Addressing the Social Determinants of CVD in EvidenceNOW Southwest

Peer Learning Workshop August 2018

UNM HEALTH SCIENCES CENTER
HERO
HEALTH EXTENSION RURAL OFFICE
OFFICE FOR COMMUNITY HEALTH

Practice Improvement Teams in ENSW

- Practice Facilitator (QI expertise)
- Clinical HIT Advisor/CHITA (HIT expertise)
- Health Extension Regional Officers/HEROs

  (community health improvement expertise)

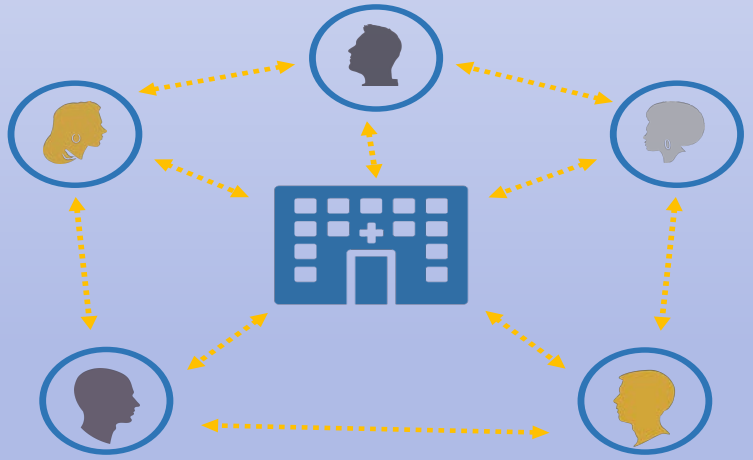
ENSW ENHANCEMENTS

Community-Developed Tools

Community-Developed Tools

Through an innovative community-engaged process called "boot camp translation," two communities in New Mexico worked for almost a year to create culturally-relevant patient materials surrounding the topic of cardiovascular disease. These materials are available free-of-charge to your practice, and can be ordered through your local health extension officer (HERO), who will work with you on discovering which materials may work best in your practice, creating a plan for how best to utilize the materials, and setting up a time frame for checking in to see if patients are resonating with the materials.

Patient Engagement



Patient Engagement

A key component of a patient-centered medical home is to have a patient engagement strategy. Patient engagement can be as simple as carrying out a patient experience survey and as robust as establishing a patient advisory council. Patient engagement provides a mechanism for receiving and responding to input, leads to increased understanding and cooperation, and supplies a link between the practice and its surrounding community. It can provide respectful and effective partnerships and offer a forum for developing creative, cost-effective solutions to problems and challenges.

EvidenceNOW SOUTHWEST

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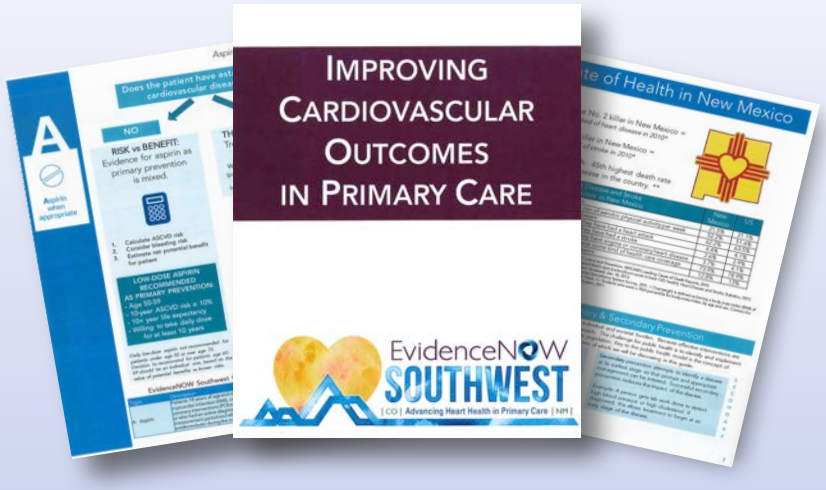
Academic Detailing



Academic Detailing

This innovative outreach education technique helps clinicians provide the latest evidence-based care to their patients. Using an accurate, up-to-date synthesis of the best clinical evidence in an engaging format, local HEROs will work with your practice facilitator to deliver the latest evidence on preventing cardiovascular disease, using guidelines that align with national initiatives such as the Million Hearts campaign's ABCS (**A**spirin when appropriate, **B**lood pressure control, **C**holesterol management and **S**moking cessation).

Social Determinants

Social Determinants

Research has demonstrated that while health care access and quality account for roughly 20% of health, social determinants – the conditions in which we are born, grow-up, live, work, and age—have a tremendous impact on the prevention and management of chronic conditions, including cardiovascular disease. As part of the tripod improvement team, HEROs can support practices in developing or expanding activities, services, and partnerships aimed at having a greater impact on heart health, in both clinical and community settings.

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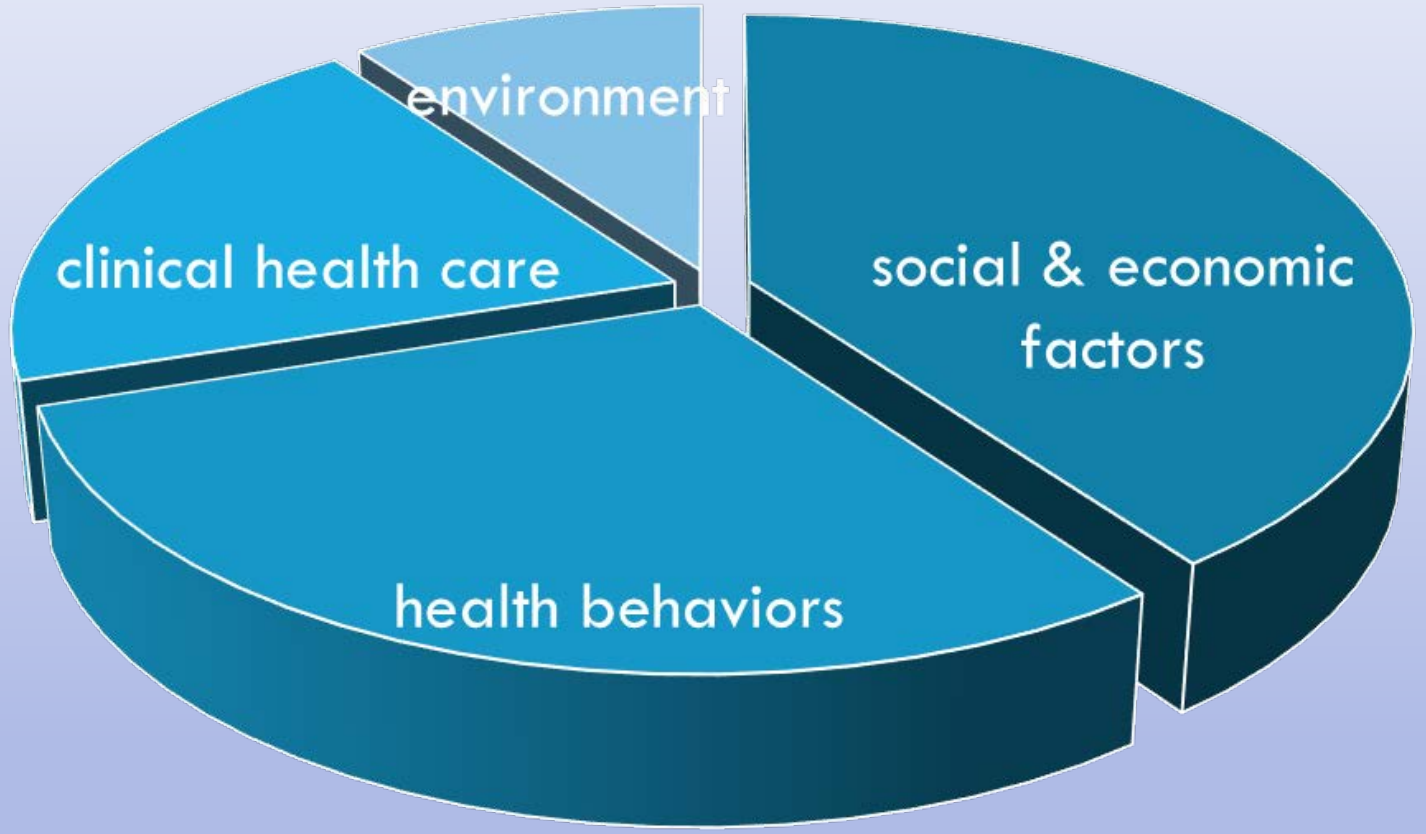
Social Determinants of Health

- Indigenous ancestry
- Early life
- Education
- Employment & working conditions
- Social inclusion
- Income & its distribution
- Food security
- Gender
- Geography
- Health care services
- Housing
- Disability
- Immigrant status

Source: Raphael, 3rd ed

Social Determinants of Health



Modifiable CVD Risk Factors

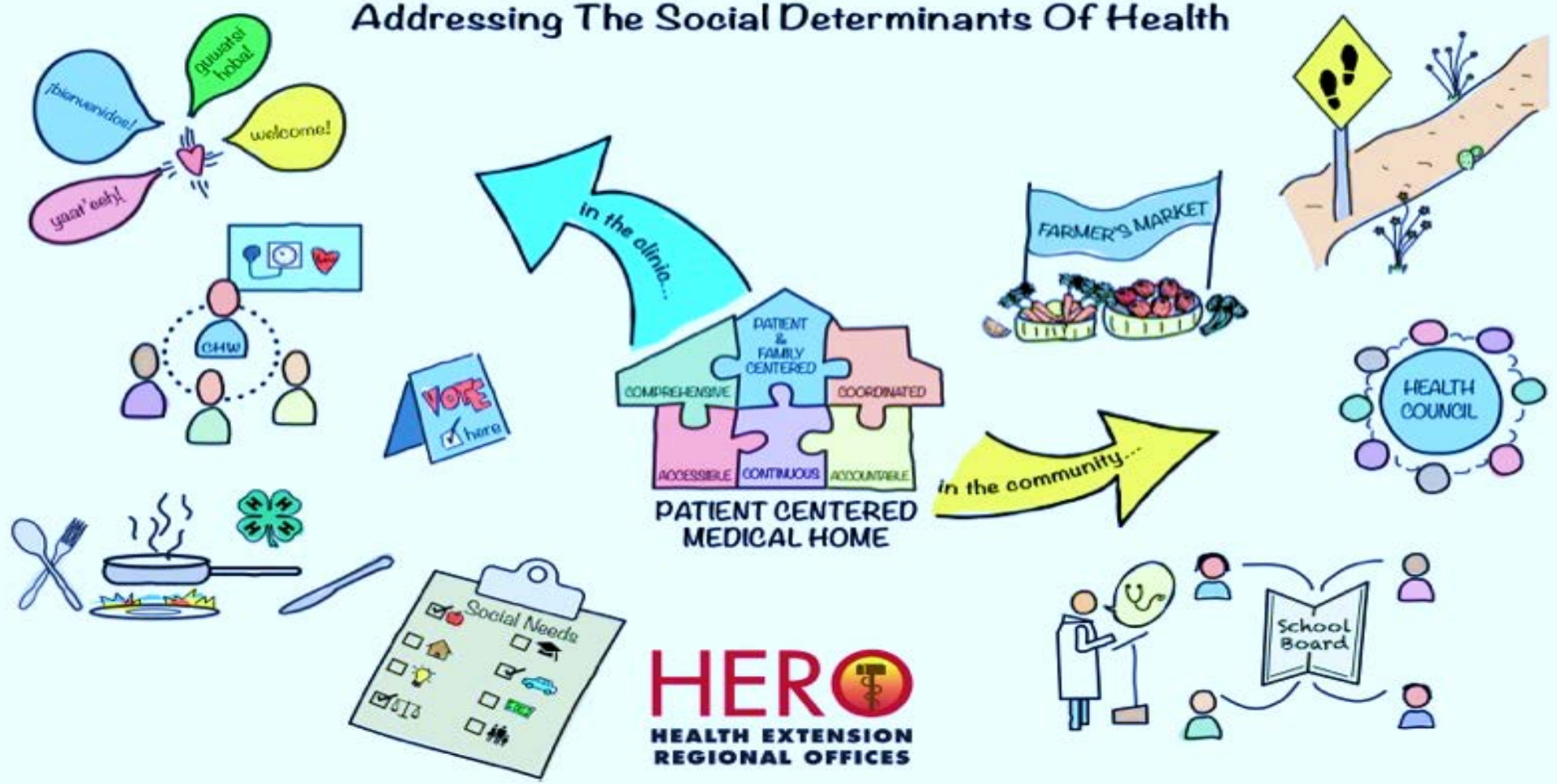
- Hypertension
- High Cholesterol
- Diabetes
- Obesity
- Physical Inactivity

- Diets high in saturated fats, cholesterol, sodium
- Low consumption of fruits & veggies
- Tobacco use
- Exposure to 2nd hand smoke
- Excessive alcohol use

Additional Risk Factors for CVD Prevention & Management

- Poverty
- Toxic Stress (ACEs, violence, oppression)
- Intergenerational Trauma
- Developmental Origins of Adult Disease (DoAD)
- Social isolation and alienation
- Social determinants of available ‘lifestyle choices’

Beyond Patient-Centered Medical Home: Addressing The Social Determinants Of Health



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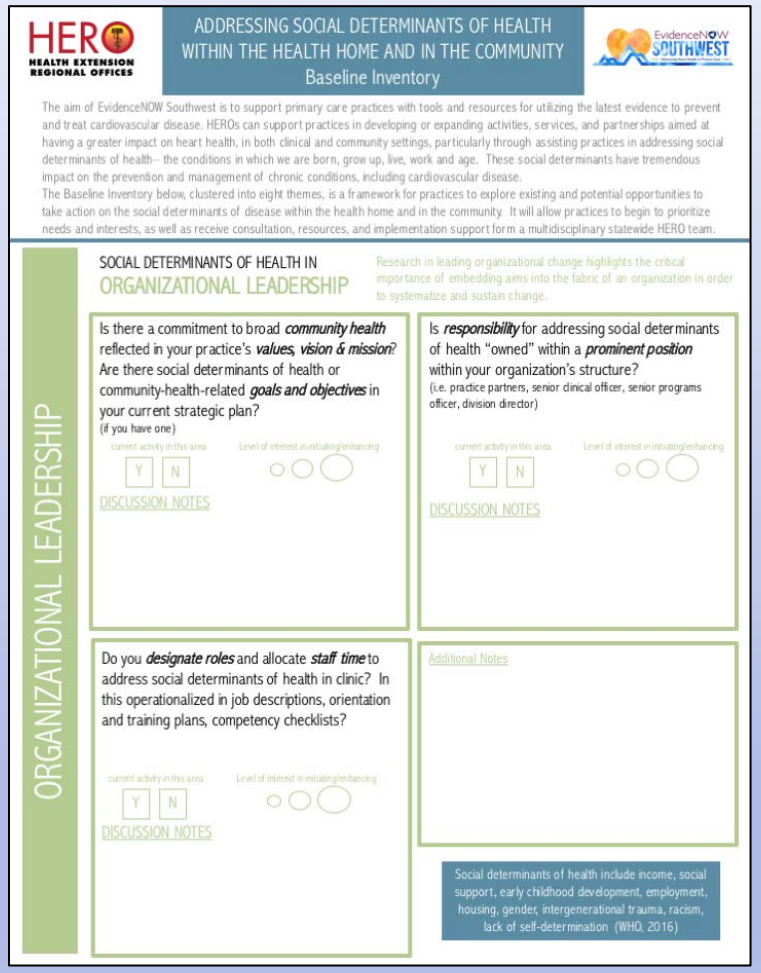
SDH Baseline Inventory

HERO



HERO HEALTH EXTENSION REGIONAL OFFICES

ADDRESSING SOCIAL DETERMINANTS OF HEALTH WITHIN THE HEALTH HOME AND IN THE COMMUNITY
Baseline Inventory

EvidenceNOW SOUTHWEST

The aim of EvidenceNOW Southwest is to support primary care practices with tools and resources for utilizing the latest evidence to prevent and treat cardiovascular disease. HEROs can support practices in developing or expanding activities, services, and partnerships aimed at having a greater impact on heart health, in both clinical and community settings, particularly through assisting practices in addressing social determinants of health– the conditions in which we are born, grow up, live, work and age. These social determinants have tremendous impact on the prevention and management of chronic conditions, including cardiovascular disease.
The Baseline Inventory below, clustered into eight themes, is a framework for practices to explore existing and potential opportunities to take action on the social determinants of disease within the health home and in the community. It will allow practices to begin to prioritize needs and interests, as well as receive consultation, resources, and implementation support form a multidisciplinary statewide HERO team.

ORGANIZATIONAL LEADERSHIP

SOCIAL DETERMINANTS OF HEALTH IN
ORGANIZATIONAL LEADERSHIP

Research in leading organizational change highlights the critical importance of embedding aims into the fabric of an organization in order to systematize and sustain change.

Is there a commitment to broad *community health* reflected in your practice's *values, vision & mission*? Are there social determinants of health or community-health-related *goals and objectives* in your current strategic plan?
(if you have one)
current activity in this area: Y N
Level of interest in initiating/enhancing:
DISCUSSION NOTES

Is *responsibility* for addressing social determinants of health "owned" within a *prominent position* within your organization's structure?
(i.e. practice partners, senior clinical officer, senior programs officer, division director)
current activity in this area: Y N
Level of interest in initiating/enhancing:
DISCUSSION NOTES

Do you *designate roles* and allocate *staff time* to address social determinants of health in clinic? In this operationalized in job descriptions, orientation and training plans, competency checklists?
current activity in this area: Y N
Level of interest in initiating/enhancing:
DISCUSSION NOTES

Additional Notes

Social determinants of health include income, social support, early childhood development, employment, housing, gender, intergenerational trauma, racism, lack of self-determination (WHO, 2016)

- ✓Organizational Leadership
- ✓Workforce/Pipeline
- ✓Clinical Environment
- ✓Service Array
- ✓Partnerships
- ✓Knowledge Systems
- ✓Organizational Practices
- ✓Community Prevention

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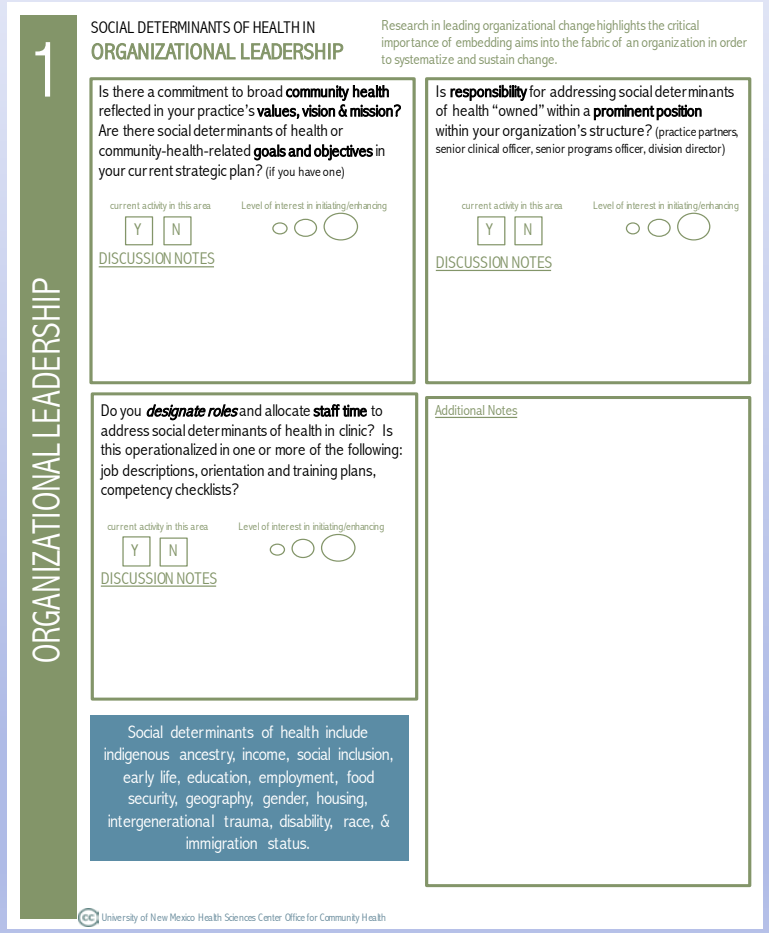
Cluster 1: Organizational Leadership



Evidence: Research on leading organizational change highlights the critical importance of **embedding aims into the fabric of an organization** in order to systematize and sustain change.

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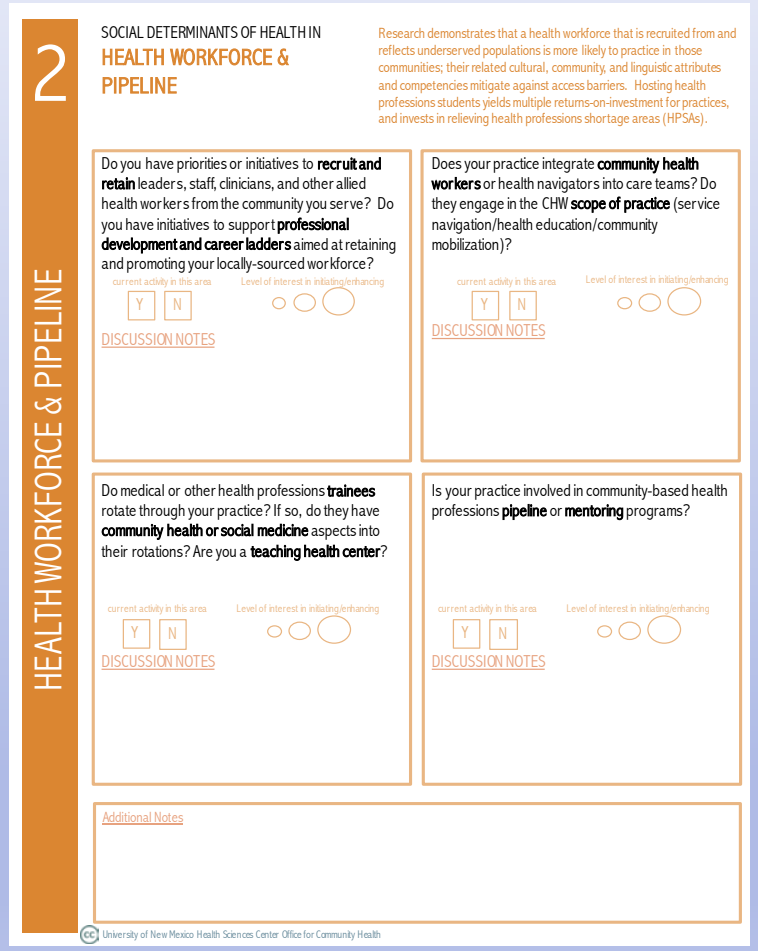
Cluster 2: Health Workforce & Pipeline



Evidence: Research demonstrates that a **health workforce** that is recruited from and **reflects underserved populations** is more likely to practice in those communities; their related **cultural, community, and linguistic attributes and competencies** mitigate against access barriers. Hosting health professions students yields multiple **returns-on-investment** for practices, and invests in relieving health professions shortage areas (HPSAs).

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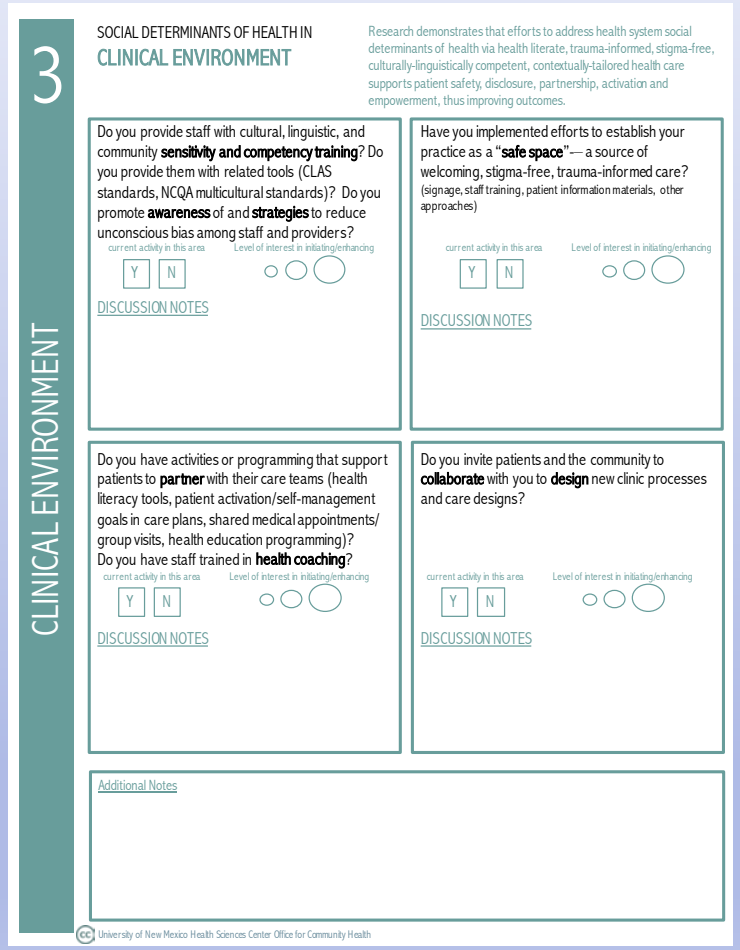
Cluster 3: Clinical Environment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CLINICAL ENVIRONMENT

SOCIAL DETERMINANTS OF HEALTH IN
CLINICAL ENVIRONMENT

Research demonstrates that efforts to address health system social determinants of health via health literate, trauma-informed, stigma-free, culturally-linguistically competent, contextually-tailored health care supports patient safety, disclosure, partnership, activation and empowerment, thus improving outcomes.

Do you provide staff with cultural, linguistic, and community **sensitivity and competency training**? Do you provide them with related tools (CLAS standards, NCQA multicultural standards)? Do you promote **awareness** of and **strategies** to reduce unconscious bias among staff and providers?

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Have you implemented efforts to establish your practice as a "**safe space**"— a source of welcoming, stigma-free, trauma-informed care? (signage, staff training, patient information materials, other approaches)

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Do you have activities or programming that support patients to **partner** with their care teams (health literacy tools, patient activation/self-management goals in care plans, shared medical appointments/ group visits, health education programming)? Do you have staff trained in **health coaching**?

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Do you invite patients and the community to **collaborate** with you to **design** new clinic processes and care designs?

current activity in this area: Y N

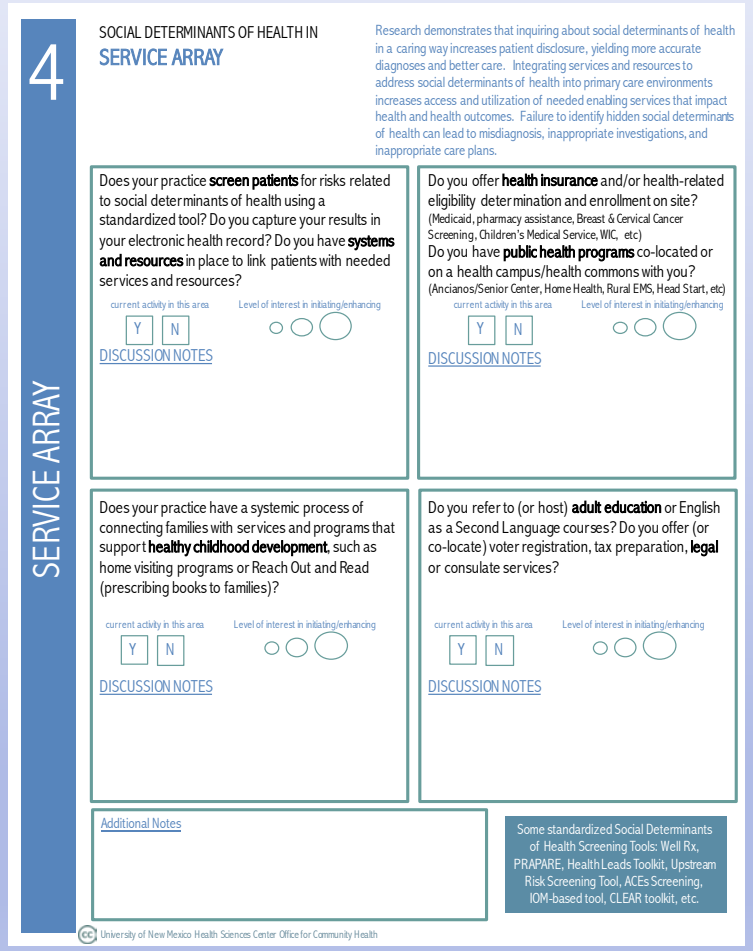
Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Additional Notes

Evidence: Research demonstrates that efforts to address health system social determinants of health via **health literate, trauma-informed, stigma-free, culturally-linguistically competent, contextually-tailored health care** supports patient safety, disclosure, partnership, activation and empowerment, thus improving outcomes.

Cluster 4: Service Array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SERVICE ARRAY

SOCIAL DETERMINANTS OF HEALTH IN
SERVICE ARRAY

Research demonstrates that inquiring about social determinants of health in a caring way increases patient disclosure, yielding more accurate diagnoses and better care. Integrating services and resources to address social determinants of health into primary care environments increases access and utilization of needed enabling services that impact health and health outcomes. Failure to identify hidden social determinants of health can lead to misdiagnosis, inappropriate investigations, and inappropriate care plans.

Does your practice **screen patients** for risks related to social determinants of health using a standardized tool? Do you capture your results in your electronic health record? Do you have **systems and resources** in place to link patients with needed services and resources?

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Do you offer **health insurance** and/or health-related eligibility determination and enrollment on site? (Medicaid, pharmacy assistance, Breast & Cervical Cancer Screening, Children's Medical Service, WIC, etc)
Do you have **public health programs** co-located or on a health campus/health commons with you? (Ancianos/Senior Center, Home Health, Rural EMS, Head Start, etc)

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Does your practice have a systemic process of connecting families with services and programs that support **healthy childhood development**, such as home visiting programs or Reach Out and Read (prescribing books to families)?

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

DISCUSSION NOTES

Do you refer to (or host) **adult education** or English as a Second Language courses? Do you offer (or co-locate) voter registration, tax preparation, **legal** or consulate services?

current activity in this area: Y N

Level of interest in initiating/enhancing: ○ ○ ○

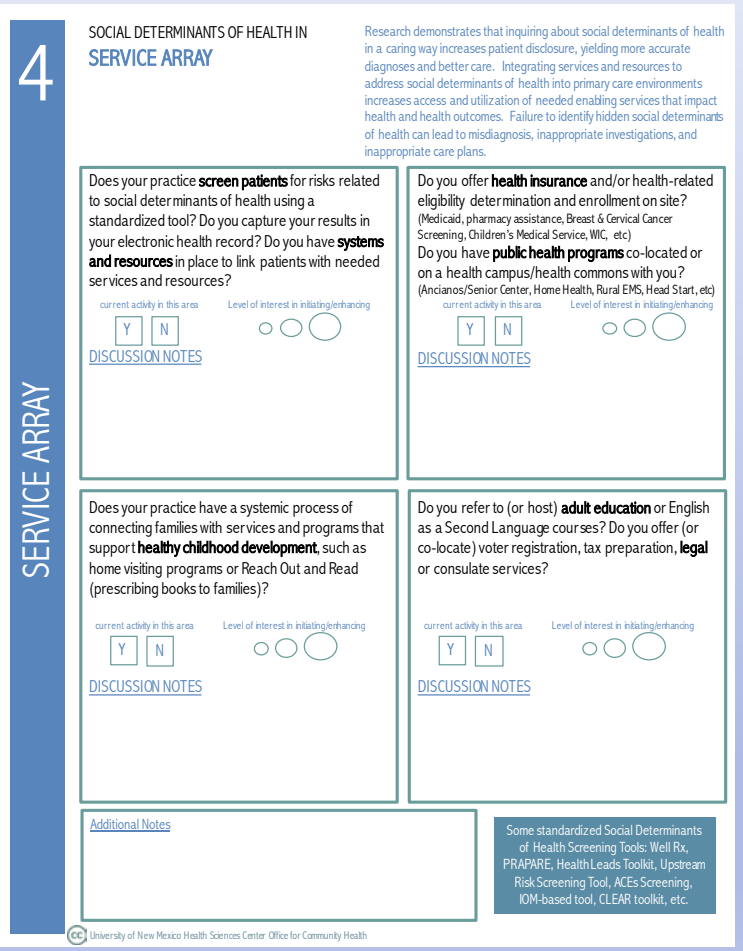
DISCUSSION NOTES

Additional Notes

Some standardized Social Determinants of Health Screening Tools: Well Rx, PRAPARE, Health Leads Toolkit, Upstream Risk Screening Tool, ACEs Screening, IOM-based tool, CLEAR toolkit, etc.

Evidence: Research demonstrates that **inquiring about SDH** in a caring way increases patient disclosure, yielding more accurate diagnoses and better care. Integrating services and resources to address SDH into primary care environments increases access and utilization of needed enabling services that impact health and health outcomes. **Failure to identify hidden SDH can lead to misdiagnosis, inappropriate investigations, and inappropriate care plans.**

Cluster 5: Knowledge Systems



Evidence: Research demonstrates the value of collection and analysis of health and health systems data to measure progress, and also to motivate, guide and focus action. Involving frontline health workers, patients, and community in inquiry, reflection, and **analysis of both quantitative and qualitative data enriches discovery and invention,** and contributes to the Quadruple Aim of better quality, reduced costs, improved patient experience, and improved care team satisfaction.

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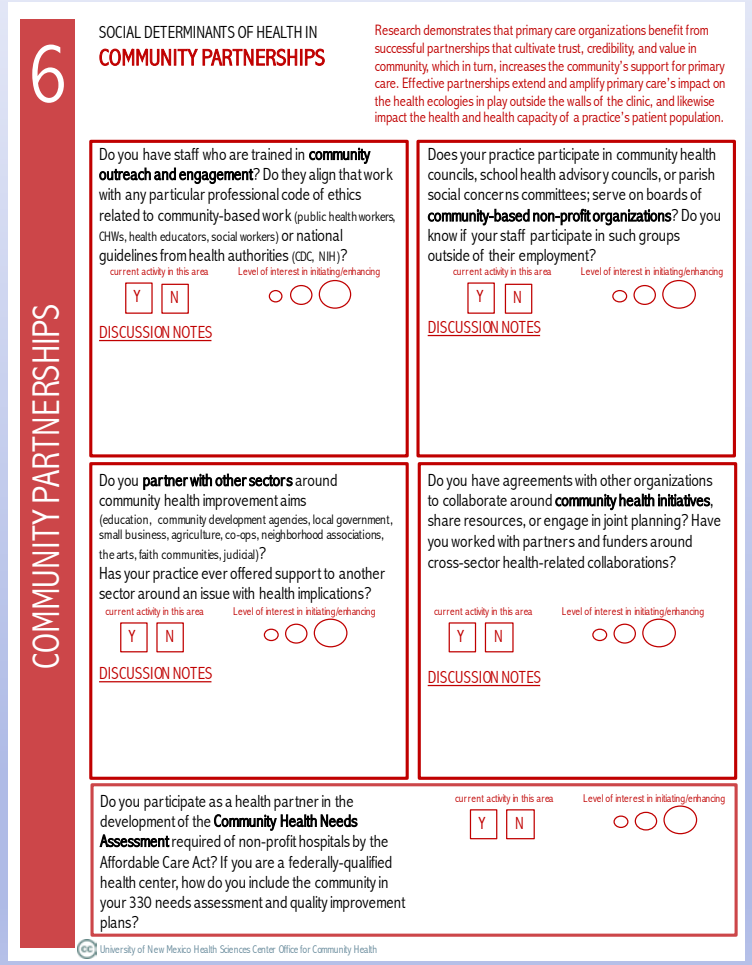
Cluster 6: Community Partnerships



Evidence: Research demonstrates that primary care organizations benefit from **successful partnerships** that cultivate trust, credibility, and value in community, which in turn, increases the community's support for primary care. Effective partnerships extend and **amplify primary care's impact on the health ecologies in play outside the walls of the clinic**, and likewise impact the health and health capacity of a practice's patient population.

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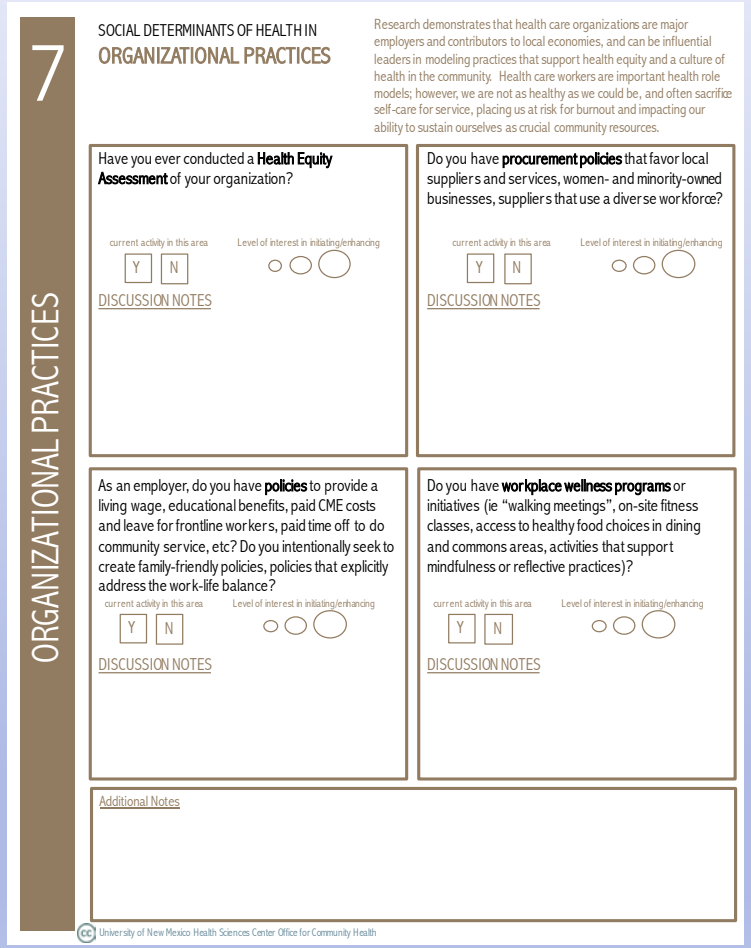
Cluster 7: Organizational Practices



Evidence: Research demonstrates that health care organizations are major employers and contributors to local economies, and **can be influential leaders in modeling practices that support health equity and a culture of health in the community.** Health care workers are important health role models; however, we are not as healthy as we could be, and often sacrifice self-care for service, placing us at **risk for burnout and impacting our ability to sustain ourselves as crucial community resources.**

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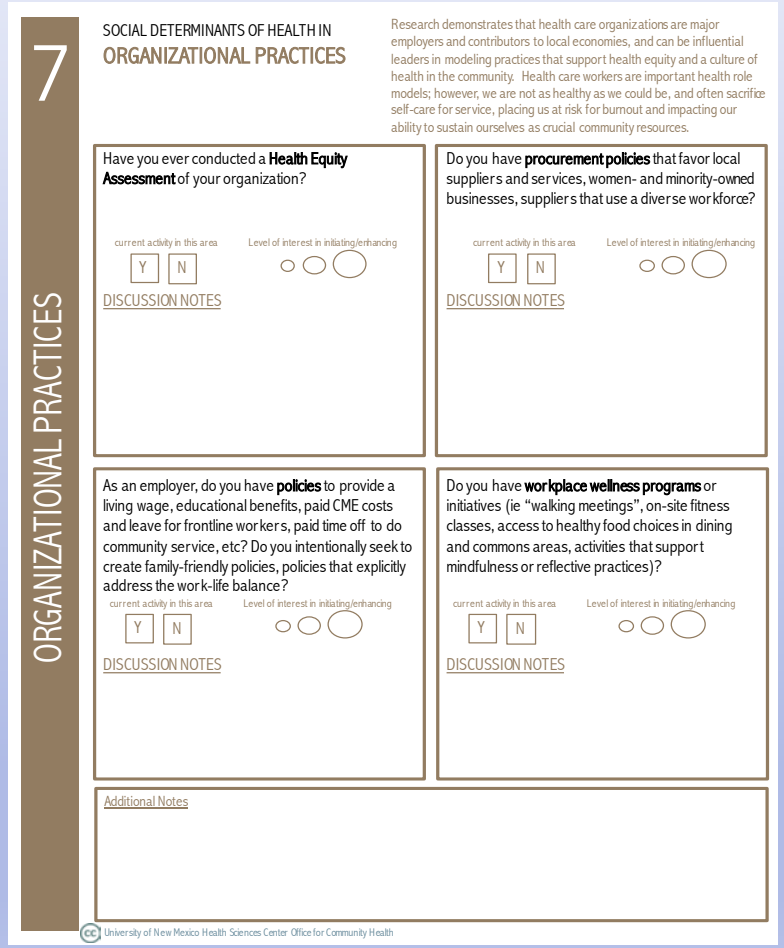
Cluster 8: Community Prevention


7

ORGANIZATIONAL PRACTICES

SOCIAL DETERMINANTS OF HEALTH IN
ORGANIZATIONAL PRACTICES

Research demonstrates that health care organizations are major employers and contributors to local economies, and can be influential leaders in modeling practices that support health equity and a culture of health in the community. Health care workers are important health role models; however, we are not as healthy as we could be, and often sacrifice self-care for service, placing us at risk for burnout and impacting our ability to sustain ourselves as crucial community resources.

Have you ever conducted a **Health Equity Assessment** of your organization?

current activity in this area: Y N

Level of interest in initiating/enhancing

DISCUSSION NOTES

Do you have **procurement policies** that favor local suppliers and services, women- and minority-owned businesses, suppliers that use a diverse workforce?

current activity in this area: Y N

Level of interest in initiating/enhancing

DISCUSSION NOTES

As an employer, do you have **policies** to provide a living wage, educational benefits, paid CME costs and leave for frontline workers, paid time off to do community service, etc? Do you intentionally seek to create family-friendly policies, policies that explicitly address the work-life balance?

current activity in this area: Y N

Level of interest in initiating/enhancing

DISCUSSION NOTES

Do you have **workplace wellness programs** or initiatives (ie "walking meetings", on-site fitness classes, access to healthy food choices in dining and commons areas, activities that support mindfulness or reflective practices)?

current activity in this area: Y N

Level of interest in initiating/enhancing

DISCUSSION NOTES

Additional Notes

Evidence: Research demonstrates that initiatives that **nurture social inclusion and belonging,** improve the "healthfulness" of the community environment and social norms, and increase access to equitable opportunity all greatly improve the health status of populations. **This reduced burden of disease factors** into meeting clinical performance measures and frees primary care to focus efforts further upstream.

THANK YOU!