HRSA
Health Resources & Services Administration

Social Determinants of Health: Advancing Equity in Behavioral Health

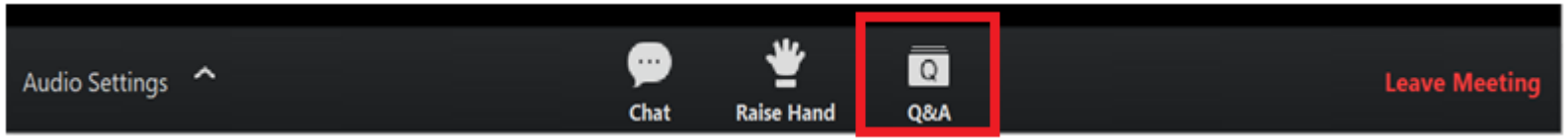
Tuesday, April 16, 2024

3:00 p.m. to 4:00 p.m. ET

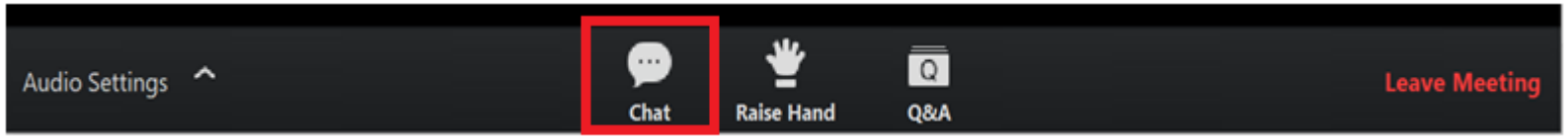
Vision: Healthy Communities, Healthy People

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 webinar, please message us through the chat feature or email healthcenter_BHTA@jbsinternational.com



Continuing Education (CE)

- We offer **behavioral health** Continuing Education units (CEUs) for participation in BHTA events.
- You must attend the event and complete the online Health Center TA Satisfaction Assessment form after the event (2-3 minutes).
- The link with instructions is provided at the end of the session.
- Continuing Education certificates will be sent within 5 weeks of the event from Health Center BHTA Team via Smartsheet <user@app.smartsheet.com>.

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

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Virtual or On-Site Technical Assistance (TA)

- Six hours of expert TA organized around staff availability
- Topics may include:
  - Implementing integrated care (IC)
  - BH skills and practice in PC settings
  - Workforce development
  - Cultural considerations in IC
- Limited number of slots available
- Interested? Contact us!
  - https://bphc-ta.jbsinternational.com/virtual-and-site-ta

Behavioral Health Technical Assistance Portal

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

Visit the Bureau of Primary Health Care Integrated Behavioral Health Technical Assistance portal

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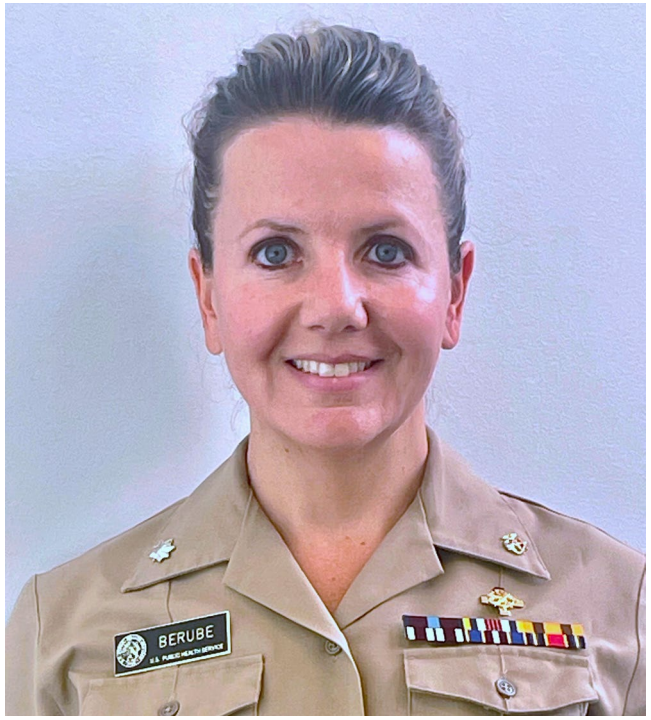
Accessing Slides and Captioned Recordings

- The 508 compliant slides for this presentation are **available now** on the BH TA Portal in the section "Technical Assistance Resources."

- Captioned videos will be posted to the same location within 2 weeks.

https://bphc-ta.jbsinternational.com/technical-assistance-resources

Health Resources and Services Administration (HRSA)
Opening Remarks



Jayne Berube, Team Lead
Office of Quality Division, HRSA Office of Quality Improvement (OQI), Health Resources and Servic es Administration (HRSA)

Presenter(s)

Natalie M. Slaughter, MSPPM
Technical Expert Lead, Behavioral
Health Technical Assistance
JBS INTERNATIONAL, INC.

Objectives

Source: iStock

Participants of this webinar will be able to:

- Define health equity and the social determinants of health (SDOH) related to behavioral health (BH)
- Describe the social determinants that drive BH inequities and impact individual-level interventions
- Identify at least three health center strategies for addressing SDOH as a pathway to behavioral health equity

What Is Health Equity?

- Absence of avoidable differences in health status and health outcomes among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality

- Attainment of one's full potential for health and well-being regardless of socioeconomic and demographic group or geographical area

Source
World Health Organization. (2024). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Health Inequities and Disparities Defined

- Health inequity—Systematic differences in health status, distribution of health resources, and opportunities to achieve optimal health between different population groups, leading to unfair and avoidable differences in health outcomes

- Health disparity—A particular type of health difference closely linked with social, economic, and/or environmental disadvantage

Sources
Centers for Disease Control and Prevention. (2023). *Health disparities.* https://www.cdc.gov/healthyyouth/disparities/index.htm#:~:text=Health%20disparities%20are%20preventable%20differences,youth%20health%20risk%20behaviors%20persist
World Health Organization. (2024). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Equity Versus Equality

Image Source
Virginia department of Health. Office of Health Equity. https://www.vdh.virginia.gov/health-equity/

Who Experiences the Highest Levels of Health Disparities?

"Communities of color, populations with a lower socioeconomic status, rural communities, people with cognitive and physical disabilities and individuals who identify as LGBTQ are often disproportionately exposed to conditions and environments that negatively affect health risks and outcomes and lead to higher rates of health disparities."

Source
National Conference of State Legislatures. (2021, March 10). *Health disparities overview*. https://www.ncsl.org/health/health-disparities-overview

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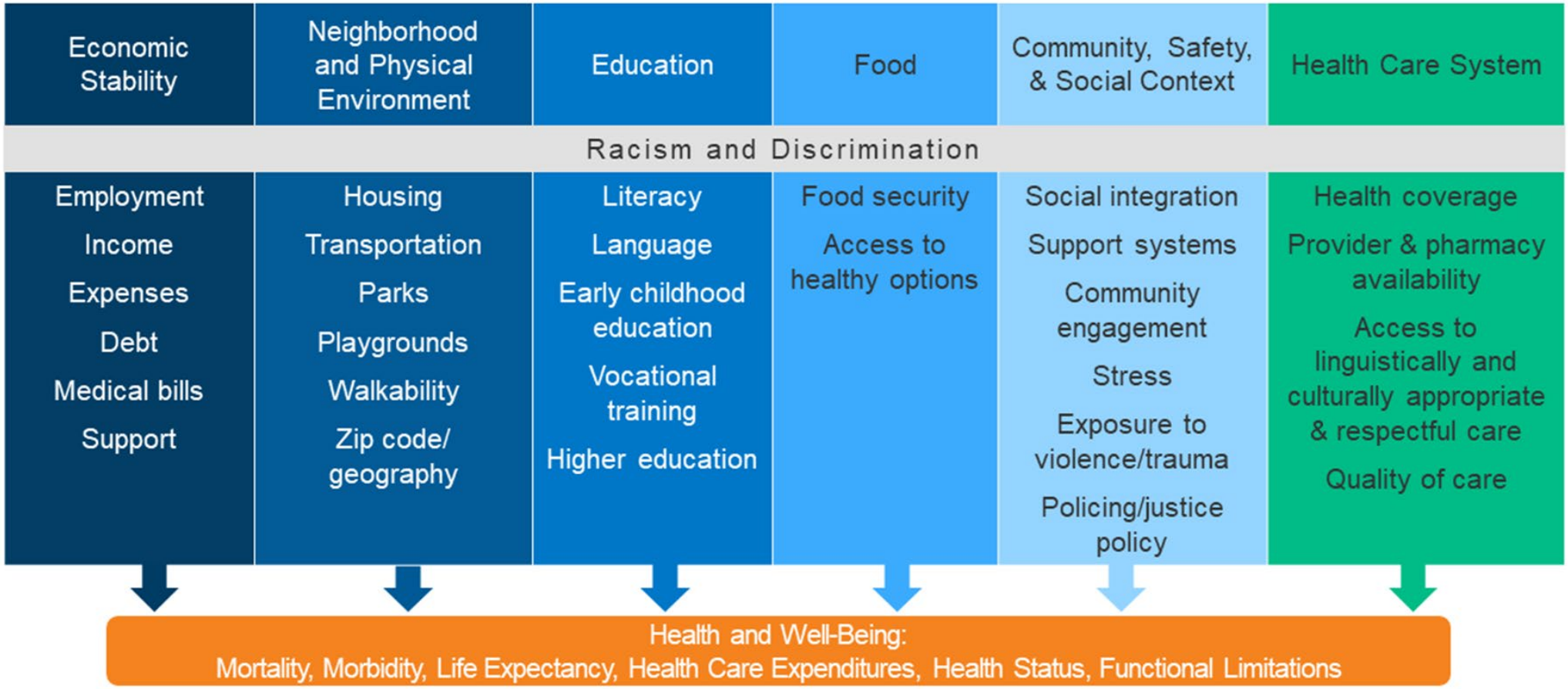
Social and Economic Factors Drive Health Outcomes



Source

Artiga, S. (2020, June 1). *Health disparities are a symptom of broader social and economic Inequities.* Kaiser Family Foundation. https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/

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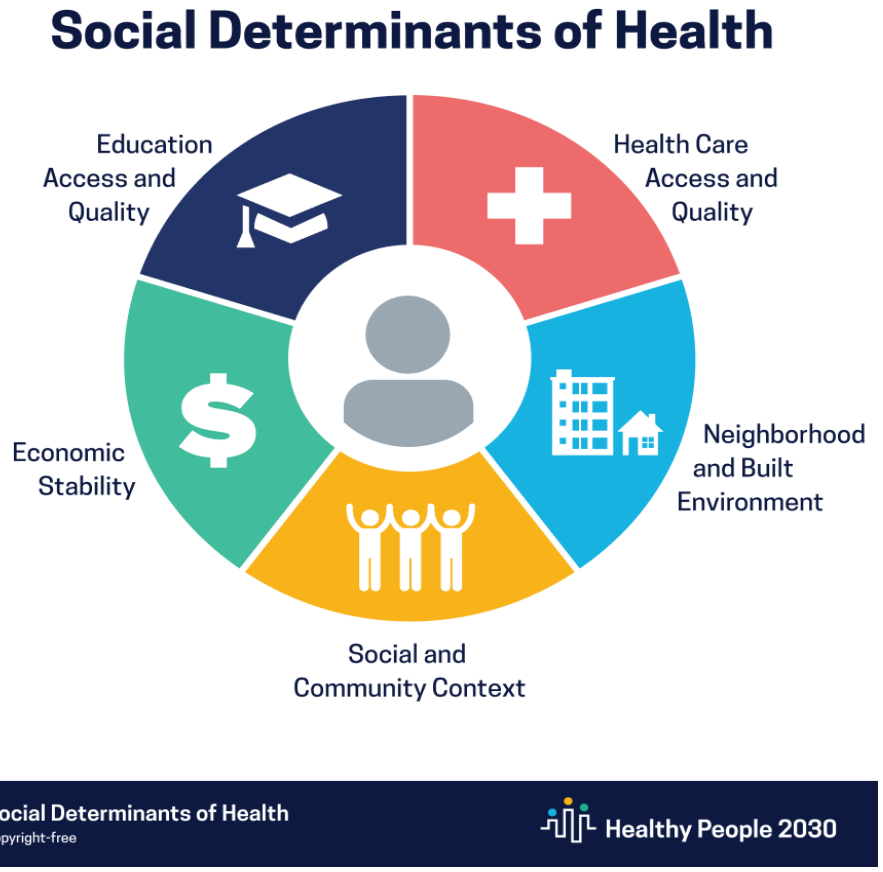
The Social Determinants of Health



Source
Healthy People 2030. (n.d.). *Social determinants of health*. Office of Disease Prevention and Health Promotion. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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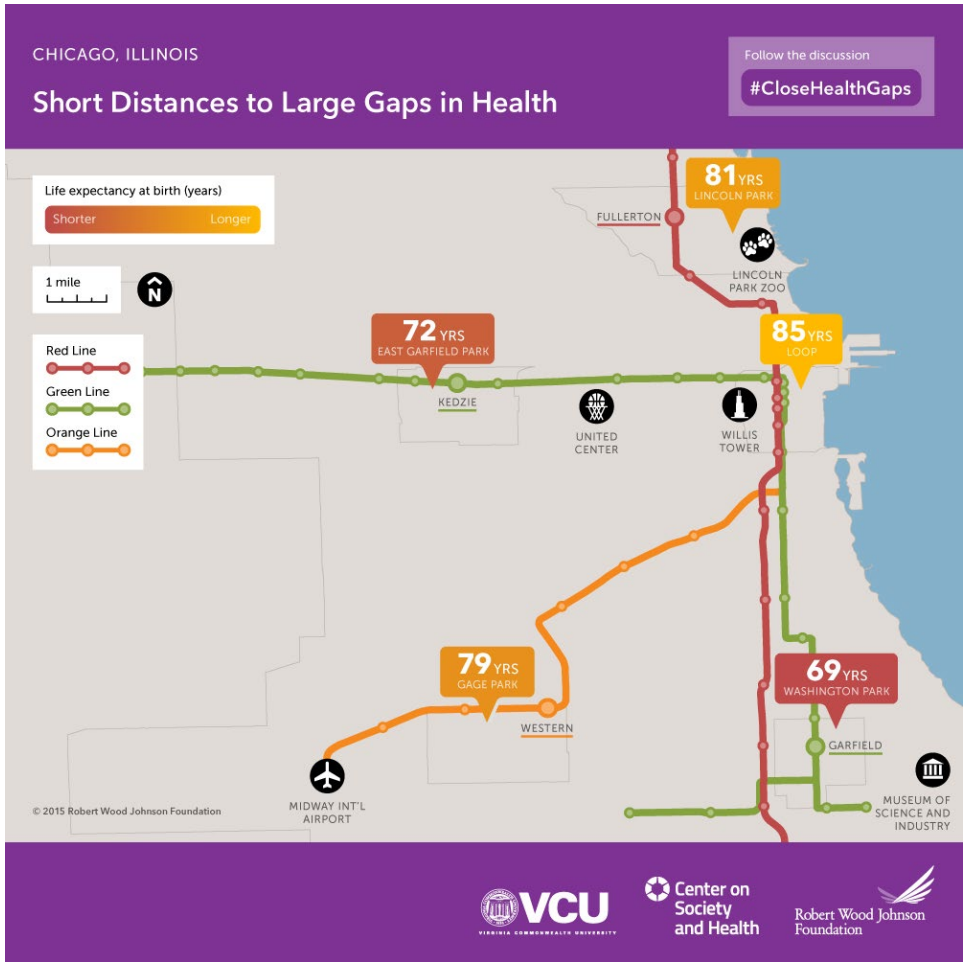
Examples of Life Expectancy by Location



Sources: Virginia Commonwealth University. (2015, November 12). *Mapping life expectancy: 16 years in Chicago, Illinois*. Center on Society and Health. https://societyhealth.vcu.edu/work/the-projects/mapschicago.html#gsc.tab=0
Virginia Commonwealth University. (2015, November 12). *Mapping life expectancy: 20 years in Richmond, Virginia*. Center on Society and Health. https://societyhealth.vcu.edu/work/the-projects/mapsrichmond.html#gsc.tab=0

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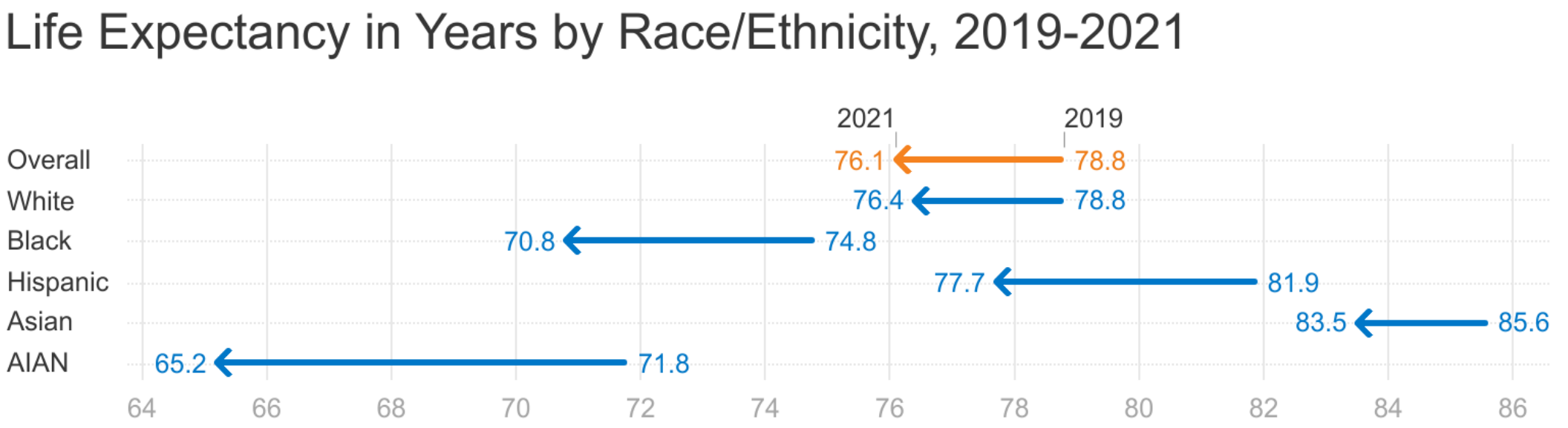
Life Expectancy by Race and Ethnicity



NOTE: Estimates based on provisional data for 2021 and final data for 2019 life expectancy at birth. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
SOURCE: Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. Provisional life expectancy estimates for 2021. Vital Statistics Rapid Release; no 23. Hyattsville, MD: National Center for Health Statistics. August 2022. DOI: https://dx.doi.org/ 10.15620/cdc:118999.

KFF

Source
Hill, L., Ndugga, N., & Artiga, S. (2023, March 15). *Key data on health and health care by race and ethnicity.* Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

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Understanding the Social Determinants of Behavioral Health

What Drives Behavioral Health (BH) Inequities?

- Social determinants of health
- Racial/ethnic disparities
- Service access barriers
- Language barriers

Image Sources: Microsoft® PowerPoint® for Microsoft 365.

Source
Substance Abuse and Mental Health Services Administration. (2023, May 25). *Behavioral health equity.* https://www.samhsa.gov/behavioral-health-equity

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What Are the Social Determinants of BH?

Image Sources: Microsoft® PowerPoint® for Microsoft 365.

- Are not distinctly different from the SDOH
- Do deserve special attention because:
  - Mental illness and substance use disorders are highly prevalent and highly disabling.
  - BH conditions are high-cost, high-morbidity, high-mortality illnesses.

Sources

Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, *13*(4), 419–425. https://doi.org/10.1176/appi.focus.20150017

Substance Abuse and Mental Health Services Administration. (2023, May 25). *Behavioral health equity.* https://www.samhsa.gov/behavioral-health-equity

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SDOH Impact Health Center Capacity and Individual-level BH Interventions

SDOH affect access to BH services and impact health centers' capacity to effectively treat BH needs, especially SDOH such as:

- Income and employment status
- Housing and homelessness
- Transportation
- Rurality
- Food insecurity
- Education and literacy levels
- Language barriers
- Cultural factors
- Stigma

Source
Staff of JBS International, Inc. (2023, December 2023). *Behavioral health integration training and technical assistance needs of health centers*. [Focus group.]. Funded by Health Resources and Services Administration/Bureau of Primary Health Care.

Groups Disproportionately Affected by Poor Mental Health Outcomes

- Racial/ethnic, gender, and sexual minorities suffer from poorer mental health outcomes
- Contributing factors are:
  - Inaccessibility of high-quality mental health care services
  - Cultural stigma surrounding mental health care
  - Discrimination
  - Overall lack of awareness about mental health

Source

American Psychiatric Association. (2024). *Mental health disparities: Diverse populations*. https://www.psychiatry.org/psychiatrists/diversity/education/mental-health-facts#:~:text=Research%20indicates%20that%20American%20Indian,trauma%20forced%20upon%20this%20population

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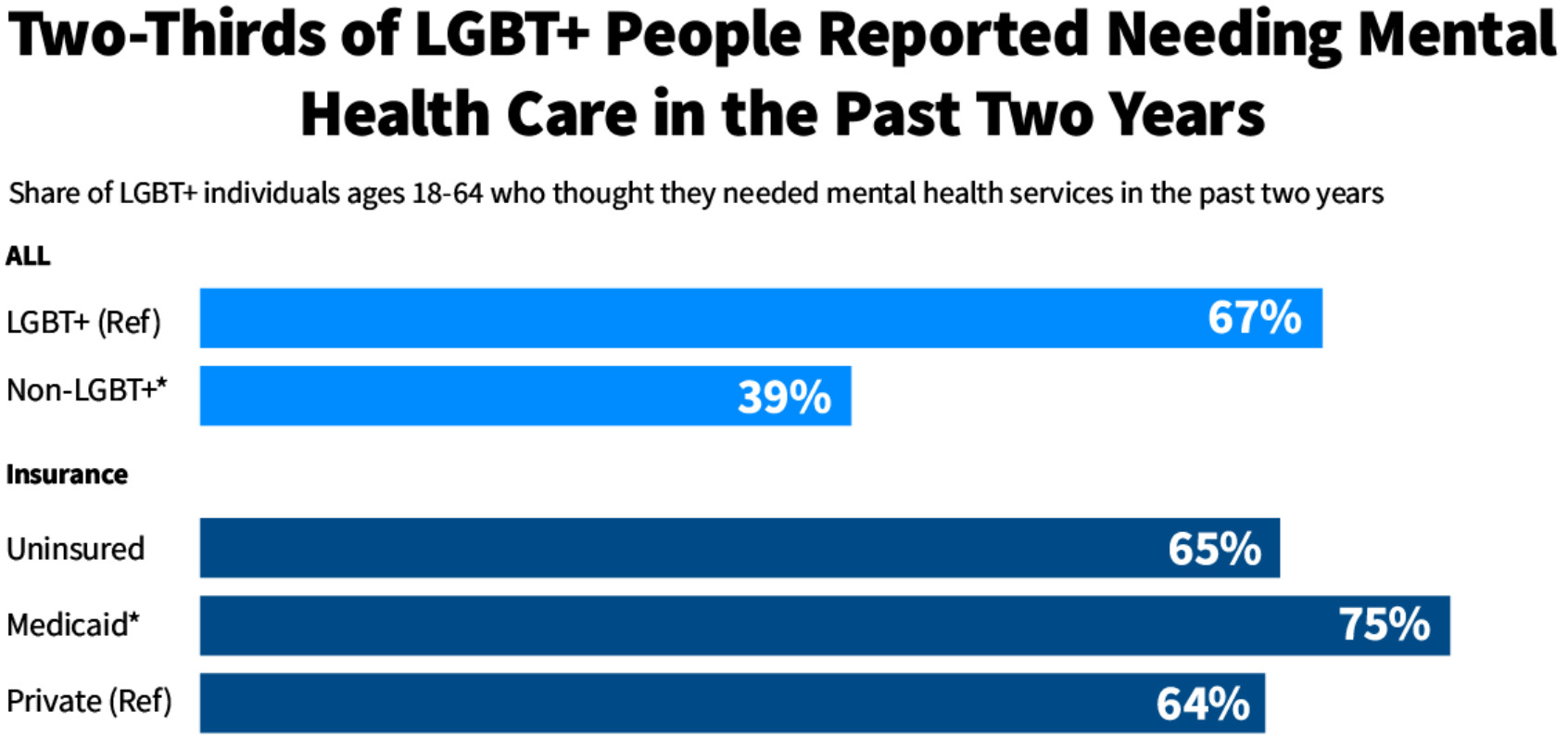
Groups Disproportionately Affected by Overdose Deaths

- Groups disadvantaged by reduced economic stability
- Groups experiencing disabilities, homelessness, mental health conditions, or incarceration
- Groups experiencing limited educational attainment, limited access to health care, limited health literacy, and/or limited access to substance use treatment
- Groups from non-English speaking populations
- Tribal populations
- Rural populations and other geographically underserved areas
- Racial and ethnic populations
- Sexual and gender minority groups

Disparities in Mental Health Needs



Source
Dawson, L., Long, M., & Frederiksen, B. (2023, June 30). *LGBT+ people's health status and access to care.* Kaiser Family Foundation. https://www.kff.org/report-section/lgbt-peoples-health-status-and-access-to-care-issue-brief/

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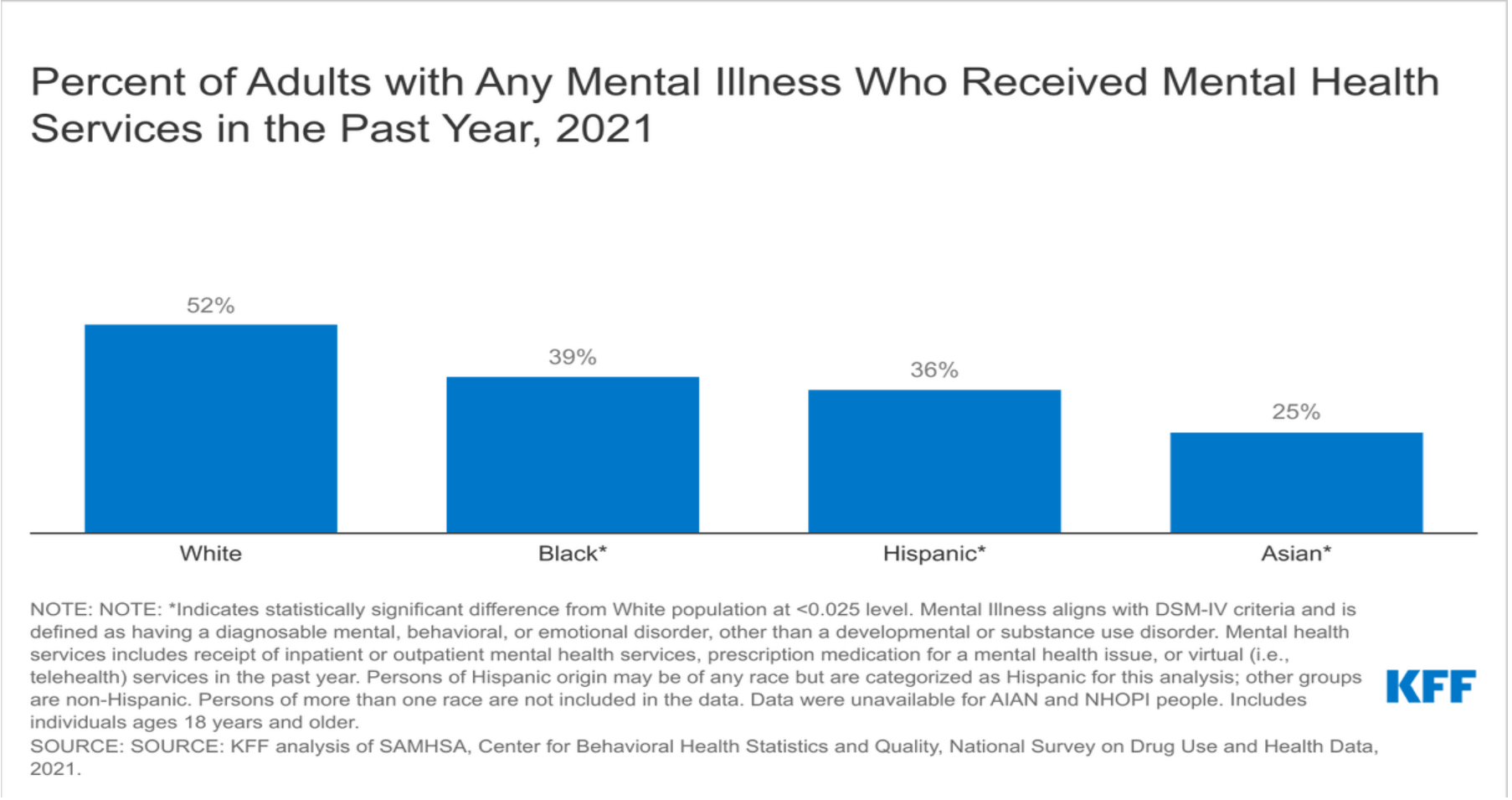
Disparities in Mental Health Services



Source
Hill, L., Ndugga, N., & Artiga, S. (2023, March 15). *Key data on health and health care by race and ethnicity*. Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

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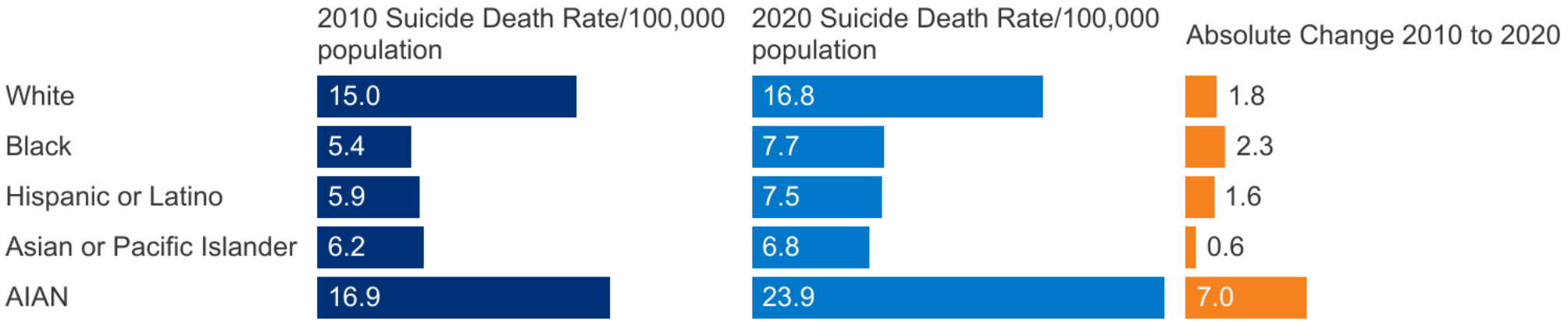
Disparities in Suicide Rates

Figure 1

Suicide Death Rates by Race/Ethnicity, 2010-2020

Click on the buttons below to see data for the different age groups:

Overall Population | Adolescents



NOTE: AIAN refers to American Indian and Alaska Native people. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic

SOURCE: KFF analysis of CDC WISQARS data, 2010-2020

KFF

Source

Panchal, N., Saunders, H., & Ndugga, N. (2022, September 22). *Five key findings on mental health and substance use disorders by race/ethnicity*. Kaiser Family Foundation. https://www.kff.org/mental-health/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/

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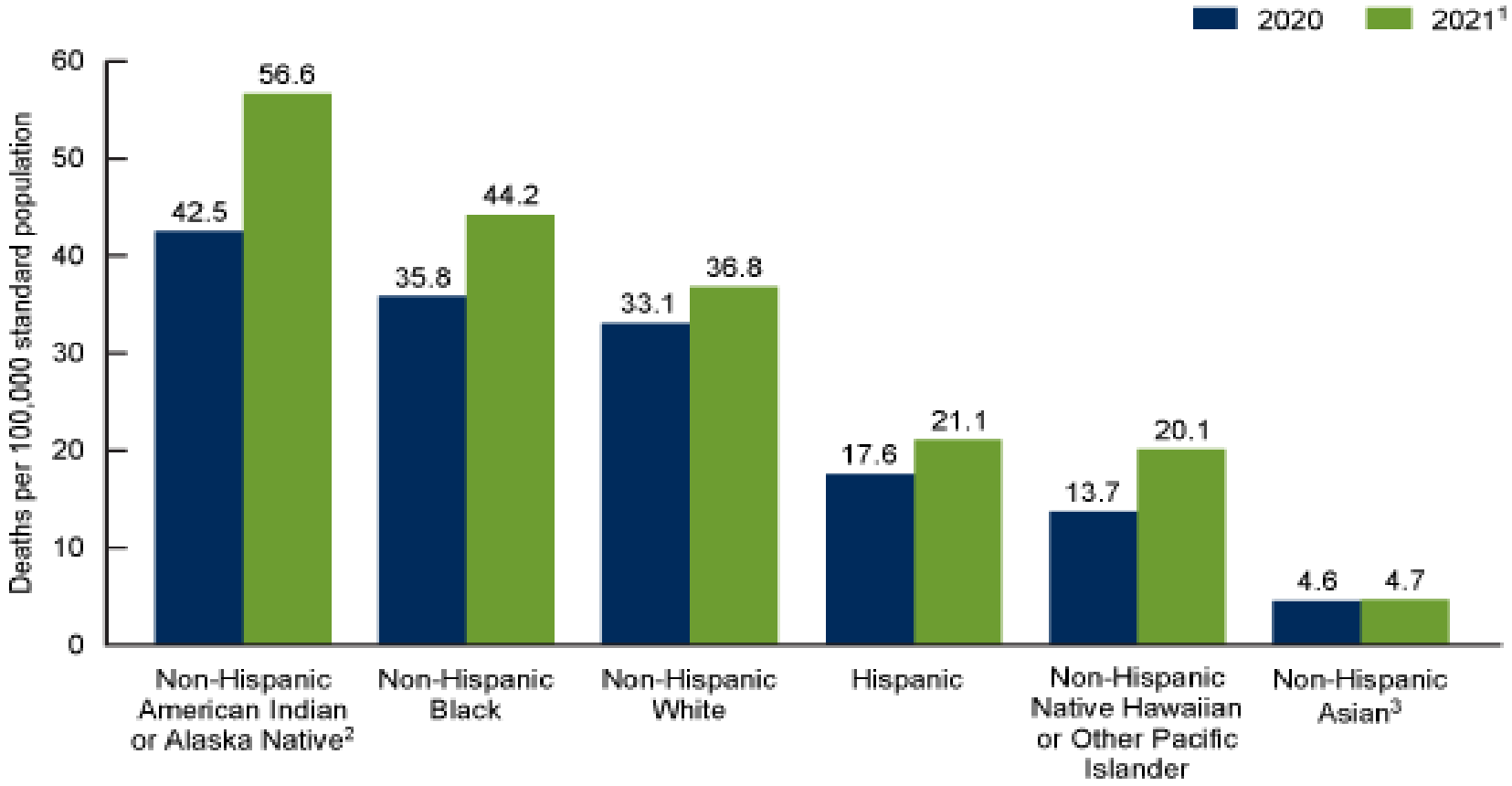
Impact of the Opioid Crisis on Racial and Ethnic Populations



Source

Spencer, M. R., Miniño, A. M., & Warner, M. (2022, December 22). *Drug overdose deaths in the United States, 2001–2021*. National Center for Health Statistics. NCHS Data Brief, No. 457. https://dx.doi.org/10.15620/cdc:122556

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Addressing SDOH: A Pathway to Behavioral Health Equity

Image Sources: Microsoft® PowerPoint® for Microsoft 365.

Polling Questions #1

Source: iStock

1a. Does your health center currently assess patients for SDOH?
***Select one of the following options*:**

- All patients are assessed for SDOH at every visit.
- Certain patients are assessed for SDOH at every visit.
- Patients are not currently assessed for SDOH.

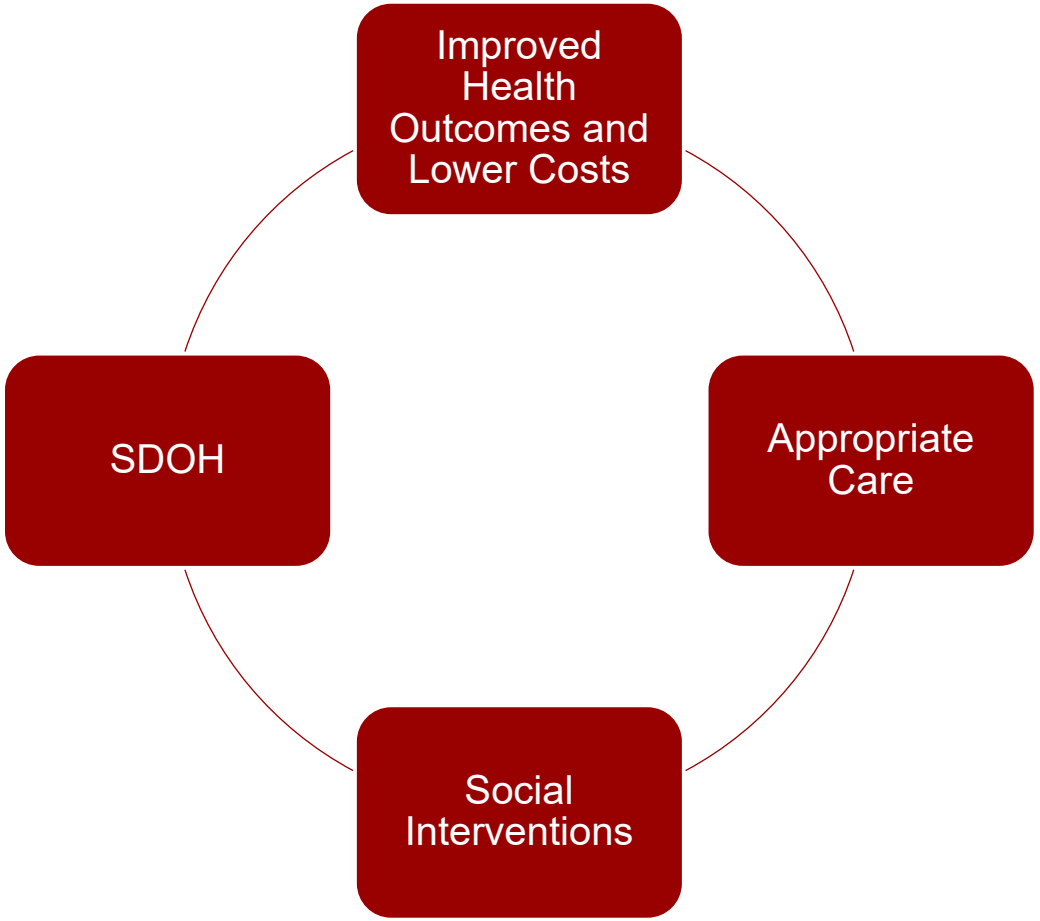
1b. Which of the following presents the biggest barrier/challenge to your health center with addressing SDOH among patients?
***Choose all that apply*:**

- Lack of staff time for SDOH screening and referral
- Inadequate or missing workflows for connecting patients with resources
- Lack of partnerships
- SDOH data collection and reporting not supported by EHR system

Assess Readiness

Source: © 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

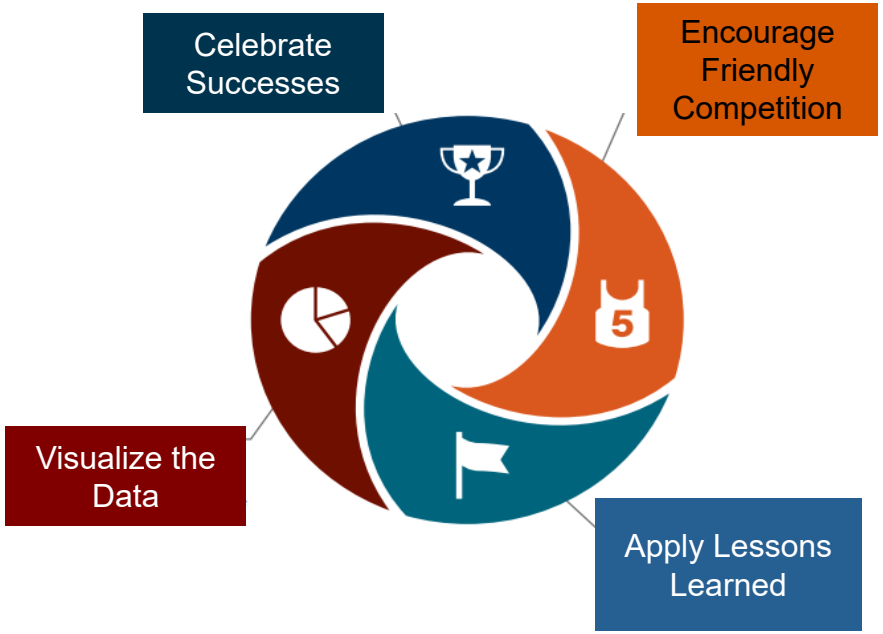
Make the Case: Outcomes of Assessing and Addressing SDOH-Related Needs



- ✓ Reduction in missed appointments
- ✓ Reduction in ER visits and hospitalizations
- ✓ Improvement in appropriate, preventive care
- ✓ Improvement in quality indicators such as A1C and overall health outcomes

Tips for Getting Started

- Start small
- Use PDSA
- Select a population of focus
- Develop a workplan to document roles and responsibilities for team members involved
- Create organizational goals with SDOH data collection
- Keep staff updated; meet regularly to discuss the use of PRAPARE
- Plan staff incentives and team celebrations for achieving PRAPARE goals



Build Capacity to Respond

People + **Processes** + **Technology**

Do you have staff time that can be dedicated to SDOH-focused initiatives at your clinic?

Do their specific roles (e.g., community health worker) focus on addressing patients' social needs?

Do you have referral workflows in place for connecting patients with resources to address their social determinant needs?

Have you formed partnerships with external organizations (e.g., local chapter of a food bank, employment agency?

Does your electronic health record system support or systematize patient referrals to social services?

Are you able to share data with external organizations?

Screen for SDOH Using Validated Tools

Image Sources: Microsoft® PowerPoint® for Microsoft 365.

- The PRAPARE Screening Tool—PRAPARE
- The Hunger Vital Sign
- Accountable Health Communities Screening Tool
- The EveryONE Project—Social Needs Screening Tool
- American Academy of Pediatrics Screening Tool Finder

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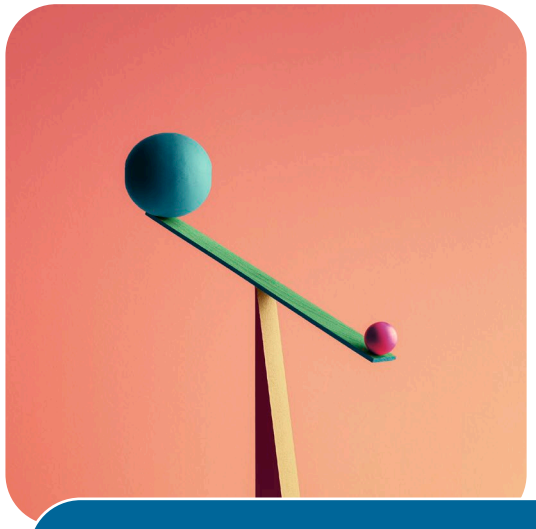
Use the Screening, Brief Intervention, Referral to Treatment (SBIRT) Approach for Addressing SDOH

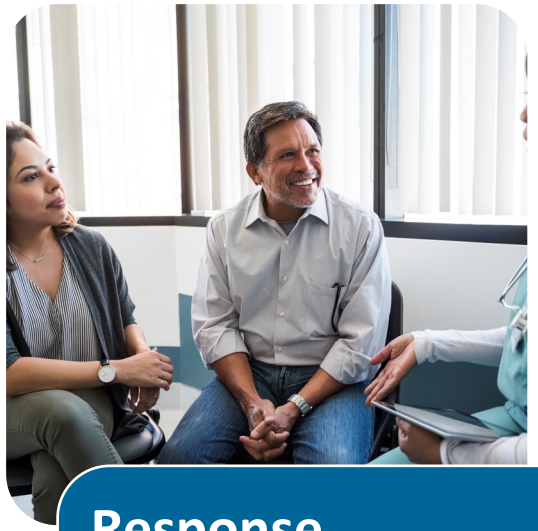
Universal SDOH Screen

- Ask questions
- Record answers
- Determine if full screen is needed



Full SDOH Screen

- Conduct targeted or secondary screening
- Use validated screening tools to identify social needs



Response

- Brief Intervention—connect to designated staff
- Referral to social services
- Warm handoff and follow-up
- Data collection with partners
- Use of data to improve service delivery

Image Sources: Microsoft® PowerPoint® for Microsoft 365.

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Who Provides Screening and Response?

Universal Screening

- Patient self-administered
- Support staff
- Medical assistants (MAs)
- Provider (BH or medical)

Targeted /Secondary Screening and Scoring

- Support staff
- Medical assistants (MAs)
- Provider (BH or medical)
- ***Prompt documentation***

Risk Stratification and Response

- Clinical provider determines risk level
- Clinical provider responds to patient

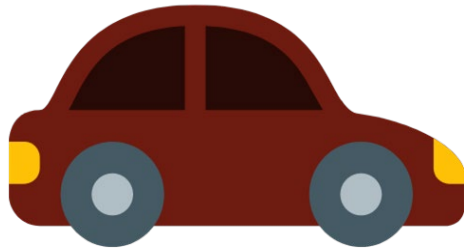
Link Patients to Community Resources

- Stratify risk to identify patients in need
- Assess individual patient needs and goals
- Provide personalized referrals and assistance
- Ensure warm-handoffs and follow-ups to successfully connect patients to services
- Collaborate with community organizations and social service agencies

Partner with Community Stakeholders

Housing providers, continuums of care, housing authority

Farmers markets, food pantries, soup kitchens, shelters, schools



City/county departments, rideshares, insurance companies

Community development organizations, after-school programs, city planning agencies

Legal aid, court system, social action organizations, police department

Source: VectorStock Images

Consider Partnership Types

Referrals

- Client referrals to preferred services
- Client-initiated referrals
- Autonomous partners and independent operations—resources generally not shared
- Low collaboration

Care Coordination

- Client-centered joint care plans
- Centralized intake (perhaps)
- Client-initiated with strong transition supports
- Independent operation of organizations—may share resources and funding
- Moderate to high collaboration with cross-training and frequent communication

Co-location

- Joint operation of partners—may retain autonomy
- Incorporation into existing site, mobile services, or new joint site
- High collaboration

Full-service Integration

- Single point of entry; integrated assessment
- Joint case planning
- Wrap-around care that may be brought to where it is most accessible to the client
- Partners operate independently or jointly
- Ability to blend with co-location
- Very high collaboration, with integrated resources and service delivery

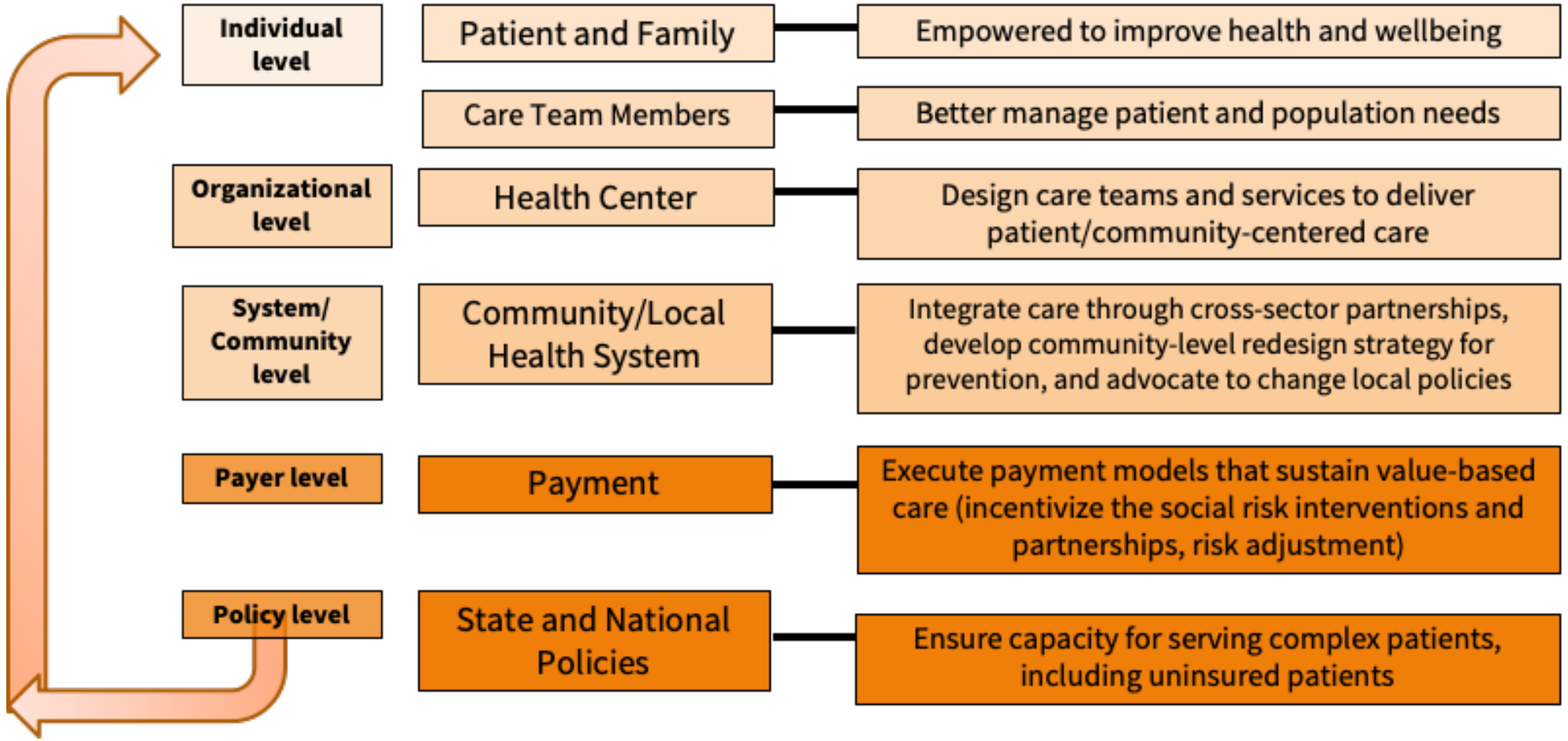
Source: Corporation for Supportive Housing

Ensure Seamless Referrals and Coordinated Care

- Strategies for improving referral networks:
  - Streamlining referral processes
  - Enhancing communication and information sharing
  - Implementing technology solutions
- Collection and analysis of data on social needs and outcomes
  - Using data to evaluate impact and drive improvement

- Seamless referrals and coordinated care:
  - Improve patient outcomes
  - Enhance the patient experience
  - Use resources efficiently
  - Create continuity of care
  - Foster collaboration among healthcare providers
  - Address SDOH

Collect Standardized Data on SDOH



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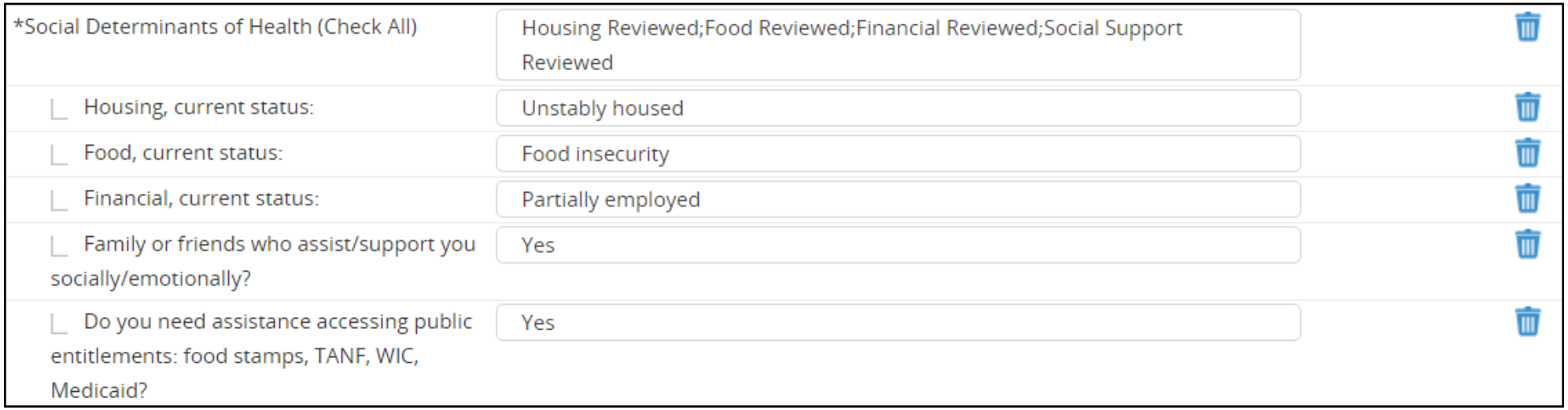
Health Center Example: SDOH Screening at Whitman-Walker Health, Washington, D.C.

1. SDOH needs are identified in the intake assessment (reassessed every 6 months).

2. Each response from the intake assessment is mapped to a specific Z code that is documented in the patient chart.



*Social Determinants of Health (Check All)	Housing Reviewed;Food Reviewed;Financial Reviewed;Social Support Reviewed
Housing, current status:	Unstably housed
Food, current status:	Food insecurity
Financial, current status:	Partially employed
Family or friends who assist/support you socially/emotionally?	Yes
Do you need assistance accessing public entitlements: food stamps, TANF, WIC, Medicaid?	Yes

WWH Pilot Selections

Domain	Z	ICD Code Description	WWH Assessment, section header	WWH assessment, Q	WWH assessment, A
Housing	z59.81	Housing Instability	Social Determinants of Health	Housing, current status?	"Unstably housed"
Housing	z59.022	Residing on the street	Social Determinants of Health	Housing, current status?	"Living on street"
Housing	z59.01	Sheltered homelessness	Social Determinants of Health	Housing, current status?	"Homeless shelter"
Housing	*NA*	*No need to code*	Social Determinants of Health	Housing, current status?	"Stable housing"
Food	z59.42	Food insecurity	Social Determinants of Health	Food, current status?	"Food insecurity"
Food	*NA*	*No need to code*	Social Determinants of Health	Food, current status?	"Stable access to food"
Financial	z59.86	Financial insecurity, not elsewhere classified	Social Determinants of Health	Financial, current status	Used your judgement based on the selections for this question to determine if client is financially insecure.
Transportation	z59.82	Transportation insecurity	Medication & Appointment Adherence barriers	Use if "transportation" is selected.	

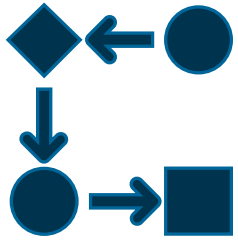
Source: Whitman Walker Health

Integrate SDOH Into Your Agency's Infrastructure

Employee Onboarding

Training

Supervision



Clinical Workflow

Data Collection and Outcome Evaluation

Policies and Procedures

Image Source: Microsoft® PowerPoint® for Microsoft 365

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Empower Staff to Address Social Needs

- Who is best positioned to talk about SDOH with your patients?
- Who has the most frequent face time with patients (MAs, CHW, Case Manager, Patient Navigator, Social Worker, etc.)?
- Who is already screening and assessing for patient needs?
- Who is connected to resources or can make connections to resources to meet SDOH needs?

Train Staff to Address Social Needs

- Recognize that these are sensitive and potentially traumatic topics
- Be clear about where staff should document SDOH needs
- Provide training, refreshers, and check-ins on the process
- Have a plan for addressing the needs patients are asked about
- Prepare staff for and support them when experiencing compassion fatigue

Incorporate Trauma-informed Care Into Service Delivery

- **Trauma-informed care seeks to:**
  - Realize the widespread impact of trauma and understand paths for recovery
  - Recognize the signs and symptoms of trauma in patients, families, and staff
  - Integrate knowledge about trauma into policies, procedures, and practices
  - Actively avoid re-traumatization

- **Steps to becoming a trauma-informed organization:**
  - Building awareness and generating buy-in for a trauma-informed approach
  - Supporting a culture of staff wellness
  - Hiring a workforce that embodies the values of trauma-informed care
  - Creating a safe physical, social, and emotional environment

Polling Questions #2

Source: iStock

2a. Rate your knowledge of the topic area presented in this webinar:

- Not at all knowledgeable
- Slightly knowledgeable
- Moderately knowledgeable
- Very knowledgeable
- Extremely knowledgeable

2b. How confident are you in applying information about this webinar topic area in your work setting?

- Not at all confident
- Slightly confident
- Moderately confident
- Very confident
- Extremely confident

Q&A

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Thank you!

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