Southeast Regional Clinicians Network

2024 Stakeholders Meeting

March 18, 2024

MOREHOUSE SCHOOL OF MEDICINE

NCPC National Center for Primary Care

NCPC
National Center
for Primary Care

Our Network

- 8 States
- FQHCs (239) and PCAs (8)
    - Over 1700 clinical sites
- 368,000 square miles
- Patients served: over 4 million

Funding Acknowledgment

This meeting is funded, in part, by the National Institutes of Health (NIH) through subawards issued through Agreement OT2HL158287.

The views and conclusions contained in this presentation are those of the authors and should not be interpreted as representing the official policies, either expressed or implied, of the NIH.

Welcome to Our Partner Advisory Board!

FACHC
THE VOICE OF PRIMARY CARE
FLORIDA ASSOCIATION OF COMMUNITY HEALTH CENTERS

APHCA
mission · members · service

Community Health Center
Association of Mississippi

KPCA
KENTUCKY PRIMARY CARE
ASSOCIATION

SOUTH CAROLINA
PRIMARY HEALTH CARE
ASSOCIATION

tpca
TENNESSEE PRIMARY CARE
ASSOCIATION

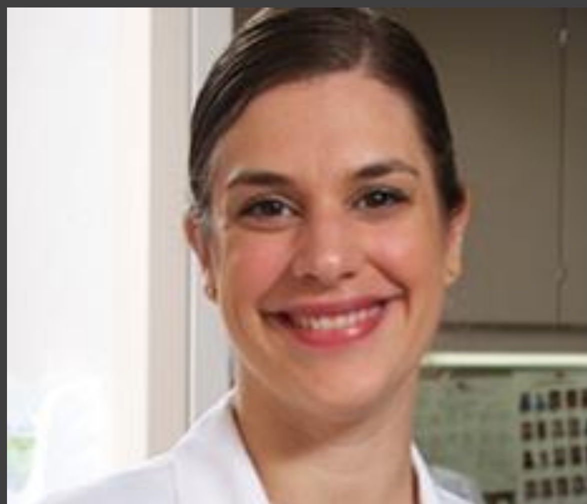
Georgia
Primary Care
Association

Welcome to Our Patient Advisory Board!

Welcome to and Thanks to Partners from the Network for Community-Engaged Primary Care Research (NCPCR)

OCHIN

Health Choice Network, Inc.



You Know Our Team!

Anne Gaglioti, MD, MS, FAAFP and
Dominic Mack, MD, MBA
SERCN Co-Directors

Denita Walston, MS
SERCN Associate Network Director
Director, Network for Community-Engaged Primary Care Research (NCPCR)

Mitchell Blount, MPH, PMP
NCPC Associate Director of Research and Policy

Pati Knight-Landrum

Dr. Chrystal Pristell

Clarissa Ortiz

Dr. Rachel Gold

James Campbell

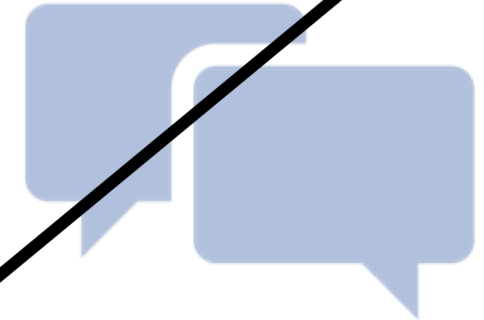
Megan Douglas

Thank you to our distinguished speakers!

Logistics: SERCN 2024 Meeting *Is Now In-Person!!!!*

Virtual Meeting Tips

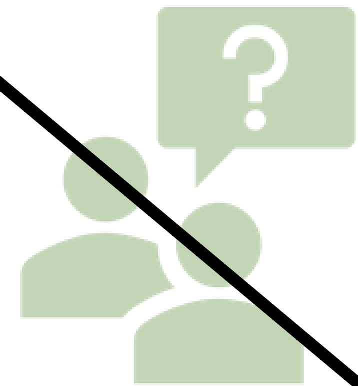
Mute your line when not speaking



Interact with each other and ask questions in the chat

Camera on when possible

Feel free to turn your camera off and step away as needed



Polls and breakout rooms

An Overview of the Day

Notes from the field

Policy Perspectives

Speaker: Social Determinants of Health Screening & Referrals

Feedback Session: NCPCR Project - Data and RCT & CDC Grant Proposal

Speaker: Intersections: At the Crossroads of Substance Use and Medicine

Vote on Priority Research Topics

Closing Activities

Goals

Engage	Engage our stakeholders around our research activities
Spark	Connection and new paths forward
Inform	Structured input on research priorities and projects
Learn	Learn from each other as researchers, clinical and organizational partners, and patients
Community	Come together as a group, connect, and enjoy!

It's Picture Time!!!

Notes From The Field

Promising Practices to Improve Colorectal Cancer Screening Rates at Florida's Community Health Centers

Clarissa JH Ortiz, MS
Director, Clinical Operations Programs
Florida Association of Community Health Centers, Inc.

SEMRHI Ryan White Program Goes Global

Pati Knight Landrum, BSN, RN-BC, CEDP
Director of Corporate Compliance
Southeast Mississippi Rural Health Initiative

Promising Practices to Improve Colorectal Cancer Screening Rates at Florida's Community Health Centers

Clarissa JH Ortiz, MS
Director, Clinical Operations Programs
Florida Association of Community Health Centers, Inc.

Colorectal Cancer Screening Learning Community

Florida

NEIGHBORHOOD MEDICAL CENTER

Palms Medical Group
Your home for health, wellness, life

true health
REAL CHOICES. REAL CARE.

Tampa Family Health Centers

Osceola Community Health Services

At the beginning of 2023, the **Florida Association of Community Health Centers (FACHC)**, **Humana**, and the **American Cancer Society** embarked on a planning and recruitment phase to create a cohort of Florida Community Health Centers to provide evidence-based intervention training to increase colorectal cancer screening rates among Florida Community Health Center patients.

2023 Colorectal Cancer Cohort:
True Health Palms Medical Group
Osceola Community Health Center
Neighborhood Medical Center and
Tampa Family Health Centers

These health centers became part of a nine-month learning collaborative with built-in touchpoints to improve colorectal cancer screening rates among their patient populations.

Scope of Work

Readiness Assessment

Letter of Commitment

April: Bootcamp Kick Off Webinar

May: QI Tools: Process Mapping

June: Gap Analysis/Root Cause Analysis

July: Evidence Based Interventions

August: Future State Process Mapping and PDSAs

Sept/Oct: Host 2 Promising Practices Calls

Nov: Sustainability Planning

Dec: Showcase Best Practices/Storyboards

Learning Collaborative Participation Requirements:

Complete Readiness Assessment Interview with ACS
Attend Kick-Off Meeting with at least 2 Team Members
Attend Monthly calls with at least 2 Team Members
Share the Colorectal Cancer Learning Collaborative Work
Complete two DART Reports
Create and showcase Best Practice Storyboard

American Cancer Society®

Partner Impacts Reported

Evidence-based Clinical Intervention Training
Steady incremental increases in screening numbers
Team members working in one accord
Newly established relationships with partners
New discounted pricing for colonoscopies
Staff t-shirts to promote cancer screening
Education and marketing materials

American Cancer Society®

Partner Impacts Reported

Transportation to patient appointments
Screenings for uninsured patients
Designated dollars to finance colonoscopies
Improved focus on benchmarking and data eval
Purchased FIT tests to give at no cost
Tools to improve cancer Increased Case Management

American Cancer Society®

American Cancer Society

Learning Community Key components

- Cross Pillar collaboration
- Abbreviated Bootcamp
- Baseline & project completion metrics
- Monthly Webinars & QI training
- ACS support & consultation
- FACHC Leadership

Overall Participant Experience

On a scale of 1-5 (1 being poor; 5 being EXCELLENT), how would you rate your team's overall experience in this Learning Community?

4.6

On a scale of 1-5 (1 being not valuable; 5 being very VALUABLE), how valuable was the learning collaborative to increasing colorectal cancer screening rates?

4.7

Thank You!

Questions?

Clarissa JH Ortiz, MS
Director, Clinical Operations Programs
Florida Association of Community Health Centers, Inc.

SEMRHI Ryan White Program Goes Global

Pati Knight Landrum, BSN, RN-BC, CEDP
Director of Corporate Compliance
Southeast Mississippi Rural Health Initiative

SEMRHI Ryan White Programs Parts C/D

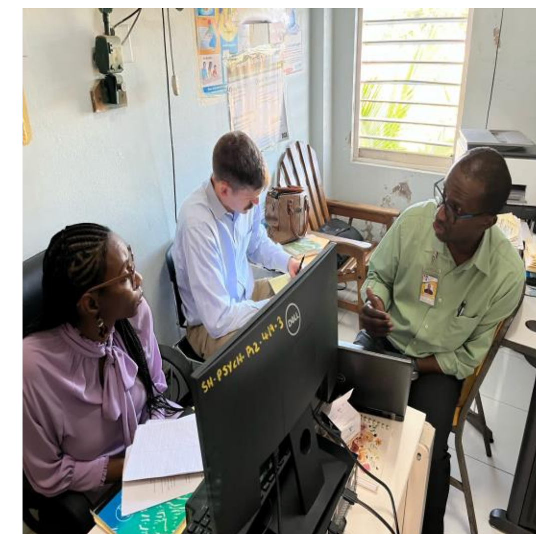
- Received Planning grant in 1999
- Awarded Part C funding in 2000
- Awarded Part D funding in 2017
- Integrated primary, HIV and behavioral health model of care
- 2nd largest provider of HIV care in the state
- RWP clinical staff:
  - 2 Internal Med physicians + 3 contract ID physicians, and 1 LCSW
  - RN Case Mangers, LMSW and other support staff
- Nationally and regionally recognized for quality care
- Recipient of the National Quality Award:
  - Center for Quality Improvement and Innovation (CQII) 2021 Award for Measurable Improvements in HIV Care to Mitigate HIV Disparities. Improved the viral load suppression of Youth Living with HIV

Ryan White Medical Services

- Primary Medical Care
- OB/GYN
- Oral Health Care
- Behavioral Health Services
- Optometry
- Comprehensive medical case management
- Antiretroviral Therapy (ART) counseling
- Onsite pharmacy
- Specialty referrals
- HIV Counseling, Testing, and Referral (CTR)
- Offers Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

HRSA PEPFAR Skills Sharing Program (SSP)

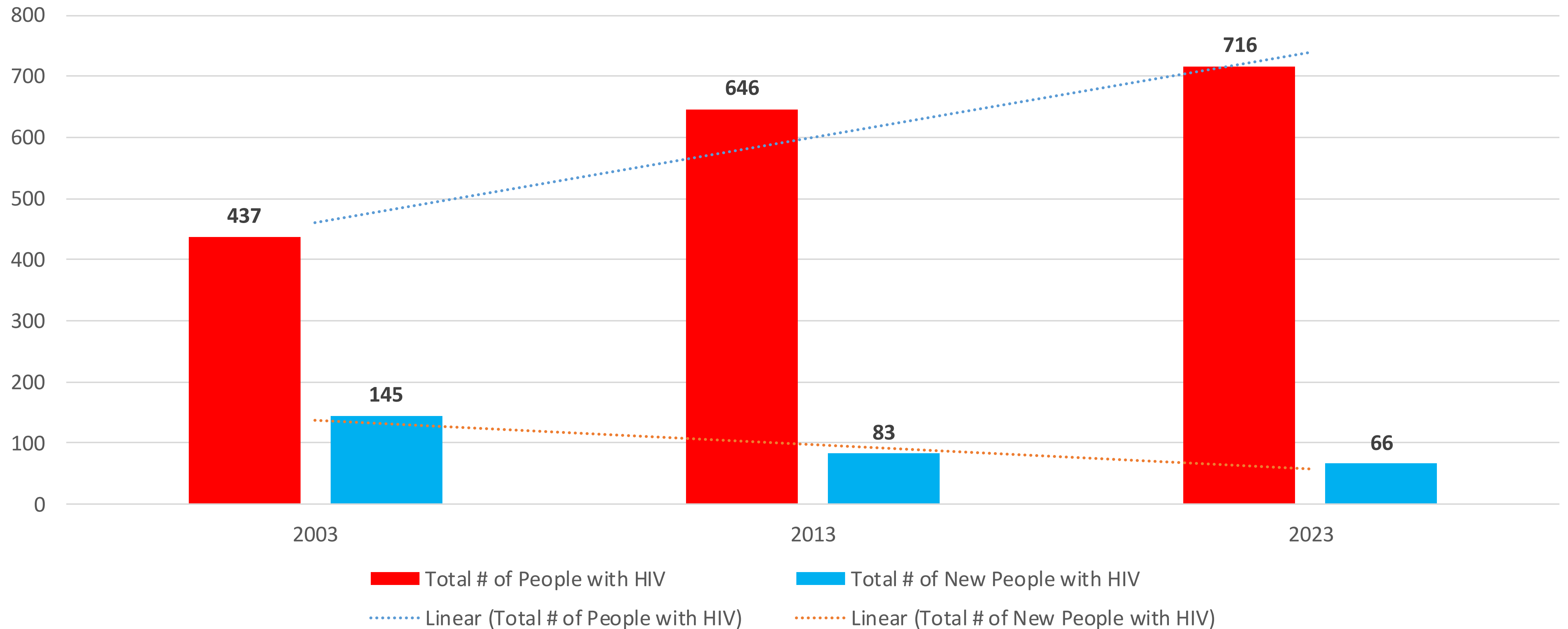
- Selected to participate in the HRSA Skills Sharing Program (PEPFAR) in Jamaica for 2024 with two on-site visits to the country: January-February 2024 and early summer 2024
- Provided peer-to-peer clinical skills and knowledge building support to improver viral suppression among priority population
- Shared best practices and interventions
- Ongoing virtual support for clinics in Jamaica via monthly Zoom calls and WhatsApp



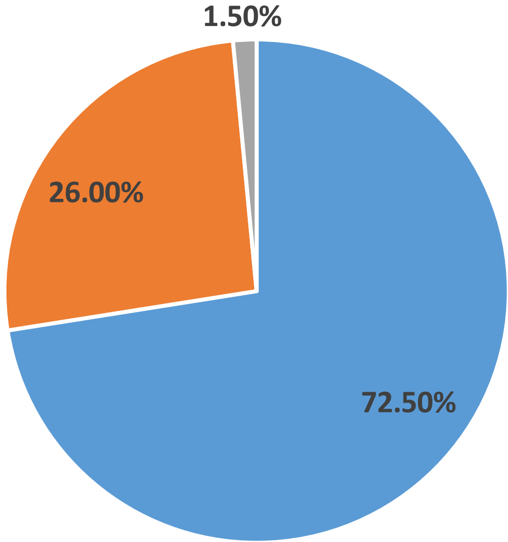
Ryan White Support Services

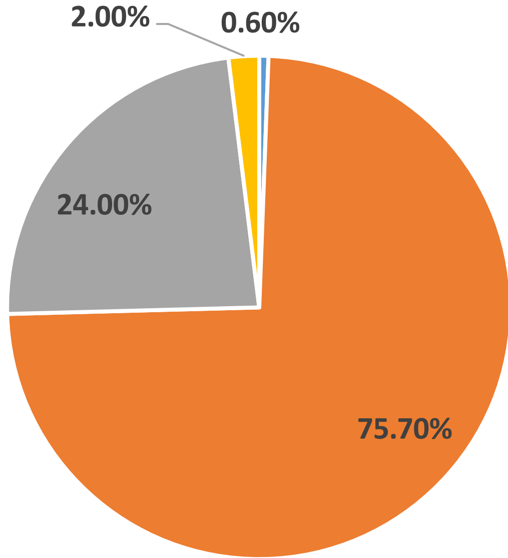
- Transportation assistance: transit, gas cards, bus passes and Lyft
- Emergency financial assistance for prescriptions, eyeglasses, dentures, and arrears for rent/utility bills
- Grocery cards, personal hygiene items and household cleaning supplies
- Consumer Advisory Board (CAB) meetings
- Targeted outreach events o reach patient population at highest risk of HIV infection
- Linkage to other community support services

SEMRHI HIV Population Over the Last 3 Decades

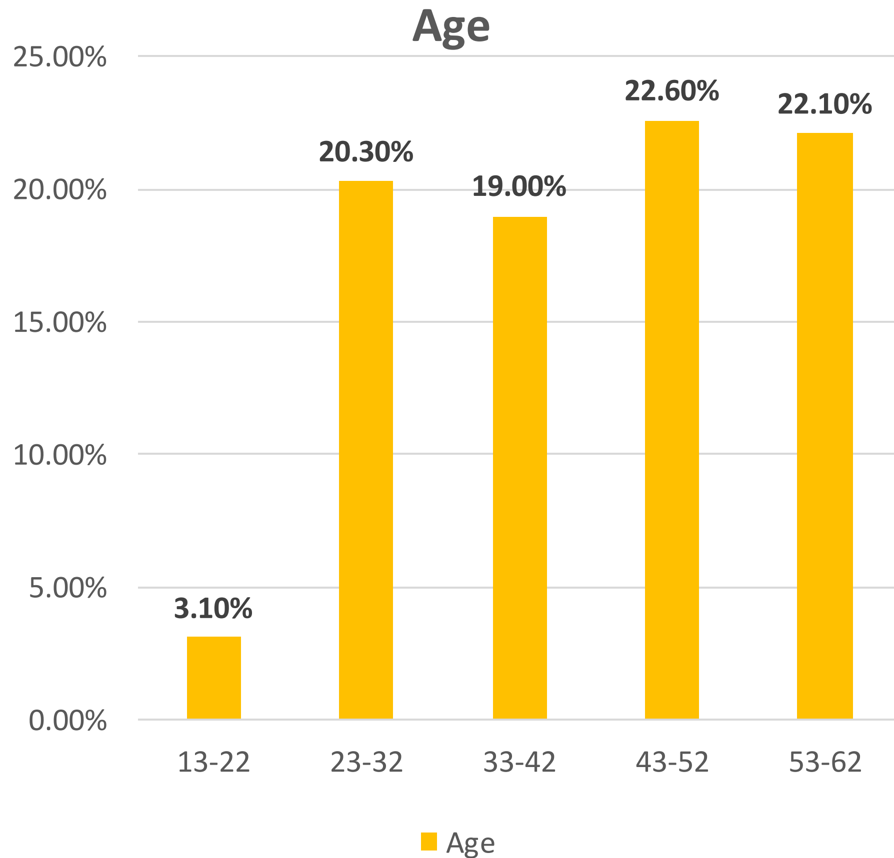


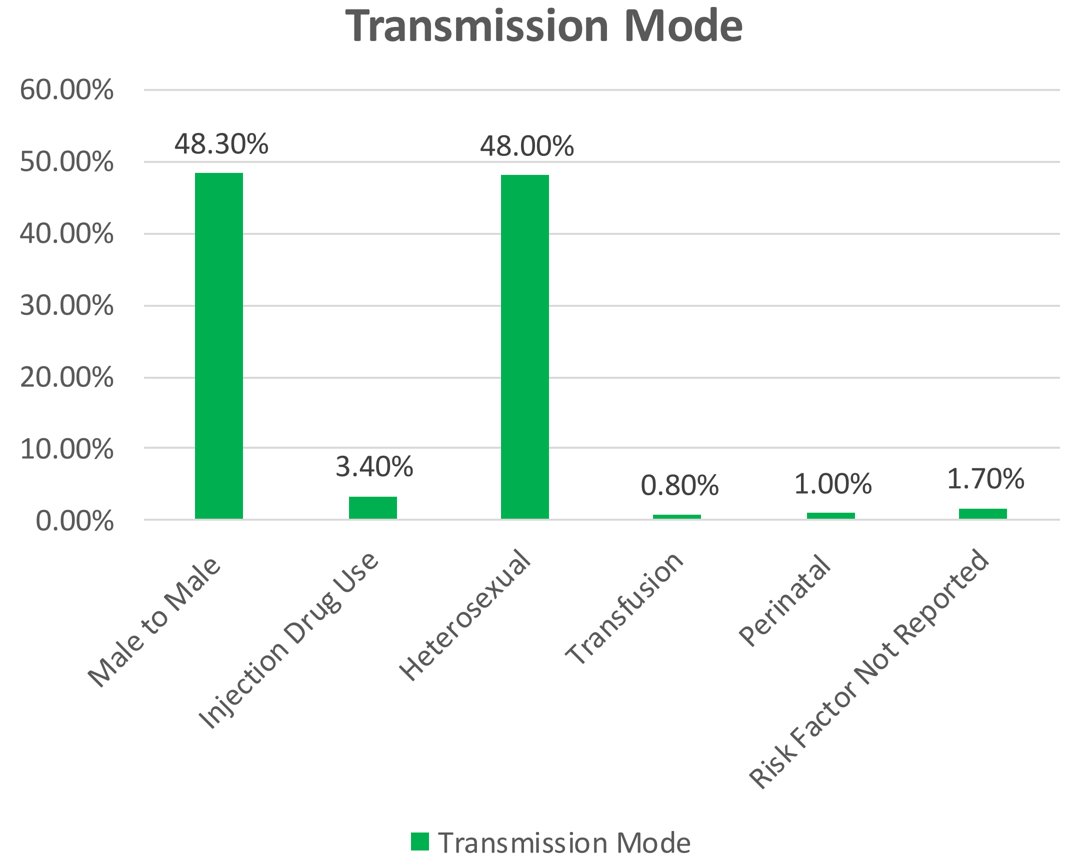
Demographics Snapshot of SEMRHI HIV Population (2023)





Demographics Snapshot of SEMRHI HIV Population (2023), continued





Challenges

- Despite available wrap-around services at SEMRHI, some people with HIV are not adherent to ART and lack viral suppression and retention in care due to overwhelming social drivers of health:
  - **STIGMA**: internal (patients) and external (stigmatizing language/behavior, personal biases, lack of knowledge, etc.)
  - **Poverty**
  - **Housing insecurity**
  - **Lack of job skills, education and access to gain employment**
  - **Active substance use**
  - **Untreated mental health**
  - **Food shortages**

Policy Perspectives:

Medical Legal Partnerships

Megan Douglas, JD
Associate Professor, Department of Community Health and Preventive Medicine
Director of Research and Policy, National Center for Primary Care
Course Director, Health Policy & Advocacy Rotation

The Relationship Between Perception of Pain and Delays in Pain Medication Access Among Adult Patients at HRSA-Funded Health Centers

Chrystal L. Pristell, D.O.
Robert L. Phillips, Jr. Health Policy Fellow
Robert Graham Center for Policy Studies in Family Medicine and Primary Care
Georgetown University Department of Family Medicine
Unity Health Care - East of the River Health Center

Medical Legal Partnerships

Megan Douglas, JD
Associate Professor, Department of Community Health and Preventive Medicine
Director of Research and Policy, National Center for Primary Care
Course Director, Health Policy & Advocacy Rotation

Medical-Legal Partnerships in Community Health Centers

Addressing Legal Needs that Impact Patients' Health

SERCN Annual Meeting
March 18, 2024
Atlanta, GA

Megan Douglas, JD
Associate Professor & Director of Research and Policy
National Center for Primary Care
Morehouse School of Medicine

When Javana Bradford took her daughter, Augyst, for a checkup, her pediatrician asked if she and her daughter were getting enough to eat. Ms. Bradford said she was having trouble adding Augyst to her Supplemental Nutrition Assistant Program (SNAP) benefits.

Adapted from: Marple K & Dexter E. (2018). Increasing Nutrition Supports for Newborns. https://medical-legalpartnership.org/wp-content/uploads/2018/04/Increasing-Nutritional-Supports-for-Newborns.pdf.

When Mrs. B came in for her annual exam, the clinician asked if she was still getting physical therapy. Mrs. B explained that her disability benefits had been terminated and she could no longer afford her therapy.

At her daughter's last appointment, Anna told the NP that their home had mold and her landlord refused to address it. Her daughter's asthma was flaring up often, but she couldn't find another affordable place to live.

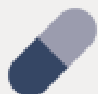
Medical-Legal Partnership (MLP)

What is an MLP?

Legal professionals are embedded within a health care organization to address health-harming social issues that have remedies in civil law

People with chronic illnesses are healthier and admitted to the hospital less frequently, saving health care costs too. Examples include:

- Improved housing conditions led to improved health in asthma patients (*Journal of Asthma* and *Journal of Health Care for the Poor and Underserved*).
- Youth with diabetes had significant improvement in their glycemic control (*The Diabetes Educator*)
- Sickle cell patients were healthier (*Pediatrics*).
- Health care spending on high-need, high-cost patients was reduced (*Health Affairs*).
- Families of healthy newborns in a randomized control trial increased their use of preventive health care (*Pediatrics*).



People more commonly take their medications as prescribed.
(*Journal of Health Care for the Poor and Underserved* and *Journal of Clinical Oncology*)

People report less stress and experience improvements in mental health.
(*Journal of Health Care for the Poor and Underserved*, *Behavioral Medicine*, and *Health Affairs*)

People are more stably housed and their utilities are less likely to be shut off.
(*Health Affairs*, *Housing Studies*, and *Journal of Health Care for the Poor and Underserved*)

People have access to greater financial resources.
One MLP program recovered $300,000 in back benefits for families over a three-year period (*Journal of Health Care for the Poor and Underserved*), while another recovered more than $500,000 in financial benefits for families over a seven-year period (*Journal of Health Care for the Poor and Underserved*).

Clinical services are more frequently reimbursed by public and private payers.
Medical-legal partnerships have been shown to save patients health care costs and recover cash benefits (*Journal of Health Care for the Poor and Underserved* and *Journal of Palliative Medicine*).

Source: https://medical-legalpartnership.org/impact/

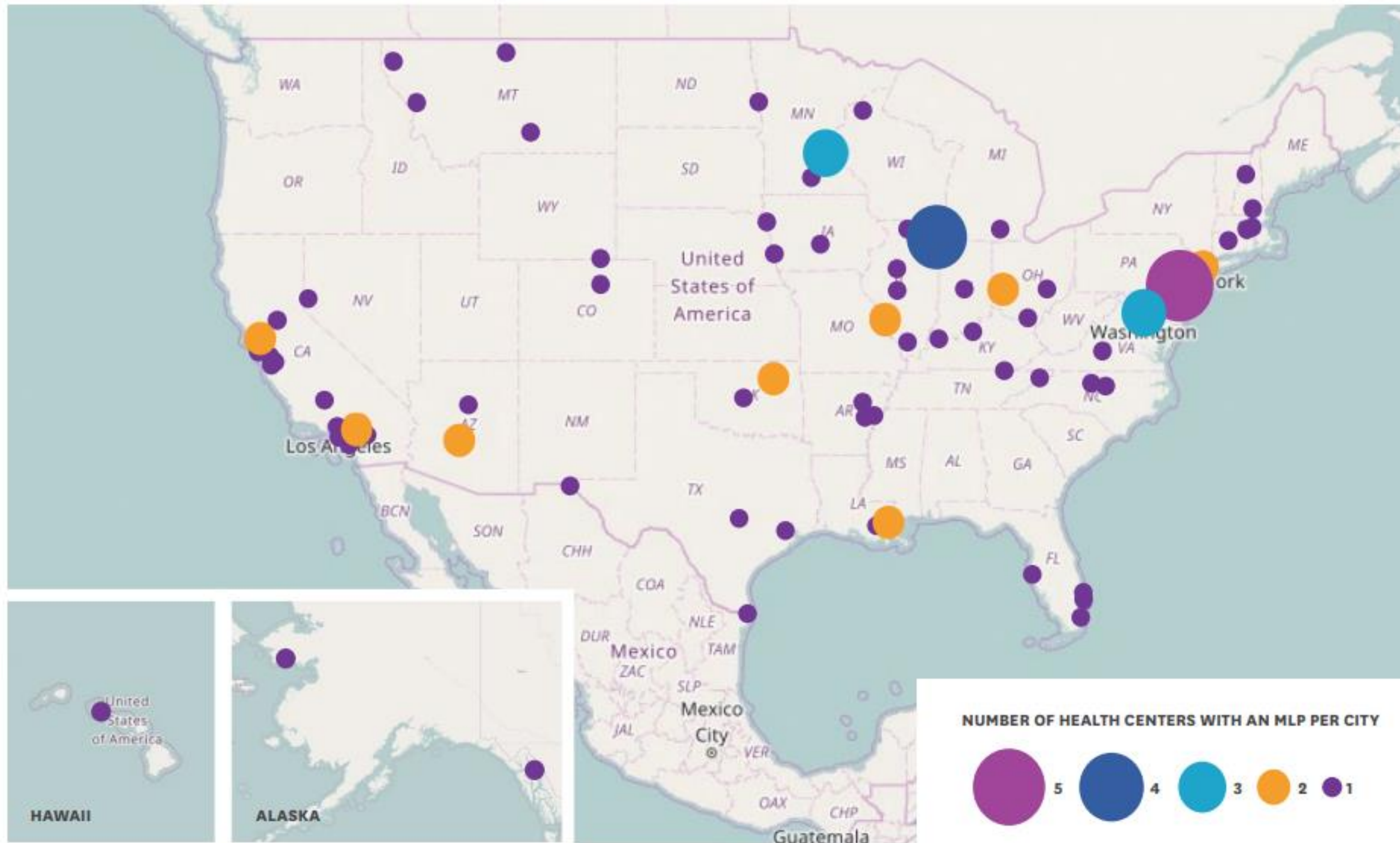
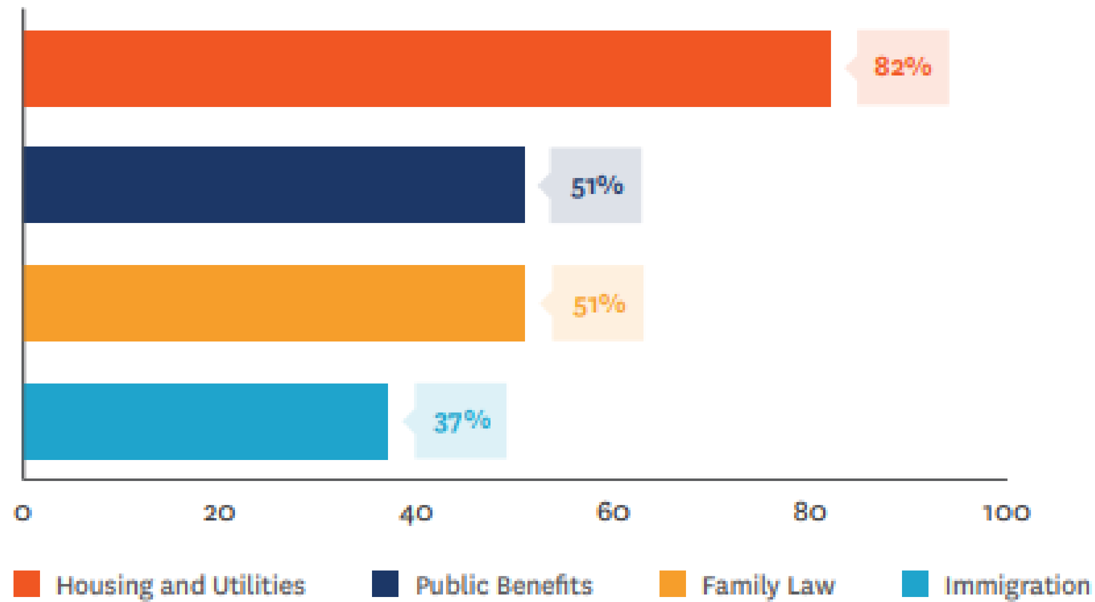
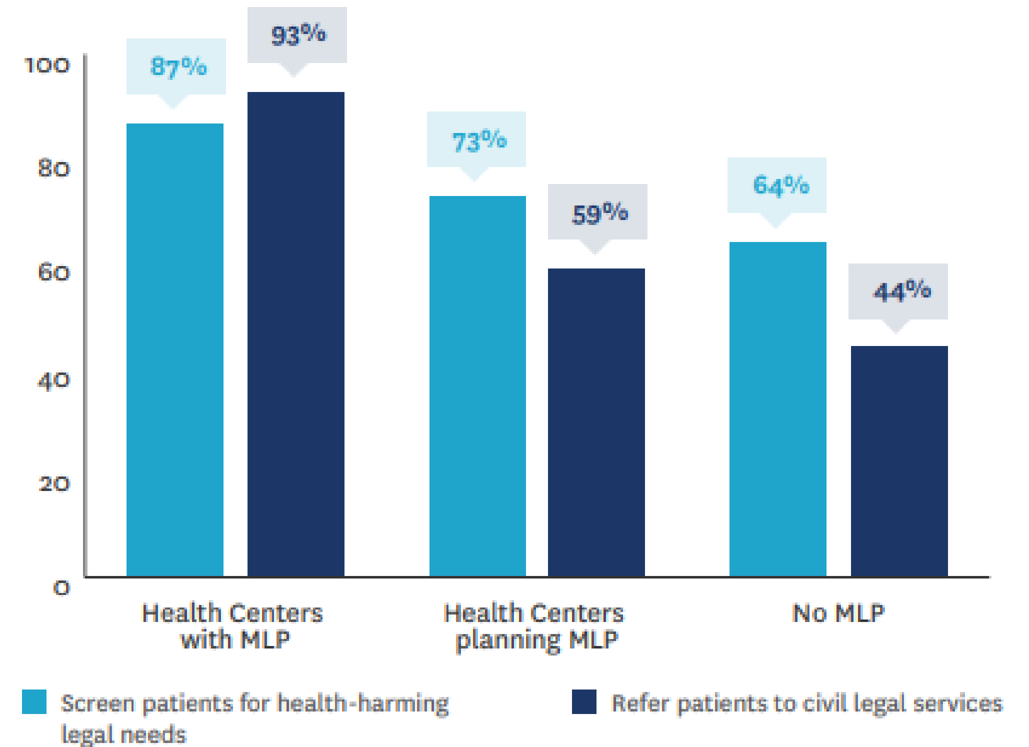
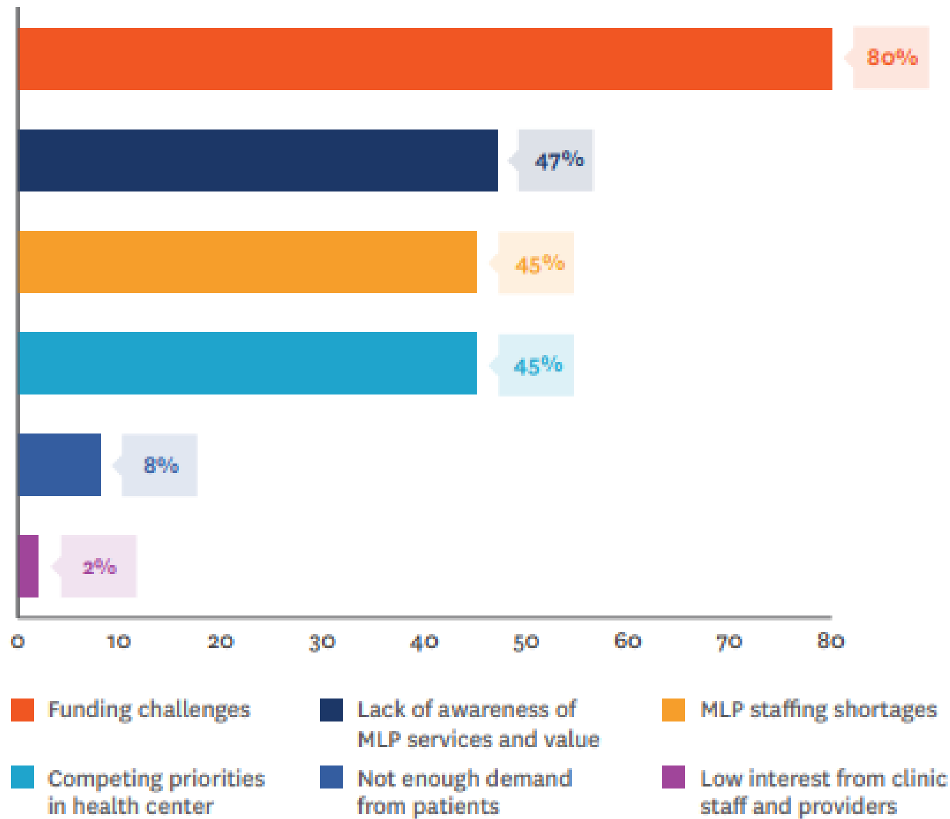


FIGURE 1: MAP OF ACTIVE HEALTH CENTER-BASED MEDICAL-LEGAL PARTNERSHIPS, 2016
HAWAII
ALASKA
NUMBER OF HEALTH CENTERS WITH AN MLP PER CITY
5
4
3
2
1





Source: National Center for Medical-Legal Partnerships. (2023). Environmental Scan of Medical-Legal Partnerships in Health Centers. https://medical-legalpartnership.org/wp-content/uploads/2023/08/Environmental-Scan_Final.pdf.



In 2014, HRSA recognized civil legal aid as an "enabling service" that health centers could include under their federal grants

Other funding sources: foundations, grants, donations, payment from insurance payers

Source: National Center for Medical-Legal Partnerships. (2023). Environmental Scan of Medical-Legal Partnerships in Health Centers. https://medical-legalpartnership.org/wp-content/uploads/2023/08/Environmental-Scan_Final.pdf.

OCTOBER 2020

Bringing lawyers onto the health center care team to promote patient & community health

A planning, implementation, and practice guide for building and sustaining a health center-based medical-legal partnership

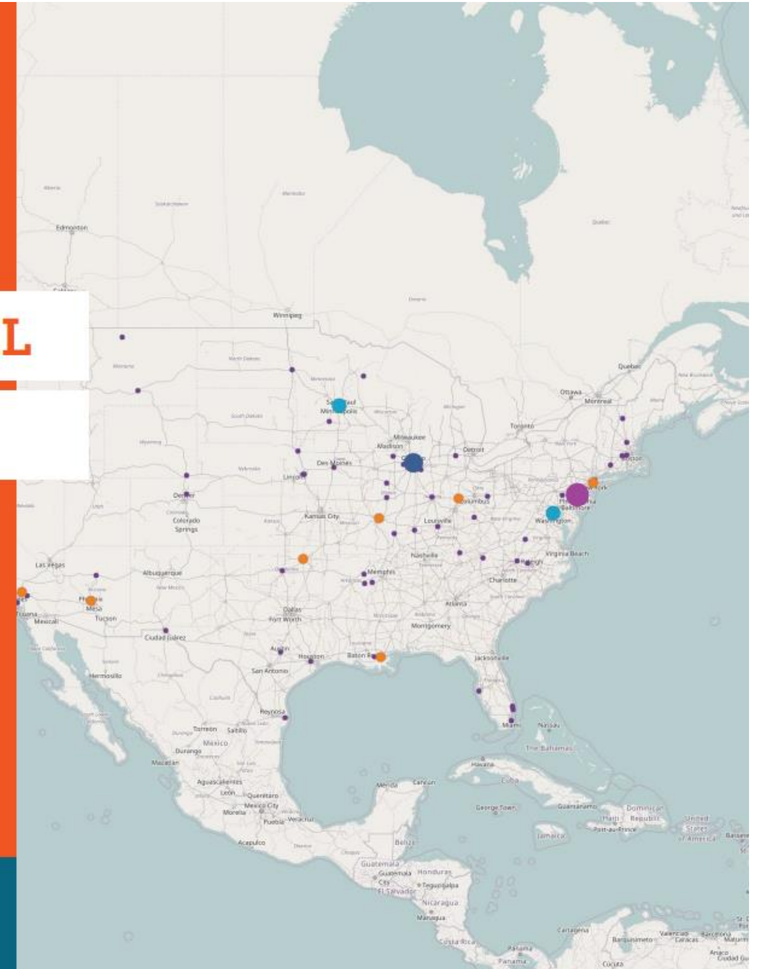
National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

HEALTH CENTER-BASED

MEDICAL-LEGAL PARTNERSHIPS

Where They Are, How They Work, and How They Are Funded

January 2018



National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

QUESTIONS?

Megan Douglas, JD
mdouglas@msm.edu

Thank You!

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National Center for Primary Care

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The Relationship Between Perception of Pain and Delays in Pain Medication Access Among Adult Patients at HRSA-Funded Health Centers

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MedStar Health

It's how we treat people.

The Relationship Between Perception of Pain and Delays in Pain Medication Access Among Adult Patients at HRSA-Funded Health Centers

Dr. Chrystal Pristell

Robert L. Philips Health Policy Fellow

Research 2023- 2024

Disclosures

- I have no actual or potential conflict of interest in relation to this presentation

Agenda

1. Epidemiology
2. Objectives and Study design
3. Principal findings
4. Policy Implications and future direction

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Epidemiology

50 million Americans which is 20% of the population experience chronic pain

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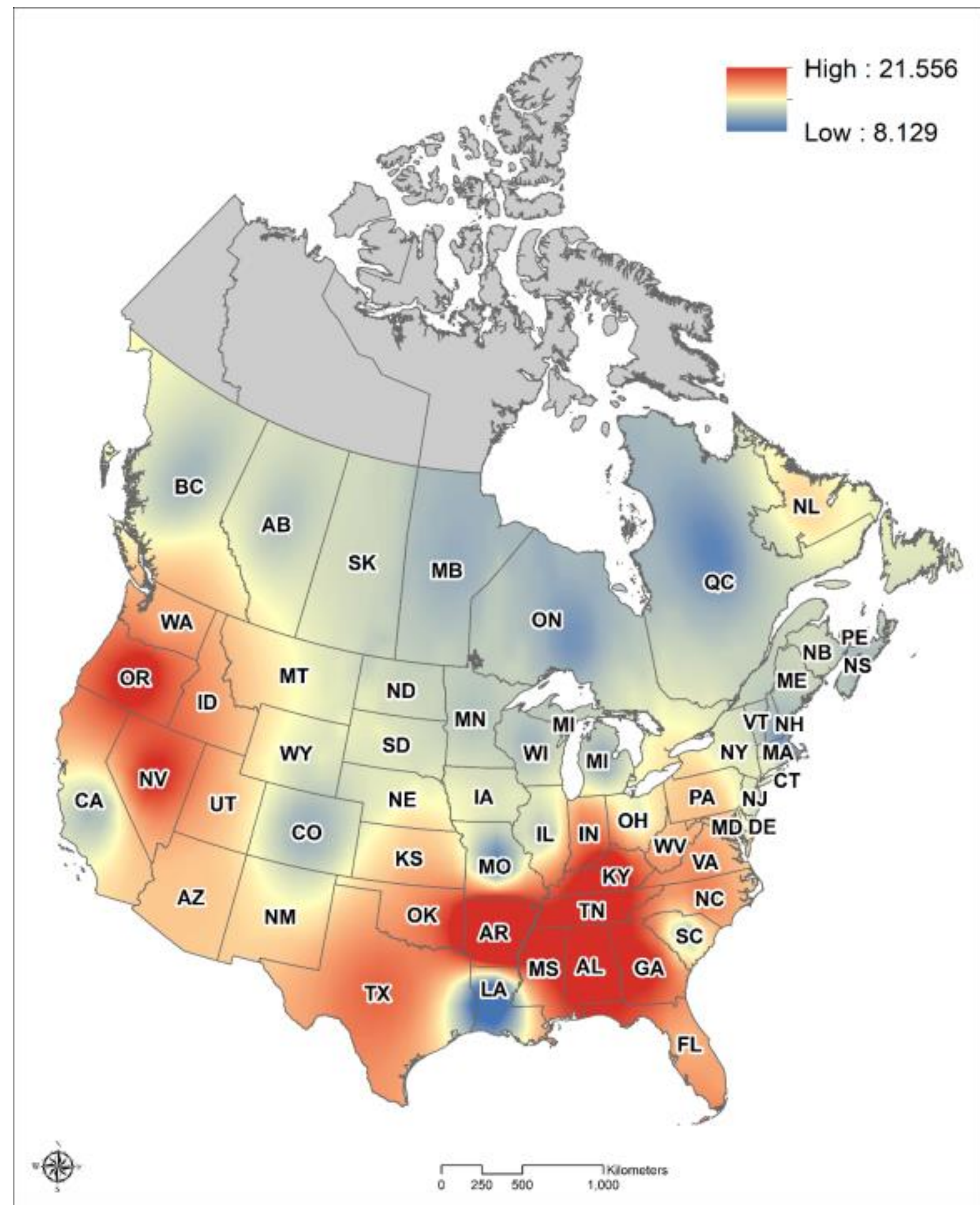
Epidemiology

Chronic pain (>3 months)

- "Inadequate and ineffective pain management pose a serious public health crisis particularly in this era of the opioid epidemic" – D'Souza et al.



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Populations undertreated for pain

- Elderly
- Children
- Mentally
- Ethnic minorities
- Gender minorities
- Unemployed
- Poverty
- Less education
- Uninsured
- Rural area
- More comorbidities
- Cancer
- HIV
- Veterans

Why this matters?

- Exacerbated by worsening mental health
- ↓Equity = ↑costs
- Bias → health outcomes

Research Project

Study Objectives

- Pain is a frequently reported issue in the CHC program.
- Lack of data on obstacles to accessing pain medication.
- This study examined the correlation between delayed access to pain medication and patient-centered pain management experience.

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Methods

- We utilized cross-sectional data from the Health Center Patient Survey (HCPS)

- Our study analyzes the association between delays in obtaining pain medication and patients' perception of pain control with generalized linear regression models

Results

Table 1: Characteristics of adult patients with pain problems inhibiting daily activities in the past 30 days (n=1568)

Variables	Obs.	Weighted Obs.	Weighted %
Dependent Variable			
Pain was Always/Usually/Sometimes Controlled (vs. Never)			
No	248	1014958.11	12.81
Yes	1318	6908601.07	87.19
Total	1566	7923559.17	100.00
Independent Variable			
Delays in Obtaining Necessary Prescription Medicine			
No	1046	5086226.16	68.58
Yes	400	2329777.45	31.42
Total	1446	7416003.61	100.00

MedStar Health

olled (vs.

	248	1014958.11	12.81
	1318	6908601.07	87.19
	1566	7923559.17	100.00
Medicine			
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MedStar Health

Results

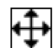

Table 3: Adjusted logistic regression models predicting pain control among adult patients with pain problems inhibiting daily activities, odds ratios

Delays in Obtaining Necessary Prescription Medicine	0.46 *
	[0.22, 0.98]
Age in Years (ref. 18-44)	
45-64	0.26 *
	[0.09, 0.73]
65+	0.15 ***
	[0.05, 0.46]
Race/Ethnicity (ref. Non-Hispanic White)	
Hispanic/Latino	2.77 *
	[1.28, 6.02]
Non-Hispanic Black/African American	0.41 *
	[0.21, 0.82]
Other	0.71
	[0.30, 1.66]
Reference Health Center Funding Type (ref. Community Health Center)	
Migrant Health Center	0.51
	[0.11, 2.37]
Health Care for the Homeless	0.39 **

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4)	
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Projections and Policy

Discussion

The study's findings emphasize the significance of researching contributing factors to the disparities to optimize access to pain management medications among underserved populations.

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Policy Implications

- Can better inform HRSA-led training and technical assistance programs
- Can help create a sustainable pain medication access model for federal programs

Current Research

- Isolating factors that contribute to pain medication delays in elderly and unhoused populations

- Creating targeted strategies to address these delays in access to pain medications

Thank you

It's how we treat people.

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Anna Zajacova, Jinhyung Lee, and Hanna Grol-Prokopczyk, *The Geography of Chronic Pain in the United States and Canada*, preprint, vols. (Epidemiology, September 20, 2021), online, Internet, 4 Mar. 2024. , Available: http://medrxiv.org/lookup/doi/10.1101/2021.09.15.21263635.

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It's how we treat people.

MedStar Health

Social determinants of health screening and referrals: What do we know?

Rachel Gold, PhD, MPH
Senior Investigator, Kaiser Permanente Center for Health Research;
Lead Research Scientist, OCHIN

Social determinants of health screening and referrals: What do we know?

SERCN Meeting 3/18/2024

Rachel Gold, PhD, MPH

Senior Investigator, Kaiser Permanente Center for Health Research;
Lead Research Scientist, OCHIN

OCHIN

A driving force for health equity

Overview

OCHIN

- What are social determinants of health (aka SOCIAL RISKS)?
- Why do they exist?
- How do they impact health?
- What do we know about healthcare setting interventions to address them?

What are social determinants of health?

- The conditions in which people live and work
- 'Adverse social determinants of health' = ***social risks***
  - *Social drivers of health*
  - *Social needs*
- Individual-level factors, e.g. **financial, housing, food, and transportation insecurity**
- Individual-level factors, e.g. stress, social isolation, exposure to racism
- Can also mean neighborhood factors (e.g., poor walkability; food desert)
- Many of these factors directly driven by **poverty**

How do social risks impact health?

- Access to affordable care ↓
- Exposure to risks, e.g.: ↑
  - Stress
  - Discrimination
  - Unsafe jobs
  - Lower health literacy
  - Adverse childhood events, conditions
- Ability to engage in healthy behaviors ↓
- Ability to act on care recommendations ↓
- These impacts interact and are cumulative

Example: chronic disease risk management

- Many chronic disease risk factors manageable with clinical / behavioral interventions:
  - Medications
  - Increased exercise, improved diet

- Social risks hamper their uptake:
  - Lack of affordable care → *Disease risk may not be identified, monitored*
  - Transportation insecurity → *Hard to attend visits, fill prescriptions*
  - Housing / food / financial insecurity →
    Hard to eat healthier foods, exercise; other needs prioritized
    - *Can impede ability to pay for medications*

- Lower income → social risks → harder to adopt preventive behaviors, interventions → unmanaged chronic disease → poor outcomes

Social Risks Impact Health Outcomes…
Even with High-Quality Care

- CHC patients with DM and transportation / housing needs were no less likely than others to have up-to-date HbA1c or microalbuminuria screening, foot exam, or statin rxs.

- **But even among those with up-to-date care:**
  - **Food insecurity** → lower rates of controlled HbA1c
  - **Transportation insecurity** → lower rates of controlled HbA1c, BP, LDL
  - **Housing insecurity** → no significant differences

- Guideline-concordant care less likely to yield desired T2DM outcomes when patients had social risks.

American Journal of
Preventive Medicine
RESEARCH ARTICLE

Cross-Sectional Associations: Social Risks and Diabetes Care Quality, Outcomes

Rachel Gold, PHD, MPH,[1,2] Jorge Kaufmann, ND, MS,[3] Laura M. Gottlieb, MD, MPH,[4] Saul J. Weiner, MD,[5] Megan Hoopes, MPH,[2] Jordan C. Gemelas, BS,[3] Cristina Huebner Torres, PhD, MA,[6] Erika K. Cottrell, PhD, MPP,[2,7] Danielle Hessler, PhD,[4] Miguel Marino, PhD,[3] Christina R. Sheppler, PhD,[1] Seth A. Berkowitz, MD, MPH[8,9]

Introduction: Social risks (e.g., food/transportation insecurity) can hamper type 2 diabetes mellitus (T2DM) self-management, leading to poor outcomes. To determine the extent to which high-quality care can overcome social risks' health impacts, this study assessed the associations between reported social risks, receipt of guideline-based T2DM care, and T2DM outcomes when care is up to date among community health center patients.

Methods: A cross-sectional study of adults aged ≥18 years (N=73,484) seen at 186 community health centers, with T2DM and ≥1 year of observation between July 2016 and February 2020. Measures of T2DM care included up-to-date HbA1c, microalbuminuria, low-density lipoprotein screening, and foot examination, and active statin prescription when indicated. Measures of T2DM outcomes among patients with up-to-date care included blood pressure, HbA1c, and low-density lipoprotein control on or within 6–12 months of an index encounter. Analyses were conducted in 2021.

Results: Individuals reporting transportation or housing insecurity were less likely to have up-to-date low-density lipoprotein screening; no other associations were seen between social risks and clinical care quality. Among individuals with up-to-date care, food insecurity was associated with lower adjusted rates of controlled HbA1c (79% vs 75%, $p<0.001$), and transportation insecurity was associated with lower rates of controlled HbA1c (79% vs 74%, $p=0.005$), blood pressure (74% vs 72%, $p=0.025$), and low-density lipoprotein (61% vs 57%, $p=0.009$) than among those with no reported need.

Conclusions: Community health center patients received similar care regardless of the presence of social risks. However, even among those up to date on care, social risks were associated with worse T2DM control. Future research should identify strategies for improving HbA1c control for individuals with social risks.

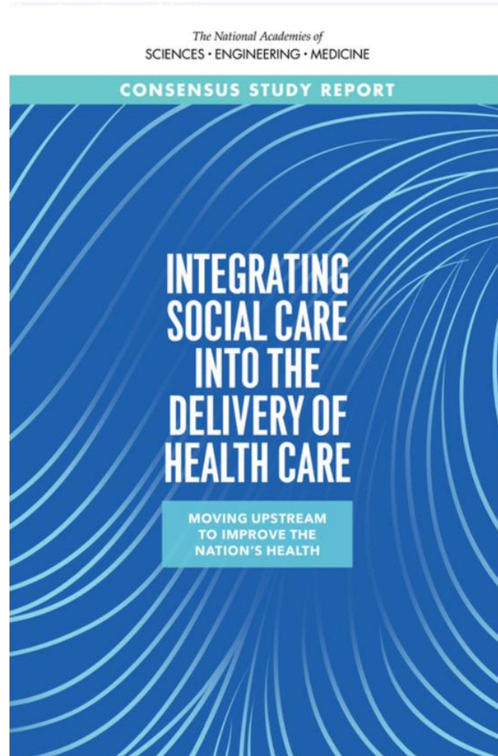
Trial Registration: This study is registered at www.clinicaltrials.gov NCT03607617.

Am J Prev Med 2022;63(3):392–402. *© 2022 American Journal of Preventive Medicine. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).*

Cross-Sectional Associations: Social Risks and Diabetes Care Quality, Outcomes. Gold R, et al. AJPM. 2022 Sep;63(3):392-402. doi: 10.1016/j.amepre.2022.03.011. PMID: 35523696

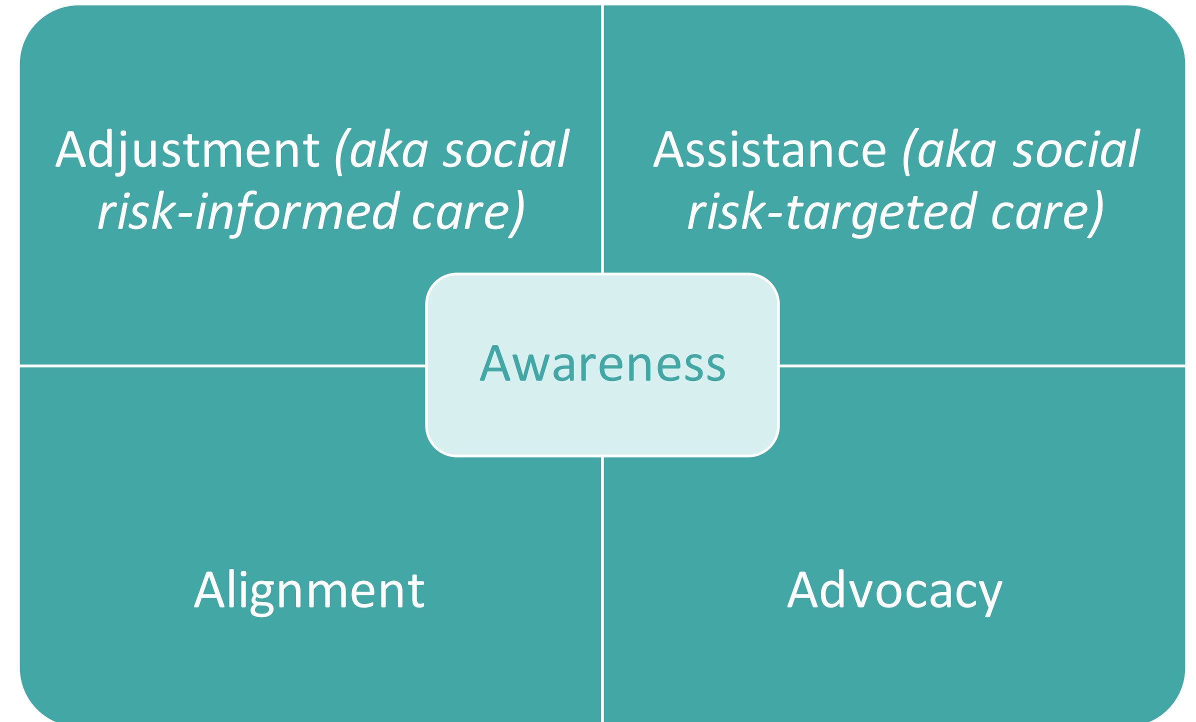
What Can Health Care Providers Do About This?

2019 NASEM Report: '5 As' of social care integration



Activities focused on heath care delivery

Activities focused on communities



Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. Washington (DC): National Academies Press (US); 2019 Sep 25

https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health

Awareness often = screening patients

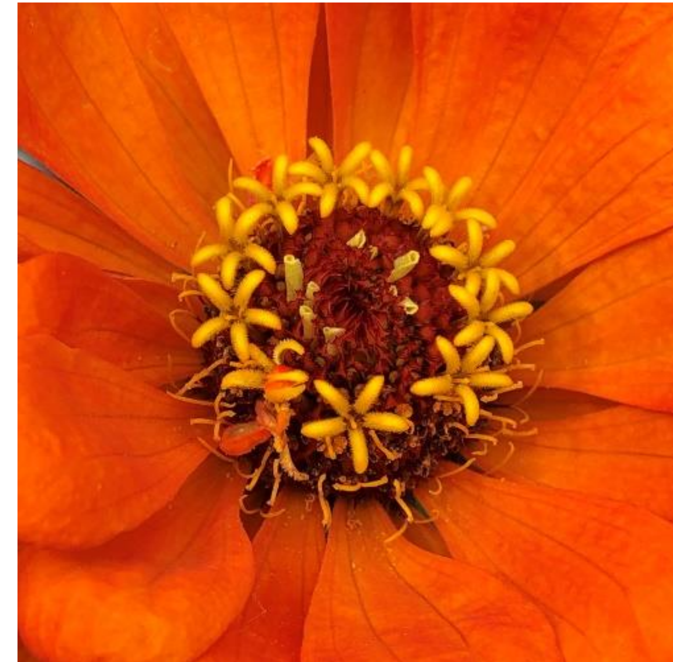
Much variation in screening prevalence

- In OCHIN's national network of >1,500 CHC clinics …
  - >2,500,000 social risk screenings conducted since 2016 … but just 15% of patients screened
  - Rates vary considerably between clinics
- Like prior findings: Substantial variation across different care settings in % screening *some* patients, i.e., ad-hoc
- These rates are going up as various national initiatives require or incentivize social risk screening
  - E.g., CMS 2024 mandates inpatient screening of selected social risks

Barriers to Implementing Screening / Awareness

- Barriers identified in NASEM report (and by many others since) include …

  - Competing needs, initiatives / Inadequate resources
  - I already know my patients' needs
  - Staff buy-in, comfort; why screen if I can't refer?
  - Lack of clarity about roles
  - Tension: standardized screening vs. having a conversation
  - Staff turnover vs. needed training
  - Identifying optimal workflows
    - Screen in person? On paper? Tablet? Text?
    - When to screen? Who will screen / enter data?
    - Which patients to screen? Which risks? Which screening tool? How often? Realistic goals?
    - Coding? Reimbursement?
  - Inadequate EHR tools for documenting screening results
  - AND MORE



Implementing Social Risk Screening: ASCEND

- ASCEND study: 31 CHC clinics, stepped-wedge design
- Implementation intervention = 6 months of
  - Technical assistance: using relevant EHR tools
  - Practice coaching / facilitation: walk through 5-step implementation process
  - Guide to: Staff training / orientation, goal identification, leadership engagement, workflow development; materials for each step
  - Meet (virtually) with clinic champions 2-3x / month
  - Peer-to-peer learning
  - Monthly feedback data
- SDH 'summary' = Tailored plan for future

SDH screening adoption step	Tasks needed for this step
Step 1. Create a 'SDH Team.'	Obtain leadership support for SDH screening.
	Identify a clinician champion (CC) for SDH screening adoption.
	Identify a project champion (PC); this may be the CC if desired.
	Give the champion(s) dedicated time for SDH efforts, including contact with study team.
Step 2. Identify clinic goals	Identify your clinic's goals for SDH screening (why you want to do SDH screening, what you will do with SDH screening results, which patients you want to screen, how this screening fits your clinic's vision, etc.). Your goals may be to adapt or scale up your existing SDH screening efforts.
Step 3. Create a 'SDH Plan.'	Create a workflow plan to meet your clinic's targeted SDH collection goals, and (if desired) SDH action.
	Create a rollout plan and a plan for tracking your clinic's SDH screening adoption.
Step 4. Train clinic staff in the 'SDH Plan.'	Orient clinic staff (e.g., at a staff meeting, via email, etc.).
	If changes are made to the plan, orient staff to the changes.
	Train new staff as needed.
Step 5. Roll out, then iteratively revise the 'SDH Plan'	Roll out your planned SDH workflow.
	Demonstrate your clinic can run SDH screening rates.
	Use SDH screening rates/workflow review to improve adoption of your SDH Plan.

ASCEND study – main results

- Social risk *screening* 2.5 times higher during intervention compared to pre-intervention (significantly improved)
- But impact not sustained post-intervention
- No difference in *referral* rates
- **Implications:**
  - Did intervention not adequately address barriers to sustained implementation? Was 6 months not enough?
  - CHCs may struggle to meet social risk screening requirements without adequate support

NEJM Catalyst | Innovations in Care Delivery

ARTICLE

Implementation Support for a Social Risk Screening and Referral Process in Community Health Centers

Rachel Gold, PHD, MPH, Jorge Kaufmann, ND, MS, Erika K. Cottrell, PhD, MPP, Arwen Bunce, MA, Christina R. Sheppler, PhD, Megan Hoopes, MPH, Molly Krancari, MPH, Laura M. Gottlieb, MD, MPH, Meg Bowen, Julianne Bava, MSN, Ned Mossman, MPH, Nadia Yosuf, MPH, Miguel Marino, PhD

Vol. 4 No. 4 | April 2023

DOI: 10.1056/CAT.23.0034

Evidence is needed about how to effectively support health care providers in implementing screening for social risks (adverse social determinants of health) and providing related referrals meant to address identified social risks. This need is greatest in underresourced care settings. The authors tested whether an implementation support intervention (6 months of technical assistance and coaching study clinics through a five-step implementation process) improved adoption of social risk activities in community health centers (CHCs). Thirty-one CHC clinics were block-randomized to six wedges that occurred sequentially. Over the 45-month study period from March 2018 to December 2021, data were collected for 6 or more months *preintervention*, the 6-month *intervention period*, and 6 or more months *postintervention*. The authors calculated clinic-level monthly rates of social risk screening results that were entered at in-person encounters and rates of social risk-related referrals. Secondary analyses measured impacts on diabetes-related outcomes. Intervention impact was assessed by comparing clinic performance based on whether they *had* versus *had not yet* received the intervention in the preintervention period compared with the intervention and postintervention periods. In assessing the results, the authors note that five clinics withdrew from the study for various bandwidth-related reasons. Of the remaining 26, a total of 19 fully or partially completed all 5 implementation steps, and 7 fully or partially completed at least the first 3 steps. Social risk *screening* was 2.45 times (95% confidence interval [CI], 1.32–4.39) higher during the intervention period compared

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ASCEND study – main results

- CHCs face barriers to implementing sustained social risk screening / referral-making
- Substantial ongoing support may be needed to implement this practice
- Implementation guide based on study findings to help clinics in these efforts →https://sirenetwork.ucsf.edu/guide-implementing-social-risk-screening-and-referral-making
- Implementation approaches that support trust / trusting relationships are key

A Guide to Implementing Social Risk Screening and Referral-making

Introduction

Adverse social determinants of health – referred to in this guide as **social risks** – include contextual factors such as food, transportation, and housing instability, and social isolation. Collecting information on these risks can help ambulatory care teams understand and address how these factors impact their patients' health.

This pragmatic guide will help your clinic implement social risk screening and (if desired) referral-making, or improve your current practices. It is meant to be used by any primary / ambulatory care staff interested in implementing social risk screening and referral-making.

Overview

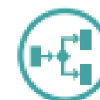
This guide uses a five-step roadmap for implementing or improving social risk screening and related activities at your clinic. It provides tools and materials to support each step, and a list of useful resources.

Step 1: Getting Ready

Materials include: Orientation to social risks; Clinic champion orientation; Draft email from leadership to staff

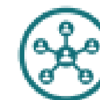
Step 2: Identify Clinic Goals

Materials include: Recommendations for setting goals; Goal-setting decision tool



Step 3: Create a Social Risk Plan

Materials include: Overview of social risk tools in the EHR; Workflow examples; Workflow development tool



Step 4: Orient Clinic Staff To Your Clinic's Social Risk Plan

Materials include: Overview; FAQs for staff; Orientation slide deck; Kick-off package (Poster, social risk champion certificate, tips for engaging staff, goals thermometer, etc.)

Step 5: Roll Out and Iterate

Materials include: Overview; Steps; Considerations and tips; Example; Roll-out template

Resources to Support Implementing Social Risk Data Collection and Referral-Making

This guide was developed as part of an NIH-funded study [1R18DK114701] by teams at the Kaiser Permanente Center for Health Research and OCHIN, Inc. The purpose of this study was to test the effectiveness of targeted implementation support at enhancing social risk screening adoption in primary care settings and community health centers.

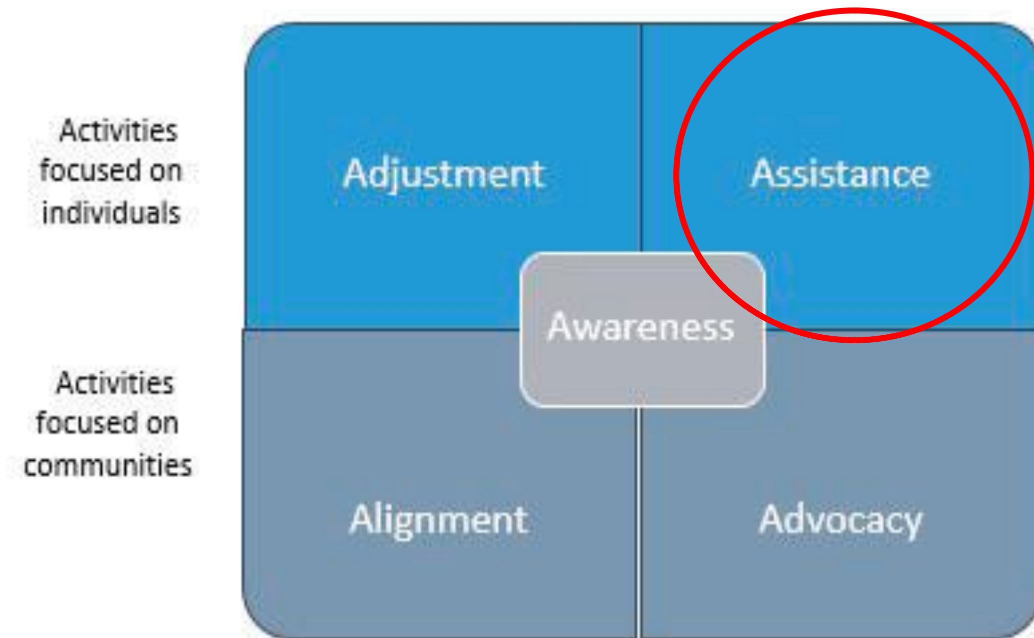
What do we know about Assistance?

- Emerging evidence: **internal** and / or **external** assistance referrals *can* modestly improve health outcomes

- Gottlieb et al 2017 evidence review found Assistance associated with improved:
  - Child health / health behaviors
  - Adult physical health or quality of life
  - Adult health-related behaviors (e.g., diet, smoking, and medication adherence)
  - Adult mental health outcomes

- But some studies found no significant health improvements associated with social risk intervention

- Fan et al 2022 evidence review (Health Equity) also found mixed evidence on Assistance effects on health, health care costs, care utilization



What do we know about Assistance?

- Assumption (per Gottlieb et al 2024):
  - Screen for social risks → refer patients with social risks to social services → patients receive social services → which help reduce or resolve social risks → changes in social risks will → improved health

- Is this true?
  - Maybe, but **no strong evidence** yet supports this pathway
  - Rather, emerging evidence suggests a **more complex pathway** linking social risk screening and outcomes
  - Navigation (support accessing social services) may play a key role

Gottlieb et al 2024, Milbank Quarterly

OCHIN

What do we know about Assistance?

There are barriers to implementing Assistance …

- Patients offered assistance interventions **do not always want them**
  - Already tried them
  - Fear of stigma, discrimination re pursuing resource referrals due, e.g. due to immigration policies (Steeves-Reece, 2022)

  - Our team found:
    - **79%** of CHC patients with reported social risks declined referrals
      - Likelihood of declining varied by # positive domains, gender, race / ethnicity
  - Others found:
    - Food insecurity referral acceptance: 21-90%, housing referral acceptance: 12-20% (De Marchis, 2020)

What do we know about Assistance?

OCHIN

There are barriers to implementing Assistance …

- **Who do you refer to when social risk is reported?**
  - Are resources **available**?
  - Inadequate / restrictive community resources local to the patient?
  - Inaccessible resources, e.g., for patients with mobility / transportation barriers?

- **Who does the referring and when?**
  - Staff must have **time, workflows** to conduct referrals (*which* staff?) … and follow up, if desired
  - **Staff** must know local CBOs and who they serve; and / or
  - List of service agencies must be kept **up to date …**

OCHIN

What do we know about Assistance?

There are barriers to implementing Assistance …

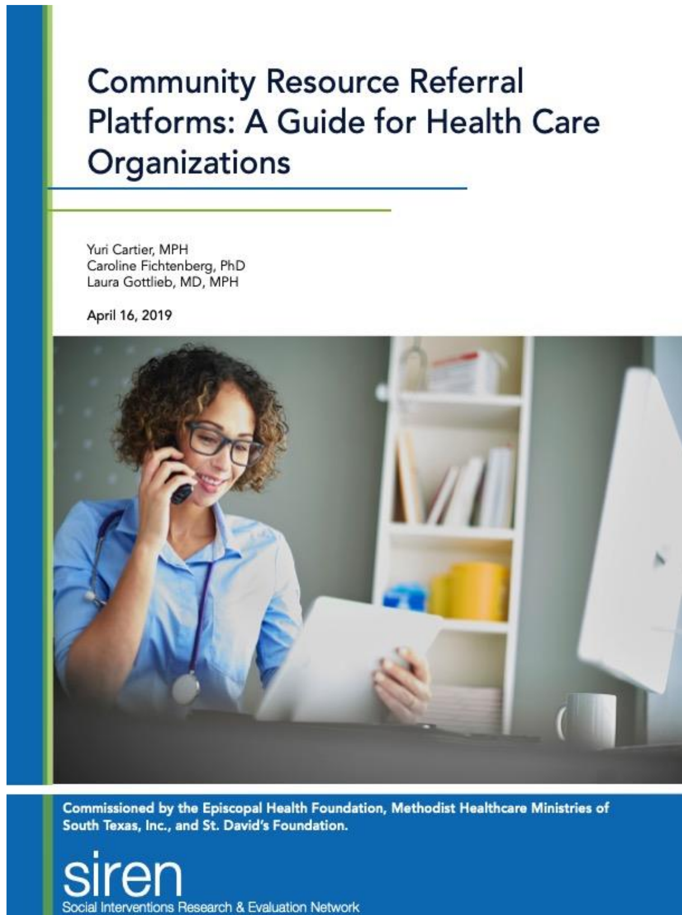
- **Use Social Service Resource Locators?**
  - Can be **costly**
  - May not work well - depends on SSRL, region, how fast updated
  - Low-cost SSRLs accessed **outside** of EHR; inefficient + requires user to know where located
  - **EHR-based** SSRLs
    - Involve multiple steps / **clicks**
    - Present referral **options** - user needs to know how to choose
    - Referral-making separate from documentation
    - CBOs must be willing to engage ….

- **How best to 'close the loop'?**

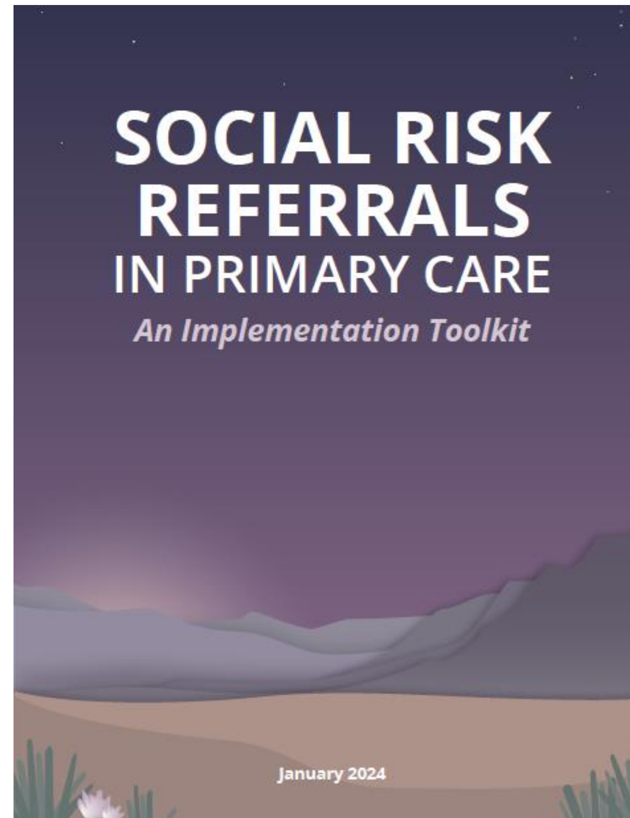
- **CBO barriers** = capacity, technology, engagement …
  - So clinics can not just use SSRLs b/c referrals require **relationships** with CBOs, and **understanding** how to best work with them for effective referrals, e.g., How best to send referrals? What capacity to address referrals?

Resources for Assistance implementation

https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations



Now being pilot tested



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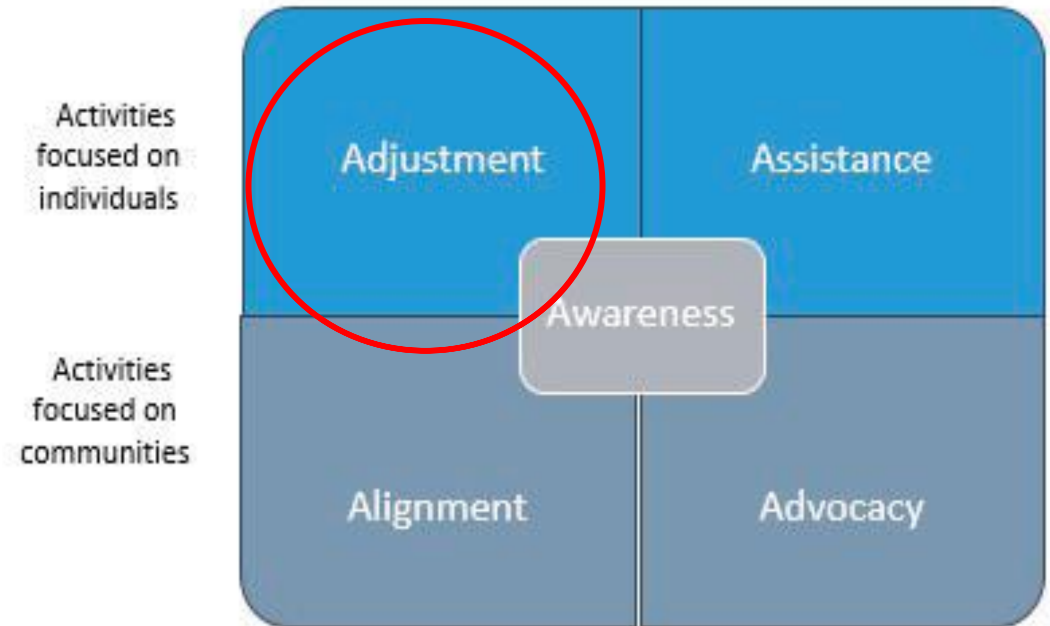
What do we know about Adjustment?

- Social risk adjustments might include:
  - Generic rxs, polypill, etc.
  - Mail rx to home
  - If transportation insecure: Follow-up care - pacing of visits, telehealth, etc.
  - If houseless: avoid refrigerated medications
  - If food insecure (DM): modify insulin doses based on monthly food benefit schedules
- Nascent evidence: better clinical outcomes associated with adjustments … But adjustments occur <25% of the time in diverse settings
- **How best to present social risk information to increase adjustments?**
- Might **EHR-based tools** help? E.g., reminders, summaries, recommendations? …



What do we know about Adjustment?

- Do social risks influence safety net primary care clinicians' decisions at the point of care? How?
- Survey: 38 CHC clinicians at point of care
- Social risks reported to influence care in 35% of surveyed encounters
- Sources of information on social risks:
    - conversations with patients (76%)
    - prior knowledge (64%)
    - EHR (46%)
- Significantly more likely to influence care among male and non-English–speaking patients, and those with discrete screening data in the EHR

Patient-Reported Social Risks and Clinician Decision Making: Results of a Clinician Survey in Primary Care Community Health Centers

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VISUAL ABSTRACT

ABSTRACT

PURPOSE To assess the extent that patients' social determinants of health (SDOH) influence safety-net primary care clinicians' decisions at the point of care; examine how that information comes to the clinician's attention; and analyze clinician, patient, and encounter characteristics associated with the use of SDOH data in clinical decision making.

METHODS Thirty-eight clinicians working in 21 clinics were prompted to complete 2 short card surveys embedded in the electronic health record (EHR) daily for 3 weeks. Survey data were matched with clinician-, encounter-, and patient-level variables from the EHR. Descriptive statistics and generalized estimating equation models were used to assess relationships between the variables and the clinician reported use of SDOH data to inform care.

RESULTS Social determinants of health were reported to influence care in 35% of surveyed encounters. The most common sources of information on patients' SDOH were conversations with patients (76%), prior knowledge (64%), and the EHR (46%). Social determinants of health were significantly more likely to influence care among male and non-English–speaking patients, and those with discrete SDOH screening data documented in the EHR.

CONCLUSIONS Electronic health records present an opportunity to support clinicians integrating information about patients' social and economic circumstances into care planning. Study findings suggest that SDOH information from standardized screening documented in the EHR, combined with patient-clinician conversations, may enable social risk-adjusted care. Electronic health record tools and clinic workflows could be used to support both documentation and conversations. Study results also identified factors that may cue clinicians to include SDOH information in point-of-care decision-making. Future research should explore this topic further.

Ann Fam Med 2023;21:143-150. https://doi.org/10.1370/afm.2953

INTRODUCTION

Despite increasing national interest in social risk screening in primary care settings[1-7] and the potential for contextual information to influence care in ways that improve patient outcomes,[8,9] little is known about whether and how social risk (adverse social determinants of health) information influences clinician decisions at the point of care. Few prior studies have explored the extent to which social determinants of health (SDOH) data informs care, and diverse definitions and measurement approaches make comparisons difficult. Broadly speaking, use of SDOH in care planning varies by practice specialty, clinician, and patient situation.[10-13] Studies that quantified the impact of SDOH on care have reported use rates of 22% to 59%,[3,11-13] and all concluded that missed opportunities are common.[8,10,11,14-16]

Social risk data could influence point of care activities in multiple ways. A 2019 National Academies of Sciences, Engineering, and Medicine report suggested 5 ways in which social care can be integrated into health care, 2 of which are applicable to actions at the point of care (assistance and adjustment).[17] Assistance, sometimes called social prescribing, involves connecting patients to community resources. Adjustment entails adapting medical care to accommodate social risk. Evidence is gradually mounting that assistance and adjustment interventions can improve health.[6,14,18-21] A recent United States Preventative Services Taskforce brief called for more high-quality research in this area.[22]

Conflicts of interest: authors report none.

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How Best to Support Adjustment Activities?

Contextualized care in CHCs' Electronic health Records (COHERE)

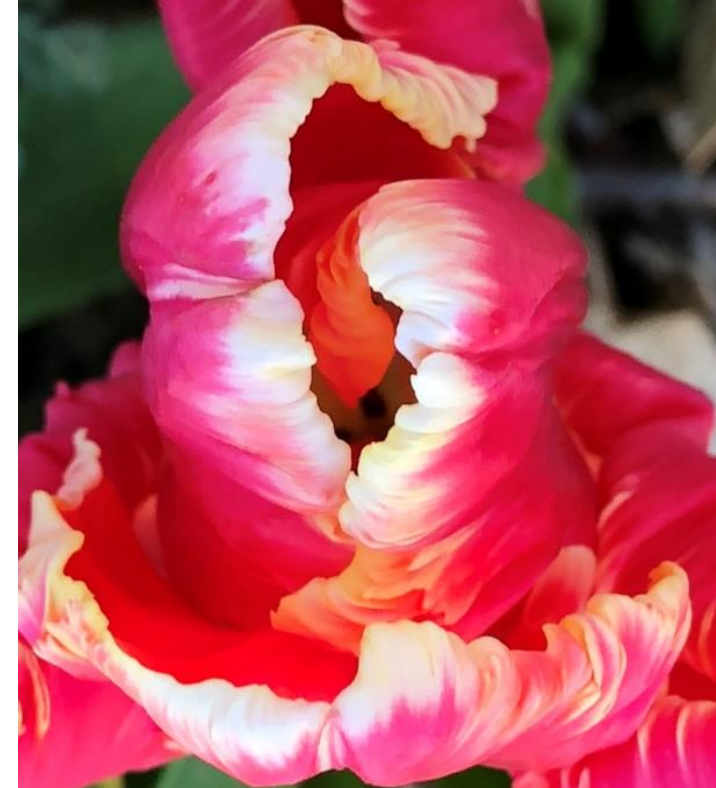
- **5-year study** funded by National Institute on Minority Health and Health Disparities
- **Co-PIs:** Laura Gottlieb, MD, MPH (UCSF); Rachel Gold, PhD, MPH (Kaiser Permanente Center for Health Research, OCHIN)
- **1st trial to develop CDS for social risk-informed care**, assess impact on provider behaviors, provider / patient satisfaction, health outcomes
- Study conducted in the **OCHIN network** of community health centers

Study Goal

Develop & test clinical decision support (CDS) tools that recommend care plan adaptations that account for a patient's social risks

What do we still *need to know*?

- Through which pathways do social risk screening, referrals impact health outcomes?
- Which approaches to addressing social risks are most effective for which patients?
- What methods for conducting social risk screening, referrals, navigation are most effective in CHCs?
- Potential *harms* of social risk screening?
- How much impact can screening have (or be expected to have) given inadequate US funding of social services?



Thank you! Questions?

Rachel Gold, PhD, MPH

rachel.gold@kpchr.org

BREAK
10:15am-10:30am

Network for Community-Engaged Primary Care Research (NCPCR) Engagement Session

Facilitated by: Anne Gaglioti, Mitchell Blount, Megan Douglas, Anna Templeton, and Denita Walston

Two
Concurrent Engagement Stations

1. Patient Advisors: Young Room

1. FQHC and PCA Advisors: Turner Room

Engagement Session Schedule:

Time	Young Room: Patient Advisors	Room: Turner PCA and FQHC Advisors
10:30-11 am	RCT Recruitment Material *Denita and Mitchell*	RCT Data Infrastructure *Megan and Anne*
11-11:30 am	CDC Capacity Building *Megan and Anne*	RCT Recruitment Material *Denita and Mitchell*
11:30-12pm	Recruitment Infrastructure *Anna and Phoebe*	CDC Capacity Building *Megan and Anne*

- What types of information on social drivers of health (SDOH) screening is most important to share when we talk about recruiting patients to participate in a study on screening and referral for social drivers of health?

- What formats would be best to share this information?

- What materials would be helpful related to chronic conditions, community health workers in relationship to SDOH screening?

NCPCR RCT Data Infrastructure: FQHC and PCA Feedback

- Is your FQHC a member of a health center-controlled network or another centralized network which accesses/houses your health center's data?
  - PCA: What percentage of your FQHCs are members of a health center-controlled network or another centralized network which accesses/houses your health center's data?
- What EHR does your health center use, or what EHRs are used by FQHC members of your PCA?
  - PCA: Is there a predominant vendor used by FQHCs in your state?
- Can your health center send patient-level deidentified data from a SQL database to a centralized data warehouse? What percentage of health centers in your state have the ability to send patient-level deidentified data from a SQL database to a centralized data warehouse?
  - If you do not have access to your EHRs SQL database, are you able to export data directly from the EHR or do you need to contact your EHR vendor for data extracts?
    - *Data types include, but are not limited to: patient demographics, encounters, labs/test, vitals, encounter findings, SDOH data*

NCPCR RCT Data Infrastructure: FQHC and PCA Feedback (cont.)

- Do you have a dedicated Data Specialist or Business Intelligence Team who can pull and share patient-level EHR data from a SQL database? What percentage of health centers in your PCA have a dedicated data specialist who can pull and share patient-level EHR data from a SQL database?
  - What is the capacity of these team members to participate in additional projects?
- Has your health center, or PCA members utilized a SFTP (Secure File Transfer protocol/SSH File Transfer Protocol) for transferring EHR data securely?
  - If not, what platforms have you used to transfer EHR data securely? (i.e., OneDrive, Encrypted email, etc.).
- Are there other data sharing/capacity issues we should be considering?

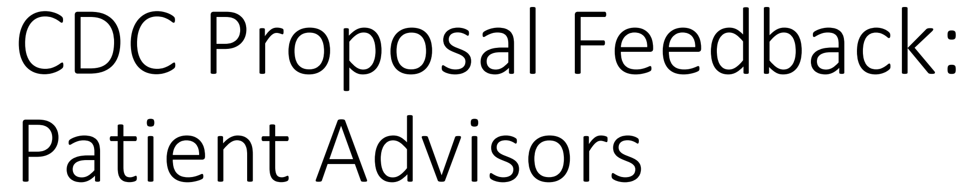
CDC Proposal Feedback: PCA and FQHC Advisors

- Is a capacity-building assistance (CBA) program like this needed?
- Would a community of practice among FQHCs focused on screening for social risks, referral for social services, and building community coalitions be an appropriate model?
    - Would a different model of CBA be better? Ex: training/fellowship, technical assistance, materials development
- Would participation incentives be necessary?
    - If so, what types of incentives? Gift cards to participants, MOU arrangement with health center, support for QI project, something else?
- Strategic Areas:
    - Organizational Capacity/Performance Improvement
    - Workforce
    - Data Modernization/Informatics/IT
    - Partnership Development & Engagement
    - Policy & Programs
- Priority topics
    - Screening – tools, processes, workflows, patient engagement
    - Referral – resource identification, community capacity, patient support, closing the loop
    - Community Partnerships – policies/processes, models
    - System-level change/advocacy
- Would you be willing to provide a letter of support?

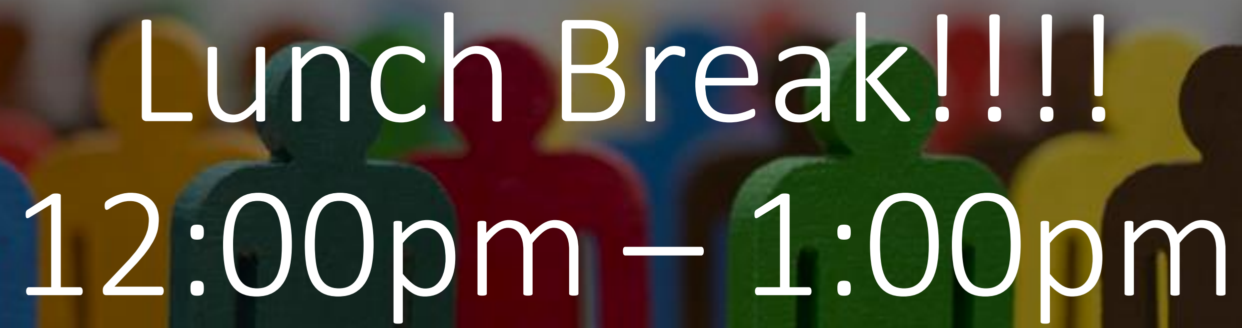
NCPCR RCT Recruitment and Informational Materials: FQHC and PCA Advisor Feedback

- What materials do you currently have/use to support both providers and patients with SDOH screening and referral?
- What additional resources are needed to support recruitment for a study that tests a CHW-led model for screening and referral for social needs?
- Do you think clinicians and FQHC staff would need some level setting/academic detailing on SDOH screening and referral if participating in the project?
  - In what format? (video, podcast, webinar, practice facilitation)
- What materials would be helpful related to:
  - The relationship between SDOH and chronic conditions and CHW navigation

- What do you think about research in health centers? About research or clinical trials in your network/health center?
- What experiences have you had being recruited for research, especially clinical trials? What did you consider as making recruitment successful? As making participation successful? If you have not, why?
- If you've taken part in a study or were being invited to take part, how would you like to be invited? How would you like a study team to reach out to you and what information or resources would be helpful for you?
- What do you think are some of the limitations or challenges inherent to recruiting in primary care and community health center settings? Patient populations?
- Are there other questions we should be asking? People we should be talking with? Approaches we should consider?



- Is a capacity-building assistance (CBA) program like this needed?
- Would a community of practice among FQHCs focused on screening for social risks, referral for social services, and building community coalitions be an appropriate model?
  - Would a different model of CBA be better? Ex: training/fellowship, technical assistance, materials development
- What CBA might FQHCs need to inform, engage, and serve patients with social needs?
  - Education/information materials – what do patients know/think when asked about social risks?
  - Community profiles – what are most common social needs in the community and what resources are available?
  - Referral/access to services – how can FQHCs support/help patients navigate access to and receipt of social services?
  - Processes/workflows – who should ask the questions and when? What does the FQHC do with the information?
  - Other?
- Would you be willing to provide a letter of support?


Lunch Break!!!!
12:00pm – 1:00pm

Intersections: At the Crossroads of Substance Use and Medicine

James Campbell, LPC, LAC, MAC, AADC
Training and Technical Assistance Manager
Southeast ATTC
Morehouse School of Medicine

ATTC

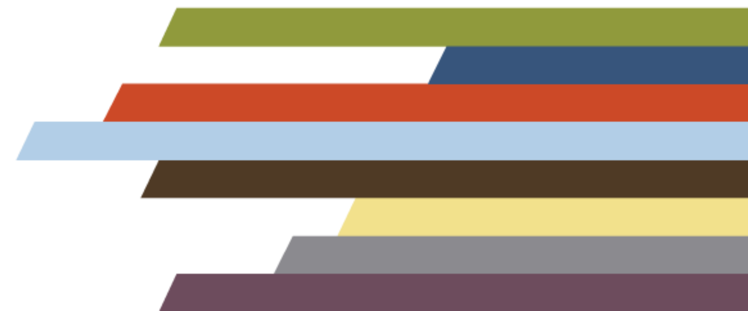
Addiction Technology Transfer Center Network

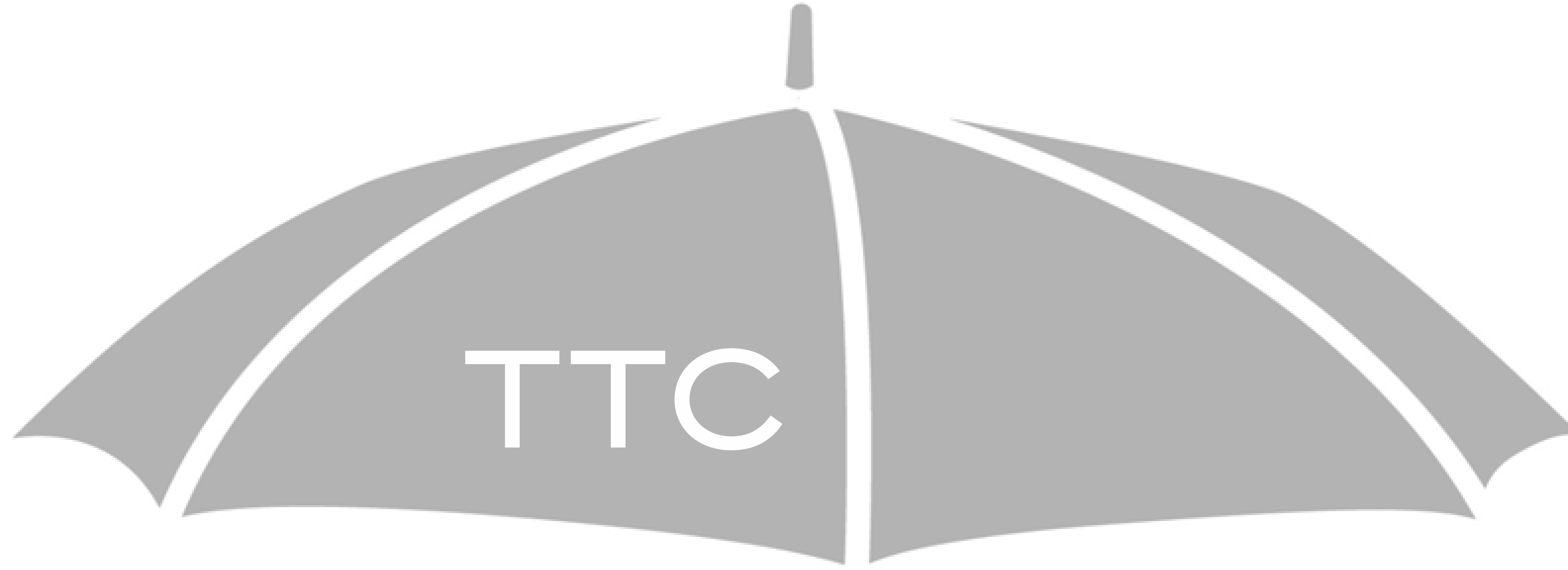
Funded by Substance Abuse and Mental Health Services Administration

James Campbell, LPC, LAC, MAC, AADC

TTC Technology Transfer Centers
Funded by Substance Abuse and Mental Health Services Administration

Technology Transfer Centers (TTC)



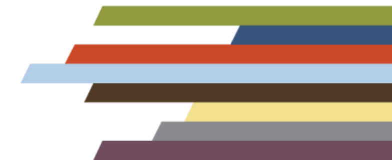


ATTC

MHTTC

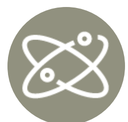
PTTC

SOURCES: Smith & Jones, 2020; Alcott et al., 2018; Bravo, 2014.



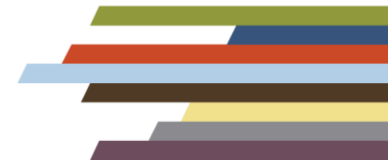
Purpose

The purpose of the Technology Transfer Centers (TTC) program is to ***develop and strengthen*** the ***specialized behavioral healthcare and primary healthcare workforce*** that provides substance use disorder (SUD) and mental health prevention, treatment, and recovery support services.



Help people and organizations incorporate ***effective practices*** into substance use and mental health disorder prevention, treatment and recovery services.

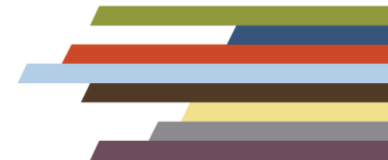
SOURCES: Smith & Jones, 2020; Alcott et al., 2018; Bravo, 2014.



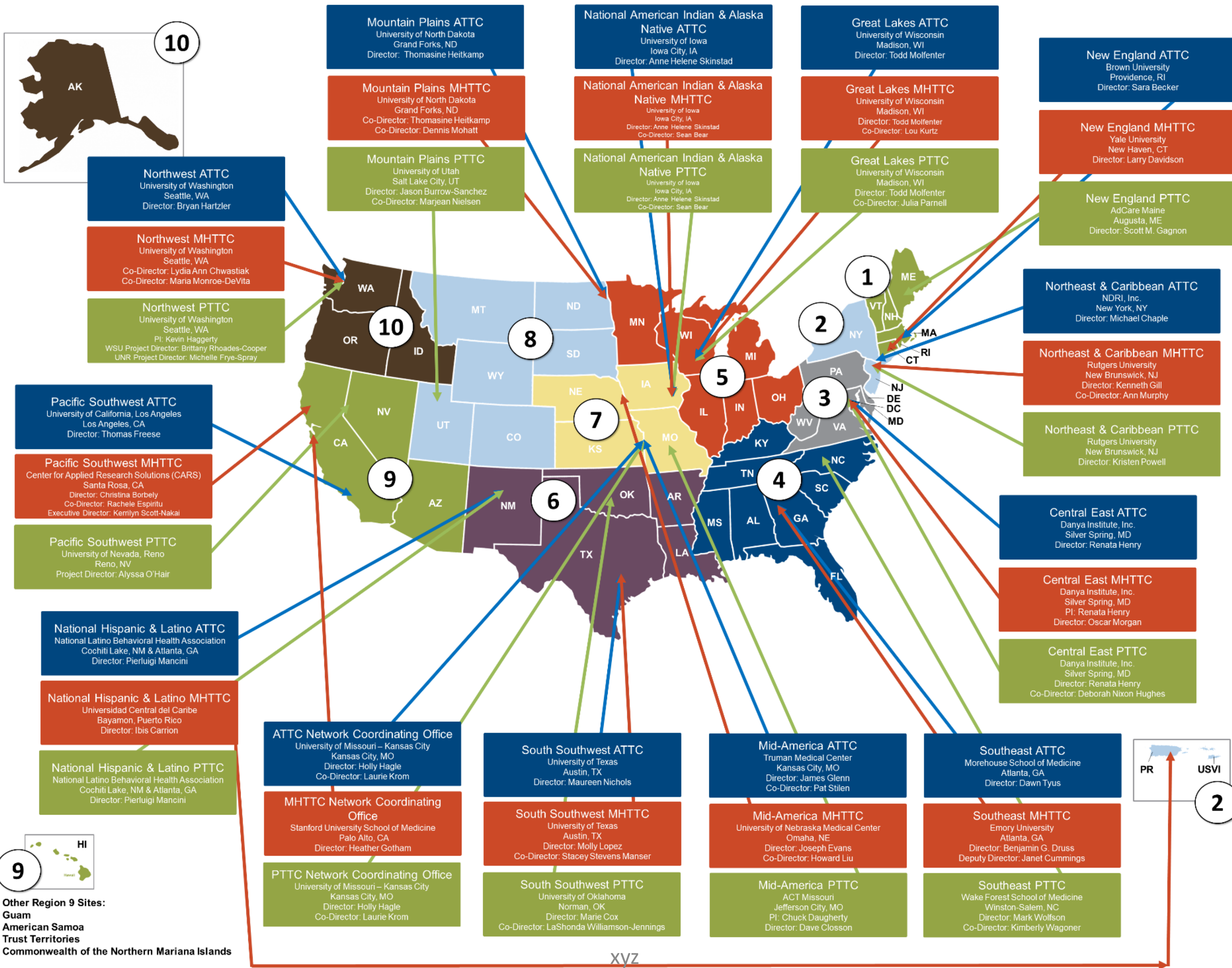
Each TTC Network Includes 13 Centers*

- Network Coordinating Office
- National American Indian and Alaska Native Center
- National Hispanic and Latino Center
- 10 Regional Centers (aligned with HHS regions)

*ATTC Network also includes
4 international HIV Centers funded by
the President's Plan for AIDS Relief



Southeast Addiction Technology Transfer Center is housed within the National Center of Primary Care at Morehouse School of Medicine.



Mountain Plains ATTC
University of North Dakota
Grand Forks, ND
Director: Thomasine Heitkamp
Mountain Plains MHTTC
University of North Dakota
Grand Forks, ND
Co-Director: Thomasine Heitkamp
Co-Director: Dennis Mohatt
Mountain Plains PTTC
University of Utah
Salt Lake City, UT
Director: Jason Burrow-Sanchez
Co-Director: Marjean Nielsen
National American Indian & Alaska Native ATTC
University of Iowa
Iowa City, IA
Director: Anne Helene Skinstad
National American Indian & Alaska Native MHTTC
University of Iowa
Iowa City, IA
Director: Anne Helene Skinstad
Co-Director: Sean Bear
National American Indian & Alaska Native PTTC
University of Iowa
Iowa City, IA
Director: Anne Helene Skinstad
Co-Director: Sean Bear
Great Lakes ATTC
University of Wisconsin
Madison, WI
Director: Todd Molfenter
Great Lakes MHTTC
University of Wisconsin
Madison, WI
Director: Todd Molfenter
Co-Director: Lou Kurtz
Great Lakes PTTC
University of Wisconsin
Madison, WI
Director: Todd Molfenter
Co-Director: Julia Parnell
New England ATTC
Brown University
Providence, RI
Director: Sara Becker
New England MHTTC
Yale University
New Haven, CT
Director: Larry Davidson
New England PTTC
AdCare Maine
Augusta, ME
Director: Scott M. Gagnon
10
AK
Northwest ATTC
University of Washington
Seattle, WA
Director: Bryan Hartzler
Northwest MHTTC
University of Washington
Seattle, WA
Co-Director: Lydia Ann Chwastiak
Co-Director: Maria Monroe-DeVita
Northwest PTTC
University of Washington
Seattle, WA
PI: Kevin Haggerty
WSU Project Director: Brittany Rhoades-Cooper
UNR Project Director: Michelle Frye-Spray
Pacific Southwest ATTC
University of California, Los Angeles
Los Angeles, CA
Director: Thomas Freese
Pacific Southwest MHTTC
Center for Applied Research Solutions (CARS)
Santa Rosa, CA
Director: Christina Borbely
Co-Director: Rachele Espiritu
Executive Director: Kerrilyn Scott-Nakai
Pacific Southwest PTTC
University of Nevada, Reno
Reno, NV
Project Director: Alyssa O'Hair
WA
OR
ID
MT
ND
SD
WY
MN
WI
MI
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UT
CO
NV
CA
AZ
NM
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OH
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ME
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RI
CT
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DE
DC
MD
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10
Northeast & Caribbean ATTC
NDRI, Inc.
New York, NY
Director: Michael Chaple
Northeast & Caribbean MHTTC
Rutgers University
New Brunswick, NJ
Director: Kenneth Gill
Co-Director: Ann Murphy
Northeast & Caribbean PTTC
Rutgers University
New Brunswick, NJ
Director: Kristen Powell
Central East ATTC
Danya Institute, Inc.
Silver Spring, MD
Director: Renata Henry
Central East MHTTC
Danya Institute, Inc.
Silver Spring, MD
PI: Renata Henry
Director: Oscar Morgan
Central East PTTC
Danya Institute, Inc.
Silver Spring, MD
Director: Renata Henry
Co-Director: Deborah Nixon Hughes
National Hispanic & Latino ATTC
National Latino Behavioral Health Association
Cochiti Lake, NM & Atlanta, GA
Director: Pierluigi Mancini
National Hispanic & Latino MHTTC
Universidad Central del Caribe
Bayamon, Puerto Rico
Director: Ibis Carrion
National Hispanic & Latino PTTC
National Latino Behavioral Health Association
Cochiti Lake, NM & Atlanta, GA
Director: Pierluigi Mancini
ATTC Network Coordinating Office
University of Missouri – Kansas City
Kansas City, MO
Director: Holly Hagle
Co-Director: Laurie Krom
MHTTC Network Coordinating Office
Stanford University School of Medicine
Palo Alto, CA
Director: Heather Gotham
PTTC Network Coordinating Office
University of Missouri – Kansas City
Kansas City, MO
Director: Holly Hagle
Co-Director: Laurie Krom
South Southwest ATTC
University of Texas
Austin, TX
Director: Maureen Nichols
South Southwest MHTTC
University of Texas
Austin, TX
Director: Molly Lopez
Co-Director: Stacey Stevens Manser
South Southwest PTTC
University of Oklahoma
Norman, OK
Director: Marie Cox
Co-Director: LaShonda Williamson-Jennings
Mid-America ATTC
Truman Medical Center
Kansas City, MO
Director: James Glenn
Co-Director: Pat Stilen
Mid-America MHTTC
University of Nebraska Medical Center
Omaha, NE
Director: Joseph Evans
Co-Director: Howard Liu
Mid-America PTTC
ACT Missouri
Jefferson City, MO
PI: Chuck Daugherty
Director: Dave Closson
Southeast ATTC
Morehouse School of Medicine
Atlanta, GA
Director: Dawn Tyus
Southeast MHTTC
Emory University
Atlanta, GA
Director: Benjamin G. Druss
Deputy Director: Janet Cummings
Southeast PTTC
Wake Forest School of Medicine
Winston-Salem, NC
Director: Mark Wolfson
Co-Director: Kimberly Wagoner
PR
USVI
2
HI
9
Other Region 9 Sites:
Guam
American Samoa
Trust Territories
Commonwealth of the Northern Mariana Islands
XYZ
*Map not to scale

- **The correlation between substance use and health**

- **The correlation between substance use and emergency rooms**

- **Medical Language**

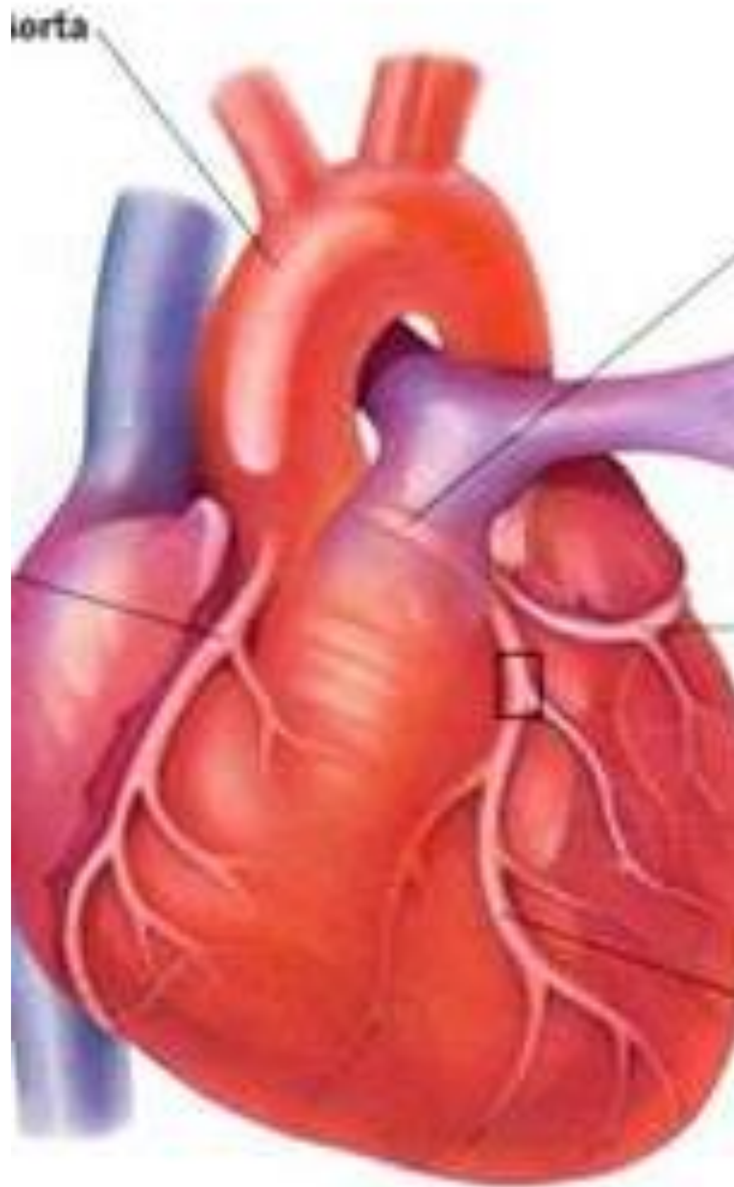
How does substance use disorder connect with healthcare?

- **<u>The correlation between substance use and health</u>**

- **The correlation between substance use and emergency rooms**

- **Medical Language**

SUDs as a Lifestyle Related Health Problem

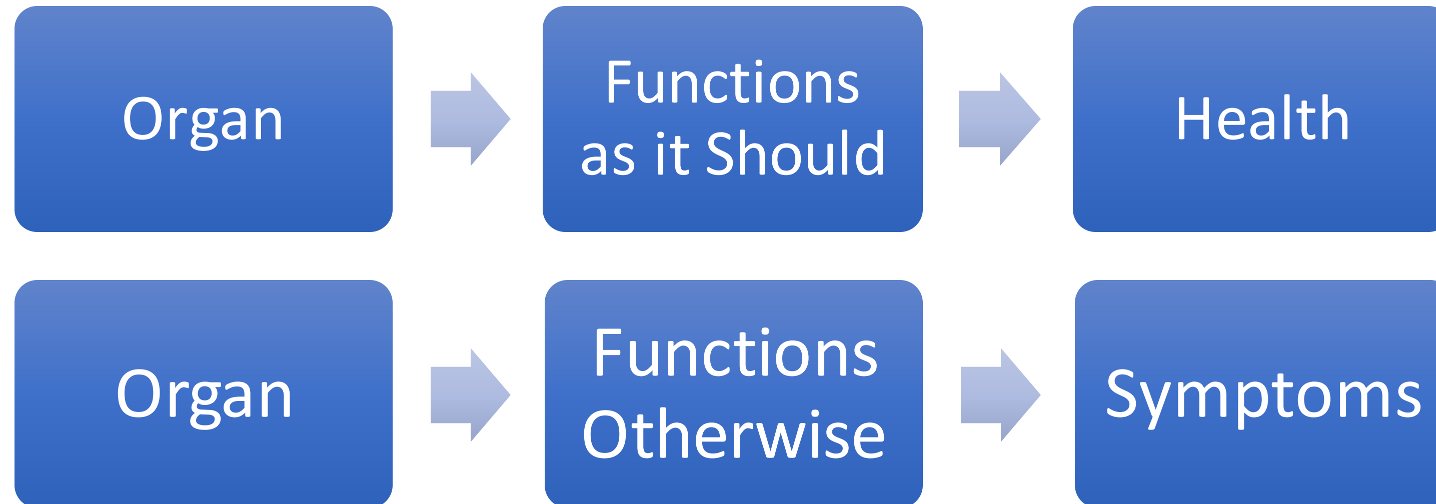


Let’s look at another example.

Heart disease.

- Has a genetic pre-disposition.
- Involves choices we make.
  - -Choices are impacted by social influences.
  - -Choices are impacted by psychological influences.
- When Biology and choices meet, there are predictable outcomes.

Disease Theory



SUDs as a Disease

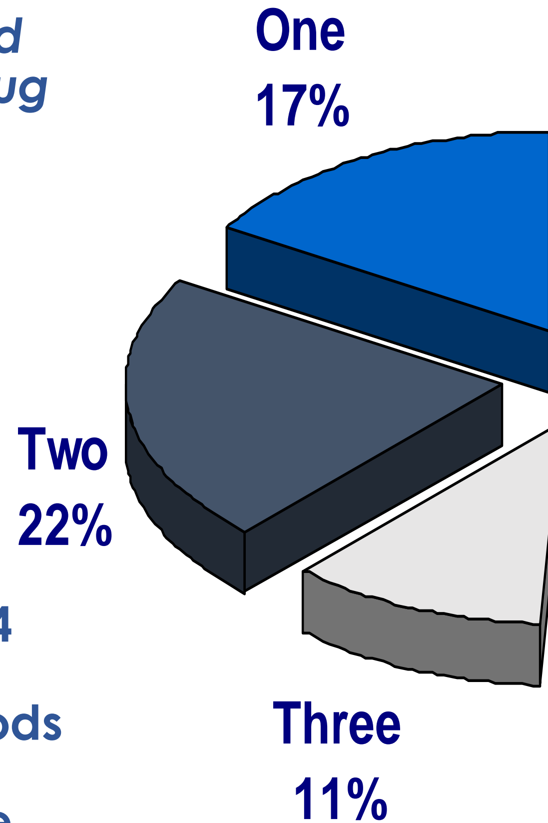
According to the American Medical Association:

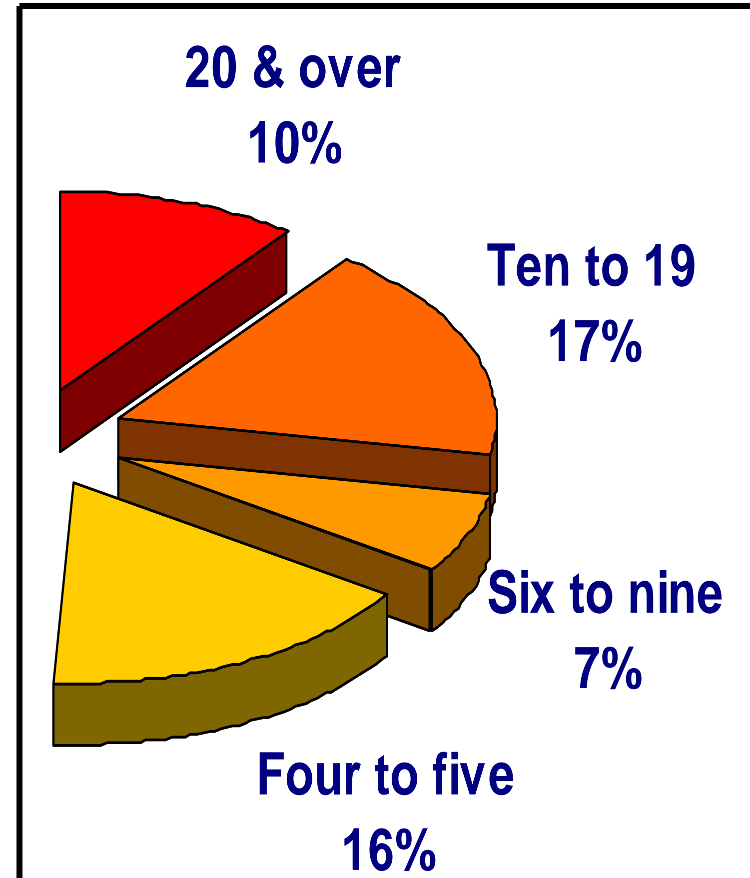
- **Cause (may or may not be known)**
- **Symptoms**
- **Prognosis**
- **May have Treatment**
- **May be Chronic**

A Chronic Disease in an Acute World

Addiction "Career"

*Number of abstinent periods one month or longer followed by return to drug use prior to current abstinence**





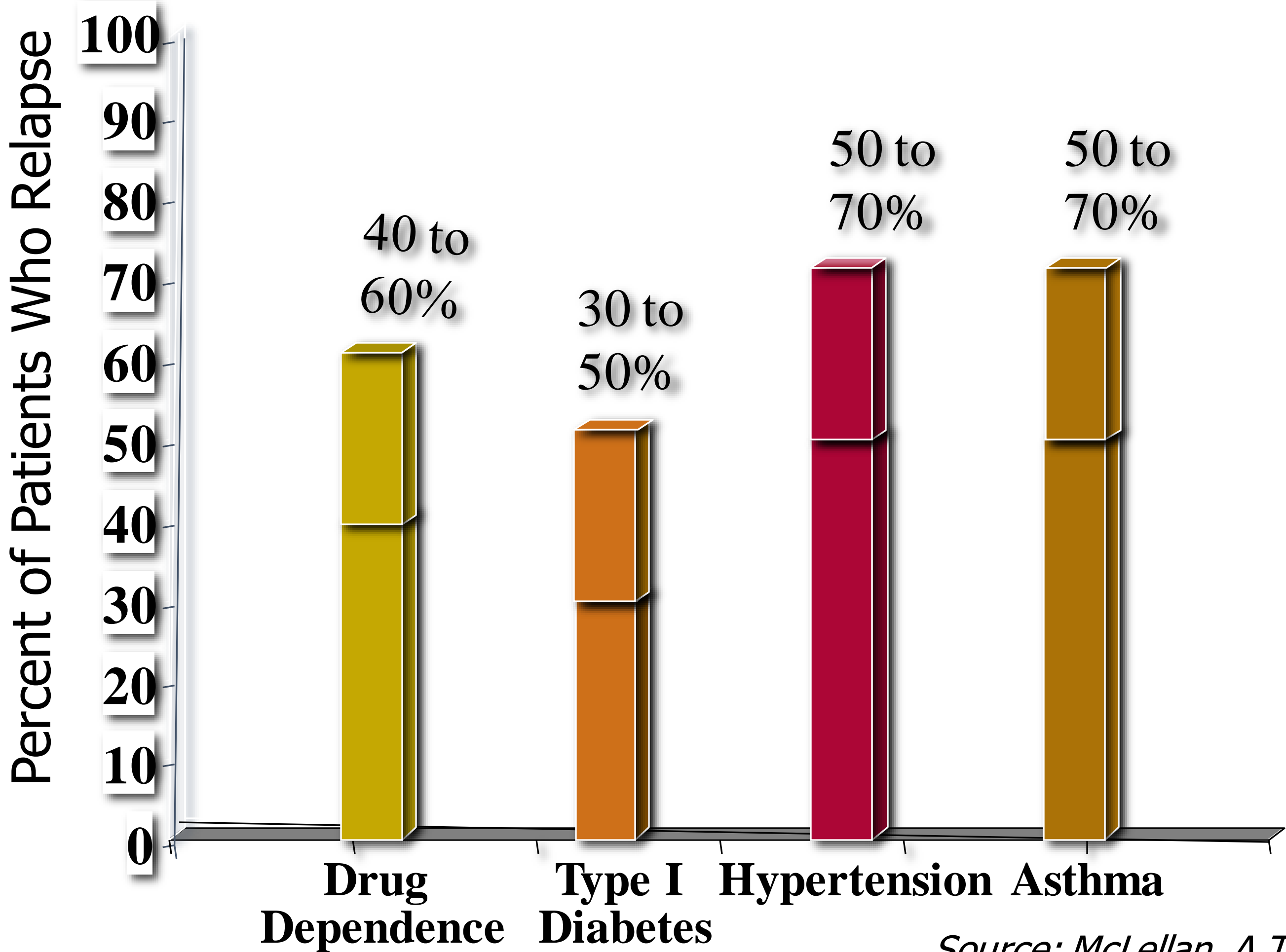
50% reported 4 or more abstinent periods followed by a return to active addiction

*Outside of controlled environment, among those who report one or more such periods: 71% N=248 Laudet & White 2004

- Encapsulated set of service activities (assess, admit, treat, discharge, termination of service relationship).
- Professional expert drives the process.
- Services transpire over a short (and ever-shorter) period of time.
- Individual/family/community is given impression at discharge ("graduation") that recovery is now self-sustainable without ongoing professional assistance.

- Initial triage and stabilization, support services are varied and open ended most concentrated early on.
- Professionals serve as consultants. Goal is for course of treatment to be patient driven to achieve highest level of adherence.
- Services are open ended, routine follow-up the norm.
- Individual/family/community educated on the “process” nature of “treatment”. Goal is to facilitate improved quality of life and wellness for the patient in whatever way works best for the patient.

“Relapse” Rates Are Similar for Addiction and Other Chronic Illnesses



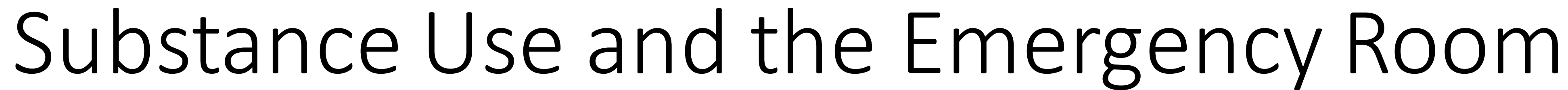
Source: McLellan, A.T. et al., JAMA, Vol 284(13), October 4, 2000.

- **The correlation between substance use and health**

- **<u>The correlation between substance use and emergency rooms</u>**

- **Medical Language**

Substance Use and the Emergency Room

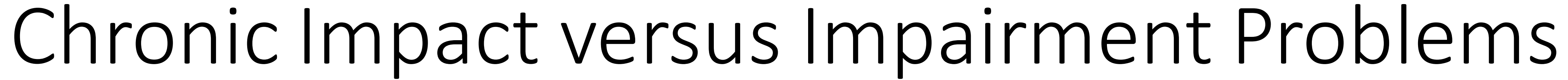


Substance Use and the Emergency Room

- The rate of emergency department visits with a primary diagnosis of a substance use disorder among adults increased from 74.4 per 10,000 population during 2018–2019 to 103.8 during 2020–2021. Between these two periods, this rate increased 42% among patients aged 18–34 years (from 86.1 to 122.5) and 38% among patients aged ≥35 years (from 69.5 to 96.1). During both 2018–2019 and 2020–2021, adults aged 18–34 years were more likely to visit an emergency department for substance use, misuse, or dependence than were those aged ≥35 years.

* Number of visits per 10,000 population, based on estimates of the civilian, noninstitutionalized population developed by the U.S. Census Bureau, which reflect the population as of July 1 each year

QuickStats: Rate of Emergency Department Visits for Substance Use Disorders Among Adults Aged ≥18 Years, by Age Group — National Hospital Ambulatory Medical Care Survey, United States, 2018–2019 and 2020–2021. MMWR Morb Mortal Wkly Rep 2023;72:1073.
DOI: http://dx.doi.org/10.15585/mmwr.mm7239a6



- Vehicle Accident
- Assault
- Falls
- Overdose/Poisoning
- Soft Tissue Infections
- Respiratory
- Other Mental Health

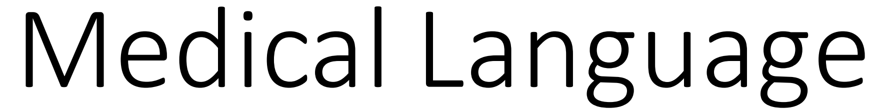
Zhang X, Wang N, Hou F, Ali Y, Dora-Laskey A, Dahlem CH, McCabe SE. Emergency Department Visits by Patients with Substance Use Disorder in the United States. West J Emerg Med. 2021 Aug 19;22(5):1076-1085. doi: 10.5811/westjem.2021.3.50839. PMID: 34546883; PMCID: PMC8463055.

How does substance use disorder connect with healthcare?

- **The correlation between substance use and health**

- **The correlation between substance use and emergency rooms**

- **<u>Medical Language</u>**



- We have long spoken of addiction as a disease or medical disorder.

- Our language does not consistently align with that description.

Clean/Dirty

Drug of ___________

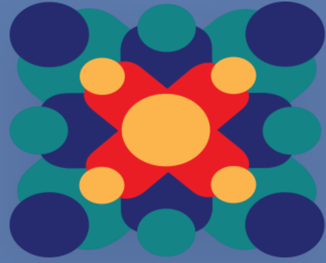
All change involves tension.

As the medical field takes a more active role in addiction, the transition comes with challenges and concerns.

These concerns exist both for the medical field as well as the non-medical addiction professions.

Questions and Observations?

One Additional Resource



African American Behavioral Health

CENTER OF EXCELLENCE

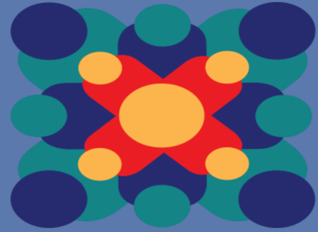
Dawn Tyus, PhD, LPC, MAC, NCC
Director / Principal Investigator

African American Behavioral Health
CENTER OF EXCELLENCE

WHO ARE WE?

Funded October 1, 2020, for 5 years by the Substance Abuse and Mental Health Services Administration:

From its administrative and academic home in the National Center for Primary Care at Morehouse School of Medicine (MSM) in Atlanta, the new Center of Excellence **develop and disseminate training, technical assistance (TA), and resources to help practitioners eliminate behavioral health disparities within this large and diverse population.**



African American Behavioral He
CENTER OF EXCELLEN

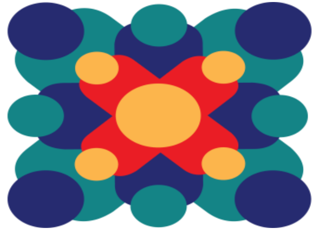
WHY WERE WE FUNDED?

- Because of the urgent need for greater Equity and Effectiveness in Behavioral Health Services for African Americans. This innovative yet deeply grounded Center has been structured to mobilize the scholarship and expertise of many distinguished voices in African American behavioral health and health equity to address:

- Systemic inequities that have blocked access to and engagement in behavioral health services and support for African Americans;

- The scarcity of culturally appropriate evidence-based interventions and approaches for African Americans—and insufficient dissemination of the resources that do exist; and

- Minimal workforce development on social determinants of health, health disparities, historical trauma, unconscious bias, and ways of building cross-cultural respect/trust



African American Behavioral Health
CENTER OF EXCELLENCE

Contact:

[AABH CoE - Home (africanamericanbehavioralhealth.org)]

Dawn Tyus, LPC, MAC, NCC

Principal Investigator

AABH CoE at the National Center of Primary Care

Morehouse School of Medicine

720 Westview Dr. SW.

Atlanta, GA. 30310-1495

404-752-1016

PRESENTER CONTACT INFORMATION:

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Training & Technical Assistance Manager, SATTC

jcampbell@msm.edu

(864) 360-1636

Southeast (HHS Region 4)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

SERCN Research Priorities

2023 Priority Research Topics Submitted

Cancer Screenings (Colorectal Cancer/HPV/Breast & Cervical)/Pancreatic cancer in rural Black females
Mental Health/Depression & Anxiety during Pandemic/ and MH access for Black men
Long lasting after-effects of COVID-19 and the tolerance level of the effects
Heart Disease, Stroke, Blood Pressure Control
Disparity of services offered to rural and impoverished areas
The effect of water quality on health
Efficacy of COVID-19 vaccinations and/or need to vaccinate annually or once
Social Determinants of Health with a focus on food insecurity and behavioral health
Childhood Obesity/Weight Management as Diabetes Prevention
Improving the US Health Care Infrastructure to deal with a national pandemic
Improving health disparities in under-privileged communities/Health Equity
Telehealth after the PHE (Public Health Emergency)
Correlation between patient identified SDoH and disease processes such as diabetes/HTN/CAD (comorbidities
Improving health equity in care of the rural patient- provider availability, services provided, etc.

2023 Voting Results

1. Cancer Screenings (Colorectal Cancer/HPV/Breast & Cervical)/Pancreatic cancer in rural Black females
2. Heart Disease, Stroke, Blood Pressure Control
3. Disparity of services offered to rural and impoverished areas
4. Social Determinants of Health with a focus on food insecurity and behavioral health

Identifying 2024 Priority Research Topics for SERCN

How were these topics collected?

Out of the 16 people surveyed 10 responded with the priority areas that we are viewing today.

All Patient and Partner Advisory Board members were surveyed via email and asked for their top 3 research priority areas

2024 Priority Research Topics Submitted

Topics
Cancer Screenings (Colorectal Cancer/HPV/Breast/Cervical/Pancreatic Cancer) in rural Black women
Mental Health /Depression & Anxiety post COVID/ access for black men
Long lasting aftereffects of COVID-19 and the tolerance level of the affects
Heart Disease, Stroke, Blood Pressure Control
Disparities in Infant and Maternal Mortality
The role of AI in Health care
Intimate Partner Violence and Substance Use Disorders
Efficacy of COVID-19 vaccinations and/or need to vaccinate annually or once
Social Determinants of Health with a focus on food insecurity and Behavioral Health / Closing the gap on disparity of services offered to rural and impoverished areas
Adult & Childhood Obesity/Weight Management as Diabetes Prevention
Improving the US Health Care Infrastructure to deal with a national pandemic

Now Let's Vote!!!

BREAK
2:00pm-2:15pm

Closing Activities

Please Share

- One thing you will take home to share in your networks

- One person you are going to connect with from this meeting in the coming weeks

Some Reflections on the Day

SERCN Stakeholder Meeting Evaluation

https://redcap.link/4zxpmd53

Concluding Remarks

Drs. Dominic H. Mack and
Anne Gaglioti

Next Steps: Coming Soon

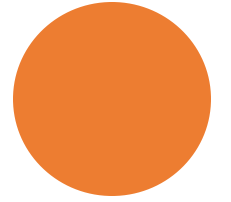
- Meeting Summary
- NCPCR Implementation Strategies from Feedback Session
- Finalized NCPCR Protocol
- Request for LOS for CDC Proposal

Thank you to our Patient and Partner Advisors!

For your support and collaboration!

For your willingness to engage honestly so we can share your experience and knowledge with those who are far removed from the front lines!

For your valuable time and the opportunity to meet in person!



Thank You Planning Team!!

MOREHOUSE SCHOOL OF MEDICINE | NCPC National Center for Primary Care

Thank you to our speakers!

Pati Knight-Landrum

Dr. Chrystal Pristell

Clarissa Ortiz

Dr. Rachel Gold

James Campbell

Megan Douglas

Thank you to our NCPCR Colleagues

OCHIN

Health Choice Network, Inc.

Thank you for your engagement, commitment and contributions today and over the last year!

Thank you for enabling this collaboration to continue as SERCN moves its 29th year !