



Training Primary Care Residents on Social Determinants of Health

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INTRODUCTION

BACKGROUND

Collaboration between primary care providers and community-based organizations (CBOs) that provide social services is critical to addressing social determinants of health. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹

Addressing social determinants of health is a major component of the New York State Department of Health's (DOH) Delivery System Reform Incentive Payment (DSRIP) program, a five-year effort to reduce avoidable hospitalizations among Medicaid consumers by 25%. As part of DSRIP, Performing Provider Systems (PPS)—which are comprised of hospitals, skilled nursing facilities, home care agencies, federally qualified health centers, community-based physicians, CBOs, and other stakeholders—must work in partnership to decrease avoidable hospitalizations. The Institute for Healthcare Improvement (IHI), an organization dedicated to improving health care worldwide, stated that the successful health care organizations of the future will deliver high-quality care at lower total costs while improving the health of their population. A key way to do this is to identify and mitigate social needs that impact health.

In New York State, residents at teaching hospitals provide primary care to high-need populations such as Medicaid consumers and other low-income individuals who receive services in hospital-based clinics. While education on social determinants and population health has increased during medical school, giving residents some exposure to the concepts, many residents still lack the critical competencies to assess and address social needs. One specific area in need of improvement is the ability to collaborate with CBOs that coordinate housing or provide food assistance, financial support, job training, and other vital services.

New York is at a crossroads in transforming its health care delivery system for those in need through implementation of DSRIP and the related development of PPS. Meanwhile, residents continue to be a key part of the primary care delivery system as they learn to practice independently. Given their roles as current caregivers and physicians of the future, there is an opportunity to ensure that residents are fully integrated into New York's delivery system reform efforts. GNYHA has been working with its member hospitals and health systems to ensure their success in delivery system reform while also supporting teaching hospitals and their graduate medical education (GME) programs. This curriculum on social determinants of health is part of this work.

¹ "Social Determinants of Health," *Healthy People 2020*.

TRAINING RESIDENTS ON SOCIAL DETERMINANTS OF HEALTH

New York hospitals serve a diverse group of patients and are primarily teaching hospitals. There are more than 100 teaching hospitals in New York training approximately 6,000 primary care (general internal medicine, family medicine, and general pediatrics) residents. In 2015, the most recent year for which data was available, New York's hospital-sponsored clinics provided 15.6 million primary care visits. Of the primary care services provided at GNYHA member hospital clinics, 35% were to Medicaid consumers, 7% were to those without health insurance and/or those who self-pay, 27% were to Medicare consumers, and 28% were to the commercially insured. Many patients served in these clinics have complex needs, and are impacted by social determinants of health.

Residency training programs are required to meet certain educational standards per the Accreditation Council for GME (ACGME), the nation's primary oversight body for accrediting training programs. Educational and program-level requirements vary depending on specialty, but generally include specific language on what clinical experiences residents must be exposed to during their residency training and what educational elements must be included in the residency program curriculum. Based on GNYHA's recent review of residency program requirements, family medicine training programs are the only primary care programs that specifically require residents to assess community, environmental, and family influences of health. Pediatric training programs are required to provide community pediatrics and child advocacy training. Internal medicine training programs, which make up the large majority of New York's primary care residency programs, have no similar requirements.

In recent years, the ACGME underwent a process to update its requirements to address both the changing health care landscape and growing health care disparities. Specifically, the newly implemented Clinical Learning Environment Reviews (CLER) require residents to be involved in addressing health care disparities at the clinical site where they are trained. CLER visits are conducted to ensure that the GME enterprise is being integrated throughout the organization's activities and review compliance with six focus areas: patient safety, quality improvement, transitions in care, supervision, duty hours oversight, and professionalism. A recent ACGME report on CLER visits indicated that residents lack involvement in community needs assessments and that only half of residents surveyed were aware of their hospitals' priorities for addressing health care disparities.² This can be attributed to primary care residents' lack of education and experience with collaborating with social service agencies that address socioeconomic factors that impact health outcomes and reduce health disparities.

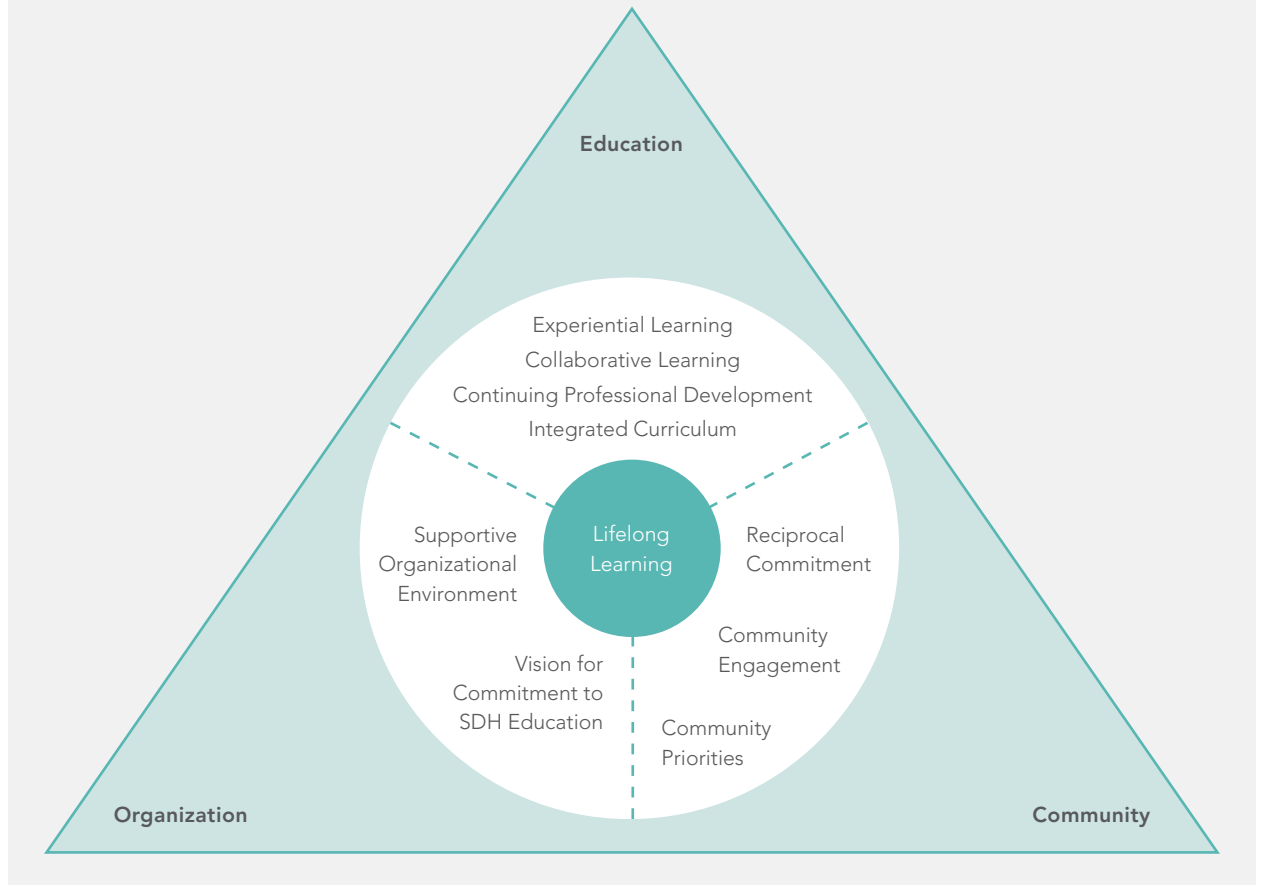
The National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine), in a 2016 study brief, called for programs to incorporate social and behavioral sciences into medical training.³ The Academies developed a framework that includes three primary domains—education, community, and organization—to build inter-professional, cross-sectoral, and experiential learning opportunities for residents and other learners (Figure 1). The framework emphasizes the need for learners to have experience partnering with various community stakeholders to address social needs in more collaborative ways, and demonstrates the need to work horizontally to address social determinants of health.

² "CLER National Report of Findings," *Journal of Graduate Medical Education* vol. 8, issue 2s1 (May 2016).

³ "A Framework for Educating Health Professionals to Address the Social Determinants of Health," *National Academies of Sciences, Engineering, and Medicine* (March 2016).

FIGURE 1. FRAMEWORK FOR LIFELONG LEARNING FOR HEALTH PROFESSIONALS

Note: SDH = social determinants of health



HOW TO USE THIS CURRICULUM

This curriculum provides several elements for primary care program directors, faculty, and GME leadership to use to develop teaching material to train residents on social determinants of health and work collaboratively with their communities. Many of these elements may also be useful for ambulatory care, population health, and workforce training leadership to teach foundational knowledge on social determinants of health to frontline staff.

The curriculum:

- Defines learning objectives for training residents on the importance and impact of social determinants of health
- Provides teaching content on the learning objectives
- Recommends learning experiences for residents that support fulfillment of the learning objectives
- Defines evaluation measures for assessing resident fulfillment of the learning objectives
- Includes appendix items that can serve as teaching tools
- References additional resources for each of the curriculum's topic areas

CURRICULUM ELEMENTS

- ✔ Learning Objectives: What knowledge and skills must the resident acquire?
- ✔ Teaching Content: How will the learning objectives be taught to residents?
- ✔ Learning Activities: What activities must the residents engage in for training to acquire the specified knowledge and skills?

ACKNOWLEDGEMENTS

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SECTION ONE

SOCIAL DETERMINANTS OF HEALTH CONTEXT & THEORY

Recent studies demonstrate that socioeconomic and environmental factors impact patient outcomes. Research also indicates that addressing social factors, such as housing and financial support, for low-income and underserved populations, can help reduce health care costs and ultimately improve community health.⁴ The following section defines the social determinants of health and describes how social factors impact both community and individual health, making the case for why physicians in training should consider social determinants in the context of the care they deliver.

The section also describes how social determinants of health fit into the current health care environment, which strives to decrease health care costs while improving overall health. Understanding the value of providing cost-conscious care is an important component of residency training. The ACGME's common program requirements state that programs should incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care, as appropriate. It is critical for residents to learn about health care spending so they practice more efficiently and effectively.

LEARNING OBJECTIVES

- ✓ Define and provide examples of social determinants of health
- ✓ Differentiate "equity" from "equality"
- ✓ Define and provide examples of health disparities
- ✓ Describe how common social needs can impact the health of an individual
- ✓ Describe how social determinants of health fit into broader health care policy

TEACHING CONTENT SLIDE DECK

GNYHA has developed a slide deck ([Appendix A](#)) for faculty to review the Section One teaching content concepts.



⁴ D. Bachrach, Pfister, H., Wallis, K., Lipson, M. "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." *The Commonwealth Fund* (May 2014).

TEACHING CONTENT

Defining Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks (Figure 2).⁵

Most social issues can be categorized into five key determinants. Challenges in one or more of these areas can impact an individual’s health (Figure 3). Research has determined that issues of health care access and quality of care comprise only 20% of the impact on one’s overall health (Figure 4).

FIGURE 2. THE SOCIAL DETERMINANTS OF HEALTH

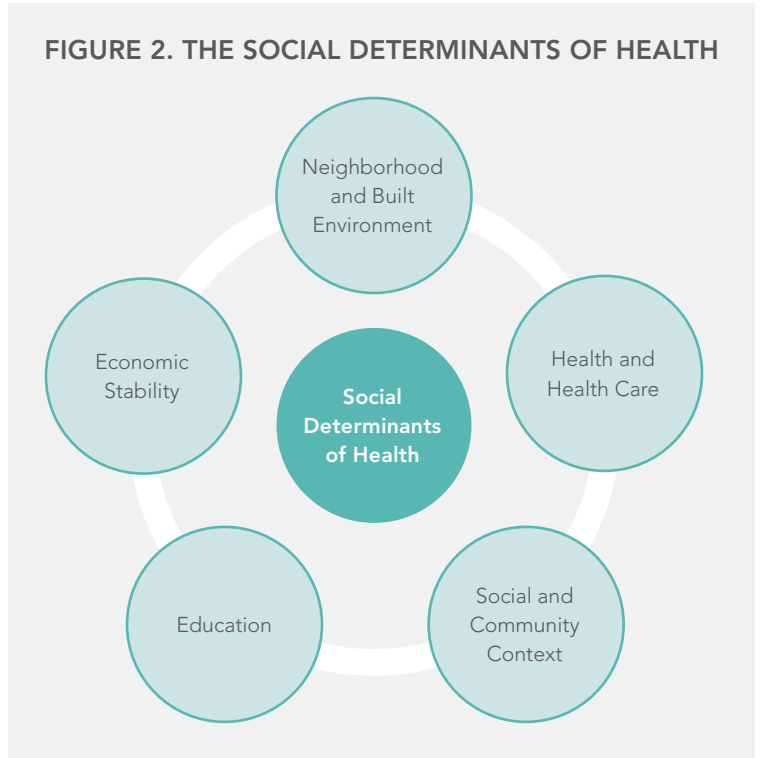


FIGURE 3: CATEGORIES AND EXAMPLES OF SOCIAL ISSUES⁶

Economic Stability	Neighborhood and Built Environment	Education	Food	Social and Community Context	Health and Health Care
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider ability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes: Mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations

⁵ "Social Determinants of Health," *Healthy People 2020*.

⁶ H. Heiman and Artiga, S. "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." *Kaiser Family Foundation* (November 2015).



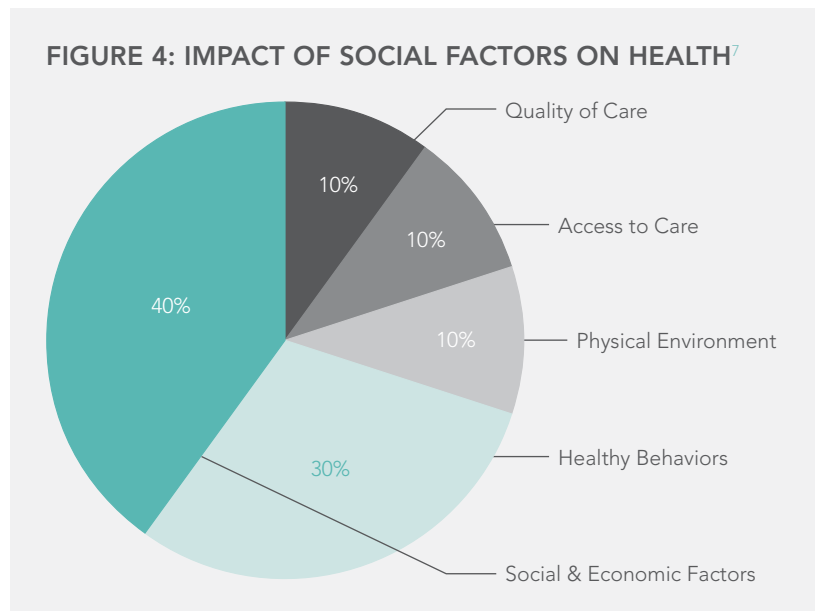
IMPACT OF SOCIAL DETERMINANTS

A video of social determinants and their impact on one's health is available here: https://www.youtube.com/watch?v=_11xLlwKgWc

Studies specifically demonstrate the link between social determinants and health. Safe and stable housing, poverty, education, public safety, and food insecurity have been linked to individuals' abilities to manage chronic diseases, stay healthy, and avoid admissions for ambulatory-sensitive conditions. A listing of such studies is available on [page 14](#).

[Appendix B](#) includes vignettes with examples of social determinants and questions to prompt

discussion about how social determinants can impact an individual's health. The vignettes can be used for didactic discussion on social determinants of health.

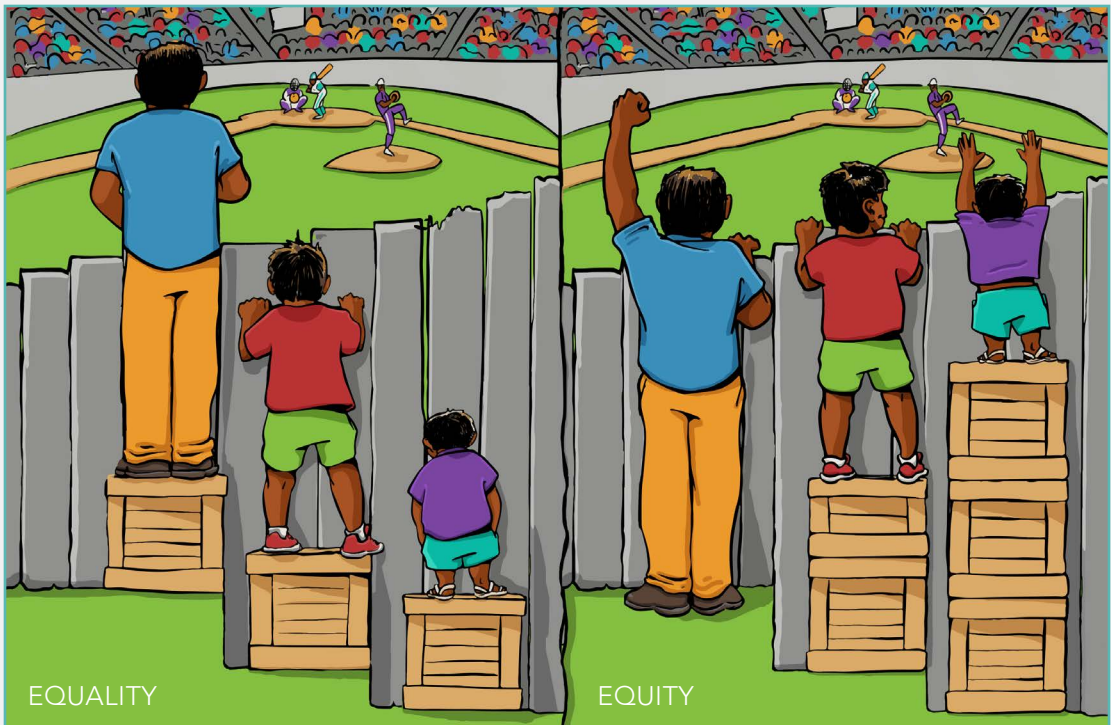
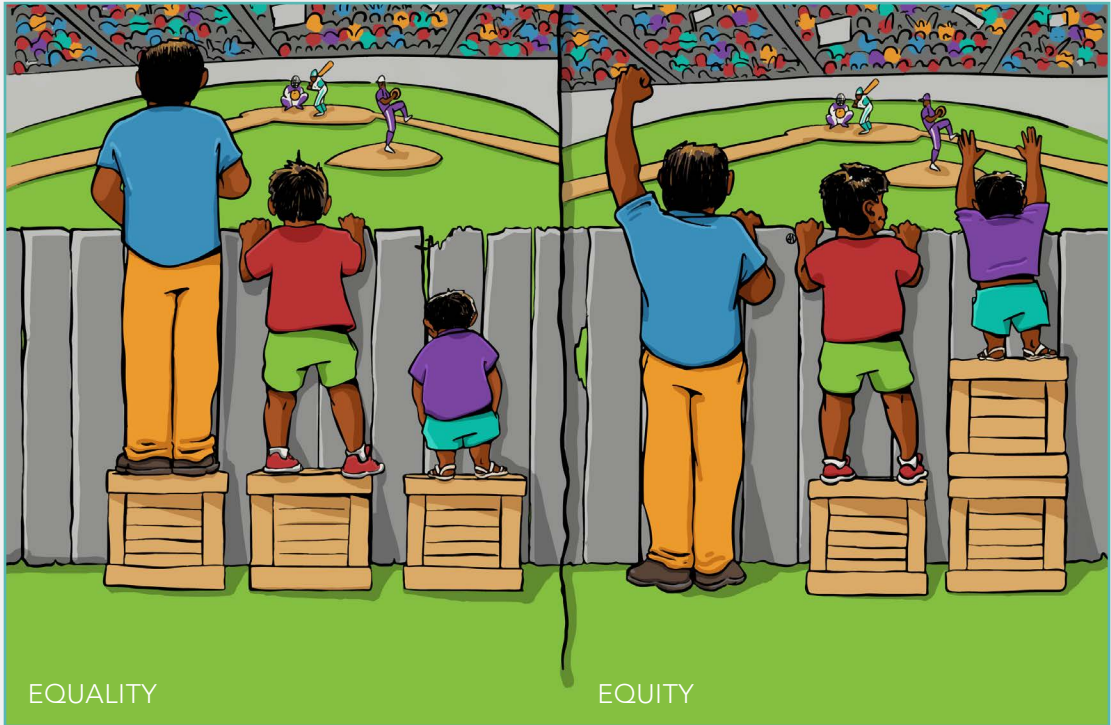


HEALTH EQUITY AND HEALTH DISPARITIES

Individuals are often impacted by social determinants of health due to inequities and inequalities affecting particular populations and communities. [Figure 5](#) demonstrates the concepts of equity and equality. Equality is reflected in the top images by the boxes of equal size, which do not consider characteristics of each individual. Equity takes individual characteristics into account, giving the necessary resources to those with the most need. The lower images depict the concepts differently, considering the environments of each individual. People may be more disadvantaged if from a particular neighborhood, race, or culture. The figure shows that to achieve equity, these environmental characteristics must also be considered.

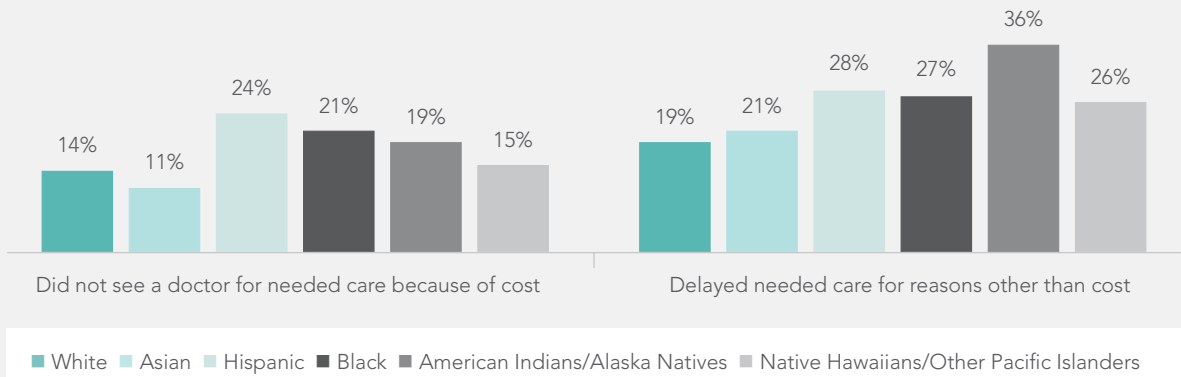
⁷ County Health Rankings & Roadmaps, (July 26, 2017). <http://www.countyhealthrankings.org/our-approach>.

FIGURE 5: EQUALITY VS. EQUITY



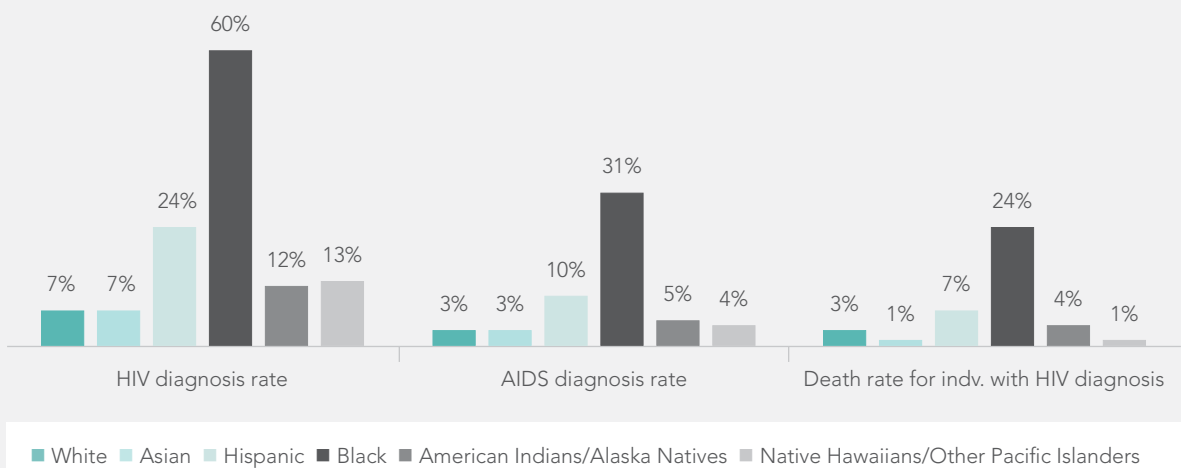
Top: Interaction Institute for Social Change | Artist: Angus Maguire
Bottom: Adapted from Interaction Institute for Social Change

FIGURE 6. PERCENT OF NON-ELDERLY ADULTS WHO DID NOT RECEIVE OR DELAYED HEALTH CARE IN THE PAST 12 MONTHS BY RACE/ETHNICITY, 2014⁹



Inequities and inequalities can lead to health disparities, which are differences in health outcomes based on a social, economic, or environmental disadvantage. Health disparities adversely affect groups of people that have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.⁸ Figures 6 and 7 are examples of health disparities.

FIGURE 7. AGE-ADJUSTED HIV AND AIDS DIAGNOSIS AND DEATH RATE PER 100,000 AMONG TEENS AND ADULTS BY RACE/ETHNICITY¹⁰



⁸ "The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, Phase I report: Recommendations for the framework and format of Healthy People 2020," US Department of Health and Human Services, (October 28, 2008). https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

⁹ Kaiser Family Foundation analysis of CDC, Behavioral Risk Factor Surveillance System, 2014.

¹⁰ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Atlas, 2014.

SOCIAL DETERMINANTS OF HEALTH IN THE CONTEXT OF TODAY'S HEALTH CARE SYSTEM

In the past several years, the United States has focused on decreasing health care costs. The US spends approximately 17% of its gross domestic product (GDP) on health care, which is significantly higher than health care spending in other countries (Figure 8). Data shows that US health care spending is the most expensive in the world, with costs projected to rise through 2020.¹¹ Despite high health care spending, the US shows poorer results for certain health care outcomes compared with other countries. Americans have lower life expectancy, higher infant mortality rates, and a higher prevalence of several chronic conditions, including hypertension, heart disease, cancer, and lung, joint, and mental health diagnoses (Figure 9).

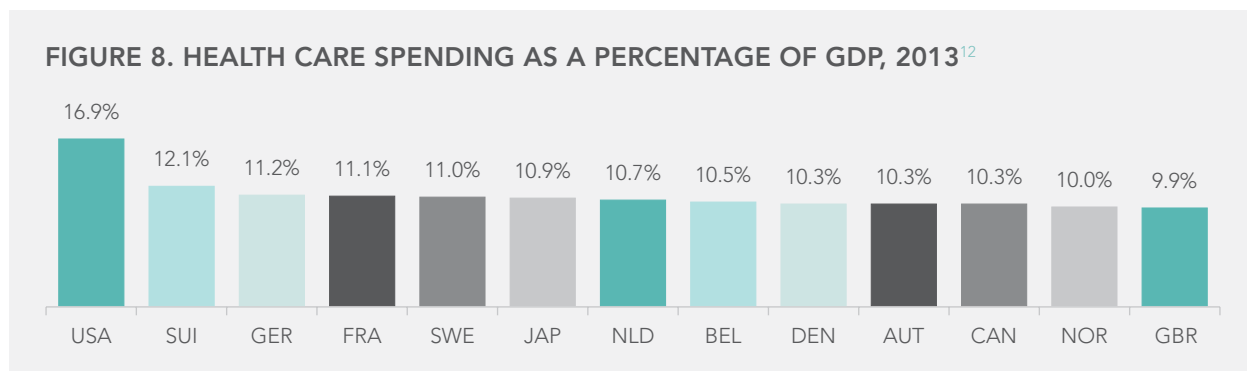


FIGURE 9: SELECT POPULATION HEALTH OUTCOMES AND RISK FACTORS¹³

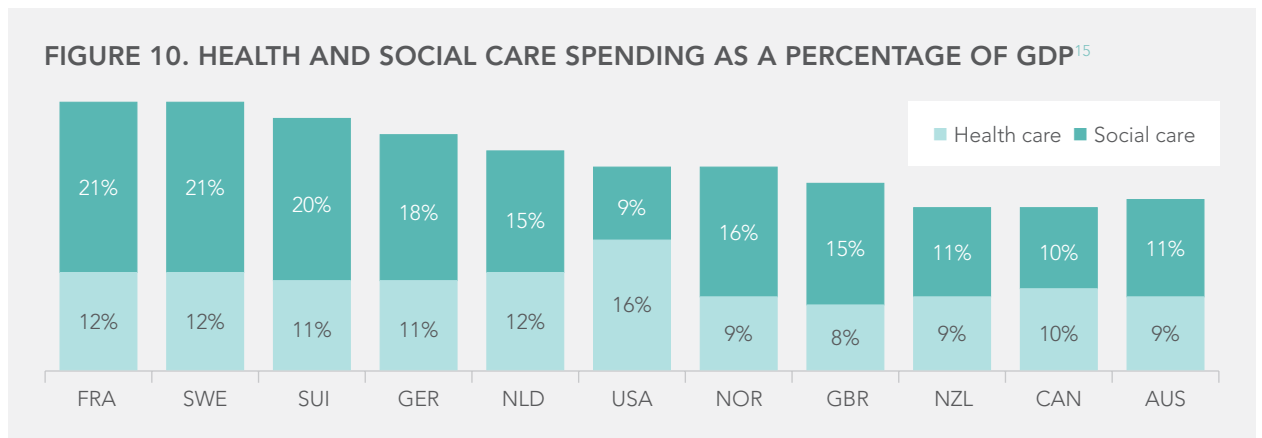
	Life exp. at birth, 2013	Infant mortality per 1,000 live births, 2013	Percent of pop. age 65+ with ≥2 chronic conditions, 2014	Obesity rate (BMI>30), 2013	Percent of pop. age 15+ who are daily smokers, 2013	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3	12.8	14.4
Canada	81.5	4.8	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5	24.1	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.	3.9	44	10.3	20.4	17.3
United Kingdom	81.1	3.8	33	24.9	20.0	17.1
United States	78.8	6.1	68	35.3	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

¹¹ "National Healthcare Expenditure Projections, 2010-2020," Centers for Medicare & Medicaid Services, Office of the Actuary.

¹² "Organisation for Economic Co-operation and Development, Health Expenditure and Financing Data 2015," (accessed July 7, 2017).

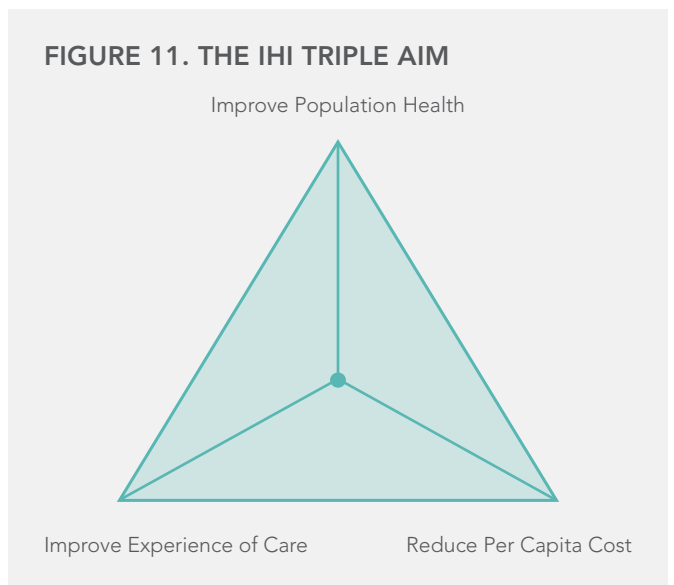
¹³ OECD Health Data 2015

Alternatively, the US spends only 9% of its GDP on social supports, significantly less than other countries. Nations from which data is collected spend approximately \$1.70 on social services for every \$1 on health services; the US spends just 56 cents (Figure 10), which suggests that additional resources are needed for social supports such as housing, employment, and education.¹⁴ Low government spend and lack of insurance company support on these social needs that impact health are driving health care providers to assess and address social needs using both hospital and community-based programs.



Initiatives underway across the country have demonstrated that addressing social factors reduces avoidable admissions and readmissions, particularly as they relate to chronic disease management, medication adherence, and patient engagement and self-management.

To address rising health care costs and related challenges, the Centers for Medicare & Medicaid Services (CMS) and many public agencies, hospitals, and health systems across the country adopted the IHI Triple Aim (Figure 11), a framework for large-scale health improvement. The Triple Aim includes the following elements, which must be achieved concurrently:



- Improve population health (improving the health of populations)
- Improve experience (improving individual outcomes)
- Decrease per capita cost (cost of care per individual)

¹⁴ D. Bowen Matthew, Cabello, M., Butler, S. "Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing," *The Brookings Institution* (February 2017).

¹⁵ E.H. Bradley and Taylor, L.A. *The American Health Care Paradox: Why Spending More is Getting Us Less* (PublicAffairs, 2013).

While the Triple Aim does not explicitly state that social determinants of health must be addressed as part of the framework, this activity is critical to concurrently meeting the goals.



DEFINING POPULATION HEALTH

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The term was coined in 2003, but is a pre-existing concept that considers the overall health and health outcomes for populations, as well as the social and economic disparities that affect the health of individuals or a population. When put into practice in a health care setting, population health views patients both as individuals and as members of a broader population. Organizations that adopt population health practices provide proactive patient support and outreach to prevent exacerbation of issues, diseases, and conditions, and ensure that individuals receive the appropriate level of care at the right time in the setting most appropriate for their needs.

Differentiating Population Health, Community Health, and Public Health

While “population health,” “public health,” and “community health” share some commonalities, the terms are distinct and should not be used interchangeably.

Public Health

Public health includes any organized measures to prevent disease, promote health, and prolong life among entire populations. Public health often includes public policies and large-scale programs on health and wellness promotion. They can be disease-specific or generally related to health.

Community Health

Community health is a field within public health that deals with the health of a population within a local geography. Typically, there is a strong focus on social interventions and activities can take place as part of a larger public health initiative or can be neighborhood or region-specific.

EMERGING PRACTICES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

There are various trends calling on health care providers—especially primary care practices—to address social needs as part of regular health care.

DSRIP

In New York, DSRIP aims to reduce avoidable Medicaid admissions, readmissions, and emergency department visits by 25% in five years. As part of the program, hospitals and primary care practices must partner with CBOs for social needs and to provide social support where needed. Examples of partnerships include:

- Coordination between PPS and CBOs that provides evidence-based asthma interventions for children and families affected by the disease

SECTION ONE (continued)

- Partnerships with CBOs to implement the Stanford Model, an evidence-based coaching model for individuals with diabetes to help them manage their condition
- Partnerships between PPS and CBOs to locate uninsured individuals and individuals with Medicaid who do not regularly access care, engage them into primary care, and enroll qualifying patients into the State's Health Home program, which provides care management services for individuals with a behavioral health diagnosis or multiple chronic conditions
- Development of feedback loops and referral trackers between health care providers and CBOs so referrals can be followed and health care systems can confirm that patients attend social needs-related appointments

The National Committee on Quality Assurance's (NCQA) 2017 Patient-Centered Medical Home (PCMH)

This model includes optional requirements for practices to address social determinants of health. The NCQA provides a framework for high-functioning primary care practices and is adopting this important aspect of care. Practices seeking recognition under the 2017 program can elect to demonstrate the following:

- Identify and establish connections to community resources to collaborate and direct patients to needed support
- Assess health care disparities using performance data stratified for vulnerable populations
- Obtain feedback on experiences of vulnerable patient groups
- Understand social determinants of health for patients, monitor them at the population level, and implement care interventions based on the data

Accountable Health Communities (AHC)

The Center for Medicare & Medicaid Innovation (CMMI) recently began AHC, which requires participating organizations to assess patients for social needs that impact health. Social conditions of particular focus include housing insecurity, food insecurity, utility needs, transportation needs, and interpersonal violence.

The AHC project has different tiers of participation and project activities include:

- Screening for these needs
- Providing information to patients if a particular need is identified
- Referring patients to organizations that can address their needs
- Formally collaborating with CBOs to improve the system by which the needs are addressed

These activities from across the country demonstrate the importance of assessing and addressing these social needs within the health care setting. Teaching hospitals should consider engaging residents in these activities when available to further their understanding of social determinants of health. Participation opportunities for residents include ensuring they have the information necessary to refer patients to organizations that provide social support, including residents in case conferences where social needs are discussed, and sharing data with residents on practice-level performance for social needs assessments and referral processes.



ARTICLES DEMONSTRATING THE LINK BETWEEN SOCIAL NEEDS AND HEALTH

The Impacts of Affordable Housing on Health: A Research Summary (The Center for Housing Policy)
http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf

Dwelling Disparities: How Poor Housing Leads to Poor Health (*Environmental Health Perspectives*)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1257572>

Feasibility and Acceptability of a Co-Located Homeless-Tailored Primary Care Clinic and Emergency Department (*Journal of Primary Care and Community Health*)
<http://journals.sagepub.com/doi/full/10.1177/2150131917699751>

Food Insecurity and Health Outcomes (*Health Affairs*)
<http://content.healthaffairs.org/content/34/11/1830.full>

Inequalities in Neighborhood Child Asthma Admission Rates and Underlying Community Characteristics in One U.S. County (*The Journal of Pediatrics*)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3746008>

Poverty, Maternal Health, and Adverse Pregnancy Outcomes (*Annals of the New York Academy of Sciences*)
<http://onlinelibrary.wiley.com/doi/10.1196/annals.1425.016/full>

Understanding the Social Factors that Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill (*The Permanente Journal*)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662286>

ADDITIONAL RESOURCES

Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment

The issue brief published by The Commonwealth Fund describes evidence that demonstrates the impact of social needs on health outcomes. The brief includes the economic rationale for investing in social interventions and provides strategies for implementing such interventions.

<http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs>

Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity

The issue brief published by the Kaiser Family Foundation describes the emerging practice of addressing social determinants of health as part of a population and community health strategy. The brief discusses public health interventions, delivery system transformations, payer and provider efforts, and state and Federal funding initiatives that have advanced the role of social determinants of health.

<http://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity>

Social Determinants of Health

A webpage published by the US Office of Disease Prevention and Health Promotion describes the social determinants of health and strategies for addressing them. Other pages on the website provide additional information, implementation resources, and examples of social and community interventions across the country.

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

US Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries

The issue brief published by The Commonwealth Fund compares health care spending, utilization, and health outcomes across 13 high-income countries, and shows that the United States has poorer health outcomes despite having the highest levels of spending. The brief suggests that emerging reimbursement models that reward outcomes may drive more cost-effective ways to improve health.

<http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>

SECTION TWO

ADDRESSING THE NEEDS OF THE COMMUNITY

During training, primary care residents should learn about the communities where their patients live. Residency program requirements emphasize developing a curriculum that includes population health and the evaluation of community health problems. ACGME institutional requirements also state that residents must have access to data to improve systems of care, reduce health care disparities, and improve patient outcomes. There are several ways for residents to learn about the communities they serve and use community-level data to help their clinical practice. The following section describes community orientation activities and resident projects that help residents learn about the environment outside of the hospital or practice's four walls.

LEARNING OBJECTIVES

- ✔ Describe the medical neighborhood and the role of CBOs within it
- ✔ Identify common social needs within the community served by the primary care practice
- ✔ Recognize the prevalence of chronic diseases within a community based on available data sources
- ✔ Identify several local CBOs that address specific social needs for patients; identify referral mechanisms for those CBOs

TEACHING CONTENT AND LEARNING ACTIVITIES

CBOs Support Addressing Social Determinants of Health

Individuals rely on health care providers, communities, and community supports to stay healthy. This multipronged approach to health means organizations must work together to improve both individual and community health. These organizations, many of which provide social services, make up the medical neighborhood (Figure 12).

CBOs provide a wide range of services that vary based on the organization. This broad category includes large multi-service organizations that provide billable health care and non-billable social services, as well as small organizations that provide social supports in their communities. Examples of CBOs include, but are not limited to:

- YMCAs
- Libraries
- Housing providers
- Faith-based organizations
- Community centers
- Food pantries and soup kitchens
- Neighborhood- or community-specific coalitions



FINDING CBOS IN YOUR COMMUNITY

GNYHA's Health Information Tool for Empowerment (HITE), at <http://www.hitesite.org>, is a public website that lists health and social service providers in New York City's five boroughs, as well as Nassau and Suffolk counties. HITE lists approximately 6,000 resources for low-income, uninsured, and underinsured individuals. Outside New York City, available resource directories include 2-1-1, NY Connects, and other locally managed databases.

Residents can search the databases for organizations that provide the services important to their patients. [Appendix B](#), which includes vignettes of social needs and their impact on health, can be used to prompt residents to use available community resource data to find organizations to address the needs of the described patients. Additional instructions are in the appendix.

CBO services can include care management, housing placement, financial assistance, benefits enrollment, food and meal assistance, employment and vocational training, and general social support. CBOs play a critical role in the medical neighborhood because they are trusted community entities with regular access to individuals outside the health care environment. Aside from providing specific services, CBOs can help with individual and community-level engagement. DOH developed a methodology for categorizing CBOs by types of services provided and the extent the services are billable to Medicaid ([Appendix C](#)).

FIGURE 12. THE MEDICAL NEIGHBORHOOD



COMMUNITY ORIENTATION

Residents should take time to tour the community they serve. Faculty can develop a self-guided tour for residents or engage a willing community member to serve as a guide. Residents can begin at a sample patient's home address. Stops could include the following types of organizations:

- Benefits enrollment site
- Food pantry
- Community center or recreational center
- Organization for individuals who are undocumented
- Cultural organizations that support a particular population
- Youth support organization

With each organization, residents could note the services provided; the communities or populations served; the number of individuals served daily, weekly, monthly (or whatever interval is appropriate); and if known, the types of health issues raised in these settings.

In addition to CBOs, residents can seek other community assets such as grocery stores, parks, banks, and pharmacies. Residents should note transportation availability, related costs, and travel time. Identifying this range of community sites and their locations will give residents a sense of the daily challenges their patients may experience, and the ways these challenges can impact health. Residents may note that long travel times can impact the abilities to pick up medications and access healthy food, and unsafe neighborhoods may prohibit physical activity. Residents who have participated in this kind of community orientation have self-reported a better understanding of the communities they serve. It also increased their empathy for individuals living in these neighborhoods.¹⁶

The community tour can be supplemented with an asset-mapping activity that helps residents note the resources available in a community that address a particular issue or set of issues. Asset mapping provides information about the strengths and resources of a community and can help uncover solutions.¹⁷ Residents can use a map of a particular area generated by Google Maps or another mapping website or software, and can note on their maps the locations of the organizations they visited. [Figure 13](#) is an example of a completed mapping activity.

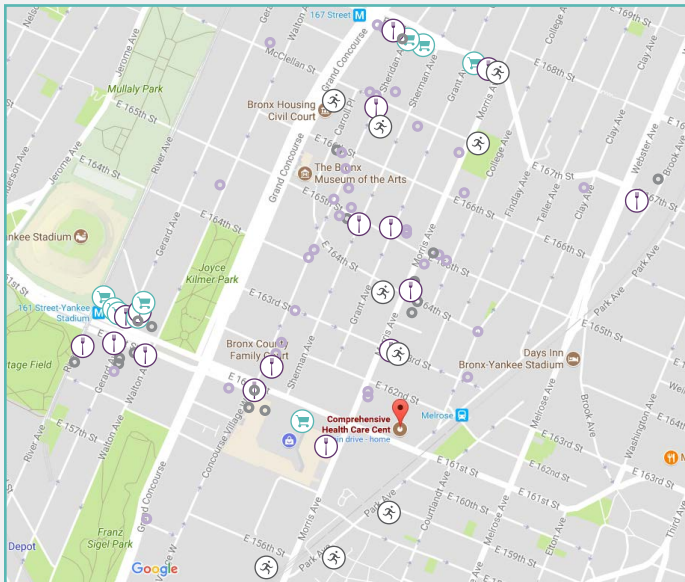
CREATING AN ASSET MAP

The University of California Los Angeles' Center for Health Policy Research has developed an overview of asset mapping and detailed instructions as part of its curriculum on performing a community needs assessment. The curriculum is available at <http://healthpolicy.ucla.edu/programs/health-data/trainings/Pages/community-assessment.aspx>, and mapping instructions are in the curriculum's Appendix A, Section 1.








¹⁶ F. Joseph Real, MD, et al. "A Self-Guided Tour of an Impoverished Neighborhood Changes Pediatric Residents' Perspectives." *Medical Science Educator* (2015).

¹⁷ UCLA Center for Health Policy Research

FIGURE 13. NEIGHBORHOOD MAPPING¹⁸

Sources of food and exercise around the Montefiore Comprehensive Health Care Center

-  Grocery store (n=9)
-  Restaurants (n=16)
-  Exercise site (n=9)
-  Fast food outlet (n=17)
-  Bodegas (small variety stores, n=34)

CONDUCTING A HOME VISIT

Visiting patient homes also can be an eye-opening experience for residents. Partnerships with a mobile crisis unit, a visiting nurse service, a Meals on Wheels service, or a provider of other home-based services can provide a brief but impactful view for residents to better their understanding of their patient's daily lives. NewYork-Presbyterian/Columbia's pediatric residency program enables residents to conduct home visits. The following guidelines are given to residents:

- Engage a patient/family from your practice to request a home visit, and agree on a date and time
- Contact the home visit faculty mentor before the visit date to arrange a meeting place with him/her
- One or two days before the visit, contact your designated patient/family to confirm they will be home
- Obtain exact directions to the patient's home—a phone app may not bring you to the exact address—and it may be helpful to confirm directions with the family
- On the day of the visit, ensure that you:
 - bring a blank encounter form to write in
 - bring your stethoscope and otoscope (if you have one)
 - consider bringing an age- and language-appropriate book for each child in the home
- If you plan multiple home visits on the same day, see the patient who lives the farthest from the hospital first, then work your way back to the hospital site

¹⁸ Map data ©2017 Google

USING DATA TO IDENTIFY COMMUNITY NEEDS

Residents can use publicly available data sources to learn about disease prevalence and health disparities in the communities they serve. The following data sources may be useful:

Community Health & Chronic Disease Data

DOH collects data on myriad chronic diseases, which is publicly available at <https://health.data.ny.gov>. The Community Health & Chronic Disease section of the site links to more than 150 reports, documents, and datasets to identify ongoing and potential initiatives to improve health and impact health disparities. Local health departments often offer data to the public to inform policy and evaluate public health programs. Datasets can be used by residents to identify community health gaps and improvement opportunities.

Mapping Medicare Disparities (MMD) Tool

The Centers for Medicare & Medicaid Services' MMD Tool contains health outcome measures for disease prevalence, costs, and hospitalization for 18 specific chronic conditions, emergency department utilization, readmissions rates, mortality, and preventable hospitalizations. The tool allows the visualization of health outcome measures at a national, state, or county level. Outcome measures are available by age, race ethnicity, and gender, and comparisons between geographic locations and racial and ethnic groups can be explored. The MMD Tool is available at <https://data.cms.gov/mapping-medicare-disparities>.

DATA2020

The US Office of Disease Prevention and Health Promotion and the Office of Minority Health support a publicly available tool called DATA2020 (<https://www.healthypeople.gov/2020/data-search/health-disparities-data>), which can query health disparities information for measurable, population-based objectives. The tool is part of Healthy People 2020, a Federal public health initiative to improve the health of all Americans.

County Health Rankings and Roadmaps

County Health Rankings and Roadmaps, at <http://www.countyhealthrankings.org>, includes snapshots and comparisons of county-level health measures. Full data sets are also available for analysis.

Electronic Medical Records (EMR)

Hospitals and health systems may also access additional data with their EMRs or other data collection and analytical tools that predict risk based on patient conditions, which may include social needs. These data warehouses, often managed by a hospital's population health department, may also include claims data on activity billed to Medicare, Medicaid, and insurance companies.

The above data sources can be used by residents to identify community-level or population-level gaps that can be addressed through a quality improvement project. Examples of resident projects include:

- "Hotspotting" to identify health issues at the specific neighborhood, community, or building level, and develop a specific intervention
- Reviewing a hospital's community needs assessment for a particular issue of importance and developing an intervention for that need. A slide deck on hospital community needs assessments is in [Appendix D](#)



WHAT IS HOTSPOTTING?

Health care hotspotting, which was developed by the Camden Coalition, is a data-driven process to identify extreme patterns in a defined region of the health care system. It guides targeted intervention efforts to better address patient needs, improve care quality, and reduce costs.¹⁹ The process typically uses hospital reimbursement claims that provide diagnostic and cost information. The data are usually cleaned up and standardized before analysis. A free toolkit on implementing hotspotting is at <http://healthcarehotspotting.com>.

ADDITIONAL RESOURCES

Community Needs Assessment as a Teaching Tool in a Family Medicine Residency

This article describes how a family medicine practice in Harlem, NY incorporated the development of a community health needs assessment (CHNA) into the resident curriculum. It discusses the steps taken to teach residents about CHNAs, the process for conducting the actual assessment, and the CHNA findings.

<http://www.stfm.org/FamilyMedicine/Vol48Issue8/Wilder635>

Community Tool Box: Chapter 3, Section 8. Identifying Community Assets and Resources

This section of the University of Kansas' toolkit describes methods to identify and map community assets. It includes concepts that learners should understand to proceed with asset mapping and tools to implement mapping activities. Other toolkit sections that may be of interest include chapters 7, 17, 18, and 19.

<http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main>

Introduction to Hotspotting

The Camden Coalition of Healthcare Providers provides a video curriculum on hotspotting. The curriculum defines hotspotting and associated terminology, reviews the development of the hotspotting technique, and discusses the role and importance of the interdisciplinary care team.

<https://www.camdenhealth.org/curriculum/intro-to-hotspotting>

Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report

This report discusses opportunities and challenges to collecting and utilizing data on social determinants of health. It contains a resource compendium of examples of social determinants data collection and referral efforts.

<https://healthleadsusa.org/wp-content/uploads/2016/06/RWJF-SDOH-Learning-Report.pdf>

¹⁹ "What is Hotspotting? Hotspotting Toolkit," *Camden Coalition of Healthcare Providers*. <http://healthcarehotspotting.com/wp/introduction> (accessed July 7, 2017).

SECTION THREE

ASSESSING SOCIAL NEEDS AND HEALTH LITERACY

Social needs—such as food, heat, and shelter—can impact a patient’s health. Residency program requirements emphasize the importance of residents' ability to independently assess community, environmental, and family influences on the health of patients. Primary care residents should assess patients for these social needs during the visit.²⁰ This is particularly important for patients from communities with high poverty rates who experience significant socioeconomic challenges that can negatively affect their health. Assessments for social needs can also be completed by other members of the care team, including medical assistants, care coordinators, or other staff. In this scenario, it is important for residents to understand the practice's communication mechanisms so that they are made aware of social needs that impact health. The following section describes various tools and resources to train residents on assessing social needs.

LEARNING OBJECTIVES

- ✔ Utilize screening tools to assess individuals for social needs that impact health
- ✔ Recognize the impact of social relationships on the health of individuals
- ✔ Identify examples of cultural differences within the practice’s patient population
- ✔ Demonstrate respect and address cultural differences within the patient population seen in the practice

TEACHING CONTENT AND LEARNING ACTIVITIES

Health care must evolve to include screening for social risks as part of clinical practice to augment public health and social policy strategies.²¹ This can be achieved by using screening tools developed to help assess individual social needs. Screening for social needs has proven valuable for certain age groups: children during well-child visits; patients with chronic habits, such as smoking; and high-risk patients with complex chronic diseases.

²⁰ J. Page-Reeves, et al. “Addressing Social Determinants of Health in a Clinic Setting: The WellRx Pilot in Albuquerque, New Mexico,” *Journal of the American Board of Family Medicine* vol. 29, no. 3, (May–June 2016).

²¹ C. Kenyon, et al “Revisiting the Social History for Child Health,” *American Academy of Pediatrics Gateway*, vol. 120, issue 3, (September 2007).



DEFINING SOCIAL RELATIONSHIPS

Social relationships—both quantity and quality—affect mental health, health behavior, physical health, and mortality risk.²² They are defined as relationships between more than one person, including networks of support and involvement of structural features such as a spouse or religious institution. Research has shown the following:

- Social relationships have significant effects on health
- Social relationships affect health through behavioral, psychosocial, and physiological pathways
- Relationships have costs and benefits for health
- Relationships shape health outcomes during the life course and have a cumulative impact on health in time
- The costs and benefits of social relationships are not distributed equally in a population

USE OF SCREENING TOOLS FOR ASSESSMENT

To understand these factors and their influence on health, residents should participate in activities to identify patients' social needs. There are many assessment tools that can help identify the needs of an individual or family. To date, no single screening tool has been identified as superior to others, though some have been clinically validated. Each clinical setting should choose a tool that identifies risks to patients in a particular community and work on consistent screening and outcome measurement.²³ The following tools can be found in the Appendix.

Social Needs Screening Tools

- The **Health Leads Social Needs Screening Tool** contains key areas clinicians should evaluate as part of a health assessment ([Appendix E](#)). Health Leads is nonprofit organization that provides health care systems with resources to address social needs and connect patients to community organizations.
- The **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)** is a national effort to help health centers and other providers collect data to better understand and act on their patients' social determinants of health. PRAPARE was developed by a group of stakeholders, including health centers and primary care associations, and aligns with nationally accepted elements for assessing social determinants of health developed by the Healthy People 2020 initiative ([Appendix F](#)).
- **IHELP** is a screening tool that collects pediatric social histories. Using an acronym (I – Income, Insurance; H – Hunger, Housing Conditions, Homeless; E – Education/Special Ed, Ensuring Safety; L – Legal

²² D. Umberson and Montez, J. K. "Social Relationships and Health: A Flashpoint for Health Policy," *Journal of Health and Social Behavior*, (August 4, 2011).

²³ A. F. Beck and Klein, M. D. "Moving From Social Risk Assessment and Identification to Intervention and Treatment," *Academic Pediatrics*, vol. 16, issue 2, (March 2016); 97–98.

Status; P – Power of Attorney), the tool assesses household needs, such as hunger and education, in addition to child-specific domains. This is a widely used tool among pediatric providers (Appendix G).

- The **AHC Health-Related Social Needs Screening Tool** combines other evidence-based screening tools into a single screener (Appendix H). The tool was developed by a multi-stakeholder advisory group comprised of nationwide experts on social determinants of health. The CMMI AHC project (page 13) requires participating programs use the screening tool it developed to assess housing and food insecurity, utility and transportation needs, and interpersonal violence.

Food Insecurity Screening Tools

Food security means access by all people at all times to enough food for an active, healthy life. Food insecurity measures were developed by the US Department of Agriculture (USDA) due to the associated negative health outcomes that accompany food insecurity, including mental health problems, chronic diseases such as diabetes and hypertension, and poor nutrition.

- A six-item questionnaire by researchers at the National Center for Health Statistics can be used on adult populations to screen for food insecurity (Appendix I).
- The Hunger Vital Sign was developed by Children’s HealthWatch (<http://childrenshealthwatch.org>), a non-partisan group of pediatricians and public health experts that improves the health of children. This two-item clinically validated survey is used to assess food insecurity among the pediatric population (Figure 14).

FIGURE 14. THE HUNGER VITAL SIGN

1

“Within the past 12 months we worried whether our food would run out before we got money to buy more.”

2

“Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”



ADDRESSING FOOD INSECURITY

The Food Research and Action Center has developed a toolkit for pediatric practices to address food insecurity among their patients: <http://www.frac.org/aaptoolkit>. The toolkit outlines Federal nutrition programs for children, some of which are also relevant to adults. Residents should become familiar with these programs, and learn about CBOs that can help patients apply for these important benefits.

Well-Being Screening Tools

According to the Centers for Disease Control and Prevention (CDC), well-being is a positive outcome meaningful for people and many sectors of society because it is an indicator for people's own perception of how their lives are going. Good living conditions (e.g., housing, employment) are fundamental to well-being.

- The Survey of Well-Being of Young Children is a free, comprehensive screening instrument for children under age five that assesses well-being in the pediatric population. It was developed at Tufts University and is available here: <https://www.floatinghospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview.aspx>.
- Cincinnati Children's Hospital Medical Center also developed a Family Well-Being Questionnaire for their primary care clinic to assess the well-being of entire families during a pediatric visit (Appendix J).

Domestic Violence Screening Tools

Screening for signs of domestic violence is a critical factor in assessing social needs. Victims of domestic violence often suffer from many other health issues, making screening by the primary care provider especially important. The HITS (Hurt, Insult, Threaten, and Scream) screening tool is a simple questionnaire to diagnose the presence of domestic violence, and also contains referral information (Appendix K).

HEALTH LITERACY AS A SOCIAL NEED

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and the services needed for appropriate health decisions. This is an important concept for engaging patients in discussions on social needs. The health care system is highly complex, so it is critical for residents and their care teams to help their patients navigate these complexities.

The Institute for Education on Health and Research created "Thumbs Up!® for Health," a comprehensive set of resources with clear and simple information on assessing health needs, including nutrition, smoking, weight management, and other chronic diseases such as diabetes and blood pressure (<http://www.thumbsupforhealth.org>). The tools are for all literacy levels and can facilitate communication between patients and providers on basic health issues.

Appendix L contains a case study from Stony Brook University Hospital on the Agency for Healthcare Research and Quality's Health Literacy Universal Precautions Toolkit, which is designed to help primary care practices reduce the complexity in health care, increase patient understanding of health information, and enhance support for patients at all health literacy levels. Developed by the North Carolina Network Consortium and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, the toolkit provides step-by-step guidance to assess a practice's health literacy environment and make changes to lessen the health literacy burden on patients. It includes 20 tools that address systems and staff behavior related to health literacy.²⁴

²⁴ A. G. Brega, et al. "Executive Summary, Demonstration of Health Literacy Universal Precautions Toolkit," (September 2014).

SECTION THREE (continued)

Screening for social needs is an important part of the visit between the physician and patient. Asking the patient about areas such as food and shelter can create a more patient-centered visit that opens a conversation about unmet needs. Once such information is obtained, it is easier for the physician to engage the entire care team and make the appropriate referral.

The below mnemonic is helpful for guiding the conversation between residents and patients.

LANES²⁵

- L Link the patient's social need to the general purpose of the visit or a health issue the patient is experiencing
- A Assess the patient's basic knowledge of the social need and how it can impact their health condition
- N Normalize the social need by providing community context and related statistics
- E Educate the patient on the connection to health
- S Share information on available community resources that address the social need

ADDITIONAL RESOURCES

Health Leads Screening Toolkit

The toolkit is a comprehensive resource that contains screening tools, best practices, and validated questionnaires at all literacy levels to be used for assessing social needs. The primary mission of Health Leads is to provide the health care community with the tools and expertise to care for patients and overall well-being. <https://healthleadsusa.org/tools-item/health-leads-screening-toolkit>

University of Michigan's Caring with Compassion

Caring with Compassion is a four-part curriculum to support health professionals who care for socioeconomically disadvantaged populations. The curriculum contains a separate module for educators to teach how to provide personalized care for at-risk patients. <https://caringwithcompassion.org>

²⁵ Adapted from Lauren Peccoraro, MD, The Mount Sinai Hospital.

SECTION FOUR

USING HOSPITAL RESOURCES TO ADDRESS SOCIAL NEEDS

Hospitals and health systems typically have infrastructure and resources in place to address social determinants of health for individual patients. Residency program requirements suggest that residents should demonstrate an awareness of, and responsiveness to, the larger context and system of health care, as well as the ability to call effectively on other resources in the system for optimal health care. This section describes how residents can work with various hospital departments to understand the role hospitals and health systems play in the health of their communities.

LEARNING OBJECTIVES

- ✔ Identify internal hospital departments and infrastructure that help to address social determinants of health
- ✔ Identify different workforce roles involved in social determinants of health

TEACHING CONTENT AND LEARNING ACTIVITIES

Residents should become familiar with the following terminology to understand the resources available at the hospital to support residents working to address patients' social needs or serve as a referral resource to support patients directly. Faculty also should review the programs available to the practice so residents understand the available resources and how to access them for their patients.

Accountable Care Organization (ACO)

An ACO is a group of doctors, hospitals, and other health care providers who voluntarily join together to give coordinated, high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and reducing overall costs, it will share in the savings it achieves for the Medicare program.

Medicare offers several ACO programs, each of which are structured slightly differently. Some states have Medicaid ACOs and some commercial insurance companies have their own ACO programs. Because ACOs decrease health care costs while increasing the quality of care for patients, participating practices often have staff dedicated to social needs, care navigation, and helping patients engage in their own care.

Centralized Care Management

Some hospitals have centralized care management departments or separate care management organizations that serve various needs across the institution. Care management can be social and/or medical in nature. Some institutions have concierge services to schedule appointments for patients requiring multiple subspecialty appointments.

Community Affairs Department

Many hospitals have departments that work with neighborhood coalitions, community advocates, and CBOs to plan community events such as health fairs and networking events. Individuals in these departments often also conduct the hospital's community needs assessments and write community service plans, which indicate the hospital's plan for community needs. They are also frequently aware of community-level issues and are very informative for residents who need community-level information.

Discharge Planning/Care Transitions

To avoid readmissions penalties, many hospitals have programs that ensure patients are prepared for discharge. The programs often include dedicated staff such as discharge planners, social workers, care managers, and care coaches who ensure patients are linked to necessary post-discharge services, some of which may include social services.

Health Home

A Health Home is a group of organizations coordinated by a lead entity that provides care management, coordination, and health promotion services for eligible Medicaid consumers. To be eligible for Health Home enrollment, individuals must meet the following minimum criteria:

- Have two or more chronic conditions, OR
- Have one serious and persistent mental health condition



HEALTH HOME CASE CONFERENCES

One way residents can ensure that their enrolled Health Home patients are receiving the services they need is to have them participate in case conferences with Health Home staff. This encourages residents to engage in structured, bi-directional communication with other members of the care team. These kinds of conferences also encourage inter-professional collaboration, which is critical to caring for patients with complex needs. DOH's AIDS Institute provides some guidelines on multidisciplinary case conferencing: https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/case_coordination_conferencing.htm.

Many New York hospitals lead or participate in a Health Home. Residents should be familiar with the ways patients can be referred for enrollment. A list of New York State's Health Homes is available at <https://www.>

health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm. The page also links to a list of Medicaid Health Homes for children.

The term “Health Home” does not refer to a particular location, unlike “PCMH,” which typically refers to a primary care practice. Health Home is also different from “home health,” which is a term typically used for health care within one’s home. Care management is a key Health Home service, and care management can be delivered by the hospital or CBO Health Home staff.

PCMH

The primary care practice, particularly one recognized by the NCQA as a high-functioning practice, should have mechanisms that support whole-person care. This may include specific care team members, such as social workers, patient navigators, care coordinators, and care managers, whose primary functions are to help patients improve their health. This also may include population health capabilities such as registries and electronic medical records access.

WORKFORCE ROLES

There are a number of roles within the hospital, or within external organizations that have partnered with the hospital, that can work with physicians on high-priority social needs for patients. Engaging individuals in these roles on the care team ensures that providers can focus on diagnosing and treating medical conditions, while also ensuring that social needs are part of the care plan, particularly if they are patient priorities. **Figure 15** lists typical roles responsible for social determinants of health as part of their day-to-day work with patients. Different institutions may have varying roles and responsibilities for these important members of the health care team. Residents should know the roles in their practice and those who fill them.

FIGURE 15: WORKFORCE ROLES

Role/Title	Potential Tasks Related to Social Determinants of Health
RN Care Coordinator Case Manager Care Transitions	<ul style="list-style-type: none"> Assess patients’ social needs and provide referrals to required services Provide clinical care management Provide self-management support Ensure patients are scheduled for required services, and follow-up with patients to ensure they received services
Social Worker	<ul style="list-style-type: none"> Assess patients’ social needs and provide referrals to required services Assess and address barriers to self-management Provide counseling and/or support for mental health issues
Care Coordinator Patient Navigator	<ul style="list-style-type: none"> Make and accompany patients to medical appointments and appointments at CBOs that address social needs Follow-up on referrals to CBOs Provide self-management support and coaching
Health Coach	<ul style="list-style-type: none"> Provide patient education on chronic disease management or other health conditions and concerns Use patient engagement techniques to assess patient priorities, and share information with the care team

SECTION FOUR (continued)

Role/Title	Potential Tasks Related to Social Determinants of Health
Community Health Worker	<ul style="list-style-type: none">• Provide self-management support• Accompany patients to appointments• Introduce patients to community-based services that can address needs• Educate patients about available ambulatory health care interventions• Visit patients in the home and escort them to appointments when needed
Peer Support Worker	<ul style="list-style-type: none">• Link patients to community supports• Advocate on behalf of patients to help support their goals

ADDITIONAL RESOURCES

Health Homes and Medical Homes (Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration)

This webpage defines the Health Home concept and the importance of integrating Health Home services, including care management, into the primary care setting. It provides detailed comparisons between Health Homes and PCMHs, as well as articles, presentations, and webinars.

<https://www.integration.samhsa.gov/integrated-care-models/health-homes>

Noncommunicable Diseases Training Modules

The CDC has a series of training materials to teach residents and other professionals to survey and prevent noncommunicable diseases, including chronic diseases. The introductory module includes learning objectives, a PowerPoint presentation, and facilitator and participant guides. Advanced modules include self-guided materials. The following modules are most relevant to topics in the curriculum:

- Prioritizing Public Health Problems
- Data Sources for NCD Surveillance
- Selecting Interventions
- Community Needs Assessments

https://www.cdc.gov/globalhealth/healthprotection/fetp/ncd_modules.htm#advanced

Weaving Whole-Person Health throughout an Accountable Care Framework: The Social ACO

This article, published in the *Health Affairs* blog, is part of a series on the culture of health. It discusses the concept of a “social ACO,” which centers on providing robust care coordination services and advanced primary care. The article includes barriers to integrating social services into primary care, important capabilities for integrating such services, and policy considerations for supporting service delivery.

<http://healthaffairs.org/blog/2017/01/25/weaving-whole-person-health-throughout-an-accountable-care-framework-the-social-aco>

SECTION FIVE

ADVOCACY

Serving as an advocate for patients within and outside the community is an important component of training in primary care. Residency program requirements state that residents should recognize the social context and environment and how a community's public policy decisions affect individual and community health. This can be achieved with active involvement in community education and policy change to improve the health of patients and communities. This section describes how residents can get more involved in community advocacy to benefit their patients.

LEARNING OBJECTIVES

- ✓ Recognize the impact of health policy on medicine and health outcomes
- ✓ Discuss key features of the legislative process in which physicians can encourage equity and promote health
- ✓ Recognize the power of the physician voice
- ✓ Advocate for individual patients and families within clinical encounters via engagement with various clinical resources
- ✓ Develop skills to communicate with legislators via e-mail, letter writing, and in-person advocacy

TEACHING CONTENT AND LEARNING ACTIVITIES

Training in health disparities and the specific social science domains of physician roles and behavior, social and cultural issues in health care, and health policy and economics should be incorporated in residency training and involve actual patient care.²⁶ A report from the Society of General Internal Medicine Task Force for Residency Reform recommended increased training to reduce health disparities, which should include curricular innovations to address social and cultural issues of care, health policy, and health economics.²⁷

Primary care residents should be equipped with the skills to engage in evidence-based community health activities and effective collaborations with CBOs. The Community Pediatrics Training Initiative of the American Academy of Pediatrics has developed a comprehensive advocacy guide to train residents on concepts such

²⁶ "Reforming Internal Medicine Residency Training: A Report from the Society of General Internal Medicine's Task Force for Residency Reform," *Journal of General Internal Medicine*, (2005).

²⁷ Ibid.

as legislative processes and how to communicate with policymakers (<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/CPTI/Pages/Advocacy-Training-Modules.aspx>).

DEVELOPING A MEDICAL-LEGAL PARTNERSHIP

Medical-legal partnerships (MLP) co-locate lawyers and paralegals in health care settings to identify and address social conditions that can impact health. This kind of partnership is valuable for patients because it provides resources to assist with non-health care issues that can have a clear and pressing impact on health. Examples of the legal issues that can be addressed by an MLP include:

- Housing conditions and landlord issues
- Discrimination in an educational or employment setting
- Exposure to domestic violence or abuse
- Child custody or guardianship

Through MLPs, residents can learn to work collaboratively with legal teams to identify and provide assistance for social needs that impact health. Legal teams are able to provide free services for patients ranging from individual consults to legal representation. Knowing that this resource is available in a practice can also help ensure that residents spend valuable time treating and diagnosing, while also ensuring that social determinants are addressed by this important extension of the care team. The National Center for Medical-Legal Partnership has comprehensive information on its website (<http://medical-legalpartnership.org>), including a toolkit on starting an MLP. Residents can play a helpful role in starting an MLP at the institution where they train, which can serve as a useful exercise in linking together social and legal issues facing their patients.

COLUMBIA'S LEGISLATIVE DAY

At NewYork–Presbyterian/Columbia's Department of Community Pediatrics, residents have a session devoted to an overview of the pediatrician's role in the legislative process. Next, they are asked to prepare a noon lecture on a current legislative topic of their choice. The department has also developed an advocacy curriculum for residents that covers topics such as healthier food options in New York City schools, Federal funding for children's hospitals, and gun violence. Under guidance from faculty, the residents themselves are asked to create a presentation using the following guidelines:

- Background of the issue
- Why should we care as pediatricians
- Past legislation/history of legislation
- Current proposed legislation
- What can we do as pediatricians

Columbia's advocacy curriculum is available here: http://www.columbia.edu/itc/hs/medical/residency/peds/new_compeds_site/y2_assignments.html.

MONTEFIORE WORKSHOP ON LOBBY DAY

Montefiore Medical Center's Social Medicine residency program conducts a lobby day for residents to

SECTION FIVE (continued)

learn about the legislative process using a timely and relevant issue in the health care industry (e.g., lobbying for universal health care). During the lobby day, local advocacy groups provide an overview of ways physicians can engage in writing for advocacy, including op-eds, opinion pieces, and social media posts. The residents then develop personal testimonials to be posted on social media.

Afterward, residents spend about 2.5 hours in a workshop to develop skills to speak to legislators. The workshop focuses on skills to relate a brief "personal" (from patient care, secondhand from a colleague, or from a family's experience) "on message" story to a legislator to convey how we as frontline providers perceive the issue and how New York State and the country as a whole have the resources to address the issue at hand. The faculty will start with a small introduction on speaking skills, how to calm nerves and get comfortable speaking, then focus on crafting the conversation as laid out above. Finally, the residents break into pairs to practice delivering the story to each other.

Residents should be prepared, have a "story," and identify the themes in advance that their story highlights. Then the residents write about something they would like to improve to become an effective speaker.

ADDITIONAL RESOURCES

Health Care Advocacy: A Guide for Busy Clinicians

The book is an introduction to health policy and advocacy and gives clinicians the knowledge and skills needed to become advocates for their patients. The book covers advocacy strategy and the importance of developing local partnerships. The text is used by the Society of General Internal Medicine (SGIM) to develop health policy leaders through its Leadership in Health Policy (LEAHP) program.

Teaching Health Policy to Residents—Three-Year Experience with a Multi-Specialty Curriculum

The Internal Medicine residency program at George Washington University has a health policy curriculum for residents that educates them on health policy, exposes them to policy makers, and promotes involvement in the development and implementation of health policy. This article details how the curriculum was implemented and improved residents' knowledge of health policy research, advocacy, and teaching.

http://www.med.unc.edu/rwj/about/news/current_scholar/Greysen_TeachingHealthPolicyResidents-JGIM.pdf

Understanding Health Policy: A Clinical Approach

This book addresses the needs of students and health care professionals to understand the health care system and how health care policy is developed. Case studies and exercises to assist the reader in applying the concepts to real-world situations are included. The text is also used by SGIM for the LEAHP program.

SECTION SIX

ASSESSMENT

The following domains of measurement can be used to evaluate residents' knowledge and understanding of the concepts of social determinants of health as outlined in this curriculum.

Domains of Measurement	Topic Areas from Curriculum	Source
Social Determinants of Health		
Identifies the roles of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention	Context and Theory of Social Determinants of Health	Adapted from ACGME Family Medicine Milestones
Identifies health inequities, social determinants of health, and their impact on individual and family health	Context and Theory of Social Determinants of Health	Adapted from ACGME Family Medicine Milestones
Demonstrates sufficient knowledge of socio-behavioral sciences, including but not limited to health care economics, medical ethics, and medical education	Context and Theory of Social Determinants of Health	Adapted from ACGME's Internal Medicine Curricular Milestones
Recognizes that disparities exist in health care among populations and that they may impact care of the patient	Context and Theory of Social Determinants of Health	Adapted from ACGME's Internal Medicine Curricular Milestones
Patient		
Demonstrates ability to care for patients with attention to the impact on their health of beliefs, values, and other social factors (e.g., language, education, finances)	Assessing Social Needs	Adapted from Montefiore Social Medicine Residency Program Competencies
Recognizes and/or screens for psychosocial problems and issues and documents as appropriate	Assessing Social Needs	Adapted from Montefiore Social Medicine Residency Program Competencies
Initiates basic counseling and referrals for most common mental health and psychosocial problems consistently and independently	Assessing Social Needs	Adapted from Montefiore Social Medicine Residency Program Competencies

SECTION SIX (continued)

Domains of Measurement	Topic Areas from Curriculum	Source
Elicits from patients and families cultural factors that impact health and health behaviors in the context of the biopsychosocial model	Assessing Social Needs	Adapted from ACGME Family Medicine Milestones
Is sensitive to and has basic awareness of differences related to culture, ethnicity, gender, race, age, and religion in the patient/caregiver encounter	Assessing Social Needs	Adapted from ACGME's Internal Medicine Reporting Milestones
Reflects awareness of common socioeconomic barriers that impact patient care	Assessing Social Needs	Adapted from ACGME's Internal Medicine Curricular Milestones
Team		
Mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals	Hospital and Community Infrastructure for Addressing Social Determinants of Health	Adapted from ACGME Family Medicine Milestones
Develops organizational policies and education to support the application of these principles in the practice of medicine	Hospital and Community Infrastructure for Addressing Social Determinants of Health	Adapted from ACGME Family Medicine Milestones
Responds welcomingly and productively to feedback from all members of the health care team, including faculty, peer residents, students, nurses, allied health workers, patients, and their advocates	Hospital and Community Infrastructure for Addressing Social Determinants of Health	Adapted from ACGME's Internal Medicine Curricular Milestones
Community		
Uses practice and community data to improve population health	Addressing the Needs of the Community	Adapted from ACGME Family Medicine Milestones
Partners with the community to improve population health	Addressing the Needs of the Community	Adapted from ACGME Family Medicine Milestones
Lists ways in which community characteristics and resources affect the health of patients and communities	Addressing the Needs of the Community	Adapted from ACGME Family Medicine Milestones
Identifies specific community characteristics that impact specific patients' health	Addressing the Needs of the Community	Adapted from ACGME Family Medicine Milestones
Understands the process of conducting a community strengths and needs assessment	Addressing the Needs of the Community	Adapted from ACGME Family Medicine Milestones

SECTION SIX (continued)

Domains of Measurement	Topic Areas from Curriculum	Source
Advocacy		
Recognizes social context and environment, and how a community's public policy decisions affect individual and community health	Advocacy	Adapted from ACGME Family Medicine Milestones
Collaborates with other practices, public health, and CBOs to educate the public, guide policies, and implement and evaluate community initiatives	Advocacy	Adapted from ACGME Family Medicine Milestones
Role-models active involvement in community education and policy change to improve the health of patients and communities	Advocacy	Adapted from ACGME Family Medicine Milestones
Identifies forces that impact the cost of health care, and advocates for and practices cost-effective care	Advocacy	Adapted from ACGME's Internal Medicine Reporting Milestones
Recognizes when it is necessary to advocate for individual patient needs to be accountable to patients, society, and the profession	Advocacy	Adapted from ACGME's Internal Medicine Curricular Milestones
Embraces physicians' role in assisting the public and policymakers in understanding and addressing causes of disparity in disease and suffering	Advocacy	Adapted from ACGME's Internal Medicine Curricular Milestones
Advocates for appropriate allocation of limited health care resources	Advocacy	Adapted from ACGME's Internal Medicine Curricular Milestones

APPENDIX A

SOCIAL DETERMINANTS OF HEALTH CONTEXT & THEORY SLIDE DECK

The full Context and Theory of Social Determinants of Health slide deck is available at <http://www.gnyha.org>.

CONTEXT AND THEORY OF
SOCIAL DETERMINANTS OF
HEALTH

GREATER NEW YORK HOSPITAL ASSOCIATION
*Over 100 years of helping hospitals deliver the
finest patient care in the most cost-effective way.*

Social Determinants of Health

3 Addressing Social Determinants of Health is an Important Component of Resident Education

Residents at New York's teaching hospitals provide primary care to high-need populations, many of which have social needs that impact health

Clinical Learning Environment Reviews (CLERs) require residents be involved in addressing health care disparities

Learners should have experience partnering with various community stakeholders to address social needs in more collaborative ways*

*Source: "A Framework for Educating Health Professionals to Address the Social Determinants of Health," National Academies of Sciences, Engineering, and Medicine (March 2016).

4 Learning Objectives

- Define and provide examples of social determinants of health
- Differentiate "equity" from "equality"
- Define and provide examples of health disparities
- Describe how common social needs can impact the health of an individual
- Describe how social determinants of health fit into broader health care policy

5 Defining Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: "Social Determinants of Health," Healthy People 2020.

6 Categories of Social Needs and Impact on Health

Studies demonstrate the link between social determinants and health. Many of the social needs listed have been linked to individuals' abilities to manage chronic disease, overall health, and avoid admissions for ambulatory-sensitive conditions.

Economic Stability	Neighborhood and Built Environment	Education	Food	Social and Community Context	Health and Health Care
Employment	Housing	Literacy	Hunger	Social Integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider ability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of Care
Medical bills	Plygrounds	Higher education			
Support	Walkability				

Health Outcomes: Mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations

7 Factors that Impact Health

- Quality and access to care have a 20% impact on overall health
- Social and economic factors have a 40% impact on overall health

Source: County Health Rankings and Roadmaps

8 How Social Needs Impact Health

- Watch this brief video on how social needs can impact health: https://www.youtube.com/watch?v=_11xLwKgWc
- Discussion questions:
 - Which social determinants of health are revealed?
 - Do patients on your panel experience any of these social needs?
 - Are there other social needs that your patients experience?
 - How have you seen those needs impact their abilities to care for themselves or their families?

9 Case Studies Demonstrating the Impact of Social Determinants of Health

For each person described, discuss the following:

- What are the social issues that impact their current health status or the health of their families?
- What are some examples of health issues that might go unaddressed because of the individual's social need?
- What services or resources are available in the primary care practice to further discuss and address the identified issues?
- What organizations in the community are you aware of that work with individuals with these needs? How would you connect a patient with those organizations?

10 SDH Case #1: Juan

Juan is a 52-year-old male with complex health conditions. He has Type 2 diabetes and congestive heart failure diagnoses. He recently lost his job after 25 years and is at risk of eviction from his apartment. He frequently visits the emergency department (ED) for a variety of reasons, ranging from chest pain to medication refills.

11 SDH Case #2: Maria

Maria is a 26-year-old single mother of two children who works long hours at a restaurant. She lives in a subsidized apartment building with her aging grandmother who has difficulty moving around and rarely leaves the apartment. Many of her neighbors smoke and there are reoccurring pest issues in the building. Maria does not have any diagnosed health issues, but her 8-year-old daughter has asthma, which has worsened over the past several months, causing Maria to leave work early a few times to bring her to the ED.

12 SDH Case #3: Kwame

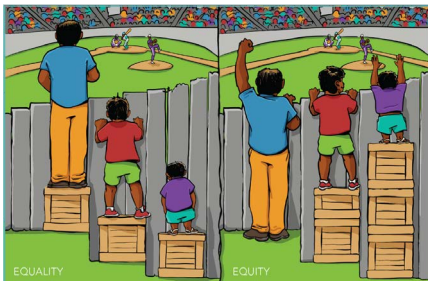
Kwame is a 45-year-old male who recently immigrated to the United States from Senegal. His family plans to join him when he can earn enough to pay for their immigration. He has a college degree from his country, but has been unable to find a job that enables him to save money. He speaks limited English, works many hours, and misses his family. He currently has no health issues, but he also does not know where to find a doctor that can speak to him in his native language.

13 SDH Case #4: Rita

Rita is a 17-year-old female and a survivor of sexual abuse from a former boyfriend. She is active in her care at an adolescent health clinic, but her parents do not know she receives care there, nor are they aware of her past abuse. She often isolates herself and has lost many friends over the past few months. She feels very lonely.

HEALTH EQUITY AND DISPARITIES

15 Equity versus Equality



Interaction Institute for Social Change | Artist: Angus Maguire

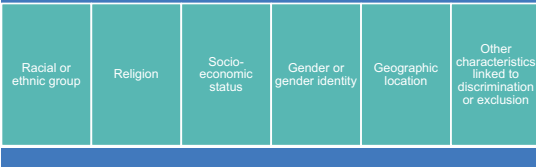
16 Equity versus Equality: Environmental Factors



Interaction Institute for Social Change | Artist: Angus Maguire

17 Defining Health Disparities

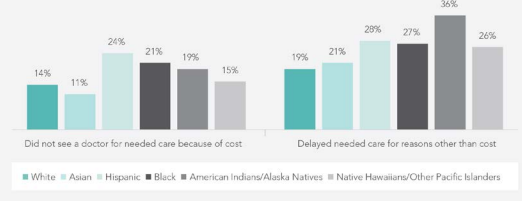
Differences in health outcomes based on a social, economic, or environmental disadvantage. Disparities adversely affect groups of people that have systematically experienced greater obstacles to health based on:



Source: "The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, Phase I report: Recommendations for the framework and format of Healthy People 2020," US Department of Health and Human Services, (October 28, 2008).

18 Example of Health Disparities: Access to Care

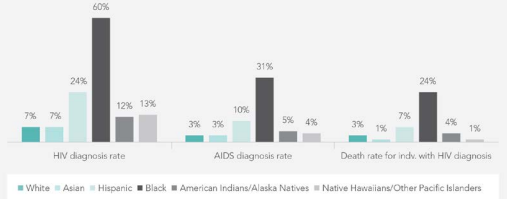
PERCENT OF NON-ELDERLY ADULTS WHO DID NOT RECEIVE OR DELAYED HEALTH CARE IN THE PAST 12 MONTHS BY RACE/ETHNICITY, 2014



Source: Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, (2014).

19 Example of Health Disparities: AIDS Mortality

AGE-ADJUSTED HIV AND AIDS DIAGNOSIS AND DEATH RATE PER 100,000 AMONG TEENS AND ADULTS BY RACE/ETHNICITY



Source: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention Atlas, (2014).

20 Importance of Addressing Health Equity as Primary Care Providers

Bias, prejudice, and stereotypes on the part of health care providers may contribute to differences in care

Although quality of care is improving for all populations, access to health care is deteriorating, and disparities are not changing

By 2060, it is estimated that 57% of the US population will be composed of members of underrepresented groups

It is estimated that eliminating health care disparities would decrease medical expenditures by ~\$29.4 billion dollars

Source: M. E. Maldonado, et al. "The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities," *Annals of the American Thoracic Society*, (March 2014).

SOCIAL DETERMINANTS OF HEALTH IN THE CONTEXT OF THE HEALTH CARE ENVIRONMENT

22 Increasing Health Care Costs

- The US spends approximately 17% of its gross domestic product (GDP) on health care, higher than what other countries spend
- Data shows that US health care spending is the costliest in the world, with costs projected to rise through 2020

HEALTH CARE SPENDING AS A PERCENTAGE OF GDP, 2013



Sources: "Organization for Economic Co-operation and Development, Health Expenditure and Financing Data 2015," (accessed July 7, 2017). "National Healthcare Expenditure Projections, 2010-2020," Centers for Medicare & Medicaid Services, Office of the Actuary.

23 Outcomes Do Not Reflect Spending Efforts

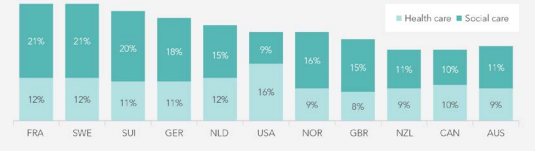
SELECT POPULATION HEALTH OUTCOMES AND RISK FACTORS

	Life exp. at birth, 2013	Infant mortality, per 1,000 live births, 2013	Percent of pop. age 65+ with 2+ chronic conditions, 2014	Obesity rate (BMI ≥30), 2013	Percent of pop. age 15+ who are daily smokers, 2013	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3	12.8	14.4
Canada	81.5	4.8	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5	24.1	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82	3.9	44	10.3	20.4	17.3
United Kingdom	81.1	3.8	33	24.9	20.0	17.1
United States	78.8	6.1	68	35.3	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

Source: OECD Health Data 2015

24 Social Supports Spending

HEALTH AND SOCIAL CARE SPENDING AS A PERCENTAGE OF GDP

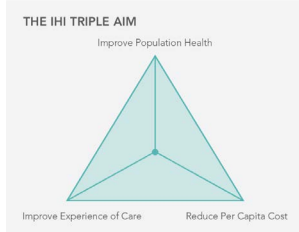


Source: E. H. Bradley and Taylor, L.A. "The American Health Care Paradox: Why Spending More is Getting Us Less." (Public Affairs, 2013).

25 Using the Triple Aim to Address Rising Health Care Costs

The Institute for Healthcare Improvement (IHI) Triple Aim includes the following elements in its framework for large-scale health improvement:

- Improve population health (improving the health of populations)
- Improve experience (improving individual outcomes)
- Decrease per capita cost (cost of care per individual)



Addressing social determinants of health is critical to meeting the Triple Aim goals

26 Policy-Driven Activities to Address Social Determinants of Health

Delivery System Reform Incentive Payment Program

- Goal to reduce Medicaid admissions, readmissions, and emergency department visits by 25% in five years
- CBO partners are engaged in projects to address social determinants, improve patient engagement and provide community support

Patient-Centered Medical Home

- Framework for high-functioning primary care practices that requires connections to community resources and assessment of health disparities and social determinants of health

Accountable Health Communities

- Federal grant project that requires participating organizations to assess patients for specific social needs that impact health. The project has different tiers of participation, and project activities include:
 - Screening for social needs
 - Providing information to patients if a particular need is identified
 - Referring patients to organizations that can address their needs
 - Formally collaborating with CBOs across the community to improve the system by which the needs are addressed

RESOURCES

28 Articles Demonstrating a Link between Social Needs and Health

The Impacts of Affordable Housing on Health: A Research Summary (The Center for Housing Policy)
http://www2.nhc.org/HISGandHealthLitRev_2015_final.pdf

Dwelling Disparities: How Poor Housing Leads to Poor Health (Environmental Health Perspectives)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1257572/>

Feasibility and Acceptability of a Co-located Homeless-Tailored Primary Care Clinic and Emergency Department (Journal of Primary Care and Community Health)
<http://journals.sagepub.com/doi/full/10.1177/2150131917699751>

Food Insecurity and Health Outcomes (Health Affairs)
<http://content.healthaffairs.org/content/34/11/1830.full>

Inequalities in Neighborhood Child Asthma Admission Rates and Underlying Community Characteristics in One U.S. County (The Journal of Pediatrics)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3746008/>

Poverty, Maternal Health, and Adverse Pregnancy Outcomes (Annals of the New York Academy of Sciences)
<http://onlinelibrary.wiley.com/doi/10.1196/annals.1425.016/full>

Understanding the Social Factors that Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662286/>

APPENDIX B

VIGNETTES DEMONSTRATING THE IMPACT OF SOCIAL NEEDS ON HEALTH

1. Juan is a 52-year-old male with complex health conditions. He has Type 2 diabetes and congestive heart failure diagnoses. He recently lost his job after 25 years and is at risk for eviction from his apartment. He frequently visits the ED for a variety of reasons, ranging from chest pain to medication refills.
2. Maria is a 26-year-old single mother of two children who works long hours at a restaurant. She lives in a subsidized apartment building with her aging grandmother who has difficulty moving around and rarely leaves the apartment. Many of her neighbors smoke and there are reoccurring pest issues in the building. Maria does not have any diagnosed health issues, but her 8-year-old daughter has asthma, which has worsened over the past several months, causing Maria to leave work a few times to bring her to the ED.
3. Kwame is a 45-year old male who recently immigrated to the United States from Senegal. His family plans to join him when he can earn enough to pay for their immigration. He has a college degree from his country, but has been unable to find a job that enables him to save money. He speaks limited English, works many hours, and misses his family. He currently has no health issues, but he also does not know where to find a doctor that can speak to him in his native language.
4. Rita is a 17-year-old female who is a survivor of sexual abuse from a former boyfriend. She is active in her care at an adolescent health clinic, but her parents do not know she receives care there, nor are they aware of her past abuse. She often isolates herself and has lost many friends over the past few months. She feels very lonely.

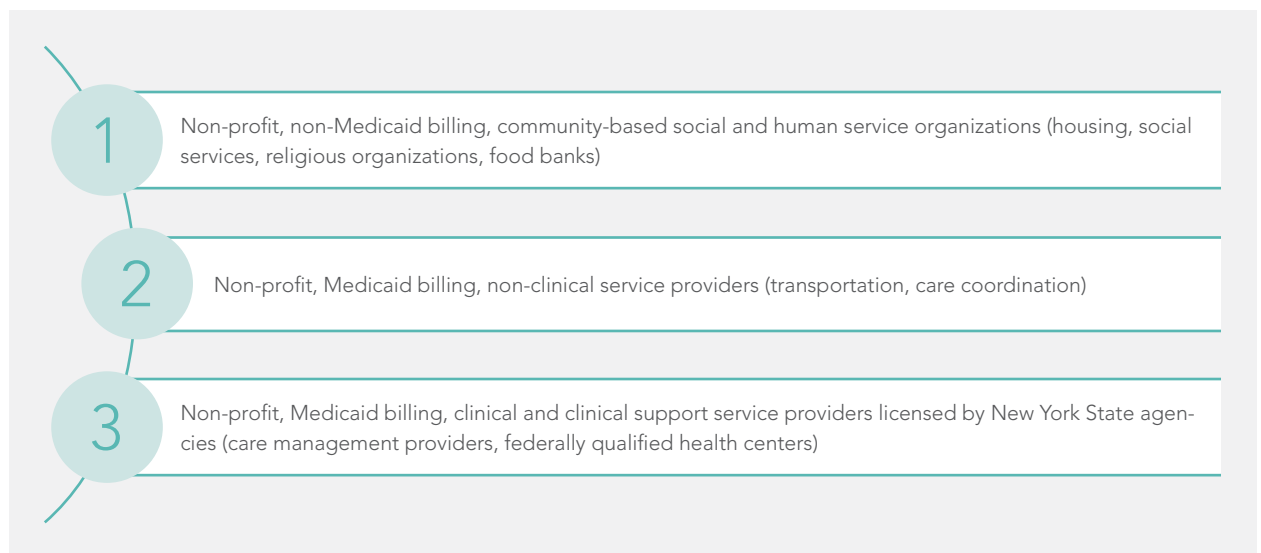
For each person described, discuss the following:

- What are the social issues that impact their current health status or the health of their families?
- What are some examples of health issues that might go unaddressed because of the individual's social need?
- What services or resources are available in the primary care practice to further discuss and address the identified issues?
- What organizations in the community are you aware of that work with individuals with these needs? Identify organizations that can address these social needs using a publicly available website or database.
 - Health Information Tool for Empowerment (www.hitesite.org) for NYC and Long Island resources
 - 2-1-1 (<http://211nys.org>) for the rest of New York State

APPENDIX C

NEW YORK STATE DEPARTMENT OF HEALTH CBO TIERS

The New York State Department of Health developed CBO tiers based on the recommendation of its Value-Based Payment Subcommittee on Social Determinants of Health and CBOs. The purpose of the tiers was to provide broad definitions that could be used to classify the many types of CBOs.



CBOs may fall into more than one category. Additional information on the development of the CBO tiers is available here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/social_determinants_of_health_and_cbos.htm.

APPENDIX D

HOSPITAL COMMUNITY NEEDS ASSESSMENTS SLIDE DECK

The full Community Needs Assessments slide deck is available at <http://www.gnyha.org>.

COMMUNITY NEEDS ASSESSMENTS

GREATER NEW YORK HOSPITAL ASSOCIATION
Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

2 Presentation Outline

- Community Needs Assessment Overview
- CNA Development Process
 - Planning
 - Data collection and analysis
 - Implementation
- CNA Considerations

3 CNA Overview: Definitions

CNA: Common terminology in the public health practice referring to a data- and information- driven review of community needs that can drive strategies policy, environmental, or systems changes

Community health assessment: part of a strategic plan that describes the health of the community by collecting, analyzing and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health

Community health needs: gaps and deficiencies identified through a community health assessment that can be addressed through multi-sectoral partnerships and building on existing community strengths

4 CNA Overview: Who Conducts a CNA?

- Community leaders and community groups** • To guide community planning decisions and resource requests
- Public health departments and planners** • To determine needed resources and develop supportive programming
- Hospitals and health systems** • Mandated by the Affordable Care Act, and as part of their Community Service Plans which are a Federal tax-exemption requirement ("Community Health Needs Assessment")
- Researchers** • To guide policy development and community-level interventions

5 CNA Development Process

The New York State Department of Health recommends a 10-step process based on existing assessment planning models and frameworks

Planning

- Establishing the assessment team
- Identifying and securing resources
- Identifying and engaging community partners

Data Collection and Analysis

- Collecting, analyzing, and presenting data
- Setting health priorities
- Clarifying the issues

Implementation

- Setting goals and measuring progress
- Choosing a strategy
- Developing a CNA document
- Maintaining and sustaining progress

Source: <https://www.health.ny.gov/statistics/chac/10steps.htm>

6 CNA Development Considerations: Planning

- Establishing the assessment team**
 - Secure buy-in and champions
 - Identify potential challenges, barriers, and training needs
- Identifying and securing resources**
 - Develop planning and implementation budgets
 - Identify existing and needed resources
- Identifying and engaging community partners**
 - Define the community being assessed
 - Identify key individuals and partners and their roles
 - Develop communications strategies

Source: <https://www.health.ny.gov/statistics/chac/10steps.htm>

7 CNA Development Considerations: Data Collection and Analysis

- Collecting, analyzing, and presenting data**
 - Use secondary data, such as State and local public health status data sources
 - Identify whether primary data is necessary, conducting surveys and collecting data as needed
- Setting health priorities**
 - Agree on criteria for determining focus areas
 - Use consensus methods with the team to select priorities
- Clarifying the issues**
 - Identify factors that contribute to areas of concern
 - Collect additional data to confirm high-impact factors

Source: <https://www.health.ny.gov/statistics/chac/10steps.htm>

8 CNA Development Considerations: Planning

- Setting goals and measuring progress**
 - Review Federal, state, or local public health goals and use as a basis for goal setting
- Choosing a strategy**
 - Review and select evidence-based strategies
- Developing a CNA document**
 - Use existing templates or guidance documents to write an implementation plan
- Maintaining and sustaining progress**
 - Develop a plan to maintain engagement with community partners and assess changes in the community over time

Source: <https://www.health.ny.gov/statistics/chac/10steps.htm>

9 CNA Resources

- NYSDOH Resources**
 - Prevention Agenda for the Healthiest State: 2013-2017 (NYS' public health improvement priorities) http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm
 - Prevention Agenda Data Dashboard https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/quest?_program=EBI/PHIG/apps/dashboard/pa_dashboard
 - NYSDOH Guidance to Local Health Departments and Hospitals on Community Service Plans and County Community Health Needs Assessments http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf
 - DCH 10 Steps in Community Health Assessment Development Process <http://www.health.ny.gov/statistics/chac/10steps.htm>
- New York City**
 - NYC Department of Health and Mental Hygiene Take Care New York (NYC's public health improvement priorities) <http://www.nyc.gov/html/doh/html/about/tcnr.shtml>
- Additional Resources**
 - University of Wisconsin and Robert Wood Johnson Foundation's County Health Rankings <http://www.countyhealthrankings.org/about-project>
 - University of Kansas Community Toolbox (CHNA Resource) <http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources>
 - National Association of County and City Health Officials' (NACCHO) Community Health Assessment and Improvement Planning <http://www.naccho.org/topics/infrastructure/CHAIP/index.cfm>
 - Healthy People 2020 <http://www.healthypeople.gov/2020/default.aspx>

APPENDIX E

HEALTH LEADS SCREENING TOOL

This is a sample social needs screening tool—please tailor it based on your population, scope, and goals. This work is licensed under a Creative Commons Attribution-ShareAlike 4.0 International License.

Name: _____ Phone number: _____
 Preferred Language: _____ Best time to call: _____

		Yes/No
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, has your utility company shut off your service for not paying your bills?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you worried that in the next two months, you may not have stable housing ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do problems getting child care make it difficult for you to work or study? <i>Leave blank if you do not have children.</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you needed to see a doctor but could not because of cost ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you ever need help reading hospital materials ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you afraid you might be hurt in your apartment building or house?	<input type="checkbox"/> Y <input type="checkbox"/> N
	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are any of your needs urgent? <i>For example: I don't have food tonight, I don't have a place to sleep tonight</i>	<input type="checkbox"/> Y <input type="checkbox"/> N

Adapted with permission from Health Leads Social Needs Screening Toolkit.

APPENDIX F

PRAPARE SCREENING TOOL

PERSONAL CHARACTERISTICS

1. Are you Hispanic or Latino?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
--------------------------	-----	--------------------------	----	--------------------------	--------------------------------------

2. Which race(s) are you? Check all that apply.

<input type="checkbox"/>	Asian	<input type="checkbox"/>	Pacific Islander	<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	American Indian/Alaskan Native
<input type="checkbox"/>	White	<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Other (please write)	<input type="checkbox"/>	I choose not to answer this question

3. At any point in the past two years, has season or migrant farm work been your or your family's main source of income?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
--------------------------	-----	--------------------------	----	--------------------------	--------------------------------------

4. Have you been discharged from the armed forces of the United States?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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5. What language are you most comfortable speaking?

<input type="checkbox"/>	English	<input type="checkbox"/>	Language other than English (please write)	<input type="checkbox"/>	I choose not to answer this question
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FAMILY & HOME

6. How many family members, including yourself, do you currently live with?

<input type="text"/>	<input type="checkbox"/>	I choose not to answer this question
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7. What is your housing situation today?

<input type="checkbox"/>	I have housing	<input type="checkbox"/>	I do not have housing (ex: staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	<input type="checkbox"/>	I choose not to answer this question
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8. Are you worried about losing your housing?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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9. What address do you live at?

Street	
City, State, Zipcode	

MONEY & RESOURCES

10. What is the highest level of school that you have finished?

<input type="checkbox"/>	Less than high school degree	<input type="checkbox"/>	High school diploma or GED	<input type="checkbox"/>	More than high school	<input type="checkbox"/>	I choose not to answer this question
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11. What is your current work situation?

<input type="checkbox"/>	Unemployed	<input type="checkbox"/>	Part-time or temporary work	<input type="checkbox"/>	Full-time work	<input type="checkbox"/>	I choose not to answer this question
<input type="checkbox"/> Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) (please write)							

12. What is your main insurance?

<input type="checkbox"/>	None/uninsured	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Other public insurance (not CHIP)	<input type="checkbox"/>	Other Public Insurance (CHIP)
<input type="checkbox"/>	CHIP Medicaid	<input type="checkbox"/>	Medicare	<input type="checkbox"/> I choose not to answer this question			

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

<input type="text"/>	<input type="checkbox"/> I choose not to answer this question
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14. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

<input type="checkbox"/>	Food	<input type="checkbox"/>	Utilities	<input type="checkbox"/>	Phone	<input type="checkbox"/>	Clothing	<input type="checkbox"/>	Child Care	<input type="checkbox"/>	Other (please write)
<input type="checkbox"/>	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)						<input type="checkbox"/> I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

<input type="checkbox"/>	Yes, it has kept me from medical appointments or from getting my medications	<input type="checkbox"/>	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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SOCIAL AND EMOTIONAL HEALTH

16. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

<input type="checkbox"/>	Less than once a week	<input type="checkbox"/>	1 or 2 times a week	<input type="checkbox"/>	3 to 5 times a week	<input type="checkbox"/>	5 or more times a week
<input type="checkbox"/> I choose not to answer this question							

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

<input type="checkbox"/>	Not at all	<input type="checkbox"/>	A little bit	<input type="checkbox"/>	Somewhat	<input type="checkbox"/>	Quite a bit	<input type="checkbox"/>	Very much	<input type="checkbox"/>	I choose not to answer this question
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OPTIONAL ADDITIONAL QUESTIONS

18. In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correctional facility?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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19. Are you a refugee?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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20. Do you feel physically and emotionally safe where you currently live?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unsure	<input type="checkbox"/>	I choose not to answer this question
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21. In the past year, have you been afraid of your partner or ex-partner?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I have not had a partner in the past year	<input type="checkbox"/>	I choose not to answer this question
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APPENDIX G

IHELP SOCIAL HISTORY TOOL

"Let me ask you some questions I ask every family."	
I <ul style="list-style-type: none"> Income Insurance 	<ul style="list-style-type: none"> Do you have any concerns about making ends meet? Do you have any concerns about your child's health insurance?
H <ul style="list-style-type: none"> Hunger Housing Conditions Homeless 	<ul style="list-style-type: none"> Do you have any concerns about having enough food? <ul style="list-style-type: none"> Have you ever been worried whether your food would run out before you got money to buy more? Within the past year has the food you bought ever not lasted and you didn't have money to get more? Do you have any concerns about poor housing conditions like mice, mold, cockroaches? Do you have any concerns about being evicted or not being able to pay the rent? Do you have any concerns about not being able to pay your mortgage?
E <ul style="list-style-type: none"> Education/Special Ed Ensuring Safety (Violence) 	<ul style="list-style-type: none"> Do you have any concerns about your child's educational needs? [Do not ask in front of child 3 or older or in front of other partner] From speaking to families, I have learned that violence in the home is common and now I ask all families about violence in the home. Do you have any concerns about violence in your home?
L <ul style="list-style-type: none"> Legal Status (Immigration) 	<ul style="list-style-type: none"> What hospital was your child born in? <ul style="list-style-type: none"> [If not in US] Are you aware that your child may be eligible for benefits even though they were not born in the U.S.? If you would like, I can have a social worker come talk to you about some possible benefits your child may be eligible for. Would you like me to do that?
P <ul style="list-style-type: none"> Power of Attorney Guardianship 	<ul style="list-style-type: none"> Are you the biological mother or father of this child? <ul style="list-style-type: none"> [If not] Can you show me the power of attorney or guardianship document you have? [Patients >17+ with mental incapacity: Ask for Guardianship] Are you the biological mother

APPENDIX H

ACCOUNTABLE HEALTH COMMUNITIES SCREENING TOOL

Turquoise answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7–10 are summed indicates a positive screen for interpersonal safety.

HOUSING INSTABILITY

1. What is your housing situation today?

<input type="checkbox"/>	I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
<input type="checkbox"/>	I have housing today, but I am worried about losing housing in the future.
<input type="checkbox"/>	I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

<input type="checkbox"/>	Bug infestation	<input type="checkbox"/>	Mold	<input type="checkbox"/>	Lead paint or pipes	<input type="checkbox"/>	Inadequate heat
<input type="checkbox"/>	Oven or stove not working	<input type="checkbox"/>	Water leaks	<input type="checkbox"/>	No or not working smoke detectors	<input type="checkbox"/>	None of the above

FOOD INSECURITY

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

<input type="checkbox"/>	Often true	<input type="checkbox"/>	Sometimes true	<input type="checkbox"/>	Never true
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4. Within the past 12 months, the food you bought didn't last and you didn't have money to get more.

<input type="checkbox"/>	Often true	<input type="checkbox"/>	Sometimes true	<input type="checkbox"/>	Never true
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TRANSPORTATION NEEDS

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply)

<input type="checkbox"/>	Yes, it has kept me from medical appointments or getting medications
<input type="checkbox"/>	Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
<input type="checkbox"/>	No

UTILITY NEEDS

6. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Already shut off
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INTERPERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?

<input type="checkbox"/>	Never (1)	<input type="checkbox"/>	Rarely (2)	<input type="checkbox"/>	Sometimes (3)	<input type="checkbox"/>	Fairly often (4)	<input type="checkbox"/>	Frequently (5)
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8. How often does anyone, including family, insult or talk down to you?

<input type="checkbox"/>	Never (1)	<input type="checkbox"/>	Rarely (2)	<input type="checkbox"/>	Sometimes (3)	<input type="checkbox"/>	Fairly often (4)	<input type="checkbox"/>	Frequently (5)
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9. How often does anyone, including family, threaten you with harm?

<input type="checkbox"/>	Never (1)	<input type="checkbox"/>	Rarely (2)	<input type="checkbox"/>	Sometimes (3)	<input type="checkbox"/>	Fairly often (4)	<input type="checkbox"/>	Frequently (5)
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10. How often does anyone, including family, scream or curse at you?

<input type="checkbox"/>	Never (1)	<input type="checkbox"/>	Rarely (2)	<input type="checkbox"/>	Sometimes (3)	<input type="checkbox"/>	Fairly often (4)	<input type="checkbox"/>	Frequently (5)
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APPENDIX I

USDA FOOD INSECURITY SCREENING TOOL

These questions are about the food eaten in your household in the last 12 months, since (current month) of last year, and whether you were able to afford the food you need.

NOTE: If the placement of these items in the survey makes the transition/introductory sentence unnecessary, add the word “Now” to the beginning of question HH3: “Now I’m going to read you....”

FILL INSTRUCTIONS: Select the appropriate fill from parenthetical choices depending on the number of persons and number of adults in the household.

HH3. I’m going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is, “The food that (I/we) bought just didn’t last, and (I/we) didn’t have money to get more.” Was that often, sometimes, or never true for (you/your household) in the last 12 months?

<input type="checkbox"/>	Often true	<input type="checkbox"/>	Sometimes true	<input type="checkbox"/>	Never true	<input type="checkbox"/>	DK or refused
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HH4. “(I/we) couldn’t afford to eat balanced meals.” Was that often, sometimes, or never true for (you/your household) in the last 12 months?

<input type="checkbox"/>	Often true	<input type="checkbox"/>	Sometimes true	<input type="checkbox"/>	Never true	<input type="checkbox"/>	DK or refused
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AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No (skip AD1a)	<input type="checkbox"/>	DK (skip AD1a)
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AD1a.[IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only one or two months?

<input type="checkbox"/>	Almost every month	<input type="checkbox"/>	Some months but not every month	<input type="checkbox"/>	Only 1 or 2 months	<input type="checkbox"/>	DK
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APPENDIX I (continued)

AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	DK
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AD3. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	DK
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APPENDIX J

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER SCREENING TOOL

Every family faces different stressors. We ask all families about these issues because we may be able to help you with them. We will keep this form confidential.

		Yes/No
1.	Within the past month, did you/your family worry whether your food would run out before you got money or SNAP/food stamps to buy more?	<input type="checkbox"/> Y <input type="checkbox"/> N
2.	Within the past month, did the food you/your family bought not last and you didn't have money to get more?	<input type="checkbox"/> Y <input type="checkbox"/> N
3.	Over the past two weeks, have you felt down, depressed, or hopeless?	<input type="checkbox"/> Y <input type="checkbox"/> N
4.	Over the past two weeks, have you felt little interest or pleasure in doing things?	<input type="checkbox"/> Y <input type="checkbox"/> N
5.	Are you currently having any problems with your WIC, SNAP/food stamps, daycare vouchers, medical card/insurance, SSI, or utilities?	<input type="checkbox"/> Y <input type="checkbox"/> N
6.	Are you currently having any housing problems (overcrowding, roaches, rodents, utilities, mold, lead) that your landlord is not helping you with?	<input type="checkbox"/> Y <input type="checkbox"/> N
7.	Are you currently being threatened with eviction or losing your home?	<input type="checkbox"/> Y <input type="checkbox"/> N
8.	Since your last appointment, have you had trouble paying for medications or have you chosen not to fill a medication due to cost?	<input type="checkbox"/> Y <input type="checkbox"/> N
9.	Do you currently have trouble getting to doctor's appointments or to the pharmacy?	<input type="checkbox"/> Y <input type="checkbox"/> N
10.	Has anything bad, sad, or scary happened to you or your child since your last clinic visit?	<input type="checkbox"/> Y <input type="checkbox"/> N
11.	Would you like to speak with someone who may be able to help you with these issues?	<input type="checkbox"/> Y <input type="checkbox"/> N
12.	Is there anything else we can help you with today? _____	

Please take a moment to update your contact information below. Remember, if you need us, we're here!

Preferred phone number: _____ Alternate phone number: _____

Email address: _____

What is the best way to reach you? Phone Text Email Other: _____

Adapted with permission from Cincinnati Children's Hospital Medical Center.

APPENDIX K

HURT, INSULTED, THREATENED WITH HARM AND SCREAMED (HITS) DOMESTIC VIOLENCE SCREENING TOOL

The following tool can be provided directly to the patient or used as a verbal assessment during a visit.

Please read each of the following activities and place a check mark in the box that best indicates the frequency with which your partner acts in the way depicted.

Date: _____ Age: _____ Sex (M/F): _____
Ethnicity: Caucasian _____ Hispanic _____ African American _____ Asian _____ Indian _____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically hurt you					
Insult or talk down to you					
Threaten you with harm					
Scream or curse at you					
	1	2	3	4	5
Total score:					

Each item is scored from 1–5 and the scoring range is between 4–20. A score greater than 10 signifies risk of domestic violence abuse, and counseling or help from a domestic violence resource center should be sought immediately.

Note: Local domestic violence hotline numbers and numbers for women’s shelters in the area can be listed here. Included in the list should be the National Domestic Violence Hotline: 1 (800) 799-SAFE (7233).

APPENDIX L

CASE STUDY: IMPLEMENTING A HEALTH LITERACY TOOLKIT

Name of Hospital: Stony Brook University Hospital

Location: Stony Brook, NY

BACKGROUND AND DESCRIPTION OF NEED

When the Agency for Healthcare Research and Quality (AHRQ) announced a pilot project for a Health Literacy Universal Precautions Toolkit (https://www.ahrq.gov/sites/default/files/publications/files/healthlit-toolkit2_3.pdf) in 2013, the outpatient practice at Stony Brook was working toward PCMH designation for both the attending practice and the resident clinic practice. Significant health literacy needs had been identified due to language, educational, cognitive, and socioeconomic barriers. Given the presence of many different learners in the practice, including students from the Stony Brook Schools of Social Work, Nursing, and Medicine, medical residents (including primary care and medicine-pediatrics residents) and geriatric fellows, the practice served as the ideal location to implement and study the health literacy toolkit.

The *Demonstration of Health Literacy Universal Precautions Toolkit* was funded by AHRQ. The objectives of the project were (1) to explore whether the Health Literacy Universal Precautions Toolkit assists primary care practices in reducing the complexity of health care, (2) to identify possible enhancements to the toolkit, and (3) to determine whether health literacy items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) are sensitive to change from health literacy-related quality improvement initiatives. With support from AHRQ, the Health Literacy Universal Precautions Toolkit was designed to provide primary care practices with guidance on enhancing the quality of communication with and support for patients of all health literacy levels.

ACTION

The practice site at Stony Brook was one of 12 primary care practice sites chosen to pilot AHRQ's first edition of the Health Literacy Universal Precautions Toolkit. Stony Brook's task was to implement tool #3 (Improve Health Literacy Awareness) and #5 (Teach-Back Method). A Health Literacy Team was assembled onsite to organize the project. Clinical staff, including residents, completed an initial health literacy survey that asked about health literacy knowledge and practice-specific questions. A "Health Literacy" team was developed in the clinic with representatives from all groups working in the clinic. The team organized quarterly health literacy conferences and "Teach-Back Tuesdays." See the actual announcements on the following page.

Quarterly Health Literacy Conferences

For the next conference, we are hoping to present information on how we are doing in the clinic. As the health literacy representatives from your departments (front desk/reception, back office, RN/phone triage, floor clinical providers, residents, attendings), we would like to hear from you how things are going with "Raising Awareness" and the "Teach-Back Method." If you are OK with this, we will block out 10 minutes for each of you during the conference so that you can give us an update and suggestions from each department. In order to help you with gathering information, we've created a survey that you can send out to everyone in your department. We will compile all of the information for your departments and can help you if you wanted to put it into PowerPoint format, etc.

"Teach-Back Tuesdays"

We will have everyone in the clinic perform a "teach-back" on the first patient that they encounter during their AM and PM session of the 1st Tuesday of every month. Practice makes perfect, and by starting this, we are hoping to encourage everyone to use it more and more with patients.

*Thanks for all your help and hard work!
- Health Literacy Team*

SUCCESSES AND CHALLENGES

Getting the entire practice to participate was essential. The entire team assembled to watch the American Medical Association's health literacy video (https://www.youtube.com/watch?v=cGtTZ_vxjyA), which they reflected on and discussed. Using an inter-professional, collaborative approach to health literacy was essential—the team wanted to work together to help patients to better navigate and experience the practice. All staff enthusiastically participated in planning and implementation of steps to improve communications, including using appropriate signage, assessing understanding, and communicating clearly with patients. Teach-back was most effectively implemented on the clinician side, with attendings assessing residents' and students' teach-back method use and skills.

LESSONS LEARNED

Increasing awareness of health literacy had the most impact. Staff understood why communication forms were important and helped the patients who had any difficulty completing them. "Ask Me 3" signs were placed in all the exam rooms and three key questions were asked at the end of each visit: 1) What is my main problem? 2) What do I need to do? 3) Why is it important for me to do this? Teach-back became the standard method for assessing how patients understood instructions and treatment plans during each visit and phone call. Frequent reminders and team meetings were essential. It was important to remind everyone in the practice that this was a change in how patients would be cared for in the long term, not just during the demonstration project. Having "champions" in each care area was important to maintain enthusiasm. Full implementation of all the tools in the toolkit would be ideal, but limited time and resources precluded this. Additionally, not having complete control over the practice's health literacy environment and the electronic health record content (patient instructions) limited the extent to which certain tools could be implemented.

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