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### Overview

- Quick review of the social needs milestone in ISP
- Approaches to overcoming barriers with practices
- What else can be done to work towards health equity?

### Shared Language

#### Social Needs/ Social Barriers to Health

•An individual's lack of a resource that is needed to support a healthy lifestyle

### Social Determinants of Health

•The conditions in which people are born, grow, work, live, and age

### Structural Determinants of Health

•The policies, regulations, values, and social hierarchies that lead to unequal access to favorable social determinants of health.











experiences



Housing





Education

Social support

Employment

Access to health services

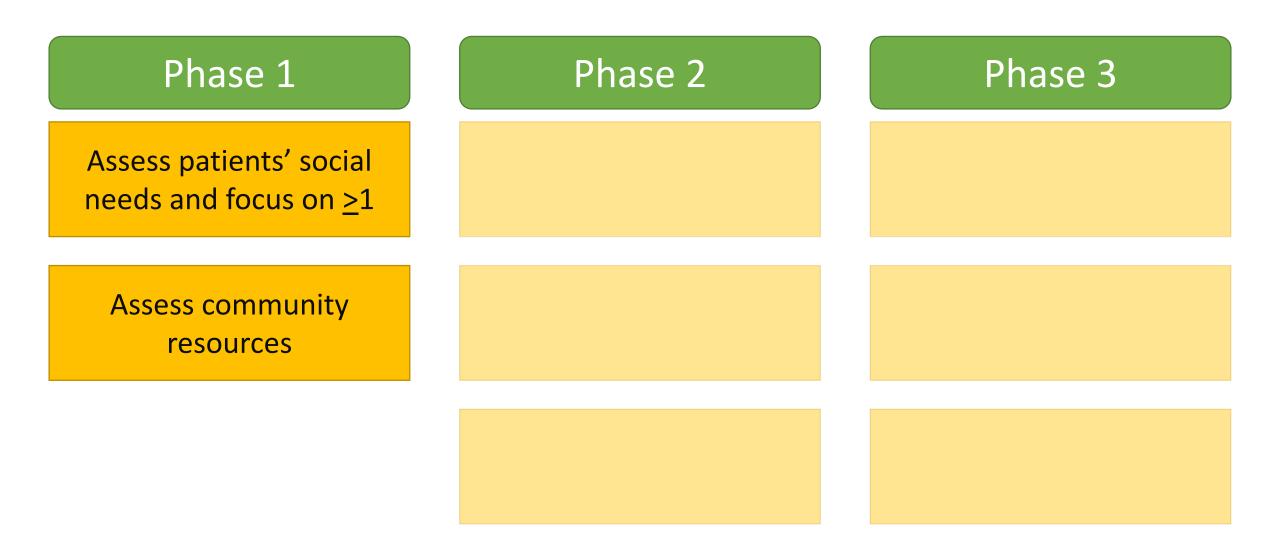
#### Structural Determinants of Health A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE **UPSTREAM DOWNSTREAM** μ<del>ιτι</del>ψ RISK **DISEASE &** MORTALITY LIVING CONDITIONS SOCIAL INSTITUTIONAL **BEHAVIORS** INJURY Infant Mortality Life Expectancy **INEQUITIES** INEQUITIES Smoking Communicable **Physical Environment** Social Environment Disease Experience of Class, Racism, Gender, Immigration **Poor Nutrition** Corporations & Businesses Land Use Class **Chronic Disease** Low Physical Activity Transportation Race/Ethnicity Injury (Intentional & Unintentional) **Government Agencies** Housing **Immigration Status** Culture - Ads - Media Violence Schools Residential Segregation Gender Violence Alcohol & Other **Laws & Regulations Exposure to Toxins** Sexual Orientation Drugs Not-for-Profit Sexual Behavior **Economic & Work** Service Environment Organizations Environment Health Care Employment Education Income Social Services Individual Health Strategic Retail Businesses Health Care Education **Partnerships** Occupational Hazards Advocacy **Community Capacity Building** Case Management **Community Organizing** Civic Engagement Social Determinants of **POLICY** Health **Current Public Health Practice Emerging Public Health Practice**

# ISP Building Block: Addressing Social Needs of Patients

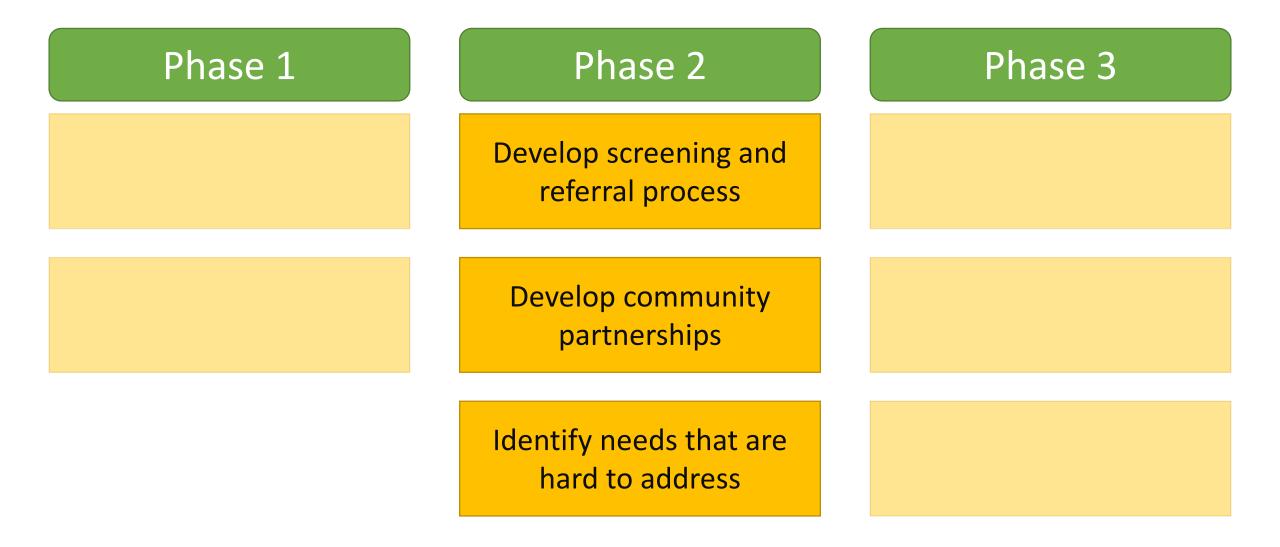
Goal: Practice routinely assesses patients for social needs and links them to appropriate community resources.



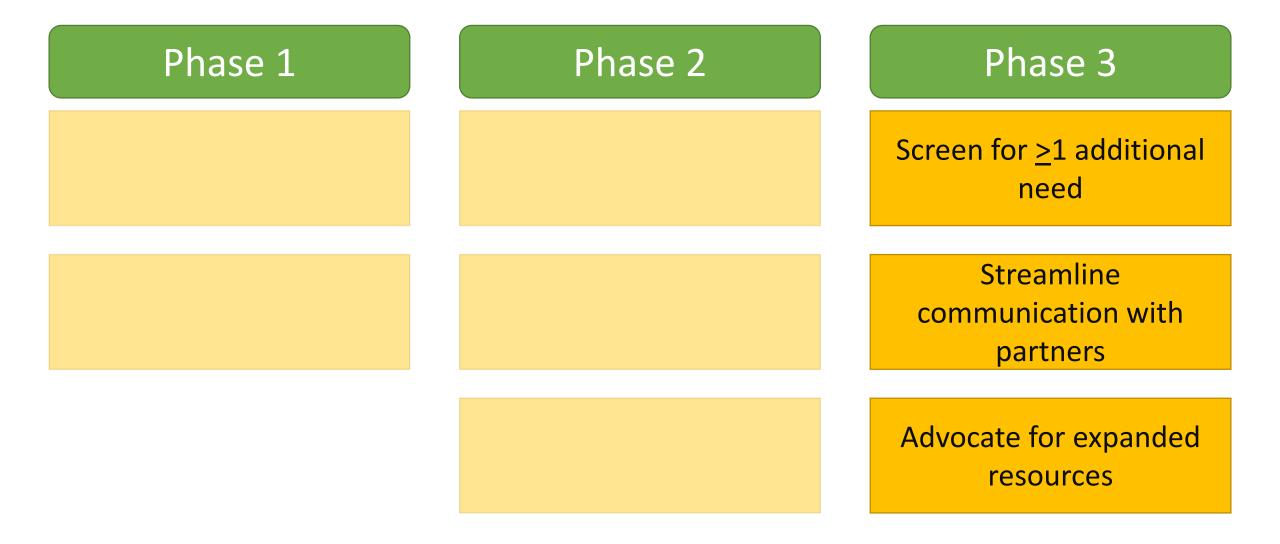
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### Strategies for Responding to Patient Social Needs

D Create Services In-House Form Coalitions and and Advocate for Advocate for Change **Community Resources** ORGANIZATIONAL RESOURCES Raise Awareness of SDOH Partner with Community Among Staff, Patients, Organizations to Provide Resources and Partners LOCAL COMMUNITY RESOURCES

## Barriers to Social Needs Screening

Tips from the PRAPARE Implementation Toolkit

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



How do we fit screening into our workflow without increasing visit time?



✓ MESSAGING SOLUTION

Use time when the patient is waiting anyway

Incorporate screening into other paperwork



#### **COMMON QUESTION**

What If We Do Not Have the Resources or Services to Address the Social Determinant Needs Identified? What Do We Do?



You have to start somewhere!

Social needs information will help you provide more effective medical care.

This information will help you find partners and opportunities for advocacy



#### **COMMON QUESTION**

How Do We Add Another New Initiative to Our Already Full Schedules and Responsibilities?



#### MESSAGING SOLUTION

Frame SN screening as an extension of other work, not as a BIG, NEW initiative

Move the conversation to SN screening organically

Find opportunities to tack SN screening onto existing processes

### Practice Challenge #4: Waning Enthusiasm

### CELEBRATE SUCCESSES

Plan a lunch, party, or other reward to recognize the achievement of goals (even small ones!)

#### ENCOURAGE FRIENDLY COMPETITION

Practice competitions or offering rewards for meeting goals can spark enthusiasm

#### **VISUALIZE THE DATA**

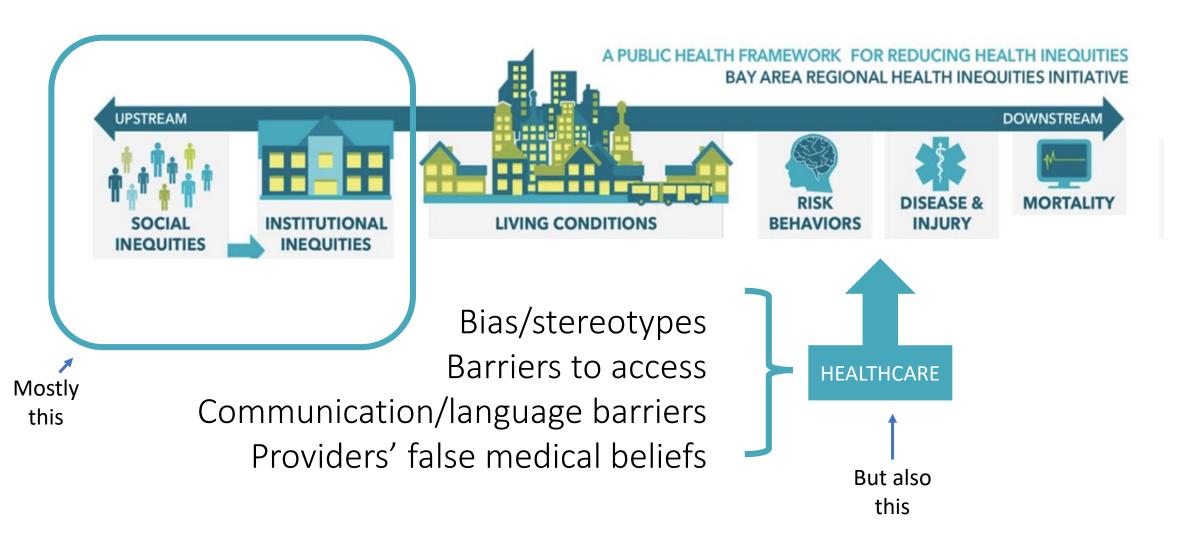
Dashboards, graphs, or infographics about screening results help engage staff, partners, and patients

#### APPLY LESSONS LEARNED

Making changes to the process based on experience and data keeps the work feeling relevant and fresh

# Other Approaches for Health Equity

### What Causes Health Inequities?



# Institute of Healthcare Improvement Framework for Healthcare Organizations to Achieve Health Equity

- Make health equity a strategic priority
- Develop structure and processes to support health equity work
- Deploy strategies to address the determinants of health on which they can have a direct impact
- Decrease institutional racism within the organization
- Develop partnerships with community organizations

# Applying the Health Equity Framework to ISP Building Blocks

Make health equity a strategic priority

(1) Leadership

- Develop structure and processes to support health equity work
- (2) Data driven QI

Deploy strategies to address the determinants of health on which they can have a direct impact

- (2) Data driven QI, (5) Pt & Fam engagement,
- (6) Pop management, (8) Access,
- (9) Comprehensive care & BH, Social needs, SUD
- Decrease institutional racism within the organization
- (4) Team based care, (5) Patient and family engagement, (6) Access

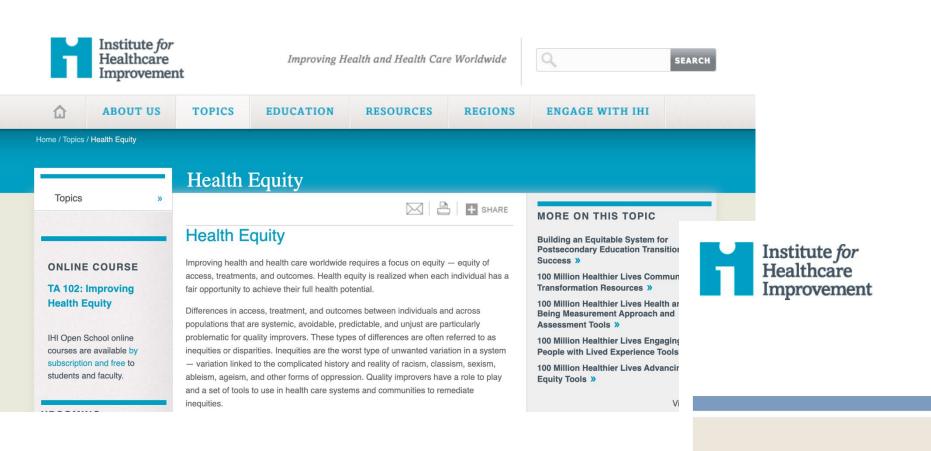
Develop partnerships with community organizations

(9) Comprehensiveness and Care Coordination, Social needs



Just kidding...ask away!

### Additional Health Equity Resources



Achieving Health Equity:

WHITE PAPER

A Guide for Health Care Organizations

### Additional Health Equity Resources

A Roadmap to Reduce Racial and Ethnic Disparities in Health Care



#### **Appendix: Best Practices to Reduce Disparities**

Finding Answers: Disparities Research for Change

Finding Answers: Disparities Research for Change



1	Practice	Rationale	Possible Strategies	Outcome
	Collect and stratify race, ethnicity, and language (REL) data in tandem with other equity efforts	REL data is an important part of reducing disparities, but it is not necessary to put all equity efforts on hold until REL data is available.	Use qualitative methods (e.g., surveys, interviews) to identify disparities if quantitative data isn't available.  Continue to foster a culture of equity across the organization while REL data collection is in progress.	Disparities efforts are not stalled.  The organization is primed to address disparities once REL-stratified data is available.
	Foster a culture of equity	Success is more likely if staff recognize that disparities exist within the organization and view inequality as an injustice that must be redressed.	Share feedback with providers and incentivize disparities reduction.  Include equitable health care as a goal in mission statements.  Build a work force that reflects the diversity of the patient population.	Staff, patients, and community members share a definition of equitable care and value equity in health care delivery.
			Institute a Community Advisory Board and develop ties with community-based organizations.	

### Additional Health Equity Resources

#### **ISSUE/DECISION - 4 P'S**

#### **PEOPLE**

Who is positively and negatively affected (by this issue) and how?

How are people differently situated in terms of the barriers they experience?

Consider physical, spiritual, emotional and contextual affects.

#### **PLACE**

What kind of positive "place" are we creating?

What kind of negative "place" are we creating?

How are public resources and investments distributed geographically?

How are you considering environmental impacts as well as environmental justice?

#### **Issue / Decision**

#### **PROCESS**

How are we meaningfully including or excluding people (communities of color) who are affected?

What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?

Are there empowering processes at every human touchpoint?

#### **POWER**

What are the barriers to doing equity and racial justice work?

What are the benefits and burdens that communities experience with this (issue)?

Who is accountable?

Source:
Balajee, Sonali S., et al., (2012).
Equity and Empowerment Lens (Racial Justice Focus), pg 28.
www.multco.us/diversity-equity

