HRSA
Health Resources & Services Administration

Collecting and Using Data to Address SDoH in Your Patient Community

Social Determinants of Health (SDoH) Roundtable Three

Wednesday, August 24, 2022

2:00 – 3:30 p.m. ET

Vision: Healthy Communities, Healthy People

Training and TA Opportunities for FQHCs

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com

EMAIL

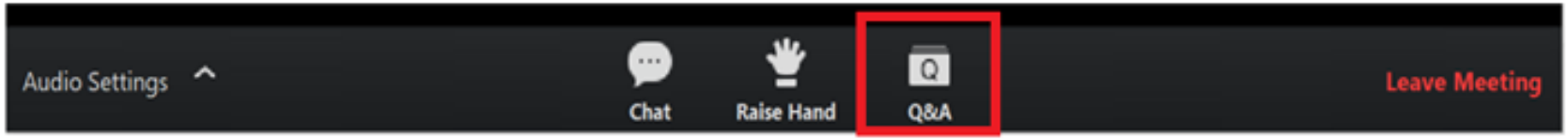
healthcenter_BHTA@jbsinternational.com

BH TA WEEKLY UPDATE

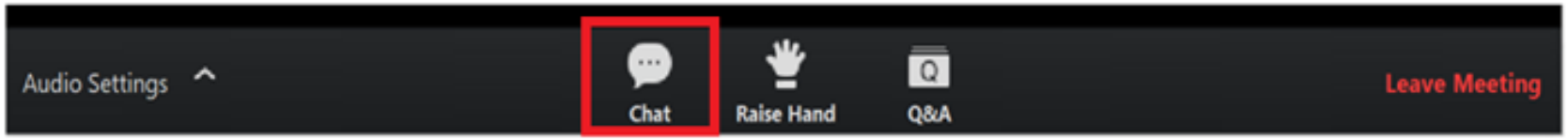
healthcenter_BHTA@jbsinternational.com

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.



Speakers

Facilitator:
Natalie Slaughter, MSPPM
JBS International, Inc.

Presenter:
Chantal Laperle, MA, CPHQ, PCMH, CCE, CTL
Advocates for Human Potential (AHP)

Agenda

- Welcome
- Participant introductions
- Rules of engagement
- Featured presentation
- Interactive small group breakout session
- Report out and roundtable discussion
- Wrap up and adjourn

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?**

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

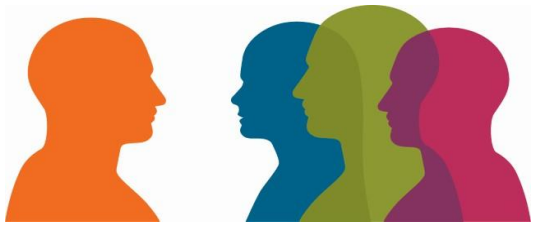
Roundtable Topics

Healthy People 2030 – SDoH-related Goals and Objectives

- What are Social Determinants of Health? (Review)
- Understanding Social Needs Impact on Wellness (Review)
- HP 2030's Focus on SDoH – Overarching Goals and Related Objectives
- Using HP 2030 in Your Work

Collecting and Using Data to Address SDoH in Your Patient Community

- Collecting Screening Data on Patients' Social Needs
- Finding SDoH Data in Your electronic health records (EHRs)
- Using Population Management Data From Your EHRs
- Using Outside Data to Gain Insights
- Understanding Your Resources to Meet Identified Social Needs
- Understanding Your Referrals
- Building Collaborative Partnerships



Source: ThinkStock

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Healthy People 2030: SDoH-related Objectives

Polling Question #1

Does your health center currently use Healthy People 2030's framework (goals and objectives) in SDoH program planning and implementation efforts?

A. HP 2030 is incorporated into **all** our SDoH program planning and implementation efforts.
B. HP 2030 is incorporated into **some** of our SDoH program planning and implementation efforts.
C. HP 2030 is **not** incorporated into our health center's SDoH program planning and implementation efforts.

Source: iStock

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REVIEW: What are Social Determinants of Health?

What are social determinants of health?

Social determinants of health (SDOH) are the **conditions in the environments** where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

HP 2030 groups SDoH into 5 domains

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved July 2022, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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REVIEW: Social Determinants of Health Examples

Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities.

REVIEW: Understanding the Impact of Social Needs on Wellness

- The World Health Organization defines Social Determinants of Health as the "structural determinants and conditions in which people are born, grow, live, work and age" (https://www.who.int/teams/social-determinants-of-health)
- Social determinants of health (SDOH) such as housing, food security and transportation can have a pivotal impact on the physical and mental wellbeing of your patients.
- SDOHs often cause significant barriers to your patient's ability to effectively manage their health.
- Integrating ways to assess and understand your patient's social needs can help your patients in profound ways and help improve overall outcomes.

Overarching Goals of Healthy People 2030

The 5th iteration of the Secretary's Advisory Committee on National Health Promotion and Disease Healthy People Initiative aimed at assessing the latest public health priorities and challenges, identified the following goals.

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- **Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.**
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved July 2022, from Healthy People 2030 Framework - Healthy People 2030 | health.gov.

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HP 2030 SDoH Domain – Health Care Access and Quality

Health Care

***Barriers to accessing health care include*:**

- Inadequate or no health insurance, and unequal distribution of coverage (i.e., out-of-pocket medical costs, medical debt causing patients to delay services, etc.)
- Transportation and residential segregation
- Limited availability of health care resources (i.e., physician shortages, providers who do not accept Medicaid)

HP 2030 SDoH-related Objectives *(not an exhaustive list)*

1. Reduce the proportion of people who can't get medical care when they need it — AHS-04
2. Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it — AHS-R01
3. Increase the use of telehealth to improve access to health services — AHS-R02
4. Increase the proportion of adults who use IT to track health care data or communicate with providers — HC/HIT-07

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Social Determinants of Health Literature Summaries. Access to Health Services*. Retrieved July 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Objectives and Data. Health Care Access and Quality*. Retrieved July 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

HP 2030 SDoH Domain – Health Care Access and Quality

Primary Care

***Barriers to accessing primary care include*:**

- Lack of insurance
- Speaking a language other than English at home
- Limited office hours and availability of services
- Travel distance and shortage of primary care providers

HP 2030 SDoH-related Objectives *(not an exhaustive list)*

1. Increase the proportion of people with a usual primary care provider — AHS-07
2. Increase the proportion of adults whose health care provider checked their understanding — HC/HIT-01
3. Increase the proportion of adults with limited English proficiency who say their providers explain things clearly — HC/HIT-D11
4. Increase the health literacy of the population — HC/HIT-R01

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Social Determinants of Health Literature Summaries. Access to Primary Care*. Retrieved July 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Objectives and Data. Health Care Access and Quality*. Retrieved July 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

HP 2030 SDoH Domain – Economic Stability

Food Insecurity

***Barriers to accessing food that supports healthy eating patterns include*:**

- Low food security – reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.
- Very low food security – report of multiple indications of disrupted eating patters and reduced food intake.
- Unemployment, neighborhood conditions, limited transportation options
- Leads to health disparities

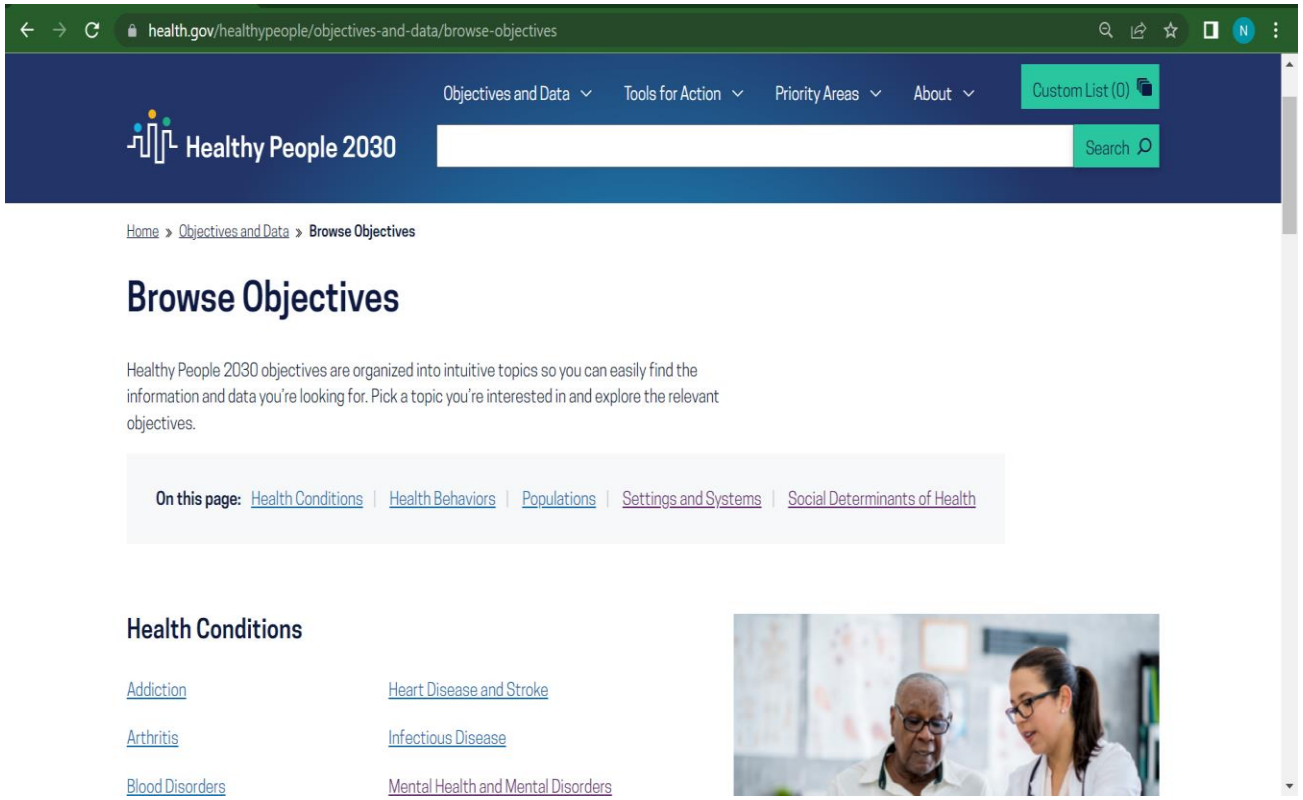
HP 2030 SDoH-related Objectives

1. Reduce household food insecurity and hunger — NWS-01
2. Eliminate very low food security in children — NWS-02

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Social Determinants of Health Literature Summaries. Access to Food that Support Healthy Eating Patterns.* Retrieved July 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-foods-support-healthy-eating-patterns

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Objectives and Data. Economic Stability*. Retrieved July 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

HP 2030 SDoH Objectives



Search objectives by topic!

- Health Conditions
- Health Behaviors
- Populations
- Settings and Systems
- Social Determinants of Health

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Objectives and Data. Browse Objectives.* Retrieved July 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives

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HP 2030 Tools for Action!

Use Healthy People 2030 in your work to address SDoH

Identify Needs	Set Targets	Find Tools	Monitor Progress
Identify needs and priority populations. Consider focusing on groups affected by health disparities.	Set your own targets. Use HP2030 and other available data to set goals and targets.	Find inspiration and practical tools for SDoH implementation through HP 2030 Tools for Action, and other available resources.	Monitor national progress and use HP2030 data as a benchmark.

How can I use Healthy People 2030 in my work?

Healthy People addresses public health priorities by setting national objectives and tracking them over the decade. Join us as we work to improve health and well-being nationwide.

1. Identify needs and priority populations

- Browse objectives to learn about national goals to improve health
- See how national goals align with your priorities
- Consider focusing on groups affected by health disparities

Use this information to make the case for your program, secure resources, and build partnerships.

2. Set your own targets

- Find data related to your work
- Use national data to set goals for your program

Healthy People 2030 establishes objectives and targets for the entire United States, but setting local targets contributes to national success.

3. Find inspiration and practical tools

- Explore critical public health topics

4. Monitor national progress — and use our data as a benchmark

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Tools for Action.* Retrieved July 2022, https://health.gov/healthypeople/tools-action/use-healthy-people-2030-your-work

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Collecting and Using Data to Address SDoH in Your Patient Community

Polling Question #2

Does your health center currently assess patients for SDoH?

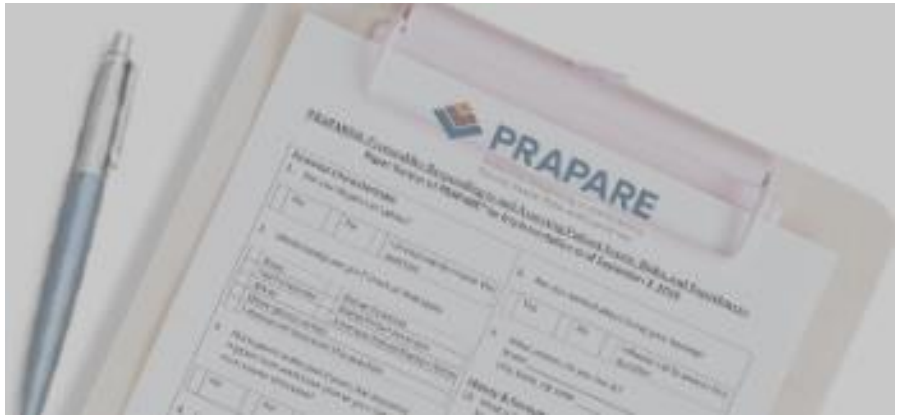
A. All patients are assessed for SDoH at every visit.
B. Certain patients are assessed for SDoH at every visit.
C. Patients are not currently assessed for SDoH.

Source: iStock

Collecting Screening Data on Patient's Social Needs

The PRAPARE Screening Tool
(Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences)

- Nationally standardized and stakeholder-driven tool
- Translated into over 25 language
- Now embedded within most EHRs



Building capacity to address the SDOHs begins with an assessment of your organization's current capacity.

- What resources does your organization have available to focus on addressing identified needs and in what context do these resources exist?
- Are they internal to your organization or do they exist outside of your organization?

Using Population Management Data from Your EHR

- Find your data and analyze it
- Start by focusing on a subset of your population most at risk
- Establish resources to support your identified population
- Do a pilot
- Develop a roll out plan
- Monitor and change as needed

Using Inside & Outside Data to Gain Insights

Inside Data

- EHRs systematically collect clinical information about patients such as **medical history, vital signs, laboratory tests and results, and medication orders.**
- Nonclinical determinants of health can often be found in the structured data elements such as **age, race, ethnicity, and diagnosis codes**.
- Some EHRs also have some lifestyle domains, such **as preferred languages, smoking and alcohol use,** in a structured format.-

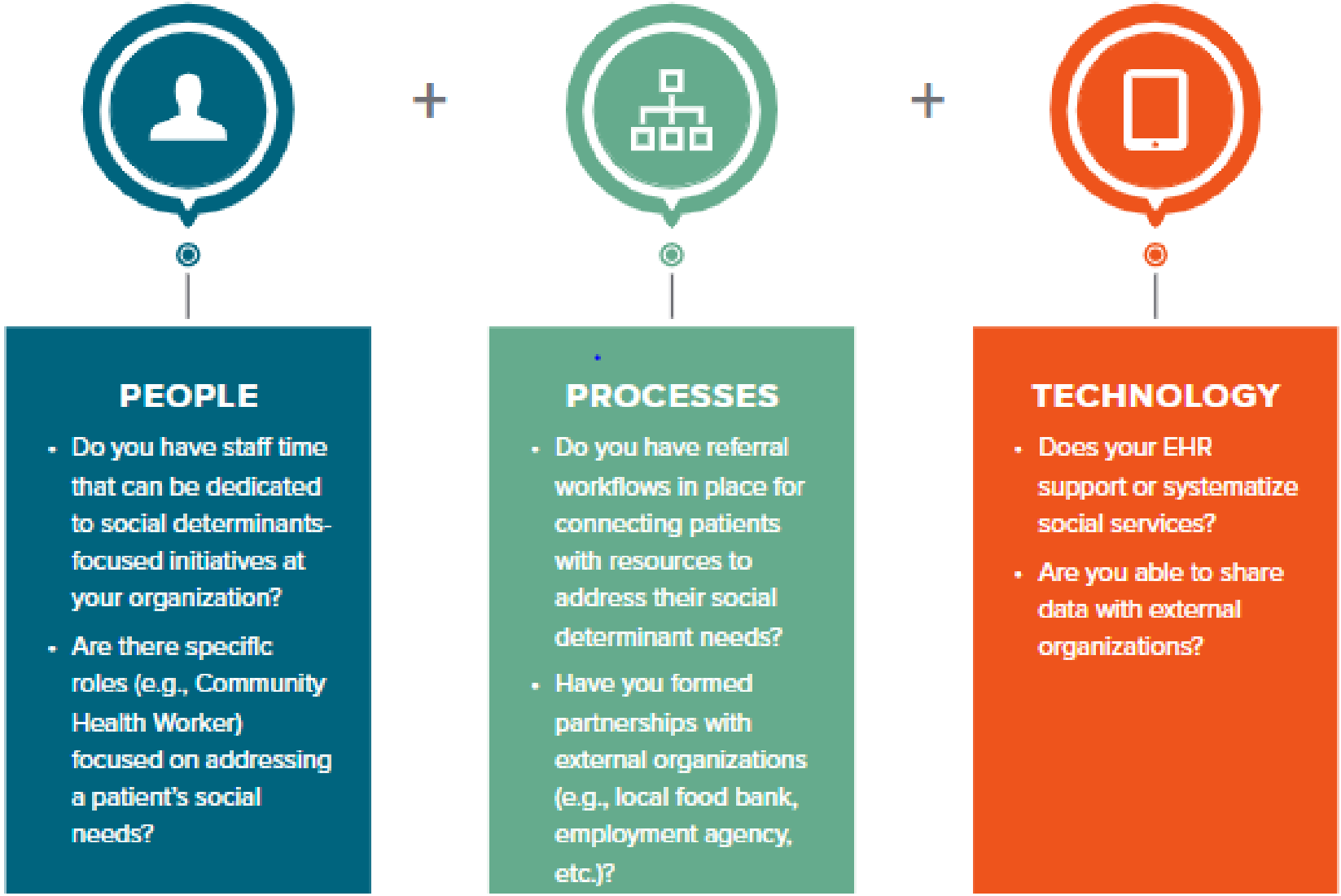
Outside

- Another way to understand the needs of your patients is by looking at the overall trends of conditions and factors that could impact overall health from outside sources.
- There are many tools supported by the CDC that can inform you at a national, state, territory and even some metropolitan areas. Here is the link you can use to see what is happening in your area: https://www.cdc.gov/socialdeterminants/data/index.htm

Source: Centers for Disease Control and Prevention (CDC) Sources for Data on Social Determinants of Health. September 30, 2021.Retrieved July 2022, from https://www.cdc.gov/socialdeterminants/data/index.htm

Understanding Your Resources to Meet the Identified Social Needs

Consider these resource categories when assessing the resources within your organization.



Source: National Association of Community Health Centers PRAPARE Implementation and Action Toolkit. March 2019. Retrieved July 2022, from PRAPARE Toolkit - PRAPARE

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Polling Question #3

Which of the following presents the biggest barrier/challenge to your organization when it comes to implementing SDoH? (Select all that apply).

1. Insufficient staff time to dedicate to SDoH screening and referral
2. Inadequate or missing workflows for connecting patients with resources
3. Lack of partnerships with community organizations as referral sources
4. Electronic health record (EHR) system does not support screening, data collection and data reporting re: social need and social risk
5. Inability to share patient information when referring patients to external resources

Source: iStock

Why Build Collaborative Partnerships?

- Primary care providers are the service of choice for 70% of families seeking behavioral health care.
- 70% of all healthcare visits are generated by psychosocial factors.
- Integrated primary care and behavioral health services are not designed to meet all needs.
- Many social determinants of health need to be addressed by community-based resources, i.e., grocery store, Boys/Girls Club.
- Health centers can play a key role in building healthier communities.

Source: Partners in Health. Mental Health, Primary Care, and Substance Use Interagency Collaboration Toolkit. Second Edition. 2013. Integrated Behavioral Health Project. Retrieved July 2022, from IBHPIinteragency-Collaboration-Tool-Kit-2013-.pdf (ibhpartners.org)

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Understanding Your Referrals

Partnerships & Community Linkages: *Cultivating connections between your agency and stakeholders.*

1. What types of formal, contractual partnerships does your organization have in place to support the SDOH program(s)?
2. If your organization already has formal partnerships in place, what are the outcomes of those partnerships?
3. What impact have they had on the target population, and what milestones have been achieved so far?
4. If your organization doesn't have any formal partnerships in place, have you identified social service organizations in your area that you would like to partner with?
5. What types of services and resources do these social service organizations provide, and do they meet the needs of your target populations?

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.

Polling Question #4

Given the information presented in this Roundtable, what barriers/challenges regarding SDoH implementation should your health center prioritize first? (Select all that apply).

Source: iStock

1. Insufficient staff time to dedicate to SDoH screening and referral
2. Inadequate or missing workflows for connecting patients with resources
3. Lack of partnerships with community organizations as referral sources
4. Electronic health record (EHR) system does not support screening, data collection and data reporting re: social need and social risk
5. Inability to share patient information when referring patients to external resources

SMALL GROUP BREAKOUT SESSION

Small Group Breakout Session

SMALL GROUP TOPIC AREAS

- **Group A:** Insufficient staff time to dedicate to SDoH screening and referral
- **Group B:** Inadequate or missing workflows for connecting patients with resources
- **Group C:** Lack of partnerships with community organizations as referral sources
- **Group D** Electronic health record (EHR) system not supporting screening, data collection and data reporting
- **Group E:** Inability to share patient information when referring patients to external resources

SMALL GROUP DISCUSSION QUESTIONS

1. **Describe the specific barriers/ challenges** your health center is struggling with as it relates to your group's assigned topic area.
2. **What strategies have been most successful** in helping your organization address these challenges?
3. **What additional resources or strategies might be useful** in helping your health center further mitigate these challenges?

Source: iStock

Roundtable Discussion and Report Out

WRAP UP

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.

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.

Upcoming TA Opportunities

SDoH Training and Technical Assistance

- SDoH 1:1 Training for Health Centers – ongoing

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

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

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Accessing Additional Training and TA Opportunities

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com

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BH TA WEEKLY UPDATE

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National SDOH Services Resources

Benefit Finder questionnaire: https://www.benefits.gov/

- The official benefits website of the U.S. government and includes information for citizens to identify benefits that they may be eligible to receive, and application information. Benefits address a variety of needs including food/nutrition, health care, housing and utilities, childcare, and tax assistance.

NowPow: https://nowpow.com/

- Community resource directory and referral platform (recently acquired by Unite Us). Uses zip code and patient-specific data to identify resources for patient families. Offers robust data analytics, metrics and reports that show what services are needed most and provide other strategic insights.

Unite Us: https://uniteus.com/

- A referral platform with closed-loop capabilities. Connects patients to social services.

National SDOH Services Resources (cont.)

Aunt Bertha (FindHelp): https://www.findhelp.org/

- Find food assistance, medical care, housing, transit, education, legal support, help paying bills, and other free or reduced cost programs in the United States, including new programs for the COVID-19 pandemic.

211: https://www.211.org/

- The 211 network in the United States responds to more than **14 million requests for help every year**. Most calls, web chats, and text messages are from people looking for help meeting basic needs like housing, food, transportation, and health care.

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Thank You!

Vision: Healthy Communities, Healthy People