HRSA
Health Resources & Services Administration

Building Relationships with Community Partners to Address SDoH

Social Determinants of Health (SDoH) Roundtable Two

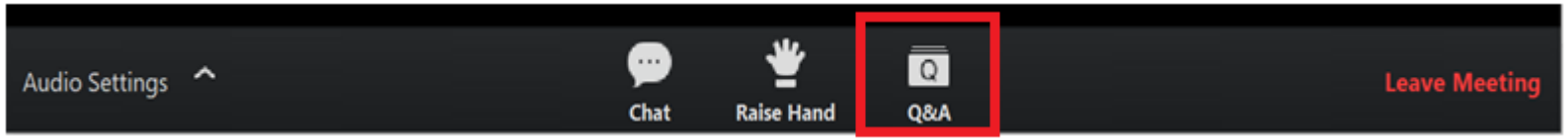
Wednesday, May 25, 2022

2:00 – 3:30 p.m. ET

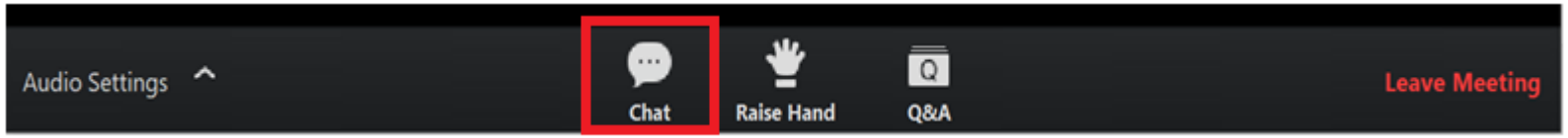
Vision: Healthy Communities, Healthy People

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.



Facilitator

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Agenda

- Welcome
- Participant introductions
- Rules of engagement
- Featured presentation
- Interactive small group breakout session (20 minutes)
- Roundtable discussion (30 minutes)
- Wrap up: available resources and TA for Health Centers and next steps

Participant Check-in & Chat: Let us know you're here!

Image source: iStock by Getty Images

Please list in the chat your **name, title/role, health center name & state** so your peers can connect with you.

Is your health center located in a **rural, urban, or suburban area?**

Rules of Engagement: What to Expect?

- **Safe space for peer learning**
- **Respect for each participant**
- **Open and meaningful dialogue**
  - Activate your camera
  - Openly share your experiences
  - Ask questions freely
  - Participate in the polls

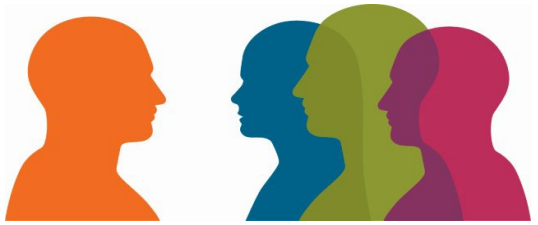
Roundtable Objectives

1. Identifying champions and connecting with leaders at partner organizations to promote engagement

2. Defining and prioritizing partnership goals and objectives

3. Building new relationships while strengthening long-standing ones

4. Developing effective and efficient screening and referral protocols.



Source: ThinkStock

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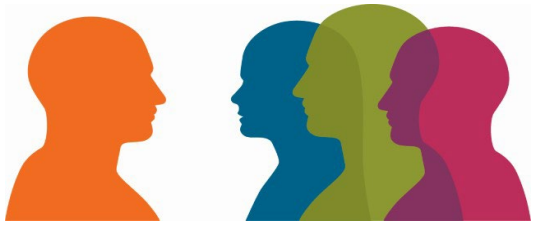
Discussion Topics

1. Identifying champions and connecting with leaders at partner organizations to promote engagement (10)

2. Defining and prioritizing partnership goals and objectives (8)

3. Building new relationships while strengthening long-standing ones (16)

4. Developing effective and efficient screening and referral protocols (16)



Source: ThinkStock

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Building Relationships with Community Partners to Address SDoH

Rhonda Waller, PhD
The Bizzell Group
Managing Director
Maternal and Child Health Initiatives

What We Know

Screening for the presence of social and economic needs in families is a critical first step in identifying people who require specific services and referring them to organizations that can help them is the next critical step!

SDOH often have a larger impact on a person's (and/or a community's) health than the medical care they receive (1,2).

Community based organizations (CBOs) can provide continuing social support and connection to needed services.

What We Also Know

Clinical practices need to establish more formal personal and organizational relationships with selected CBO partners, so that they can jointly develop an effective process for screening, referral, and the provision of needed services.

Building a clinical-community partnership to address social needs in a patient population requires significant change management.

Increased screening is likely to increase the demand for services provided by CBOs. It is not clear that those organizations—particularly the smaller human service organizations with fixed funding—have the resources needed to increase service supply to meet growing demand.

Federally Qualified Health Centers (FQHC)

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FQHC's are trusted sources in addressing the health needs of patients.

- Serve patients with complex medical and social problems, living in underserved communities;
- Have traditionally taken a more expansive view of their role, often going beyond the provision of primary care in serving their communities; and
- Generally, have augmented staff (social workers, care managers, behavioral health staff, designated enrollers) who are familiar with the resources already in place.

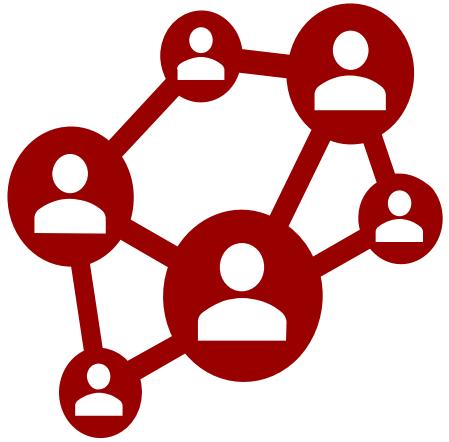
FQHC's can screen for SDOH and refer patients to community-based organizations.

What We Assume

We assume the steps for a referral process are simple:

- Screen at the primary care practice / FQHC;
- Referral to the appropriate CBO;
- Provision of social services by the CBO; and
- Close the communication loop between the CBO and the practice.

The Reality Is…



Successfully executing these steps is extremely complex and involves:

- Developing effective and efficient screening protocols.
- Identifying champions and connecting with leaders at partner organizations to promote engagement.
- Developing a realistic workflow and referral protocols.
- Identifying appropriate CBO partners / Defining and prioritizing partnership goals and objectives.
- Building new relationships while strengthening long-standing ones.

Clinical – Community Partnership Framework Logic Model

Inputs	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes
• SDH screen • Referral network investigation and development • Workflow modification at Primary Care Practice and CBO to receive and make referrals • Staff education on CBO services	• Referrals • Patient follow-up (self report at next patient encounter) • CBO/Primary Care Practice closed loop communications • Workflow and service mapping between Primary Care Practice and CBO • Referral evaluation (process and outcome measures)	• Patient/Client data sharing • Referral uptake and adherence • "Preferred provider" relationship development	• Develop Primary Care Practice staff knowlwedge of CBO services, increase appropriate referrals • Improved # of patients with needs met • Develop CBO network of peer organizations providing similar or related services to same population	• Improved health outcomes/Stabilized patients • Bi-directional data sharing • Bi-directional data referrals • Service attribution for VBP Contracting

Developing effective and efficient screening and referral protocols

Before implementing SDoH screening and referral protocols, clinical leaders must ensure:

1. Staff recognize the value of SDoH screening for and addressing patient's social issues; and understand the benefits to physical health.
2. Everyone is willing to tackle the difficult issues that have kept them from screening in the past and understand that implementing screenings will involve a new workflow.
3. Training is implemented for ALL staff, even non-clinical staff.

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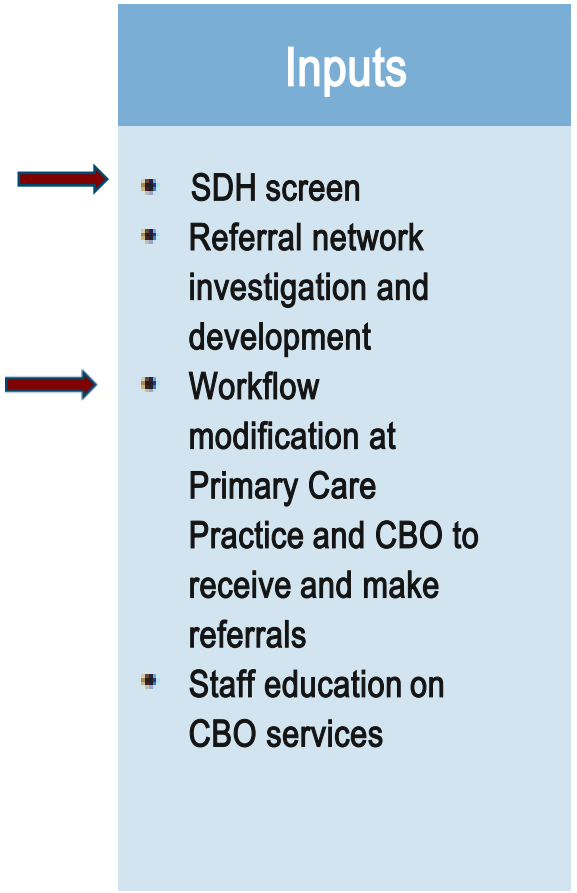
Which Social Problems to Screen For?



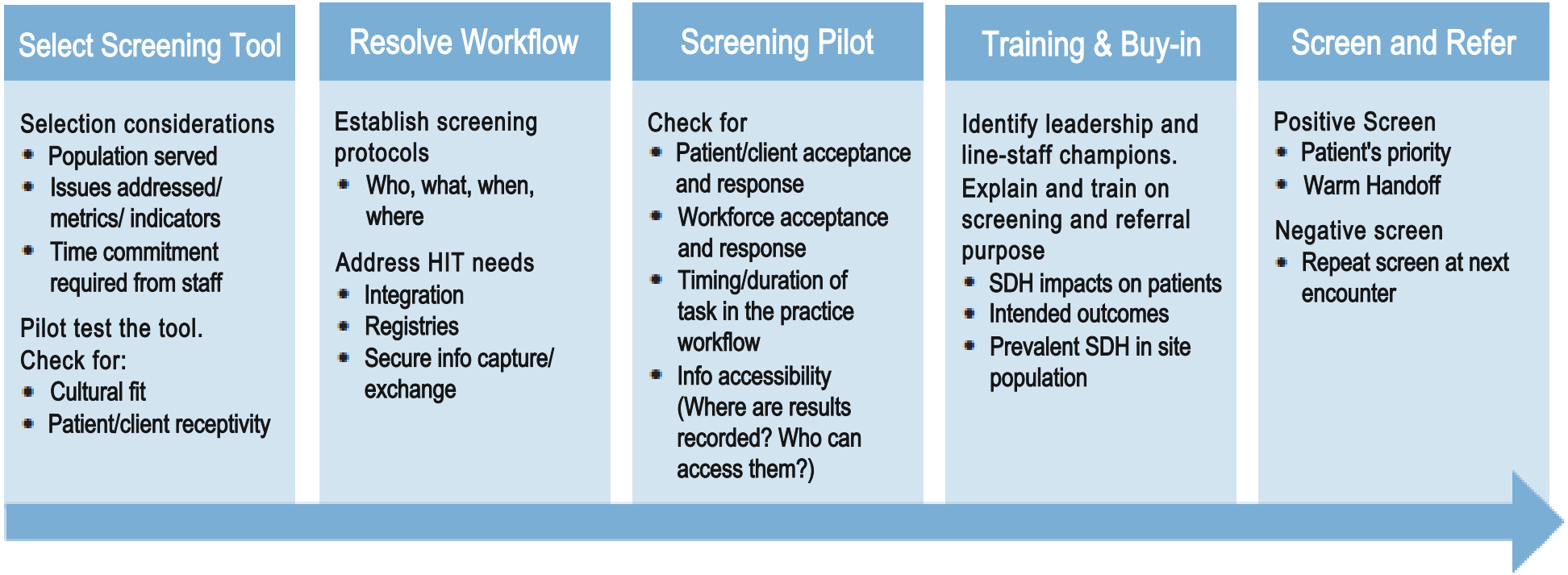
Providers currently screening for social needs generally focus on between 5 and 10 broad categories. These include:

- Food / Nutrition
- Housing
- Family income / Financial support
- Social and Emotional Health
- Safety
- Transportation
- Literacy
- Intimate Partner Violence / Child maltreatment
- Education / Employment
- Household substance misuse

SDoH Screening / Workflow Process Map

The process of determining which tool to use should not be taken lightly! Screening tools vary widely according to several factors:

- the types of social needs that are addressed;
- reading level and language availability; and
- the assessment of health behaviors, behavioral health factors, and health status.



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Developing effective and efficient referral network

Inputs

- SDH screen
- Referral network investigation and development
- Workflow modification at Primary Care Practice and CBO to receive and make referrals
- Staff education on CBO services

- SDoH screening is done! You have a list of client needs. Now What?
- Community Based Organizations to the rescue!
  - Not so fast!!
  - Can the CBO meet the needs of the client?
  - Do you have an existing relationship with the CBO?
  - Is there a collaborative agreement or Memorandum of Understanding (MOU) in place?
  - Has anyone on staff visited the organization?
  - Is the CBO accessible to the client (location & cost)?
  - Is your client comfortable with the referral?
  - Have you received positive feedback from previous referrals?

How do you develop a referral relationship?

It is important for organizations to develop criteria for selecting CBOs to partner with.

- The relationship should yield reciprocity.
- Prior knowledge and positive working relationships
- Range of social services provided
- Capacity to accept and serve additional clients
- Alignment of social services provided with high prevalence needs among the client population
- Proximity to clinic and/or patient residence (or accessible by public transportation)
- Language and cultural alignment with patient population

Do your research before referring a client!!

Build relationships that will yield strong partnerships!

Polling Question #1

Does your health center have formal agreements with partner organizations?

A. No, our health center does not have a formal agreement in place with our partner organizations.

B. Yes, our health center has a formal agreement in place with some but not all of our partner organizations.

C. Yes, our health center has formal agreements with all of our partner organizations.

Source: iStock

Connecting with leaders at partner organizations to promote engagement

Inputs

- SDH screen
- Referral network investigation and development
- Workflow modification at Primary Care Practice and CBO to receive and make referrals
- Staff education on CBO services

Effective relationships require a commitment from leaders on both sides to establishing a true partnership allocating the time and staff to develop and help manage that relationship.

- Clinical providers may not be aware of the range of services available from the CBO
- CBOs may generally understand their clients' health needs but may not be familiar with the medical needs and treatment available for clients at the primary care site.

Start by becoming more familiar with each other's services and issues

- Informal interactions between the staff and senior leaders at the CBO and clinical provider
- Begin exploring the idea of a broader and more formal partnership
- Explore what the referral and feedback system could look like.
- Develop a memoranda of understanding between and among the partners

Polling Question #2

How effective are your organization's formal agreements with partner organizations in addressing the social need of your patient population?

A. Very effective
B. Effective
C. Moderately effective
D. Slightly effective
E. Not effective

Source: iStock

Levels of Collaboration

CASUAL

RELATIONSHIP

PARTNERSHIP

Collaborative Practices that Yield Success

Build New Relationships

- Attend open houses, community health fairs, and talk to other practitioners for recommendations.
- Pop-up visits to referral sites with clients.
- Invite potential collaborators in the “relationship stage” to your staff meetings.
- Solicit client feedback and testimonials.

Strengthen Long Term Relationships

- Revisit your MOU annually to ensure it is serving you both well.
- Thank your CBOs!!
  - Ice cream social once a year
  - Holiday meet and greet for staff
  - Notepads or other useful swag with your organization information on it.
  - Feature your partners in your newsletter or on your website.

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Put it in the Chat!

What strategies do you use to build relationships with new and established collaborators?

Source: iStock

SMALL GROUP BREAKOUT SESSION

Small Group Breakout Exercise:

Instructions

1. Read the case study. Identify a volunteer to take notes and report out to the larger group.
2. Identify the strengths of the family/partnership.
3. Identify clinical-community referral opportunities.
4. Map out the current process from screening to closing the referral using best practices based on what is actually available to those in the breakout session.
5. Opportunities for improvement or expansion of referral sources and processes.

Interactive Small Group Breakout Exercise: Group/Scenario A

The James family recently moved to your area (3 months ago) and began accessing services at your FQHC. Ms. James is 47 years old and 5 months pregnant with her 2nd child. She works as a preschool teacher at a Head Start facility in town and uses public transportation to get from home to work daily. Her first child, a son, is 6 years old and enrolled in the neighborhood elementary school with before and after care. Ms. James' partner is a sales associate and travels out of state a lot for work, using their only mode of transportation, and often needing to be in another state 8-10 days per month. During recent appointments at their local FQHC the family presented for their annual physicals and the following was noted by nurses/physicians:

- Ms. James' blood pressure was elevated, and she reported concerns about balancing new responsibilities at work, preparing for the birth of the baby, and looking for a new apartment that will accommodate the family
- She is receiving WIC and plans to try breastfeeding since she keeps hearing about the infant formula shortage.
- Her son is healthy, up to date on his immunizations, but Mom has concerns about recent eczema flare ups and nail biting.
- Her partner attended the prenatal appointment and agreed to an appointment for a physical when he mentioned previously being on cholesterol medicine but not being able to afford the prescription and not making it to his last appointment before they moved to get a refill.

Interactive Small Group Breakout Exercise: Group/Scenario B

Scenario B:

You receive a call from the Social Worker at your local hospital. He has an elderly patient who was brought to the hospital by her neighbor with complaints of swelling in her hands and feet. During the ER visit the patient mentioned that she doesn't have any family living nearby and hasn't selected a medical provider under her Medicaid managed care plan. She also mentioned that she is low on food and could use someone to talk to because she thinks she may be depressed. The Social worker has referred her to you for assistance and is calling to help her set up the appointment.

Interactive Small Group Breakout Exercise: Group/Scenario C

Scenario C:

You receive a call from a 21-year-old who is a student at the local university. She is in need of assistance with food, transportation to and from her off campus job, a Covid vaccine, and a referral for counseling to address a recent breakup with her boyfriend (his Mom works in the counseling center on campus, so she prefers not to go there). She says she was told to call your facility by the student health center who said you can help her.

Roundtable Discussion

WRAP UP:
Available Resources and Technical Assistance for Health Centers, Continuing Education and More

Technical Assistance Opportunities for Health Centers

- One-on-One Coaching
- Communities of Practices
- Individualized Training and TA for Health Centers
- SDoH Roundtables
- Office Hours
- Roundtables

Upcoming TA Opportunities

SDoH Training and Technical Assistance

- SDoH 1:1 Training for Health Centers – ongoing
- SDoH Roundtable #3: *Building the Evidence Base for SDoH* – August 24, 2022

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

You can receive 1.5 hours of Continuing Education credit for your participation.

Accessing Additional Training and TA Opportunities

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com

EMAIL

healthcenter_BHTA@jbsinternational.com

BH TA WEEKLY UPDATE

healthcenter_BHTA@jbsinternational.com

Continuing Education (CE) Credits

- We will be offering **1.5 CE credit** for attending today's Roundtable 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 Roundtable.

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 Roundtable.
- 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!

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Thank You!

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