Emerging Strategies to Address SDOH Through Community Referrals and Cross-Sector Partnerships

October 29, 2020

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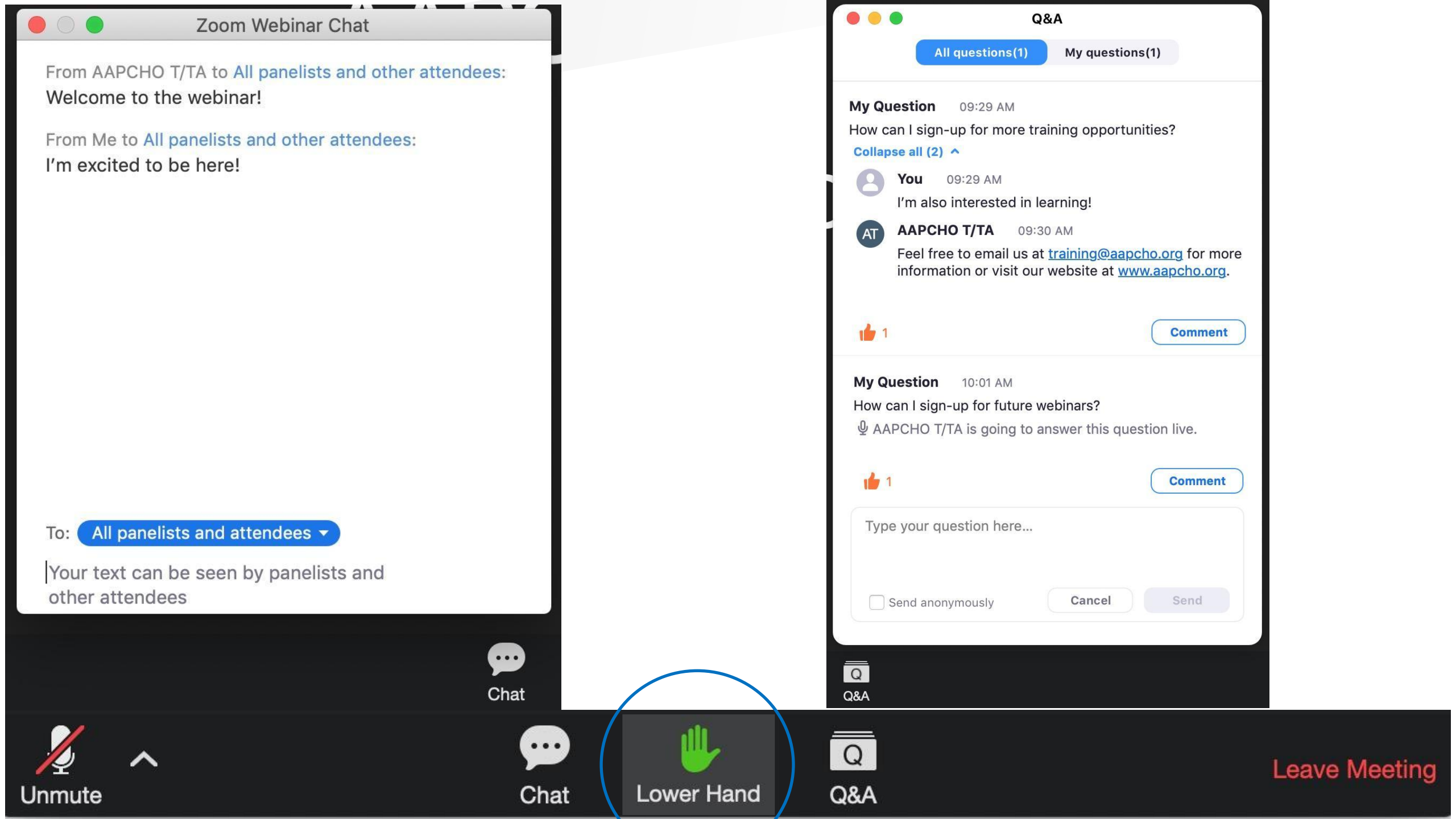
Housekeeping

- Webinar will be recorded
- Relevant resources and next steps will be emailed after
- Tips on Zoom and features for engaging with us and each other
- New realities: kiddos, furry friends, unstable internet, renovations, etc.


Zoom Webinar Chat
From AAPCHO T/TA to All panelists and other attendees:
Welcome to the webinar!
From Me to All panelists and other attendees:
I'm excited to be here!
To: All panelists and attendees
Your text can be seen by panelists and other attendees
Chat
Q&A
All questions(1)
My questions(1)
My Question 09:29 AM
How can I sign-up for more training opportunities?
Collapse all (2)
You 09:29 AM
I'm also interested in learning!
AAPCHO T/TA 09:30 AM
Feel free to email us at training@aapcho.org for more information or visit our website at www.aapcho.org.
1
Comment
My Question 10:01 AM
How can I sign-up for future webinars?
AAPCHO T/TA is going to answer this question live.
1
Comment
Type your question here...
Send anonymously
Cancel
Send
Unmute
Chat
Lower Hand
Q&A
Leave Meeting

Quick Polls

Get a sense of who is in the virtual room

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Agenda

Topic	Timing in EST
Opening and Housekeeping	4:00pm
Health Centers' Use of SDOH Data to Create Cross-Sector Partnerships • Yuriko de la Cruz, SDOH Manager, NACHC	4:05pm
Regional Approach for Cross-Sector Partnerships in Northern California • Artair Rogers, Director of Programs in California, Health Leads (CA)	4:10pm
Health Center Spotlight: Cross-Sector Partnerships for Upstream Change • Lynn Salazar-Wadford, Director of Care Management Services, Piedmont Health Services (NC) • Jennifer Medearis Costello, Consultant, Project Co-lead, EMBRACe Project at Chatham County Health Department (NC)	4:25pm
Panel Interview and Q&A • Albert Ayson, Jr., Associate Director of Training and Technical Assistance, AAPCHO	4:40pm
Closing and resources	4:55pm

Project Team at NACHC & AAPCHO

Michelle Proser
Director of Research
NACHC

Jason Patnosh
Associate VP, Partnership & Resource Development
NACHC

Rosy Chang Weir
Director of Research
AAPCHO

Joe Lee
Training and Technical Assistance Director
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Sarah Halpin
Program Associate
NACHC

Yuriko de la Cruz
SDOH Manager
NACHC

Vivian Li
Research Project Manager/Analyst
AAPCHO

Albert Ayson, Jr.
Associate Director, T/TA
AAPCHO

Today's Guest Speakers and Panelists

Artair Rogers, *Director of Programs, California*
Health Leads
(Los Angeles, CA)

Lynn Salazar-Wadford, *Director of Care Management Services*
Piedmont Health Services
(Chapel Hill, NC)

Jennifer Medearis Costello, *Consultant/Project Co-lead,*
EMBRACe Project at Chatham County Health Department
(Pittsboro, NC)

Acknowledgements

Support for this program was provided by a grant from the Robert Wood Johnson Foundation®

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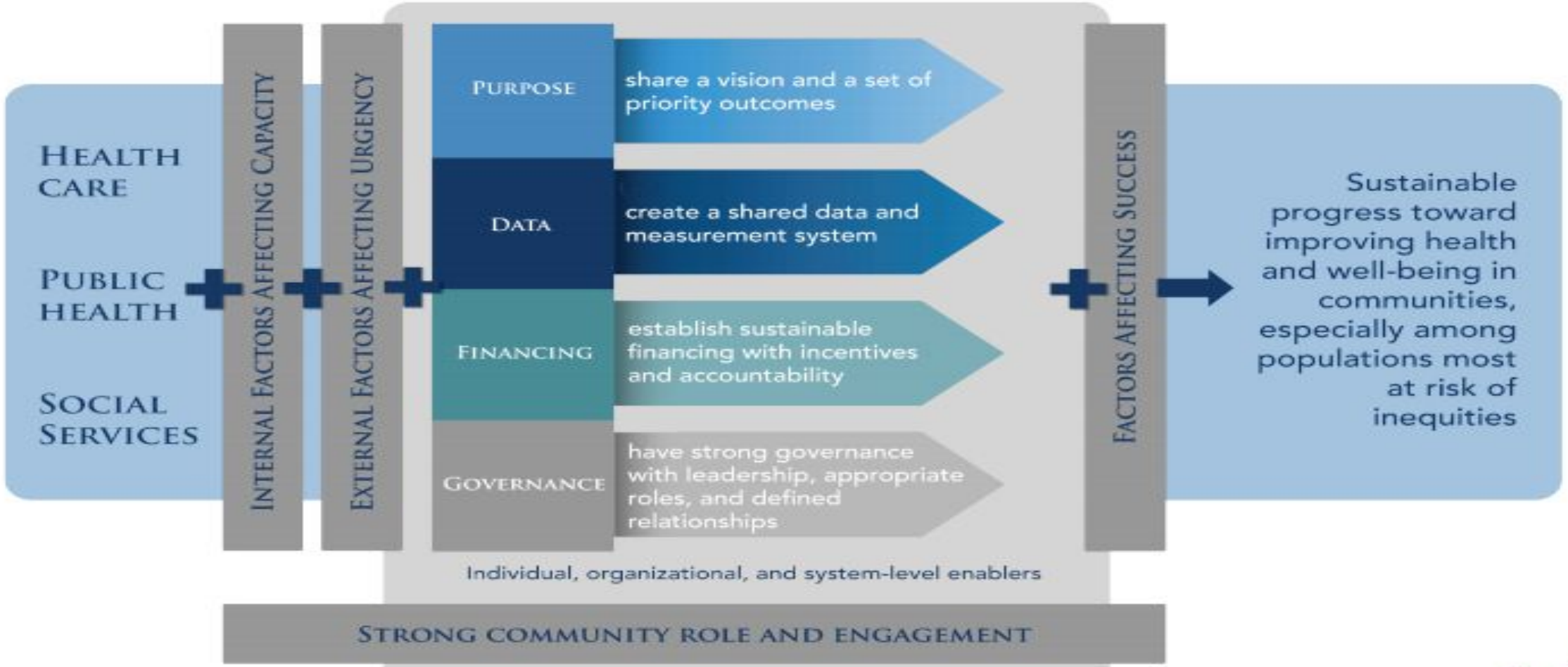
ALIGNING SYSTEMS FOR HEALTH
Health Care + Public Health + Social Services

CROSS-SECTOR ALIGNMENT THEORY OF CHANGE



Georgia Health Policy Center

Robert Wood Johnson Foundation

"Assessing and Addressing Social Determinants of Health During COVID-19" – Webinar Series

The goal of the series is to provide an overview, relevant updates, and promising practices on how community health centers are leveraging resources, including their workforce, technology, and external partners to assess and address their patients' SDOH needs. Moreover, health centers are using the SDOH data to develop new and/or stronger collaborations with community partners to provide social interventions during the COVID-19 pandemic.

"Assessing and Addressing Social Determinants of Health During COVID-19" – Webinar Series

Session #1: "Adapting SDOH Data Collection Workflows during COVID-19"

- Slides (click here)
- Webinar Recording (click here)

Session #2: "Practical Strategies for Social Risk Screening during COVID-19"

- Slides (click here)
- Webinar Recording (click here)

Health Centers' Use of SDOH Data to Create Cross-Sector Partnerships

Yuriko de la Cruz, NACHC

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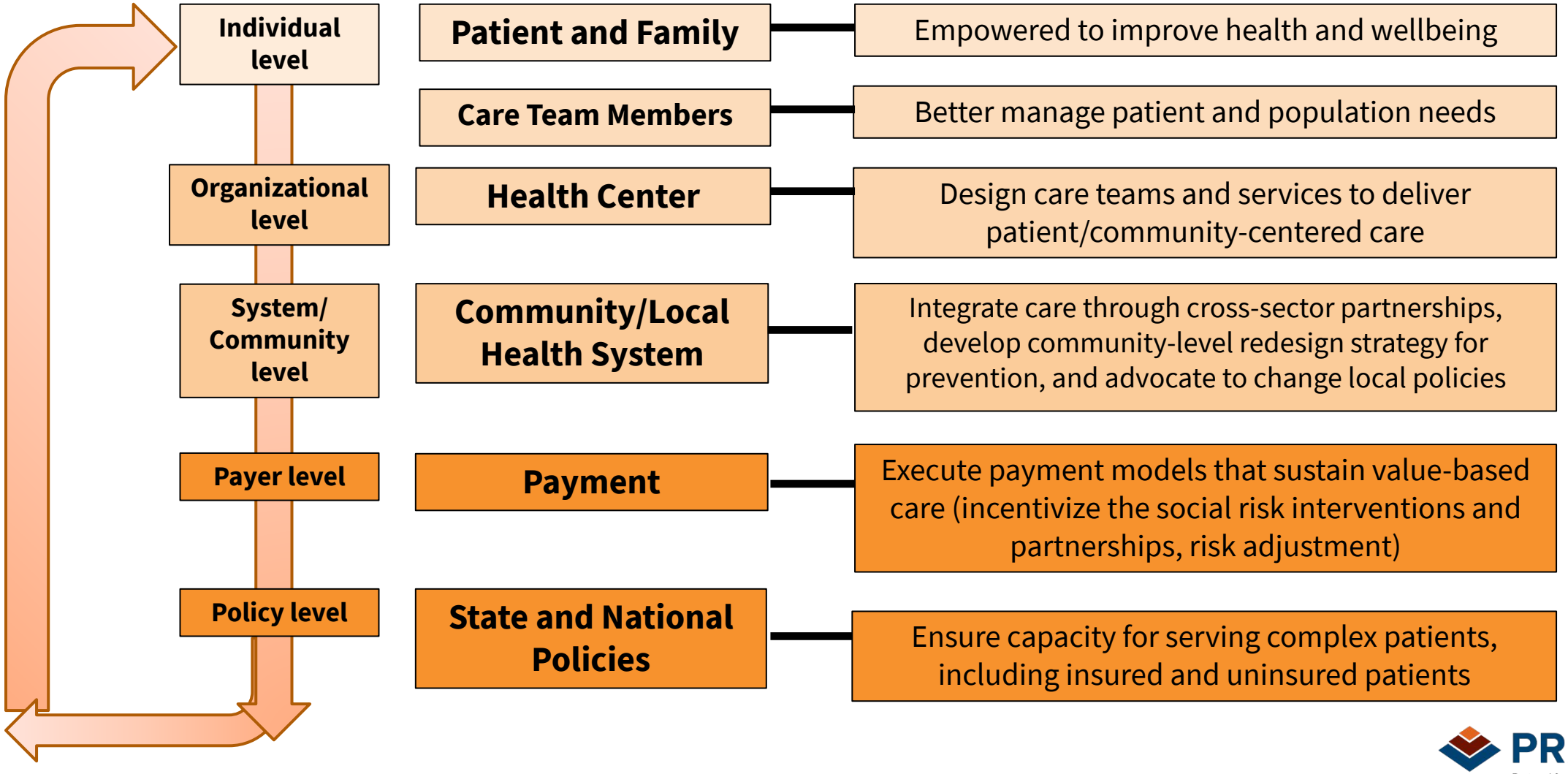
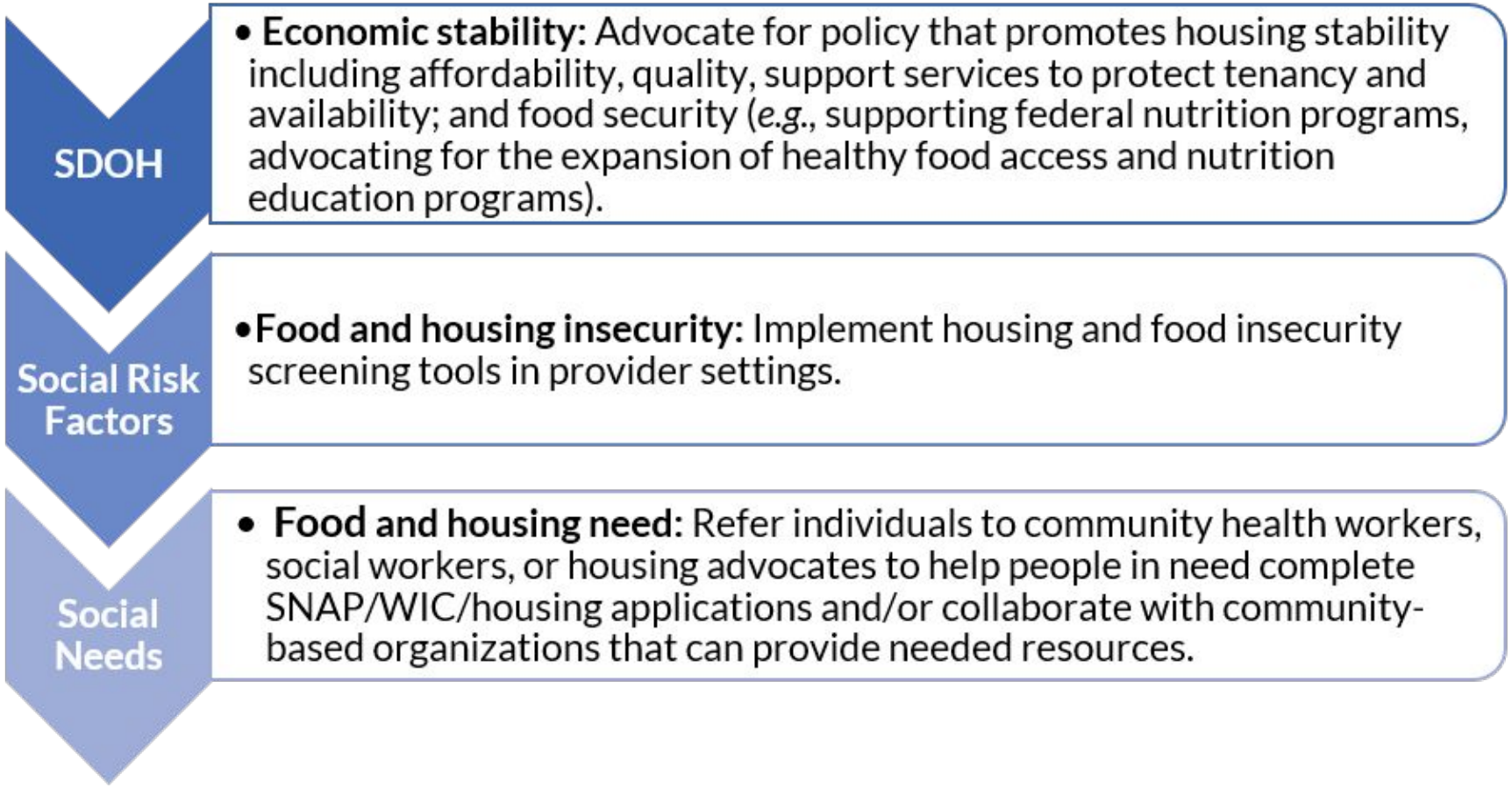
Why do Health Centers Collect Standardized Data on SDOH?



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Examples of interventions across the continuum



Source: Health Affairs https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/

Acting on SDOH Data

Indiana Primary Health Care Association

Indiana 211 Partnership

share referral information back to the health centers to close the referral loop

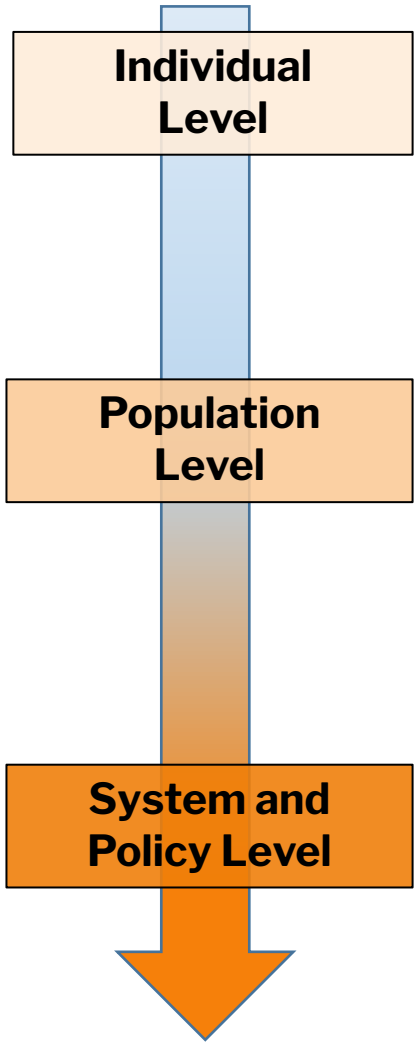
Michiana Health Information Network

aggregate data to share with local communities in assessing needs and allocating resources

Link: https://www.nachc.org/wp-content/uploads/2019/04/Round-One-Train-the-Trainer-Academy-Case-Studies.pdf

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Using PRAPARE Data to Improve Care Delivery and Health Outcomes



Individual Level	Build new or expand existing services in-house for same-day use as clinic visit (children's book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)	Ensure prescriptions and treatment plan match patient's socioeconomic situation (all)
Population Level	Build partnerships with local organizations (transportation partnerships)	Guide work of local foundations (ex: New York housing)
	Use for Population Segmentation/Risk Stratification	Streamline care management plans for better resource allocation (ex: Hawaii)
System and Policy Level	Inform health delivery redesign (ex: Medicaid and Medicare ACO discussions)	Calculate ROI for social determinant interventions and revenue generated from reducing no-show rates
	Use data for "seat at the table" with payers to discuss sustainable payment and APM	

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Regional Approach for Cross-Sector Partnerships in Northern California

Artair Rogers, Health Leads

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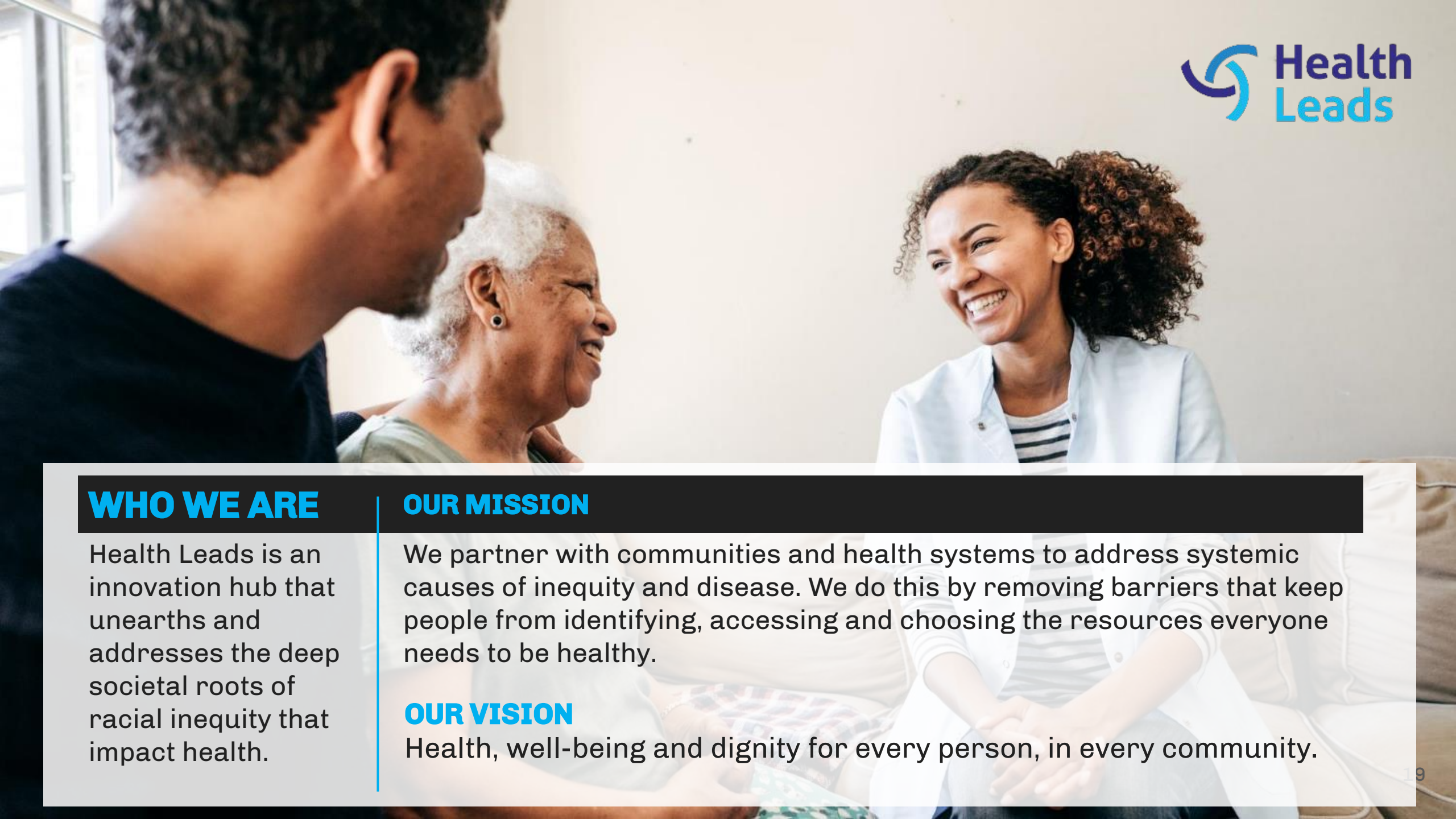
Health Leads Respond and Rebuild Approach to the COVID-19 Crisis

Health Leads

October 2020



WHO WE ARE

Health Leads is an innovation hub that unearths and addresses the deep societal roots of racial inequity that impact health.

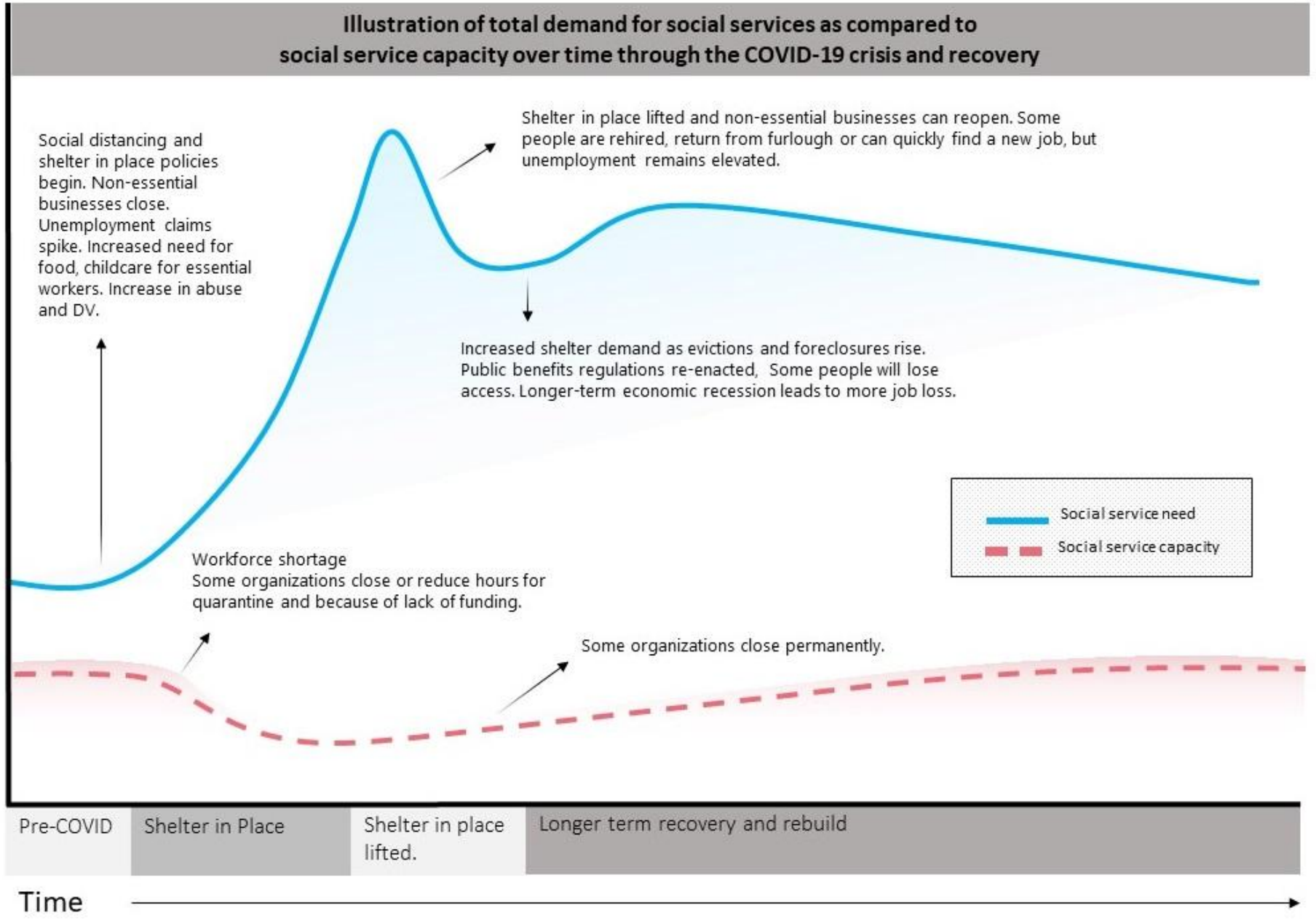
OUR MISSION

We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

OUR VISION

Health, well-being and dignity for every person, in every community.

The Crisis: Essential Needs



Sheltering in place for COVID-19 will drive dramatic increases in the demand for essential resources (food, housing, mental health services).

Each intervention (school closures, non-essential employees, reduction in hours) weakens the already fragile social safety net.

Demand for access to social essential resources is at critical levels now.

Connecting to resources is becoming harder due to changing landscape and shelter-in-place orders.

Full post:
https://healthleadsusa.org/communications-center/blog/flattening-the-next-covid-19-curve/
See slide 23 for "story behind the curve"

Our Focus: Respond Now, Rebuild for an Equitable Future

Deep community engagement allows us to both deliver critical essential resources now and restructure our systems to address societal roots of racial inequity that impact health.

Respond

Enable faster, equitable and more coordinated access and connection to essential resources (e.g. food, mental health services, childcare)

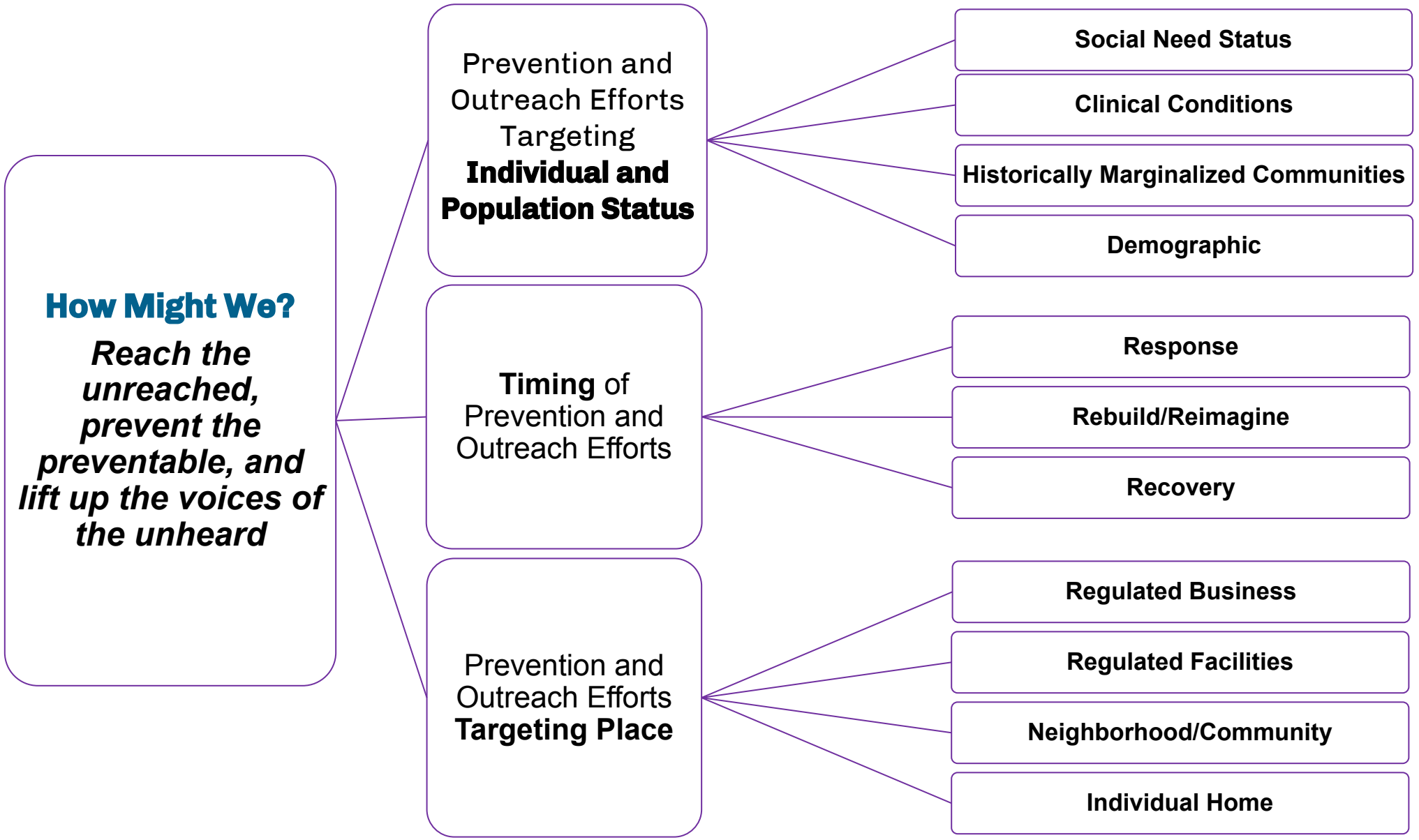
Offer real-time learning, collaboration opportunities, data & analysis to support immediate needs

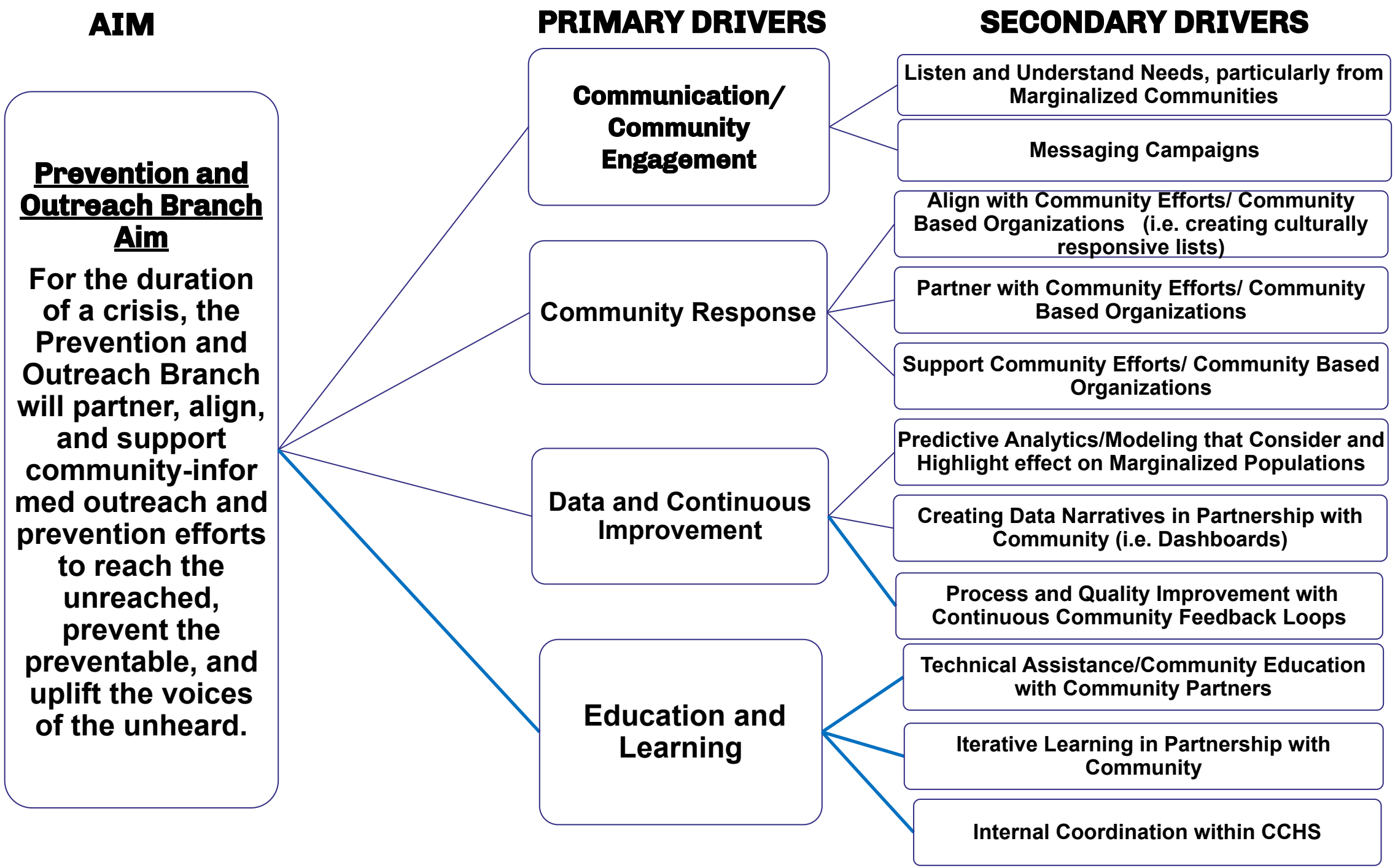
Rebuild

Create crisis-resilient, sustainable essential resource networks that enable community organizations to work together to both react effectively to immediate needs and proactively build health

Share learnings and data to support and

The Question at Hand




AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
Prevention and Outreach Branch Aim
For the duration of a crisis, the Prevention and Outreach Branch will partner, align, and support community-infor med outreach and prevention efforts to reach the unreached, prevent the preventable, and uplift the voices of the unheard.
Communication/ Community Engagement
Community Response
Data and Continuous Improvement
Education and Learning
Listen and Understand Needs, particularly from Marginalized Communities
Messaging Campaigns
Align with Community Efforts/ Community Based Organizations (i.e. creating culturally responsive lists)
Partner with Community Efforts/ Community Based Organizations
Support Community Efforts/ Community Based Organizations
Predictive Analytics/Modeling that Consider and Highlight effect on Marginalized Populations
Creating Data Narratives in Partnership with Community (i.e. Dashboards)
Process and Quality Improvement with Continuous Community Feedback Loops
Technical Assistance/Community Education with Community Partners
Iterative Learning in Partnership with Community
Internal Coordination within CCHS

Health Leads

Savior-Designed System

Originally designed to rescue, save, and deliver services to "vulnerable" communities by members of the oppressing community

Do not consider the root causes and institutions that make the population vulnerable in the first place

Have policies and practices that harm specific racial groups while benefiting others

Are impacted by segregation and division, which often results in habits, policies, and institutions that are not explicitly designed to discriminate.

Ally-Designed System

Focused on building self-awareness among the oppressing group while partnering with oppressed groups to spark change.

Intend to identify and challenge institutional and systematic oppression; and,unite with disparity groups to create a system dedicated to respect, and equality

Recognize that individuals' unique circumstances and social conditions need to be factored into health care decisions

Reflect on points of privilege, and oppression to inform additional perspectives needed "at the table"

Equity Empowered System

Truly equitable health care requires purposefully reconstructing systems that are rooted in and advance equity of the historically marginalized group

Accept racism and other forms of oppression that adversely impact systems of care

Place specific emphasis on addressing unique needs and root causes of inequitable outcomes

Share power by not only ensuring diverse representation, but also redistributing resources to establish equitable decision-making

Source: National Institute for Children's Health Quality

Staff, NICHQ. "From Savior-Designed to Equity-Empowered Systems." NICHQ, 2020 National Institute for Children's Health Quality., 29 Apr. 2020, www.nichq.org/insight/savior-designed-equity-empowered-systems?utm_campaign=Newsletters.

Contra Costa Covid-19 Social Needs Task Force

Timeline of Meetings

Inaugural Meeting

- Introduced problem statement
- Shared hopes for how we work together
- Identified needs/barriers and assets/opportunities related to Covid-19 response

2nd Meeting

- Revisited problem statement and reviewed drafts of Task Force's purpose and proposed short-term goals to offer feedback

3rd Meeting

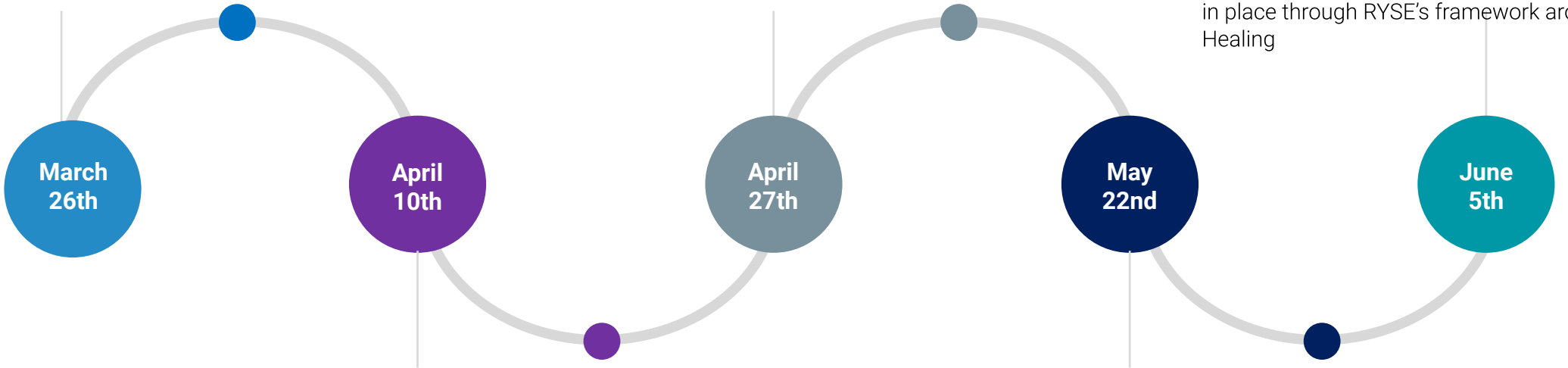
- Ratified revised problem statement, purpose, and goals that included explicit emphasis on equity as well as our core values
- Centered discussion around presentations by leads of leading activities connected to our developing goals

4th Meeting

- Began weaving in threads from West and Central & East Community Care Calls by way of community updates Engaged in a group dialogue around questions to better understand how we might ultimately cede and seed power to and within community

5th Meeting

- Held space to uplift Black voices
- Made space for hope by inviting NAACP Richmond Chapter President to speak on the long arc of systems change and contextualizing the system of oppression in place through RYSE's framework around Trauma & Healing



Problem Statement

Flattening the curve for Covid-19 has major implications on demand for social needs. Each intervention (closing schools, non-essential employees, reduction in hours) will put additional strain on the already fragile social safety net and disproportionately impact vulnerable communities and historically marginalized populations.

Essential Health Resource Network

What: Bay Area Essential Resource Network (i.e. Community Information Exchange)

Cultivate a network of partners that employ a centralized resource database within an integrated technology infrastructure to improve community health and well-being by uplifting community-driven solutions to enhance access to essential resources.

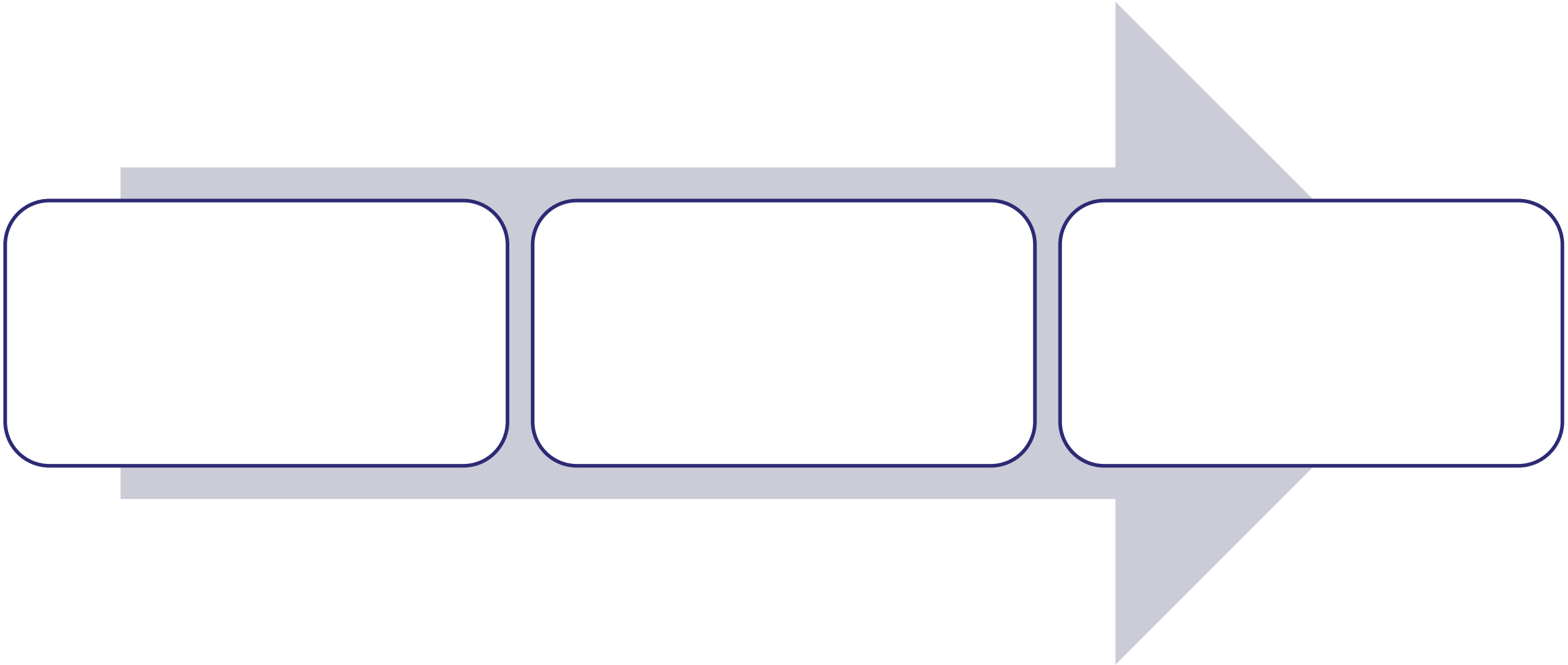
Where: Beginning in Contra Costa County, California, with plans for a regional approach including surrounding counties.

How:

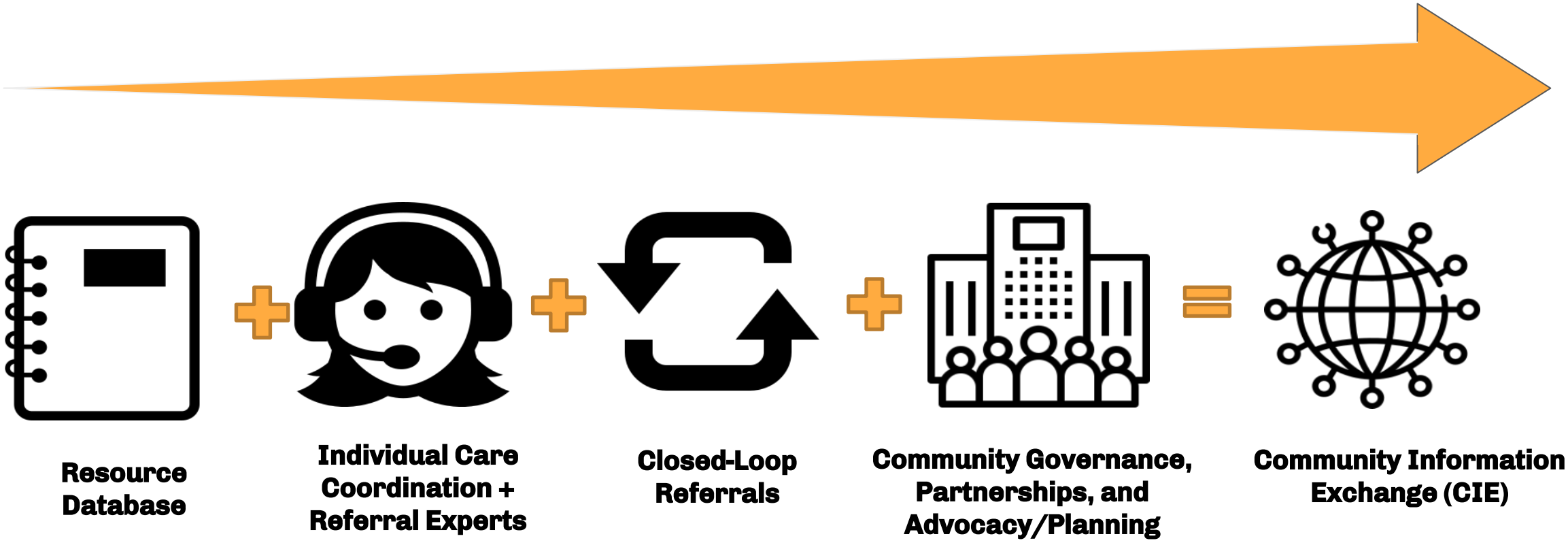
- Building a Foundation of Trust
  - Strengthen existing relationships by forming new connections
  - Perform individualized community stakeholder engagement
- Coalescing Consensus Around Tools & Processes
  - Determine a technology platform that allows for interoperability and data collection
  - Develop sustainable processes for maintaining a comprehensive resource database
- Centering Community
  - Establish a governance structure and legal framework that protects and elevates community

Spread: In addition to the phased expansion across Bay Area counties, we are in deliberations around two novel regions. Knowledge curated from these efforts will serve as a model for replication and continued innovation both regionally and nationally.

Our Glide Path



Components of the Community Information Exchange



Resource Database

Individual Care Coordination + Referral Experts

Closed-Loop Referrals

Community Governance, Partnerships, and Advocacy/Planning

Community Information Exchange (CIE)

ANTI-RACISM FOCUS
(centering the experiences, needs, and perspectives of the historically underinvested and historically underrepresented)

CHANGING THE STATE OF SOCIAL NEED INTERVENTIONS

CURRENT STATE

- Addresses agenda that is created by anchor institutions and CBOs without community input
- Historically underinvested and underrepresented parts of the community are not represented
- Works with larger CBOs with more resources; smaller CBOs that directly work with community members are often left out
- Lack of community participation, particularly with technology solutions, leads to barriers in acceptability and adoptability
- Focuses on resource connections instead of root causes
- Measures align with interests of institutional power

FUTURE STATE

- Addresses a co-developed community agenda
- Facilitates a true investment into the most marginalized aspects of the community
- Facilitates investment into CBOs that directly serve for the most marginalized in the community.
- Community awareness and participation, particularly regarding technology (right people are at the table)
- Explicitly calls out and illustrates the role of structural racism and inequity within a local context
- Measures align with community's interests; data democratization approach

The Pathway to a Community Information Exchange

Steps to developing a community information exchange

I

Identify the CIE's Vision and Governance

Do all stakeholders (healthcare, CBOs, SSOs, etc.) believe there is a need for this? If so, what is the share aim/community vision for what this effort will accomplish? What data needs to be collected? Who should own and manage the shared data?

M

Mobilize the Community Network

Who should be engaged as partners and participants of this effort? What are the shared vision and values required for this group. What are the roles and responsibilities associated with partners and participants for this network? What characteristics and capabilities would indicate an individual organization's readiness to participate?

P

Prepare a Legally Compliant Framework

Establish data sharing agreements, ensuring adequate security and privacy measures.

A

Adopt Interoperable and Scalable Technology

Identify and adopt technology platform with ability to integrate with existing data systems, and address the community networks' specific data collection needs

C

Cultivate Sustainability

Long term strategy to ensure the sustainability of program including a clear understanding of how much it actually costs to effectively run the program, development of payment models and evidence backed value propositions across stakeholders.

T

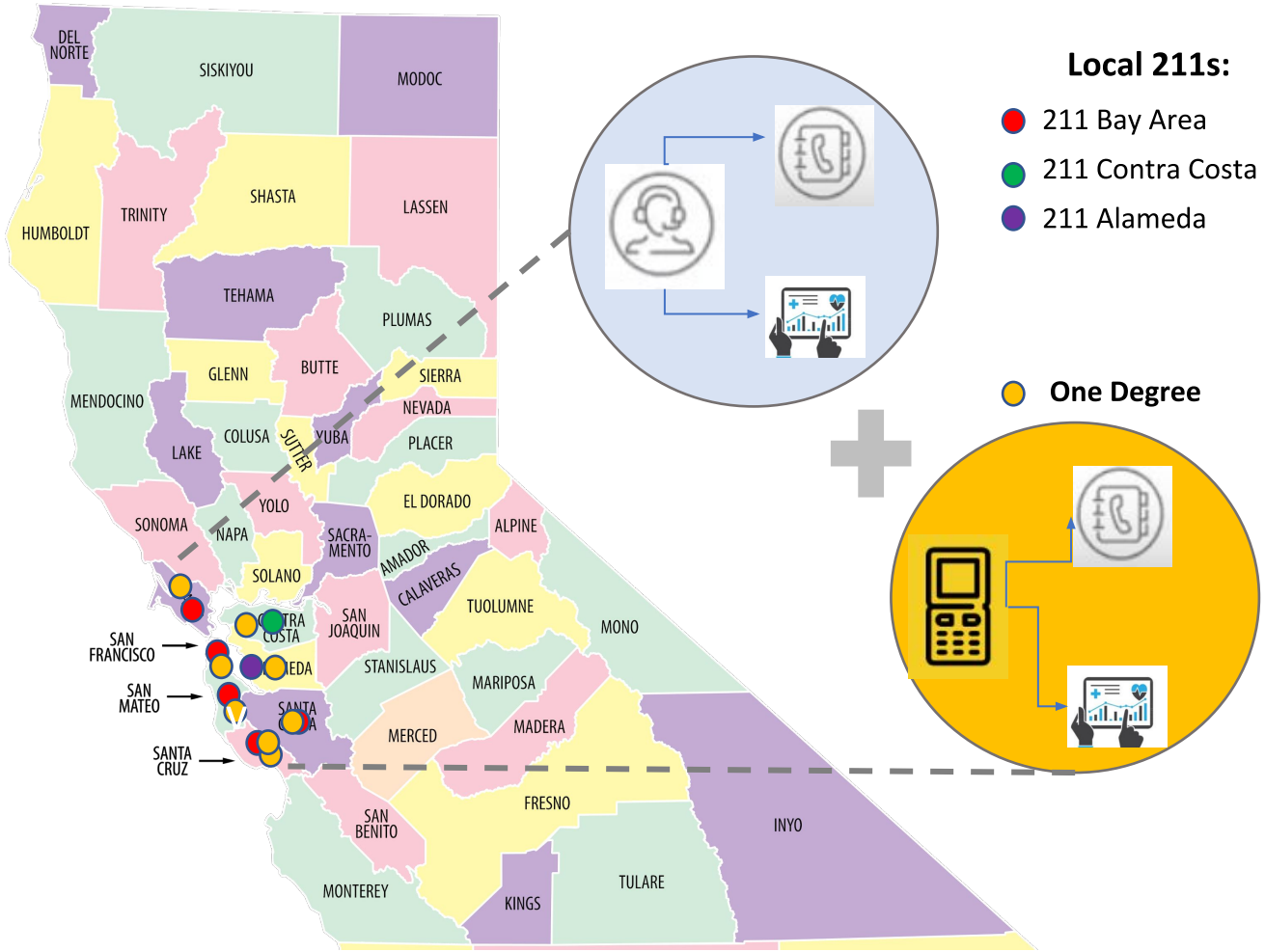
Transform the Movement

Leverage resulting data for Advocacy; as a tool for shaping the local conversation around policy and public awareness.

Source: 211 San Diego/CIE Toolkit "Collaboration and Cross Sector Data-Sharing to Create Healthier Communities, November 2018

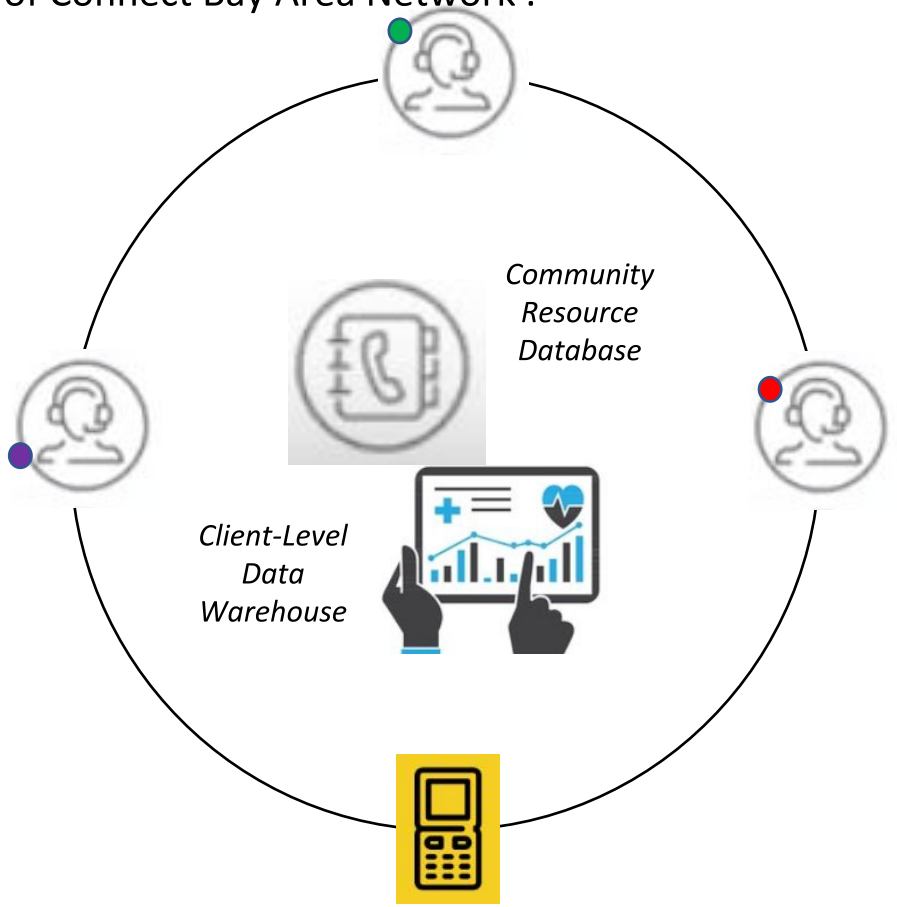
Current Situation and Opportunity

Today, the Connect Bay Area Network members act independently to service the needs of individuals across 7 counties, leveraging their own client interface (211 call center, web interface), community resource database, and collecting their own client data.



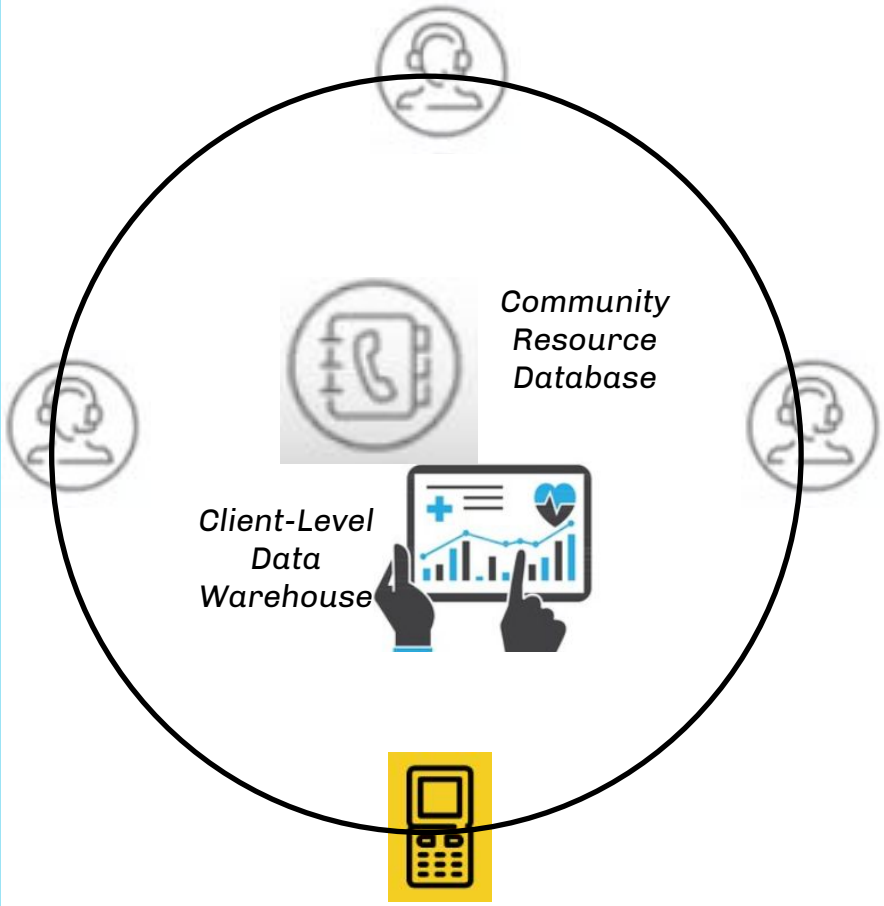
Building the Connect Bay Area Network

A deeper partnership amongst Connect Bay Area Network participants which includes the shared ownership and governance of community resource data and client data could increase the collective bargaining power of Connect Bay Area Network .



The Value of a Regional Approach to Data Sharing

Proposed Regional Approach



Benefits to a Regional Approach to Data Sharing

Community Resource Data

- Ability to leverage best practices around community resource data collection, maintenance, and management
- Differentiation of community resource data leads to higher quality (and usability) of data

Client-level Data

- Standardization of data collection methods/practices upon client intake enables easier interoperability of data sets across organizations.
  - ❖ CIE Tools for Consideration/Adoption:
    - — Screening Tool (e.g., 211 SD's Comprehensive Social Continuum Assessment)
    - — Client Consent for Broadscale Data Sharing
- A broader client data warehouse composed of client-intake information and activity across counties enhances the collective's ability to appeal to initiators of a CIE seeking to recruit primary partners.

Implications for a CIE

- Consolidated regional database with consistent methods for maintenance to ensure optimal usability of community resource information
- Ability to manage the client datasets of a broad geographic regions enables builders of CIEs to leapfrog the gradual dataset build process associated with building individual client records from the ground up within the CIE
- Various Client-Level Warehouse could contribute to CIE records to ensure a fuller picture of clients across multiple regions which could appeal to larger funders (e.g., insurance plans, large healthcare system, city government) who are seeking to leverage information for a broader client base that spans multiple counties.
- Learning collaboratives could be established to share findings, process improvement activities, community engagement approaches, and evaluation methods.

Questions?

Health Center Spotlight: Cross-Sector Partnerships for Upstream Change

Lynn Salazar-Wadford, Piedmont Health Services

Jennifer Medearis Costello, EMBRACe Project at Chatham County Health Department

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Piedmont Health Services

PIEDMONT HEALTH

EMBRACe

Equity for Moms and Babies Realized Across Chatham

Relationships

Now and in our emerging strategies

- **With the individual patient**
  - Able to connect in a way that encourages identification of issues
- **With the community**
  - Identifying dedicated people who have a connection to the community
- **With(in) the organization**
  - A colleague who all clinicians can turn to when a patient needs referrals

- **With the patient:**
  - The most impactful services
  - Guided / identified by community voice / experiences
- **With the community**
  - Shared goals, shared vision
  - Begin with improving / expanding what we know is working
- **Within the organization**
  - Equity and trauma-informed work training

Panel Interview and Q&A

Albert Ayson, Jr., AAPCHO

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Panel Interview

Upstream Prevention and Policy Change

- How can your experiences with cross-sector collaboration work towards sustainable, upstream prevention?

Data Strategy & Sharing

- How can data help cross-sector collaborations identify priorities and develop strategies?
- How does your organization approach data sharing with cross-sector partners?

Questions from the audience

Questions & Discussion

Next Steps

- Webinar recording and slides will be posted
- Office hours will be launched soon
- Please complete evaluation
- Share topics for future webinars

PRAPARE Related Resources

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Association of Asian Pacific Community Health Organizations

PRAPARE IMPLEMENATION AND ACTION TOOLKIT

www.nachc.org/prapare

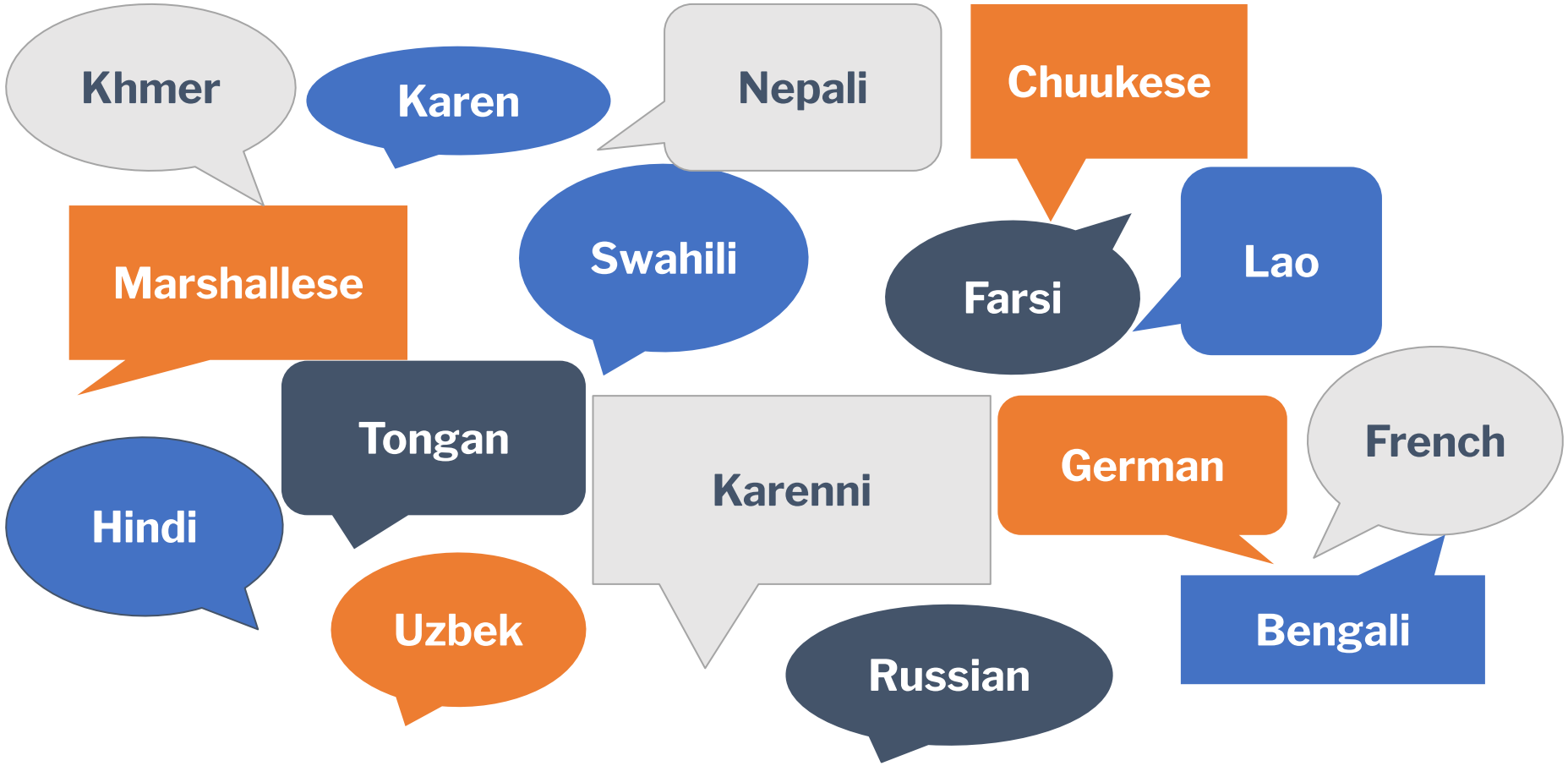
- Chapter 1: Understand the PRAPARE Project
- Chapter 2: Engage Key Stakeholders
- Chapter 3: Strategize the Implementation Process

- Chapter 4: Technical Implementation with EHR Templates
- Chapter 5: Develop Workflow Models
- Chapter 6: Develop a Data Strategy
- Chapter 7: Understand and Evaluate Your Data

- Chapter 8: Build Capacity to Respond to SDH Data
- Chapter 9: Respond to SDH Data with Interventions
- Chapter 10: Track Enabling Services

PRAPARE is Now in 26 Languages!

- **Validated at community health centers for comprehension and cultural competence**
- **New additions include:**



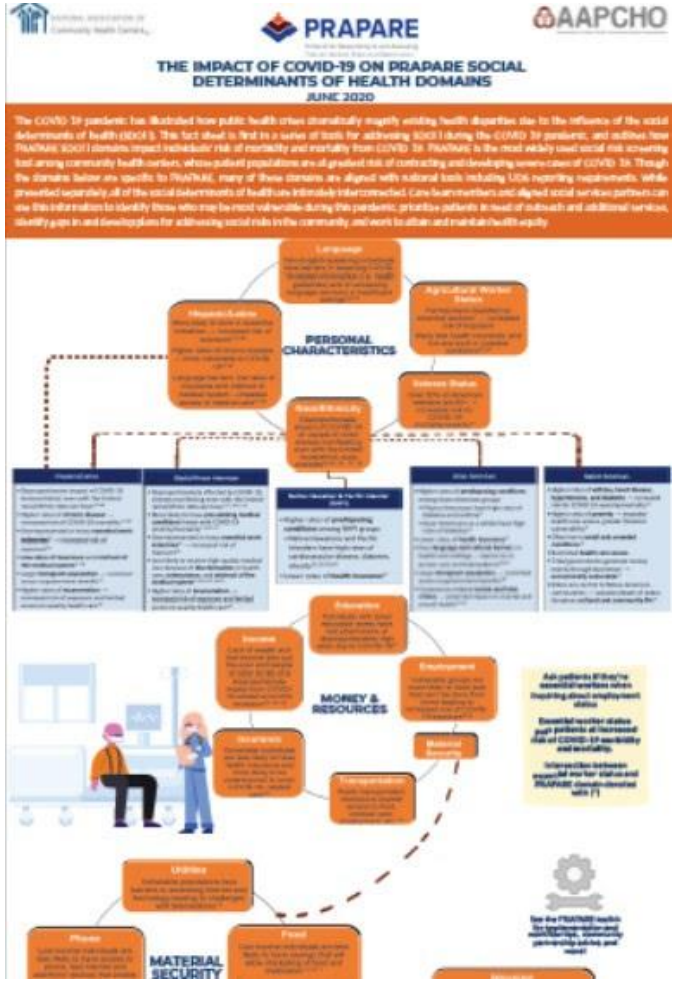
PRAPARE SDOH & COVID-19 Fact Sheet

NEW

Fact Sheet: The Impact of COVID-19 on PRAPARE Social Determinants of Health Domains

This fact sheet outlines how PRAPARE SDOH domains impact individuals' risk of morbidity and mortality from COVID-19. Care team members and aligned social service partners can use this information to identify those who may be most vulnerable during the pandemic, prioritize patients in need of outreach and additional services, and develop plans for addressing social risks in the community.

Access now: Printer-friendly version available here!



We appreciate your time and commitment!

Have any questions or feedback?

E-mail: prapare@nachc.org
Website: www.nachc.org/prapare

Twitter: @prapare_sdoh
Join our Listserv