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Program Evaluation and Research Unit

Social Determinants of Health

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Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. **1.25 hours is approved for this course**.

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.25 continuing education credits.**

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Objectives

By the end of the session, participants will:

- Define SDOH
- Examine the impact of SDOH
- Examine the factors that make up SDOH
- Describe the process of selecting/ creating a SDOH assessment tool
- Outline processes for implementing SDOH assessment at the COE
- Present examples of assessing COE clients for SDOH
- Identify steps for addressing SDOH within the COE

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Agenda

1. SDOH overview – Erin Seger
2. SDOH Assessment, JADE Wellness Center – Daniel Garrighan
3. SDOH Assessment, Community Health and Dental Care – Derek Hammacher

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SDOH Overview

Share in the Chat...

How would you describe or define the social determinants of health?

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Determinants of Health

In general, there are **five types of factors** that affect health:

1. Genetics
2. Behavior
3. Environment
4. Health care
5. Social factors

Centers for Disease Control and Prevention (2019)

Determinants of Health

In general, there are **five types of factors** that affect health:

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2. Behavior
3. Environment
4. Health care
5. **Social factors**

Centers for Disease Control and Prevention (2019)

Social Determinants of Health (SDOH) Defined

"…the **non-medical** factors that influence health outcomes. They are the **conditions** in which people are **born**, **grow**, **work**, **live**, and **age**, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include **economic policies** and **systems**, **development agendas**, **social norms**, **social policies** and **political systems**"

World Health Organization

World Health Organization (n.d.)

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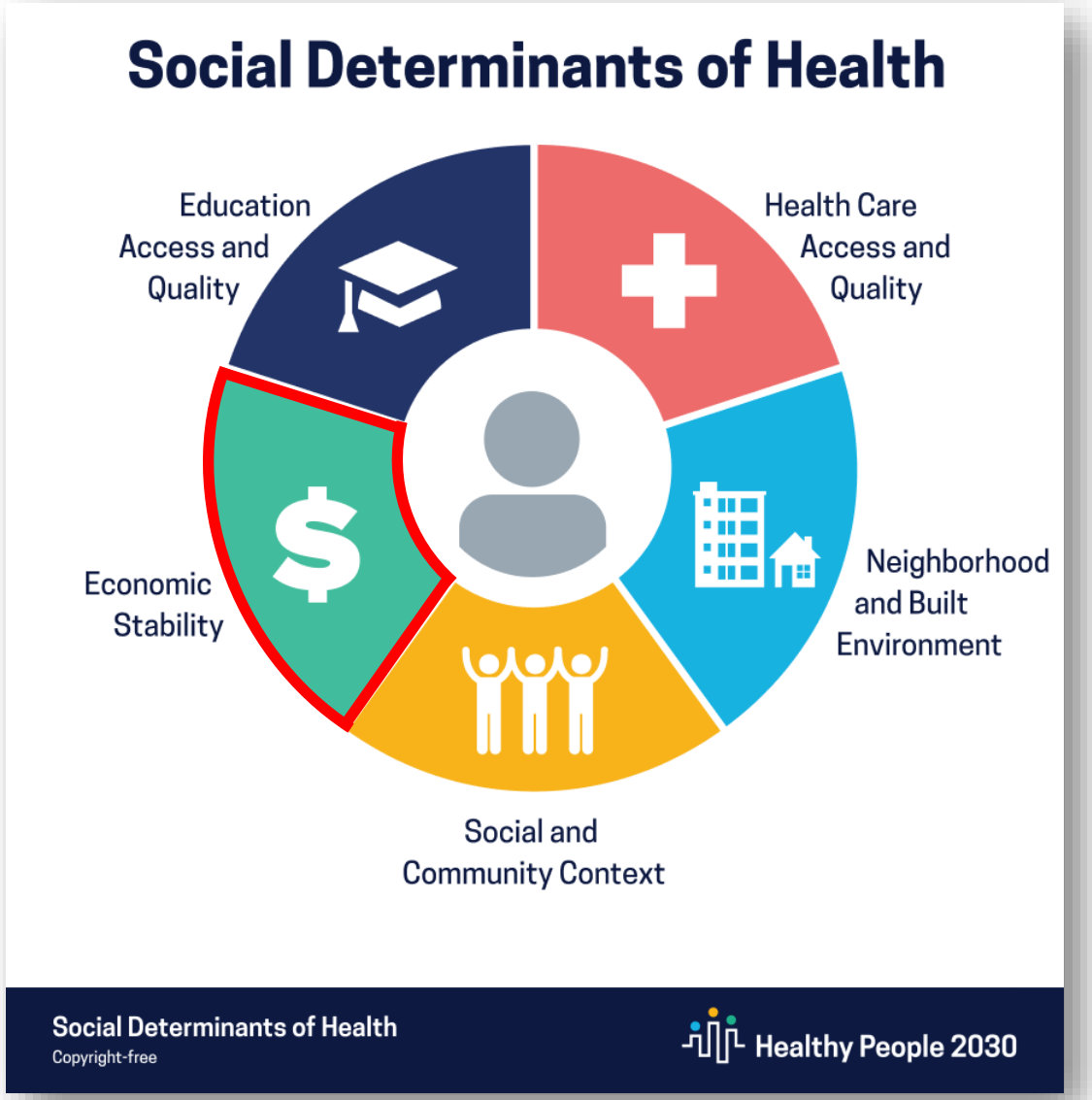
Impact of SDOH

- Research suggests that SDOH might affect health **more** than **other factors** such as health care or lifestyle choices
- A number of studies indicate that SDOH account for **30-55%** of health **outcomes**.
- Addressing SDOH is important for **improving** health and **health disparities**

World Health Organization (n.d.)



Economic Stability

- **Poverty** affects access to food, healthcare, and housing
- People with **steady jobs** are **less likely** to experience poverty, but:
  - It can be hard to **find** or **keep a job**
  - **Disabilities** can make it hard to work
  - Some steady jobs **don't pay enough**

Potential interventions: employment programs, career counseling, food/ housing assistance, educational opportunities

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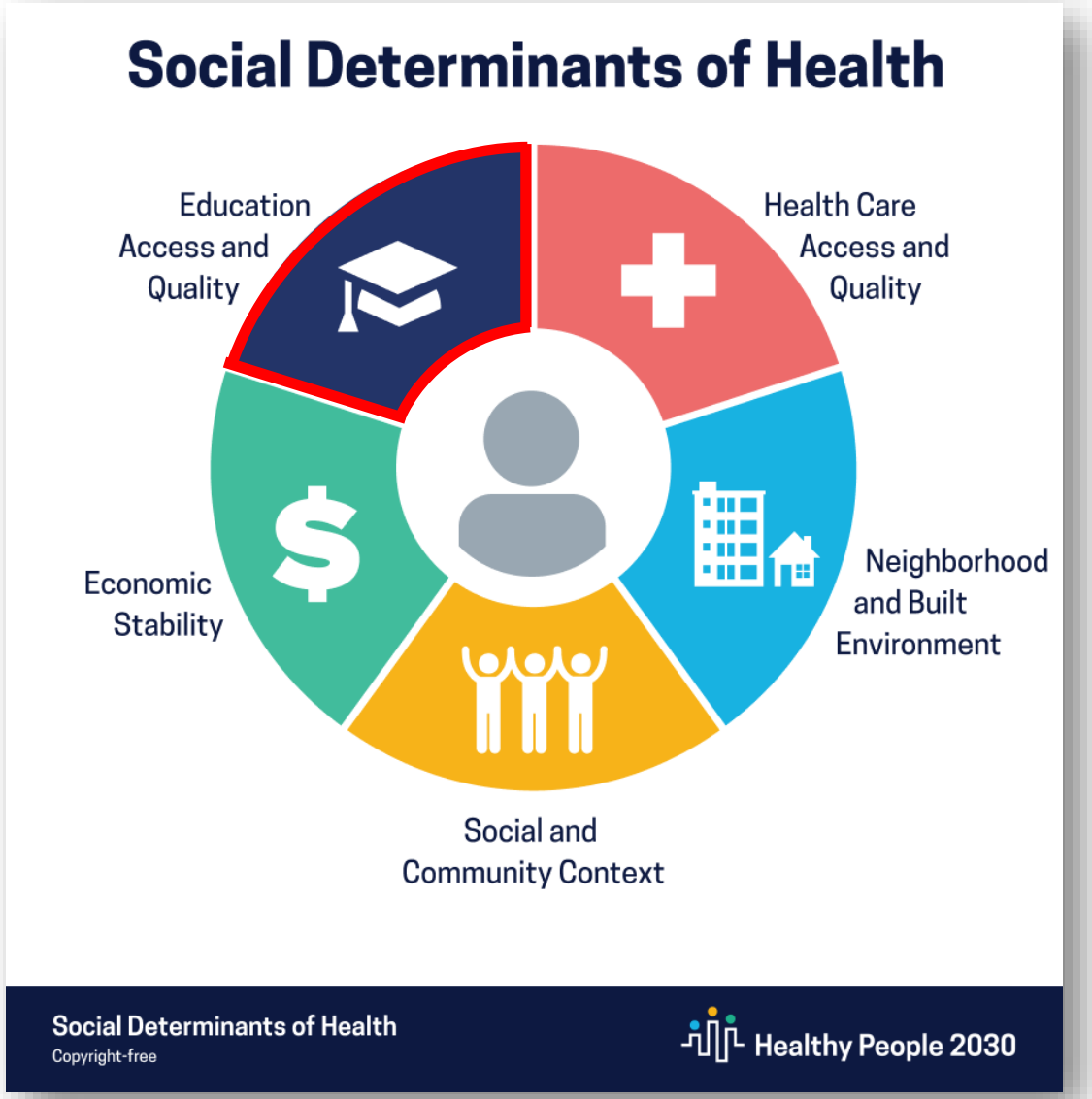
U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [ODPHP] (n.d.)



Education Access & Quality

- Education is **linked** to **better health** and **longer life**
- **Social discrimination** and **stress** can affect kids' performance in school
- Living in a place with **poorly performing schools** and **ability to pay** for higher education also has an effect

Potential interventions: Support for children to do well in school, financial support for higher education

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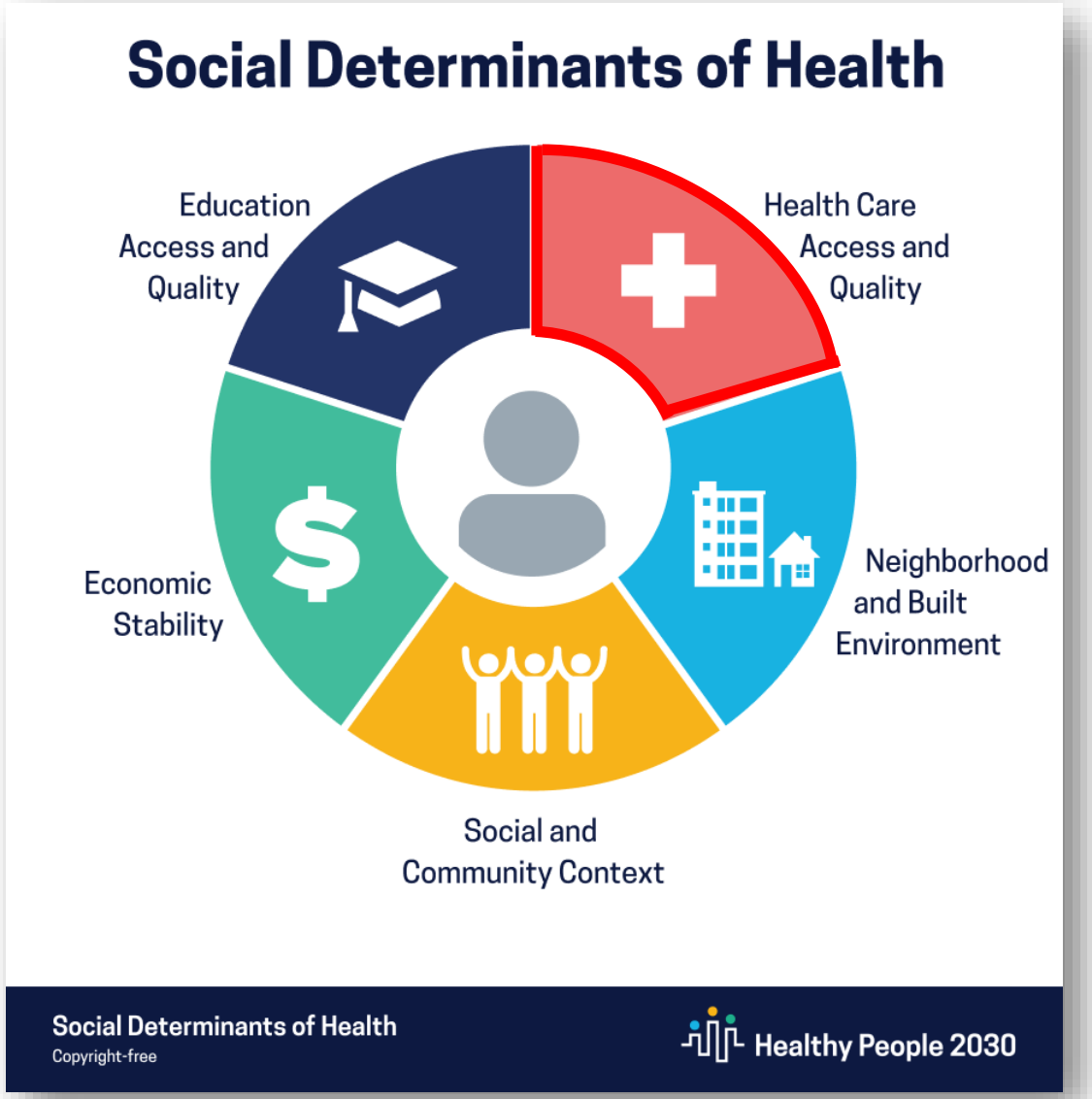
U.S. Department of Health and Human Services, ODPHP (n.d.)



Healthcare Access & Quality

- People **without health insurance** often can't get the care they need
- Lack of a **primary care provider** limits care
- **Living far away** from a health care provider limits access

Potential interventions: Increasing access to health care providers, increasing communication with providers

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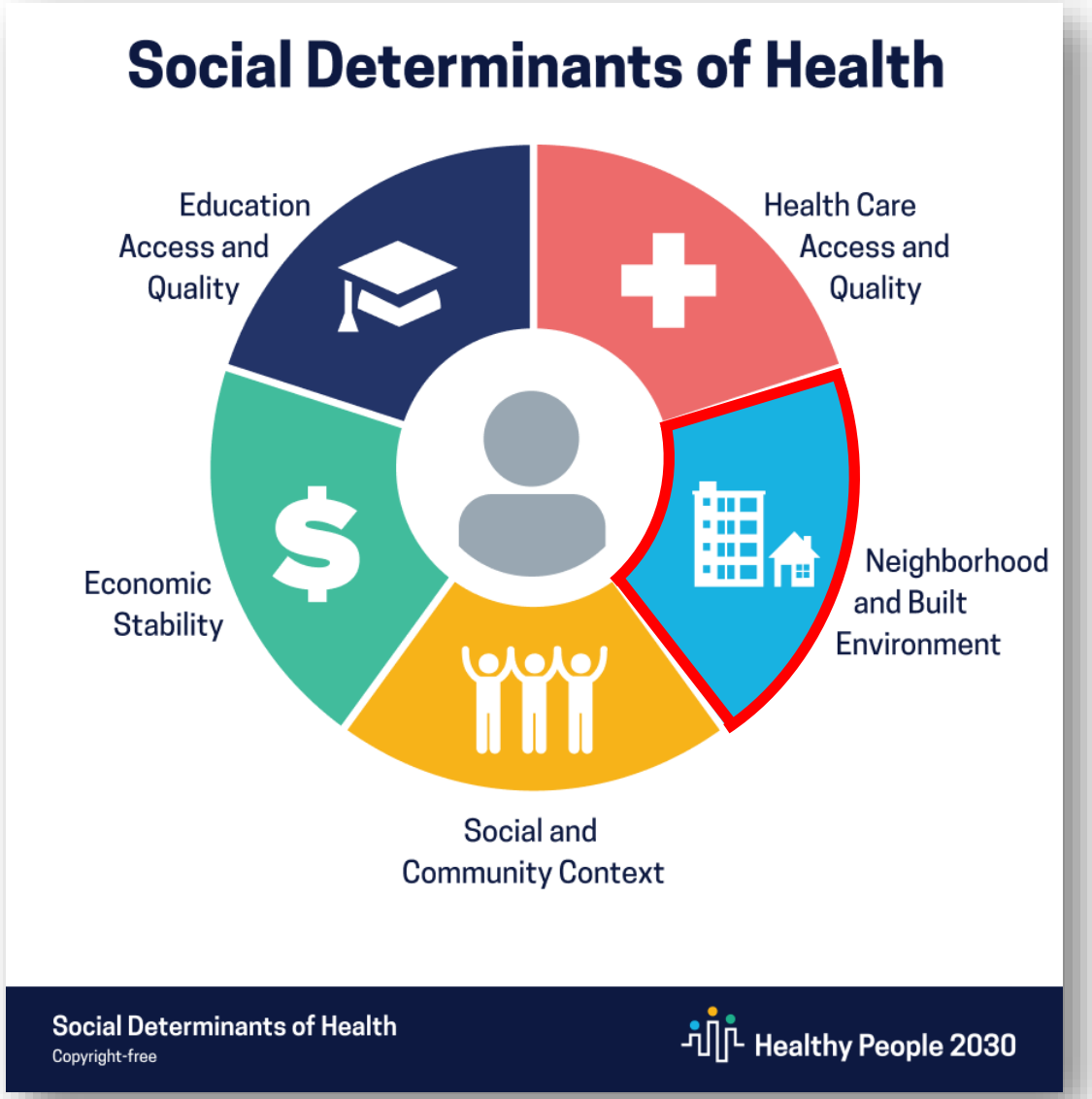
U.S. Department of Health and Human Services, ODPHP (n.d.)



Neighborhood & Built Environment

- Where **people live** affects health:
  - Violence
  - Air and water quality
  - Health and safety risks
- Those with **low income** and **people of color** are **more likely** to live in neighborhoods with risks

Potential interventions: policy changes to reduce risks

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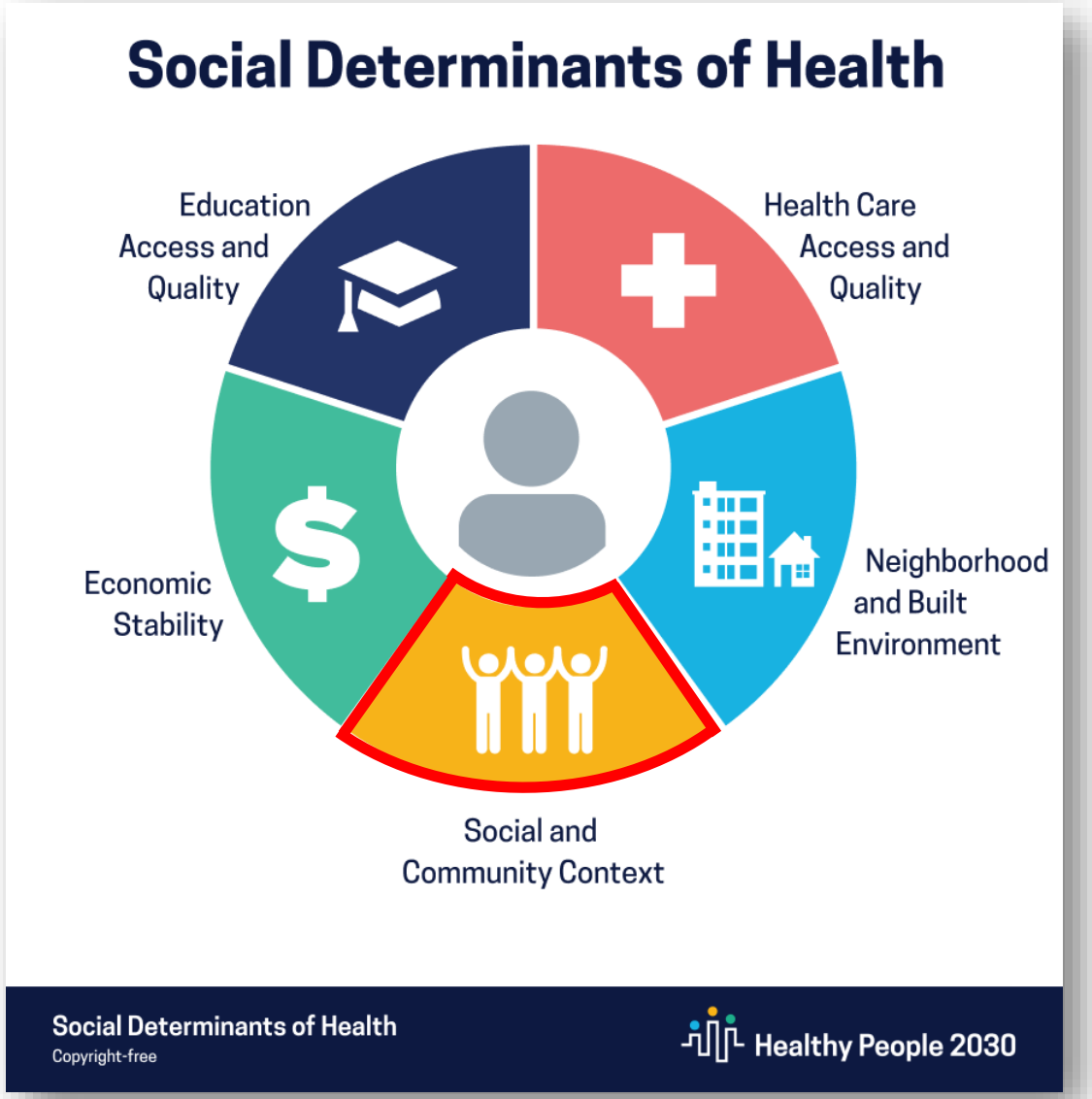
U.S. Department of Health and Human Services, ODPHP (n.d.)



Social and Community Context

- **Relationships** with friends, family and community can affect health[1]
- Positive relationships can help **reduce the impact** of **stressors** that are out of one's control[1]

Potential interventions: increased social and community support[1], eliminating bias[2], training for practitioners[3,4]

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[1]U.S. Department of Health and Human Services, ODPHP (n.d.)
[2]Hall, et al. (2015) [3]Horvat, et al. (2014) [4]Maharaj, et al. (2021)

Poll

Which of the five SDOH factors do you think has the biggest impact on COE clients?

a. Economic stability

b. Education access & quality

c. Healthcare access & quality

d. Neighborhood & built environment

e. Social and community context

SDOH & Health Disparities

- **Health Disparities:** "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage"[1]
- SDOH **contribute** to health disparities[2]

[1]U.S. Department of Health and Human Services, ODPHP (2021) [2]U.S. Department of Health and Human Services, ODPHP (n.d.)

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SDOH & Health Disparities

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SDOH and Inequities

- **Health Inequities:** "**systematic differences** in the **opportunities groups have** to achieve optimal health, leading to unfair and avoidable differences in health outcomes"
- **Structural Inequities:** "personal, interpersonal, institutional, and systemic drivers—such as, **racism, sexism, classism, able-ism, xenophobia, and homophobia**—that make those identities salient to the fair distribution of health opportunities and outcomes"
- These inequities shape **who experiences** more negative SDOH

National Academies of Sciences, Engineering, and Medicine (2017)

SDOH, Opioid Use & Overdose

Research indicates:

- SDOH (*income, employment, insurance, housing, social support*) impact inpatient **OUD presentation**[1]
- Zip codes with greater SDOH disadvantage (*poverty, unemployment, ≤ high school education*) often see **elevated rates of opioid overdose**[2]
- A wide **variety of SDOH** factors are associated with opioid overdose[3]

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[1]Sulley & Ndanga (2020) [2]Pear, et al., 2019 [3] Van Draanen, et al. (2020)

How COEs can Help

- **Outpatient care** that **addresses SDOH** is important for **addressing SUD**[1]
- Research indicates that **meeting** clients' **service needs** is related to a **reduction in substance use**[2]

[1]Sulley & Ndanga (2020) [2]Friedmann, et al. (2004)

SDOH Assessment Processes

- **Daniel Garrighan**- JADE Wellness Center, Pittsburgh, PA
- **Derek Hammacher**- Community Health and Dental Care, Pottstown, PA

SDOH Assessment

JADE Wellness Center

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Community Health Initiatives

Social Determinates of Health

For Substance Use Disorders

- JADE Wellness Center - Licensed SUD treatment provider including PHP, IOP, OP levels of care with multiple locations in Allegheny County, PA.
- Offering psychiatric, co-occurring capable tracks with access to addiction psychiatrists.
- Certified Recovery Specialist available to clients assisting in building Recovery Capital and non-clinical needs.
- MAT services available through Buprenorphine (Suboxone/Sublocade) and Naltrexone (Vivitrol/ReVia).

SDOH Assessment Tool

- Modeled after Certified Assessment Center LOCA - Non-clinical barriers.
- Provides direct referral and warm-handoffs to services and supports.
- Reduction in initiation obstacles.
- Iterative process working at the preferred pace of the client throughout the course of treatment services.
- Ensure treatment initiation and access to non-clinical resources.

COE Benchmark & Goals

Recommended Community Partners

- Housing Services
- Transportation
- Educational Services
- Food Services
- PCP
- Dental
- MCO
- Recovery Support Groups
- Community Center
- Legal Services

Intake COE Assessment

- Screen for Psychiatric Needs
- Biomedical Concerns
- Do you have a PCP?
  - Date of last physical
- Hx of Mental Health Tx
- Pain Screening & current interference in activities
- Involvement in Community Support Groups
- Spiritual & Cultural preference
- Education History
  - Highest Grade Completed
  - Highest Grade completed
  - Learning Difficulties & Barriers
- Employment
  - History of job performance
  - Employment interests/skills
- Transportation
- Legal involvement & History of Charges
- Current Living Situations
- Hobbies/Interest
- Ability to manage finances

Case Management Domain Needs

- Basic Needs
  - Food, Clothing, Utilities, Transportation
- Child Care
  - Custody, Visitation, Child Care
- Education / Vocation
  - GED, Tutoring, OVR
- Emotional / Mental Health
- Employment
- Family
- Healthcare Coverage
- Legal Issues
- Life Skills
  - Paying Bills, Grocery Shopping, Time Management
- Living Arrangements / Housing
- Physical Health
- Social
  - Develop social Skills, Leisure Activities

Recovery Plan

Should reflect needs of SDOH

Addresses Resources, Strengths and Skills / Barriers & Problems

- Mental And/or Emotional Health
- Medical and/or Physical Health
- Living Situation and/or Environment
- Employment and Financial Stability
- Independency from Legal Issues
- Relationships & Social Support
- Education and/or Intellectual
- Spirituality
- Additional Area of Recovery
  - Basic Life Necessities
  - Leisure Activities / Community Service
  - Meaning & Purpose to Life / Spirituality

SDOH Assessment

Community Health and Dental Care

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Community Health Initiatives

Community HEALTH & DENTAL Care

Social Determinants of Health

351 W. Schuylkill Rd., Suite G-15A, Pottstown, PA 19465

1315 Route 100 North, Barto, PA 19504

700 Heritage Drive, Suite 701, Pottstown, PA 19464

800 Heritage Drive, Suite 802, Pottstown, PA 19464

Fully integrated Federally Qualified Health Center (FQHC)

- Medical: adult and pediatric primary care
- Dental, Vision, OB/GYN, Physical Therapy, Podiatry, Phlebotomy, 340B Dispensary, Transportation
- Behavioral Health, Center of Excellence (COE), Medication Assisted-Treatment (MAT), Case Management

Center of Excellence

- Established 2016 as PH-COE
- Primarily serving Montgomery and Chester Counties
- Masters-level Community Based Care Managers (CBCM), Certified Recovery Specialists (CRS), Licensed Behavioral Health Consultants (BHC)

Selecting SDoH Assessment Tool

- CHDC has been using **PRAPARE** to assess SDoH insecurities for several years
- "**P**rotocol for **R**esponding to and **A**ssessing **P**atient **A**ssets, **R**isks, and **E**xperiences"
- Implemented into COE Protocols and workflow over a year ago

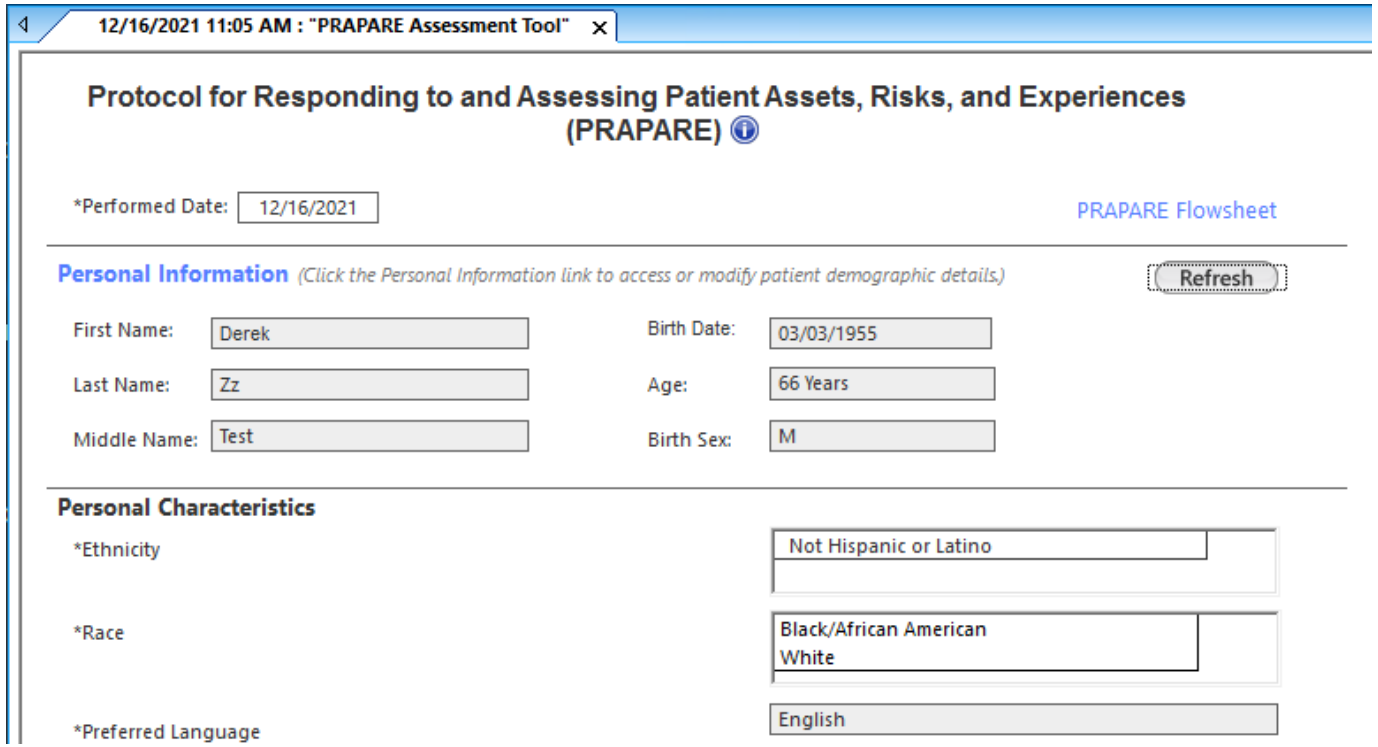
From the National Association of Community Health Centers (NACHC) website…

- Consists of a set of national core measures
- Informed by research, the experience of existing social risk assessments, and stakeholder engagement
- Aligns with 'Health People 2020' – national initiative promoting SDoH
- Is evidenced-based, patient-centered, actionable

- https://www.nachc.org/research-and-data/prapare/

Community HEALTH & DENTAL Care

Core Measures in PRAPARE


12/16/2021 11:05 AM : "PRAPARE Assessment Tool"
Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)
*Performed Date: 12/16/2021
PRAPARE Flowsheet
Personal Information (Click the Personal Information link to access or modify patient demographic details.)
Refresh
First Name: Derek
Last Name: Zz
Middle Name: Test
Birth Date: 03/03/1955
Age: 66 Years
Birth Sex: M
Personal Characteristics
*Ethnicity
Not Hispanic or Latino
*Race
Black/African American
White
*Preferred Language
English

Family & Home

*How many family members, including yourself, do you currently live with? ☐ I choose not to answer this question

*Address

Street 1: 999 BH Street

Street 2:

City: Pottstown State: PA Zip: 19465

*What is your housing situation today?

- ○ I have housing
- ○ I do not have housing
- ○ I choose not to answer this question

Details:

*Are you worried about losing your housing? ○ Yes ○ No ○ I choose not to answer this question

Community HEALTH & DENTAL Care

*In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- Food ○ Yes ○ No
- Utilities ○ Yes ○ No
- Clothing ○ Yes ○ No
- Child Care ○ Yes ○ No
- Medicine or Any HealthCare ○ Yes ○ No
- Phone ○ Yes ○ No
- Others:
- ○ I choose not to answer this question

*Has lack of transportation kept you from medical appointments, meetings,work, or from getting things needed for daily living? Check all that apply.

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ No
- ☐ I choose not to answer this question

Implementation

- Introduced to medical and behavioral health
- Followed by COE, care and case management
- COE staff, BH staff, MAs, care and case managers
- All staff are trained on how to complete Prapare
- Clinical Practice and Performance Improvement

Assessing and Addressing Patient Need

- Identify insecurities
- Provide internal and external referrals and resources
- Follow-up
- Re-assess

Run Date: 12/17/2021 11:28:23 AM

Date Range: 11/1/2021 - 11/30/2021

SDOH QUALITY METRICS BY PATIENT POPULATION

Item	Value	%
1. TOTAL POPULATION		
A. [DENOMINATOR]: Total number of unique patients who had a medical visit during the reporting period	1135	100 %
1. # of Patients who received SDoH Assessment within last 12 months	396	34.89 %
[redacted]		
B. QUESTIONS ANSWERED BY TOTAL POPULATION		
[redacted]		
2. Patients who answered the question(s) pertaining to Food Insecuriies	382	96.46 %
a. # of No Insecurities	354	92.67 %
b. # of Yes Insecurities	36	9.42 %

Run Date: 12/17/2021 11:28:23 AM
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[redacted]	[redacted]	[redacted]
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Yes Insecurities

group by this column.

ID	Name	DOB
5041	[redacted]	[redacted]
38988	[redacted]	[redacted]
2281	[redacted]	[redacted]
28473	[redacted]	[redacted]
48851	[redacted]	[redacted]
42488	[redacted]	[redacted]
33060	[redacted]	[redacted]
19161	[redacted]	[redacted]

Next Steps

- Z Codes
- TriCounty Health Council Workgroups: standardization of SDoH assessment and referrals

Questions?

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Community Health Initiatives

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