Washington Association for Community Health

Community Health Centers
Advancing Quality Care for All

Using Social Determinants of Health Data: Advancing the Health Center Mission

Hosted by: Karie Nicholas

February 24, 2022

WELCOME

	Attendees' microphones have been muted
QUESTIONS/COMMENTS	Type questions/comments in QUESTIONS and CHAT BOXES
	Link to webinar slides and recording will be emailed
EVENT EVALUATION	At the end of the event, please fill out Event Evaluation

THIS EVENT IS BEING RECORDED

OBJECTIVES

After attending the session, participants will be able to:

- Describe the essential role of SDOH data in advancing the health center mission
- Recognize examples from 3 health centers that use SDOH data to:
  - identify gaps in community resources
  - inform areas for future partnership and program development
  - develop patient relationships and deliver personalized care
  - refine health center programs and processes

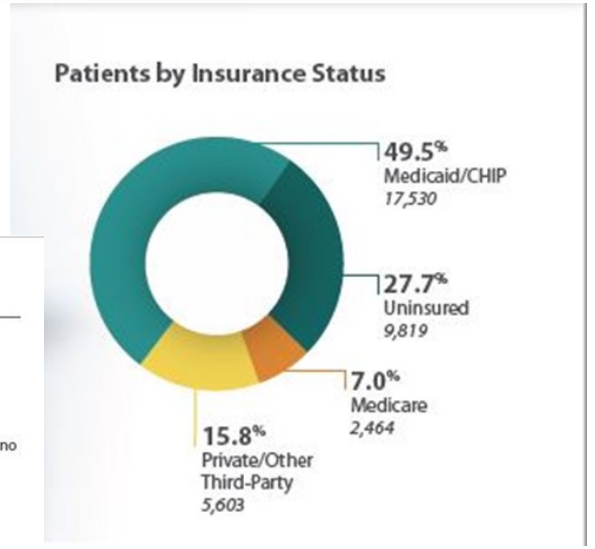
Presenters

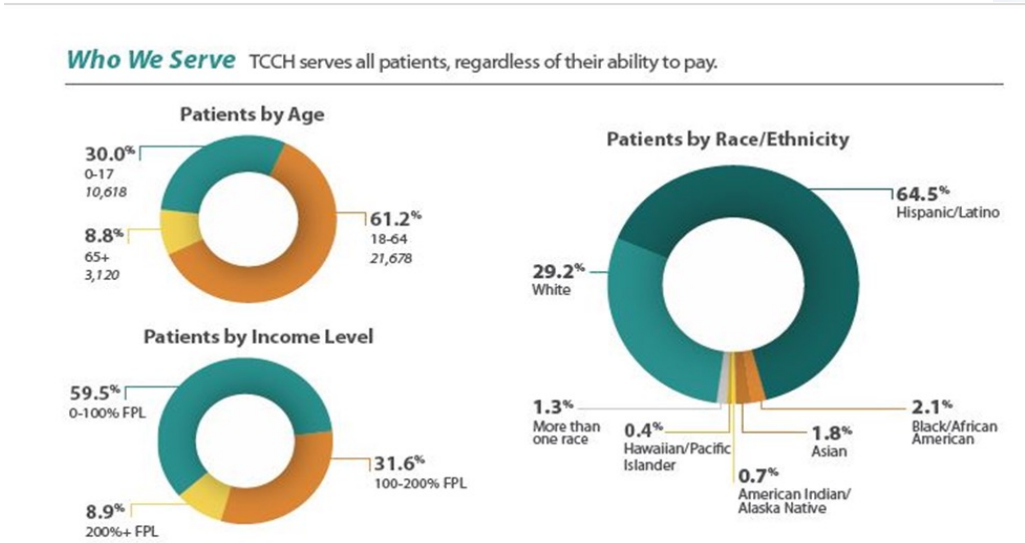
Gaby Araico, Registered Dietitian, Diabetes Ed., Lifestyle Coach

Gaby is a Registered Dietitian and currently works as a Clinical dietitian, Diabetes educator, and Lifestyle Diabetes coach at Tri-Cities Community Health and as a Family Services Registered Dietitian at Columbia Basin Health Association in Mattawa and Othello. She graduated from Seattle Pacific University and has a Master of Nutrition and Food Science from Leon University in Spain. Passionate about helping others, she is a believer that education and prevention is the key to being healthy. With more than 10 years teaching experience, Gaby serves as coordinator of the Diabetes Prevention Program sponsored by the CDC and the National Hispanic Alliance for Health in Tri-Cities. She also volunteers with Prevent Homeless Pets and Pronto Puppy Rescue.

" WHY TREAT PEOPLE AND SEND THEM BACK TO THE CONDITIONS THAT MADE THEM SICK IN THE FIRST PLACE" Sir Michael Marmot

Access to medical care. PCP? Last physical exam? Last mammogram? Dental?
Access to clean water? Functioning utilities? (electricity, heating, cooling)
Education and Health Literacy
Ethnicity and Cultural Orientation
Family and Social Support
Housing
Transportation
Linguistic and Communication
Occupation and job security
Socioeconomic status





What programs are we building or tailoring based on the SDOH needs that we see?

- BCHP Breast Cervical Colon Health Program 588
- Mammogram and Cancer screening 972
- WIC 4715 participants
- First steps 560 (IBCLC, Nurse, BHS, RD)
- Enrollment and insurance 923 patients (Medicaid, and Qualified Health Plans)
- Sliding fee (Customer Service)
- Diabetes Prevention Program 600 participants
- Childhood Obesity
- Chemical Dependency
- School Based Centers
- Manejo de su Diabetes (In progress)
- Tomando Control de su Salud (In progress)
- Control de la Hipertension (In progress)

Examples

Let's talk about Maria

- "I think I'm Pregnant"
- Walk-in PG Test. (Positive)

- Maternity Support Services (RN, Behavioral Health, Social Work/CHW, IBCLC, RD)
- Insurance
- Screening Tool for Risk Assessment (Lets look at it, in next slide)

- Establish Risk
- Schedule OBGYN appointment (TCCH or outside clinic)

Washington State Health Care Authority

MSS Prenatal Screening Tool

CLIENT NAME	
DATE OF BIRTH	CLIENT ID

Instructions:
- An * asterisk indicates a MSS clinician (CHN, RD, BHS) needs to make the final determination on a client's risk criteria (A, B or C).
- After screening the client for the MSS targeted risk factors, document the date(s) in the appropriate A, B or C column for any identified criteria, sign the last page noting who made the determination and assign the level of service.

TARGETED RISK FACTOR	DO NOT USE SHADED AREAS A	B	C	RISK FACTOR CRITERIA
Race				C. American Indian, Alaska Native or non-Spanish speaking indigenous women from the Americas (e.g. women whose primary language is Mixteco, Mam, or Kanjobal, etc.)
				C. African American or Black
				C. Pacific Islander
Prenatal Care				A. Greater than or equal to **(≥) 14** and less than **(<) 24 weeks** gestation **and no prenatal care** started at the time of screening
				B. Greater than or equal to **(≥) 24** weeks gestation when prenatal care started.
				B. Greater than or equal to **(≥) 24** weeks gestation **and no prenatal care** started at the time of screening
Nutrition				**Food Insecurity**: A. Runs out of food before the end of the month or cuts down on the amount eaten to feed others
				Pre-pregnancy BMI: IOM = Institute of Medicine *A. Pre-pregnancy BMI less than **(<) 18.5** and weight gain **within** IOM guidelines
				*C. Pre-pregnancy BMI less than **(<) 18.5** and weight gain **outside** of IOM guidelines
				A. Pre-pregnancy BMI **25.0 to 29.9**
				*A. Pre-pregnancy BMI greater than or equal to **(≥) 30** and weight gain **within** IOM guidelines
				*B. Pre-pregnancy BMI greater than or equal to **(≥) 30** and weight gain **outside** of IOM guidelines
Medical				**Inter-pregnancy interval:** A. Current pregnancy conception less than (<) 9 months from the end of the last pregnancy
				Diabetes: B. History of gestational diabetes in the last pregnancy.
				C. Pre-existing Diabetes- Type 1 or 2
				C. Current gestational diabetes
				Multiples: C. Currently pregnant with multiples (2 or more babies)
				Hypertension/Gestational Hypertension: A. Gestational Hypertension in past pregnancy
				C. Chronic Hypertension: Hypertension diagnosed prior to pregnancy or before 20 weeks gestation
				C. Current pregnancy induced hypertension (gestational hypertension) starting greater than (>) 20 weeks gestation
				Low Birth Weight (LBW) or Preterm birth/labor/fetal death: C. Prior LBW infant (less than (<) 5lb 8 oz) **and/or** premature infant (less than (<) 37 weeks); Prior fetal death (fetus greater than (>) 20 weeks gestation)
				C. Current pregnancy-diagnosed with **preterm labor** during this pregnancy or is on treatment or bed rest to prevent preterm birth

TARGETED RISK FACTOR	DO NOT USE SHADED AREAS A	B	C	RISK FACTOR CRITERIA
Maternal Age				A. 16 years old at conception
				B. Up through age 15 at conception
				A. 35 years of age or older at conception **and** this is not her first pregnancy **and** she did not use assisted reproductive technology (ART) for this pregnancy
				B. 35 years of age or older at conception **and** one of the following: (1) First pregnancy (2) Current pregnancy via assisted reproductive technology (ART)
Maternal Tobacco/ Nicotine Use				A. Quit smoking/using tobacco or nicotine products no more than 3 months prior to pregnancy or upon diagnosis of pregnancy
				B. Smokes and/or uses tobacco or nicotine products during pregnancy
Alcohol and Substance Abuse or Addiction				*B. **Stopped use** of alcohol (see clarification table), illicit substances, or non-prescriptive use of prescriptive drugs following pregnancy diagnosis and has not used for more than or equal to **(≥) 90 days**
				*B. **Actively engaged** in alcohol/drug **treatment** program and has not used for greater than or equal to **(≥) 90 days**.
				*C. **Stopped use** of alcohol (see clarification table), illicit substances, or non-prescriptive use of prescriptive drugs following pregnancy diagnosis and has not used for less than **(<) 90 days**
				*C. **Any use** of alcohol, illicit substances, or non-prescriptive use of prescriptive drugs **once the client knows she is pregnant**
Intimate Partner Violence				A. IPV has occurred more than one year ago
				B. In the last year, the woman's intimate partner or father of baby (FOB) has committed or threatened physical/sexual violence against her
Mental Health Severe Mental Illness (SMI) and Perinatal Mood Disorder				*A. **No history** of mental health diagnosis, but answers "Yes" to "In the last month, have you felt down, depressed or hopeless?" or showing potential symptoms of depression, but has **negative score on standardized** depression **screening** tool, i.e. Edinburgh, CES-D
				*B. **History** of mental health treatment but is stable, **or** history of postpartum depression with previous pregnancy, **and negative score on standardized** depression screening tool
				*B. **Current** mental health diagnosis and is **engaged** in mental health treatment
				*C. Mental health symptoms of depression are evidenced by **positive score** on standardized depression screening tool
				*C. Client has a **mental health diagnosis** and exhibits **active symptoms** which interfere with general functioning
Develop-mental Disability				*A. Severe developmental disability which could impact the woman's ability to take care of herself during the pregnancy or an infant, but has **adequate** support system, and **demonstrates** evidence of follow through with health care appointments/advice and self-care
				*C. Severe developmental disability which impacts the woman's ability to take care of herself during the pregnancy or an infant and has an **inadequate** support system **or does not demonstrate** evidence of follow through with health care appointments/advice and self-care

☐ Check this box to acknowledge all the MSS targeted risk factors have been screened for and initial _____

Screen date _____ Completed by _____ Level of service _____

Screen date _____ Completed by _____ Level of service _____

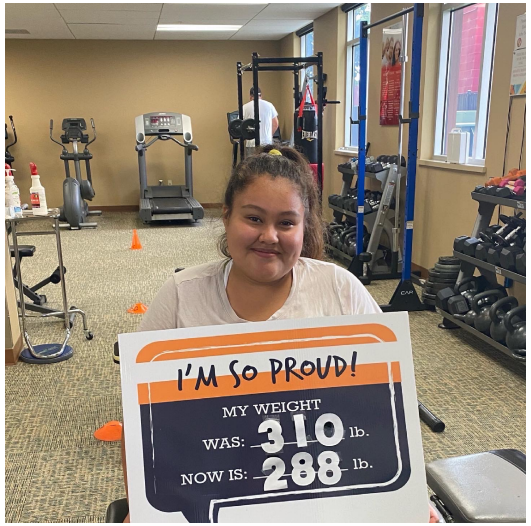
Screen date _____ Completed by _____ Level of service _____

Level of Service (available during pregnancy through two months post pregnancy; see Provider Guide for number of units allowed):

Basic = No targeted risk factor or A level risks and no Bs or Cs

Expanded = At least one B and no Cs

Maximum = At least one C


I'M SO PROUD!
MY WEIGHT
WAS: 310 lb.
NOW IS: 288 lb.


ZUMBA Kids
With Analy


I'M SO PROUD!
MY WEIGHT
WAS: 287 lb.
NOW IS: 260 lb.


Diabetes
Prevention
DIABETES

Presenters

HealthPoint

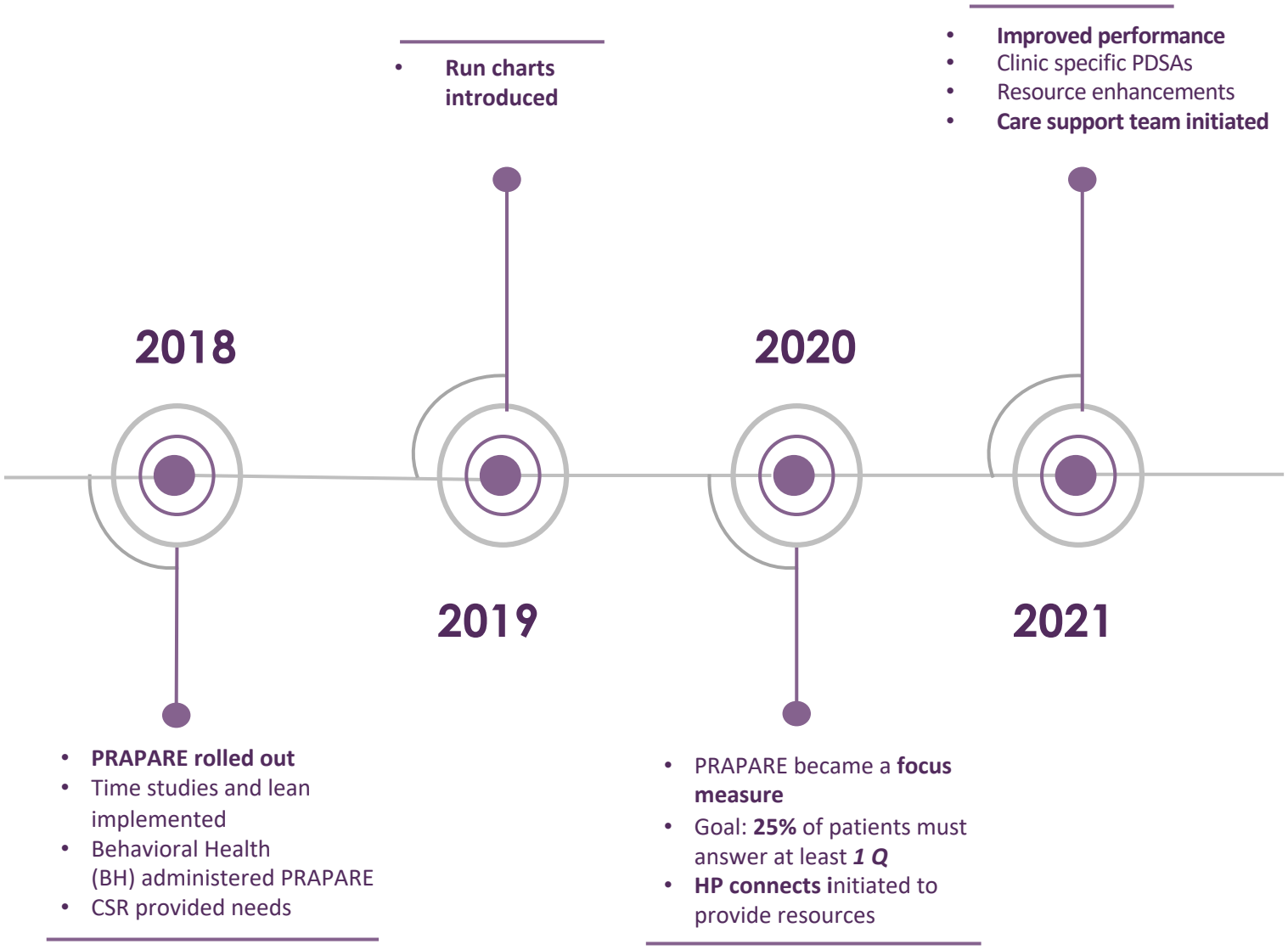
Harika Adiraju, Quality Improvement Coordinator

Harika is a healthcare professional with expertise in project management, quality improvement and data analysis. Prior to her introduction to community health in 2021, she has held positions in healthcare quality improvement in the private sector. HealthPoint is a community-based, community-supported and community-governed network of non-profit health centers dedicated to providing expert, high-quality care to all in need regardless of circumstances. This has drawn Harika's interest towards understanding deeply the different populations, their social needs and its' implications on operational workflows in community health centers. She has a bachelor's degree in dental surgery, a master's degree in healthcare management and certificates in Healthcare Quality and Safety and Business Analysis. Her interests include better understanding the social needs of patients, optimizing workflows to provide equitable care, population management, healthcare quality and safety, and continuing to learn about community health so that she can better support the needs of her community.

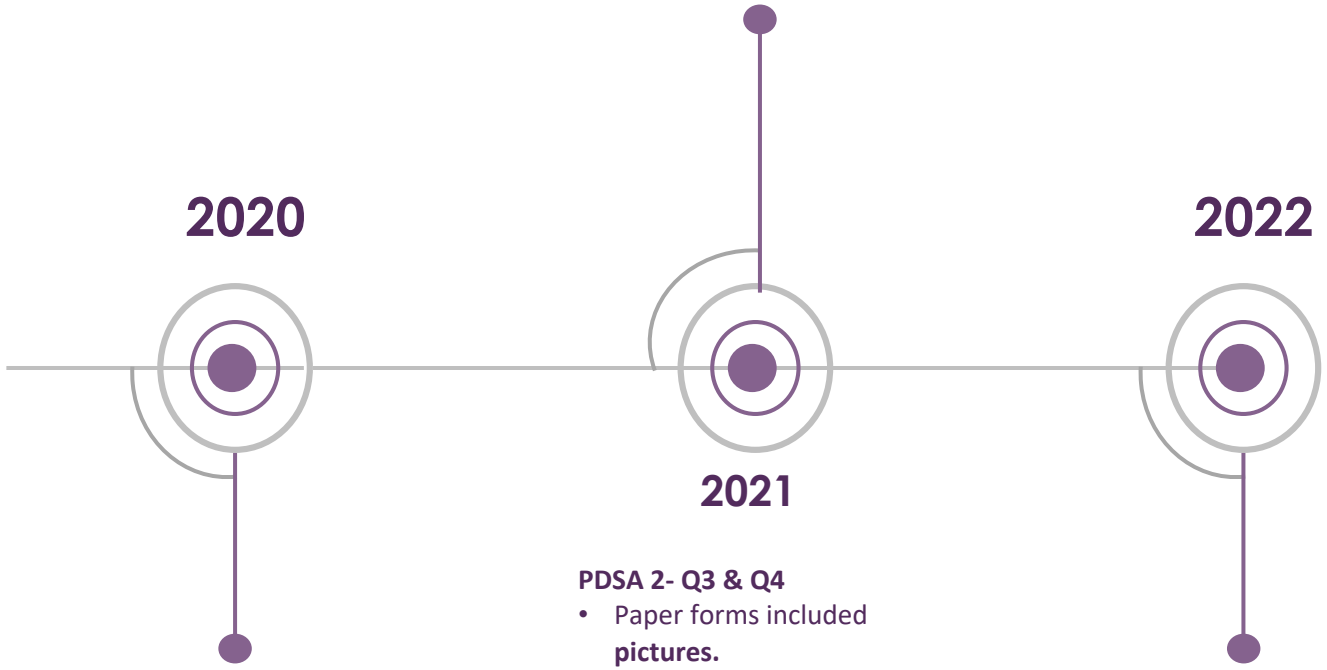
Agenda

- About HealthPoint
- Our Journey
- Plan-Do-Study-Act (PDSA) summary
- Workflow
- Data analysis
- Resources
- Closing the loop
- Future State

HealthPoint story



Federal Way story



2020

- PRAPARE became focus measure
- Goal: 25% wt 1 Q
- HP connects initiated to provide resources
- **Administering PRAPARE template in NG directly**

2021

PDSA 1- Q2

- **Paper forms started with needs mentioned (1Q only)**
- Alerts placed in charts
- **SDOH tracker** initiated
- CSR provided resources

PDSA 2- Q3 & Q4

- Paper forms included **pictures.**
- Manual data entry into EHR
- SDOH tracker continued
- **Care support team** initiated for outreach
- **Reached target!**

2022

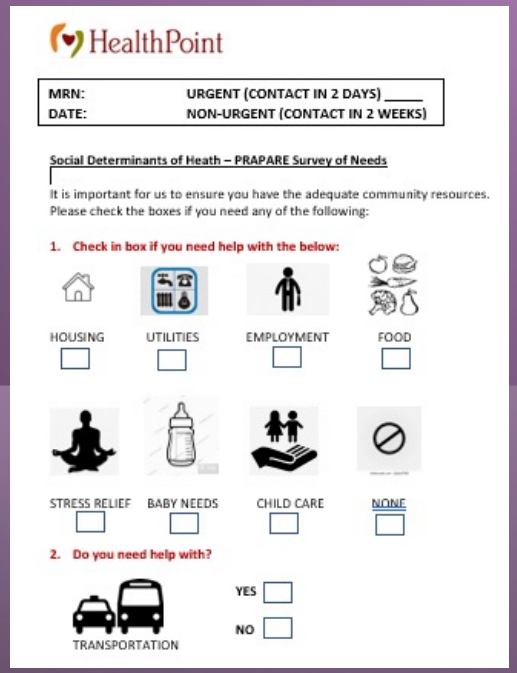
PDSA 3:

- **Goal increased** to 2Q
- PRAPARE administered by MA and remove paper forms
- Needs identified as P in appt list
- CSR resources- in clinic appts
- Feedbacks taken from pts-pilot
- **REL(Race Ethnicity Language) stratification initiated**

PDSA Summary

Timeline	Challenges	Workarounds	Post PDSA
PDSA 1	• *Incomplete forms* • Redundancy • *Poor metrics* • Robust data entry process	• Medical Assistant/Front Office cautious of completion • Alerts placed in charts • Quality Improvement Coordinator (QIC) monitoring, constant reminders	• Continuous monitoring • Data entry and tracker to be done by Dental Assistant Coordinator • Tracker to be kept updated • Alerts to be added in patient chart
PDSA 2	• *Constant changes in process* • *Patients' lack of clarity* • *Staff burnout* • Failed text links • Lag for tasking	• soft reminders • Staff explaining the imp • Continuous feedback, workload sharing • Emailed links, missed pts who didn't have emails	• Include PRAPARE process in team meetings- for updates • Paper forms to be continued • MAs to data enter PRAPARE to EHR • Tracker to be maintained by QIC, add alerts • ***Shared outreach:*** *Care support and Client Services Representative (CSR)*
PDSA 3	• Declined accountability	• Regular reminders • Depended on care support channel and direct provider requests	• Paper forms re-introduced • Feedback collected from patients • ***QR code*** for resources made available in exam rooms

Process



HealthPoint

MRN: URGENT (CONTACT IN 2 DAYS) ____
DATE: NON-URGENT (CONTACT IN 2 WEEKS)

Social Determinants of Heath – PRAPARE Survey of Needs

It is important for us to ensure you have the adequate community resources. Please check the boxes if you need any of the following:

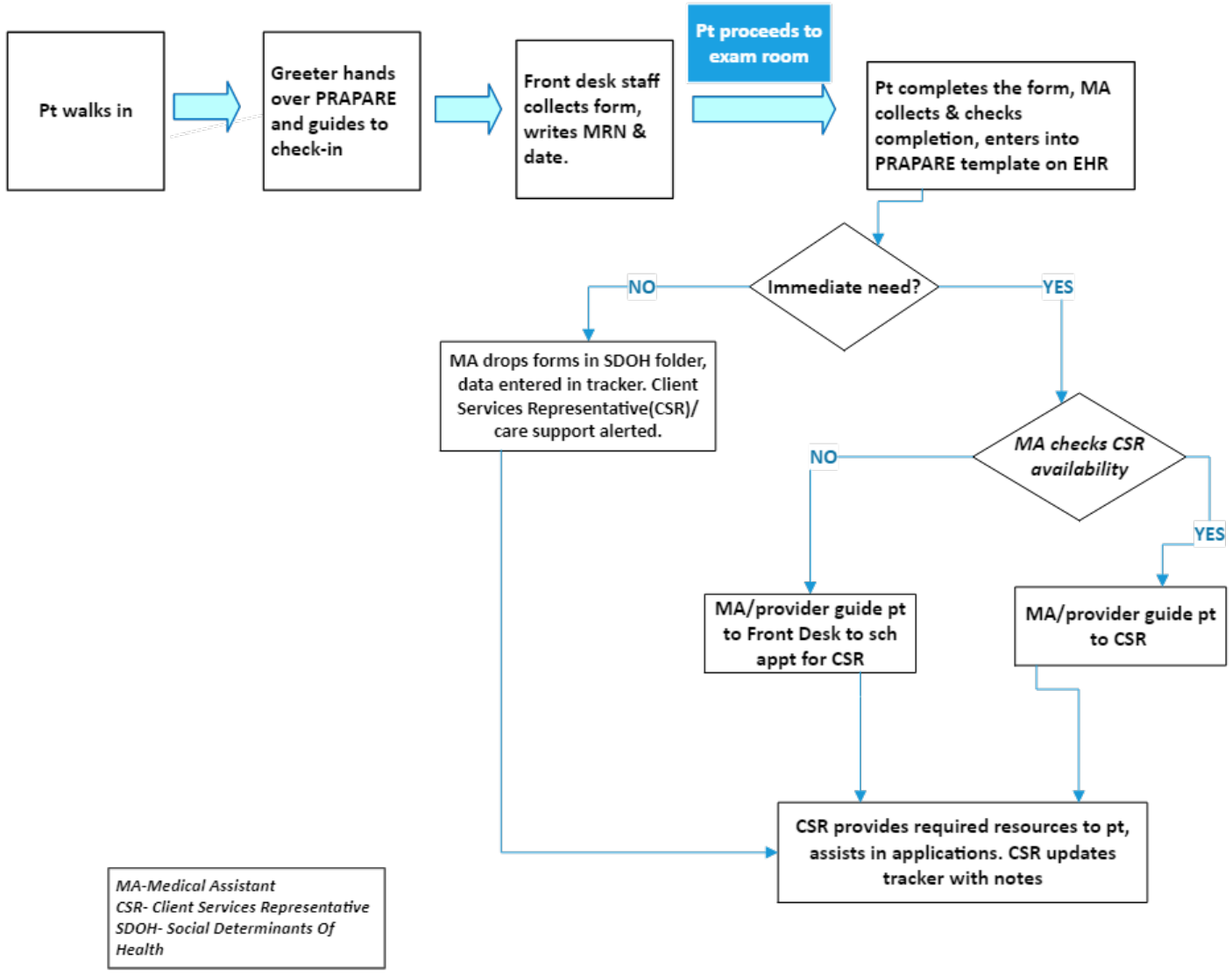
1. Check in box if you need help with the below:

HOUSING ☐ UTILITIES ☐ EMPLOYMENT ☐ FOOD ☐

STRESS RELIEF ☐ BABY NEEDS ☐ CHILD CARE ☐ NONE ☐

2. Do you need help with?

TRANSPORTATION YES ☐ NO ☐

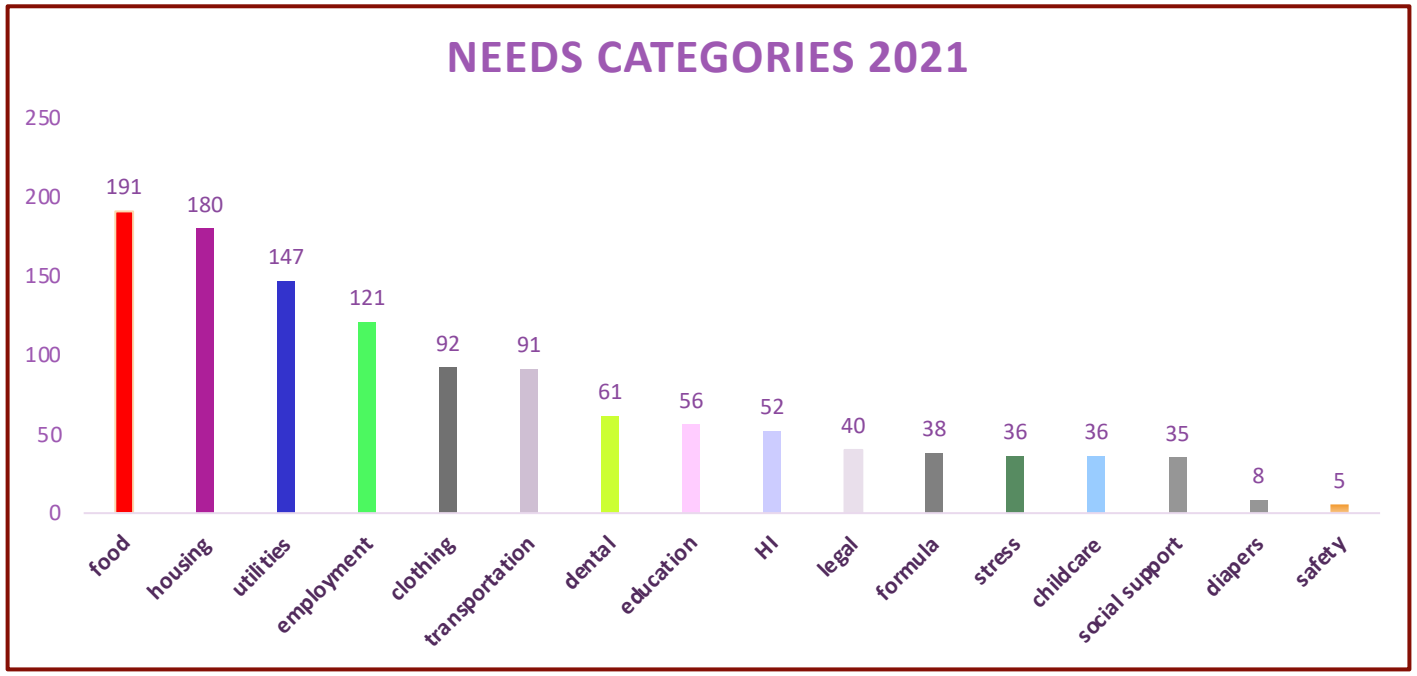


2021 Data


We are your
HEALTH CARE HOME
where you and your family
can find many health care services
all together in one place.
HealthPoint
EVERYONE Deserves GREAT CARE

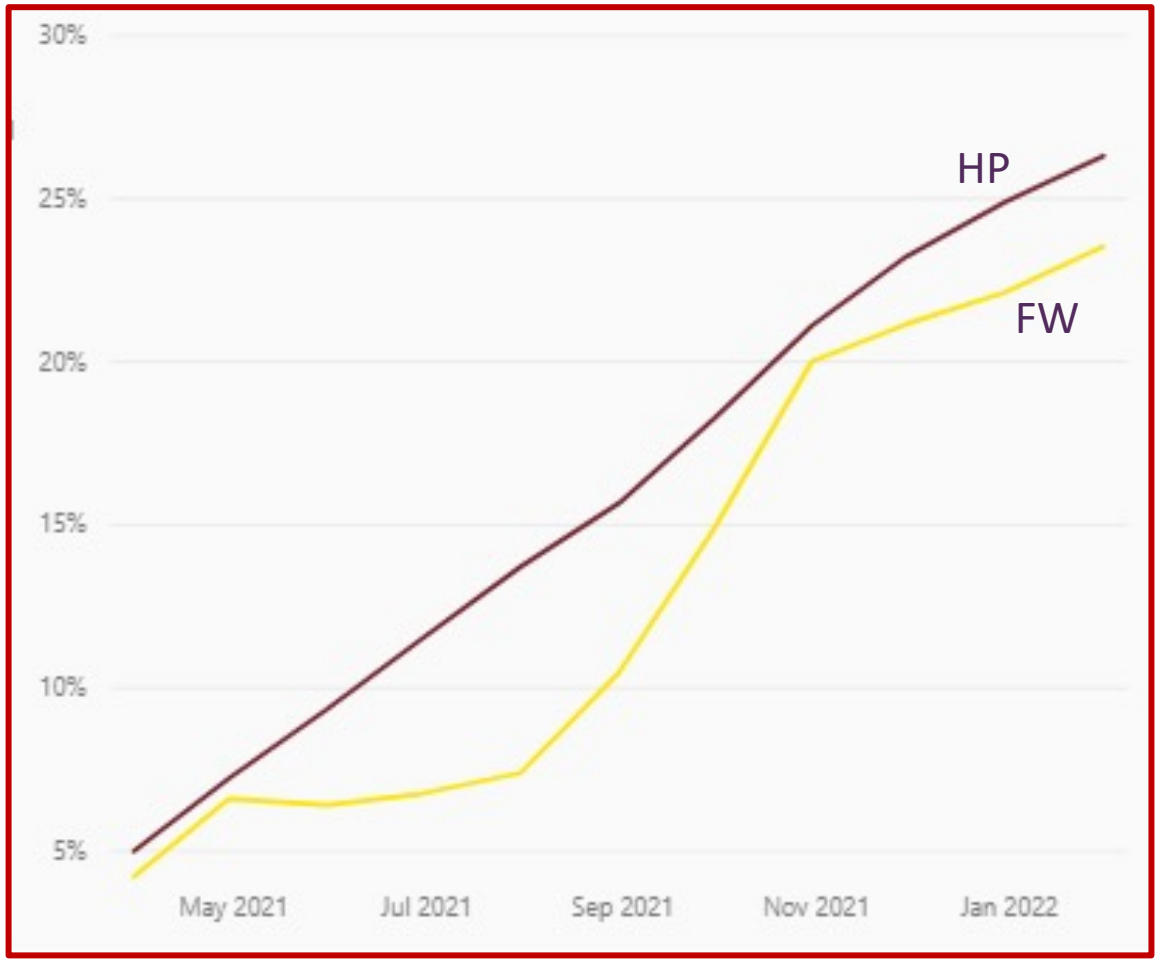
Data Analysis

Patients answered 1 Q in 2021	3421
Total patients in SDOH tracker	579
Patients tasked/provided resources	424
% of pts contacted	**73%**
Pts with >1 need	**302 (52%)**



PRAPARE Metric (%)- 2021

MONTH	HP	FW
Apr	18	12
May	21	12
Jun	23	13
Jul	26	14
Aug	28	19
Sep	29	23
Oct	30	27
Nov	30	30
Dec	31	30
Jan	26	23



Resources

- https://healthpointconnects.findhelp.com/
  - *Database for resources*
  - Resources can be shared through email or texts to patients
  - *Data available:* f/u if patient is contacted and when, when is the next f/u and so on

Personnel	workflow
Client Services Representative (1 per clinic)	• Health insurance, food- specialty • provides resources: texts, emails • One time outreach unless needed • Uses HealthPoint connects
Care support team (3 per clinic)	• All needs- specialized calls • Full intake- continuous outreach • Multi language support • Support application process • Uses HealthPoint connects

Closing the Loop

Sample size	20 patients
Patients responded	6
Comments	Housing • Inability to navigate- language barrier • No answer post-application- housing, king & pierce counties • Happy patient- CSR provided DSHS resource Employment: • Resources helpful Insurance: • Pt is happy that CSR helped with WAH & CHPW
f/u calls	Most of the patients preferred f/u calls after resources provided
Learnings	• Continuous outreach needed • Simpler application process- needed • QR codes appreciated • Standardization of the process • Availability of resources info with QR codes at public places can be more helpful for happier communities

Pt's feedback:

"I am very happy and thankful with the resources and assistance provided, I was able to get approved for food, cash and Health Insurance. I am diabetic and have other health issues, the CSR helped me a lot with the application process. I don't know what I would have done without HealthPoint's assistance since I am very new in WA state and did not know the system."

Future State

- ***Federal Way***:
  - **Customized approach to patient care plan**
  - **Closing the loop process**
  - **Advance our resources' inventory**
  - **Optimum utilization of HealthPoint connects**
  - **Stratification of SDOH tracker by race**

- ***HealthPoint:***
  - **Administer full PRAPARE**
  - **Stratification of needs - health equity approach**
  - **Build community-based approach to address social needs**
  - **Sharing resources community-wide beyond HealthPoint patients**

Presenters

Peninsula Community Health Services

Jennifer Johnson-Joefield, BSN, RN, OHCC, CPHQ, Quality Director

Jennifer is passionate about equal, high quality healthcare access for all people as a basic human right and has spent her career serving underserved populations. She's been involved in primary preventative care for over 15 years with experiences that range from a volunteer-run non-profit clinic to an Indian Health Services clinic to a Federally Qualified Health Center. When Jennifer is not working, she is with her husband and three children. She loves the outdoors and all the majestic beauty the Great Northwest offers like rock climbing, hiking, cycling, and snowshoeing.

Custom Screening Tool

* Low literacy
* Rapid screening
* Low barrier

Peninsula Community Health Services

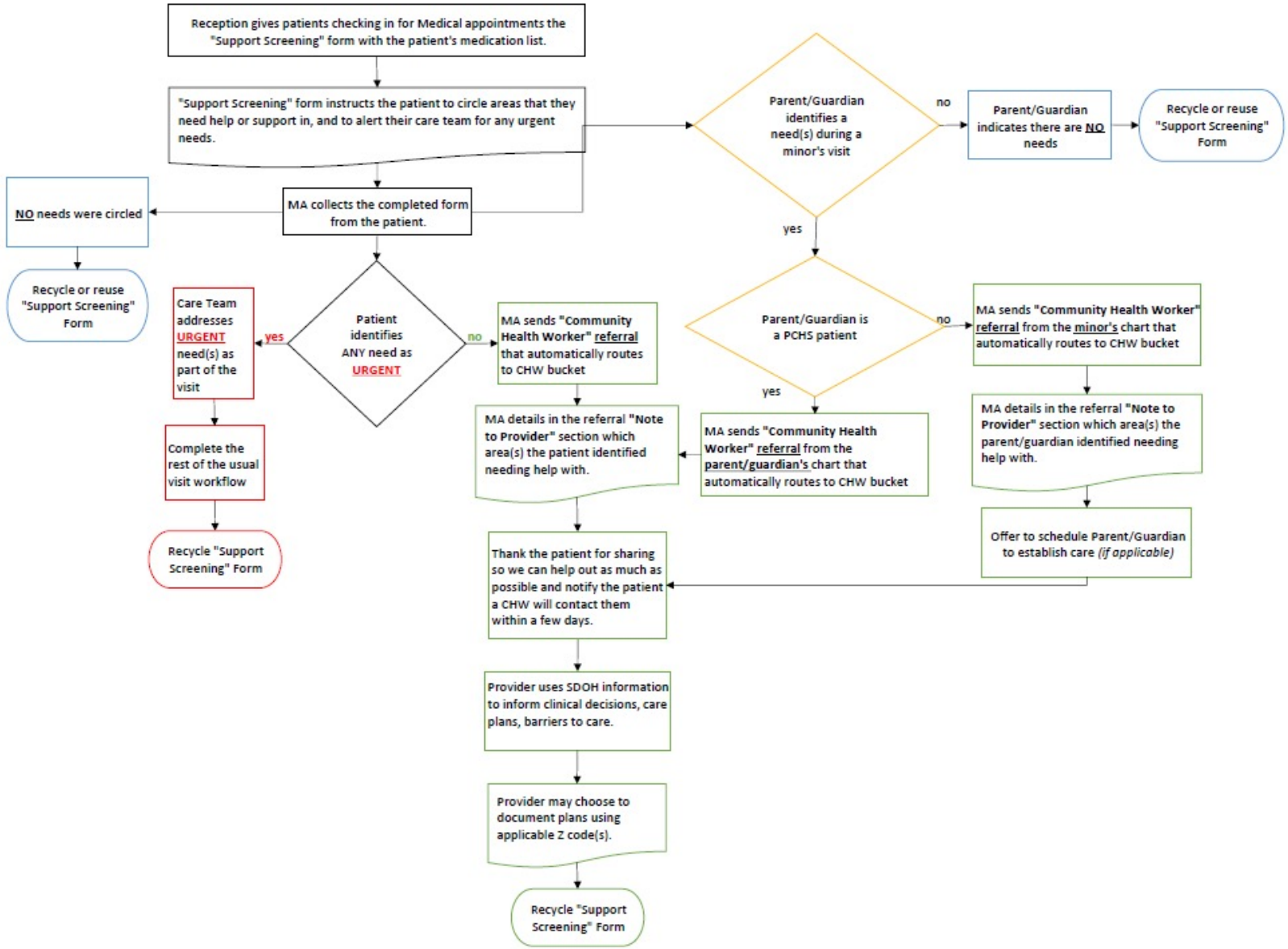
Support Screening

PCHS is proud to offer a wide range of services to support those seeking better health.

Circle the item(s) we can help you with!

Alert your care team if any of your needs are URGENT

- Food
- Transportation
- Housing Support
  Rental Support
- Utilities
- Health Insurance
- Dental Care
- Pharmacy
  Prescription Costs
- Cancer Screening
- Smoking Cessation
- Immigration Support
- Disability
- Employment
- Education
- Infant/Toddler Supplies
  (Clothing, Car Seat, etc.)
- Childcare
  Eldercare
- Counseling
- Substance Use
  Recovery
- Violence
  Bullying


Reception gives patients checking in for Medical appointments the "Support Screening" form with the patient's medication list.
"Support Screening" form instructs the patient to circle areas that they need help or support in, and to alert their care team for any urgent needs.
MA collects the completed form from the patient.
NO needs were circled
Recycle or reuse "Support Screening" Form
Patient identifies ANY need as URGENT
yes
Care Team addresses URGENT need(s) as part of the visit
Complete the rest of the usual visit workflow
Recycle "Support Screening" Form
no
MA sends "Community Health Worker" referral that automatically routes to CHW bucket
MA details in the referral "Note to Provider" section which area(s) the patient identified needing help with.
Parent/Guardian identifies a need(s) during a minor's visit
no
Parent/Guardian indicates there are NO needs
Recycle or reuse "Support Screening" Form
yes
Parent/Guardian is a PCHS patient
yes
MA sends "Community Health Worker" referral from the parent/guardian's chart that automatically routes to CHW bucket
no
MA sends "Community Health Worker" referral from the minor's chart that automatically routes to CHW bucket
MA details in the referral "Note to Provider" section which area(s) the parent/guardian identified needing help with.
Offer to schedule Parent/Guardian to establish care (if applicable)
Thank the patient for sharing so we can help out as much as possible and notify the patient a CHW will contact them within a few days.
Provider uses SDOH information to inform clinical decisions, care plans, barriers to care.
Provider may choose to document plans using applicable Z code(s).
Recycle "Support Screening" Form

SDOH Data

Number of Referrals by Key Word:

- **Housing/Rental Support = 226**
- **Transportation = 131**
- **Dental Care = 111**
- **Utilities = 103**
- **Food = 97**
- Disability = 59
- Employment = 55
- Counseling = 40
- Health Insurance = 37
- Pharmacy/Prescription Costs = 35
- Education = 24
- Infant/Toddler Supplies = 20
- Cancer Screening = 17
- Childcare = 15
- Smoking Cessation = 10
- Violence/Bullying = 8
- Eldercare = 8
- Immigration Support = 5
- Substance Use/Recovery = 3

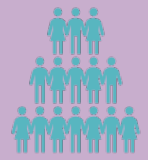
~38,955 medical visits with 875 CHW referrals. About ~2% of visits screened with a need.

1

Referrals

There were 875 referrals are for 785 people.

Most had 1 referral.



Diversity

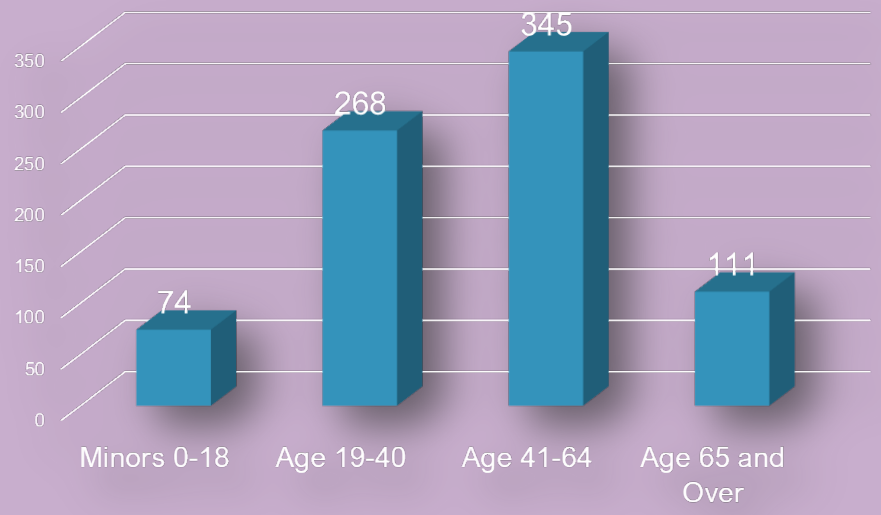
~36% of people identifying a need were from a racial or ethnic minority group.

Homeless

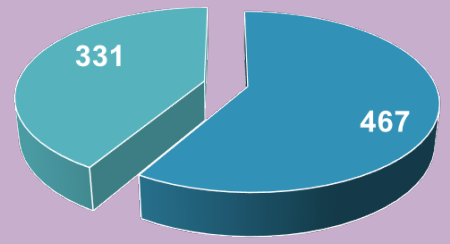
295 of the referrals are from patients identified as homeless.

Other Languages

54 people identified speak a language other than English.



Household/Family Size	Patients
1	305
2	148
3	107
Not answered	78
4	76
5	45
6	20
7	13
8	3
9	2
11	1
Grand Total	798



ICD10 Z code Utilization

6 Months

PRIOR to SDOH Screening

Support Screening ICD-10 Codes Used 1.7.2021-7.6.2021	Count
Family stress	30
Food insecurity	46
Homelessness	63
Housing or economic circumstance	22
Inadequate material resources	131
Insufficient social insurance or welfare support	4
Limitation of activities due to disability	2
Low income	1
Problems related to education and literacy, unspecified	5
Tobacco abuse counseling	2
Unemployment	5
Grand Total	311

ICD10 Z code Utilization

6 Months

AFTER SDOH Screening

Support Screening ICD-10 Codes Used 7.7.2021-1.6.2022	Count
Family stress	36
Food insecurity	41
Homelessness	35
Housing or economic circumstance	16
Inadequate material resources	707
Insufficient social insurance or welfare support	8
Limitation of activities due to disability	2
Low income	1
Need assistance with community resources	1
Need for assistance at home and no other household member able to render care	2
Problem related to social environment	1
Problems related to education and literacy, unspecified	6
Tobacco abuse counseling	1
Unavailability or inaccessibility of other helping agencies	2
Unemployment	2
Grand Total	861

ICD10 Z Codes Utilization by Patient Insurance Type

Support Screening ICD-10 Codes Used 7.7.2021-1.6.2022	Commercial	Health Maintenance Organization (HMO)	Medicaid	Medicare Part B	Other	Personal Payment (Cash - No Insurance)	Grand Total
Family stress	2		29	1		2	36
Food insecurity	4		30	5	1		41
Homelessness	1		20	9	2	3	35
Housing or economic circumstance	2		10	1		3	16
Inadequate material resources	5	3	14	640	25	5	707
Insufficient social insurance or welfare support			2			6	8
Limitation of activities due to disability			1	1			2
Low income				1			1
Need assistance with community resources			1				1
Need for assistance at home and no other household member able to render care				2			2
Problem related to social environment			1				1
Problems related to education and literacy, unspecified	1		5				6
Tobacco abuse counseling			1				1
Unavailability or inaccessibility of other helping agencies			1				2
Unemployment			1				2
Grand Total	15	3	116	660	28	19	861

THANK YOU

Please complete our short evaluation.

https://www.surveymonkey.com/r/Health_Center_Mission

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Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

wacommunityhealth.org