Mid-America (HHS Region 7)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Context Clues: Using Social Determinants of Health (SDOH) to Enhance Treatment-Social Determinants of Health in Primary Care Settings

Jennifer Burt, Ph.D.

Bill Baerentzen, Ph.D., CRC, LMHP

UNMC MUNROE-MEYER INSTITUTE

SAMHSA Substance Abuse and Mental Health Services Administration

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At the time of this presentation, Tom Coderre served as Acting Assistant Secretary for Mental Health and Substance Use at the Substance Abuse and Mental Health Services Administration (SAMHSA). The opinions expressed herein are the views of the speakers and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

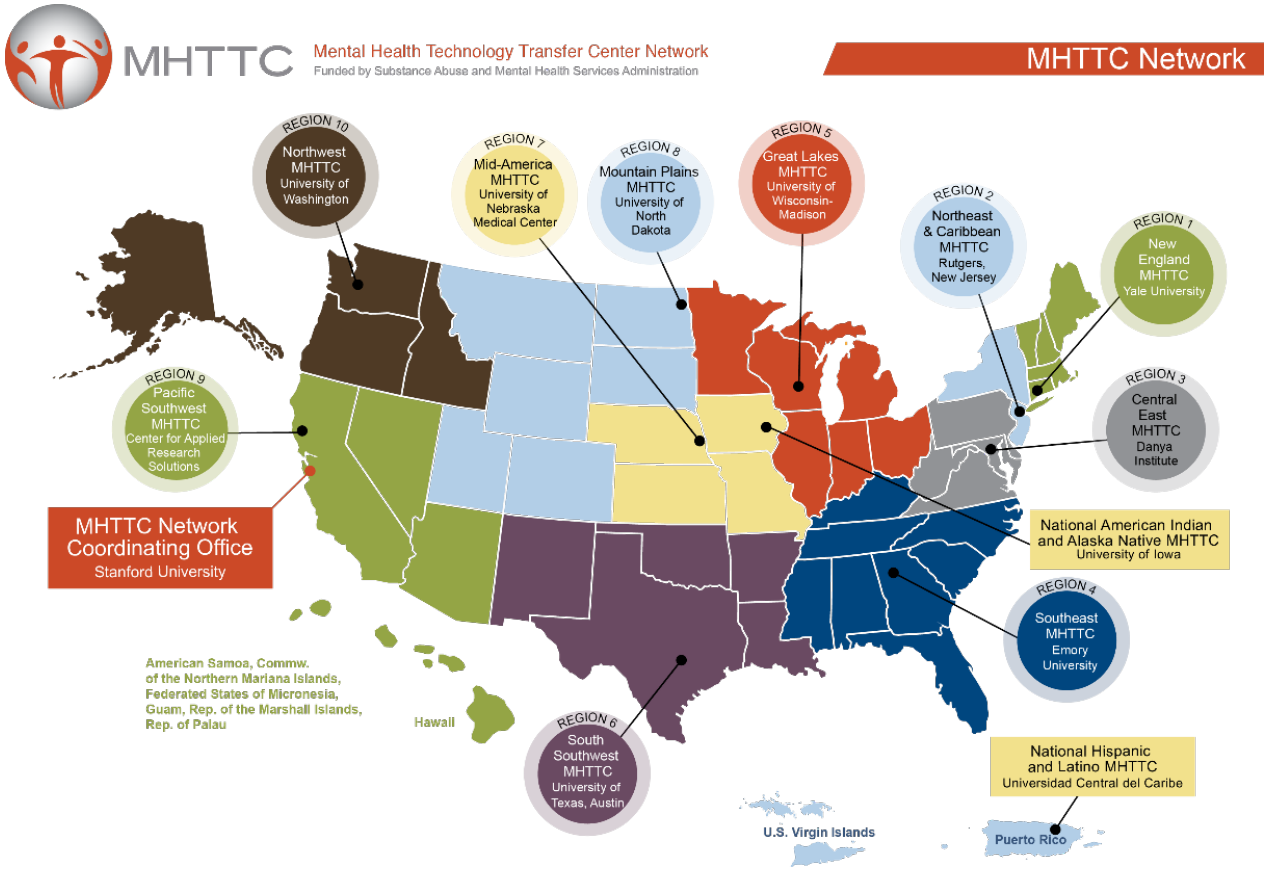
- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/ trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Mid-America Mental Health Technology Transfer Center

Established to increase utilization of evidence-based mental health practices.

- Missouri, Iowa, Nebraska, and Kansas.
- Free training and technical assistance.
- SAMHSA grant awarded to the Behavioral Health Education Center of Nebraska at University of Nebraska Medical Center.
  (5 years, $3.7 million, grant number: H79SM081769)



Learning Objectives

- Define social determinants of health, health equity and health disparities
- Describe the impact of social determinants on health outcomes
- Understand the importance of assessing for common social determinants of health in primary care settings
- Identify actionable steps to screen and refer to community supports for social determinants of health

Define social determinants of health, health equity and health disparities

Social Determinants of Health (SDOH)

"Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."

-Center for Disease Control (CDC)

Disparities vs. Inequities

- **Health Disparities:** Differences in health status among distinct segments of the population, including differences that occur by gender, race, or ethnicity, education or income, inability or living a various geographic locations.

- **Health Inequities:** Disparities in health that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunities.

- Source: Cuff, P. A., & Hammers Forsag, E. (2020). Educating health professionals to address the social determinants of health: Proceedings of a workshop. The National Academic Press. Washington, DC.

Example:

Why is Jason in the hospital?

- *Because he has a bad infection in his leg*

But why does he have the infection?

- *He has a cut on his leg and it got infected*

But why does he have a cut on his leg?

- *He was playing in the junk yard next to his apartment building and fell on some sharp, jagged*

But why was he playing in the junk yard?

- *His neighborhood is run down. This is where kids play because there are no playgrounds or parks and no one is there to supervise them.*

But why does he live in that neighborhood

- *His parents can't afford a nicer place*

But why can't his parents afford a nicer place to live?

- *His dad is unemployed, his mom is sick*

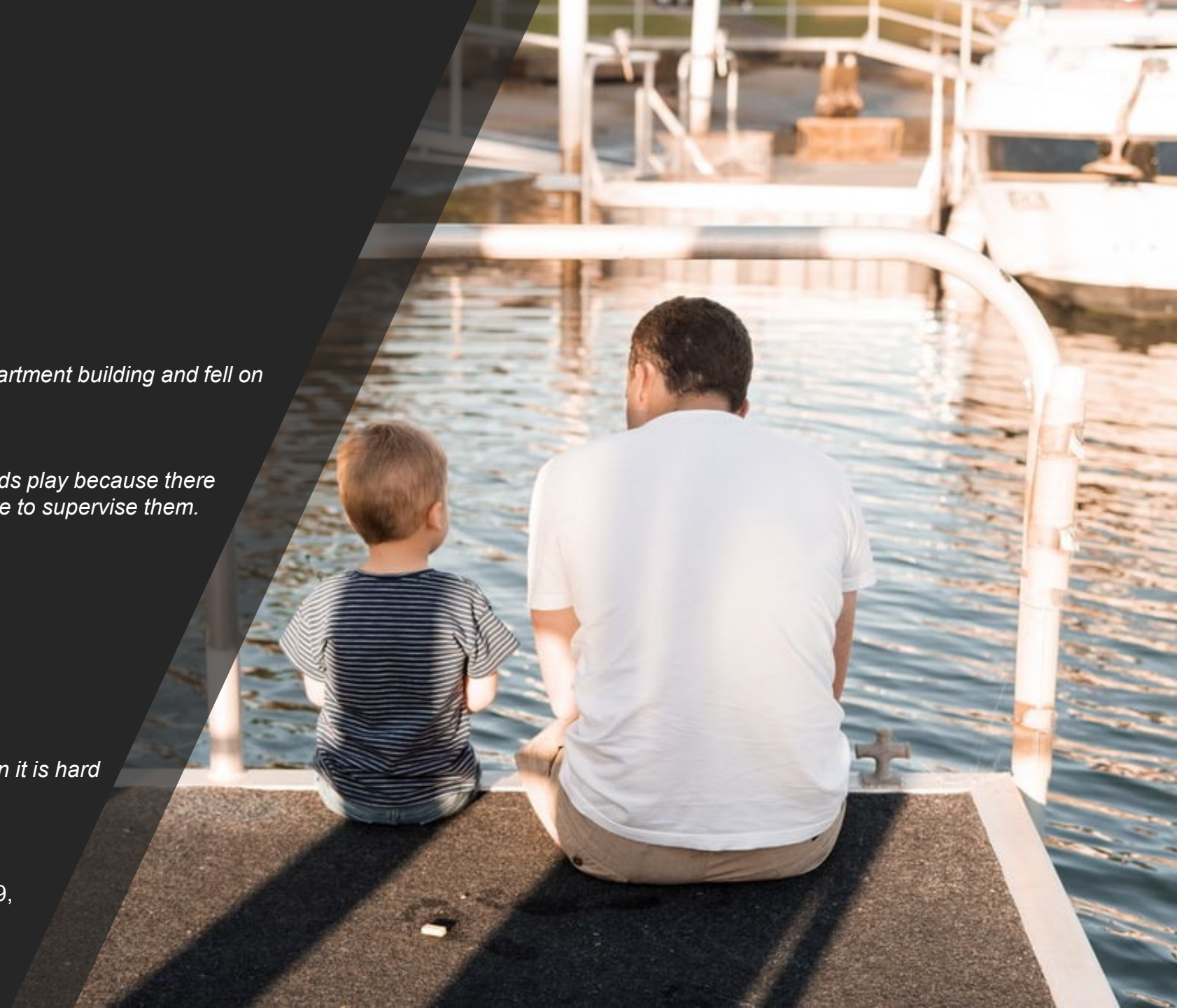
But why is his dad unemployed?

- *Because his dad doesn't have much education it is hard for him to find a job*

But why….?

Source: Presented by Ruth Shim on November 15, 2019,

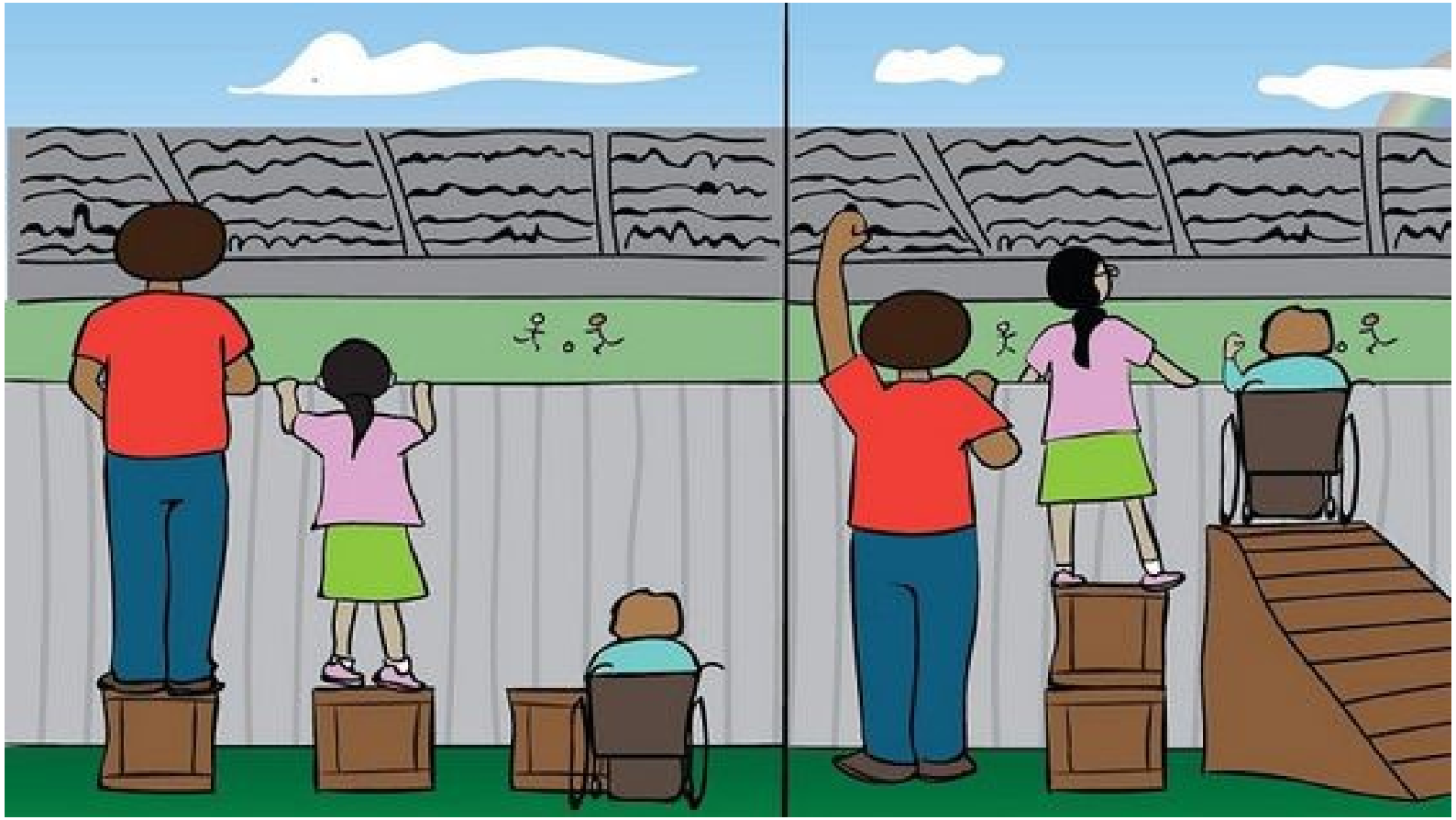
Government of Canada 2013.



Health Equity

“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

-Robert Wood Johnson Foundation (RWJF)



Health Equity

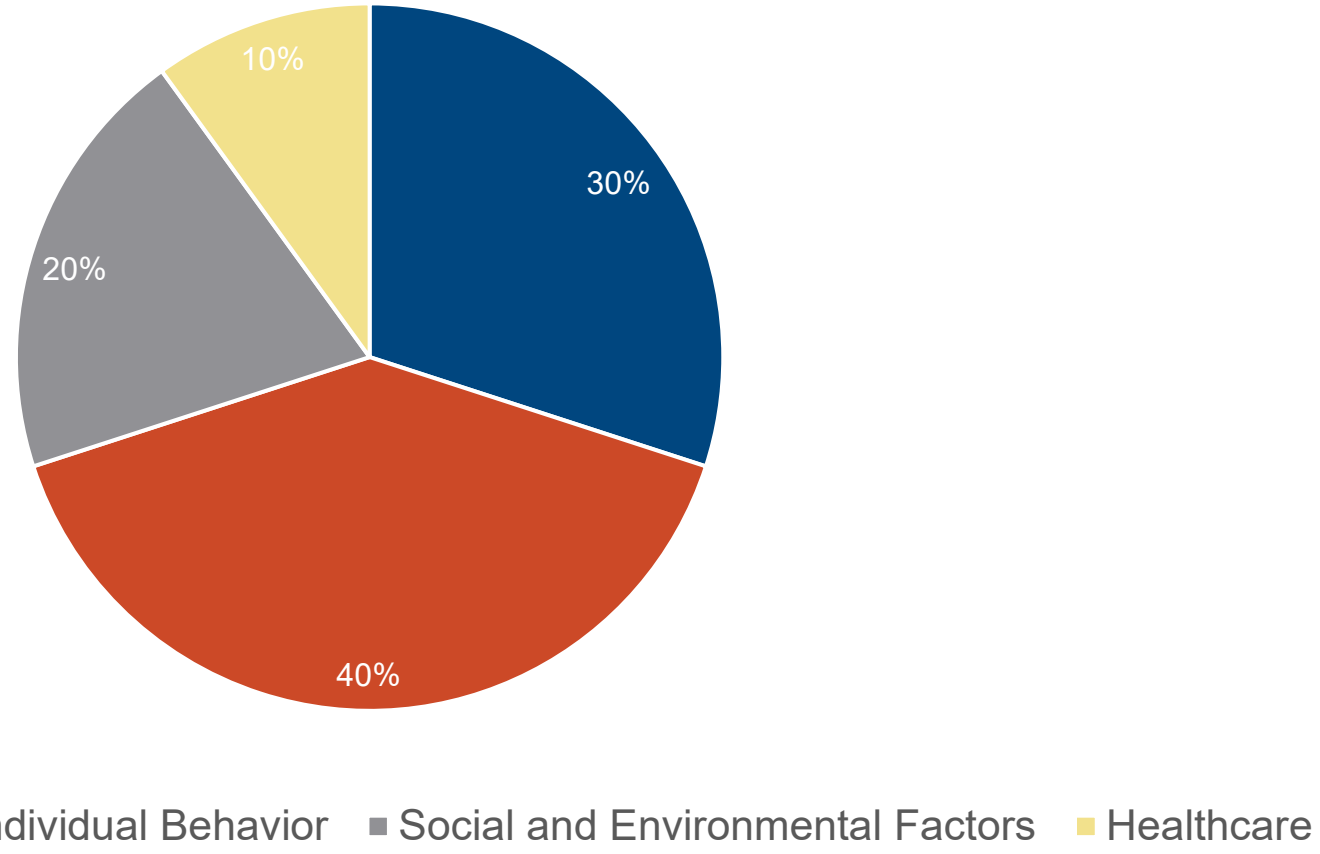
Impact on Health

CDC Data on Deaths by Race and Ethnicity

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases	1.9x	0.7x	1.1x	1.3x
Hospitalizations	3.7x	1.1x	2.9x	3.2x
Deaths	2.4x	1.0x	1.9x	2.3x

Source: CDC

Determinants of Health and Their Contribution to Premature Death



Source: Beyond Healthcare: The Role of Social Determinants in Promoting Health and Healthy Equity. Kaiser Family Foundation, 2015.

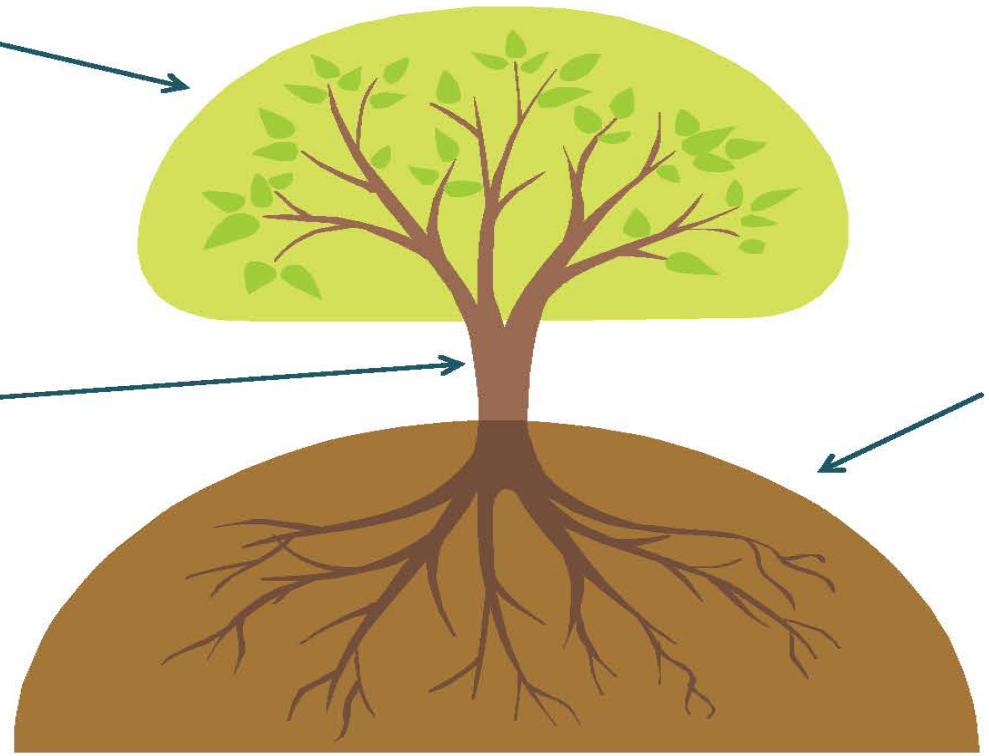
Social Determinants of Health

Health outcomes:

- cancer
- diabetes
- asthma
- depression

Health choices:

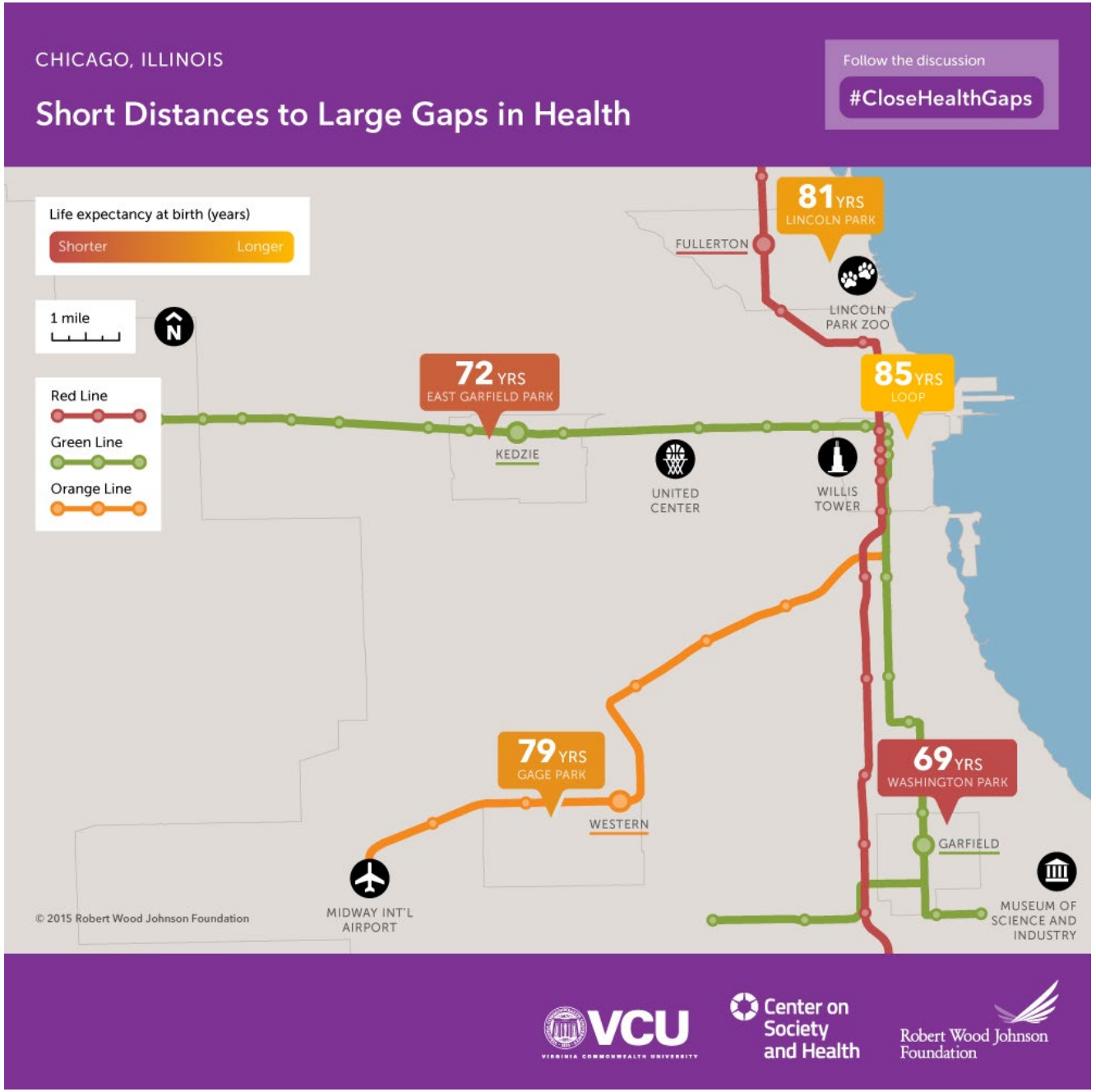
- diet
- exercise
- drinking
- smoking



Social, economic & environmental factors :

- education
- child care
- healthy food
- housing
- health care
- work environment
- wages & benefits
- transportation
- air & water quality
- A.C.E.s

IMPACT


CHICAGO, ILLINOIS
Short Distances to Large Gaps in Health
Follow the discussion
#CloseHealthGaps
Life expectancy at birth (years)
Shorter
Longer
1 mile
N
Red Line
Green Line
Orange Line
81 YRS
LINCOLN PARK
FULLERTON
LINCOLN PARK ZOO
72 YRS
EAST GARFIELD PARK
85 YRS
LOOP
KEDZIE
UNITED CENTER
WILLIS TOWER
79 YRS
GAGE PARK
69 YRS
WASHINGTON PARK
WESTERN
GARFIELD
MIDWAY INT'L AIRPORT
MUSEUM OF SCIENCE AND INDUSTRY
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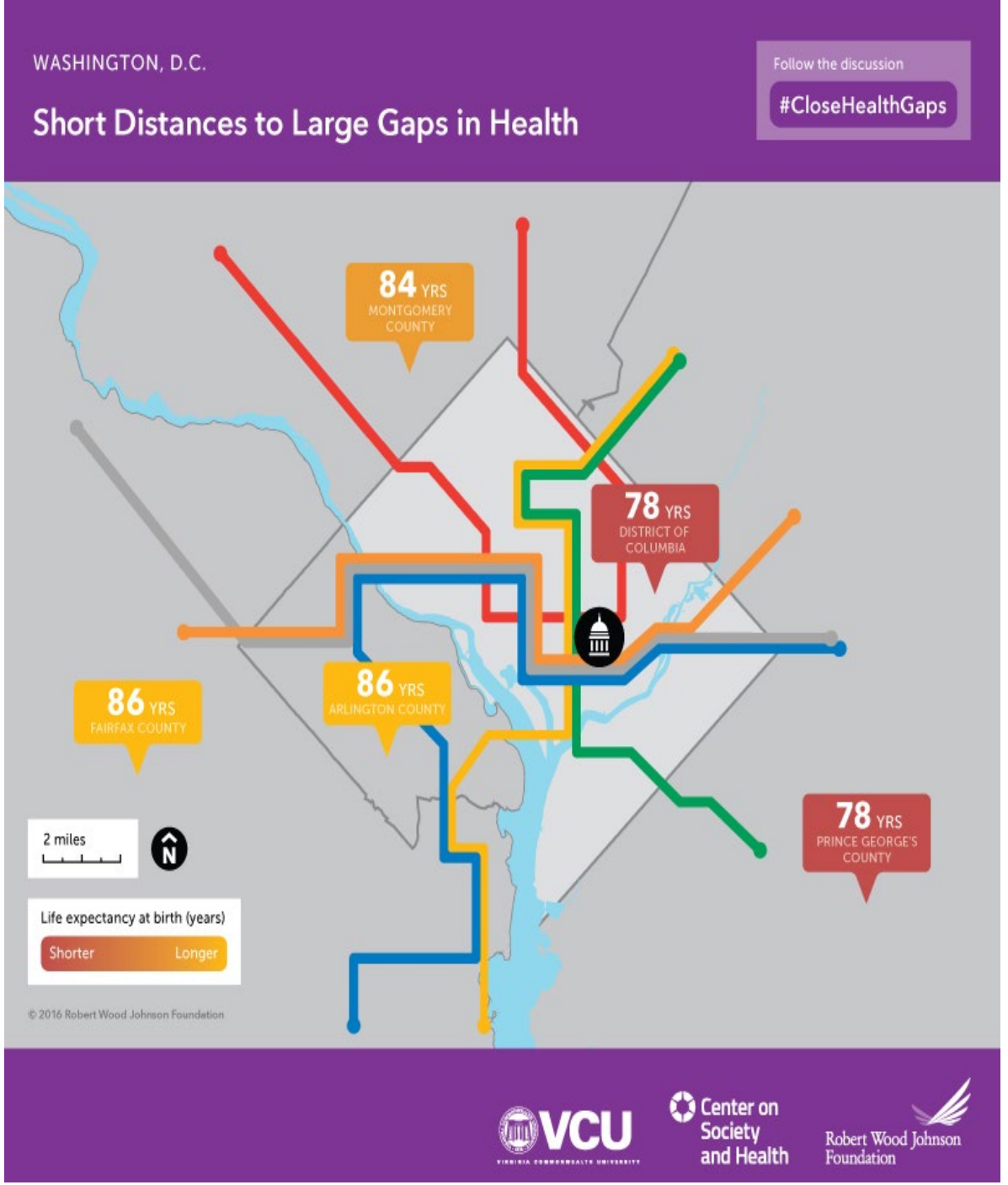
WASHINGTON, D.C.
Short Distances to Large Gaps in Health
Follow the discussion
#CloseHealthGaps
84 YRS
MONTGOMERY COUNTY
78 YRS
DISTRICT OF COLUMBIA
86 YRS
ARLINGTON COUNTY
86 YRS
FAIRFAX COUNTY
78 YRS
PRINCE GEORGE'S COUNTY
2 miles
N
Life expectancy at birth (years)
Shorter
Longer
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IMPACT


RWJF Commission
to Build a Healthier America
Robert Wood Johnson Foundation
N
83
YEARS*
SHOAL
CREEK
LIBERTY
THE COVES
82
YEARS*
LINDEN
PARK
GLADSTONE
29
435
35
435
BIRMINGHAM
635
KANSAS CITY,
MISSOURI
KANSAS CITY
40
71
YEARS*
WASHINGTON
WHEATLEY
CUNNINGHAM
RIDGE
70
BLUE
HILLS
69
YEARS*
71
83
YEARS*
ARMOUR
HILLS
3MI
*Life expectancy at birth by zip code
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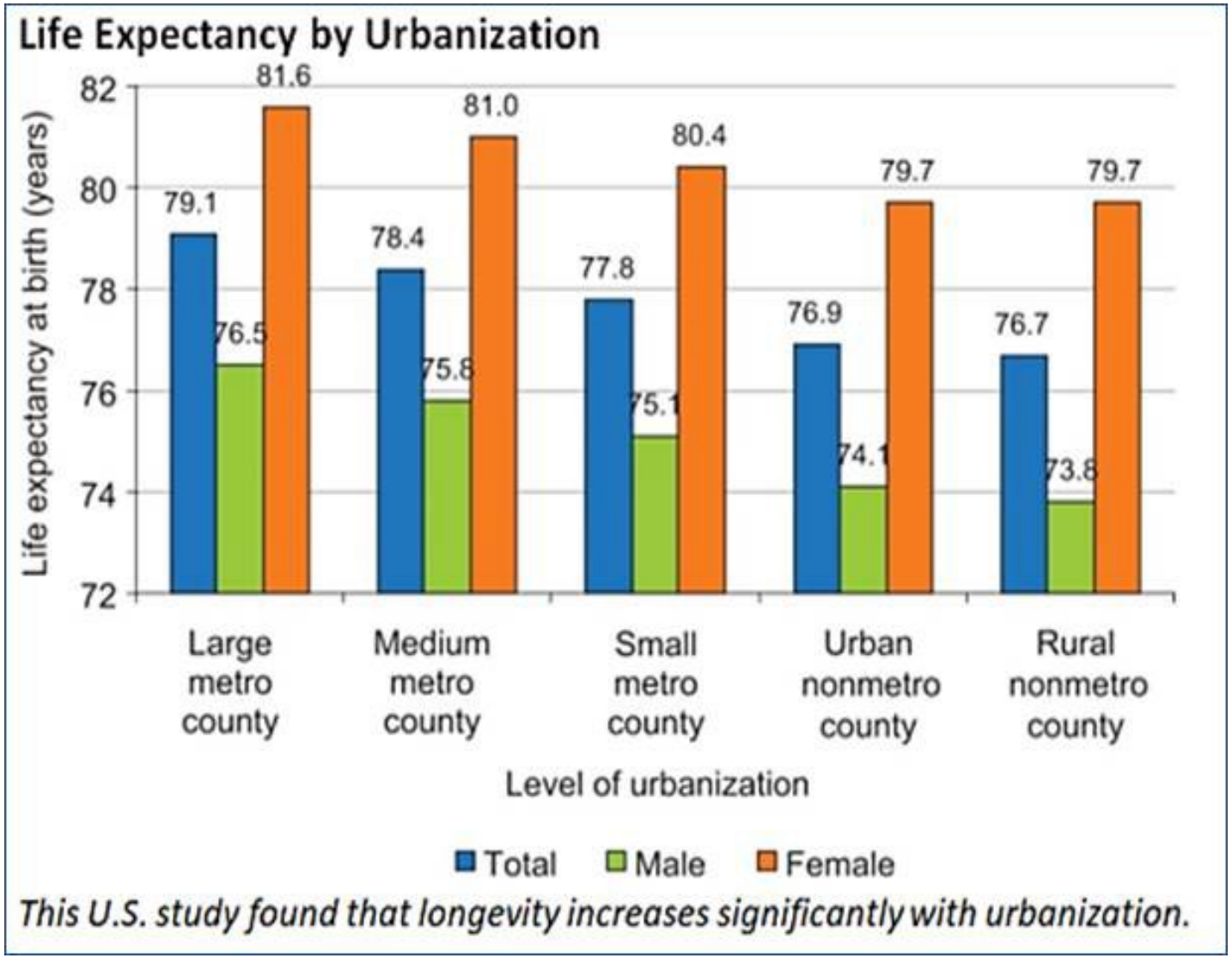
Rural Disparities



Intersectionality

Building Resilience

Risk Factors

- Behavioral risks
- Physiological and genetic risks
- Environmental and cultural risks

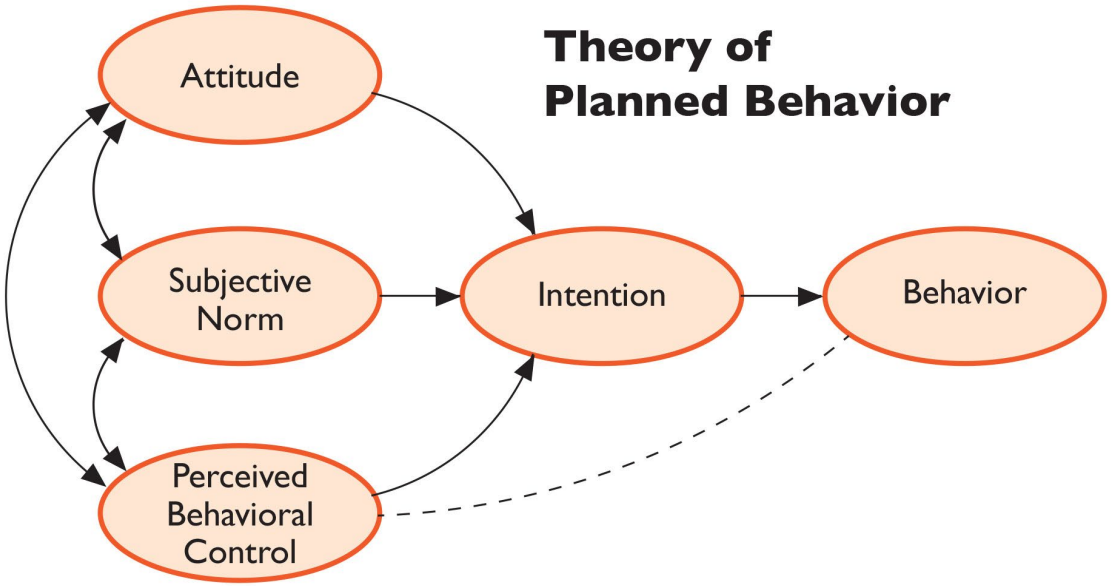
Protective Factors

- Supportive relationships
- Healthy coping strategies
- A sense of purpose
- Positive parenting by caring adults
- Emotional self-awareness
- Socioeconomic stability
- The willingness to seek help
- Problem-solving skills

Promoting Resiliency in Healthcare Settings

Each patient is unique

and has the capacity for change



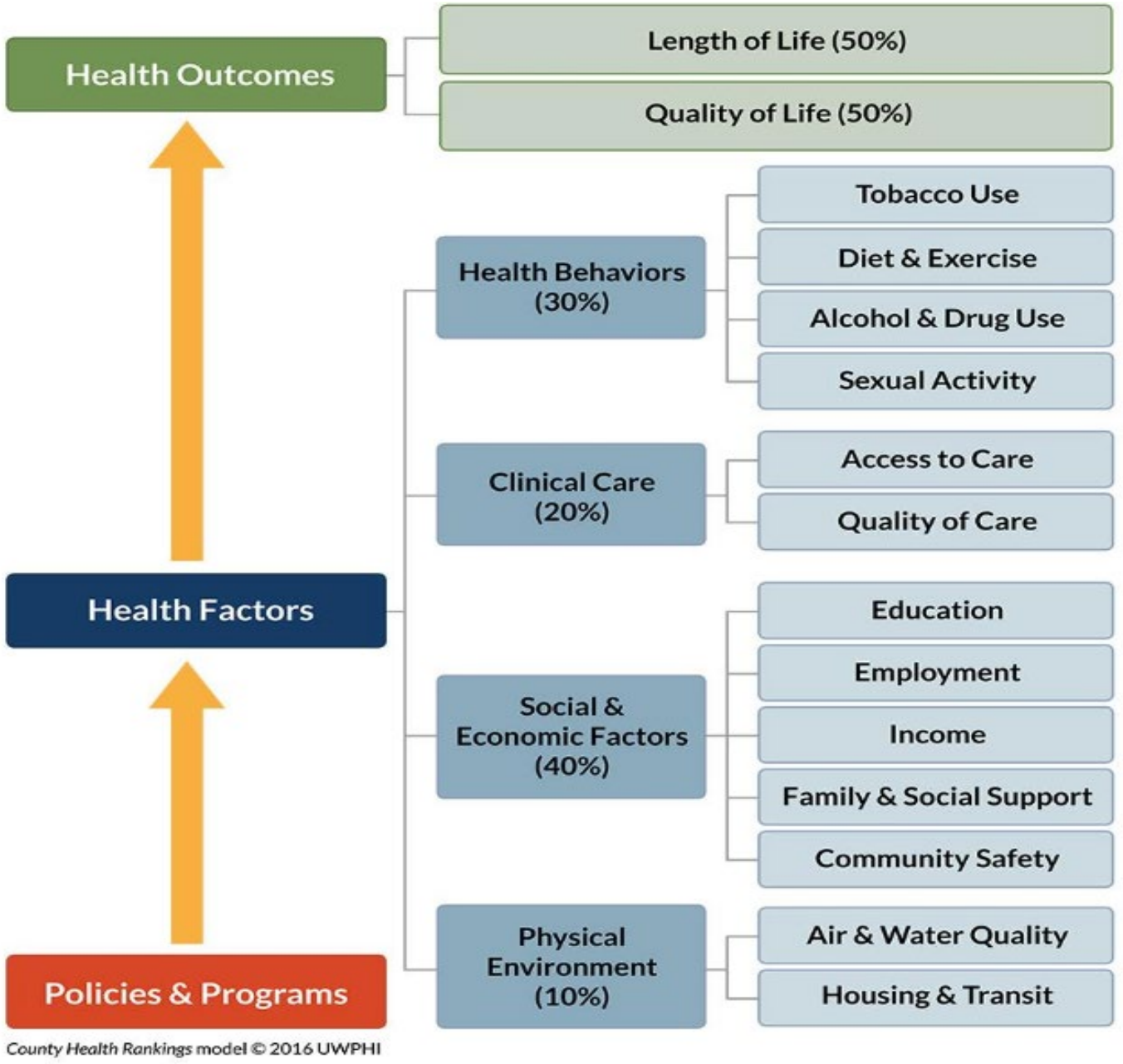
Norms. Ask patients about their values and beliefs about health. Help shape positive attitudes and foster confidence that small changes goes a long way to a healthy life.

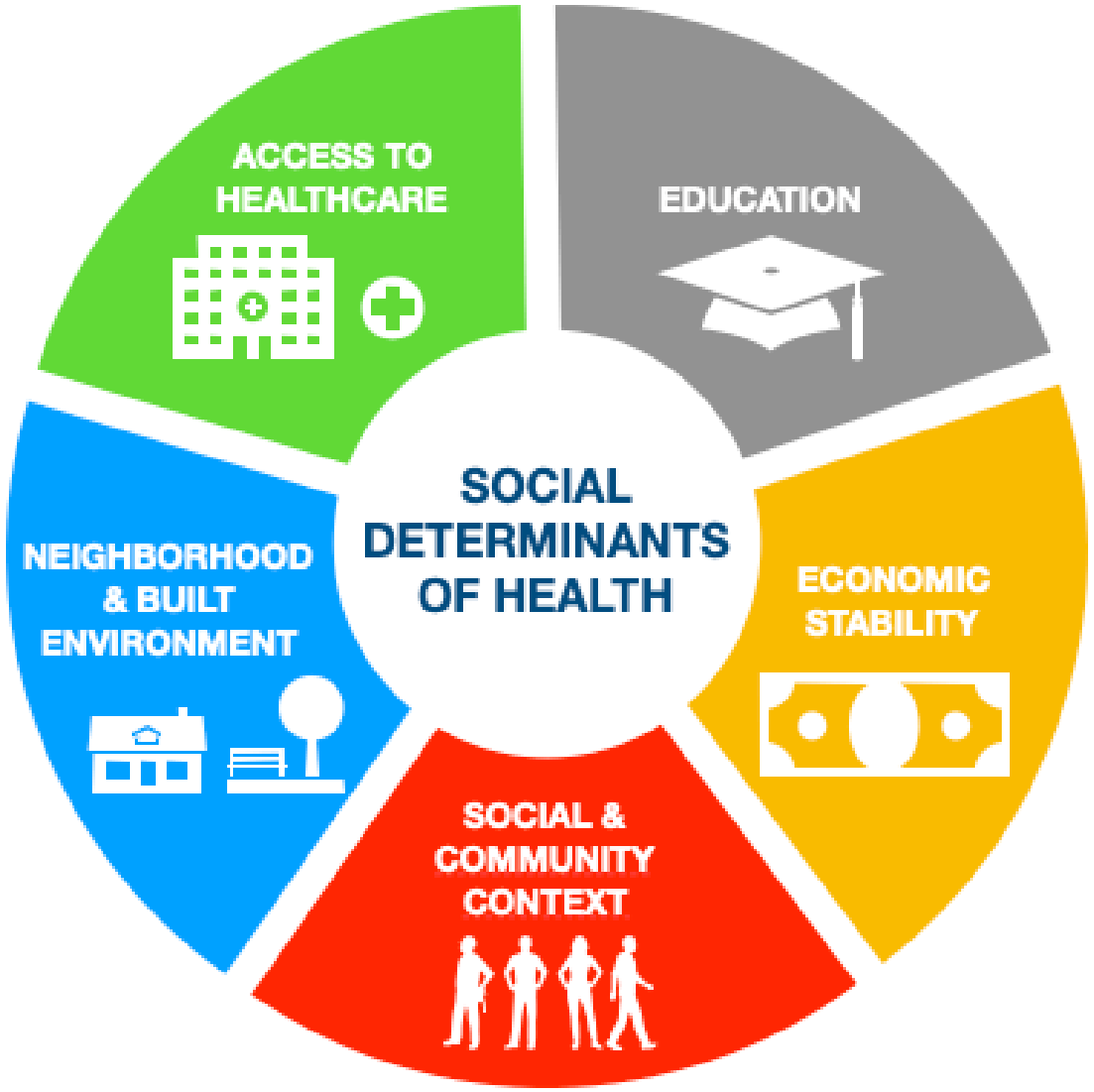
Intention. Ask patients for permission to help make plans to adjust health practices. Be considerate to cultural norms and current behavior.

Behavioral. Teach people how to do things. Have conversations with patients about how to follow through on healthcare recommendations and to accept health practices.

Social Determinants of Health in Primary Care

Impact of Social Determinants of Health

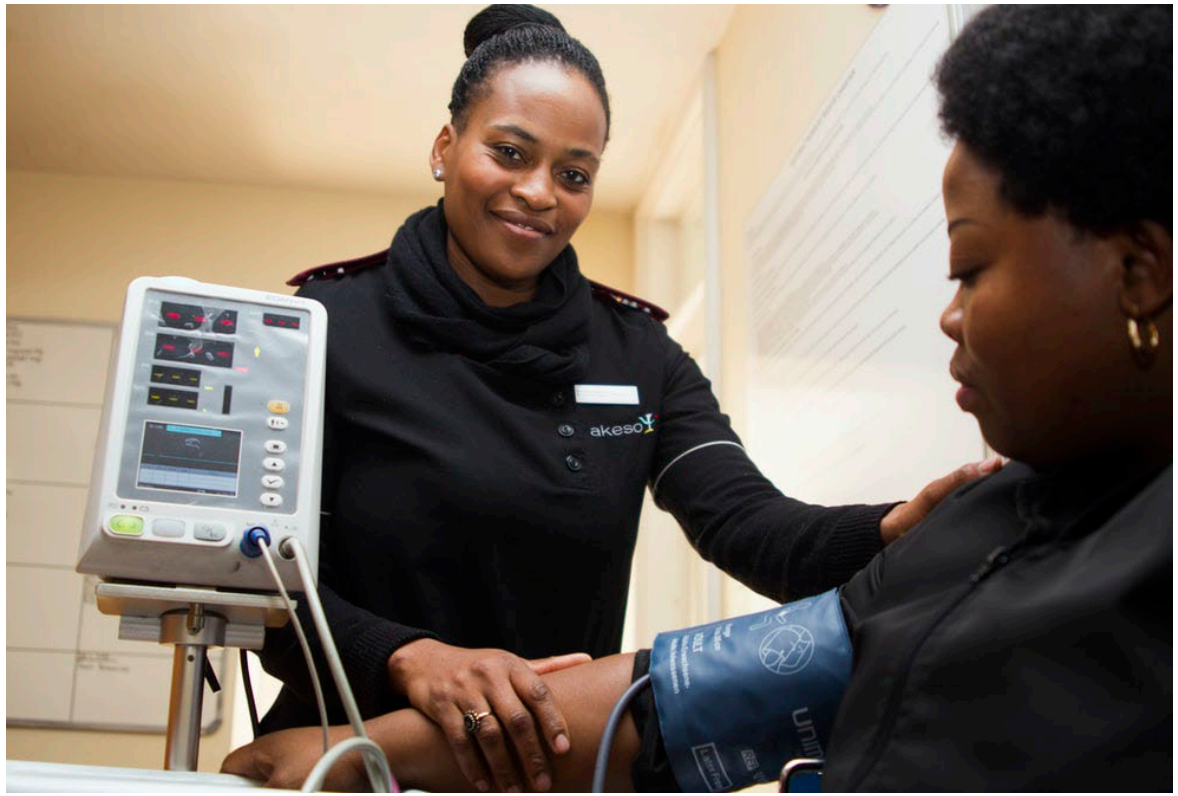


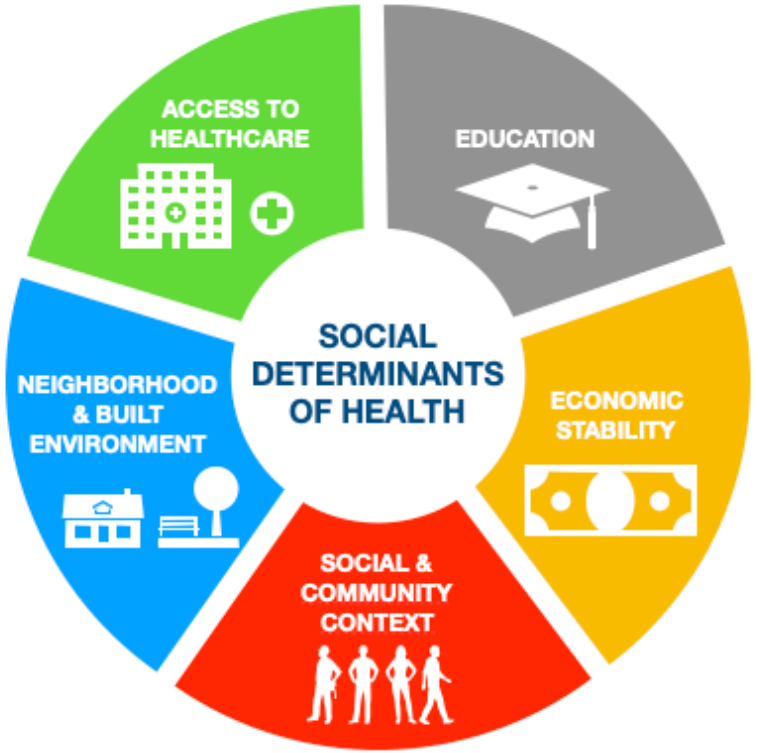


Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [May, 2021) from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Access to HealthCare

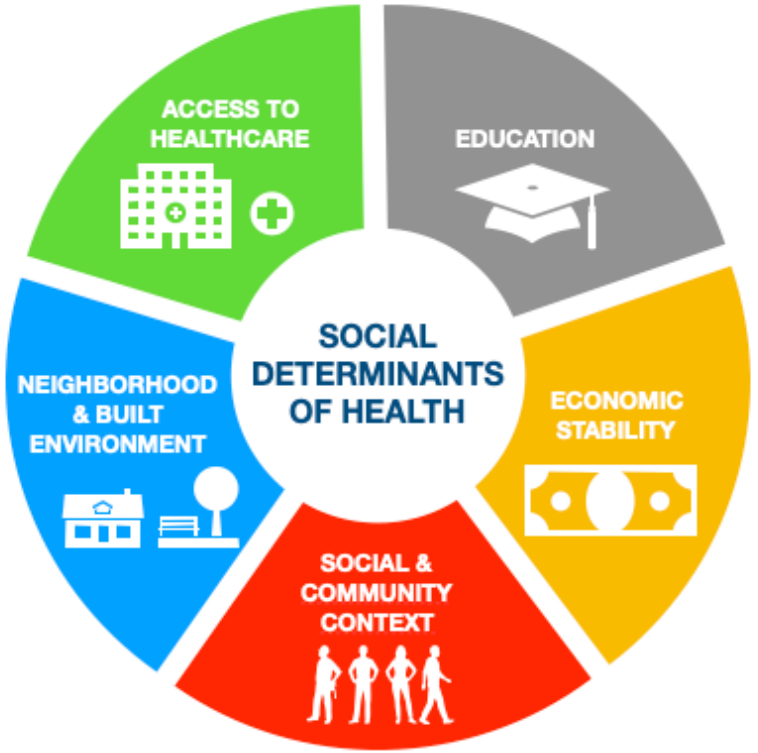
- The connection between people's access to and understanding of health services and their own health.





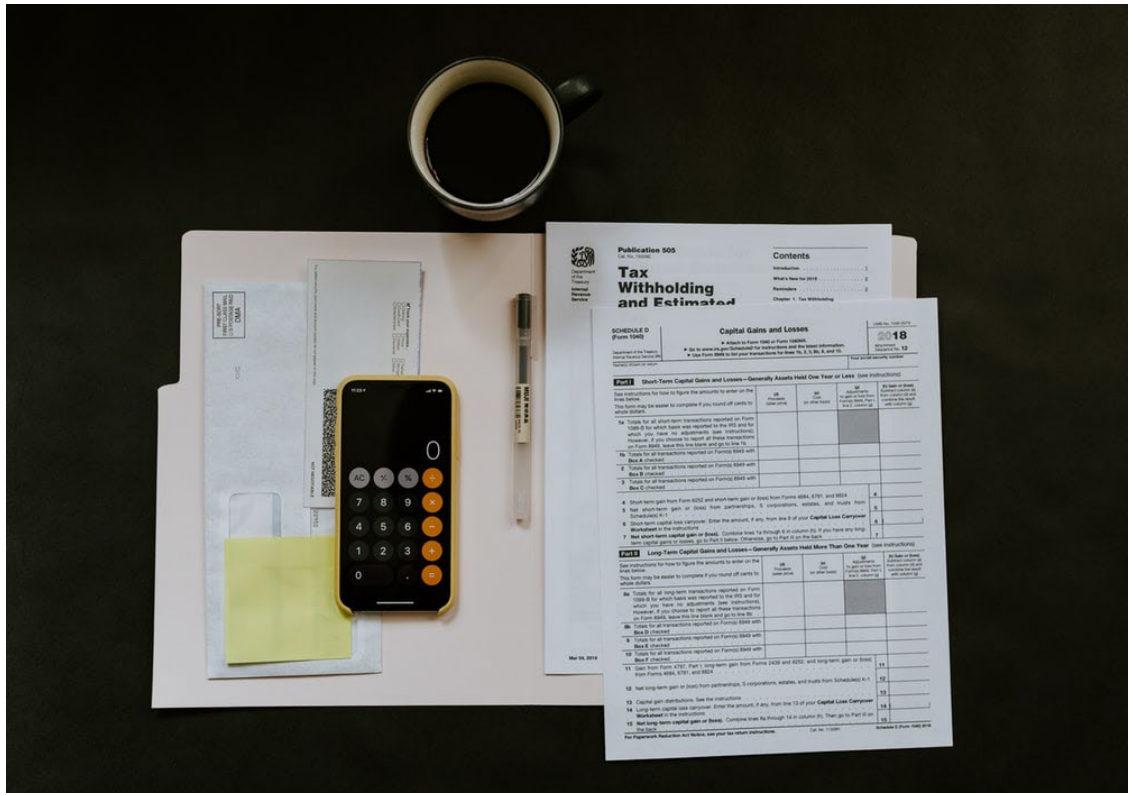
Education Access & Quality

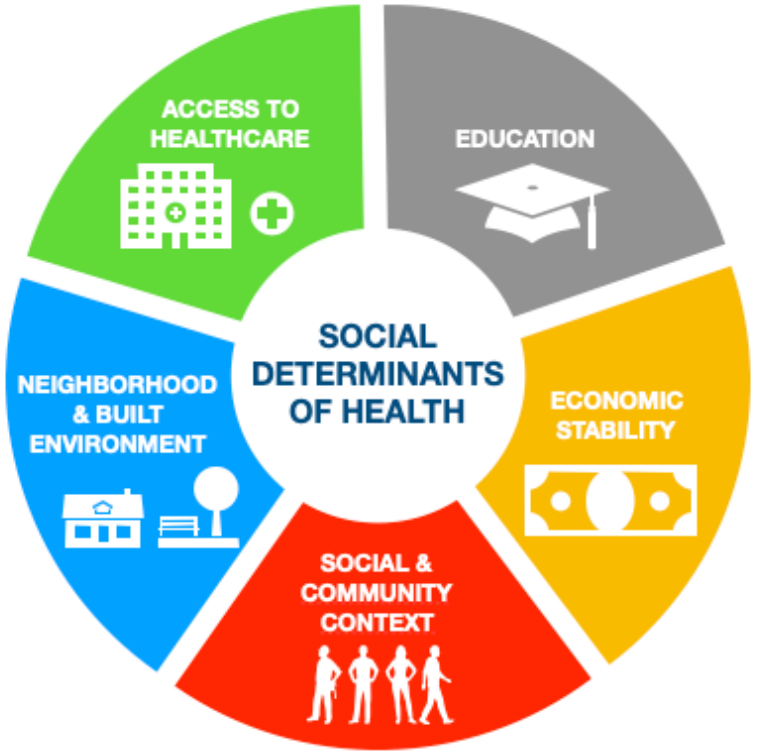
- The connection of education to health and well-being.



Economic Stability

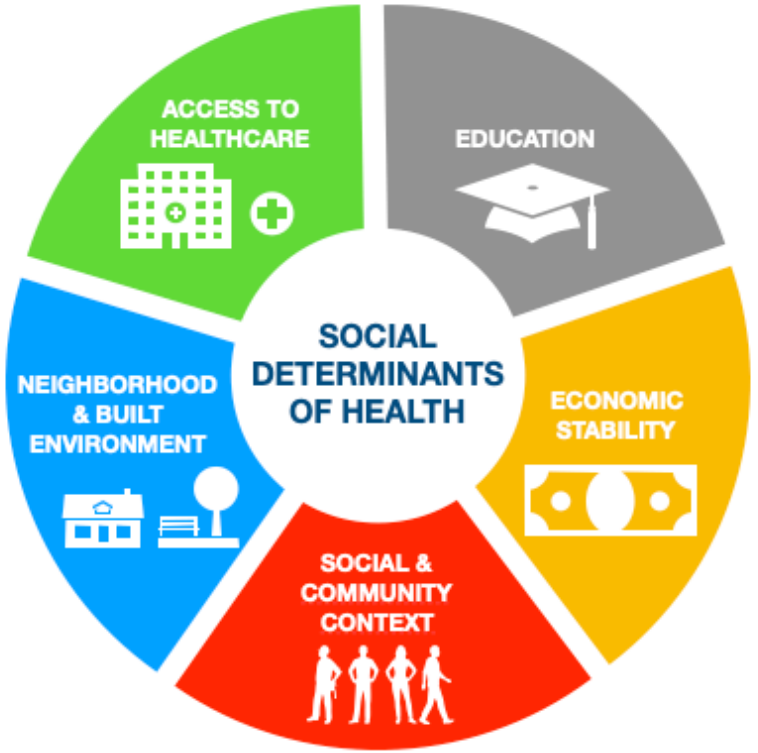
- The connection between the financial resources people have- income, cost of living, and socioeconomic status- and their health.





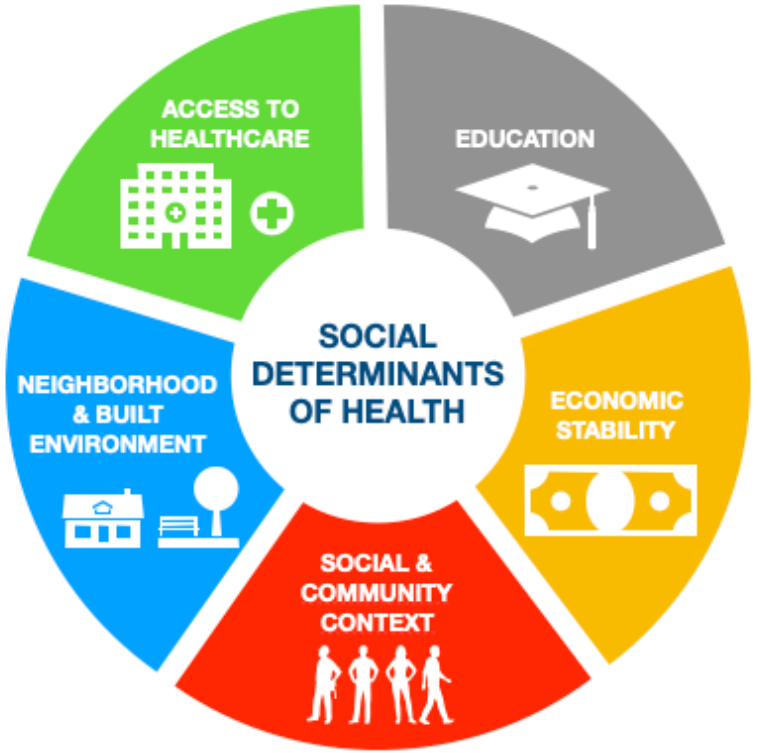
Social & Community Context

- The connection between characteristic of the contexts within which people live, learn, work and play, and their health and well-being.

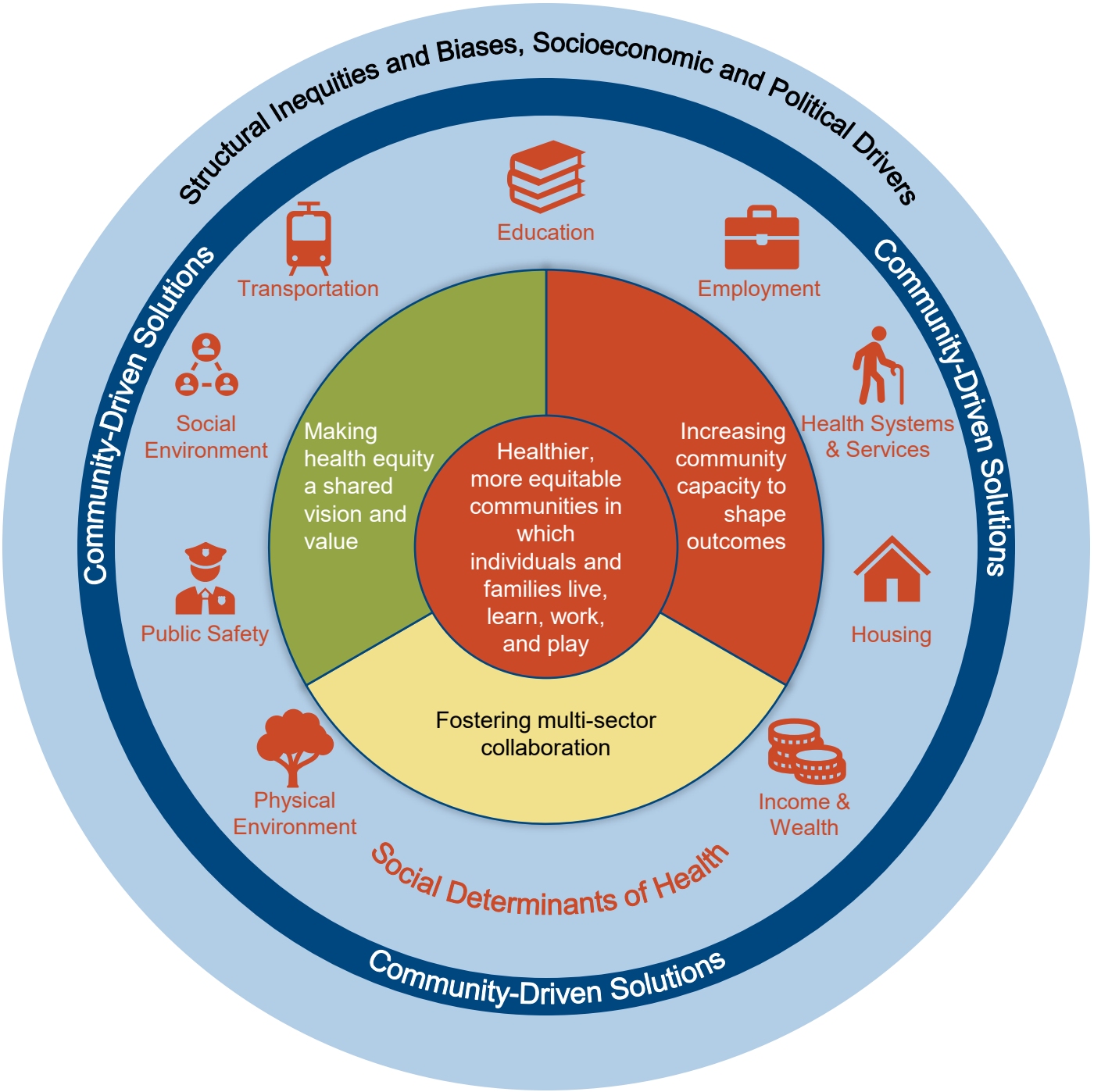


Neighborhood & Built Environment

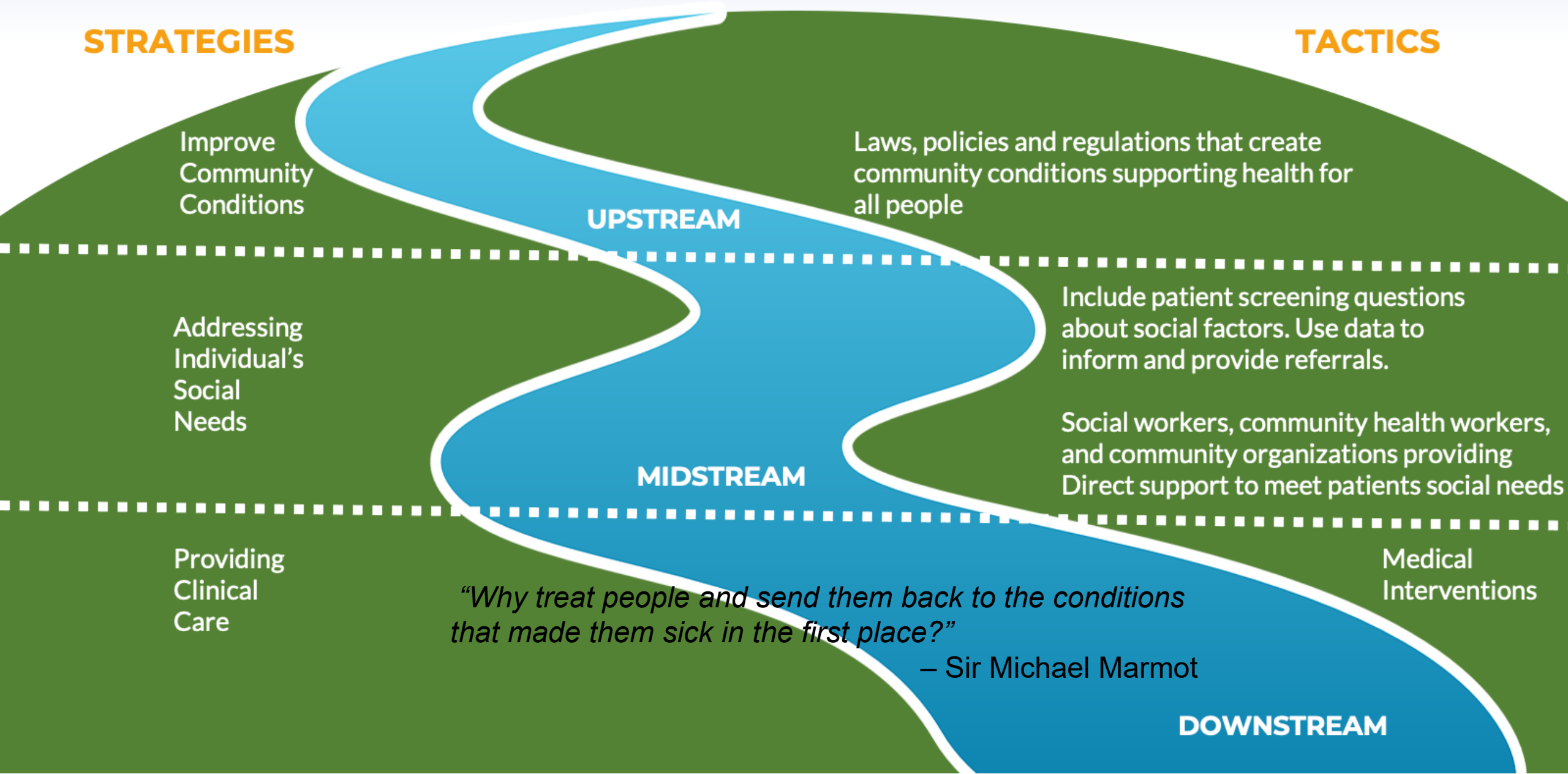
- The connection between where a person lives- housing, neighborhood, and environment- and their health and well-being.



Actionable Items to Address SDOH


Structural Inequities and Biases, Socioeconomic and Political Drivers
Community-Driven Solutions
Community-Driven Solutions
Community-Driven Solutions
Education
Transportation
Employment
Social Environment
Health Systems & Services
Making health equity a shared vision and value
Healthier, more equitable communities in which individuals and families live, learn, work, and play
Increasing community capacity to shape outcomes
Public Safety
Housing
Fostering multi-sector collaboration
Physical Environment
Income & Wealth
Social Determinants of Health

SOCIAL DETERMINANTS AND SOCIAL NEEDS – MOVING UPSTREAM



1

Integrated Care Model

Engage community-based teams to promote relationship building

Facilitate community-wide discussions on best practices related to integrated care

Provide a framework for the development of community-driven protocols and best practices

2

Z-Code Claims

Establish pilot sites to implement community-wide adoption of routine SDoH screening

Offer training to providers on the usage of z-codes and best practices for related interventions

Identify Medicaid members with unmet SDoH needs based on z-code claims

Identify gaps in care based on correlations between SDoH and health outcomes

3

Interventions

Internal

Identify and refer Medicaid members who could benefit from case management or other services

External

Provide support to community partners to make referrals through Aunt Bertha

Systemic

Partner with communities to develop data-driven, coordinated responses to local and regional barriers

Source: Aetna Better Health of Kansas

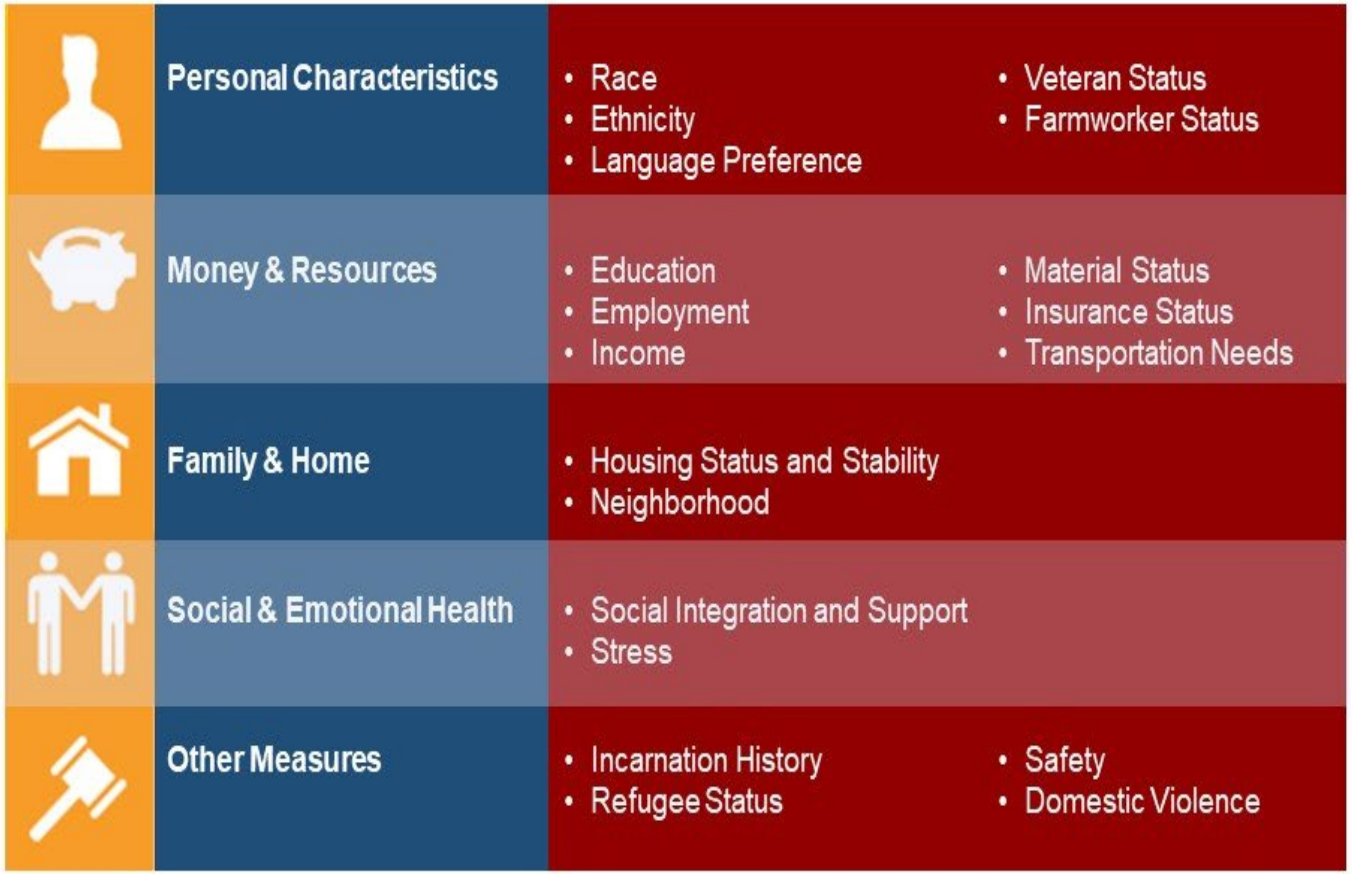
Patient-Centered Practices to Address SDOH

1. **Understand your patient's community**
2. **Learn about how social factors influence health**
3. **Confront implicit bias in your practice**
4. **Empower the whole health care team**
5. **Develop processes that promote health literacy**

AAFPs Framework to Address SDOH

ASK	• About SDOH
IDENTIFY	• Resources in patients' communities that can help address SDOH
ACT	• To help connect patients with resources to address patients' SDOH

ASK: Assess Patients For



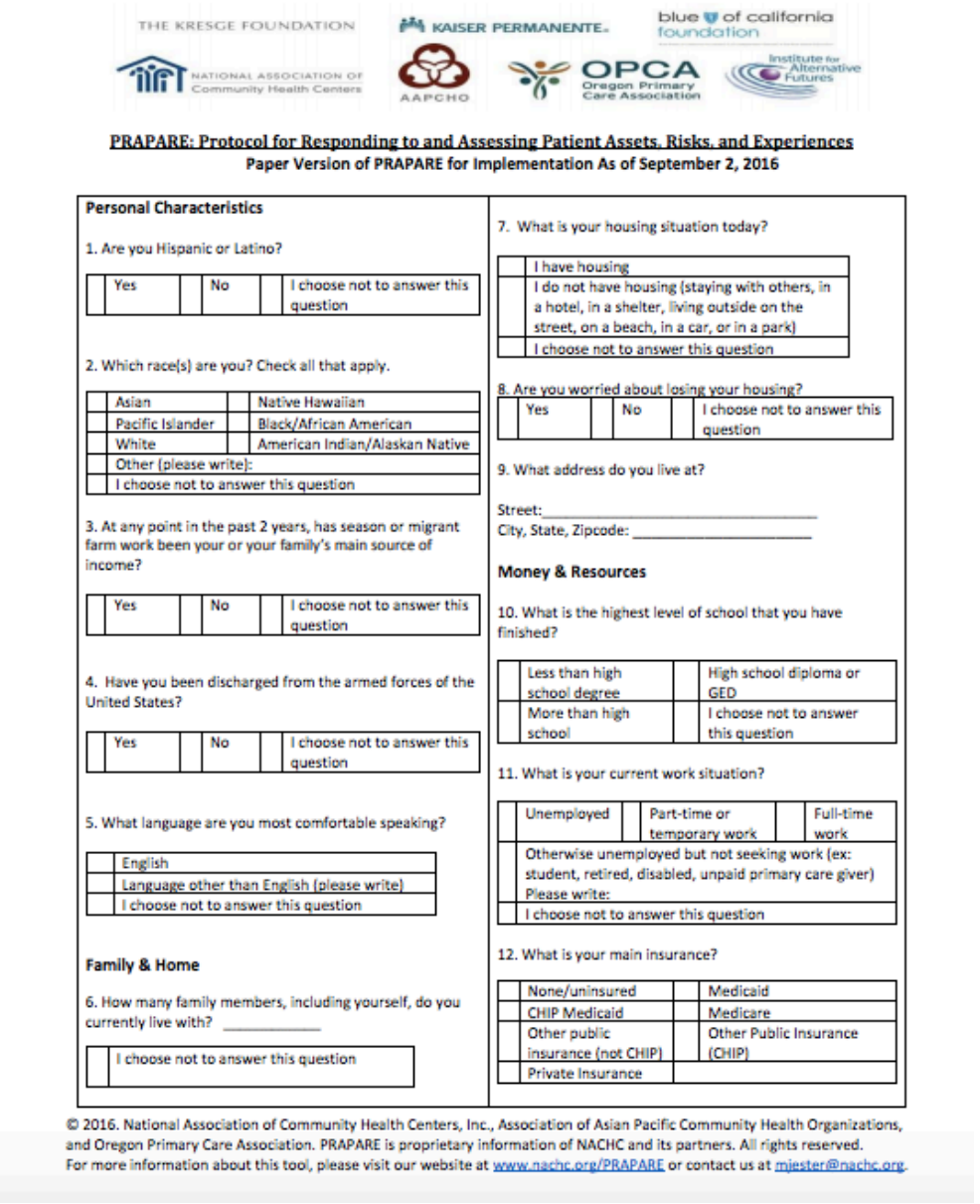
ASK

- Protocol for Responding to and Assessing Patients' Assets, Risk and Experiences (PRAPARE)

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

- American Academy of Family Physicians Guidelines

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf



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?

	English
	Language other than English (please write)
	I choose not to answer this question

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, Zipcode: _____

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		

IDENTIFY

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

ACT

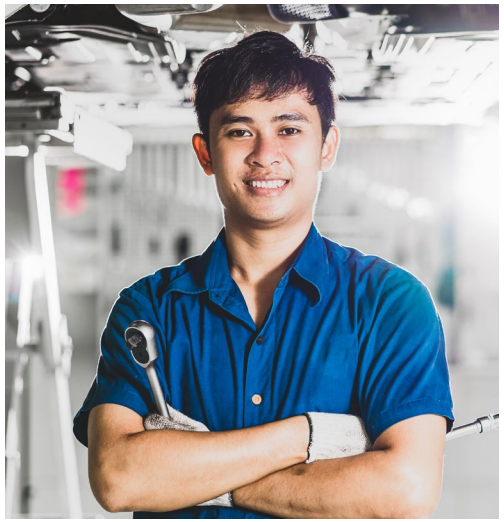

Education
Wealth
Shelter
Transportation
Food
Employment

What to expect at future trainings

Claudia

Mother
Age: 38
Race: Latina
Employment: Waitress
Insurance: through employer

Patrick



Father
Age: 41
Race: White/Thai
Employment: Auto detailer
Insurance: marketplace plan

Ivonne

Grandmother
Age: 63
Race: Latina
Employment: N/A
Insurance: none

What to expect at future trainings

Tyler

Eldest daughter
Age: 16
Race: biracial
Employment: student
Insurance: Medicaid

Elliot

Son
Age: 13
Race: Latino
Employment: student
Insurance: Medicaid

Edith

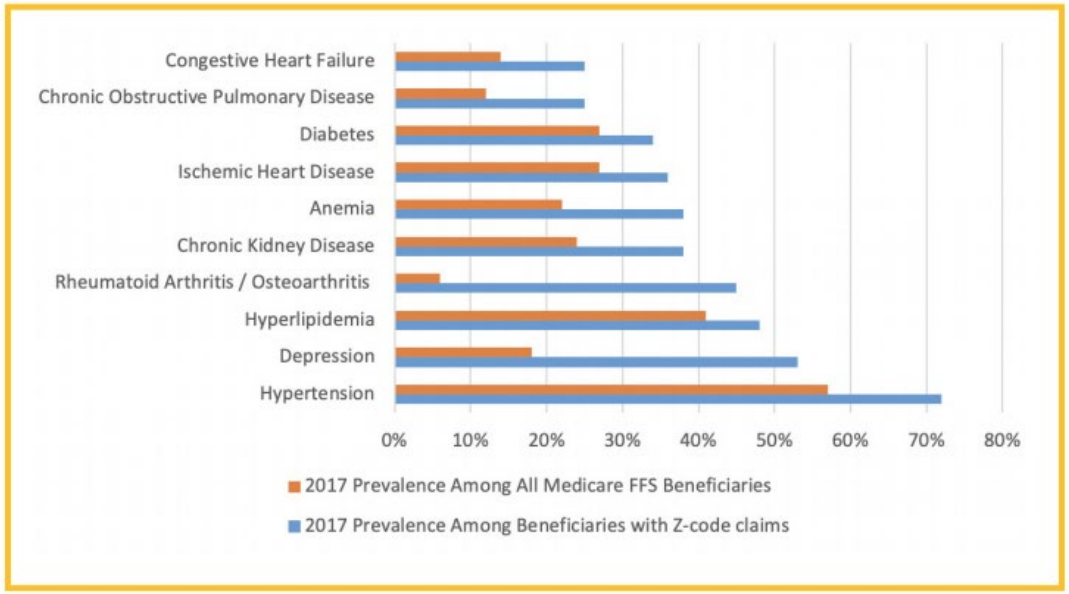
Youngest daughter
Age: 2
Race: biracial
Employment: N/A
Insurance: Medicaid

Session 2: Z-Codes - Using Social Determinants of Health (SDOH) to Enhance Treatment

August 19, 2021, 12 noon – 1PM

SCAN ME

- Z-Codes are used to track Social Determinants of Health
- They inform care teams of the social contexts affecting health and health outcomes
- The most common z-codes includes homelessness, problems with spouse or partner, and other psychosocial circumstances.



(Hodge & Khau, 2020)

Session 3: Food Insecurity - Using Social Determinants of Health (SDOH) to Enhance Treatment

SCAN ME

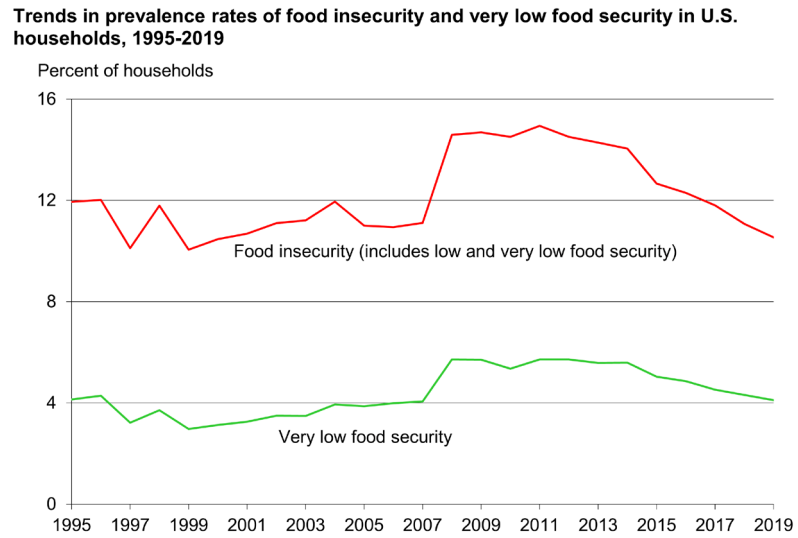
August 19, 2021, 12 noon – 1PM

Food insecurity is a major health threat:

- 12.3% of households had trouble providing food at some point.
- 4.9% of households had reduced food intake and normal eating patterns were disrupted at some point.

- 15.0% of households in non-metropolitan counties experienced food insecurity.
- 14.2% of households in metropolitan counties experienced food insecurity.

(Rabbitt, Coleman-Jensen & Gregory, 2017).



(Coleman-Jensen, Rabbitt, Gregory, & Singh, 2020)

Session 4: Homelessness - Using Social Determinants of Health (SDOH) to Enhance Treatment

September 16, 2021, 12 noon – 1PM

Homelessness is a major health threat

- 567,715 homeless people in 2019
- 37, 085 homeless veterans in 2019

(HUD, 2019)

- 129,370 unaccompanied homeless youth in US
- 271,464 homeless students in US with a disability (age 3 through 12th grade)

(NCHE, 2020)

Session 5: Employment - Using Social Determinants of Health (SDOH) to Enhance Treatment

September 16, 2021, 12 noon – 1PM

Unemployment is a major health threat that affect individuals and families

- 3.7% annual unemployment rate, 2019
- 8.1% annual unemployment rate, 2020

(BLS, 2020)

Selected References

American Academy of Family Physicians (2019). Social determinants of health: A guide to social needs screening. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

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Resources

- Mid-America MHTTC https://mhttcnetwork.org/centers/mid-america-mhttc/home
- Aetna Better Health of Kansas https://www.aetnabetterhealth.com/kansas/ [aetnabetterhealth.com]

SoCKansas@aetna.com

- Aunt Bertha (within KS) https://aetna-ks.auntbertha.com/ [aetna-ks.auntbertha.com]
- Aunt Bertha (outside KS) https://www.findhelp.org/ [findhelp.org]

Questions?

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MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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