HEALTH MANAGEMENT ASSOCIATES

Addressing Social Determinants of Health to Achieve Health Equity

Learning Collaborative Modality
September 21, 2022

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AGENDA

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- ❑ Terms and definitions
- ❑ Social and Economic Context of Health
- ❑ Moving from Policy to Action with Million Hearts Strategies
- ❑ Deep Dive on Social Determinants of Health and Linkages to Support Self-Management

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- Define health equity, health disparities, and social determinants of health.
- Describe the social and economic factors that drive health outcomes and have impact on health equity.
- Identify the key components of SDOH screening and referral management for social care organizations.
- Summarize the key considerations for partnerships with CBOs to address SDOH and health equity.

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What are your patients' biggest barriers to good health?

Examples include:

- Physical environment
- Healthy foods access
- Access to care
- Language barriers/access
- Trust in health system
- Transportation
- Safety

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- **Social Determinants of Health**
  - Conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a range of outcomes and risks
- **Health Equity**
  - The conditions under which everyone has an equal opportunity to be as healthy as possible
- **Health Disparities**
  - Measured differences in health outcomes between groups within a population that are systemic, avoidable, and unjust

Removing obstacles to health and making systemic changes are fundamental steps toward achieving health equity.

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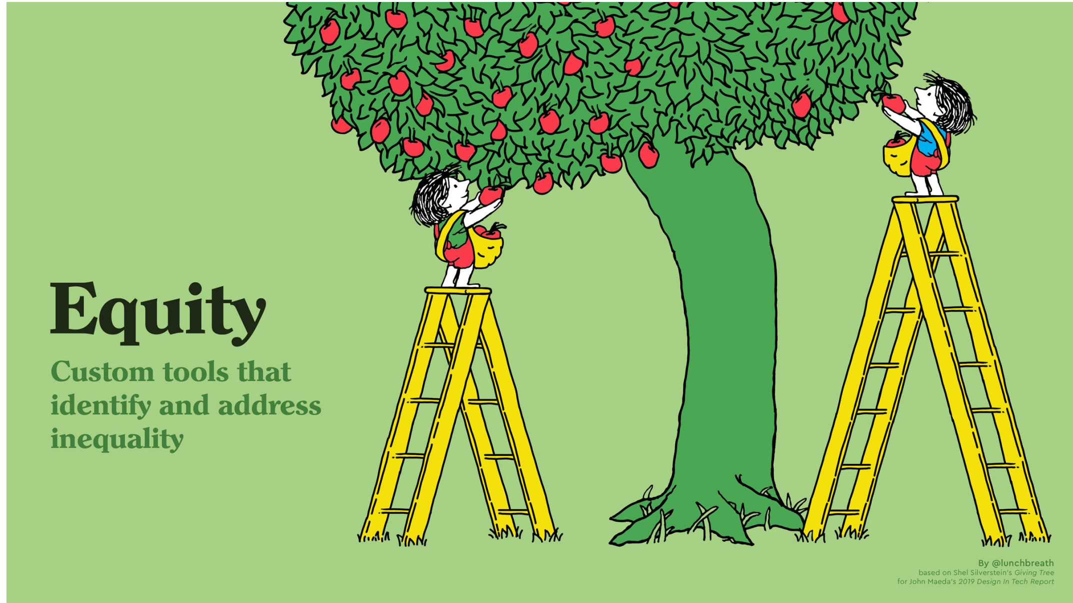

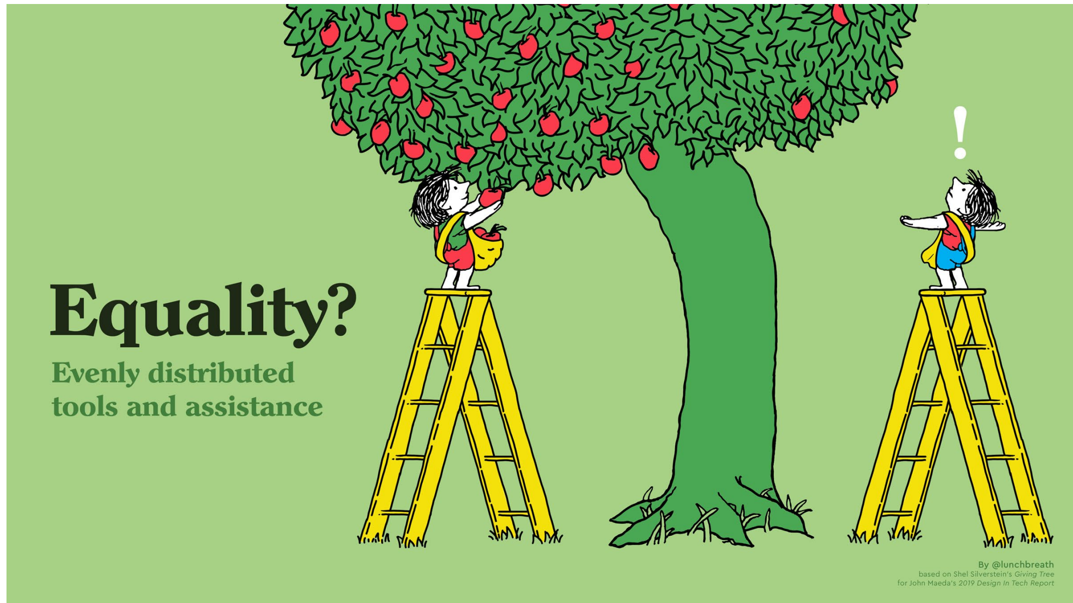

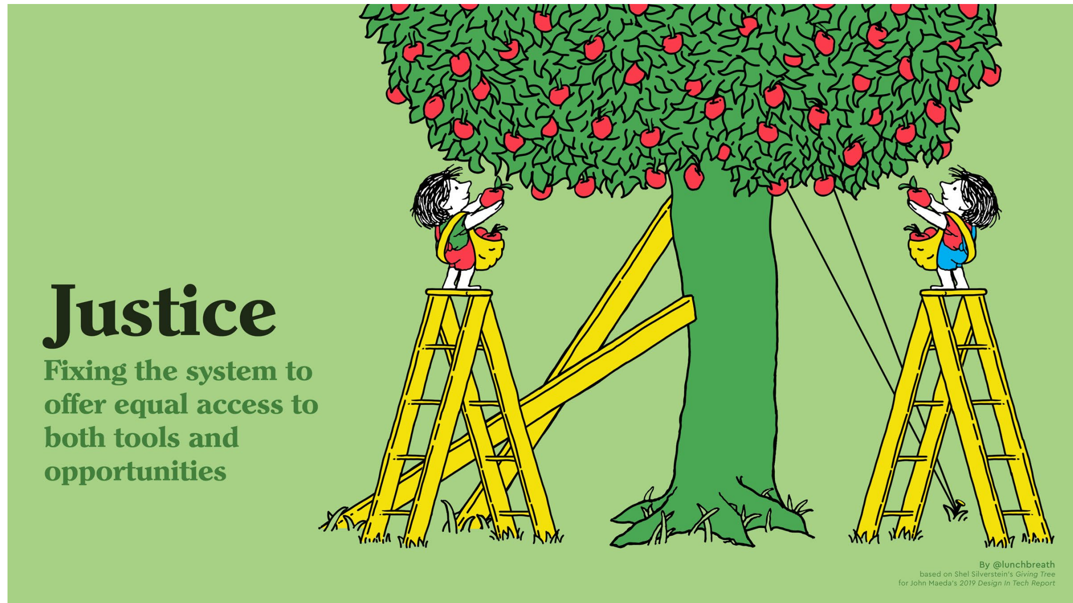

Art credit: 2019 [Design In Tech Report] | "Addressing Imbalance" Illustrations by @lunchbreath

CASE EXAMPLE – MEDICAID EXPANSION DID NOT GUARANTEE EXPANDED ACCESS TO CARE

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- Call, et al (2014) found that expanded access to health insurance (Medicaid) did not meaningfully expand access to care for low-income or racial/ethnic minority populations in their study area, Minnesota.
- Persistent barriers to access included:
  - Lack of transportation
  - Short clinic hours
  - Access to childcare
  - Language barriers
  - Lack of trust

Call, Kathleen T., Donna D. McAlpine, Carolyn M. Garcia, Nathan Shippee, Timothy Beebe, Titilope Cole Adeniyi, and Tetyana Shippee. "Barriers to care in an ethnically diverse publicly insured population: is health care reform enough?." Medical care (2014): 720-727.

Social and structural determinants of health may still create persistent barriers to care, despite policy changes meant to help.

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Social and Economic Factors Drive Health Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Racism and Discrimination					
Employment	Housing	Literacy	Food security	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Stress	Quality of care
Medical bills	Playgrounds	Higher education		Exposure to violence/trauma	
Support	Walkability				
	Zip code / geography				

Health Outcomes: Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Artiga, S. Health Disparities are a Symptom of Broader Social and Economic Inequities, KFF, June 1, 2020. https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/. Accessed 9/8/22.

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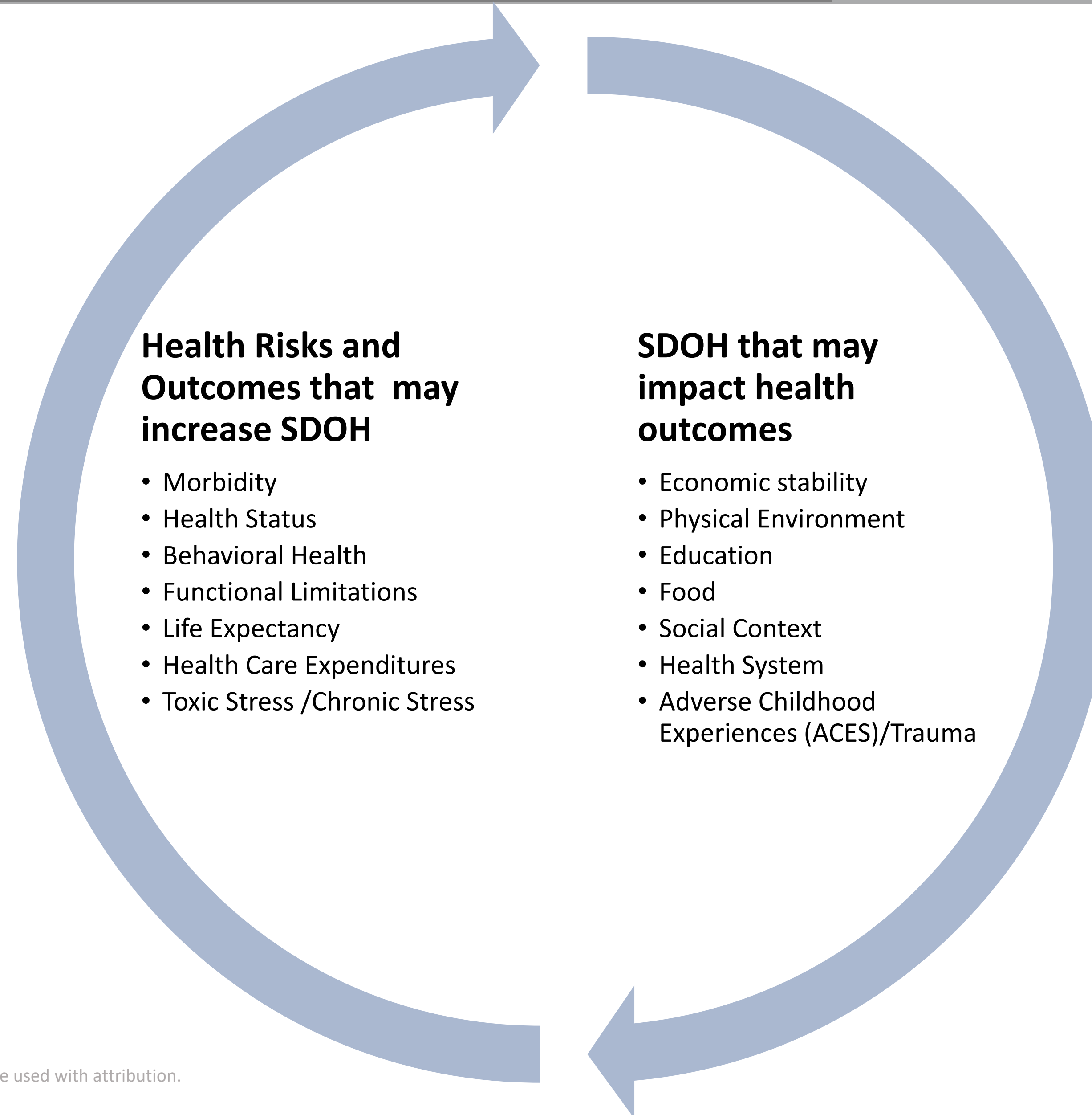

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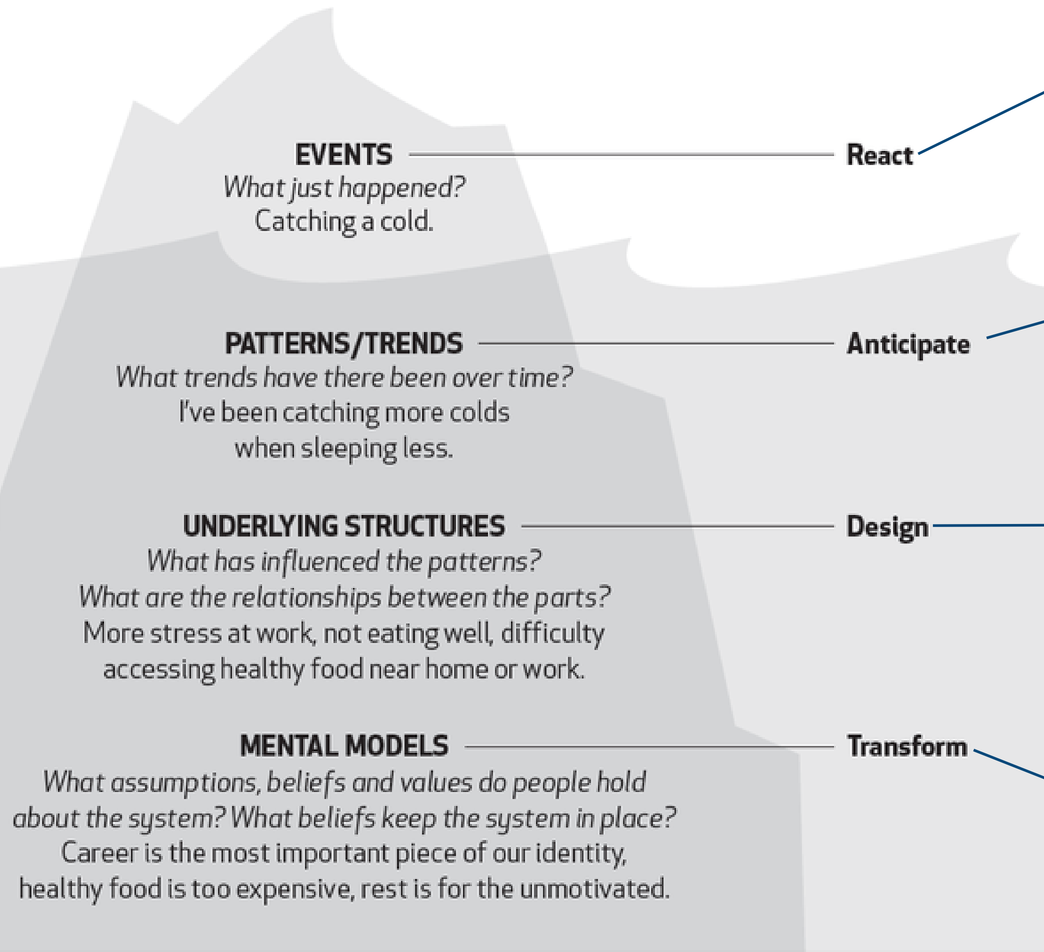
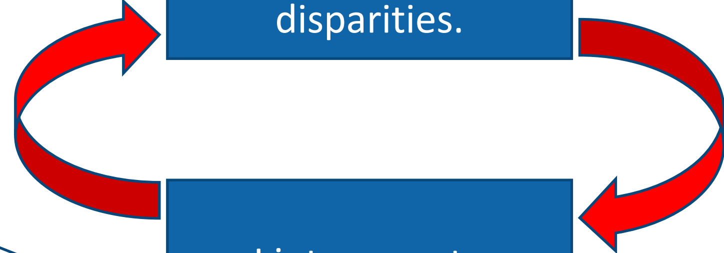


People in my clinic panel have poorly controlled CVD

I see disparities in who is most affected

I understand what influences these disparities.



I intervene to mitigate barriers to good health.

Ecochallenge (FKA Northwest Earth Institute), "A Systems Thinking Model: The Iceberg," https://ecochallenge.org/iceberg-model/. Accessed 9/8/22.

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Reducing Disparities in Cardiovascular Health

-Reaching for Health Equity-

People from Racial/Ethnic Minority Groups	Pregnant or Postpartum Women with HTN	People with Lower Incomes	People Who Live in Rural Areas and Other 'Access Deserts'	People with Behavioral Health Issues Who Use Tobacco
Deliver MTM, SMBP, and other HTN management in trusted spaces like barbershops, salons, and churches	Support widespread SMBP use for hypertensive disorders during pregnancy	Expand Medicaid for SMBP devices, medications, and CR	Support availability of robust virtual and remote models of CR	Expand barrier-free Medicaid for tobacco cessation
Support policies that prohibit the sale of flavored tobacco products, including menthol	Expand Medicaid for SMBP devices, medications; 1-year postpartum coverage	Support SMBP device loaner programs	Support SMBP use and related telehealth	Support integration of tobacco cessation treatment into mental health and substance use care

MTM = medication therapy management SMBP = self-measured blood pressure monitoring HTN = hypertension CR = cardiac rehabilitation ♡ = Heart Health

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Population Health Management

- Use registries to identify and target most complex or most at-risk
- Identify disparities
  - Disease presentation in a sub-population
  - Outcomes
  - Access to care
  - Quality of care

Self-Monitoring Supports

- Train patients on self-monitoring
- Provide BP monitors
- Provide Glucometers

Risk Reduction

- Use linkages to promote SDOH mitigation and lifestyle changes to reduce CVD exacerbation
  - Stress management
  - Smoking cessation
  - Physical activity
  - Nutrition supports

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Population Health Management

- Use registries to identify and target most complex or most at-risk
- Identify disparities
  - Disease presentation in a sub-population
  - Outcomes
  - Access to care
  - Quality of care

Strategy A

- Health IT – Use EHR and HIT to improve healthcare delivery and optimize outcomes
  - Share population health level data for DC Health's electronic Chronic Condition Reporting Dashboard (CCRD) to track and monitor clinical quality measures (CQMs) related to hypertension, type 2 diabetes, and cholesterol.

Strategy B

- Track and analyze quality measures at the provider level to monitor and decrease disparities
  - QI interventions to improve monitoring by subgroups and develop data driven activities to address them

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Self-Monitoring Supports

- Train patients on self-monitoring
- Provide BP monitors
- Provide Glucometers

Strategy C

- Support engagement of non-physician team members in disease management in clinic setting
  - Implement QI interventions to align best practices in engaging non-physician team members

Strategy D

- Facilitate use of self-measured blood pressure monitoring (SMBP) with clinical support among adults with hypertension
  - Implement QI interventions incorporating best practices to facilitate implementation of self-measured blood pressure monitoring (SMBP).

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Risk Reduction & Health Promotion

- Use linkages to promote SDOH mitigation and lifestyle changes to reduce CVD exacerbation
  - Stress management
  - Smoking cessation
  - Physical activity
  - Nutrition supports

Strategy E

- Implement systems to facilitate systematic referral of adults with hypertension and/or high blood cholesterol to community-based chronic disease management and prevention programs/resources.
  - Implement QI interventions strengthening referral processes of adults with hypertension and/or high blood cholesterol to community programs and resources including National Diabetes Prevention Program (NDPP), Weight Watchers, and Supplemental Nutrition Assistance Program Education (SNAP-ED).

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SCREENING TOOL AND RESOURCES - EXAMPLES

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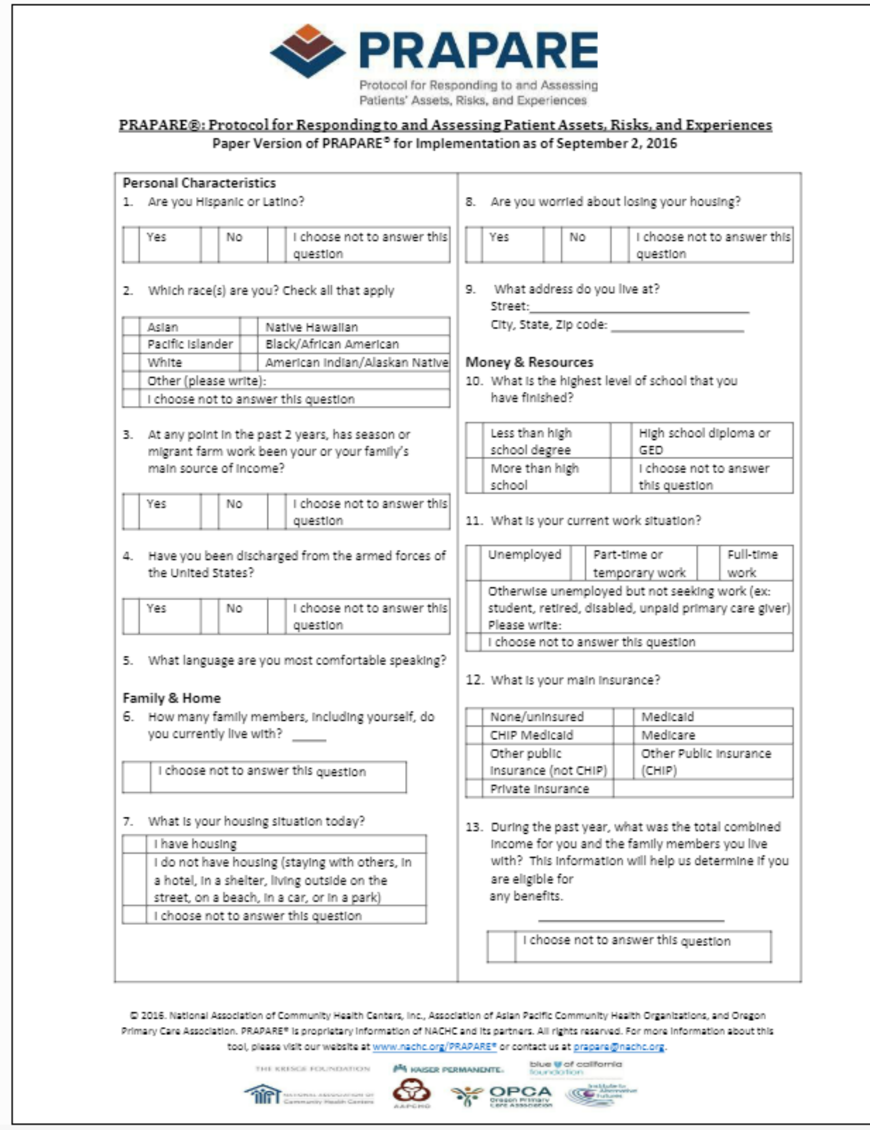


PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

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?

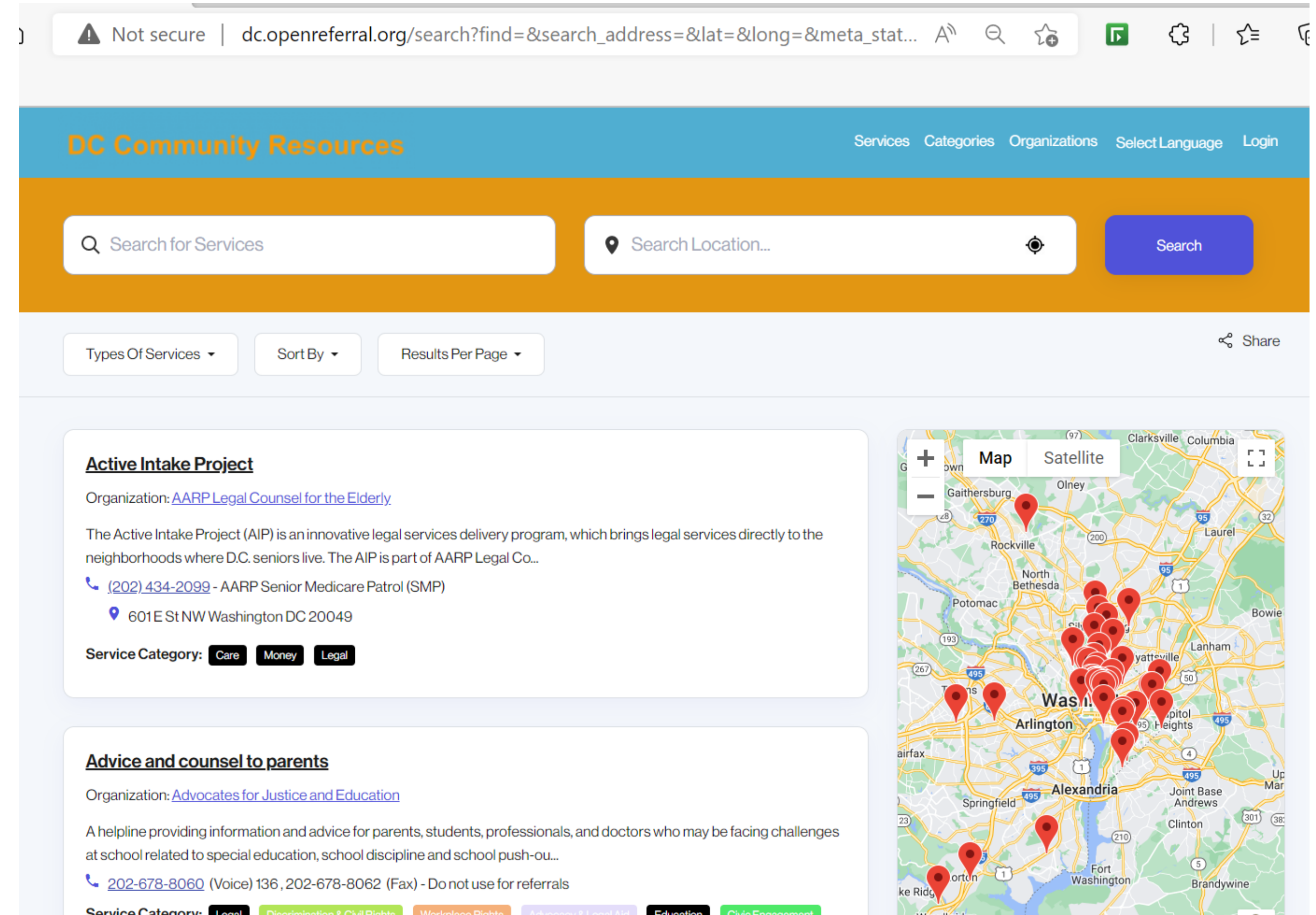
None/uninsured	Medicaid
CHIP Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private Insurance	

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

© 2016. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, and Oregon Primary Care Association. PRAPARE® is proprietary information of NACHC and its partners. All rights reserved. For more information about this tool, please visit our website at www.nachc.org/PRAPARE® or contact us at prapare@nachc.org.

Many of you are already using these or similar tools!



PRAPARE screening tool, available in 25 languages at www.prepare.org.
English: https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf

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CLOSING THE LOOP - EXAMPLE

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CRISP DC

DC Portal - Social Needs

← HIE InContext

ANNA CADENCE
Female | Nov 16, 1981

- PATIENT INFORMATION
- MEDICATION MANAGEMENT
- CLINICAL DATA
- CARE COORDINATION
- SOCIAL NEEDS DATA
- DATA FROM CLAIMS
- HIE PORTAL

ASSESSMENTS CONDITIONS REFERRAL HISTORY

Referral History

Date of Referral	Last Updated
2021-11-18	2021-11-18
2021-11-24	2021-11-24
2021-11-24	2021-11-24
2021-11-24	2021-11-24
2021-11-24	2021-11-24
2022-01-18	2022-01-18
2022-01-18	2022-01-18
2022-02-15	2022-02-15
2022-02-15	2022-02-15
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2022-02-15	2022-02-15
2022-02-15	2022-02-15
2022-02-15	2022-02-15

Rows per page: 25 1-1

Referral History ×
Community Health Worker
Date Updated: 2021-11-18

Referral Sender
- ***Referring Provider:*** Betty Test
- ***Referring Provider Organization:*** Jai Medical System
- ***Referring Provider Phone:*** Not Provided
- ***Referring Person:*** Doctor Who
- ***Referring Person Organization:*** Cheasapeake Regional InformationSystem for our Patients
- ***Referring Person Email:*** referrals@crisphealth.org

Referral Recipient
- ***Organization:*** Test Organization 1
- ***Program:*** Community Health Worker
- ***Program Description:*** Generic Program Description 8
- ***Referral Coordinator:*** Evan
- ***Referral Coordinator Phone:*** 333-555-5555
- ***Referral Coordinator Email:*** solange@crisp.org

Referral Recipient Updates
- ***Date:*** 2021-11-18
- ***Note :*** Test referral data 1

Screenshot: CRISP DC Portal – social needs module

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Screening tools reveal categories of need that require next-step discussion to identify best next action.

- Housing issues
  - Homelessness
  - Unstable housing/ "couch surfing"
  - Poor housing quality/inadequate housing
  - Eviction risk
  - Financial difficulty with rent or utilities
  - Overcrowded housing
  - Interpersonal/Domestic Violence

Each issue may require referral to a different, specialized CBO via a warm handoff to support a referral/feedback loop to document impact.

Most screening tools are designed for efficiency of use and focus on social needs at a high level.

- Without discussion, these won't trigger helpful referrals.
- Many patients are doubtful of the provider's ability to help.

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- Who do you screen and why?
- What tools do you use?
- Who does the screening?
- What do you do with a screening result?
- How do you know what you've screened for is the patient's priority?

A key component of Health Equity is ensuring that people are empowered to make decisions that are most meaningful to their health and wellbeing.

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- *Tina is screened for SDOH by a provider at her clinic. Clinic staff identify food insecurity and financial instability as SDOH factors and make a referral to a food pantry and a job placement program.*
- *A review of the referrals list from the organizations the clinic partners with shows Tina did not access either resource.*
- *At follow up, a provider learns that Tina found accessing either resource difficult because she does not have childcare at the times those activities occur.*
- *Tina believes if she had access to childcare, she would be able to hold a job that would help her become more financially solvent, and address both her job and food insecurity problems.*

- How do you know what you've screened for is the patient's priority?

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ADDRESSING SDOH AND HEALTH EQUITY THROUGH SCREENING AND REFERRAL MANAGEMENT: UNDERSTANDING PATIENT STATE OF CHANGE

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7 Translated from Spanish.

Illustration Credit: Public Agenda, 2019

Patient Sensitivities & Perceptions of Provider's Ability to Help

A 2019 qualitative research study by Public Agenda and United Hospital Fund on parents' perceptions of SDOH screening shows a range of sensitivities on what parents/patients felt clinics could help with or what they were comfortable discussing, and what they trusted providers for help with.

Adapted from: Public Agenda & United Hospital Fund, 2019. *It's About Trust: Low-Income Parents' Perspectives on How Pediatricians Can Screen for Social Determinants of Health.* Accessed August 3, 2022. Available at www.publicagenda.org/pages/its-about-trust-low-incomeparents-perspectives-on-howpediatricians-can-screen-for-socialdeterminants-of-health

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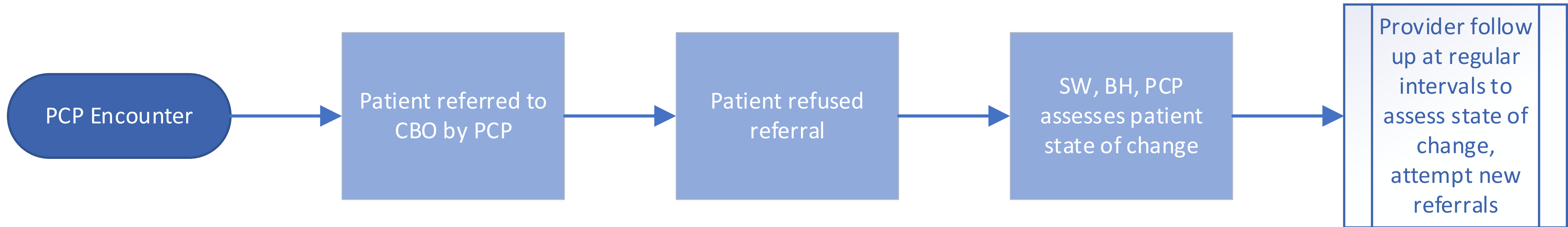
Patient refuses referral



Theoretical model adapted from UHF, 2019

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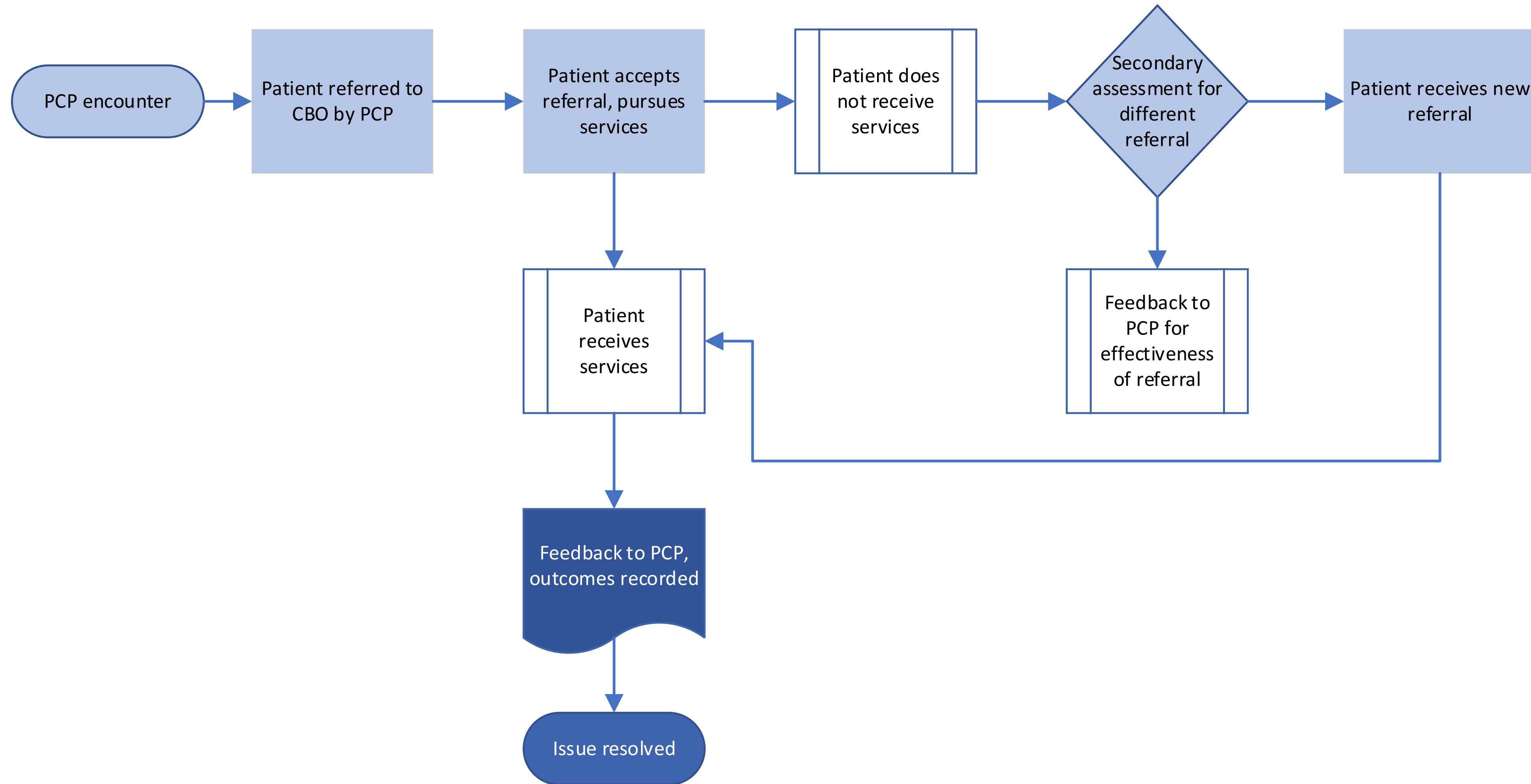
Patient accepts referral, service attempted, loop closed with CBO



Theoretical model adapted from UHF, 2019

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MAKING THE RIGHT REFERRAL - PATHWAYS

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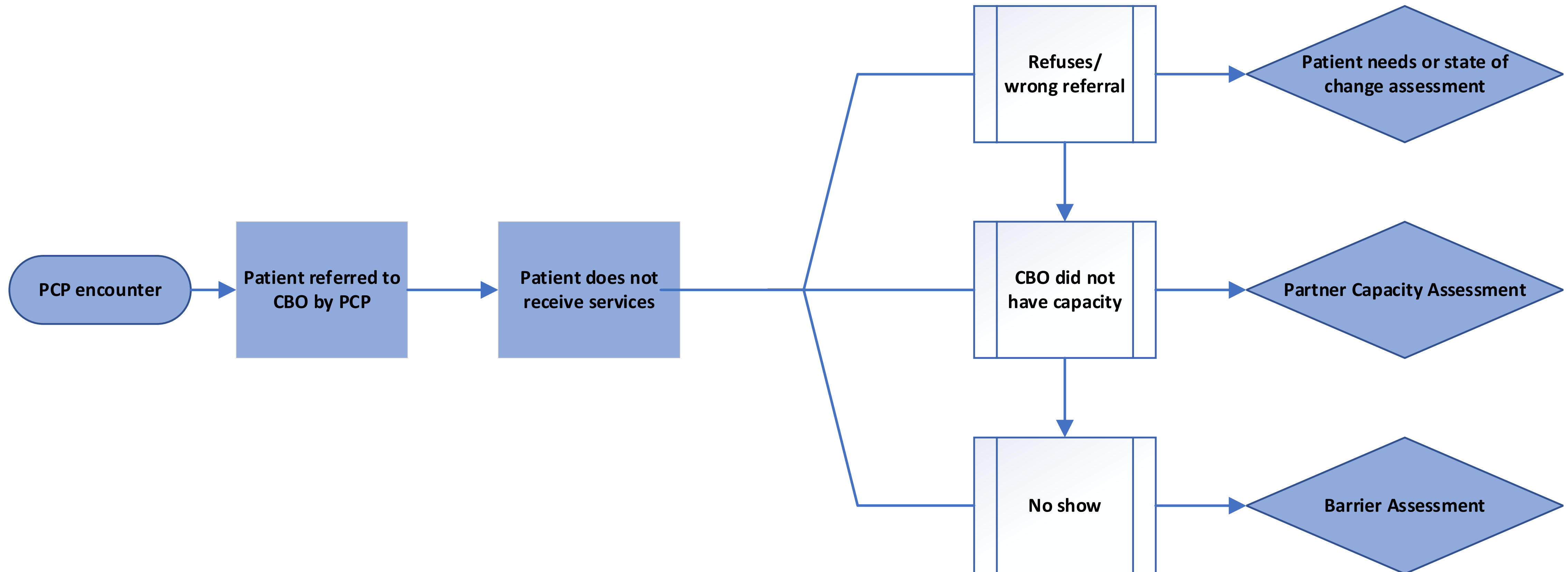
Patient accepts referral but does not receive services – reason?



Theoretical model adapted from UHF, 2019

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MAKING THE RIGHT REFERRAL: KEY CONSIDERATIONS FOR LINKAGES TO COMMUNITY SUPPORTS

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High Level

- Is this what the patient wants
- What intervention is most meaningful to them?
  - How will you know
- What were their priorities when they were screened for SDOH relative to their current social context?
- What organizations are best positioned to help your patients?
  - Who has capacity?
  - Who has credibility?
  - Who is has capacity for data exchange?

Detailed Considerations

- Operational capacity scan
  - What services do they offer?
  - Are they committed to partnership/have leadership buy-in
  - Data capacity and IT infrastructure
- Expectation setting
  - Mutual goal development
  - Sustainability planning
  - Protocol development
  - Quality measurement and performance management

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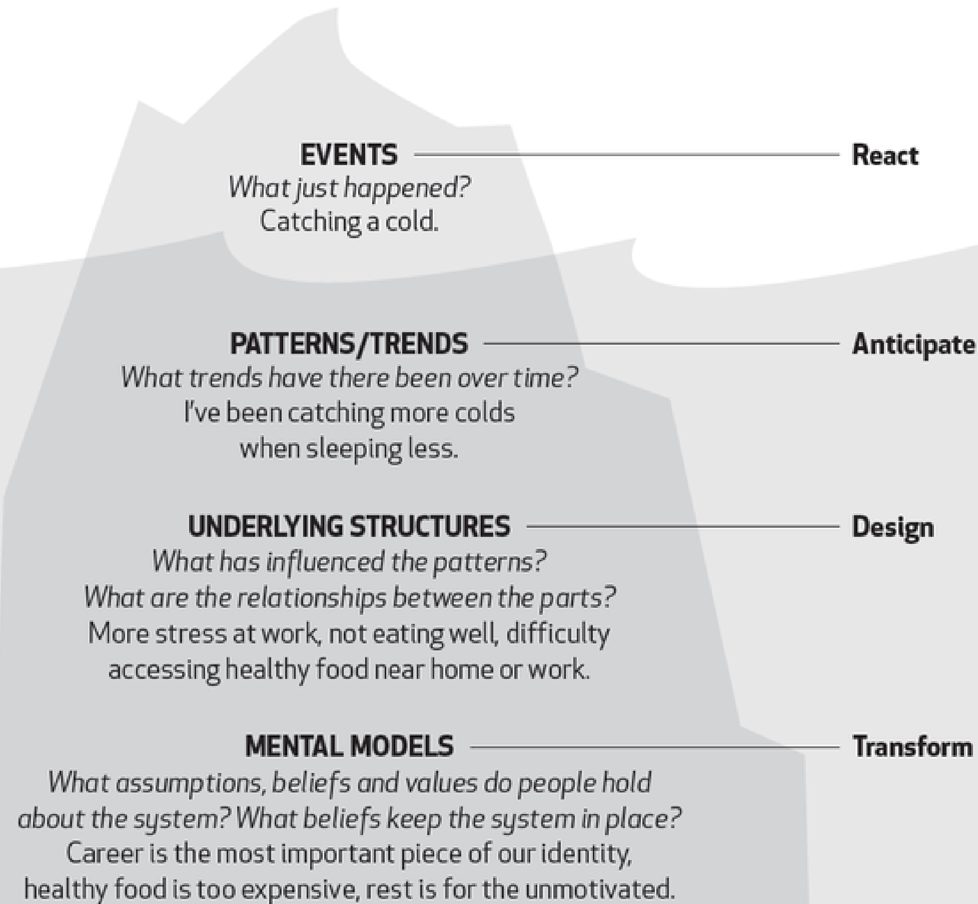

How will you take your interventions to the next level?

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MAKING THE RIGHT REFERRAL: DISCUSSION

- Are you currently using closed loop referrals to track interventions? *e.g., CRISP DC Portal – Social Needs*
- Where are some of your challenges or successes using that approach?
- Other ideas:
  - How do you establish referral relationships?
  - Do you evaluate at the high level and detailed level ?
  - What are the top three priorities for these relationships? (data exchange, patient preference, offering multiple services, what else?)

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MHLC **Facilitated Discussions** provide an opportunity to share your work to improve care with the learning collaborative.

Grantees will **share lessons learned, barriers encountered, and promising or best practices**.

Grantees should **conduct advance preparation** and brainstorming **with your team** and be prepared to talk through their responses.

Some **slides/talking points are encouraged**.

Each **grantee will participate in one session** and assigned a topic from their selections in the survey.

- Social determinants of health
- Workflow testing/adaptation
- Patient self-monitoring
- Clinical decision support
- Data to support improvement
- Sustainability

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- EECH's goal: Schedule 80% SMBP patients for a follow up visit with a provider within 30 days
- A scheduled visit provided the opportunity for us to
  - Assess accuracy of home BP's
  - Review their home BP results when electronic submission was not possible
  - Review medications and make adjustments
- Challenge:
  - Patients wanted to only see their preferred provider. One provider was only available one day a week resulting in having to schedule patients beyond the goal of 30 days or scheduling patients with another provider.
  - Roughly half of the patients who were scheduled for a follow up visit either cancelled or failed to show

- The Solution:
  - Schedule patients within the 30 days with a medical assistant for a blood pressure check
  - Based on their BP result the patient would be:
    - Given educational information to reinforce healthy behaviors and
    - Scheduled for a follow up visit

      OR, if the BP was elevated
    - We would contact their preferred provider and facilitate a telehealth session
    - Or ask them to see the onsite provider for an immediate appointment

- The end result:
  - 80% (24/30) of the SMBP patients had an in-office BP check
  - 3 were referred for a telehealth visit with their preferred provider
  - 1 patient was referred to the onsite provider due to a dangerously high BP

We have incorporated the BP checks into our daily routine and assigned an MA to this process

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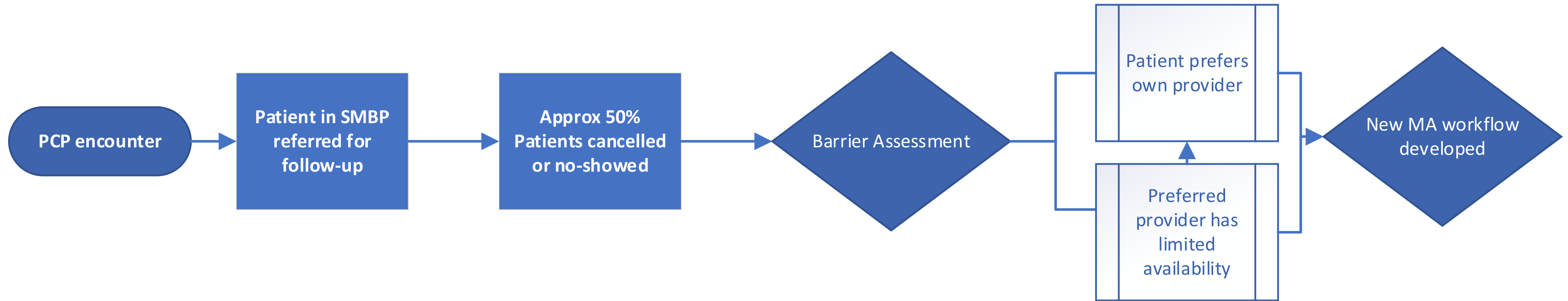

- What were your steps for doing the barrier assessment?
- How did you decide on a new workflow?
- Why do you think patients who were reluctant to see a different provider were willing to see the MA?

DISCUSSION

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1. **To what extent did the session meet the stated objectives?**
   (1 - not at all to 5 - met all objectives)

- Define health equity, health disparities, and social determinants of health.
- Describe the social and economic factors that drive health outcomes and have impact on health equity.
- Identify the key components of SDOH screening and referral management with social care organizations.
- Summarize the key considerations for partnerships with CBOs to address SDOH and health equity.

2. **How would you rate the session overall?**
(1 - poor to 5 - excellent)

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We are here to help you !

- ✓ For 1:1 site specific coaching, contact an HMA team member.
- ✓ To access previously recorded sessions and tools, visit https://livingwell.dc.gov/page/million-hearts-providers or see the technical assistance inventory document sent via email.

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