Screening For Housing Status: Demystifying The Conversation And Developing Skills To Support Patients Who Are Experiencing Housing Instability

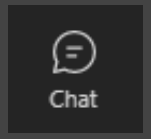
Virtual Learning Event: Tuesday, June 21, 2022, 1-2pm, PST

Welcome

Please mute when not speaking.

Cameras are encouraged.

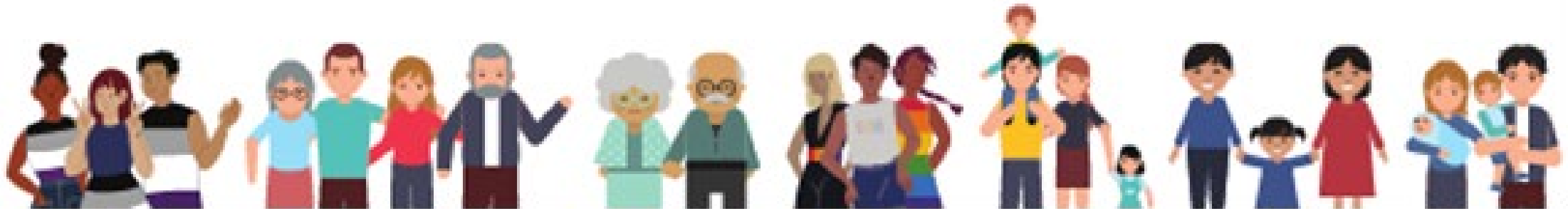
Interact and raise your hand with reactions.



Participate in discussion in the chat.

This learning event is being recorded.
Recording and slides will be shared.

BACKGROUND



The Association supports community health centers to establish and maintain social needs screening programs to connect clients to needed resources and better inform care leading to improved health outcomes and lives for clients.

We host a monthly Social Determinants of Health Workgroup to enable peer discussion, share best practices and challenges and training on helpful topics.

Washington Association for Community Health

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With generous support from the Kaiser Foundation Health Plan of Washington

LEARNING OBJECTIVES

At the end of the presentation participants will be able to:

- Identify staff barriers to discussing housing status with patients
- Understand the impact housing status can have on health outcomes
- Describe a validated screening question about housing status
- Apply the housing status screening question to a clinical scenario

INTRODUCTIONS

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Screening for Housing Status:

Demystifying the Conversation and Developing Skills to Support Patients Who are Experiencing Housing Instability

June 21, 2022

Kate Gleason-Bachman, RN, BSN, MPH
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HRSA Disclaimer

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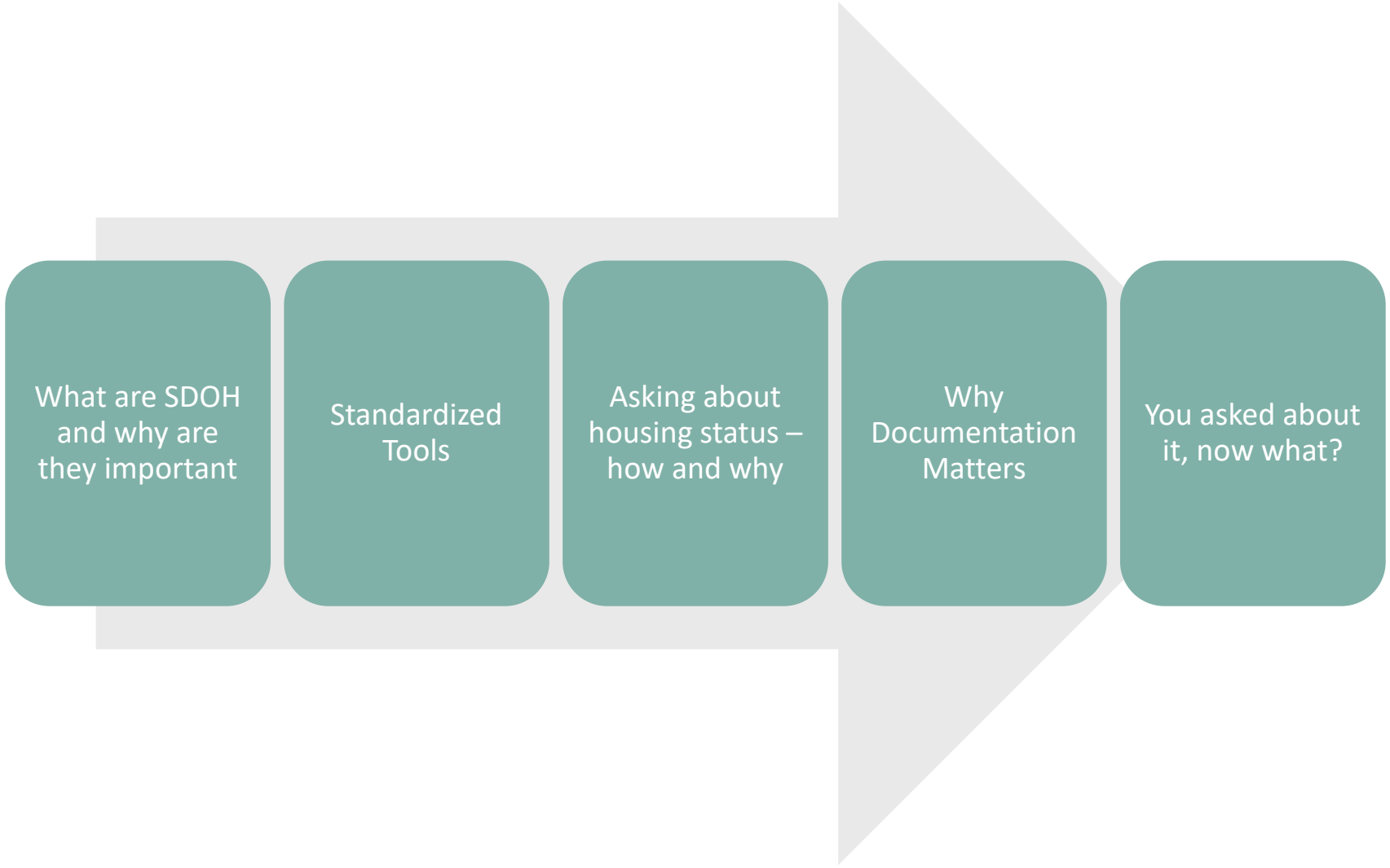
Agenda


What are SDOH and why are they important
Standardized Tools
Asking about housing status – how and why
Why Documentation Matters
You asked about it, now what?

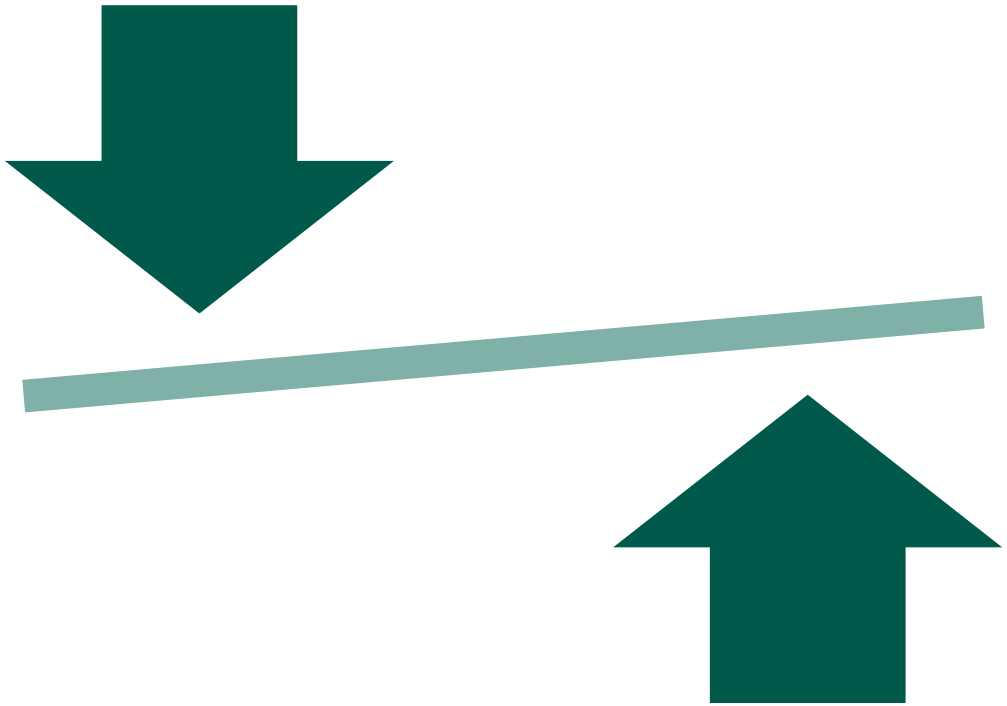
What are Social Determinants of Health?

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.

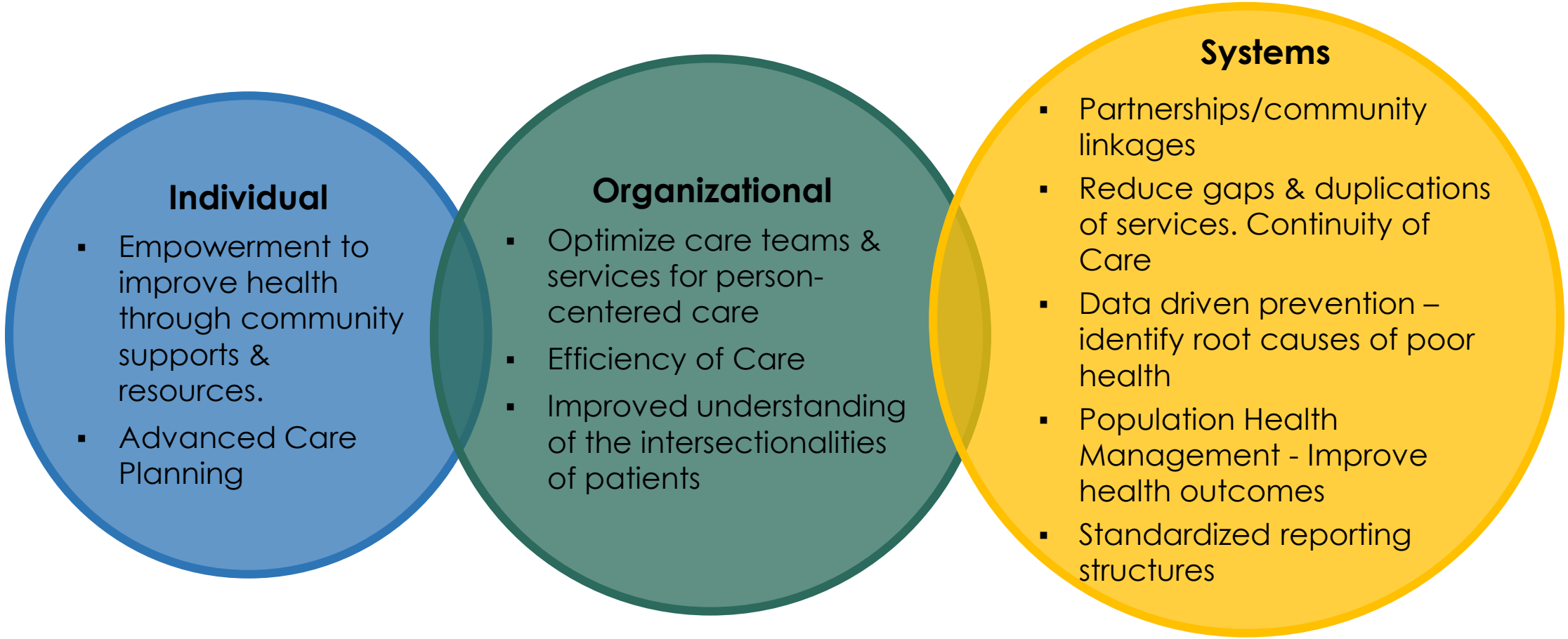
https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Why do SDOH Matter to Health Centers?

Level of Security	*Why treat people and send them back to the conditions that made them sick in the first place?*	Health Outcomes
Food		hypertension, hyperlipidemia, poor physical & mental health
Housing		Asthma, lead poisoning, other respiratory conditions
Employment		Overall poor health, heart disease, stroke

Presentation: Advancing the interoperability of social and behavioral determinants of health. Daniel Vreeman Indiana University

Why do SDOH Matter to Health Centers?



1. Health Information Technology, Evaluation and Quality (HITEQ). Using Social Determinants Data & New Technology Tools to Connect with Appropriate Community Resources: We asked the questions, now what? October 2018.
2. NACHC, AAPCHO, and OPCA: Assessing and Addressing the Social Determinants of Health Using PRAPARE. Presentation for Kansas Association for the Medically Underserved

Social Determinants of Health Equity for People who are Homeless

Source: Adopted from HealthyPeople 2020, Social Determinants of Health
*Image developed on Piktochart.com

Social Determinants of Health Equity for People who are Homeless

Neighborhood & Built Environment

Health & Health Care

Social & Community Context

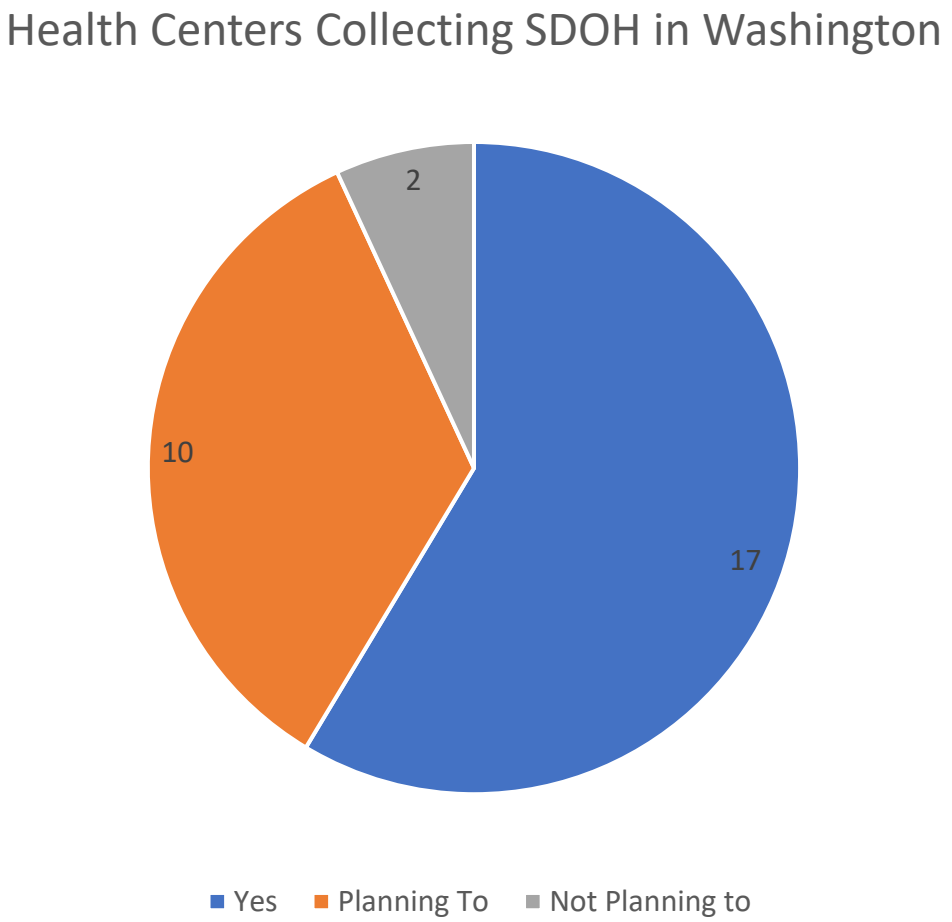
Education

Economic Stability

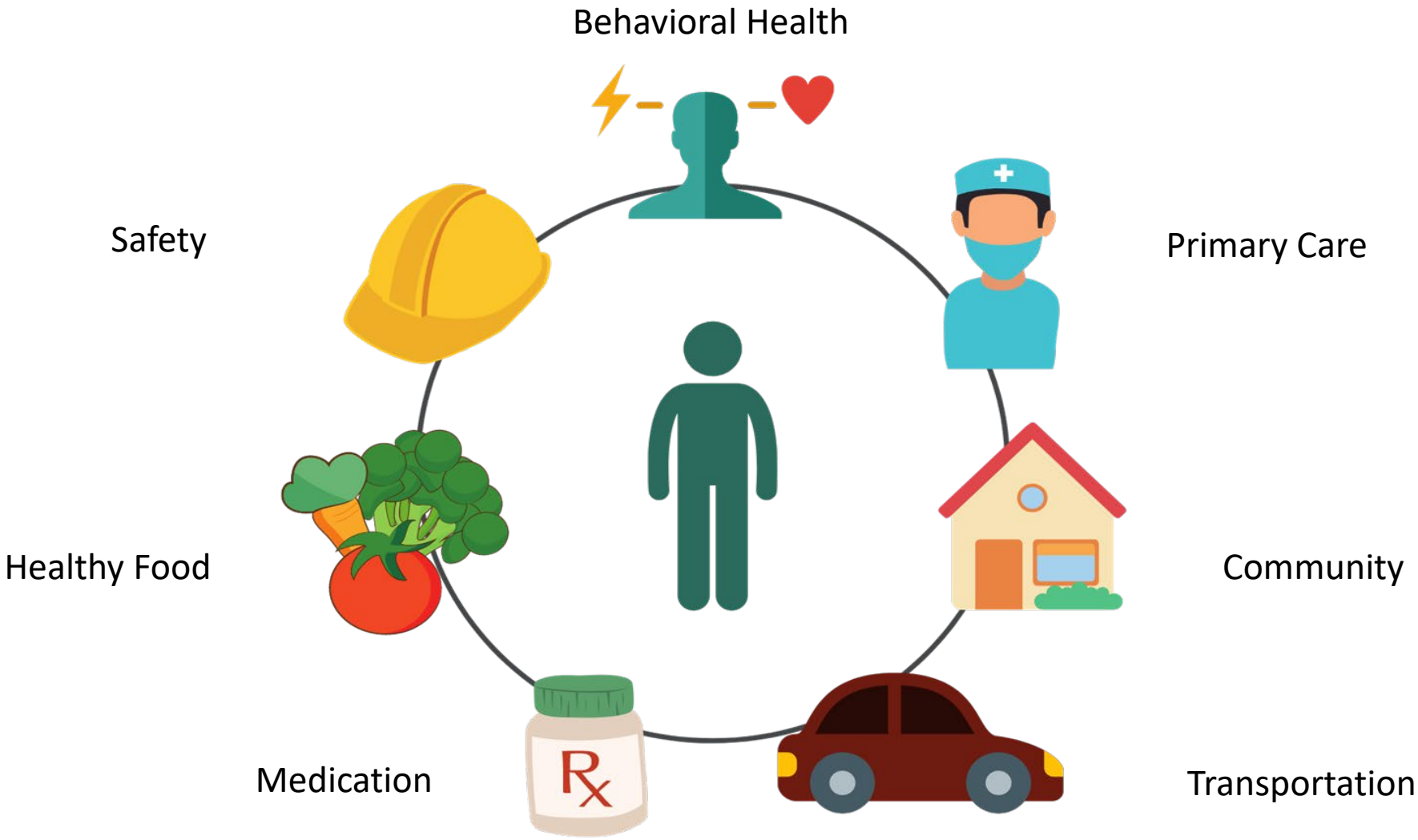
Adapted from Healthy People 2020, Social Determinants of Health

What SDOH Tools are being used in Washington

- There are many different SDOH tools out there:
  - Protocol for responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
  - Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
  - Accountable Health Communities Screening Tools (AHC)



Housing impacts…



Examples of Housing Screening Questions

WE Care: Do you think you are at risk of becoming homeless?	• Yes (if yes, would you like help with this? Yes, no, maybe later) • No
AHC: What is your living situation?	• I have a steady place to live • I have a place to live today, but I am worried about losing it in the future • I do not have a steady place to live

Additional Example

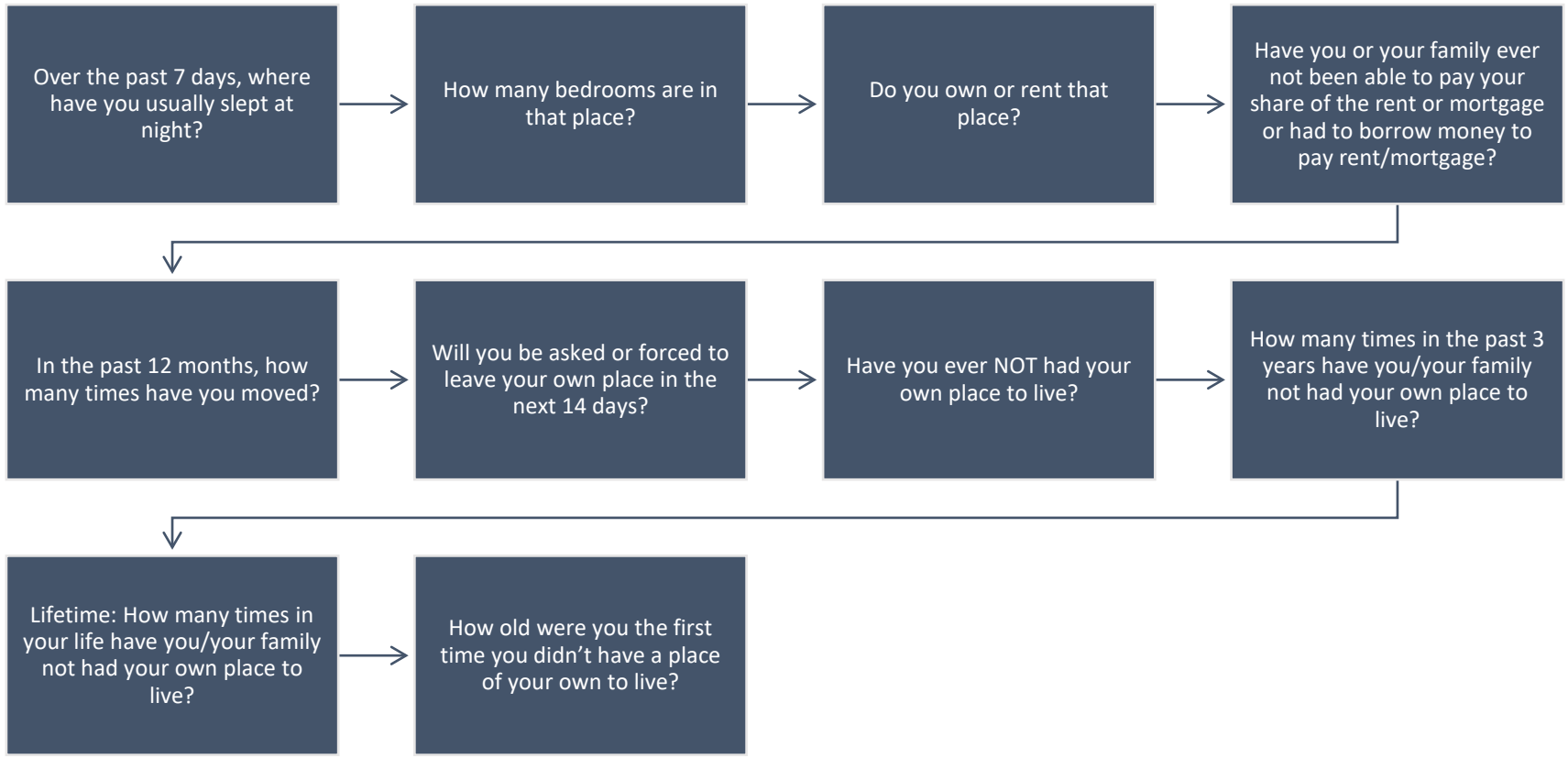
PRAPARE: What is your housing situation today?

- I have housing
- I do not have housing
- I choose not to answer

Follow-up: Are you worried about losing your housing?

- Yes
- No
- I choose not to answer

Multi-tiered Questioning



Benefits and challenges of more complex questions

Benefits	Challenges
• More complete information • Insight into history and present situations • Can improve service connect	• Time consuming • Data tracking is more complex • Answers will be impacted by setting and person asking • Client may get frustrated

Less effective ways to ask about housing

Not all Homelessness looks the same

Who at your health center is currently asking about housing status?

It's not just the how, it is also the who and the where

May feel more comfortable with certain staff

Prefer to write the answer rather than say it

Waiting room may be too public of a place

May need to be away from others they are with

Sometimes feel rushed, ashamed, or scared

Important to consider cultural differences

Data Collection Tools Experience

"Health providers are trained to find cures. We get frustrated when we know about SDOH and can't make a referral that solves the problem."

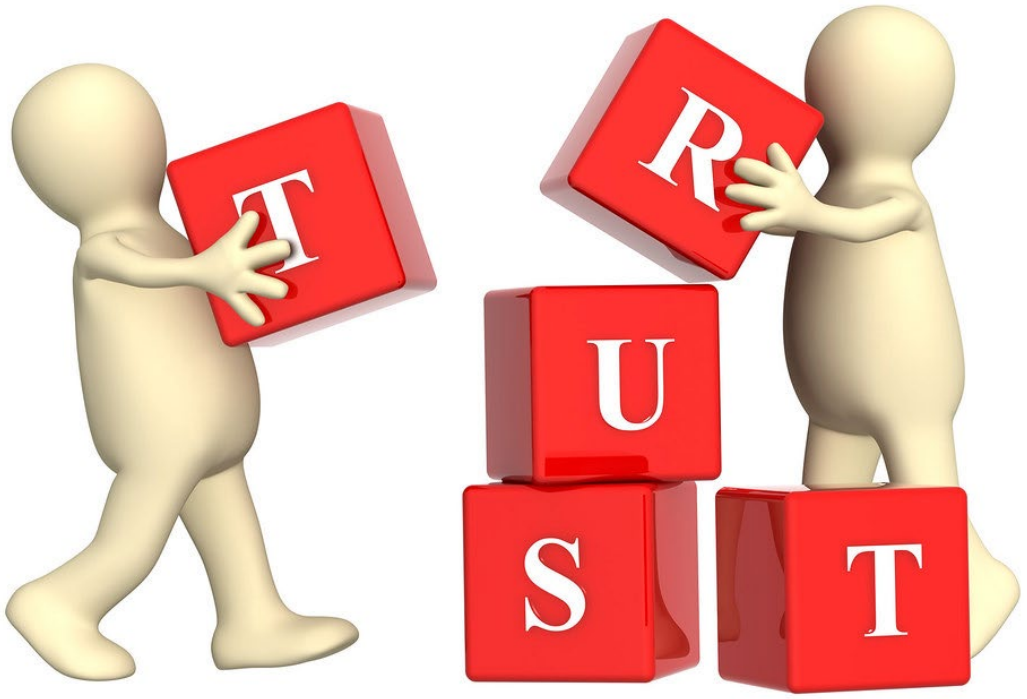
Challenge	Success
Staff not comfortable or lack training asking about housing status and other 'sensitive questions.'	Collecting SDOH data requires training on details of the data collection tool, and ensuring staff have a general comfort with asking personal, non-medical questions.
Data collection can be challenging or burdensome.	Interviewers find it helpful for tools to be conversational and distinct from the medical history or other health forms.
Various data collection tools are being used.	More health centers are implementing SDOH data collection, and PRAPARE specifically. PCAs/HCCNs are working with national organizations to deliver training and developing tools to encourage and support SDOH data collection and data validation.
How data is being stored varies by health center.	Ideally the data is being collected in the EHR to be used by providers and other staff members. However, it was reported that aligning the systems takes significant effort.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf

What concerns do staff raise about screening for housing status or SDOH in general?

Building Staff Confidence and Buy-in

- Explain the “why”
- Acknowledge the potential for discomfort
- Provide training on “how”
- Build referral resources
- Seek input for where it makes sense in current workflow
- Provide data on the results



Essential for asking hard questions

Trauma-Informed Care

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

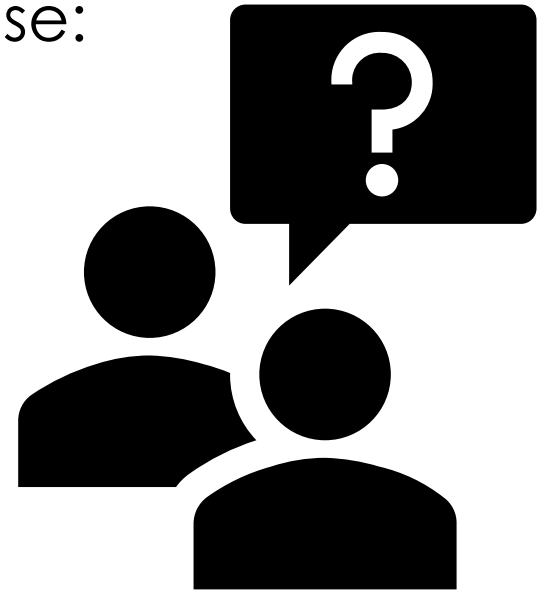
Motivational Interviewing

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support autonomy & self-efficacy

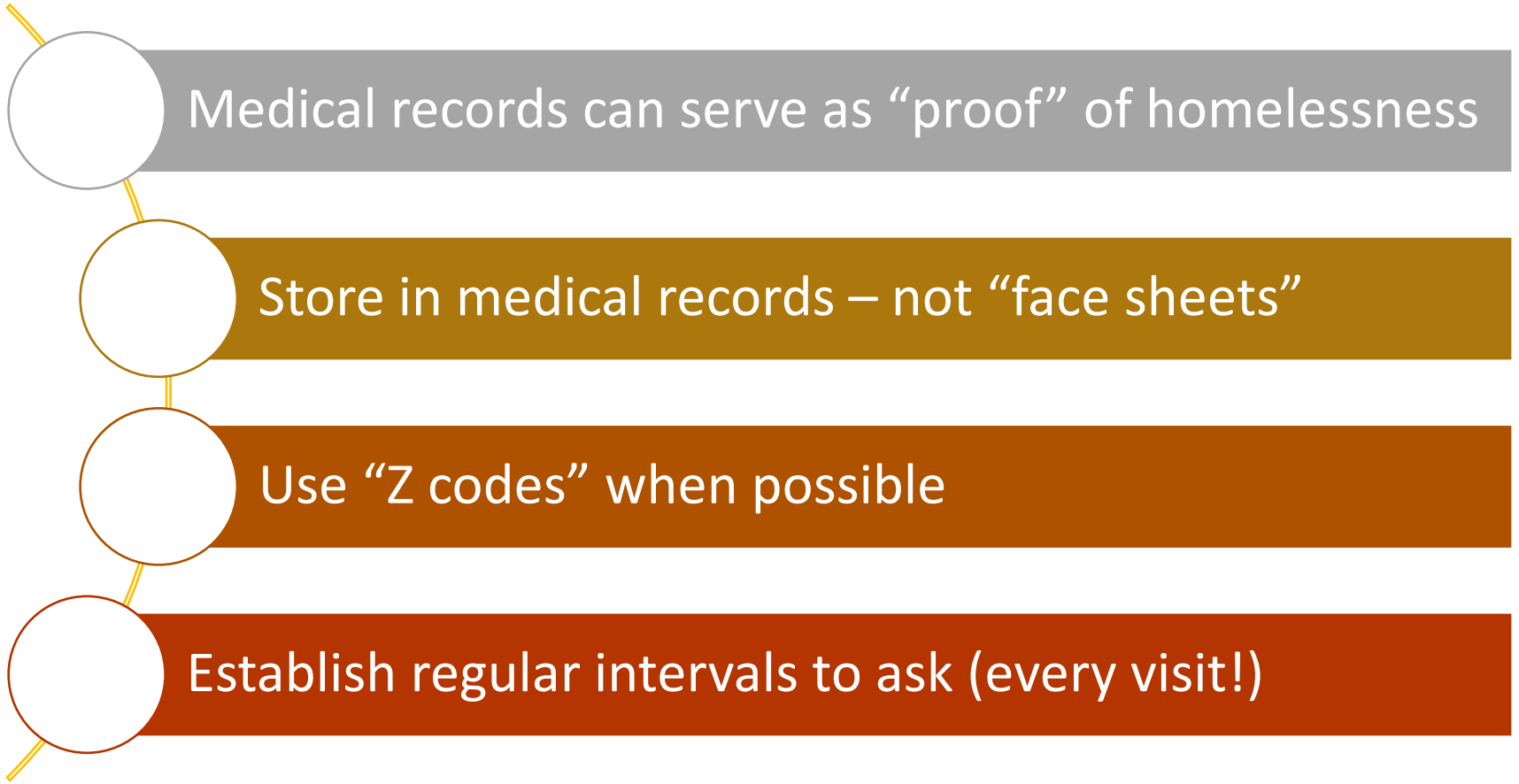
Source: http://www.nhchc.org/wp-content/uploads/2011/09/DecHealingHandsWeb.pdf

What to do if you get different answers

- Different answers do NOT mean person is lying
- Housing status often changes regularly
- Document difference and seek clarification from client
- Discuss with care team
- Difference in answers may indicate something else:
  - Lack of understanding
  - Feeling of safety
  - Staff confusion over answer



Why Documentation matters and how to do it



Organizational ways to Support Staff

Move individual knowledge about community resources into institutional knowledge

Seek expertise in the hiring process

Establish community partnerships

Be willing to change workflows based on staff feedback

Build out system for reporting data

Acknowledge this could be triggering

Implementing & Care Planning

Individual

- Use case conferences to discuss impact on care plan
- Identify referrals – social and homeless services

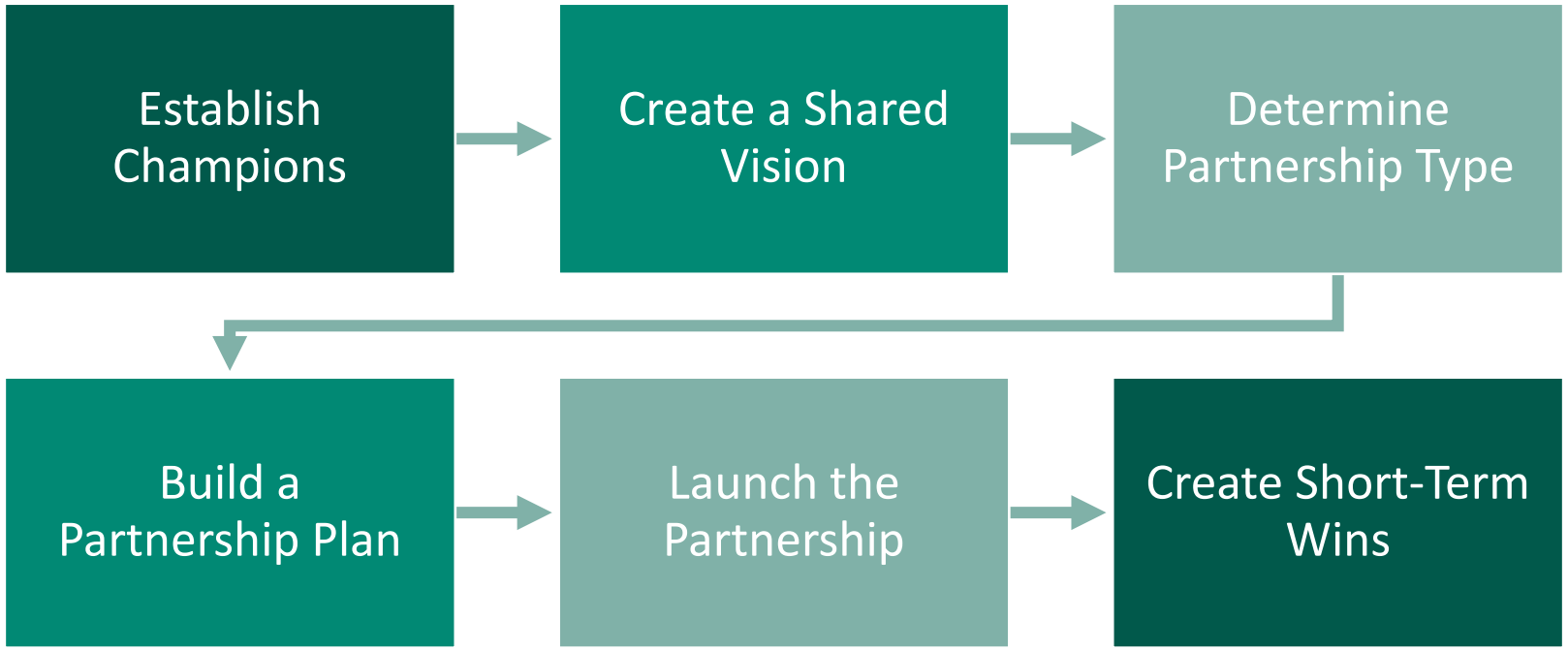
Organizational

- Establish champions
- Build organizational partnerships

Community

- Participate in CoC activities
- Leverage data for additional housing

Partnerships: Make it Work



Source: https://www.csh.org/wp-content/uploads/2015/12/CSH-Health-Housing-Partnerships-Guide.pdf

Using Data for Referrals & Care Coordination

"Some parents are not wanting to disclose information on social determinants for fear of children being removed from the family by the authorities"

Challenge	Success
Knowing where to make referrals, and how to follow-up.	Generally, a health center's care coordinator, navigator or other 'enabling services staff' creates a resource guide to be adapted by health center staff for the community.
Understanding how SDOH can impact care plans.	Data may inform a person-centered approach to include health, and quality of life.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf

Building Partnerships & Program Design

"Many of our health centers are just getting to this point. We're encouraging health centers to build partnerships and identify programs that are needed and leverage existing resources."

Challenge	Success
Many health centers do not have the capacity to provide needed services and there are limited resources in the community.	Health centers have been able to identify potential partnerships based on high prevalence of a certain population with housing instability.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf

Opportunities to Leverage that SDOH Screening Adds Value To…

- Delivery System Transformation Activities (VBP, Shared Savings, etc.)
- Payment Reform Efforts
- Payers Interested in Social Determinants Data Collection (e.g., Medicaid, private, etc.)
- PCMH and QI Initiatives
- Data Sharing and Aggregation Opportunities (e.g., HIE, CIE, etc.)
- Quality Incentives that Reward for Social Determinant Data Collection
- State Foundation Interests in Social Determinants or Related Topics (Opioids, etc.)
- Community Health Worker Initiatives

PRAPARE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Questions?

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Follow us on social media!

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National Institute for Medical Respite Care

THANKS

EVENT EVALUATION :
Click on link in CHAT Box to fill out Event Evaluation or scan

EVENT MATERIALS:
Link to recording & slides will be emailed

QUESTIONS/COMMENTS:
Contact Patricia Gepert (pgepert@wacommunityhealth.org)

Washington Association for Community Health