KEY CONSIDERATIONS FOR DESIGNING YOUR ORGANIZATION’S SOCIAL NEEDS STRATEGY

Connie Davis and Kelly Reilly
May 23, 2018

www.centreCMI.ca
At your tables:

› Name
› Place you work
› Role

› Read one of the questions on the colored slips of paper out loud and answer it
WHAT WE’LL DO IN THIS LEARNING LAB

Definitions
Share and Learn
Action
DETERMINANTS OF HEALTH

- Income and social status
- Education and literacy
- Social support network
- Employment/working conditions
- Social environments
- Physical environments

- Personal health practices
- Healthy child development
- Biology and genetic factors
- Health services
- Gender
- Culture
DETERMINANTS OF HEALTH

- Individual Behavior: 36%
- Social Circumstances: 24%
- Genetics and Biology: 22%
- Medical Care: 11%
- Environment: 7%

http://determinantsofhealth.org
SOCIAL DETERMINANTS OF HEALTH - DEFINED

The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

- World Health Organization
Figure 1 | County Health Rankings & Roadmaps | Source: Reprinted with permission from County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/our-approach (accessed July 18, 2017).
# CORE DOMAINS & MEASURES FOR EHR WITH SUGGESTED FREQUENCY OF ASSESSMENT

<table>
<thead>
<tr>
<th>DOMAIN/MEASURE</th>
<th>MEASURE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>3 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Race and Ethnicity</td>
<td>2 questions</td>
<td>At entry</td>
</tr>
<tr>
<td>Residential Address</td>
<td>1 question (geocoded)</td>
<td>Verify every visit</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>2 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Census Tract-Median Income</td>
<td>1 question (geocoded)</td>
<td>Update on address change</td>
</tr>
<tr>
<td>Depression</td>
<td>2 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Education</td>
<td>2 questions</td>
<td>At entry</td>
</tr>
<tr>
<td>Financial Resource Strain</td>
<td>1 question</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>4 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>2 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Social Connections &amp; Social Isolation</td>
<td>4 questions</td>
<td>Screen and follow up</td>
</tr>
<tr>
<td>Stress</td>
<td>1 question</td>
<td>Screen and follow up</td>
</tr>
</tbody>
</table>

**NOTE:** Domains/Measures are listed in alphabetical order; domains/measures in the shaded area are currently frequently collected in clinical settings; domains/measures not in the shaded area are additional items not routinely collected in clinical settings.
SOMETHING TO REMEMBER...

Statistics are human beings with the tears wiped off.

- Paul Brodeur
SHARING OUR EXPERIENCES

Photo by Andreanna Moyer
I diagnosed “abdominal pain” when the real problem was hunger, I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.

Laura Gottlieb, MD
San Francisco Chronicle 8/23/10
DISCUSSION

› Good or not-so-good stories about addressing social determinants of health

› Share the story with your group (< 2 min ea.)

› Decide on one story to share to represent your table
SHARE STORIES
IMAGINE A FUTURE...
VIDEO

https://www.youtube.com/watch?v=Ee4CKIPklik&app=desktop
Working by yourself, start with 1 of your “How Might We’s” and complete this sentence:

How might we ____________________________
(verb that implies change)

that lets ________________________________
(specific audience)

feel ________________________________
(emotion)

while ________________________________.
(where/when/doing what)
How might we partner with community resources (verb that implies change)

that lets our patients
(specific audience)

feel empowered to access healthy food (emotion)

while challenged with transportation issues. (where/when/doing what)
OUR THEMES
GATHERING IDEAS

› Working alone, write down your ideas for addressing Social Determinants of Health, one idea per post-it note. Use the themes to guide you.

› Think back to what you heard from the stories.

› Make sure it is a specific idea.

› You have 2 minutes.
STRETCH BREAK
REFLECTIONS ON VIDEO

Bowron Lakes, BC
Photo by Alice Domes
Investigate the link you are provided. Answer these questions to report out:

› What is the goal of the resource or service?
› What are the key features of this resource or service?
› Would this resource help your setting address social determinants of health?
Caring with Compassion supports health professionals who care for socioeconomically disadvantaged populations: homeless, uninsured, and underserved patients. The curriculum introduces the bio-psychosocial model for the provision of personalized care for at-risk patients.

There are 4 main components to this curriculum: online modules, a downloadable version of the modules called "The Caring Book", a learning game called "Care Consequences", and a collection of implementation resources. For more detailed information, please review the For Educators section, including the formal Instructor's Guide. To access the formal curriculum or the Care Consequences game, create a free login. You will be provided with a personalized learning dashboard to track your progress.

https://caringwithcompassion.org/about
HEALTH BEGINS

MOVE HEALTHCARE UPSTREAM
Ready to improve outcomes by treating health-related social needs? We're here to help.

Improve outcomes by treating your patients' health-related social needs.

http://healthbegins.org/
HEALTH LEADS

SOCIAL NEEDS SCREENING TOOLKIT

Local action on health inequalities

**Improving health literacy to reduce health inequalities**

Practice resource summary: September 2015

There's more to Health than Healthcare

We help organizations address the social determinants of health

https://www.healthify.us/
PATHWAYS COMMUNITY HUB MODEL

OPCA TOOLS AND RESOURCES

› Screening tools
› Current efforts
› **Screening and workflow**
› Food insecurity tools and resources
› Housing insecurity tools and resources
› Tools and resources to integrate SDoH into clinical care
› Tools and resources for CHC-Community partnerships

https://www.orpca.org/initiatives/social-determinants-of-health/251-sdoh-tools-resources
OPCA WORKFLOW EXAMPLE

Social Determinants of Health (SDH) Screening Sample Workflow

Steps for Using a "No Wrong Door" Approach

Take-Aways:
- Any staff can administer parts of the SDH screening at any time during the clinic visit and at any location within the clinic.
- By dividing the responsibility of data collection among more staff, the burden is less on everyone involved.
- Helps with staff buy-in as everyone has an opportunity and responsibility to paint a fuller picture of their patients and better meet their needs.
- Demonstrates that the whole team is behind the patients care and the whole team is accountable.
- May result in duplication of questions if not entered in the electronic health record.
- No single point of accountability.

The Steps:

#1 Patient Checks-In at Front Desk
- Front desk staff checks patient in and verifies and/or collects demographic information (age, gender, ethnicity, language, insurance, veteran status, family size, income, etc.)

#2 Clinic Staff Rooms Patient
- Checks vitals.
- Begins SDH screening until provider enters the room (stress, safety, social integration, education, etc.)

#3 Patient Sees Provider
- Provider conducts clinical visit.
- Refers patient to non-clinical staff if needs merit additional resources or services.

#4 Non-Clinical Staff Completes SDH Screening
- Non-clinic staff connects patients to resources and services.
- Records and date patient’s answers in electronic health record.

#5 Follow Up
- Non-clinic staff and/or Front desk follows up by phone to determine if resources and services were utilized.
- Document in electronic health record.

Adapted from National Association of Community Health Centers’ PREPARE Toolkit:

https://www.orpca.org/initiatives/social-determinants-of-health/251-sdoh-tools-resources
**POVERTY SCREENING TOOL**

**Centre for Effective Practice**

**Poverty: A Clinical Tool for Primary Care Providers (BC)**

Poverty is not always apparent: In British Columbia, 14% of the population lives in poverty.  
1. **Screen Everyone**
   
   “Do you ever have difficulty making ends meet at the end of the month?”
   
   (Sensitivity 94%, specificity 69% for living below the poverty line)

2. **Poverty is a Risk Factor**

   Consider:
   
   New immigrants, women, Indigenous peoples, and LGBTQ+ are among the highest risk groups.
   
   Example 1: If an otherwise healthy 35-year-old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.
   
   Example 2: If an otherwise low-risk patient who lives in poverty presents with chest pain, this elevates the pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations.

3. **Intervene**

   **Ask Everyone:** “Have you filled out and sent in your tax forms?”
   
   - Ask questions to find out more about your patient—their employment, living situation, social supports, and the benefits they receive. Tax returns are required to access many income security benefits e.g., GST / HST credits, child benefits, working income tax benefits, and property tax credits. Connect your patients to Free Community Tax Clinics.
   - Even people without official residency status can file returns.
   - Drug Coverage: The patient must have up-to-date tax filings and be registered with the Medical Services Plan and have a BC Services Card or Care Card. Visit [drugcoverage.ca](http://drugcoverage.ca) for more options.

   Ensure you and your team are aware of resources available to patients and their families. Start with [CanadaBenefits.ca](http://canadabenefits.ca) and 2-1-1.

   Intervene by connecting your patients and their families to benefits, resources, and services.

   New immigrants, women, Indigenous peoples, and LGBTQ+ are among the highest risk groups.

   Consider:
   
   - Those living below the poverty line experience depression at a rate 58% higher than the Canadian average.
   - Those in the lowest-income group experience circulatory conditions at a rate 17% higher than the Canadian average.
   - Cardiovascular Disease
   - Chronic Disease
   - Mental Illness
   - Toxic Stress

   Visit [http://www.cfpc.ca/uploadedFiles/CPD/_PDFs/Poverty_flowBC%202016%20Oct%2031.pdf](http://www.cfpc.ca/uploadedFiles/CPD/_PDFs/Poverty_flowBC%202016%20Oct%2031.pdf)
POVERTY AS A RISK FACTOR

Chart 1.12 - "Poor" or "fair" self-reported health among Canadians 18 to 64 years, 2005

Adjusted household income quintile

May 14, 2018

New ROI Calculator Assesses Risks and Rewards of Integrating Social Services with Health Care

Many health care delivery systems are working to address the social determinants of health, especially for patients with complex needs. To do so, they need to partner with local organizations that provide social services, such as nutritional support and transportation.

ROI CALCULATOR

Roots Program - CCI

Roles Outside Of Traditional Systems

https://www.careinnovations.org/programs/roots/
SCREENING FOR POVERTY

“Do you ever have difficulty making ends meet at the end of the month?”

Brcic et al, 2011 Int Jnl Fam Med

https://healthprovidersagainstpoverty.ca
FIGURE 1. FRAMEWORK FOR LIFELONG LEARNING FOR HEALTH PROFESSIONALS

Note: SDH = social determinants of health

TRAINING RESIDENTS IN SDOH - GREATER NYHA

“Do you have enough money to buy the things that you need to live every day such as food, clothing, or housing?” Yes, always; sometimes; no

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192475

HOW ARE WE DOING RIGHT NOW?
HOW WILL WE KNOW A CHANGE IS AN IMPROVEMENT?
MEASURES

- Screening for social determinants
- Referrals, navigation, connection
- Provision of care management services
- Eligibility assistance provision
- Health education or supportive counseling
- Outreach
- Transportation provision
CONVENING PASSPORT

Center for Care Innovations
Population Health Learning Network
May 23-24, 2018
GETTING STARTED...

￼ Aim
  ▶ Scope!!!!

▶ Measures

▶ Tests of Ideas!!!!
  ▶ Tools
  ▶ Roles
  ▶ Partnerships
REFLECTIONS

Abhau Lake, BC. Photo by Denielle Wiebe
"Ultimately, the secret of quality is love. You have to love your patients, you have to love your profession.... If you have love, you can work backward to monitor and improve the system."

- Donabedian
Feedback
(One Day Workshops or Final Day of Multiple Day Workshops)
8 Feb 2015

Name: (optional) Organization (optional) Date:

1. What were the highlights of today’s session?

2. Were there any topics discussed today that you have additional questions about or would like to have clarified?

3. Indicate whether the balance between presentations, discussion and activities fit your style of learning.

4. Do you have any advice for the facilitator/s?

5. Other comments or suggestions?

6. How confident are you that you can use the skills from this workshop?
   Not at all Confident Very Confident
   0 1 2 3 4 5 6 7 8 9

7. How likely are you to recommend this workshop to your colleagues?
   Not Likely Very Likely
   0 1 2 3 4 5 6 7 8 9

8. How much do you agree or disagree with this statement?
   I intend to use the skills I learned in this workshop in my practice.
   Strongly Disagree Strongly Agree
   0 1 2 3 4 5 6 7

HANDOUT – EVALUATIONS
CONTACT US

› Connie: connie.davis@centreCMI.ca
› Kelly: kellyrnreilly@gmail.com
› Office hours
› Google doc for sharing plans
› Portal – watch for further development about sharing on the portal
FOR MORE INFORMATION, CONTACT INFO@CENTRECMII.CA
LEAN ON ME

Link: https://youtu.be/LiouJsnYytI