2021 SDOH Academy "Breakthrough" Series:

Webinar 1 – Improving Access to Quality Health Care and Services

April 8, 2021

Presented by the Association of Asian Pacific Community Health Organizations, the Center for Supportive Housing, the National Association of Community Health Centers, and National Center for Farmworker Health.

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CSH The Source for Housing Solutions

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The Social Determinants of Health Academy

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The Social Determinants of Health Academy

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SDOH Academy 2021: Breakthrough Series
Webinar 1 – Improving Access to Quality Health Care and Services

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Health Center Guest Speaker

MyCare HEALTH CENTER

Nashia A. Choudhury, MPH
Director of Operations,
MyCare Health Center

Housekeeping

- Webinar will be recorded
- PowerPoint slide deck and resources are available for download
- Use the Zoom platform for engaging with us and each other: chat, Q&A section, reactions, and raise your hand
- New realities: kiddos, furry friends, unstable internet, renovations, etc.

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About the 2021 “Breakthrough” Series

Using our core competencies framework, the SDOH Academy is offering a “Breakthrough Series” of webinars and office hours where SDOH Academy faculty will help you “break through” the clutter to find the: resources, experts, and peer linkages.

Each webinar will equip participants with the tools needed to increase their competency in four core areas SDOH response strategies and will be immediately followed by an optional, half-hour office hours session from 4:00pm - 4:30pm.

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About the 2021 "Breakthrough" Series

- **Target Audience:** Staff from health centers, PCAs & health center-controlled networks

- **Time Commitment:** One hour, with an optional 30 minutes for "office-hours"

- **Registration:** Use the link at the end of this presentation or in the chat box to register for each session you plan to attend

- **Recordings:** All trainings are recorded and made available under the "SDOH Trainings" tab on the SDOH Academy website

Learning Objective 1:

Participants will describe the importance of SDOH and enabling services data and its role in assessing, addressing, and tracking patient-level needs and interventions.

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01 Improve Access to Quality Health Care and Services by Increasing Capacity for Patients to Access SDOH Services

- **Enabling services** for SDOH, including how to provide, document, and track for underserved populations; and

- **Technology** needs for SDOH, including what infrastructure is needed to address, assess, collect data for, and track SDOH, as well as the necessary infrastructure to improve health access, quality services, and patient engagement.

To Address Social Risks, You First Need to Document Social Needs…

- Likely already are focusing on social determinants in some way given mission but without standardized data, it is harder to systematize and streamline this work into workflow
- Standardized data on social determinants of health is needed to inform care planning and population health management activities
- Standardized data on social determinants of health is also needed to demonstrate value of health centers and your focus on addressing non-clinical needs

Use Cases for SDOH Data and Interventions from Patient to Policy Level

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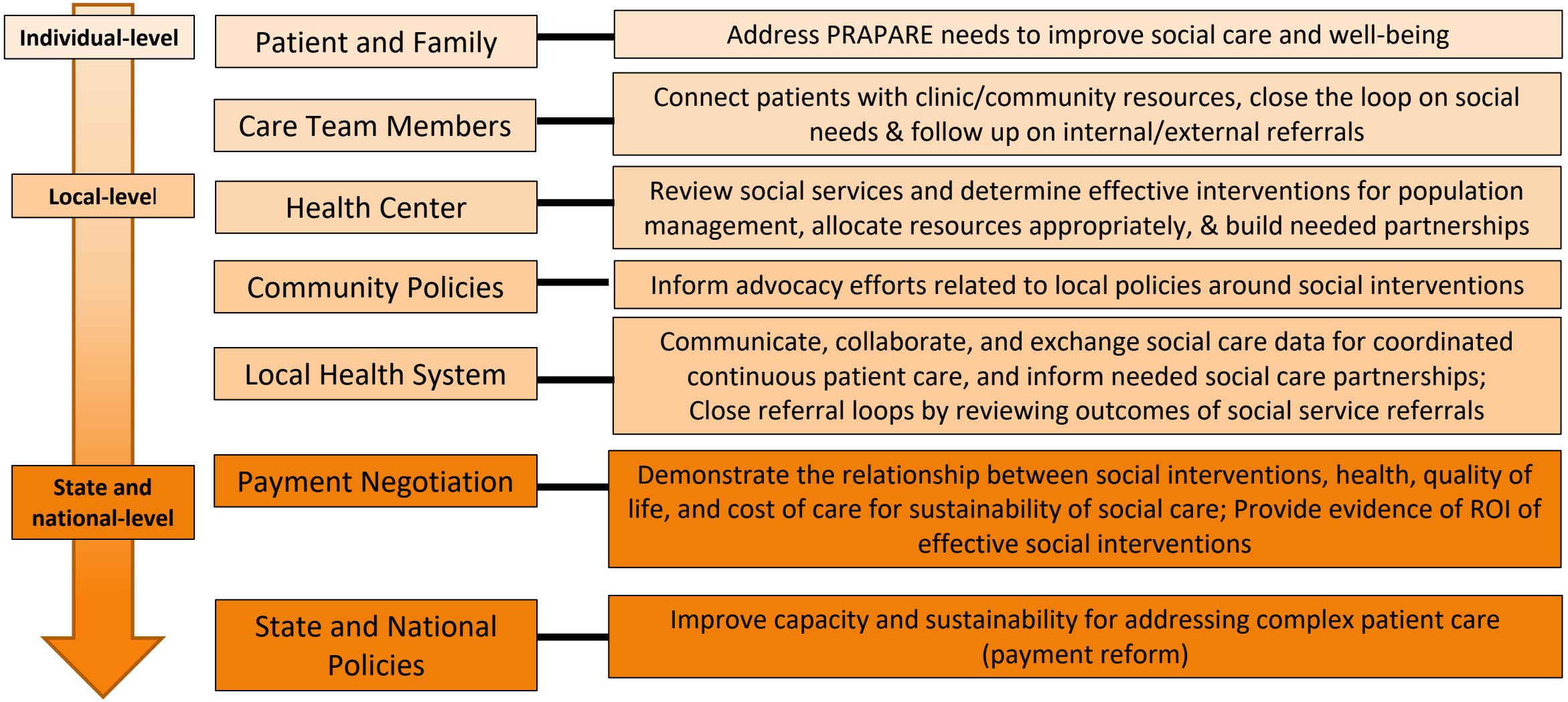

PRAPARE

Patient Perspectives

James
No transportation

Ashanti
Limited English

Maritza
Single parent

Kai
Depends on caregiver

Two Sides of the Same Coin: SDOH & ES Data Go Hand-in-Hand

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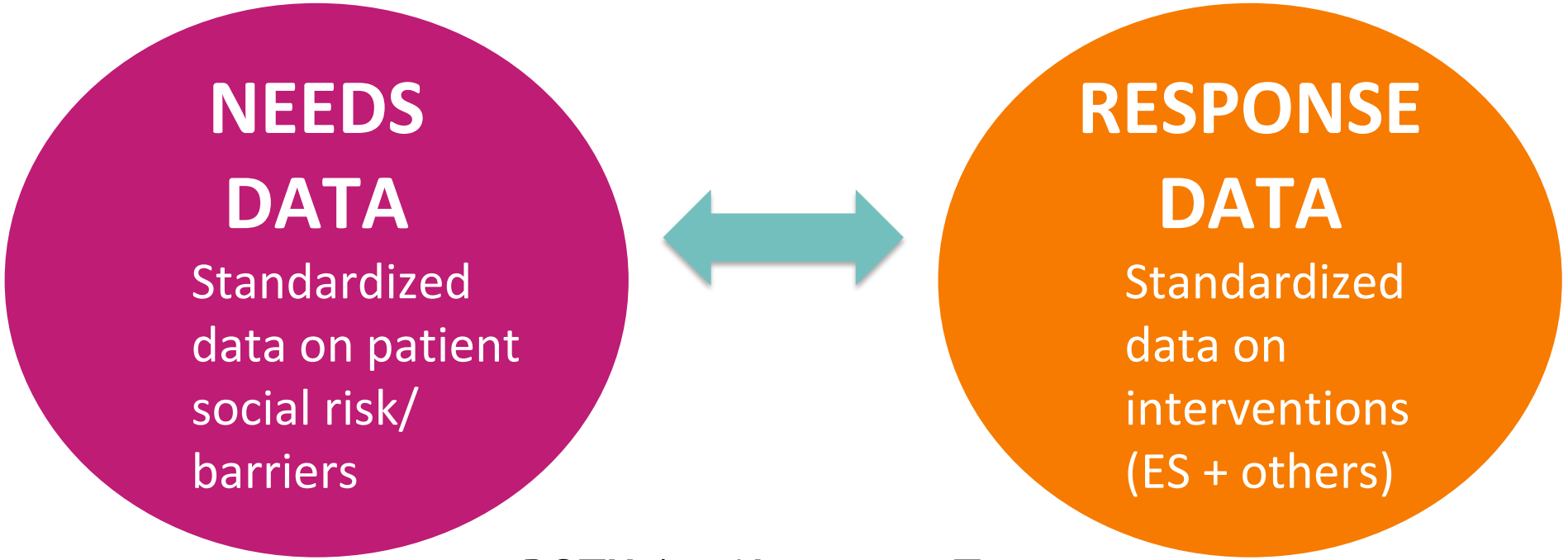


BOTH Are Necessary To:

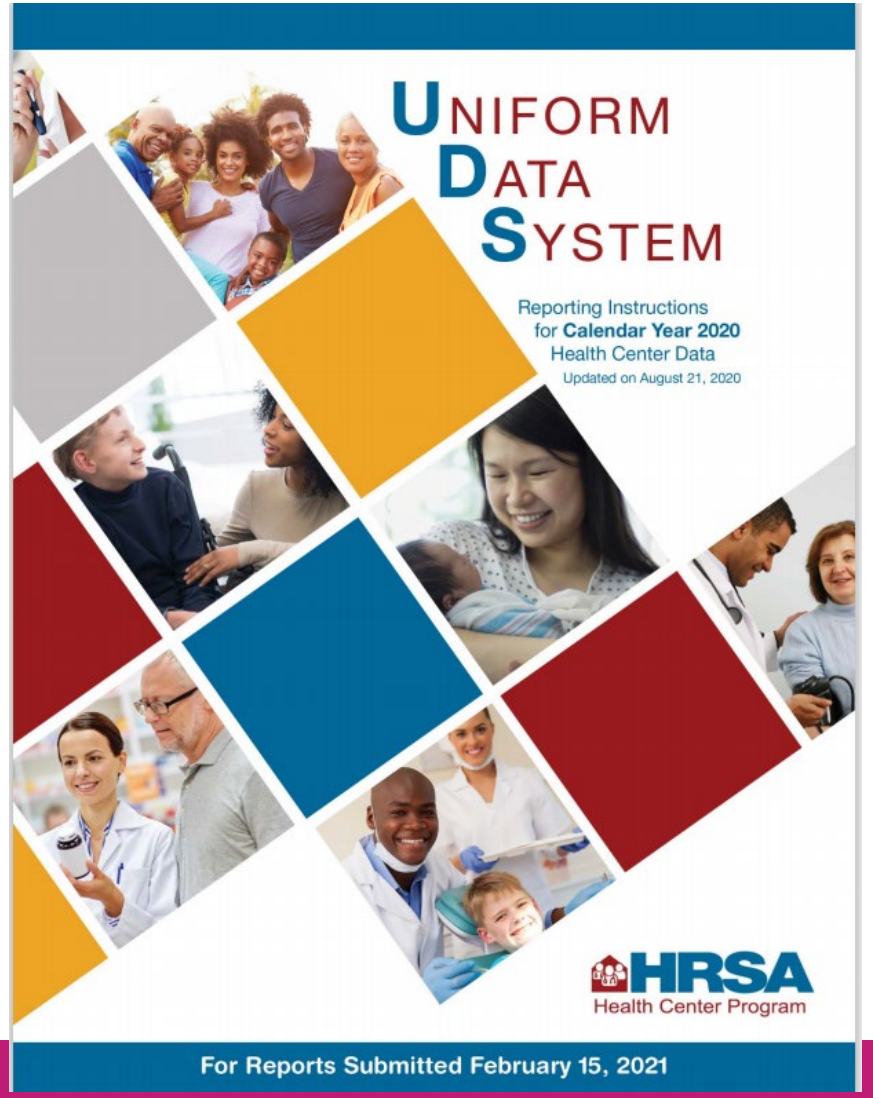
- ✔ Demonstrate health center value to payers
- ✔ Seek adequate financing
- ✔ Better target and/or improve services
- ✔ Achieve integrated, value-driven delivery system reform and reduce total cost of care

PRAPARE

UDS Reporting Requirements

The Health Information Technology (HIT) form includes a series of questions on HIT capabilities including:

1. EHR implementation
2. Certification of systems
3. How widely adopted the system is throughout the health center



HIT Questions

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?

    a. Yes

    b. No, but we are in planning stages to collect this information

    c. No, we are not planning to collect this information

Poll #1

Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?

- Yes
- No, but we are in planning stages to collect this information
- No, we are not planning to collect this information

HIT Questions

12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply.)

    a. Accountable Health Communities Screening Tools

    b. Upstream Risks Screening Tool and Guide

    c. iHELLP

    d. Recommend Social and Behavioral Domains for EHRs

    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

    f. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)

    g. WellRx

    h. Health Leads Screening Toolkit

    i. Other (please describe _____)

    j. We do not use a standardized screener

Poll #2

Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply.)

- Accountable Health Communities Screening Tools
- Upstream Risks Screening Tool and Guide
- iHELP
- Recommend Social and Behavioral Domains for EHRs
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)
- WellRx
- Screening tools built into EHR
- We do not use a standardized screener

HIT Questions

12a. Please provide the total number of patients that screened positive for the following:

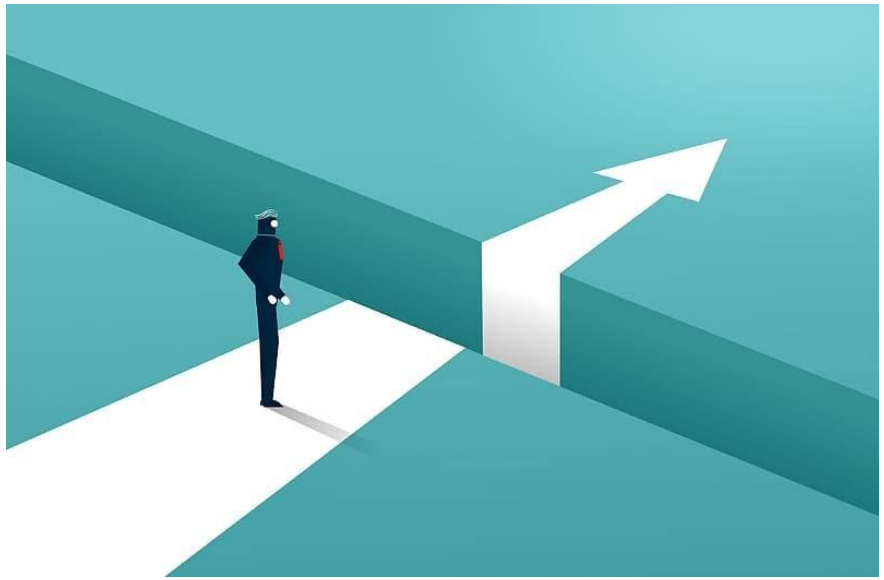
a. Food insecurity _____

b. Housing insecurity _____

c. Financial strain _____

d. Lack of transportation/access to public transportation _____

HIT Questions



12b. If you do not use a standardized assessment to collect this information, please indicate why. (Select all that apply.)

a. Have not considered/unfamiliar with assessments

b. Lack of funding for addressing these unmet social needs of patients

c. Lack of training for staff to discuss these issues with patients

d. Inability to include with patient intake and clinical workflow

e. Not needed

f. Other (please describe _____)

Poll #3

If you do not use a standardized assessment to collect this information, please indicate why.

- Have not considered/unfamiliar with assessments
- Lack of funding for addressing these unmet social needs of patients
- Lack of training for staff to discuss these issues with patients
- Inability to include with patient intake and clinical workflow
- Not needed
- Other

Learning Objective 2:

Participants will identify key resources related to Increase Access to Care (IAC) core competency and where to locate them on the SDOH Academy and Clearinghouse websites.

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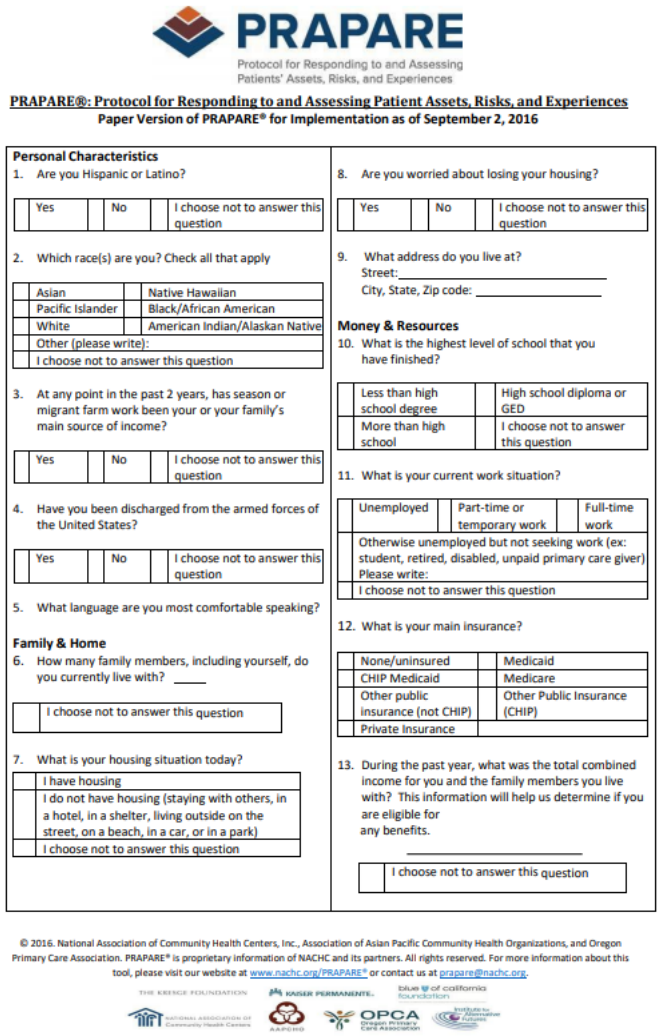
Overview of SDOH Screening Tools

- PRAPARE:developed by NACHC, AAPCHO, and OPCA
- Screening Tool (Available in 26 languages)
- Implementation and Action Toolkit
- PRAPARE Readiness Assessment Tool
- Coding- Crosswalks include ICD-10, LOINC, SNOMED
  - PRAPARE Data Documentation (January 2020)
- PRAPARE Tiger Team



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

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
7. What is your housing situation today?
   ☐ I have housing
   ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   ☐ 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
13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.
    _____
    ☐ I choose not to answer this question

Overview of SDOH Screening Tools

National Center for Farmworker Health:

- Health Center SDOH Self Assessment tool (Available in English)
- Patient SDOH Screening Tool & Action Plan (Available in English)
- IAC PLUS SDOH Checklist
- Customizable SDOH Screening tool

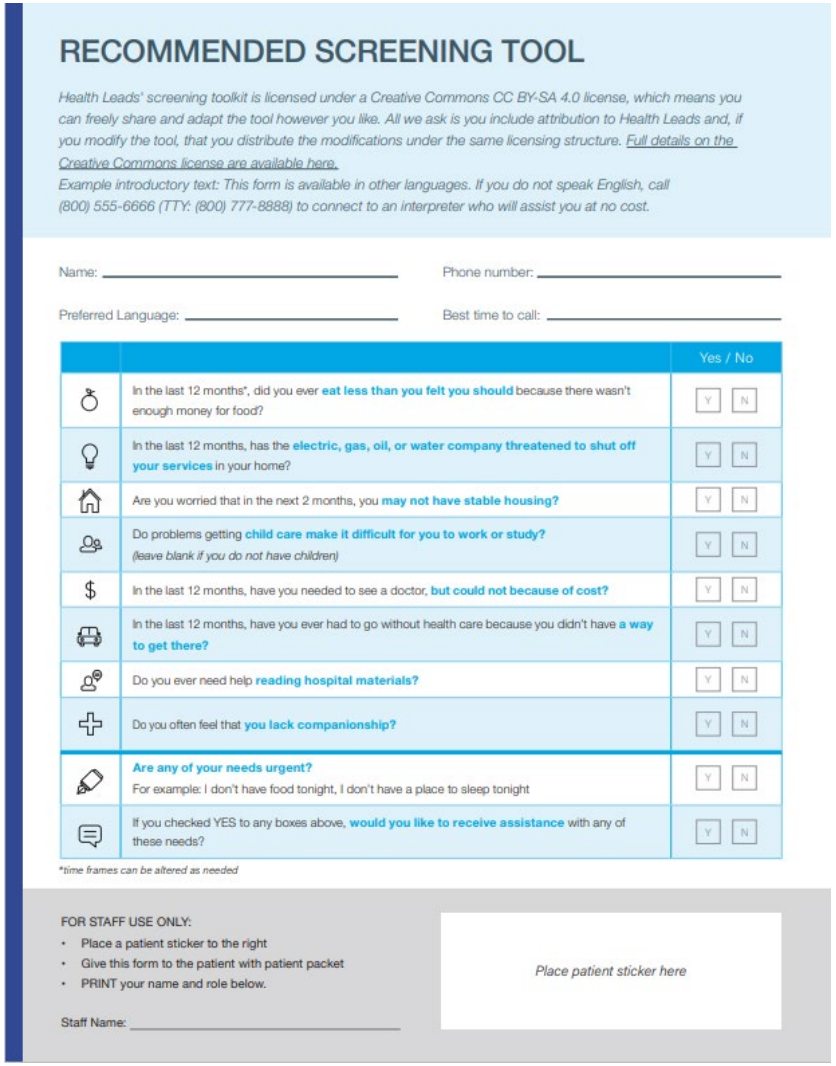
SDOH Hub coming soon!

Additional SDOH Resources from NCFH

- Language Competency Checklist
- Language Access Services Assessment and Planning Tool
- Implementing a Language Access Program
- FHN 2019 SDOH Webinar series
- COVID-19 web page

Overview of SDOH Screening Tools

- CMS: Accountable Health Communities Screening Tool
- Health Begins:Upstream Risks Screening Tool & Guide
- iHELLP Social History Questionnaire
- Boston Medical Center: WE CARE Survey
- Health Leads:Social Needs Screening Toolkit
- Well Rx Questionnaire



RECOMMENDED SCREENING TOOL

Health Leads' screening toolkit is licensed under a Creative Commons CC BY-SA 4.0 license, which means you can freely share and adapt the tool however you like. All we ask is you include attribution to Health Leads and, if you modify the tool, that you distribute the modifications under the same licensing structure. Full details on the Creative Commons license are available here.

Example introductory text: This form is available in other languages. If you do not speak English, call (800) 555-6666 (TTY: (800) 777-8888) to connect to an interpreter who will assist you at no cost.

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

	Yes / No
In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
Do you ever need help **reading hospital materials?**	Y N
Do you often feel that **you lack companionship?**	Y N
Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

FOR STAFF USE ONLY:

- Place a patient sticker to the right
- Give this form to the patient with patient packet
- PRINT your name and role below.

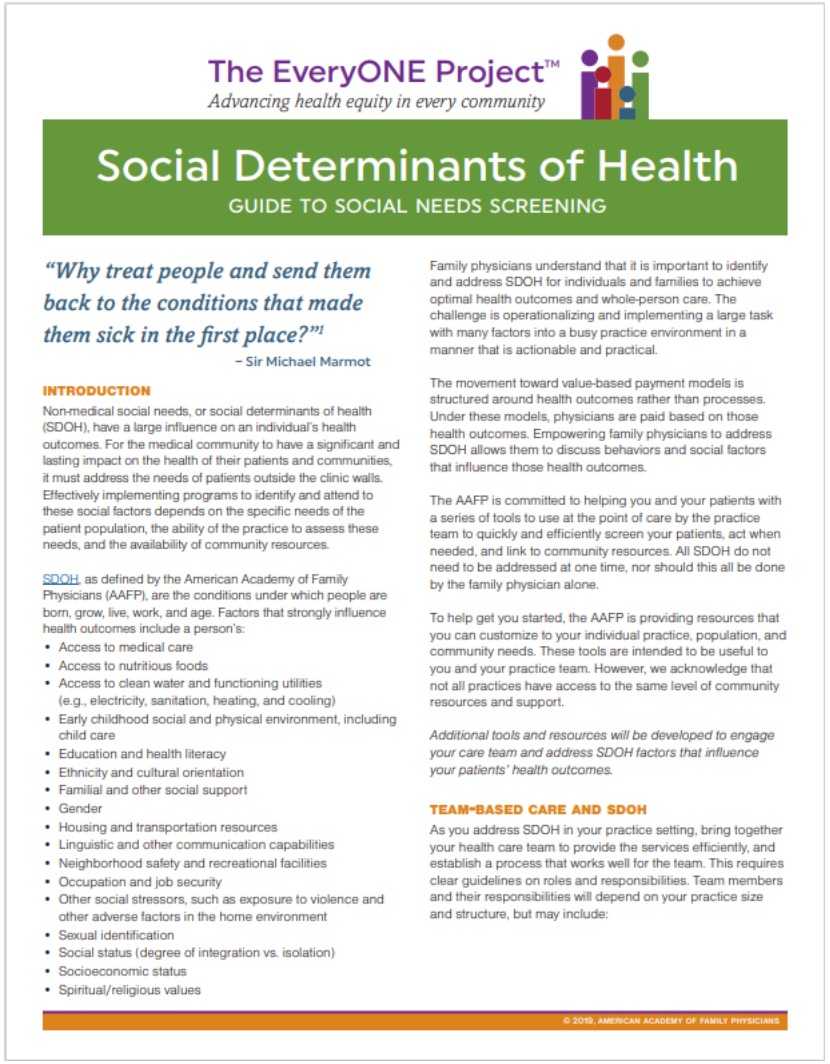
Staff Name: _____

Place patient sticker here

Overview of SDOH Screening Tools

The EveryONE Project by the American Academy of Family Physicians (AAFP):

- Guide to Social Screening
- Social Needs Screening Tool
- Neighborhood Navigator
- Action Plan



The EveryONE Project™
Advancing health equity in every community

Social Determinants of Health

GUIDE TO SOCIAL NEEDS SCREENING

"Why treat people and send them back to the conditions that made them sick in the first place?"[1]

– Sir Michael Marmot

INTRODUCTION

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

SDOH, as defined by the American Academy of Family Physicians (AAFP), are the conditions under which people are born, grow, live, work, and age. Factors that strongly influence health outcomes include a person's:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling)
- Early childhood social and physical environment, including child care
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs. isolation)
- Socioeconomic status
- Spiritual/religious values

Family physicians understand that it is important to identify and address SDOH for individuals and families to achieve optimal health outcomes and whole-person care. The challenge is operationalizing and implementing a large task with many factors into a busy practice environment in a manner that is actionable and practical.

The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

The AAFP is committed to helping you and your patients with a series of tools to use at the point of care by the practice team to quickly and efficiently screen your patients, act when needed, and link to community resources. All SDOH do not need to be addressed at one time, nor should this all be done by the family physician alone.

To help get you started, the AAFP is providing resources that you can customize to your individual practice, population, and community needs. These tools are intended to be useful to you and your practice team. However, we acknowledge that not all practices have access to the same level of community resources and support.

Additional tools and resources will be developed to engage your care team and address SDOH factors that influence your patients' health outcomes.

TEAM-BASED CARE AND SDOH

As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team. This requires clear guidelines on roles and responsibilities. Team members and their responsibilities will depend on your practice size and structure, but may include:

Addressing SDOH Needs

Enabling Services:

- AAPCHO Enabling Services Data Collection
- PCA Enabling Services Virtual Summit Podcast Series
- NACHC Outreach and Enabling Services

Health Center Data Integration:

- Corporation for Supportive Housing (CSH) Data Integration Best Practices for Health Centers and Homeless Services

Learning Objective 3:

Participants will define how health centers have used SDOH screening tools to improve health access, quality services, and patient engagement.

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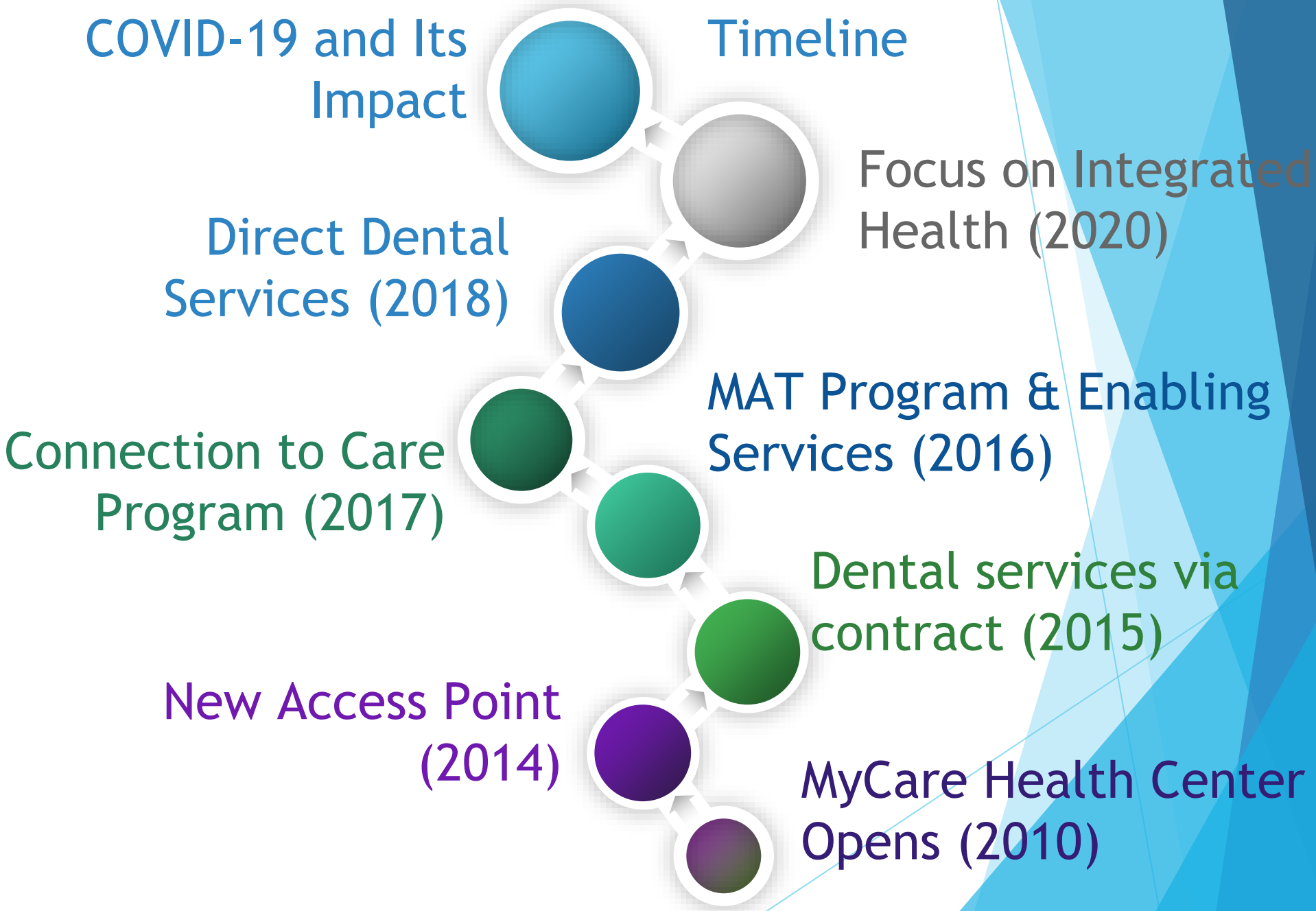
MyCare
HEALTH CENTER

Addressing Social Determinants of Health Needs through Enabling Services

Nashia A. Choudhury, MPH
Director of Operations
MyCare Health Center (Michigan)

Overview

- Overview of MyCare Health Center
- Defining Social Determinants of Health and Its Impact
- Importance of Data Collection
- Closing the Loop through Enabling Services


COVID-19 and Its Impact
Timeline
Focus on Integrated Health (2020)
Direct Dental Services (2018)
MAT Program & Enabling Services (2016)
Connection to Care Program (2017)
Dental services via contract (2015)
New Access Point (2014)
MyCare Health Center Opens (2010)

2019 UDS Report Data

- Macomb County, MI
  - Center Line, MI
  - Mt. Clemens, MI
  - Clinton Township, MI (currently closed)
- 14,356 patient visits
  - 9,554 medical visits (3,626 patients)
  - 3,797 dental visits (1,337 patients)
  - 485 mental health visits (179 patients)
  - 42 enabling services
  - 872 substance use disorder visits (135 patients)
- 4,565 total patients
  - 43% Male (1,966) 57% Female (2,599)

- Age of patients (years)
  - 0-19: 23%
  - 20-44: 38%
  - 45-64: 34%
  - 65+: 5%
- Race
  - 57% White
  - 30% Black/African American
  - 4% Asian
  - 5% Unreported
- Insurance source
  - 7% Sliding Fee Discount Program Eligible
  - 55% Medicaid
  - 14% Medicare
  - 5% Medicaid/Medicare Dual Eligible
  - 19% Private/Commercial

Social Determinants of Health Model

- Availability of resources to meet daily needs
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation
- Public Safety
- Social support, social norms, and attitudes

MyCare
HEALTH CENTER

Importance of Data Collection

Collecting SDOH in AllScripts (EHR)

- AllScripts does not utilize PRAPARE
- SDOH Questionnaire available in AllScripts
- Mapping the questions to the integrated data system (IDS)
- Follow-up after collection of SDOH data and coordination of care
- Diagnosis codes for SDOH

1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- ○ Very hard
- ○ Hard
- ○ Somewhat hard
- ○ Not very hard

Questionnaire Interactive Fill: Copy of Social Determinants of Health

2. What is the highest grade or level of school you have completed or the highest degree you have recieved?

- ○ Never attended/kindergarden only
- ○ 1st grade
- ○ 2nd grade
- ○ 3rd grade
- ○ 4th grade
- ○ 5th grade
- ○ 6th grade
- ○ 7th grade
- ○ 8th grade
- ○ 9th grade
- ○ 10th grade
- ○ 11th grade
- ○ 12th grade, no diploma
- ○ High school graduate
- ○ GED or equivalent
- ○ Some college, no degree
- ○ Associate degree: occupational, technical, or vocational program
- ○ Associate degree: academic program
- ○ Bachelor's degree (e.g., BA, AB, BS)
- ○ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ○ Professional school degree (example: MD, DDS, DVM, JD)
- ○ Doctoral degree (example: PhD, EdD)
- ○ Refused
- ○ Don't know

3. Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?

- ○ Not at all
- ○ Only a little
- ○ To some extent
- ○ Rather much
- ○ Very much

4. Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day
- ○ Decline to specify

5. Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day
- ○ Declined to specify

6. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

- ○ 1 x week
- ○ 2 x week
- ○ 3 x week
- ○ 4 x week
- ○ 5 x week
- ○ 6 x week
- ○ Daily
- ○ Declined to specify

7. On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?

- 5-10 minutes
- 10-15 minutes
- 15-20 minutes
- 20-30 minutes
- 30-45 minutes
- 45-60 minutes
- More than 1 hour
- Declined to specify
- None

8. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

Questionnaire Interactive Fill: Copy of Social Determinants of Health

9. How many standard drinks containing alcohol do you have on a typical day?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

10. How often do you have 6 or more drinks on 1 occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

11. Are you now married, widowed, divorced, separated, never married or living with a partner?

- Married
- Widowed
- Divorced
- Separated
- Never married
- Living with partner
- Refused
- Don't know

12. In a typical week, how many times do you talk on the telephone with family, friends, or relatives?

- 3 or more interactions per week
- Less than 3 interactions per week
- Declined to specify

13. How often do you get together with friends and relatives?

- 3 or more interactions per week
- Less than 3 interactions per week
- Declined to specify

14. How often do you attend church or religious services?

- More than 4 times per year
- 4 or less times per year
- Declined to Specify

15. Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

- Yes
- No

16. Within the last year, have you been humiliated or emotionally abused by your partner or ex-partner?

- Yes
- No
- Decline to specify

17. Within the last year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Decline to specify

18. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

- Yes
- No
- Declined to specify

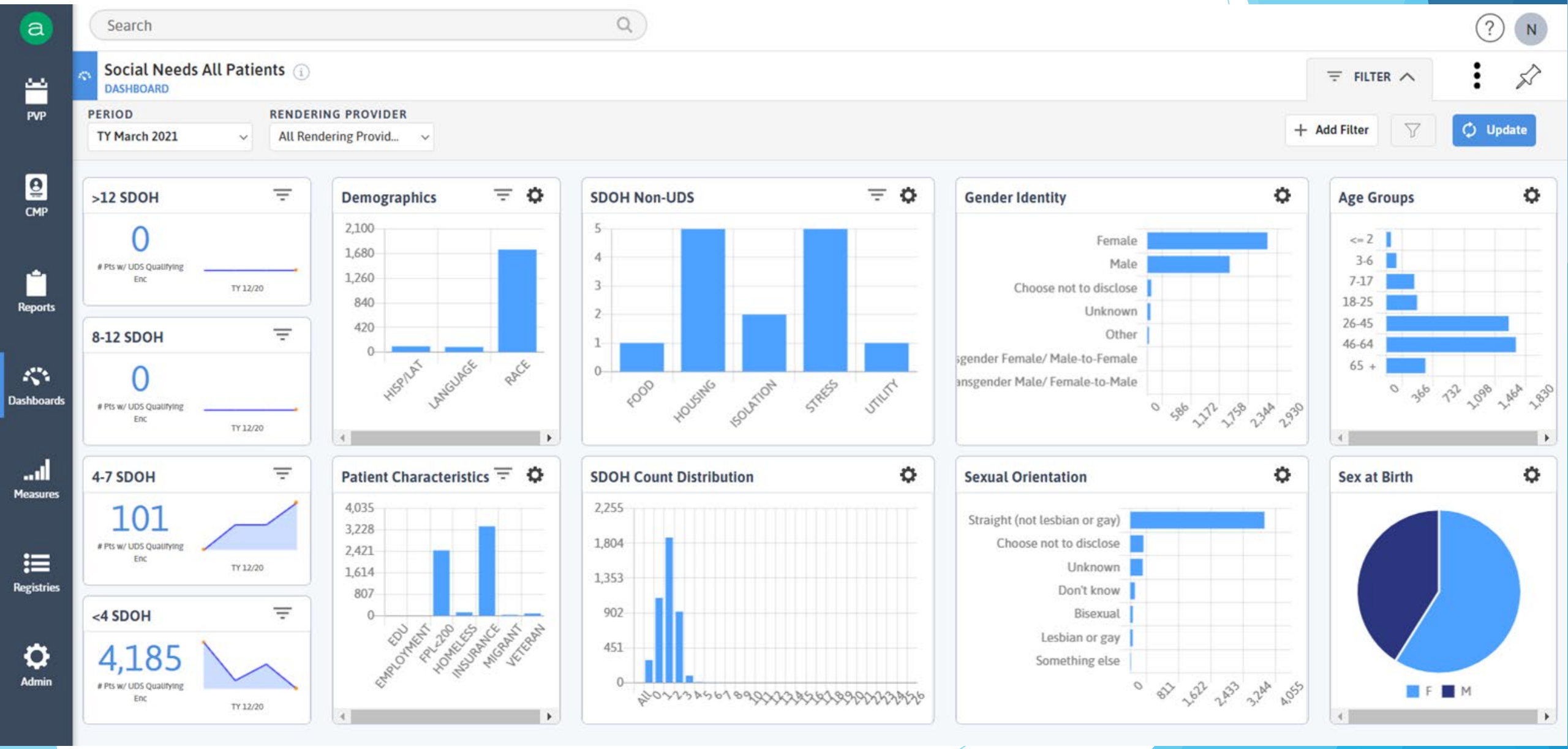
19. Within the last year, have you been kicked, hit, slapped, otherwise physically hurt by your partner or ex-partner?

- Yes
- No
- Declined to specify

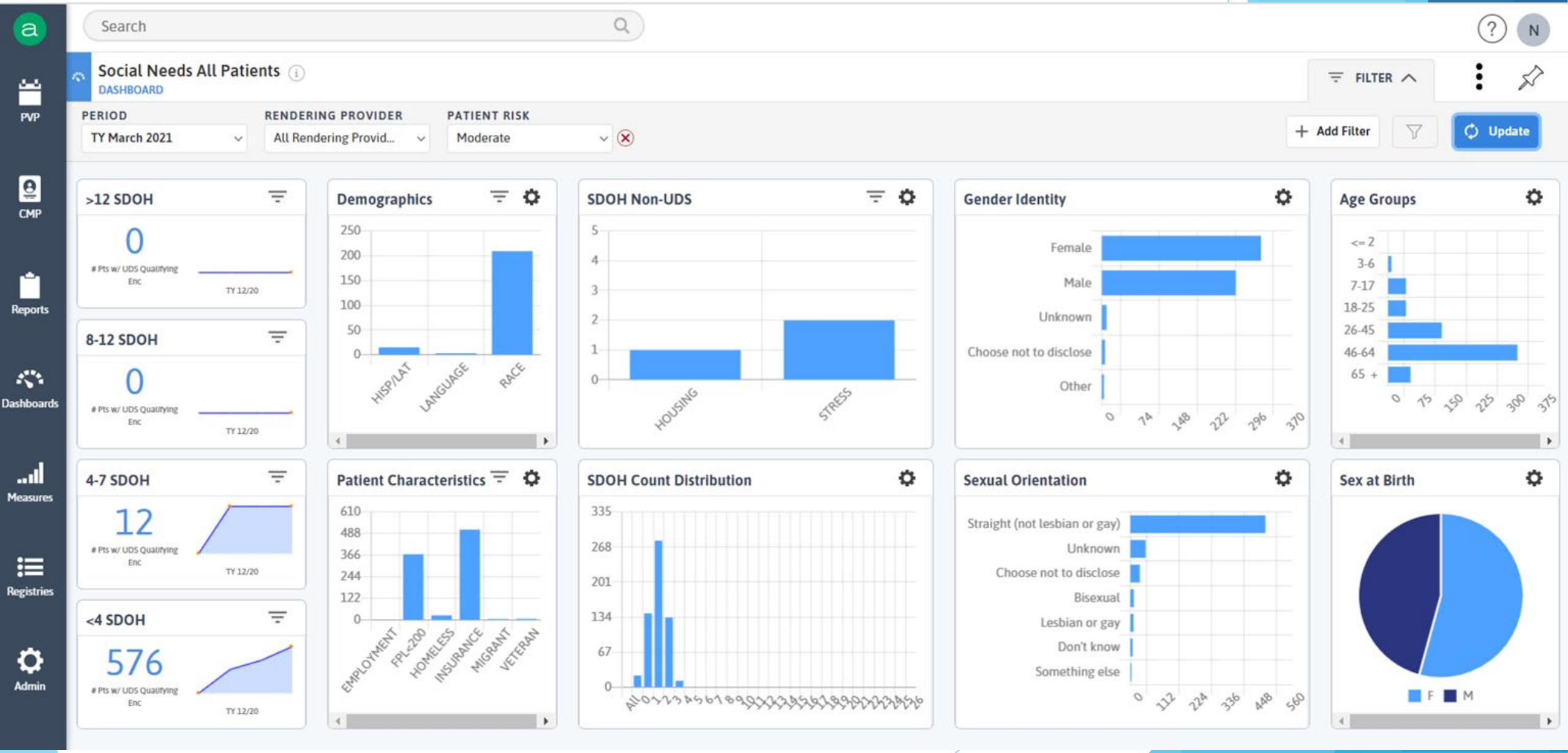
Integrated Data System: Azara DRVS

- Social needs
- Risk stratification tool
- Risk category of high, medium, and low appearing in red on visit planning and care management passport reports
- Risk as a filter available on a number of features throughout DRVS

Social Needs All Patients



Risk Stratification: Patient Risk (Moderate)



Closing the Loop through Enabling Services

- Collect and apply data to understand patients' needs in the communities served
- Care transformation
- Improve health and reduce costs
- Effect change at the patient, organization, and community levels
- State policy and transformation initiatives

For more information

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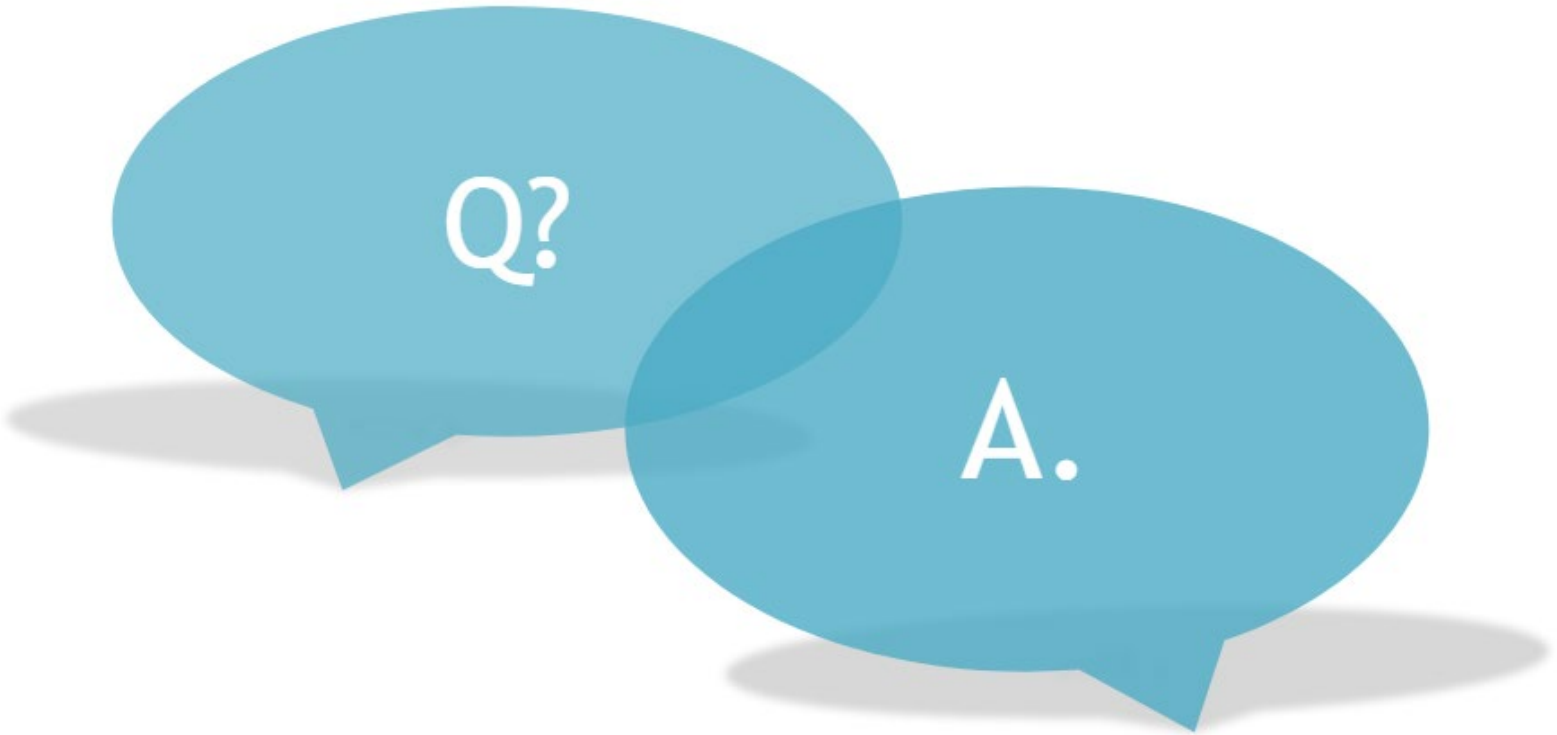
Questions?

The Social Determinants of Health Academy



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Key Take-aways

- Better track which services and interventions are most effective in addressing needs
- Develop evidence base to demonstrate to payers what it takes to care for complex patients
- Use evidence to inform care transformation and payment models to sustain non-clinical work
- Small steps lead to sustainable progress… work your way towards SDOH screening and ES documentation

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The Social Determinants of Health Academy

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The Faculty

AAPCHO
Association of Asian Pacific Community Health Organizations

CSH
The Source for Housing Solutions

Health Outreach Partners
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Capital Link

acu
association of clinicians for the underserved

National Center for Equitable Care for Elders

MHP Salud

National LGBT Health Education Center
A program of the Fenway Institute

Migrant Clinicians Network
MCN

NCFH
National Center for Farmworker Health, Inc.

National Center for Medical Legal Partnership
at the George Washington University

NCHPH
National Center for Health in Public Housing

National Health Care for the Homeless Council

National Nurse-Led Care Consortium
a PHMC affiliate

National Association of Community Health Centers®

Office Hours:
30 minutes

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