing

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

National Center for Health in Public Housing

- 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.

NCHPH
National Center for Health in Public Housing

Today's speakers

Fide Pineda Sandoval, CHES
Manager of Training and Technical Assistance

Kevin Lombardi MD, MPH
Manager of Policy, Research, and Health Promotion

Jose Leon MD
Chief Medical Officer

NCHPH
National Center for Health in Public Housing

Health for All LC: Curriculum Description

Understanding the perspective of individuals experiencing disability:

This session will include the following material (overview):

In our final session we will engage collectively with data, research and case studies which outline the clinical and non-clinical realities faced by individuals with different types of disability. This will include:

1. Case Study Review
2. Recent Data Overview
3. Review of recent publications and resources on the topic

This session is designed to illicit discussion, process sharing and support between colleagues. The session framework will reflect these priorities. The – Discussion – Support – Assistance model describes NCHPHs approach to Training and Technical Assistance

Discussion

- Two discussion questions are integrated into the session material.
- Participants are asked to please write or type their response and to be open to share.

Support

- Participants include a range of clinical and non-clinical professionals from FQHC's, PHPCs and PHAs around the country.
- This interdisciplinary support can be an asset to better understanding the challenges your organization is facing.

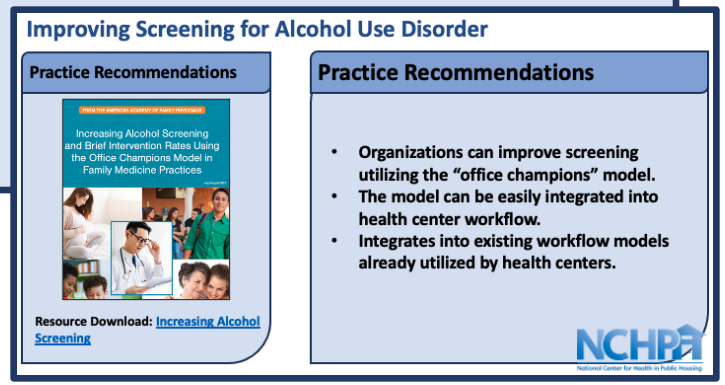
Assistance

- Discussion session format is designed to illicit the main themes in the learning objectives and are related to the resources and recommendations reviewed in this session

NCHPH presentations are designed to be utilized as external resources by FQHCs PHPCs and PHAs these can be freely circulated to partners and colleagues as needed.

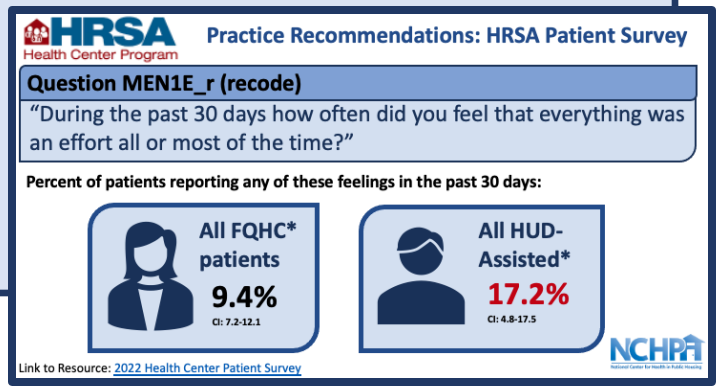
Research and Clinical Resources

- Cited resource links are located at the bottom right of the slides.
- Resources are publicly available and can shared internally or externally.
- Cited research is investigated and validated during a structured review process.



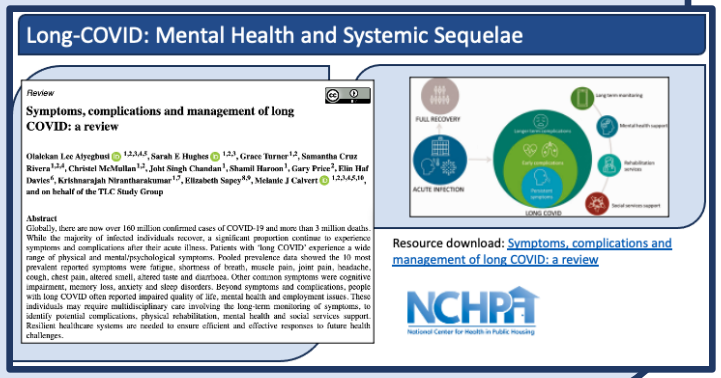
Guidance and Recommendations

- Recommendations are based on NCHPH internal research or validated external research.
- Practice recommendations presented are reviewed and validated by the NCHPH team.



Support and Consultation Resources

- NCHPH staff members and SMEs are available to FQHCs, PHPCs, PHAs and partner organization for consulting and advising services.



Link to Resource: NCHPH

NCHPH
National Center for Health in Public Housing

National Center for Health in Public Housing

Learning Collaborative Session 3

Please take a moment to type your response to the following:

Where are you joining us from?

What is your role at your organization?

Improving Primary Care Access for Patients with Disability

36% of individuals of individuals with disabilities have delayed or missed needed health care in the last year and almost half have yet to schedule missed primary or preventive health care

40.7% of physicians were very confident about their ability to provide the same quality of care to patients with disabilities, and

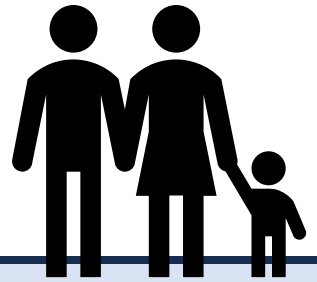
56.5% of physicians strongly agreed that they welcomed patients with disability into their practices.

Facilitating a strong relationship between patients with disabilities and their primary care physicians is among the most effective and well studied ways of improving outcomes

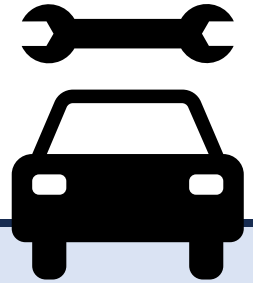
NCHPH
National Center for Health in Public Housing

Home Visitation Services Utilized by Health Centers

Health Centers Utilize Home utilize a variety of practices to improve access to primary care amongst patients with disabilities



Many Health Centers have had success using Home Visits utilizing CHWs and social services personnel.



Many patients with disabilities struggle with access to transportation. Health centers can improve access to primary care.

Home safety checks are utilized by health centers to lower fall risk for patients older adults who were recently discharged from the hospital

National Center for Health in Public Housing

Practice Recommendations: UDS Data

What the data tells us:

FQHCs

2.6%

CI: 1.9-3.5

PHPCs

6.5%

CI: 3.0-13.7

Patients of PHPCs are **2.5 times as likely** to have received a home visit by their Health Center than those from other FQHCs.

Program interventions:

Residents of Public Housing are more reliant on home visit than other demographics

For PHPCs home visits offer unique opportunities to reach patients

Link to Resource: [2022 Health Center Patient Survey]

Marketing Preventative Services

Emphasize Convenience

Reduce Stigma

Increase Access to Care

Case Study: Supporting Patients with Housing Instability

Mr. Tsu is a 67 year-old man who presents for a wellness exam. He has a past medical history of spinal chord injury with paraplegia, T2DM and hypertension. The patient has a behavioral health history of Major Depressive Disorder (MDD), and Generalized Anxiety Disorder (GAD). Mr. Tsu utilizes a wheelchair for mobility. He has not seen his primary care physician since 2018 and does not have medical insurance.

The patient undergoes a standard intake, including vitals and an SDOH screener. The results are as follows:

BP: 188/98
HR: 98
RR: 18

A review of Mr. Tsu's medical records indicates the following:

Vitals (2018):
BP: 130/98
HR: 60
RR: 18

HbA1c: 7.0

Prescribed Medications: Metformin, Chlorothiazide, Citalopram (Celexa)

National Center for Health in Public Housing

The results of Mr. Tsu's SDOH screener reveal the following:

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

---

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

National Center for Health in Public Housing

_____ 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

Link: To Resource

National Center for Health in Public Housing

Case Study: Supporting Patients with Housing Instability

Mr. Tsu is treated by his provider. Upon physical examination Mr. Tsu is noted to be withdrawn and to exhibit closed body language. His responses are terse, and he seems depressed. His physical examination is positive for 1+ pitting edema and darkened skin around his neck and groin area. New results are positive for an HbA1c of 8.2. His depression screen is positive.

When Questioned Regarding the Results of His SDOH Screener and exam Mr. Tsu Reveals the following:

1. Mr. Tsu was the victim of a car accident in 2004 that resulted in a severe lumbar spinal injury
2. Mr. Tsu previously had a remote job as a cybersecurity analyst. He was laid off 8 months ago.
3. Mr. Tsu was previously receiving unemployment, which ran out 60 days ago.
4. Mr. Tsu lives in HUD-supported housing and is currently 90 days late on his rent.
5. Mr. Tsu cannot drive and consistently struggles to gain access to transportation.
6. He previously utilized an electric automated mobility device, which has since broken. He know uses a self-propelled wheelchair.
7. Mr. Tsu is single and does not have any family in the area.
8. Mr. Tsu has been taking a half dose of his prescription medications because he can no longer afford the medication.

Mr. Tsu is asked if he is interested in assistance for his SDOH issues (including housing instability) but notes that he does not like doctors. When questioned **he notes that he prefers to deal with his private life by himself. When asked why he notes that in the past he has had difficulty connecting with his providers and that he felt judged.**

National Center for Health in Public Housing

Learning Collaborative Session 4

Please take a moment to type your response to the following:

What SDOH issues provide the greatest barrier to primary care for Mr. Tsu?

How can we ensure that Mr. Tsu can build a relationship with his primary care provider and Health Center?

Case Study: Continuity of Care to Support Patients with Disabilities

Intake

- *Relationship building Screening*
- *Networking.*

Goal Setting

- *Goals set during SDOH Screening.*

Follow-up engagement

- *Keeping focus on goals.*
- *Encouragement and networking.*

Navigation

- *Relationship building, Screening*
- *Networking.*

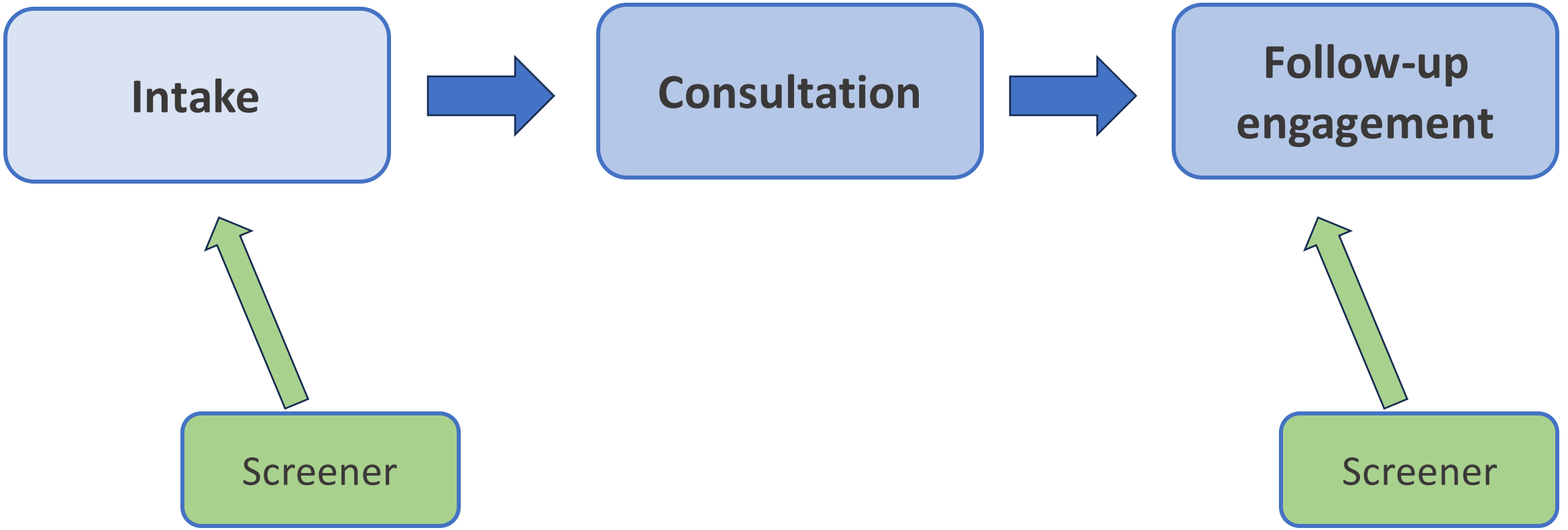
Coaching

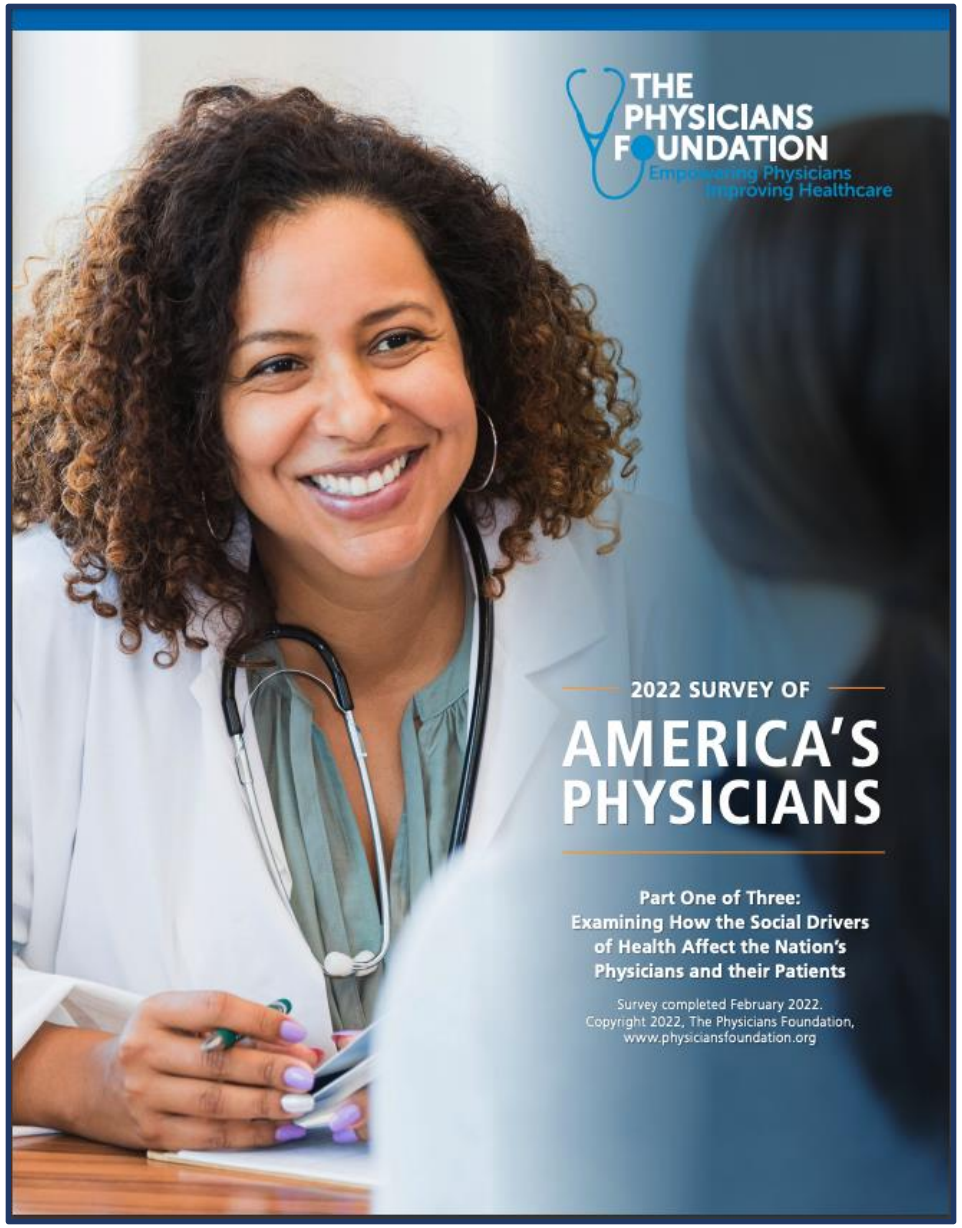
- *Relationship building Screening*
- *Goal achievement.*

Case Closure

- *Closure when all goals are achieved.*

The use of SDOH Screening tools: Application



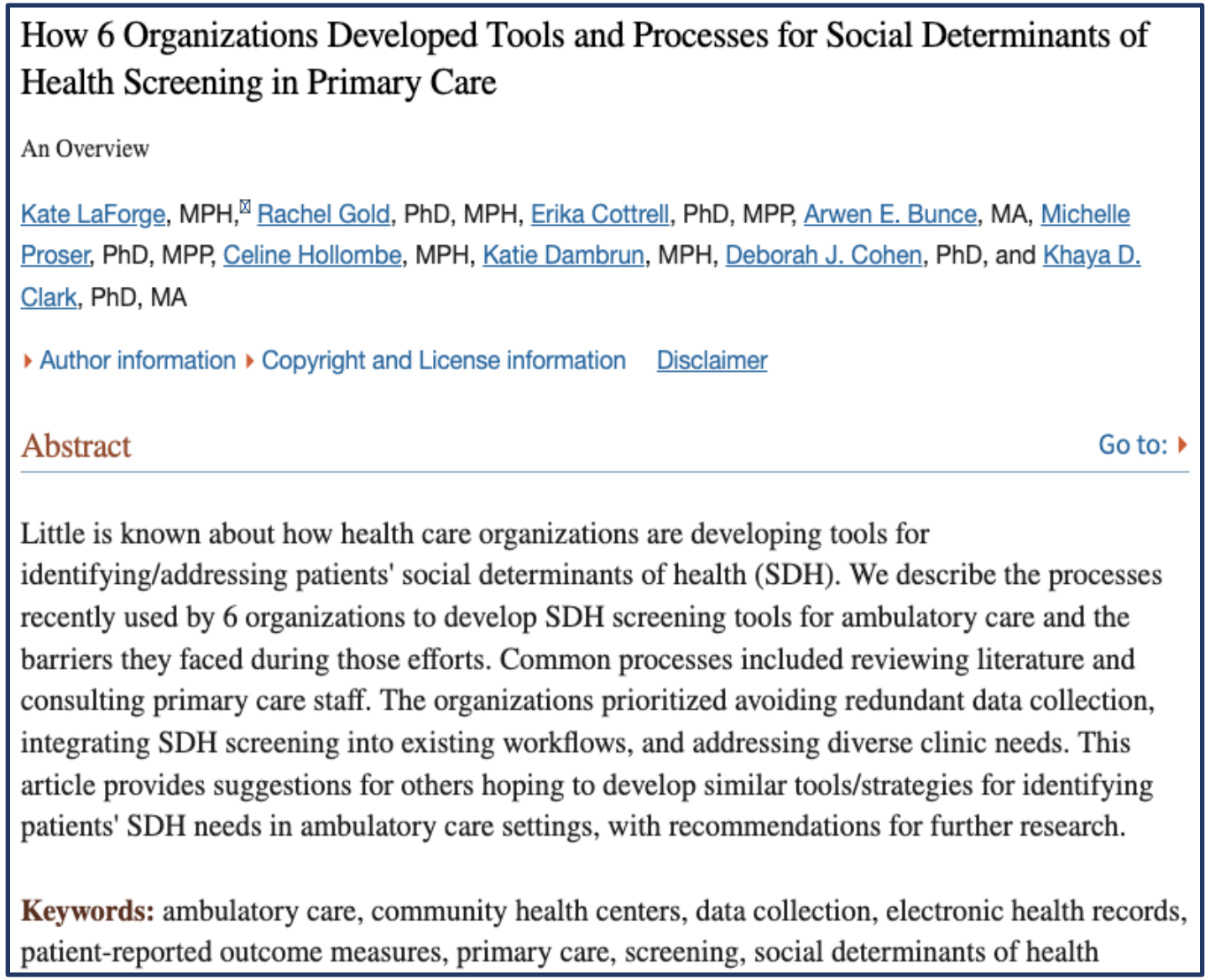


[Link: To Publication]

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.

NCHPH
National Center for Health in Public Housing



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.

NCHPH
National Center for Health in Public Housing

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.

NCHPH
National Center for Health in Public Housing

Capacity to Address Social Needs Affects Primary Care Clinician Burnout

Alina Kung, MD, MS[1]
Telly Cheung, MD[2]
Margae Knox, MPH[3]
Rachel Willard-Grace, MPH[3]
Jodi Halpern, MD, PhD[1,4]
J. Nwando Olayiwola, MD, MPH, FAAFP[5]
Laura Gottlieb, MD, MPH[6,7]

[1]University of California Berkeley–UCSF Joint Medical Program, Berkeley, California

[2]Albany Medical College, Albany, New York

[3]University of California San Francisco, Center for Excellence in Primary Care, San Francisco, California

[4]University of California Berkeley, School of Public Health, Berkeley, California

[5]Department of Family Medicine, Ohio State University College of Medicine, Columbus, Ohio

[6]University of California San Francisco, Department of Family and Community Medicine, San Francisco, California

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.

[Link: To Publication]

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.

NCHPH
National Center for Health in Public Housing

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work

[Link to resource]

Additional considerations for community use of PRAPARE:

1. Housing details related to health and safety.
2. Access to transportation.
3. Location data.
4. Community-specific trauma-informed care.
5. Eviction and debt collection risk.

When altering a screener, be sure to consult your data steward.

National Center for Health in Public Housing

Discussion Section

Please take a moment to type your response to the following:

Please utilize the chat or raise your hand to participate in the discussion.

Q&A Session

Upcoming LC Sessions

Session 4 (03/18/2024): Conclusion and case studies engagements

National Center for Health in Public Housing

Complete our Post Evaluation Survey

National Center for Health in Public Housing

Contact us

Robert Burns
Program Director
Bobburns@namgt.com

Jose Leon, M.D.
Manager of Clinical Quality
jose.leon@namgt.com

Kevin Lombardi, M.D., M.P.H.
Manager of Policy, Research, and Health Promotion
Kevin.lombardi@namgt.com

Fide Pineda Sandoval, C.H.E.S.
Training & Technical Assistance Manager
Fide@namgt.com

Chantel Moore, M.A.
Manager of Communications
Cmoore@namgt.com

Please contact our team for Training and Technical Support
703-812-8822

NCHPH
National Center for Health in Public Housing

Thank you!