HRSA
Health Resources & Services Administration

Building the Evidence Base for Social Determinants of Health (SDoH)

Key Findings From the Report and Screening for SDoH

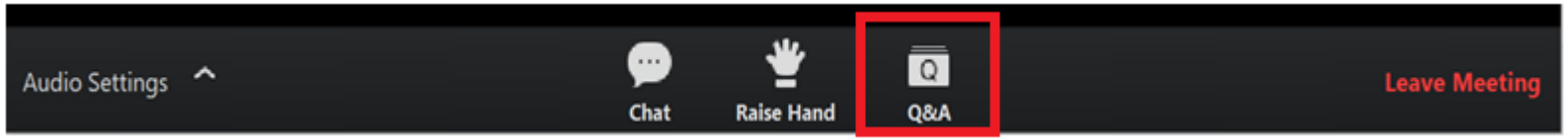
Wednesday, February 16, 2022

From 1:00 – 1:30 p.m. ET

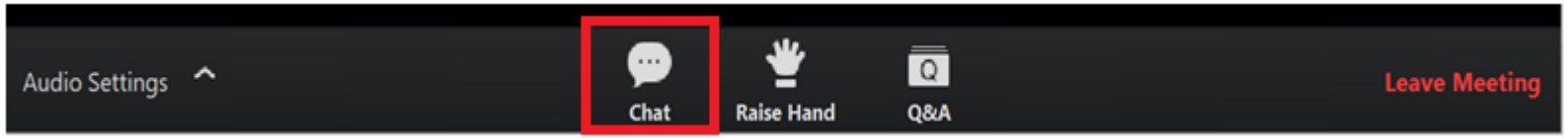
Vision: Healthy Communities, Healthy People

Submitting Questions and Comments

Submit questions by using the Q&A feature. To open your Q&A window, click the Q&A icon on the bottom center of your Zoom window.



If you experience any technical issues during the information session, please message us through the chat feature, or email healthcenter_BHTA@jbsinternational.com.



Presenter

Natalie M. Slaughter, MSPPM
Technical Expert Lead,
JBS International, Inc.

Key Findings From the Report: *Building the Evidence Base for Social Determinants of Health Interventions*

A Report Prepared for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) by RAND Health Care

Source: U.S. Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation. (2021, May). *Building the evidence base for social determinants of health interventions*. Microsoft Word - PR-A1010-1_final_mw.docx (hhs.gov)

HRSA Health Center Program

Agenda

- Welcome
- Presentation and Q&A
- Training and Technical Assistance(T/TA) Opportunities
- Wrap-Up and Adjournment
  - Completing the Health Center Satisfaction Assessment
  - Obtaining CE Credits

Objectives

Source: iStock

Participants of this webinar will be able to:

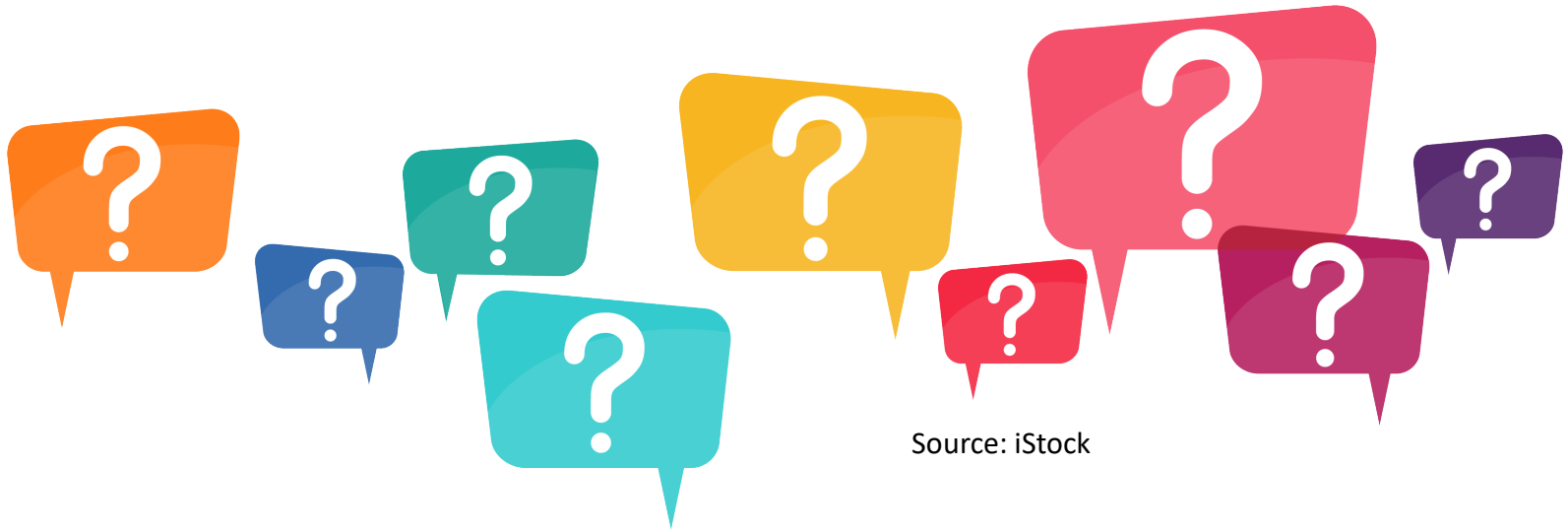
- Convey key findings from the HHS ASPE Report "Building the Evidence Base for Social Determinants of Health (SDoH)" as it pertains to the five domains
- Identify specific SDoH intervention components that improve health outcomes
- Describe tools and resources for screening for risk related to SDoH
- Access additional T/TA opportunities available for Federally Qualified Health Centers (FQHCs)

Polling Question #1

Have you read the HHS ASPE report “Building the Evidence Base for SDoH Interventions”?

A. Yes

B. No

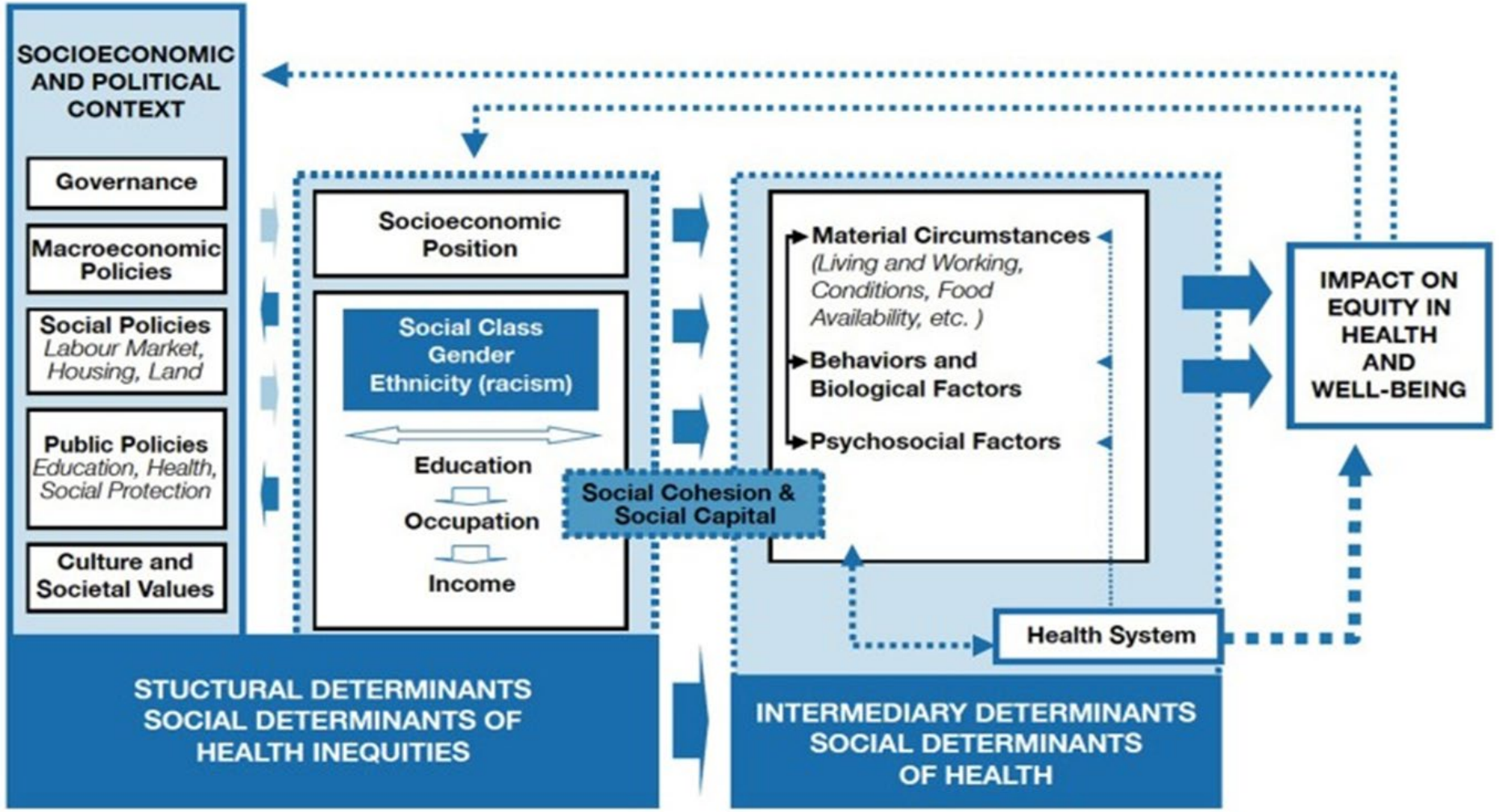


Source: iStock

SDoH and Integrated Care: Why it is Important

- United States spends more per capita for health care than other high-income countries yet ranks in the bottom third for health outcomes.
- Medical care accounts for **10-20%** of modifiable contributors to improved health outcomes; the remaining **80-90%** is driven by non-medical factors or SDoH.
- SDoH contributes to a **40%** difference in the health status of individuals.
- Inequities in health and the health care system contribute to economic burden in direct and indirect costs (e.g., lost productivity) and lower quality of life.
- Addressing SDoH promotes more **equitable health outcomes** for patients, families, and communities; **increases access** to high-quality health care; **reduces** health care **costs**, **health disparities**, and **inequities**; and **improves overall health metrics**.

World Health Organization SDoH Framework



Source: Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health: Social determinants of health discussion paper 2 (policy & practice).* World Health Organization. https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

SDoH and Integrated Care: What We Know

- SDoH interventions are generally implemented in clinical and community settings.
- Interventions for SDoH typically require multisector investment and collaboration from sectors other than health (e.g., housing, transportation, economic development).
- Interventions that improve access to affordable, high-quality health care through integrated care programs demonstrate positive outcomes in chronic disease care and behavioral health care.
- While the evidence is clear that SDoH interventions yield positive health outcomes, lack of evidence remains on which SDoH programs and policies are most effective, replicable, and scalable.

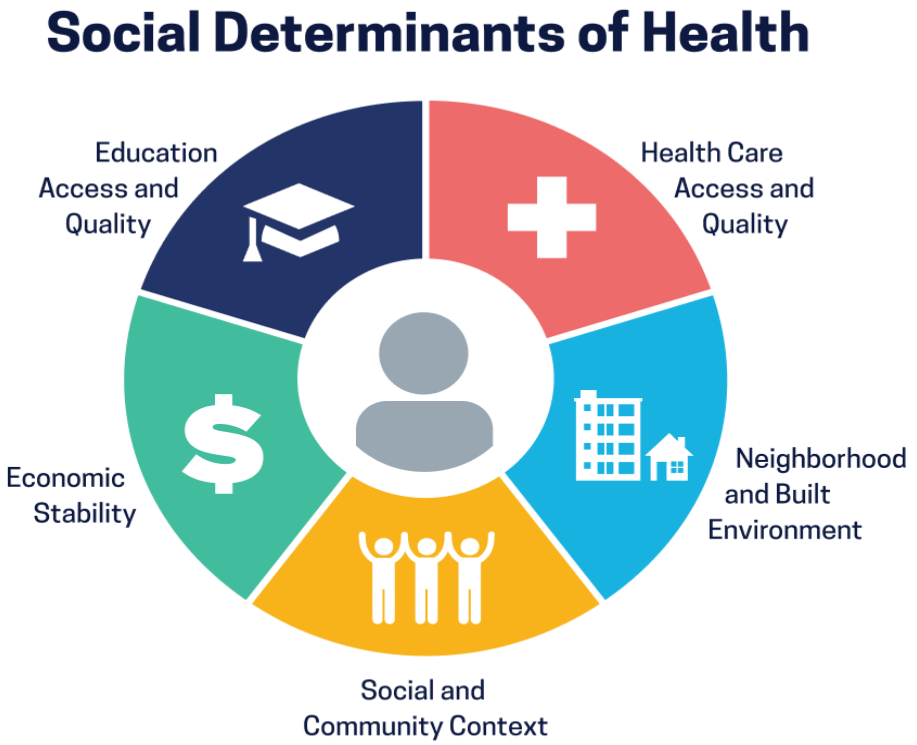
Evaluating the Evidence

- ASPE engaged RAND Health Care to evaluate current evidence from programs/policies targeting SDoH and to identify research questions, data sources, and gaps to inform a SDoH research agenda.

- RAND used a mixed method approach.

- Final report was released May 2021 and included:
  - Findings from an environmental scan
  - Summary of evidence gaps
  - Issues to be addressed and resources needed for a SDoH research agenda

Healthy People 2030: Five Domains of SDoH



Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

SDoH Domains and Subdomains

Economic Stability

- Employment
- Food Insecurity
- Housing Instability
- Poverty

Education Access & Quality

- Early Childhood Education and Development

Social and Community Context

- Discrimination
- Social Cohesion
- Social Support

Health Care and Quality

- Access to Health Care Services
- Health Literacy and Education
- Culturally and Linguistically Competent Care

Neighborhood and Built Environment

- Access to Foods That Support Healthy Eating Patterns
- Crime and Violence
- Environmental Conditions
- Quality of Housing
- Transportation Access

Source: U.S. HHS, ODPHP. (n.d.).

SDoH Domain: Health Care Access and Quality

- Domain focuses on increasing access to comprehensive, high-quality health care services.

- Intervention targets may include access to affordable, high-quality, and culturally and linguistically appropriate health care, particularly primary, specialty, and preventive care; health insurance and prescription drug coverage; and health literacy.

- Examples include:
  - Integrated medical, behavioral health, and social services; patient navigation; care coordination; and self-management interventions, including those involving community health workers, home visits, and health care professionals
  - Culturally or linguistically tailored, technology-enabled, educational or communication interventions

Positive Health Outcomes Demonstrated by Health Care Interventions

- Improvements in chronic disease management outcomes (*e.g., blood pressure, pain management, HbA1c, and asthma symptom monitoring*)
- Improvements to treatment and medication adherence, hospitalization, health care utilization, and mental health outcomes (*e.g., crisis stabilization*)
- Improvements in self-reported behavioral outcomes and preventive health behaviors (*e.g., cancer screening, dietary and vaccination behaviors*)
- Improvements in diabetes outcomes, psychosocial outcomes, and reduction in cardiovascular disease risk factors

Intervention Examples with Demonstrated Improved Health Outcomes

Intervention Examples	Demonstrated Improved Health Outcomes
Integrated medical, behavioral health, and social services to increase access to health care	Improved health care utilization and behavioral health outcomes for adults, children, and adolescents
Tailored collaborative care and support programs (e.g., include team-based care, self-management support, linkages to community resources)	Increased positive outcomes for depression and anxiety symptoms
Patient assistance programs (e.g., to reduce cost of prescription drugs) and community paramedics	Cost-effective and improved diabetes outcomes and medication adherence
Expanded Medicaid implementation	Improved access to health care and quality of care for uninsured people with diabetes

Additional Intervention Examples and Improved Health Outcomes

Intervention Examples	Demonstrated Improved Health Outcomes
Transportation services embedded into multicomponent interventions involving patient navigation and chronic disease education	Reduction in unnecessary emergency department (ED) visits
Pregnancy-related interventions among women involved in the criminal justice system	Increased used of contraception, behavioral health services, and overall health care outcomes
School-based case management for children with complex care needs	Improvements in asthma symptoms and decreased utilization of urgent care and ED visits

Positive Health Outcomes Demonstrated by Education interventions

- **SDoH Education Access and Quality domain** focuses on increasing educational opportunities and help children and adolescents do well in school.

- Intervention targets may include early childhood education and development; high school graduation; enrollment in higher education; and language and literacy.

- An example includes:
  - **Home visit interventions** delivered by professionals reduced child behavioral and mental health problems and increased mental health treatment for children.

Positive Health Outcomes Demonstrated by Education interventions (cont'd)

- **SDoH Economic Stability domain** focuses helping people earn steady incomes that allow them to meet their health needs.

- Intervention targets include employment, food insecurity, housing instability, and poverty and yielded a range of positive health outcomes.

- Examples include:
  - **Housing interventions** (e.g., rental assistance, supportive housing, housing vouchers) demonstrated positive outcomes for HIV-related clinical outcomes, hospital utilization, and birth weight.
  - **Food security interventions** (e.g., summer feeding programs, meal delivery programs for seniors, Supplemental Nutrition Assistance Program) showed increased intake of nutritious foods, including fruits and vegetables.
  - **Anti-poverty interventions** (e.g., minimum wage increases, Earned Income Tax Credit) improved birth and maternal mental health outcomes but showed no effect on obesity and health behavior outcomes.

Positive Health Outcomes Demonstrated by Interventions Targeting the Neighborhood and Built Environment

- **SDoH Neighborhood and Built Environment domain** focuses on creating neighborhoods and environments that promote health and safety.

- Intervention targets include quality of housing, access to foods that support healthy eating patterns, environmental conditions, crime and violence, and transportation access.

- Examples include:
  - **Housing quality** interventions to improve respiratory and infectious disease outcomes reduced asthma symptoms, improved infectious disease outcomes, and asthma acute care visits.
  - **Lead hazard** control interventions reduced blood lead levels in children.
  - **Food and physical activity** interventions yielded improved diabetes and dietary outcomes.
  - **Violence prevention** interventions (e.g., inmate partner violence prevention programs) reduced intimate partner violence.

Positive Health Outcomes Demonstrated by Interventions Targeting Social and Community Contexts

- **SDoH Social and Community Context domain** focuses on increasing social and community support. The social characteristics of the contexts in which people live, as well as on the social, religious, cultural, and other institutions with which they interact.

- Intervention targets include civic participation, discrimination, incarceration, social cohesion, and social support.

- An example includes:
  - **Chronic disease self-management** involving social support; supportive, community-based behavioral interventions; family-based interventions; and broader, community-wide health interventions were all associated with a range of positive health and well-being outcomes.

Building the Evidence Base: Screening for Social Risk Related to SDoH

Polling Question 2

What is your health center's level of implementation and success in using data to address risks associated with SDoH?

A. **We do not screen for risks associated with SDoH at all.**

B. **We have a process/plan in place for screening for risks associated with SDoH, but it is not fully implemented.**

C. **We can screen for some risks associated with SDoH but could be more effective in using data to address identified risks.**

D. **We have fully implemented a process for effectively screening for risks associated with SDoH and for utilizing data to address identified risks.**

Source: iStock

Polling Question 3

Which area is the biggest challenge for your health center when it comes to screening for risks associated with SDoH and to using data to address identified risks for SDoH?

A. **People:** leadership, workforce capacity, culture, patients, and partners

B. **Services:** workflow, staffing, and identification of indicators and metrics

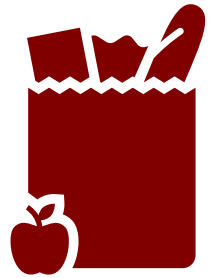
C. **Infrastructure:** equipment, information systems, funding mechanisms, and policies

D. **Other**

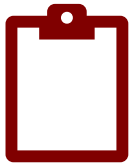
Source: iStock

Best Practices in Screening for Risks Related to SDoH

- **The Hunger Vital Sign**
  - Identification of young children living in households at risk for food insecurity
  - Two-question food insecurity screening tool based on the U.S. Household Food Security Scale



- **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**
  - Standardized patient social risk assessment protocol
  - Assessment of patients for personal characteristics, money and resources, family and home, social and emotional health, and other measures



Best Practices in Screening for Risks Related to SDoH (cont'd)

- **The EveryONE Project – Social Needs Screening Tool**
  - Screening for five, core, health-related social needs
  - Screening for additional needs of employment, education, child care, and financial strain

- **Accountable Health Communities Health-Related Social Needs Screening Tool**
  - Centers for Medicare & Medicaid Services' 10-item screening tool
  - Identification of patient needs in 5 different domains (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety)
  - Community services addressing of needs possible

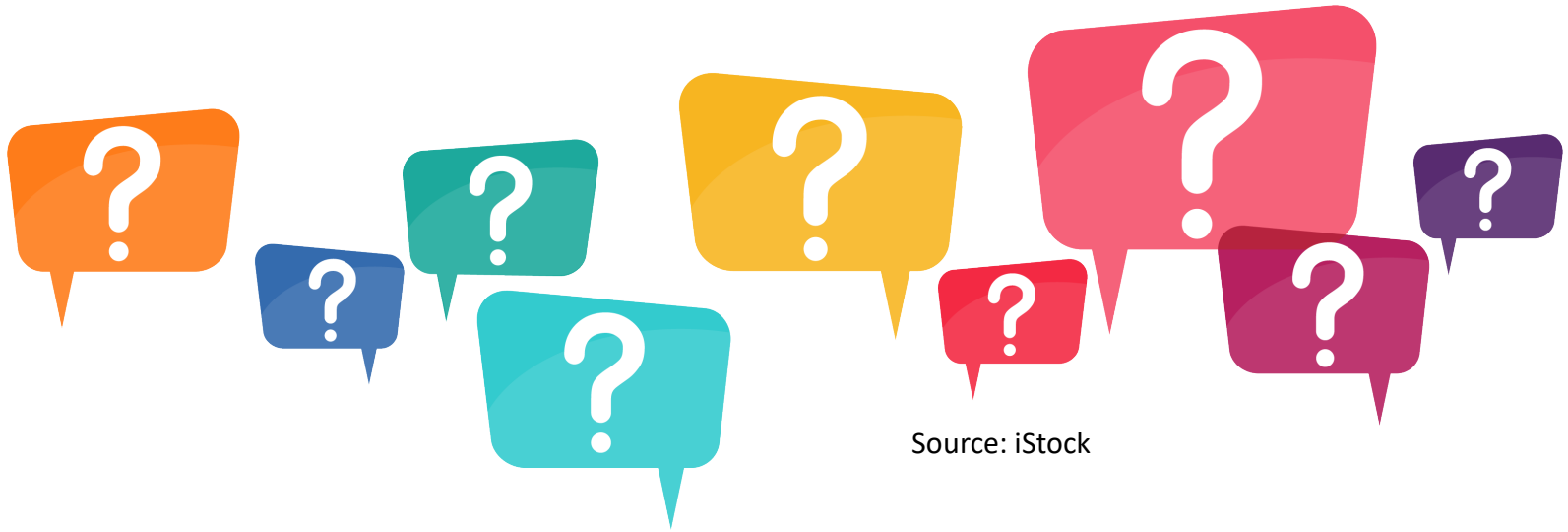
Q&A / Discussion

Polling Question 4

I am interested in receiving information on additional T/TA opportunities for FQHCs.

A. Yes

B. No



Source: iStock

TA Opportunities for Health Centers

- One-on-One Coaching
- Communities of Practices (CoPs)
- Virtual Site Visit T/TA
- SDoH Roundtables
- Office Hours
- Webinars

HRSA Health Center Program

Accessing Additional T/TA Opportunities

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com/ta-request-form

EMAIL

healthcenter_BHTA@jbsinternational.com

BH TA WEEKLY UPDATE

healthcenter_BHTA@jbsinternational.com

Upcoming TA Opportunities

SDoH Roundtables

- **Addressing Health Disparities in Behavioral Health in the Primary Care Setting Roundtable**
  Thursday, February 24, 2022, 1:00–3:30 p.m. ET

- ***Building Relationships With Community Partners to Address SDoH***
  Wednesday*, May 25, 2022, 1:00–3:30 p.m. ET*

- ***Building Relationships With Community Partners to Address SDoH***
  August 2022 – TBD

Registration links for each roundtable can be found on the BPHC-BH TA Portal.

You can receive 1.5 hours of CE credit for your participation.

Upcoming TA Opportunities in February/March 2022

Webinars

March 17, 2022, from 1:00-2:00 p.m. ET
Addressing Polysubstance Misuse in the Primary Care Setting
https://us06web.zoom.us/webinar/register/WN_0VcFMY_jRhKCmHyqp1t9NA

CoPs

January 25 – May 3, 2022 (eight Sessions) from 2:00-3:30 p.m. ET
"Pediatric and Adolescent Behavioral Health"
https://us06web.zoom.us/meeting/register/tZEufuuhrjwrH9EhS4Ft-OhCCbCeHMTHQxzd

Office Hours

March 1, 2022, from 2:30-3:00 p.m. ET
Integrating Psychiatry into Primary Care Treatment of Patients with Substance Use Disorder
https://us06web.zoom.us/meeting/register/tZEqceqrrDMuHNTYaplqVHNudsE9C4AvzG3s

April 6, 2022 from 12:00-1:00 p.m. ET
Billing and Coding Best Practices to Sustain Integrated Behavioral Health Services
Registration Link: Coming Soon

Site Visits

Request Link: https://bphc-ta.jbsinternational.com/ta-request-form

CE Revisited

- We will be offering **0.5 CE credit** for attending today's webinar session.
- You **must** complete the Health Center Satisfaction Assessment after this session.
- **CE credit will be distributed to participants who complete the Satisfaction Assessment within 2 weeks of this information session.**
- We will provide details to complete the Satisfaction Assessment at the end of the webinar.

JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

Health Center Satisfaction Assessment

- **You MUST complete the Health Center Satisfaction Assessment after this session to receive CEs.**
- The link to the Satisfaction Assessment will automatically open in your browser at the conclusion of this webinar.
- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature; click the link now to have the browser open.
- We will also email you a link to the Satisfaction Assessment.

Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.

Thank you!

Additional Resources for Addressing SDOH

- The EveryONE Project: The EveryONE Project Toolkit (American Academy of Family Physicians)
  https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html
- Tools for Putting Social Determinants of Health Into Action (Centers for Disease Control and Prevention [CDC])
  https://www.cdc.gov/socialdeterminants/tools/index.htm
- Center for Health Care Strategies
  https://www.chcs.org/about-us/
- Health and Well-Being for All – Accelerating Learning About Social Determinants – Meeting-in-a-Box (CDC Foundation)
  https://www.cdcfoundation.org/health-in-a-box
- Addressing Social Determinants of Health and Development (Community Toolbox); recommended by Healthy People Toolkit
  https://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main

HRSA
Health Resources & Services Administration

Thank You!

Natalie M. Slaughter, MSPPM

nslaughter@jbsinternational.com