Screening for the SDOH Among Persons with HIV Webinar

February 19, 2025

National Center for Health in Public

- 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 $668,800 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.
- 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.

Training and Technical Assistance

Research and Evaluation

Outreach and Collaboration

Increase access, quality of health care, and improve health outcomes

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Speakers and Moderators

Kevin Lombardi MD, MPH
Director of Research

Fide Pineda Sandoval, CHES
Training and Technical
Assistance Manager

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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

Video Conference via

zoom

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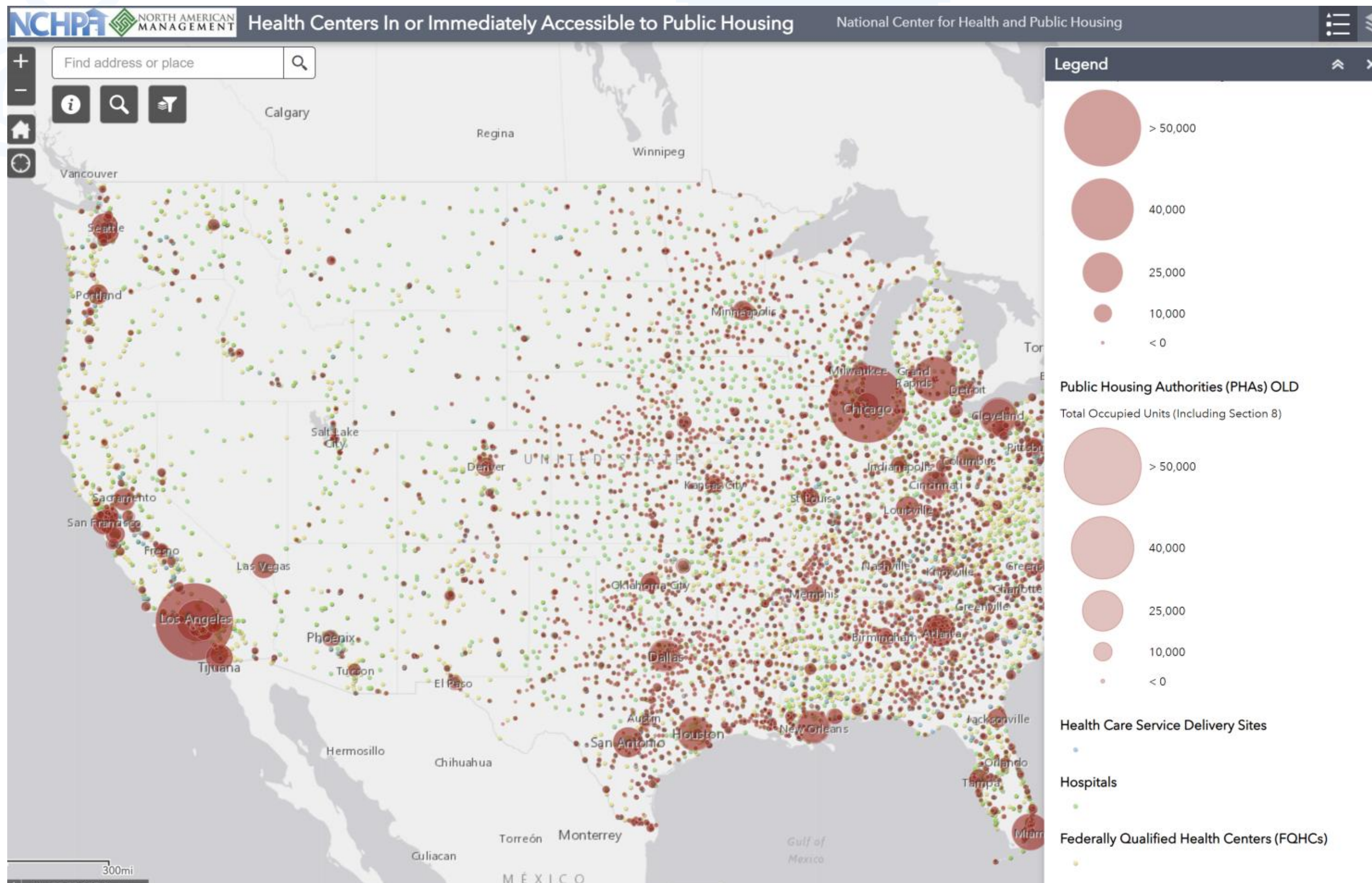
Location of PHPC Health Centers and Public Housing Developments



1,363 Federally Qualified Health Centers (FQHC)=31.2 million patients

475 FQHCs near Public Housing= 6.5 million patients

107 Public Housing Primary Care (PHPC) = 992,815 patients

Source: UDS 2023

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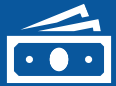
PHPC Health Center Patient Demographics 2023



Below Federal Poverty 77.36%

Female 58.15%

Children 29.96%

Elderly 10.75%

Uninsured 18.9%

Source: UDS 2023

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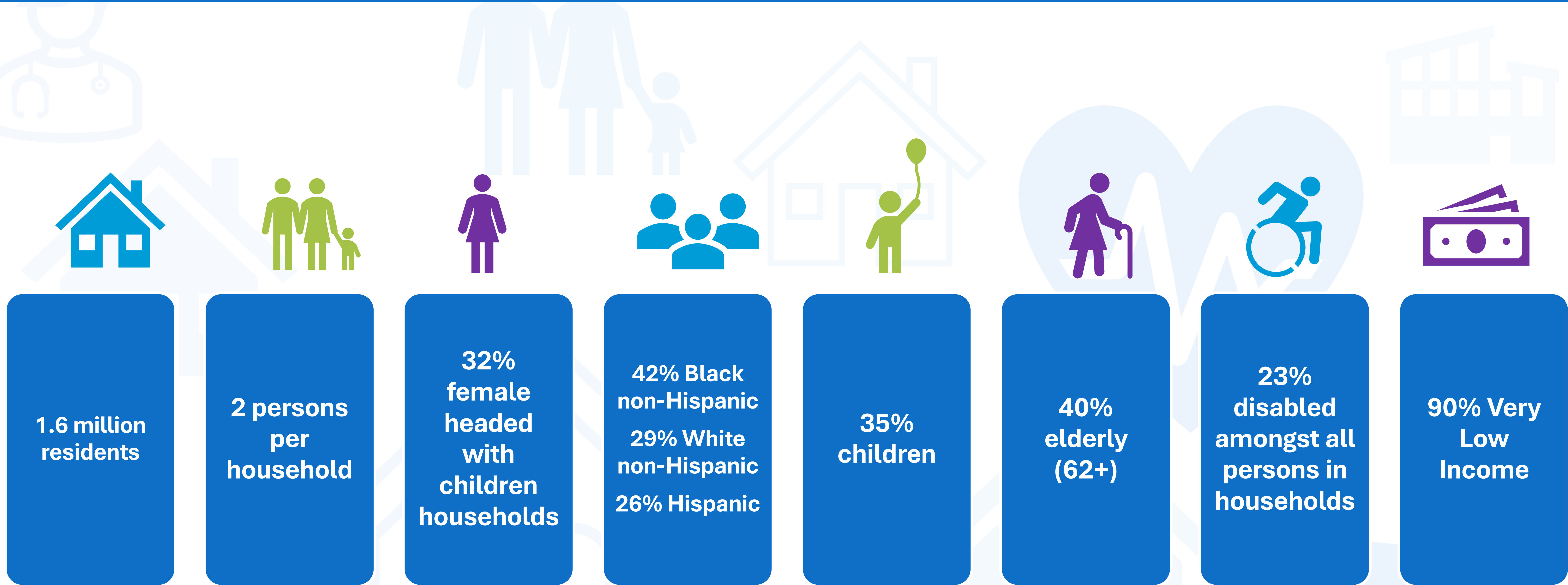
Public Housing Resident Demographics 2023



Source: HUD Picture of Subsidized Adults

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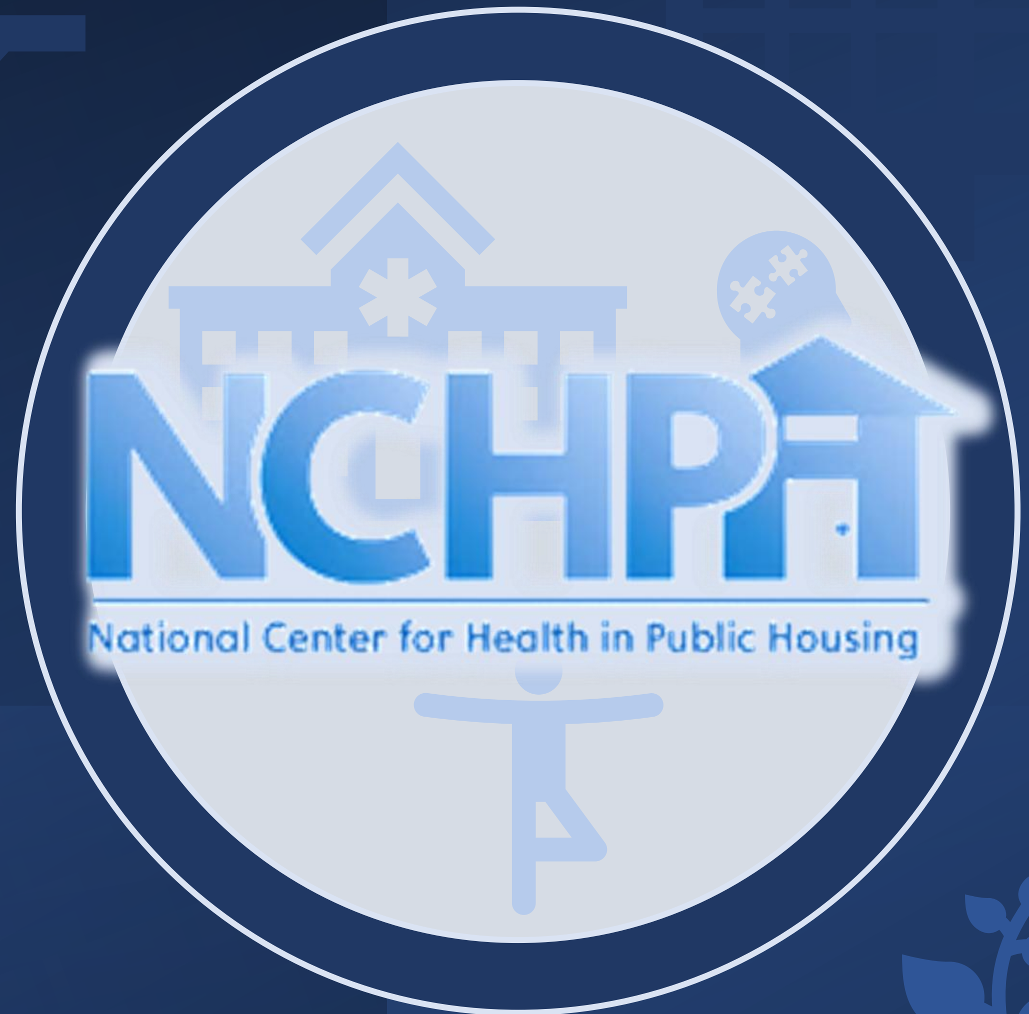
Screening for the SDOH amongst persons with HIV

Dr. Kevin Michael Lombardi MD, MPH

Director of Research
The National Center for Health in Public Housing
North American Management



Dept of Research T/TA Model

Literature Review

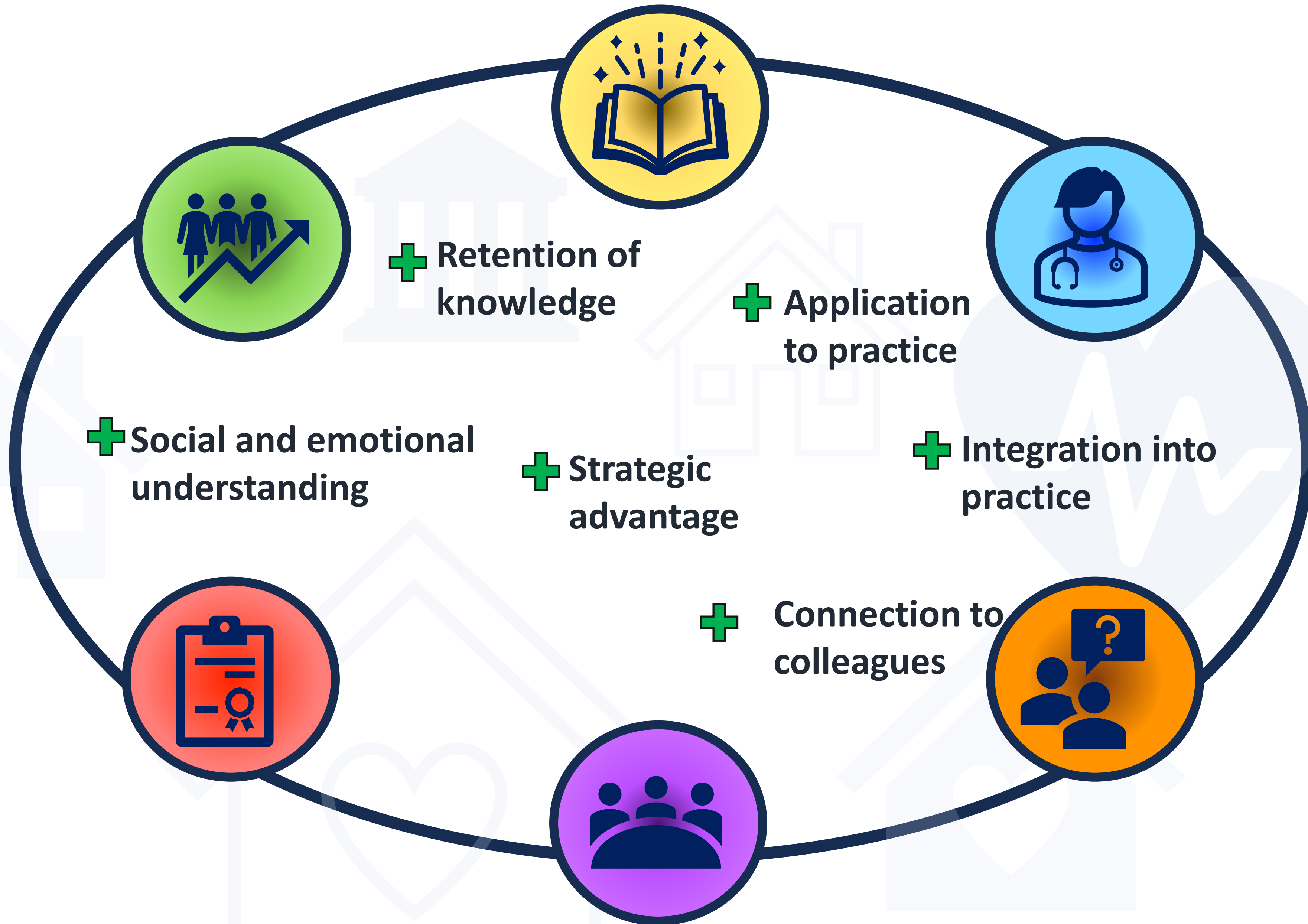
Clinical case review

Epidemiology

Discussion

Findings and recommendations

Implementation and advising



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Screening for SDOH in HIV+ Patients

1

Screening for SDOH and Social Risk Factors in HIV-Vulnerable Populations: Guide for Health Centers Serving Residents of Public Housing and the HUD-Assisted

I. Forward

HIV+ patients and individuals from HIV-vulnerable populations often experience barriers when accessing needed medical care, including key services such as primary and preventative medicine, prescribed medications and behavioral health care. These patients are also more likely to exhibit socioeconomic factors which are linked to poor health outcomes, such as low income, limited formal education, and experiencing unstable housing or living in public or assisted housing.

Research has consistently indicated that providing non-medical support to HIV+ patients and those at risk for HIV, such as IV-drug users and Men Who have Sex with Men, leads to better health outcomes[1]. Changes in housing status have specifically shown to significantly reduce risk of behaviors associated with HIV such as drug use, needle sharing and unprotected sex[2]. Additionally, according to the Centers for Disease Control and Prevention (CDC), in 2020 17% of U.S. adults with HIV experienced homelessness or unstable housing[3]. Health centers, Public Housing Authorities (PHAs), and partner organizations can support the non-medical needs of their patients and community by implementing policies that address the Social Determinants of Health (SDOH).

Health centers can support HIV+ patients and those vulnerable to HIV by integrating screening for the SDOH into their standard operating procedures. In this reference guide, we present a step-by step approach to integrating SDOH screening into the clinical and social support operations of health centers and PHAs and it is designed for use by both organizations that have existing social support infrastructure and wish to review their current delivery model and by those with limited social support infrastructure who are interested in expanding their SDOH program footprint.

II. SDOH and HIV

Health centers, PHAs and partners play a significant role in HIV care on both the individual and population level. These organizations provide critical services to patients and clients, which have significant impacts on patient care and outcomes. Through public health initiatives, health centers and

Link to resource

Screening for SDOH in HIV+ Patients

FOCUS POPULATION ?

Reset

LOCATION	RACE/ETHNICITY	AGE GROUP	TRANSMISSION CATEGORY	SEX
National	Select one	Select one	Select one	Select one

National

Ending the HIV Epidemic (EHE) Indicators

Indicator	Scope	2022	2025 Goal
INCIDENCE	NATIONAL	31,800	9,300
KNOWLEDGE OF STATUS	NATIONAL	87.2 %	95 %
DIAGNOSES	NATIONAL	37,601	9,588
LINKAGE TO CARE	NATIONAL	81.6 %	95 %
VIRAL SUPPRESSION	NATIONAL	65.1 %	95 %
PrEP COVERAGE	NATIONAL	36 %	50 %

Link to publication: AHEAD Dashboard

Screening for SDOH in HIV+ Patients

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?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

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
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

Link to publication: [PRAPARE]

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Screening for SDOH in HIV+ Patients

Upstream Risks Screening Tool & Guide

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	☐ Elementary School ☐ High School ☐ College ☐ Graduate / Professional School	+1 for "Elementary School "	☐
		1b. What is the highest degree you earned? Check one.	☐ High school diploma ☐ GED ☐ Vocational certificate (post high school or GED) ☐ Associate's degree (junior college) ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	☐
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	☐ YES ☐ NO ☐ Not applicable	+1 for YES	☐
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	☐ Homemaker, not working outside the home ☐ Employed (or self-employed) full time ☐ Employed (or self-employed) part time ☐ Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	☐

Manchanda, Rishi and Gottlieb, Laura (2015). Upstream Risks Screening Tool and Guide V2.6. HealthBegins; Los Angeles, CA.

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*Several domains have been adapted from (Institute of Medicine). 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press

**Suggested minimum frequency of screenings for new and ongoing patients

Link to publication: Upstream Risks Tool

Screening for SDOH in HIV+ Patients

Name: ______________________________________ Health Plan #: _______________

Your Current Life Situation (Shorter Form)

Please answer the following questions to help us better understand you and your current situation. The information you provide will be entered into your Kaiser Permanente medical record and will be used by your health care team to develop a plan to help you maintain or improve your health and well-being.

1. Which of the following best describes your current living situation? *(Select ONE only)*

☐ Live alone in my own home (house, apartment, condo, trailer, etc.); may have a pet
☐ Live in a household with other people
☐ Live in a residential facility where meals and household help are routinely provided by paid staff (or could be if requested)
☐ Live in a facility such as a nursing home which provides meals and 24-hour nursing care ☐ Temporarily staying with a relative or friend
☐ Temporarily staying in a shelter or homeless
☐ Other

2. Do you have any concerns about your current living situation, like housing conditions, safety, and costs?

☐ Yes → ☐ Condition of housing ☐ Lack of more permanent housing ☐ Ability to pay for housing or utilities ☐ Feeling safe ☐ Other
☐ No

3. In the past 3 months, did you have trouble paying for any of the following? *(Select ALL that apply)*

☐ Food ☐ Housing ☐ Heat and electricity ☐ Medical needs ☐ Transportation
☐ Childcare ☐ Debts ☐ Other ☐ None of these

4. In the past 3 months, how often have you worried that your food would run out before you had money to buy more? ☐ Never ☐ Sometimes ☐ Often ☐ Very often

5. Has lack of transportation kept you from medical appointments or from doing things needed for daily living? *(Select ALL that apply)*

☐ Kept me from medical appointments or from getting medications
☐ Kept me from doing things needed for daily living

Link to publication: YCL Tool

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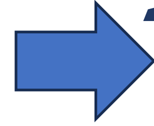
Intake → Consultation → Follow-up engagement

Screener → Intake

Screener → Follow-up engagement

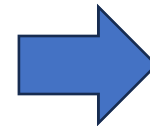
Intake

- *Relationship building Screening*
- *Networking.*



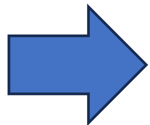
Goal Setting

- *Goals set during SDOH Screening.*



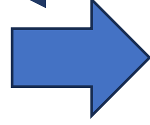
Follow-up engagement

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



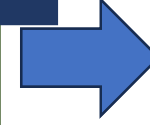
Navigation

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



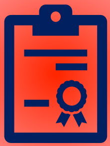
Coaching

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



Case Closure

- *Closure when all goals are achieved.*



Screening for SDOH in HIV+ Patients

HHS Public Access
Author manuscript

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Developing electronic health record (EHR) strategies related to health center patients' social determinants of health

Rachel Gold, PhD, MPH[1,2], **Erika Cottrell, PhD, MPP**[2], **Arwen Bunce, MA**[1], **Mary Middendorf**[2], **Celine Hollombe, MPH**[1], **Stuart Cowburn, MPH**[2], **Peter Mahr, MD**[3], and **Gerardo Melgar, MD**[4]

[1]Kaiser Permanente Northwest–Center for Health Research

[2]OCHIN, Inc

[3]Multnomah County Health Department

[4]Cowlitz Family Health Center

Abstract

Background—These 'Social determinants of heath' (SDH) are non-clinical factors that profoundly impact health. Helping community health centers (CHCs) document patients' SDH data in electronic health records (EHRs) could yield substantial health benefits, but little has been reported about CHCs' development of EHR-based tools for SDH data collection and presentation.

Methods—We worked with 27 diverse CHC stakeholders to develop strategies for optimizing SDH data collection and presentation in their EHR, and approaches to integrating SDH data collection and use (*e.g.*, through referrals to community resources) into CHC workflows.

Results—We iteratively developed a set of EHR-based SDH data collection, summary, and referral tools for CHCs. We describe considerations that arose during the tool development process, and present a number of preliminary lessons learned.

[Link to publication]

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Screening for SDOH in HIV+ Patients

[Link to publication]

Case Study:

A 45-year-old male patient living with HIV presents to a primary care clinic for routine follow-up. Despite adherence to antiretroviral therapy (ART), his **viral load remains detectable**, and he reports **frequent missed appointments**. During a structured SDOH screening using the PRAPARE tool, the care team **identifies significant social risk factors**, ***including unstable housing, food insecurity, and transportation barriers***.

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Case Study:

What are some appropriate SDOH interventions for this patient at this time?

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Case Study:

The clinic's case manager connects the patient with a local ***housing assistance program, enrolls him in a food pantry service, and arranges transportation vouchers for medical visits***. Over six months, the patient's appointment adherence improves, ***his viral load becomes undetectable***, and he reports reduced stress and improved overall well-being.

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Case Study:

Now that the patient's viral load is undetectable, what additional resources would they benefit from?

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Case Study:

A federally qualified health center (FQHC) serving a predominantly low-income, urban population ***would like to integrate routine SDOH screening into its electronic health record (EHR) system*** to improve care for patients living with HIV.

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Case Study:

What steps can program managers take to ensure the SDOH screening is implemented effectively?

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Case Study:

Th Health Center decides to use the **PRAPARE tool**, and that providers **screen all patients** during intake and annual visits. Their implementation research ***indicates high rates of housing instability, unemployment, and food insecurity*** and their community.

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Case Study:

What types of partnerships can be built and leveraged by this Health Center to provide a SDOH referral network?

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Case Study:

In response, the health center **develops a referral network *with local housing organizations, workforce development programs, and food assistance services.***

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Case Study:

What role does program monitoring and evaluation play at this point?

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Case Study:

Over one year, data analysis reveals ***that patients linked to social services demonstrate improved retention in HIV care, higher medication adherence, and better viral suppression rates***.

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Case Study:

A **32-year-old woman with HIV** presents to the clinic reporting **difficulties with medication adherence due to severe depression and financial strain**. Through SDOH screening, the care team identifies a lack of social support, unstable housing, and food insecurity as contributing factors.

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Case Study:

What SDOH resources are most appropriate for this patient at this time?

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Case Study:

A 40-year-old man with HIV presents to the clinic with **inconsistent ART adherence**, citing **difficulties managing his substance use**. SDOH screening reveals housing instability, unemployment, and limited access to addiction treatment as major barriers to his care.

Case Study:

What SDOH resources are most appropriate for this patient at this time?

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Q & A Session

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Enhancing Health Care Delivery for Residents of Public Housing

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2024 Public Housing Demographic Fact Sheet

The National Center for Health in Public Housing (NCHPH) has released an updated fact sheet featuring the latest statistics on public housing residents. It includes data on general demographics, families with children, seniors, individuals with disabilities, income levels, and health status. To view/download the publication, click on the link below.

Click Here to View/Download Publication

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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 and Technical Assistance Manager
Fide@namgt.com

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

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

Olajumoke Oladipo, MPH
Health Communications and Research Analyst
Olajumoke@namgt.com

Thank you!

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