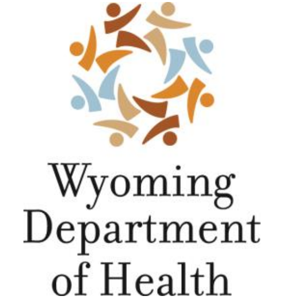
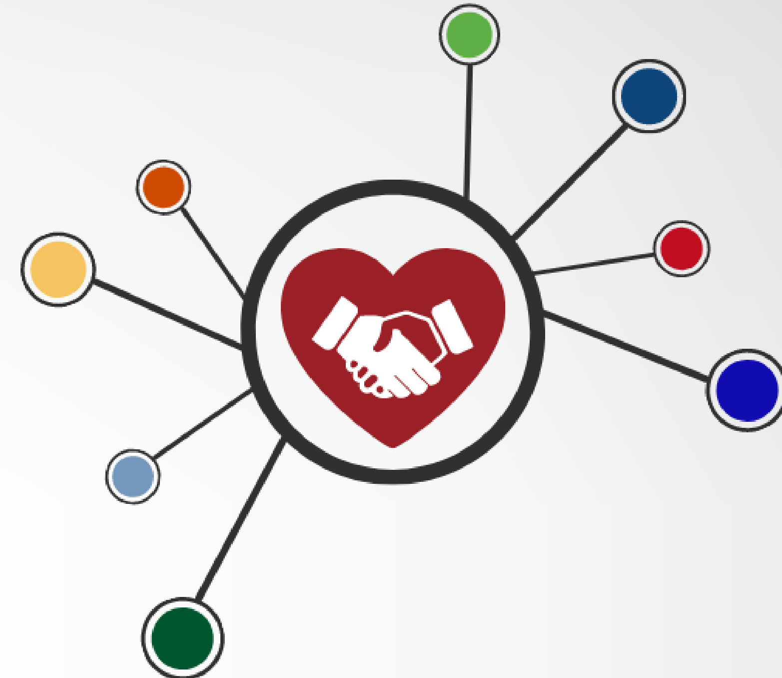
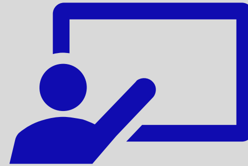


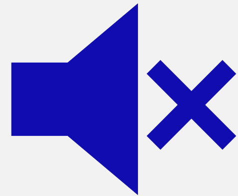
Working Together to Improve Health Outcomes



Housekeeping

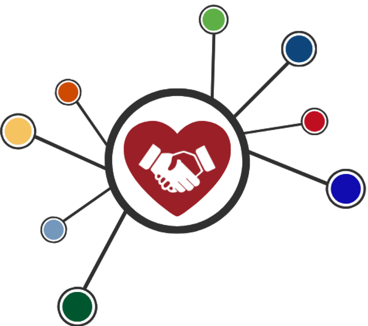


Be prepared to share.

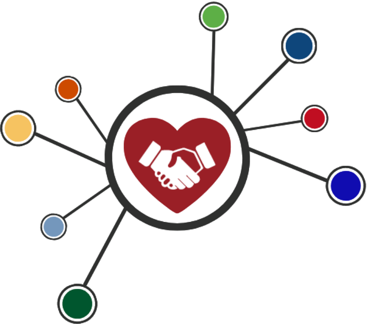


Mute when not speaking

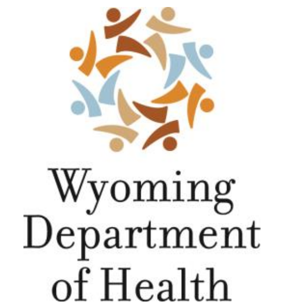
Put your questions in chat.

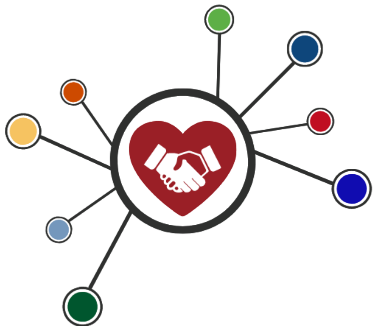


Are you sweet or savory?



Regional Chronic Disease Collaborative Partners





Today’s Presenters

Patty Kosednar

Mountain-Pacific Quality Health

Senior Account Manager

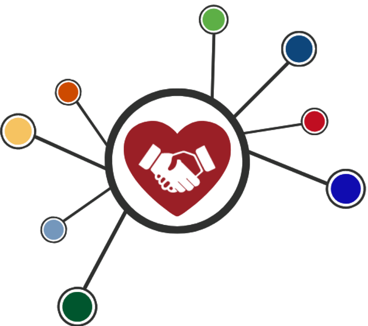
pkosednar@mpqhf.org

Deb Anderson

Mountain-Pacific Quality Health

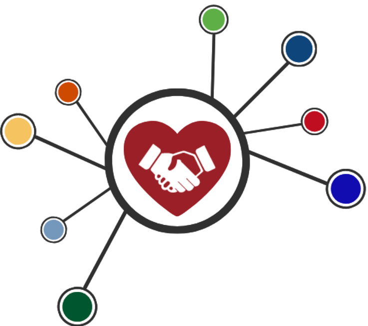
Health IT/QI Consultant

danderson@mpqhf.org



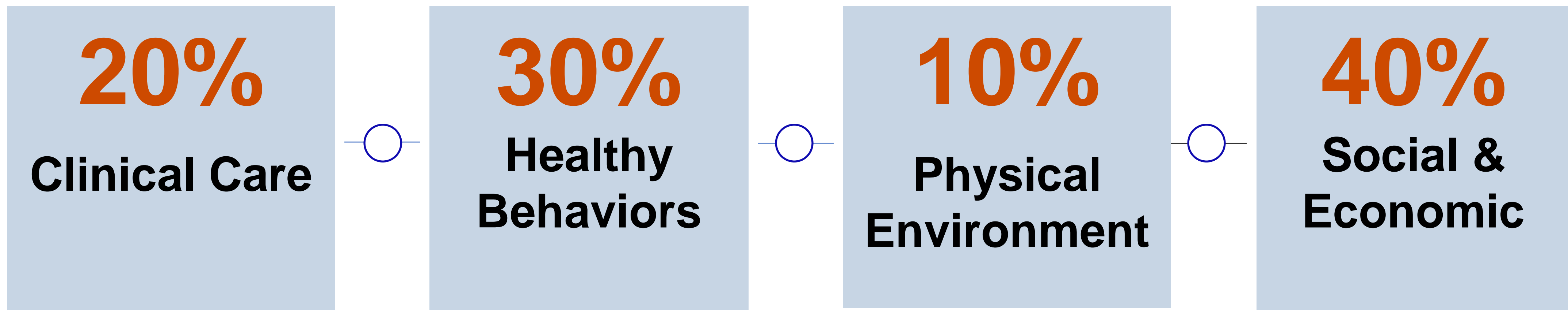
Today’s Agenda

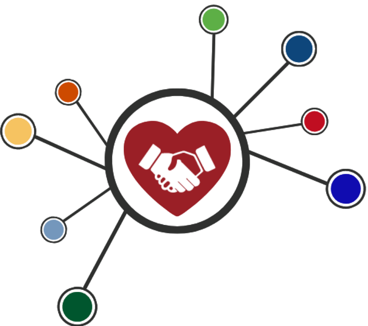
- Health equity and expanding care by connecting to community-based organizations (CBOs) and resources
- Social determinants of health (SDoH) and ways to assess need
- Practice presenters – sharing ideas and experiences
- Breakout session – state-based resource information
- Calls to action and next steps



Relative Impact of Key Health Factors

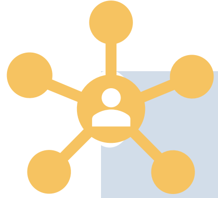
Relative impact of key categories of health determinants



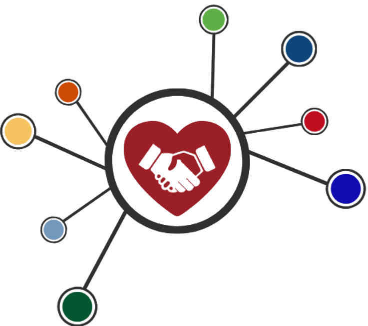


Source: Price Waterhouse Coopers (PcW): The urgency of addressing social determinants of health

Leveraging Community Resources

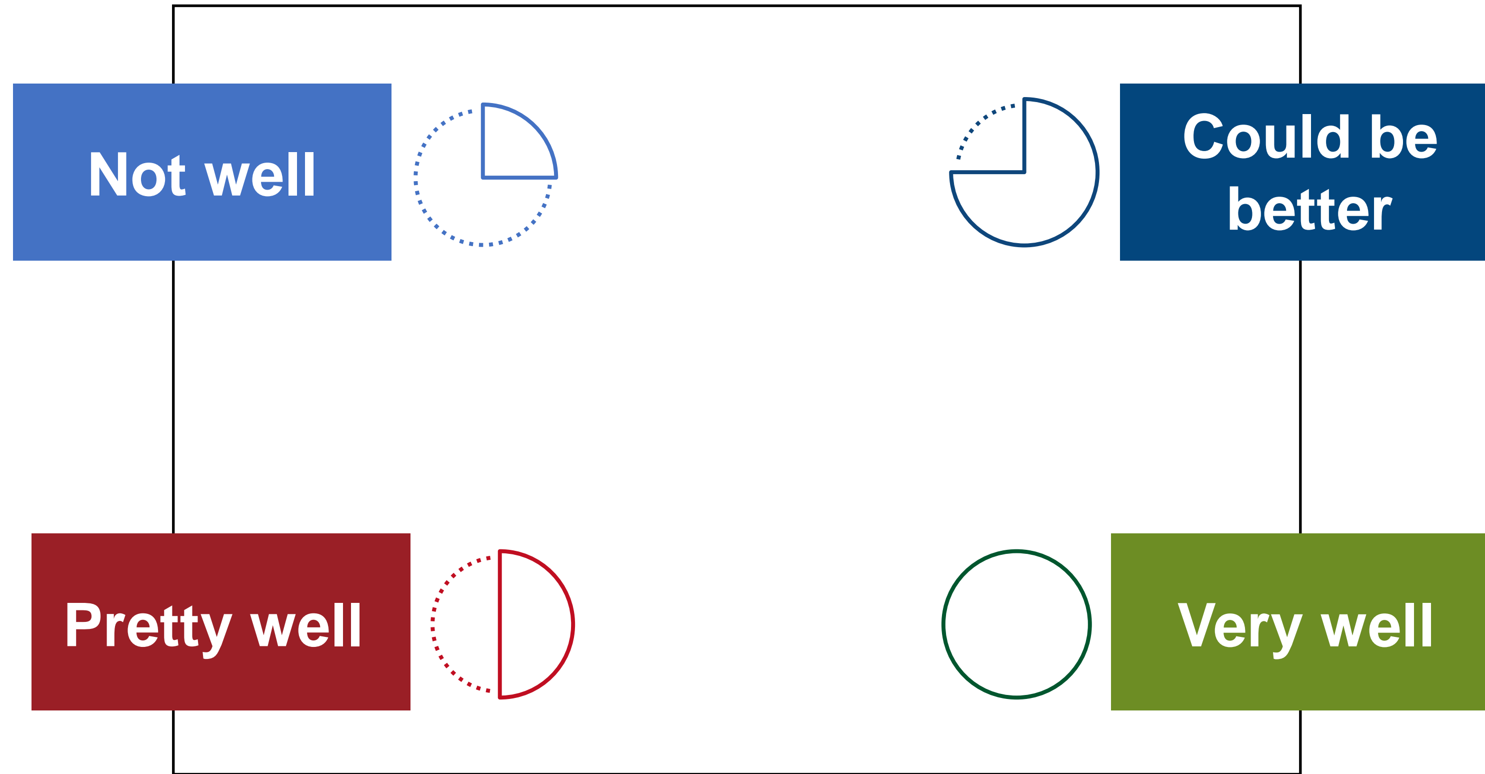


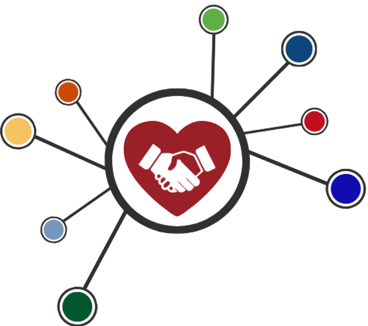
Improve health outcomes and lower costs by addressing medical, social, environmental and behavioral needs.



How well do you feel you utilize community resources?

Polling question #1

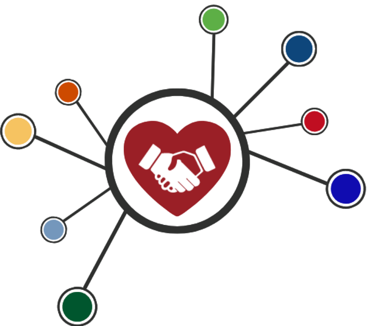




Health Equity

Health equity is when each person has the chance to reach "his or her full **health** potential,"

without facing obstacles from "social position or other socially determined circumstances."



Source: CDC (Centers for Disease Control and Prevention)

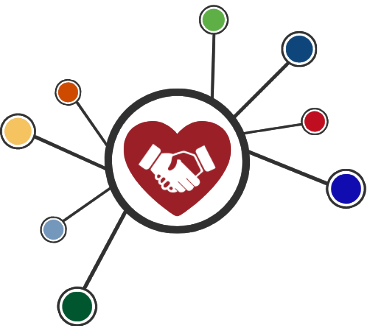
Heath Equity

Some factors contributing to health disparities:

Social determinants of health such as poverty, lack of education, racism, community conditions

Behavioral factors such as diet, tobacco use and engagement in physical activity

Medical services such as the availability and quality of medical services

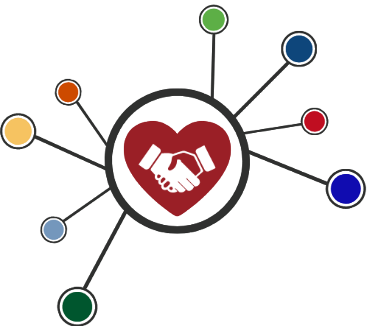


Health Equity and Chronic Disease

Heart disease, cancer, diabetes and stroke

Tend to be:

- More common
- Diagnosed later
- Result in worse outcomes for individuals whose life conditions place them at risk for poor health

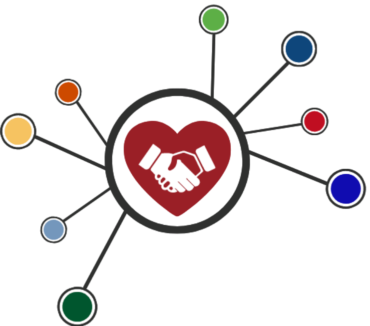


Source: Centers for Disease Control and Prevention's (CDC's) Practitioner's Guide for Advancing Health Equity

Health Equity and SDoH

"Addressing social determinants of health is a primary approach to achieving health equity."

- Centers for Disease Control and Prevention (CDC)



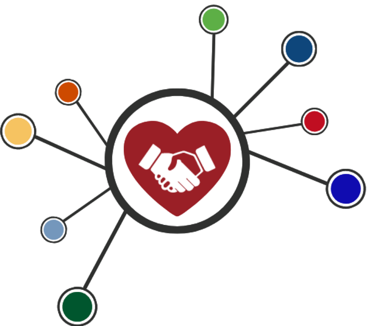
Health Equity – SDoH

A big nut to crack

Start small!
Don't try to solve the "whole" problem

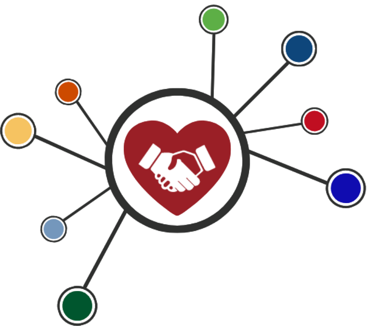
Ask:
What can your organization handle now?

Consider:
What is within your power to address?



Screening/Assessing for SDoH

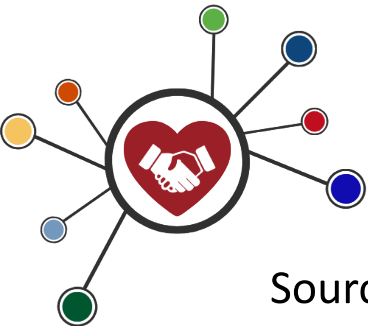
Collecting information about social needs allows clinicians to develop treatment plans that are better tailored to a patient's unique needs and priorities.



SDOH

Conditions in the environments where people are born, live, work, play, worship and age that affect health outcomes and risks

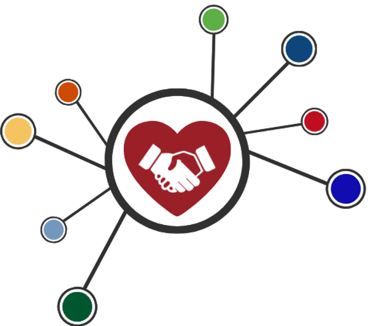
Safe housing, transportation, and neighborhoods	Racism, discrimination and violence	Education, job opportunities and income
Access to nutritious foods and physical activity opportunities	Polluted air and water	Language and literacy skills



Source: Healthy People 2030, ODPHP

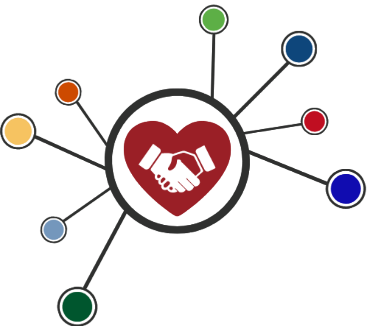
Screening/Assessing for Social Needs

National Association Community Health Centers (NACHC)	Centers for Medicare & Medicaid Services (CMS)
PRAPARE assessment tool	Health-related social needs assessment/screening tool



Discussion Question 1

Are you currently assessing for SDoH needs?



Community-Based Resources

Sources to help identify state-based and community-based resources:

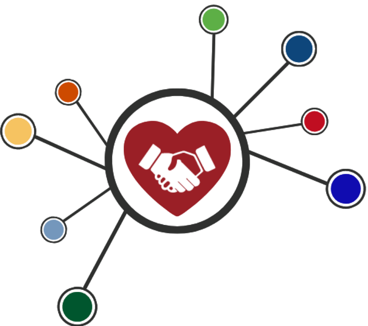
State-based 211 databases

Community-based resource guides

Facility-based resource guides

Database/Bi-directional referrals systems

Others (chat in)



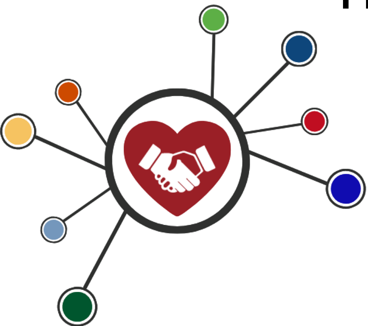
Other Potential Connections

Typical Organizations

- Healthy behaviors
  - Tobacco Quit Line
  - National Diabetes Prevention Programs
  - State-based chronic disease self-management program
- Hunger
  - Food banks/pantries
  - SNAP/WIC
- Housing
  - Local housing assistance programs
- Transportation
  - Local transportation assistance programs
  - Area Agencies on Aging

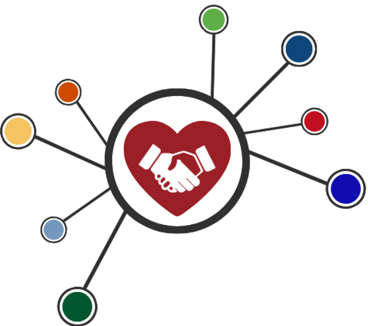
Other Possibilities

- Faith-based organizations in your community
- Senior centers
- Fitness centers/exercise gyms
- Community kitchens
- University extension offices
- County public health departments



Discussion Question 2

What community organization(s) do you refer to regularly?

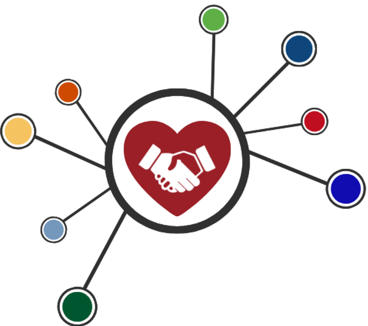


Health Equity and Quality Improvement (QI)

Ensure QI efforts don't widen the health equity gap

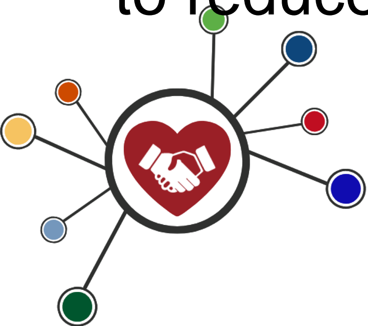
Unknowingly, QI efforts can improve care for one group of patients while worsening it for another group of patients.

Use a health equity "lens" when planning your QI projects.



Health Equity and Quality Improvement

- Focus on improving care for a population that has historically experienced disparities in care or is an underserved population
- Analyze data to demonstrate gaps in care by comparing a quality measure among two (or more) groups
  - A1c rates for English-speaking patients vs. non-English speakers
  - Hypertension blood pressure control for elderly living alone vs. not
  - Breast cancer screening rates based on ethnicity
  - Other examples (chat them in)
- Leverage CBOs that can help support the social needs of your patients to reduce health equity gaps

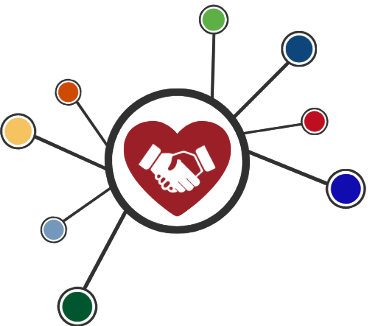


Practice Presenter

Maureen Hurley, RN

Chronic Care Coordinator

Campbell County Health Clinics, Wyoming

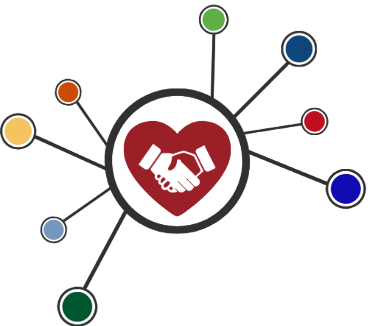


Practice Presenter

Jeanne Scooter Gates, BSW, MHA

Care Manager Team Coordinator

Riverstone Health – Montana



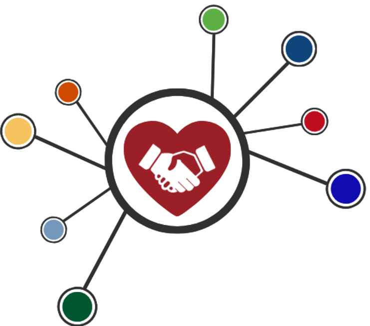
Break Out Sessions

15-minute break out session

You will choose the appropriate break out room

State Department of Health staff will share resources and facilitate discussion

Return to full group to continue discussion



Health Equity – SDoH

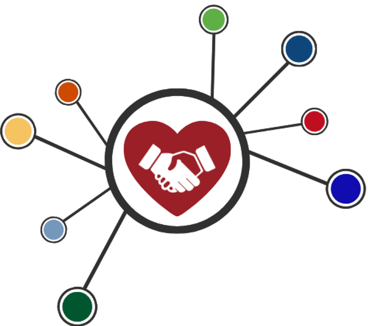
A big nut to crack

Start small!
Don't try to solve the "whole" problem

Ask:
What can your organization handle now?

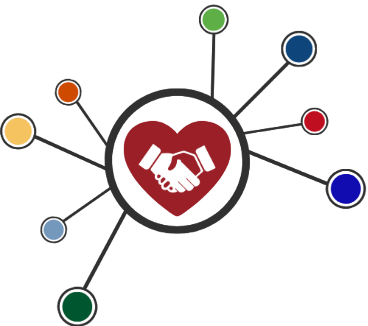
Consider:
What is within your power to address?

Don't let perfect be the enemy of better!



Call to Action

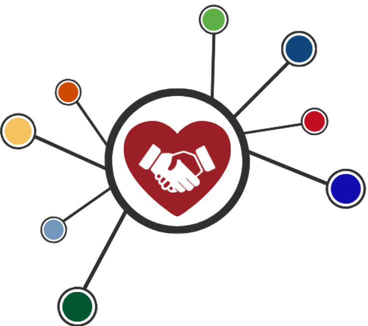
1. Implement a SDoH assessment/ screening tool.
2. Reach out to one community service partner and discuss shared goals/ a possible partnership.
3. Connect with your state on what bi-directional referral tool is available (or other services).
4. Include a health equity component in your next QI project.



How to continue on this topic?

Polling question #2 (choose one)

- Affinity Group – implement a SDoH screening tool, risk stratification that includes SDoH/health disparities and data collection and analytics
- Affinity Group – Establish a community partner/referral system process and workflows that track and close the referral loop of referrals to community resources
- Affinity Group – Create a quality program/project that includes a health equity focus

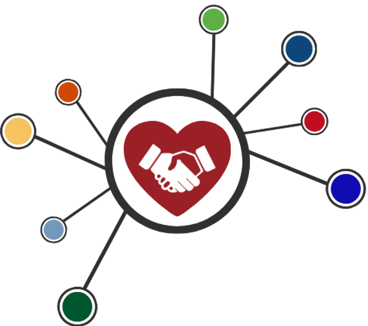


Chat in other ideas

Health Equity/SDOH Affinity Group

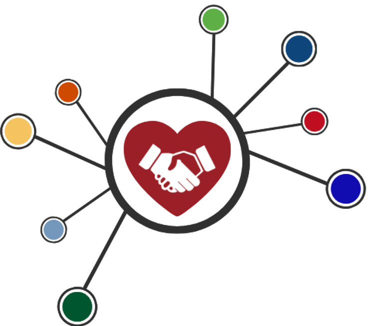
If you are interested in joining a health equity/SDoH affinity group, please indicate this in the chat, and we will contact you

Chat in “affinity group”



Resources

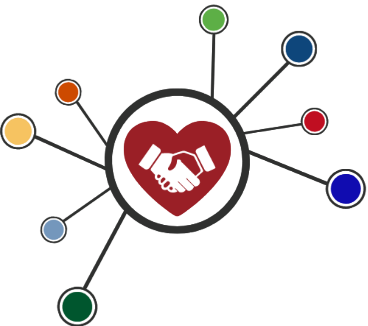
- CDC – Health equity resources & SDoH resources
- American Heart Association – Health equity resources
  - How to Collect Accurate Race/Ethnicity Data
  - Race-Ethnicity Data Collection Essentials
- American Academy of Family Physicians – Addressing SDoH in Primary Care
- National Association of Community Health Centers – PRAPARE Implementation and Action Toolkit
- CMS – Health-Related Social Needs Screening – user guide
- Action Program - Bringing Equity into Quality Improvement
- Agency for Healthcare Research and Quality – SDOH website



Next Education Event Topic?

Polling question #3 (Choose all that apply)

- Clinical overview of cardiovascular disease, diabetes and chronic kidney disease
- Protocols/care guidelines and workflows
- Identifying high risk patients or gaps in care
- Use of data, data analytics, electronic health record (EHR) and other health information technology (HIT) functionality
- Increasing patient/family engagement and self management
- Deep dive on health equity and accessibility
- Deep dive social determinates of health



Chat in other ideas

Thank You!

Please complete the evaluation.