COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Member Driven. Patient Focused.

Swimming Upstream: LA Health Center Efforts to Address the Social Determinants of Health

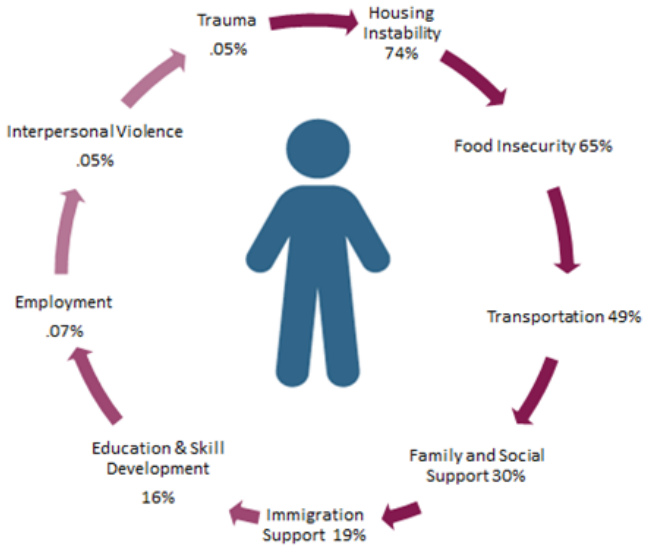
The social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age. Research shows that clinical care accounts for a minority of the health outcomes of patients, while health behaviors, social and economic factors, and physical environment combined influence the bulk of health outcomes.

Across Los Angeles and beyond, communities are working to address the SDoH through a variety of channels. Rooted in their communities and mission-driven to improve the health of the underserved, community clinics and health centers are well-positioned to advance health equity in Los Angeles County. Following are the results of a needs assessment[1] conducted by CCALAC to understand what support health centers need to foster conversations and interventions around SDoH.

Top Areas of Interest

First clinics ranked their top areas of interest. Of the 9 available areas, housing instability, food insecurity and non-emergency medical transportation ranked as the top priorities, in that order. Family and social support, immigration, and education and skill development followed.

SDoH Priority Areas for Clinics

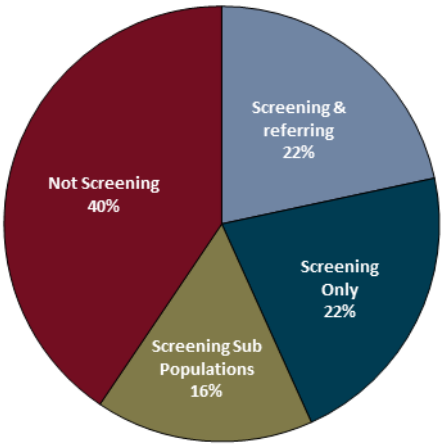


Screening Patients for SDoH

Clinics use various validated questionnaires to screen patients for SDoH. These tools assess multiple, overlapping social needs and are applicable to diverse care settings. Using a widely accepted, validated tool allows health centers to streamline the data collection process and better capture unique factors that inform patient care.

Some health centers have already implemented such tools, with some starting by targeting specific patient populations and others screening all patients. While 60% do some level of screening, only 16% have tools in place to refer patients to needed social services.

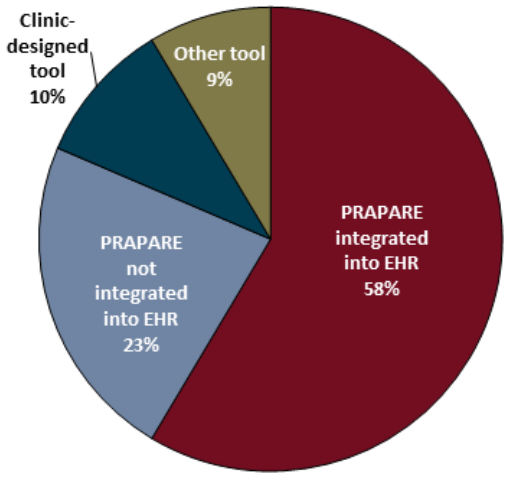
Clinics Screening for SDoH



The screening tools used by clinics vary, with some using tools integrated into their Electronic Health Records (EHRs), and others using custom tools specific to their clinic. Of the respondents that screen for SDoH, the majority use the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). PRAPARE is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' SDoH, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. Tools not used by respondents include the PRAPARE screening tool (paper version), American Academy of Family Physicians The EveryONE Project, CMS Accountable Health Communities' Health-Related Social Needs Screening Tool, and The Hunger Vital Sign.

While 60% of respondents screen, only 16.28% enter diagnosis or procedure codes specific to SDoH into the EHR.

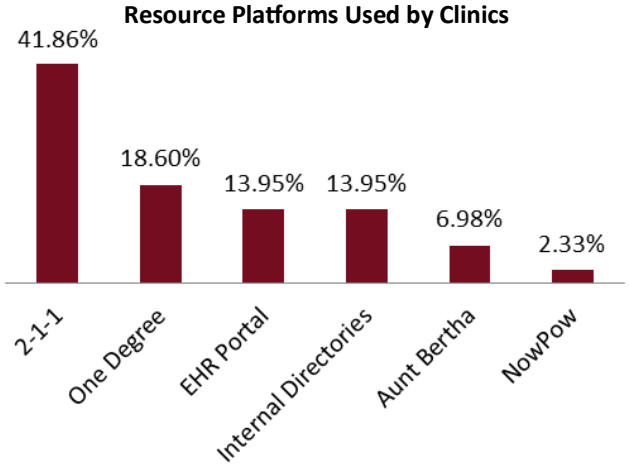
Screening Tools Used by Clinics



Community Resource Platforms

Community resource platforms allow for a data-driven approach to social service referrals. Clinics use tools such as 2-1-1 LA County, One Degree, an EHR-specific care coordination portal, internal resource directories, Aunt Bertha, and NowPow to navigate patients to community resources. Tools not used by respondents include, ActMD, Healthify (Purple Binder), and Health Leads Reach.

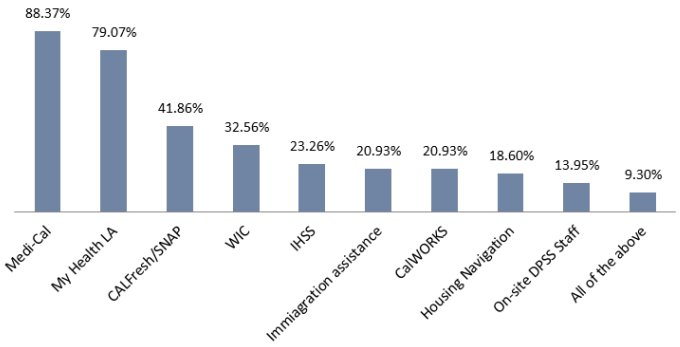
Resource Platforms Used by Clinics



Outreach and Enrollment Assistance Efforts

The large majority of clinics are currently helping patients enroll into social services at their sites.

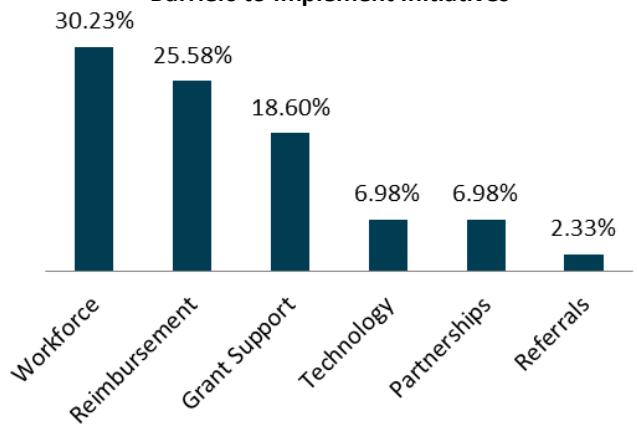
Enrollment Services Offered by Clinics



Barriers to Implementing SDoH Initiatives

Clinics and many nonprofits struggle to implement SDoH initiatives. Respondents cite a number of policy, payment and technology barriers to successful implementation of their initiatives.

Barriers to Implement Initiatives



The main barrier for clinics is the lack of workforce infrastructure and staffing, with the lack of reimbursement or payment structure to support SDoH activities following close behind. Other barriers include limited funding or grants to support initiatives, lack of or insufficient technology to support social needs assessment tools, and the need to identify appropriate social service agencies and community based organizations to partner with.

Support Needed
Clinics identified several priority areas in which they would like CCALAC's support: training, technical assistance, advocacy, and technology, in particular:

- Training of workforce to implement initiatives and sharing of best practices and tools, community resources and funding opportunities.
- Technical assistance to implement workflows, develop partnerships for closed loop referrals, and build infrastructure to integrate SDoH efforts.
- Advocacy for reimbursement for SDoH efforts and alternative payment models for FQHCs, demonstration of return on investment for SDoH activities, and discounted pricing for software to support SDoH initiatives.
- Implementation of technology, such as centralized regional linkages between clinics and agencies working in SDoH, EHR integration of referral software, and bidirectional tracking of social service referrals across agencies.

Each of these areas can be quite broad. Clinics will need to navigate complex issues that transcend the already-complicated health arena. For example, one respondent specified that they would like to understand liability issues for food distribution to patients experiencing food insecurity.

Next Steps
The results of the needs assessment provide some insight into how LA's clinics are gathering and using SDoH data to support their patients. They also shed light on the significant work yet to be done to support clinics and their partners in moving forward.

In follow up to this assessment, CCALAC will convene a Health Equity Advisory Group consisting of internal and external stakeholders to guide CCALAC's efforts in the social determinants of health. The learnings from this group will help inform SDoH discussions and best practice sharing at CCALAC's peer networks, including the Quality Improvement Roundtable, Clinical Advisory Group, Health Education Roundtable, and Homeless Health Advisory Group, among others.

Priority Support Areas for Clinics

The Advisory Group will also inform the development of training to support collaborative learning across the healthcare continuum, technical assistance to support integration of SDoH efforts, and advocacy to advance SDoH efforts. CCALAC will work with partners in LA and beyond to improve and advance SDoH integration across the healthcare continuum.

More Information
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[1] CCALAC 2019 SDoH Needs Survey. 2019. 43 sites from 29 organizations responded (44% of membership).