Social Determinants of Health Integration and Collaborative Strategies to Address Inequities

2023 Public Health Nursing Virtual Conference

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Session Objectives

At the end of this session, participants will be able to:

1. Examine the Social Determinants of Health (SDOH) and conceptual frameworks used to describe the Social Determinants of Health.
2. Identify how historical factors that have shaped the Social Determinants of Health present in many American Indian and Alaska Native communities and the resultant impacts to health equity.
3. Implement current strategies and opportunities that the Indian Health Service is engaging to address the Social Determinants of Health and Health Related Social and key intersections with community-based strategies and organizations.


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Social Determinants of Health (SDOH)

The conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. (Healthy People 2030)

The conditions in which people are born, grow up, live, work and age. These conditions influence a person's opportunity to be healthy, his/her risk of illness and life expectancy. Social inequities in health – the unfair and avoidable differences in health status across groups in society – are those that result from the uneven distribution of social determinants. (World Health Organization)

Figure 1

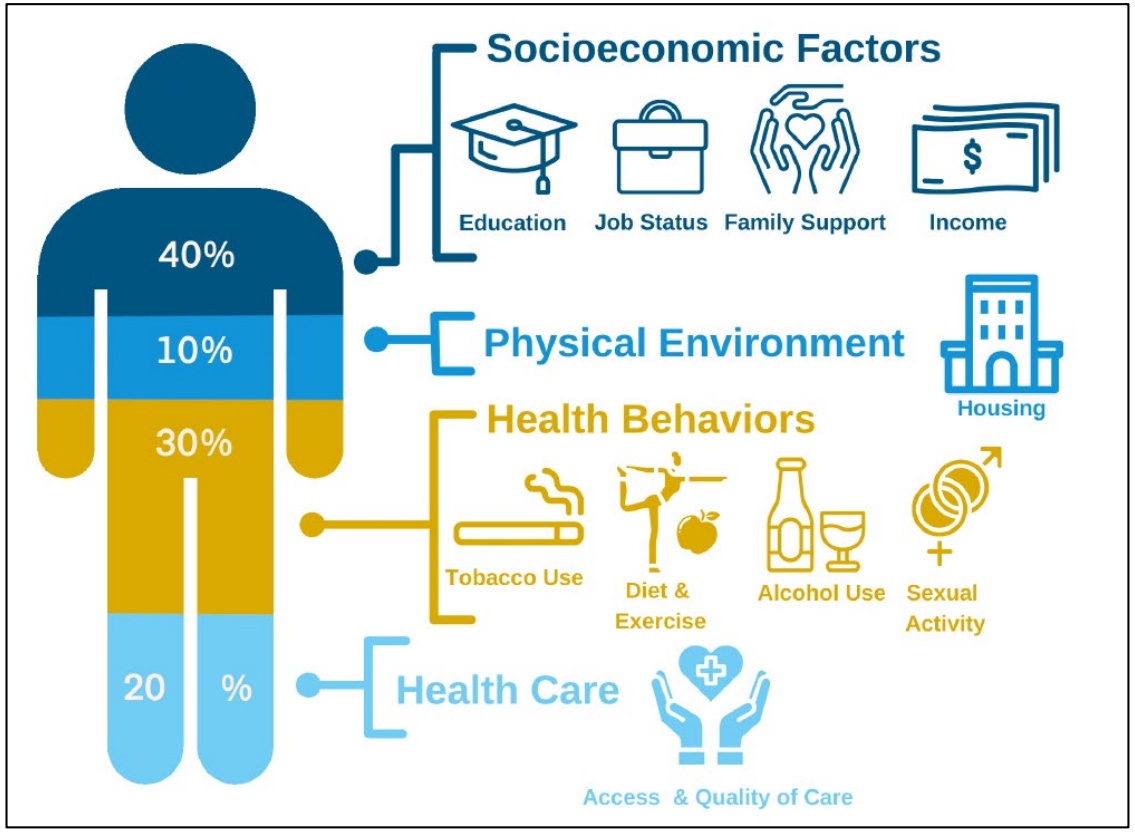
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	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		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

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

KFF

Impact on Health Outcomes



Source: https://www.uclahealth.org/sustainability/social-determinants-of-health

Disproportionate Impact

Mortality Disparity Rates	AI/AN Rate 2009-2011	U.S. All Races Rate – 2010	Ratio: AI/AN to U.S. All Races
All Causes*	999.1	747.0	1.3
Diseases of the heart (Heart Disease)	194.7	179.1	1.1
Accidents (unintentional injuries Including MVA)	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol Induced	50.5	7.6	6.6
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Drug Induced	23.4	12.9	1.8
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intention self-harm (suicide)	20.1	12.1	1.7

Source: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

Rooted in the Past

Neighborhood, As-built and Ambient Environments
- Where we live—geographically remote locations impact access to food, water, utilities, services
- Pollution—affected water sources, particulate matter from dust, smoke
- Transportation limitations
- Ability to own land
- Lack of housing
- Access to broadband—emerging SDOH with impacts for telehealth, virtual education, commerce, access to information

Food/Nutrition Security
- Removal from traditional agriculture, hunting and gathering lands
- Remote locations impact food availability and nutritional quality
- Commodity foods

Social Cohesion/Belonging
- Removal from family, community, and cultural practices integral to who we are as Native People

Education
- Boarding schools
- Limited educational opportunities

Economic stability
- Ability to work and provide for families historically restricted
- Segregation policies impacted education and employment opportunities

Access to Health Care
- Limited
- Funding challenges


Depression
Anxiety
Diabetes
Obesity
Heart Disease
Cancer
Social Determinants of Health
Intergenerational Trauma: neglect, abuse, unhealthy/harmful coping strategies
Topsoil
Disruption in family, parenting, community, cultural practices & food ways; poverty; lack of opportunity & economic mobility; discrimination; violence
Subsoil
Historical Events, Policies & Trauma
Parent Material
The People: Family, Identity, Community
Bedrock

Social Determinants of Health (SDOH)

The conditions in which people are born, grow up, live, work and age which influence a person's opportunity to be healthy, his/her risk of illness and life expectancy.

Social Risk Factors

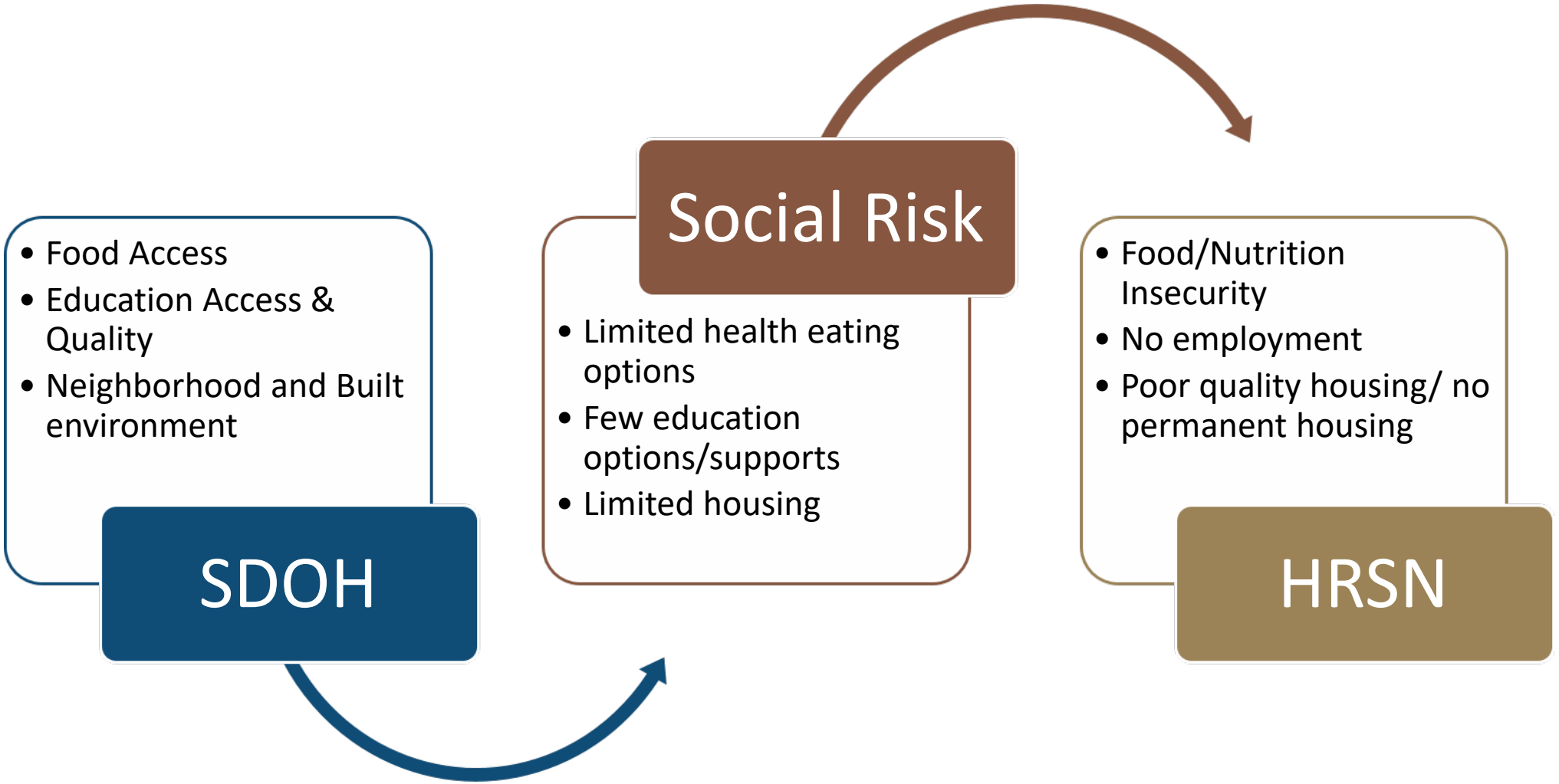
Adverse social conditions associated with poor health, such as food insecurity and housing instability.

https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/

Health Related Social Needs (HRSN)

An individual's unmet, adverse social conditions that contribute to poor health.

https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/


• Food Access
• Education Access & Quality
• Neighborhood and Built environment
SDOH
Social Risk
• Limited health eating options
• Few education options/supports
• Limited housing
• Food/Nutrition Insecurity
• No employment
• Poor quality housing/ no permanent housing
HRSN

National Actions to Address SDOH

HHS Social Determinants Of Health Work Group

HHS SDOH Action Plan: 3/31/2022

- Action Plan at a Glance
  - https://aspe.hhs.gov/topics/health-health-care/addressing-social-determinants-health-federal-programs
  - Implementation Phase—January 2022 to present
    - 4 Affinity Groups
      1. **Measurement and Data Collection**
      2. **Social Care and Referral and SDOH Interoperability**
      3. **Community and Peer Health Workers**
      4. **Health and Social Services Collaboration**

- Journal of the American Medical Association (JAMA) Health Forum article (3/31/2022)
  - Addressing Social Determinants of Health in Federal Programs

HHS SDOH Action Plan: Goals

The HHS strategic approach to SDOH will drive progress through the coordinated strategies and activities to better integrate health and human services and to advance public health initiatives involving cross-sector partnerships and community engagement to address specific SDOH drivers.

HHS SDOH Action Plan: Action Steps

Examples of initial actions HHS will take to advance the 3 goals include:

Goal 1

- Establish interoperability standards to enhance collection of SDOH data and facilitate referrals between health and human service providers
- Use data to assess where program beneficiaries or communities are facing SDOH challenges and to develop strategies to help mitigate these challenges
- Advance research to identify evidence-based interventions that address SDOH

Goal 2

- Expand community health worker services to address SDOH including those exacerbated by COVID-19
- Expand the Community Health Aide Program nationwide to increase health care access for American Indian and Alaska Native populations in rural and underserved areas

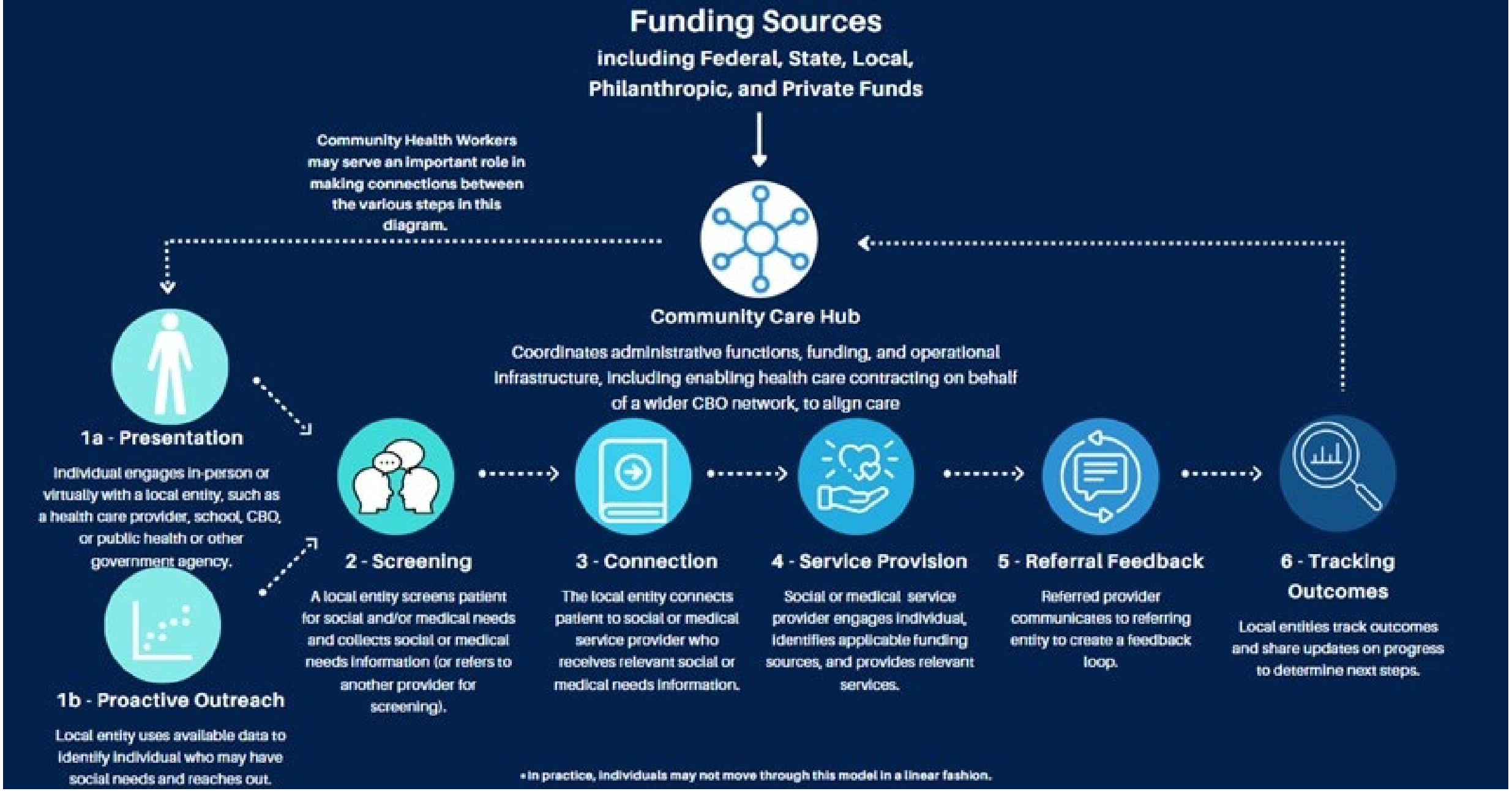
Goal 3

- Partner with other federal departments to enhance access to safe and affordable housing, increase access to transportation, and increase access to healthy food and nutrition assistance
- Develop best practices and partner with stakeholders to braid funding sources for state and local governments and community-based organizations to address social needs and drivers of health outcomes

HHS Social Determinants Of Health Work Group

Health Affairs community care hubs blog (11/29/2022)

- Improving Health And Well-Being Through Community Care Hubs
  - Community-focused entities supporting a network of [Community Based Organizations] CBOs which provide services to address health-related social needs
  - Improved coordination and continuity of care, data-sharing capabilities, and ability to provide services by centralizing administrative functions and operational infrastructure



https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

Select HHS Outcomes to Date

Centers for Medicare & Medicaid Services (CMS)

- Accountable Health Communities Pilot to test screening, navigation, and connection to community resources
- Mandated hospital reporting on HRSN screening in January 2024
- Medicaid 1115 waiver approvals to test programs
  - California: assistance with housing, caregiver respite, food insecurity, and transitions from nursing home care to the community
  - Oregon and Massachusetts: nutritional assistance (e.g. medically tailored meals) and clinically tailored housing supports
  - Arizona: services to address housing stability for youth leaving the child welfare system and homeless individuals with unique clinical needs
  - Arkansas: address health-related social needs (HRSN) of targeted populations via intensive, evidence-based, coordinated, and integrated care coordination

Select HHS Outcomes to Date

Office of the National Coordinator (ONC)

- United States Core Data for Interoperability (USCDI) - SDOH data elements and classes required to achieve Electronic Health Record (EHR) certification.
- Health IT Certification Program - Driving interoperable SDOH data capture, use, and exchange within Health IT
- ONC Interoperability Standards Advisory (ISA)
- SDOH Clinical Care FHIR Implementation Guide
- SDOH projects - STAR HIE, LEAP into Health IT, Advancing SDOH Health IT Enabled Tools and Data Interoperability- eCDS and Data Tagging, and others

Select HHS Outcomes to Date

Agency for Healthcare Research and Quality

- Resource aggregation and dissemination (e.g., screening tools)

Agency for Community Living (ACL) and Centers for Disease Control (CDC)

- Community Care Hub (CCH) National Learning Community
  - Includes 58 CCHs across 32 states
  - Shared learning, technical assistance, information and resource exchange, and expert consultation
  - Centralizes and coordinates a network of Community Based Organizations (CBOs) which address social needs and leverages contracts to connect health care entities to build strength and preparedness to address health-related social needs

Indian Health Service SDOH Initiative design process for the Agency through the Office of Clinical and Preventive Services (OCPS)

THE WHITE HOUSE
WASHINGTON

Social Determinants of Health Interagency Policy Committee (IPC) Meeting

Convened by the White House Domestic Policy Council (DPC) and the Office of Science and Technology Policy (OSTP)

IHS Office of Clinical and Preventive Services (OCPS) SDOH Initiative Design

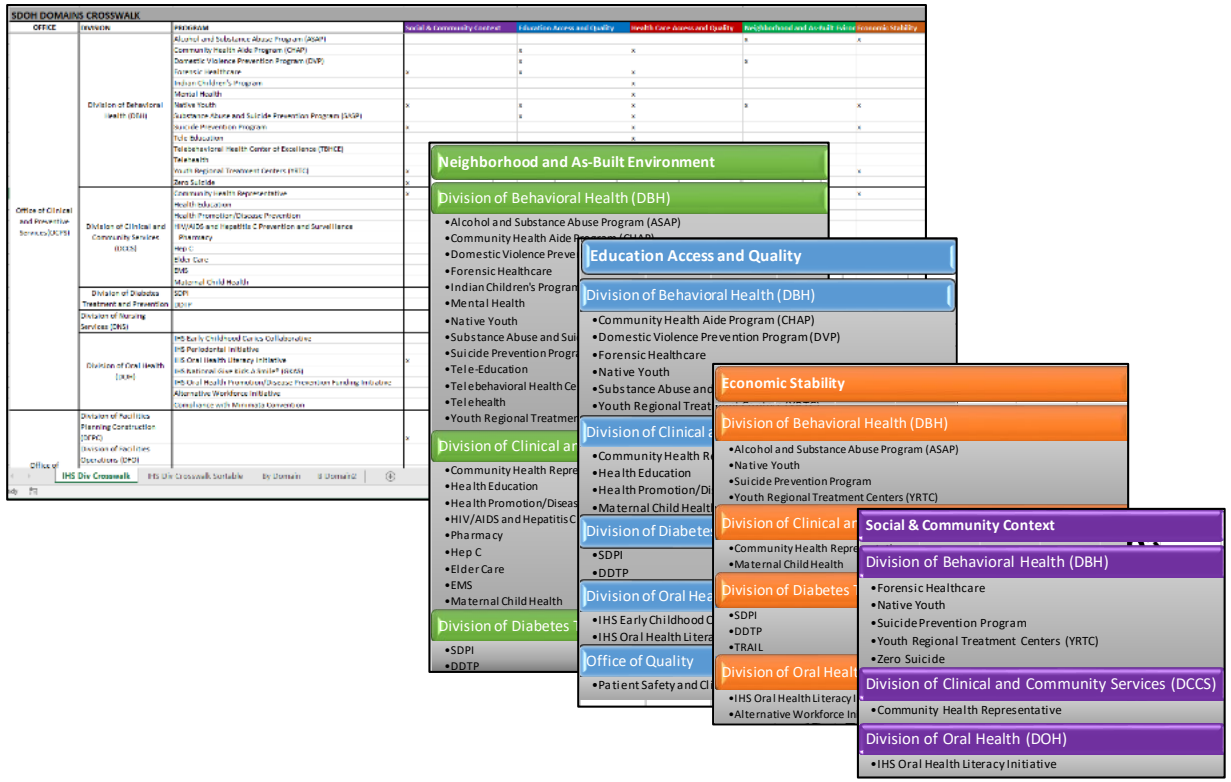
The OCPS Design Process outcomes included:

- Draft conceptual model translating SDOH and Health Related Social Needs into the Indian Health Service context
- Driver diagram for strategy prioritization
- Screening tool recommendations
- Report and strategy proposal to Senior leadership: three pathways for approach in the IHS
- OCPS and OQ partnership: pilot to test screening tools and processes with early adopter teams

IHS SDOH Planning

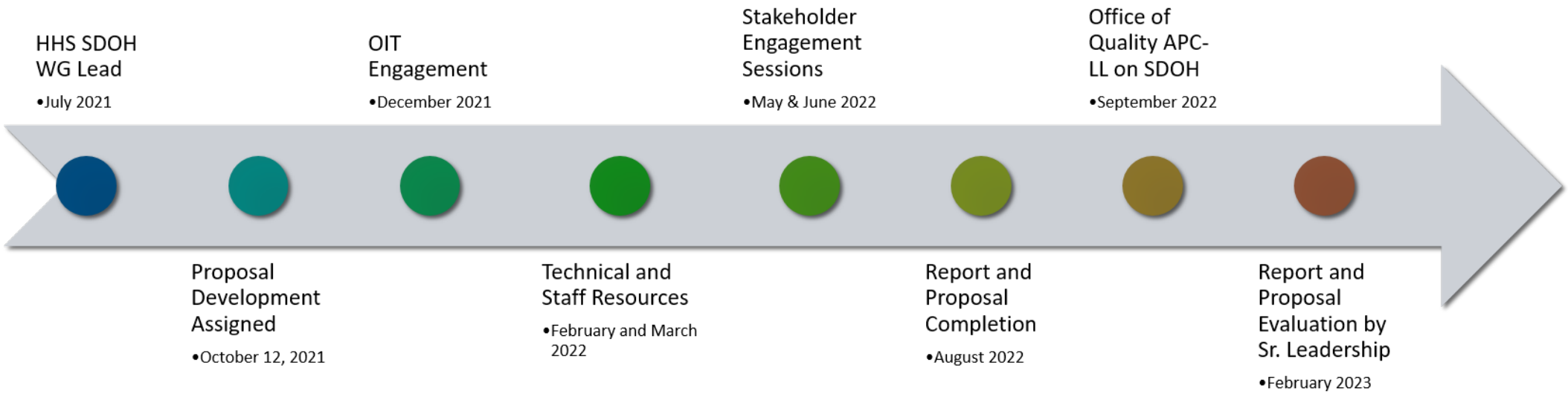
Development of a proposed strategy

- SDOH “Mapping”
- Identifying Key Drivers
- Understand Data and Information System Needs
- Strategy Development Proposal
- Key Stakeholder Engagement



Understanding the Drivers

IHS SDOH Initiative

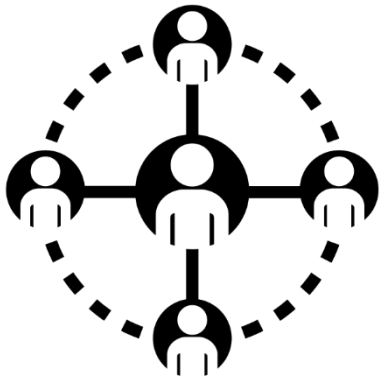


Environmental Scan, Data & Information System Needs Evaluation, Identification of Key Drivers

Stakeholder Engagement Key Findings

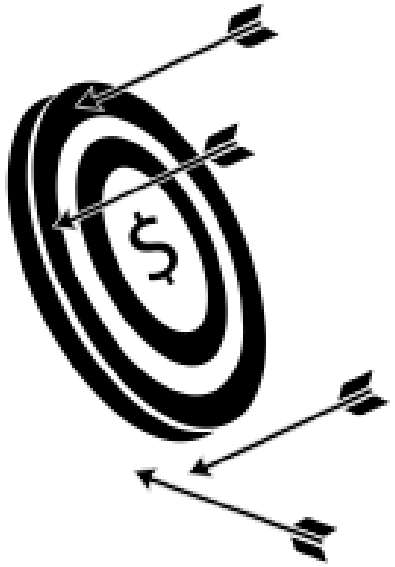
Clarify unique Native American and Alaska Native SDOH challenges.

Clarify SDOH expectations and roles across IHS Divisions and in Tribal communities.



Staff are overwhelmed, and we should stress SDOH roles as conveners and collaborators.

Stakeholder Engagement Key Findings



Lost funding opportunities due to lack of an organized system between IHS and Tribes.

IHS field staff have begun SDOH efforts and a positive energy exists to address SDOH, with guidance and support from Headquarters.

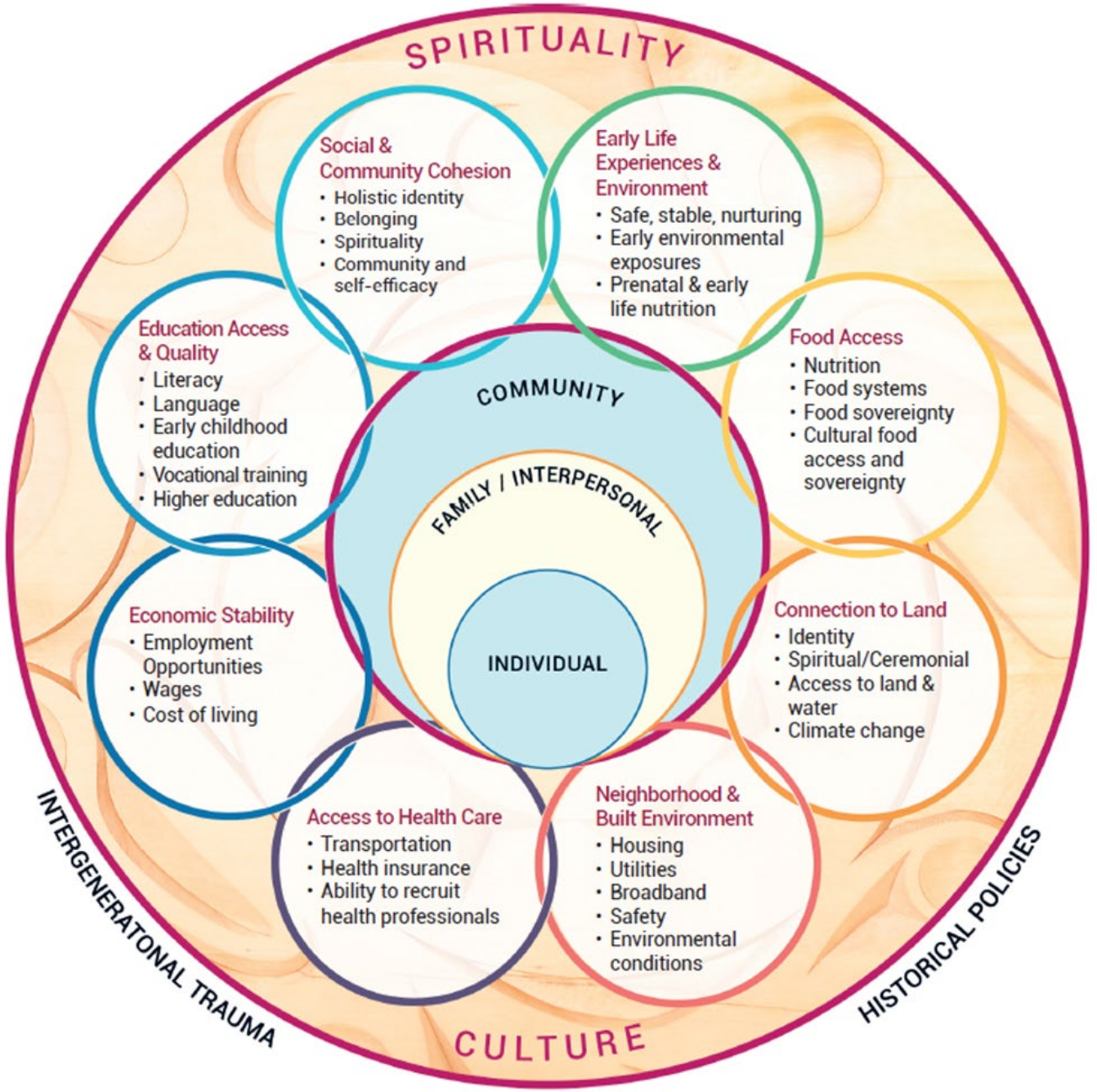
Bright spots in Tribal communities IHS supports-Zuni Youth Enrichment Program

Screening Tool Recommendations

- Health Leads
- Accountable Health Communities (AHC)
- American Academy of Family Practice (AAFP)
- PRAPARE

		AAFP-Tool	AccessHealth: Spartanb	AHC-Tool	Arlington	BMC-Thrive	HealthBegins	Health Leads	MLP IHELLP	Medicare Total Health	NAM Domains	NC-Medicaid	PRAPARE	Structural Vulnerabi	WellRx	Your Current Life
	Food Inecurity validated questions	*		*	1 of 2	*		**				*				
	Number of social needs questions	15	10	19	11	11	24	10*	10	9	12	11	17	37	10	19
	Number of non-social needs questions	0	28	8	0	0	4	0	0	30	12	0	4	6	1	10
	Total Number of Questions	15	38	27	11	11	28	0	10	39	24	11	21	43	11	29
	Reading Level	7th grade	5th grade	8th grade	10th grade	7th grade	11th grade	6th grade	8th grade	College	6th grade	5th grade	8th grade	6th grade	2nd grade	9th grade
IHS identified Social Drivers of Health	Social & Community Cohesion	0		1		0		1				0	1			
	Early Life Experiences & Environment	0		0		0		0				0				
	Food Access	1		1		1		1				1				
	Connection to Place	0		0		0		0				0				
	Neighborhood and Built Envrionment			1		1		1				1	1			
	Access to Health Care	1		0		0		1				0	1			
	Economic Stability	1		1		1		1				0	1			
	Education Access & Quality	1		1		1		1				0	1			
	Domains Matched	4		5		4		6				2	5			
CMS Measures	**Housing Security**	Y	N	Y	Y	Y	Y	Y	Y	Y*	N	Y	Y	Y	Y	Y
	Housing Quality	Y	N	Y	Y	N	Y	N	Y	Y	N	N	N	Y	N	Y
	Transportation	Y*	N	Y	Y	Y*	Y	Y*	N/A	N	N	Y	Y	N	Y	Y
	Utility	Y		Y		Y		Y				Y	Y			
	IPV	Y		Y		N		Y*				Y	Y			
Current IHS Health Factors Screening Areas	EToH	N		Y		N		Y				N	N			
	Substance Use	N		Y		N		Y				N	N			
	Tobacco Use	N		Y		N		Y				N	N			
	PHQ 2	N		Y		N		N*				N	Other			
	Physical Activity	N		Y		N		Y*				N	N			
Add'l IHS Use Considerations	Reading level (<8th grade)	Y		Y		Y		Y*				Y	Y			
	Includes Food Insecurity Validated Questions	Y		Y		Y		Y*				Y	N			
	High Domain Match (>5)	N		Y		N		Y				N	Y			
	20 questions or less?	Y		N		Y		Y				Y	N (*21)			

Indigenous Social Drivers of Health



SDOH Data

Health Care System Data

- Health-Related Social Needs Assessment (HRSNs)
- Health Care System Users

IHS Office of Quality Advancing Primary Care Learning Lab on SDOH

Aim: Select, test and implement Health Related Social Needs (HRSN) Screening Tools

Four (4) Sites

1. **Zuni Comprehensive Health Center**—Albuquerque Area
2. **Wagner Indian Health Service Clinic**—Great Plains Area
3. **Lawton Indian Hospital**—Oklahoma City Area
4. **Warm Springs Service Unit**—Portland Area

IHS Learning Lab on SDOH Work to Date

The work of the teams:

- Best practice tool review; questions selected questions to test
- Identified initial population for screening
- Workflow testing
- Disciplined approaches to quality improvement
- EHR template development for screening and data capture in collaboration with Clinical Informaticists

Insights gained:

- A single tool will not meet all needs
- Sites prefer autonomy over tool and questions used to match community needs
- Community resource lists need to be developed to facilitate referral
- Although staff is initially hesitant to screen (workload, lack of interventions for positive screening), overall process is well received by patients and staff
- Patients overwhelmingly support HRSN screening
- Documentation and data work (aggregation, analysis) is time-consuming as a manual process-- RPMS improvements are needed
- Limited Clinical Informaticist bandwidth will require central support to accelerate template development

IHS Learning Lab – EHR Enhancement

Recommendations for EHR (RPMS) Improvement

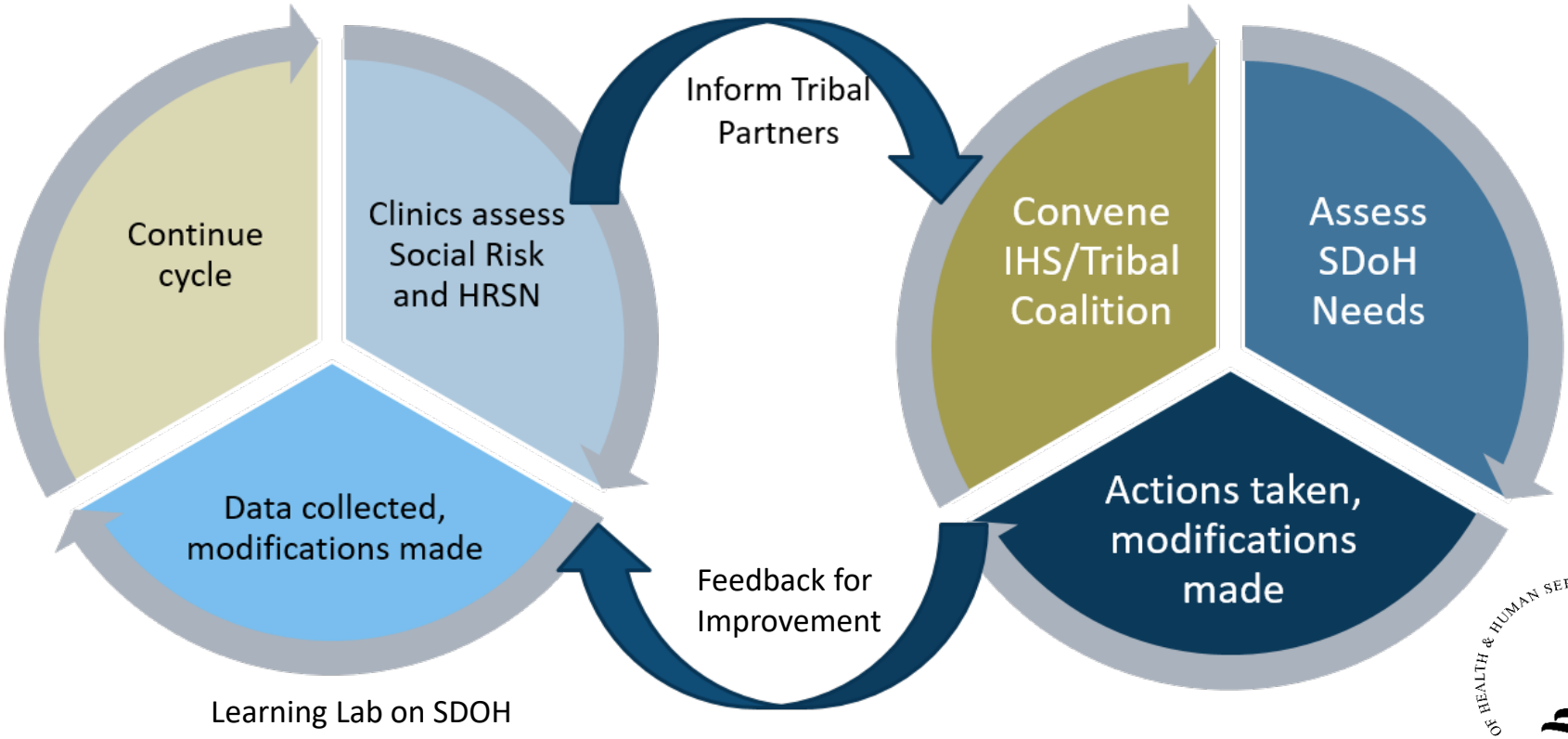
1. Structured data for HRSN overall screening and by domain (e.g. food, housing, transportation, utilities, personal safety)

2. Clinical reminder with dialog template to document and record data

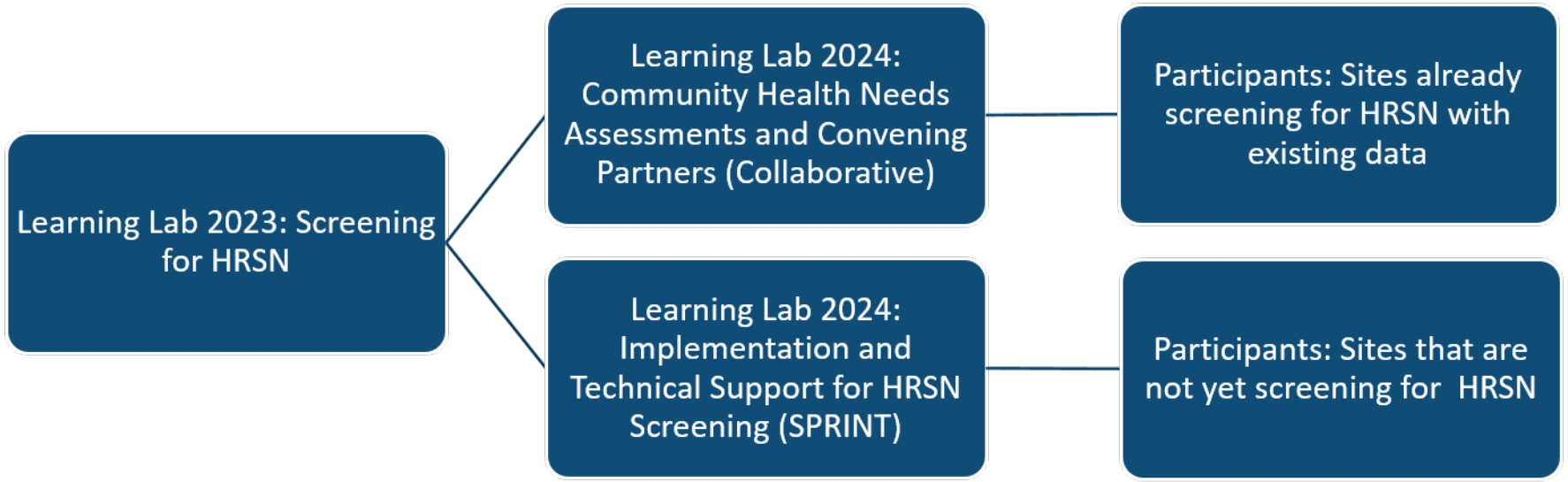
3. Create future reminders for positive findings to facilitate closing the loop in clinical workflow

3. Create standard report(s) for HRSN across agency

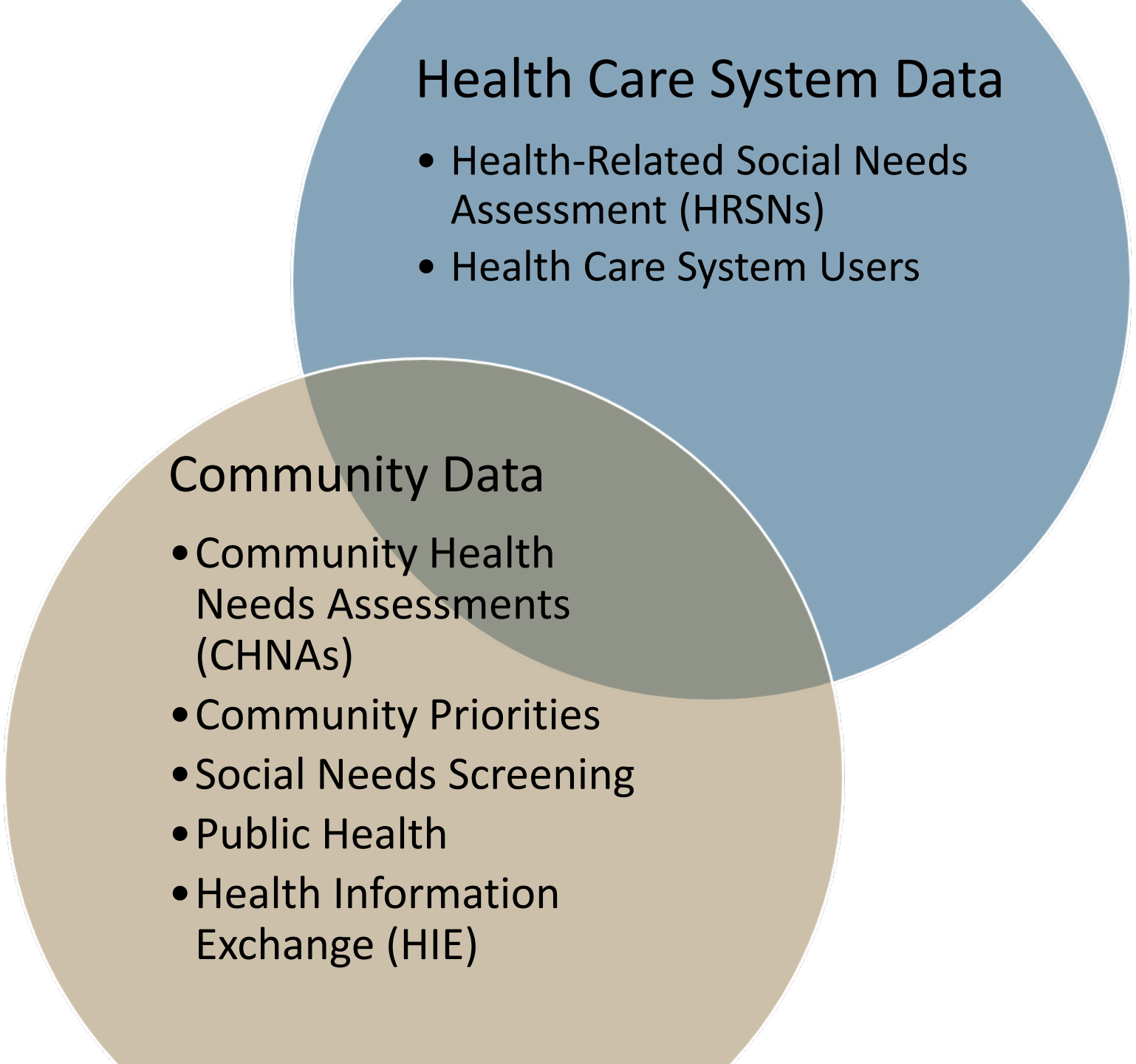
Next Steps: SDOH Cycles of Improvement



IHS Learning Lab in 2024



SDOH Data


Health Care System Data
• Health-Related Social Needs Assessment (HRSNs)
• Health Care System Users
Community Data
• Community Health Needs Assessments (CHNAs)
• Community Priorities
• Social Needs Screening
• Public Health
• Health Information Exchange (HIE)

Next Steps: Community Health Needs Assessment (CHNA)

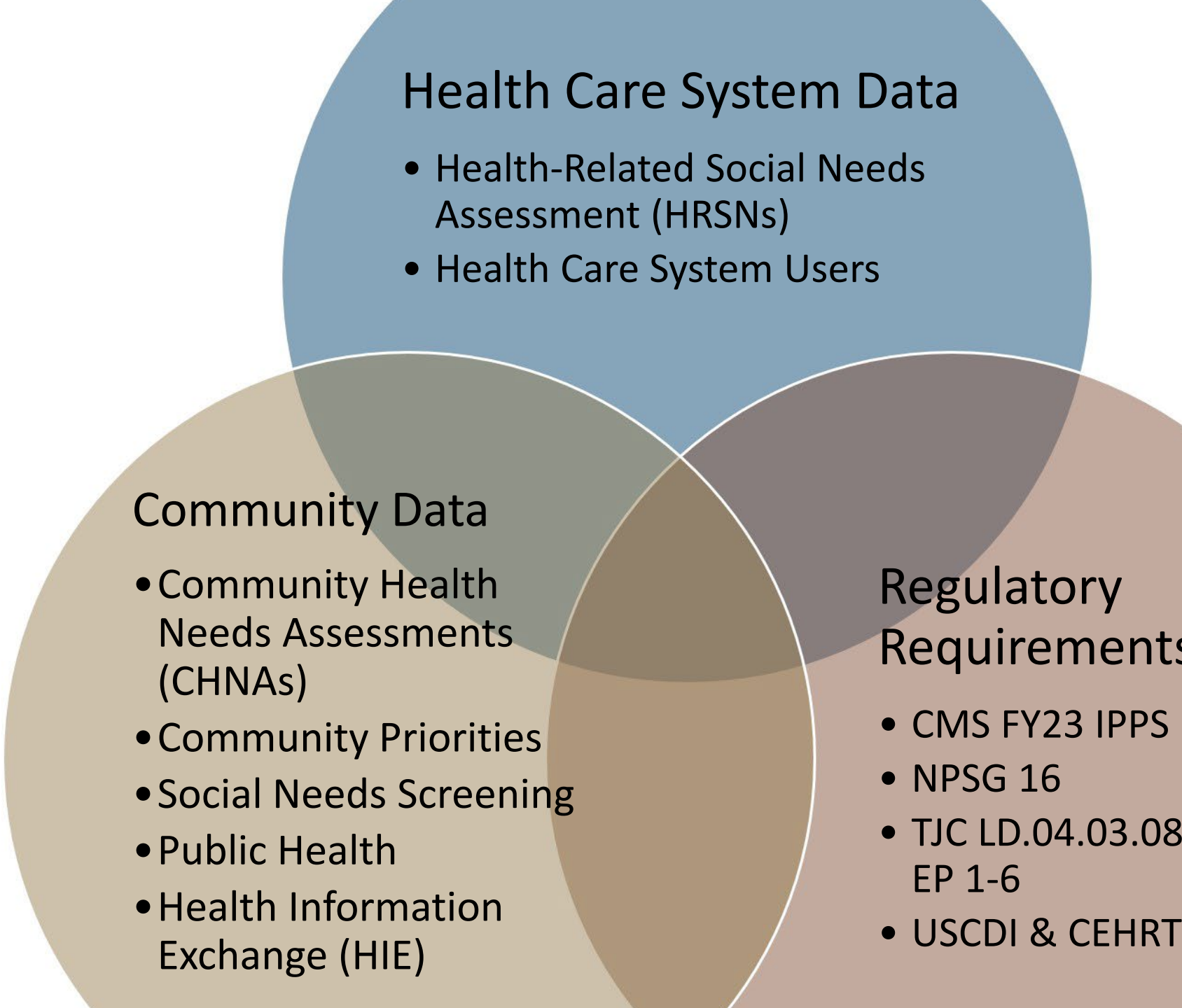
GAO Recommendation 1:

- The Director of IHS should develop a process to ensure that IHS area offices systematically assess how the scope of services provided by federally operated facilities will effectively meet the current and future needs of their patient populations, which could include the incorporation of a current community health needs assessment.

IHS Circular in DRAFT: Incorporation of Community Health Needs Assessment into Management and Oversight.

- Purpose: provide a standard to establish the policy, procedures, and responsibilities for incorporating CHNAs to be used in management and oversight by all IHS federally operated service units.
- Incorporate CHNA reports in the Governing Body process.

SDOH Data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• Community Priorities
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• Public Health
• Health Information Exchange (HIE)
Regulatory Requirements
• CMS FY23 IPPS
• NPSG 16
• TJC LD.04.03.08 EP 1-6
• USCDI & CEHRT

Accreditation and Regulatory Requirements

CMS FY23 Hospital Inpatient Prospective Payment System (IPSS):

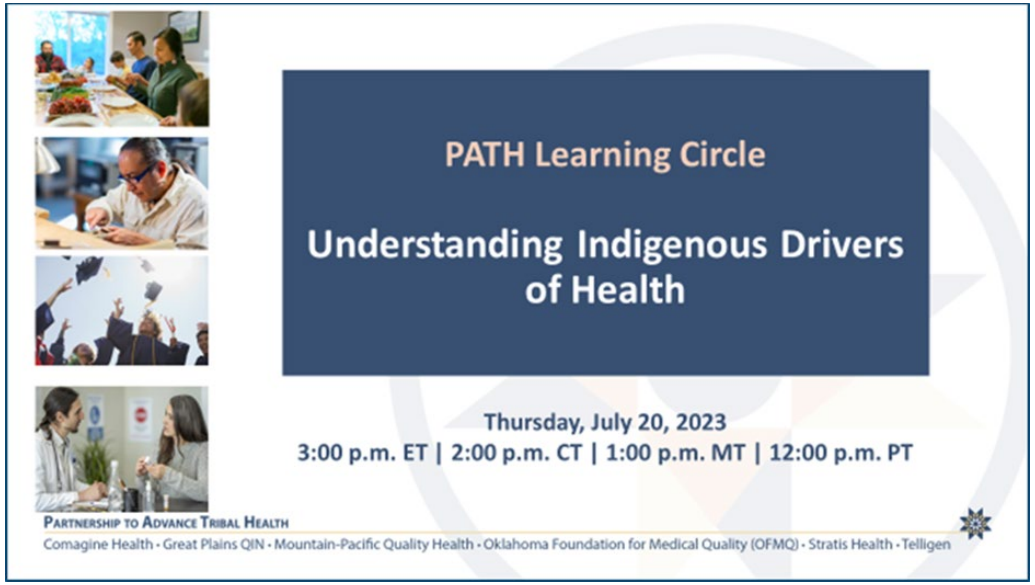
- Screening for Social Drivers or Health/Health Related Socials Needs

National Patient Safety Goal Standard NPSG.16.01.01:

- Improving health care equity for the [organization's] [patients] is a quality and safety priority.

The Joint Commission (TJC)

- Leadership Chapter 04.03.08, Elements of Performance 1-6

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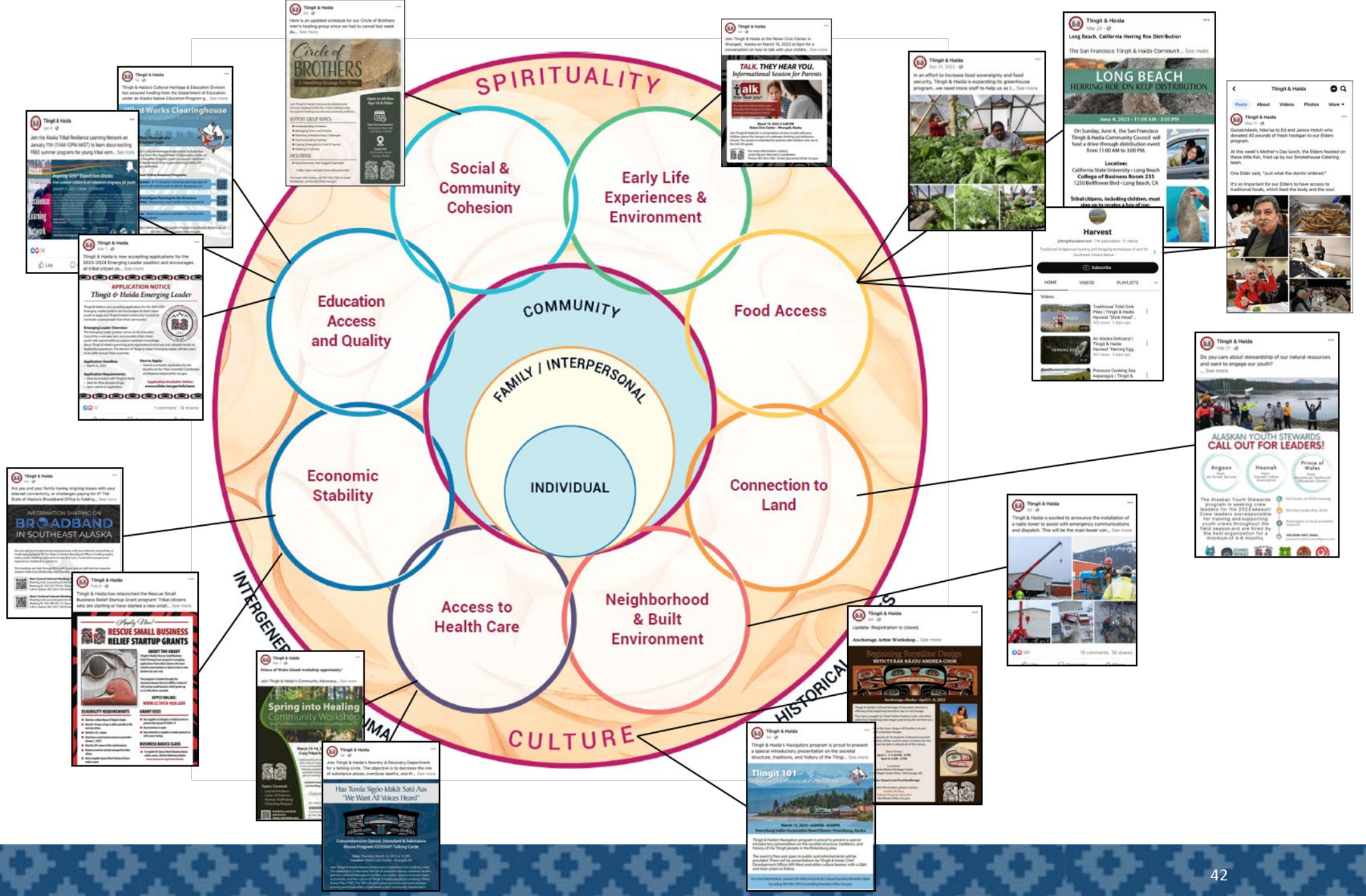
SPIRITUALITY
Social & Community Cohesion
Early Life Experiences & Environment
Education Access and Quality
Food Access
COMMUNITY
FAMILY / INTERPERSONAL
INDIVIDUAL
Economic Stability
Connection to Land
Access to Health Care
Neighborhood & Built Environment
CULTURE
INTERGENER
HISTORICAL
Circle of BROTHERS
A Healing Group for Men
TALK. THEY HEAR YOU.
Informational Session for Parents
LONG BEACH
HERRING ROE ON KELP DISTRIBUTION
Harvest
APPLICATION NOTICE
Tlingit & Haida Emerging Leader
ALASKAN YOUTH STEWARDS
CALL OUT FOR LEADERS!
INFORMATION SHARING ON
BROADBAND
IN SOUTHEAST ALASKA
RESCUE SMALL BUSINESS
RELIEF STARTUP GRANTS
Spring into Healing
Community Workshop
Haa Tuwáa Sigóo Idakát Satú Aax
"We Want All Voices Heard"
Tlingit 101

Háw'aa/Gunalchéesh/Thank you