Ingham Community Health Centers

Addressing Social Determinants of Health in Community Health Centers

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Federally Qualified Health Centers

Ingham Community Health Centers
is dedicated to provide affordable, high quality, and comprehensive primary care to medically underserved people regardless of their insurance status or ability to pay.

COMMUNITY HEALTH CENTER FQHC QUALITY SM

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SDOH and Federally Qualified Health Centers

- How do CHC's use SDOH data?
  - Connect individual patients to community resources outside medical settings
  - Direct advocacy and investment to improve patient and community health outcomes
  - Identify vulnerable or underserved patient subpopulations and stratify risk

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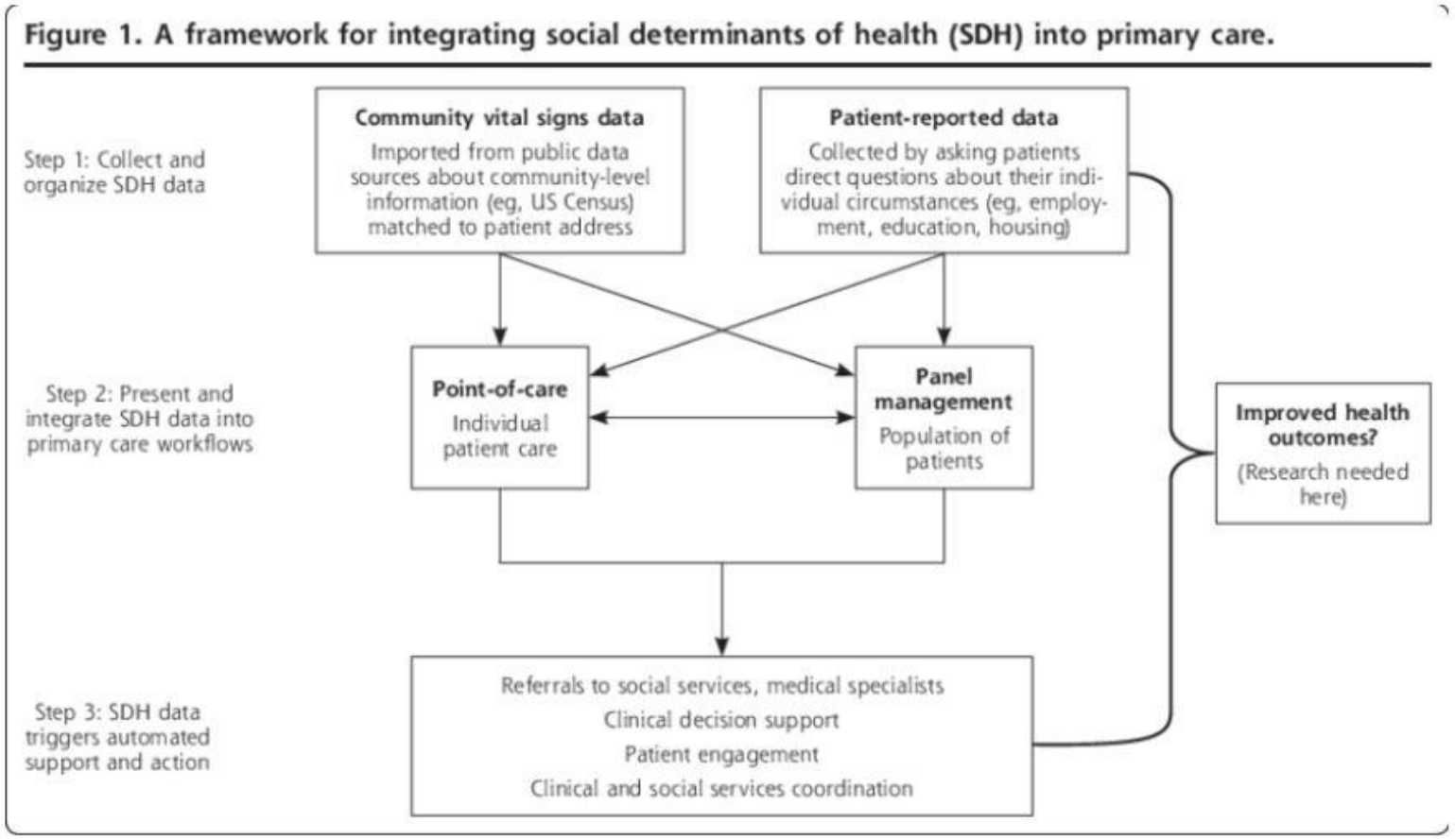
Integrating SDOH in Primary Care



Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice - Scientific Figure on ResearchGate. Available from: https://www.researchgate.net/figure/A-framework-for-integrating-social-determinants-of-health-SDH-into-primary-care_fig1_297661112 [accessed 19 Jul, 2019]

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SDOH of CHC Patients

Neighborhood Safety

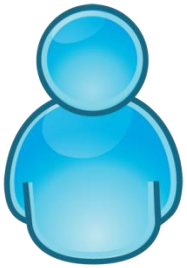
Stress

Food Security

Violence/ Abuse

Housing

Language Barrier



Discrimination

Access to Care

Poverty

Health Insurance

Transportation

Health Literacy

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ICHC: Identifying SDOH

Community Vital Signs

- Need Assessment
  - Target Population <200% FPL
  - Health Environment
  - Socio-economic Community Factors
  - Medically Underserved Population (Homeless, Refugees, LGBTQ)

Patient Reported Data

- Forms
- Intakes
- Inquiry

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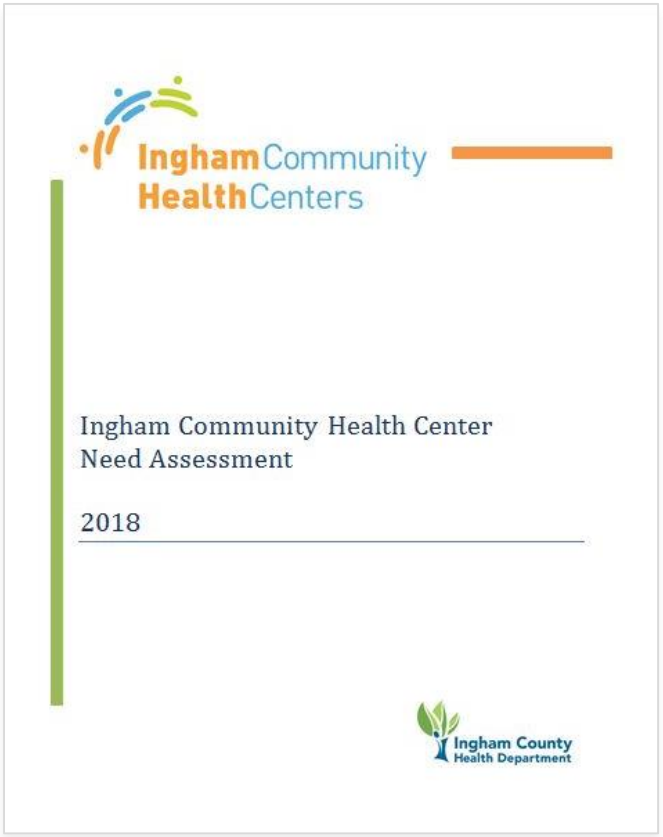
Community Vital Signs: SDOH

Sources of Community Data:

- Census Data
- BRFSS
- CDC National Health Statistic Reports
- MDHHS Data
- HMIS/Point in Time Data
- Ingham Health Department Data
- Healthy! Capital Counties
- Focus Groups*



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Individual Patient Data: SDOH

Forms and registration information

- Housing/Homelessness
- LGBTQ Status
- Language
- Income
- Insurance status

Health Histories

- Sexual Health
- Prior Access to Medical/Dental/Mental care
- Substance use
- Family history
- Abuse/Neglect

Screenings

- Risk Assessments
- Mental Health Assessments

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2018 Need Assessment Data

SDOH Status	# of Patients	% of Patients	% Service Area Target Population	% of Service Area Population
People Experiencing Homeless	2,311	9.5%	0.4%	0.2%
Refugees*	1,850	7.6%	-	3.5-4.5%
People Living with HIV/AIDS**	362	1.5%	-	~0.2%
People identifying as Lesbian, Gay, Bisexual, and Transgender	831	3.4%	3.2%	3.4%

Data Sources: Patient data reflects UDS reported data from 2017 unless otherwise noted.

*Estimate based on number of patients who have received a refugee screening within the last five years at ICHC (Current and former refugees) -~370 a year x 5 years =1850

**Number of patients with a diagnosis and eligible for Ryan White services as reported for 2017 Ryan White programs (Part B and D)

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SDOH: Homelessness

SDOH Factors		
Social	Discrimination Abuse/violence Poverty	Food security Stress Housing
Physical	Unstable and unsafe living space Overcrowding conditions Lack of Transportation	
Healthcare Environment	Lack of insurance Lack of Substance Use Disorder providers Lack of providers that accept Medicaid/underinsured	

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SDOH Approach: Homelessness

Identify Risks/Risk Impacts

- Immunizations and medications
- Scope of services: Dental, wound care, SUD, Mental Health

Investments and advocacy

- Co-Located clinic in shelter with on-site oral and SUD Services
- Interagency collaboration to address shared opportunities and threats

Connecting to resources

- Community Health Worker – navigate and link
- Care Coordination – CMH, Street Med, SUD Services

SDOH: Refugee/Immigrants

SDOH Factors		
Social	Discrimination Food security Unemployment Abuse/violence	Stress Poverty Language Barriers Housing
Physical	Stable and safe housing Lack of transportation Neighborhood safety	
Healthcare Environment	Lack of Insurance Lack of providers accepting Medicaid/Uninsured Lack or providers with interpreters	

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SDOH Approach: Refugees

Investment and Advocacy

Language Services

- In-person Interpreter Services
- Tele-interpreters
- Staff training and orientations for Cultural Appropriate Care

Identify Risks/Risk Stratification

- Communicable Disease
- Mental Health Assessments
- Trauma-Informed Care

Connection to Community

Care Management

- Partnership with resettlement agency for case management services and navigation of community resources

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SDOH: LGBTQ

SDOH Factors	
Social	Discrimination Abuse/violence Stress
Physical	Neighborhood Safety
Healthcare Environment	Lack of providers serving LGBTQ healthcare needs

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SDOH Approach: LGBTQ

Identify Risks/Risk Impacts

- Screenings and risk assessment– mental, sexual, violence/abuse
- Remove discrimination barriers - Promote LGBTQ Health Leader Status
- Services –PrEP/PEP

Investments and advocacy

- Services – HRT and Trans care
- Staff trainings and clinical and cultural competency

Connecting to resources

- Community Engagement and PRIDE

SDOH Approach: LGBTQ

Standard of Promoting Equitable and Inclusive Care for Lesbian, Gay, Bisexual, Transgender and Queer Patients and their Families

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What's Next

Enhanced SDOH Tracking and Risk Stratification

- **Integration of SDOH in Electronic Medical Records using PREPARE**
- **Population Management Software to assist in risk stratification**
- **Enhanced application of Community Health Workers to address SDOH through enabling services**

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Thank You

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