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MEASURING SOCIAL DETERMINANTS OF HEALTH: EXPLORING STRATEGIES TO REDUCE DISPARITIES IN ACCESSING VIRTUAL CARE

U.S. Department of Health and Human Services
Health Resources & Services Administration
Bureau of Primary Health Care

Through the Optimizing Virtual Care (OVC) program, the Health Resources & Services Administration (HRSA) funded 29 health centers to develop, implement, and evaluate innovative evidence-based virtual care strategies that:

- Expand on the national surge in virtual care utilization at health centers in response to the COVID-19 public health emergency.
- Optimize the use of virtual care to increase access and improve clinical quality for populations who are medically underserved and have historically faced barriers to care.
- Can be adapted and scaled across HRSA's Health Center Program.

This program is the first in the Quality Improvement Fund, the Bureau of Primary Health Care's (BPHC) investment to activate and accelerate innovation. During the first twelve months of the OVC program (March 2022 to February 2023), awardees began implementing new or enhanced virtual care strategies. Awardee activities addressed four key OVC program objectives: 1) increase access to care; 2) improve clinical quality and health outcomes; 3) enhance care coordination; and 4) promote health equity.

This brief is part of a series of OVC materials released by HRSA to share innovative strategies and actionable tips from OVC awardees to support other health centers in planning virtual care approaches in their communities. For more information or to access other briefs and OVC resources, visit the OVC webpage.

Capturing OVC Awardee Insights on Measuring Health Equity

OVC awardees are currently piloting new self-reported measures to capture information about virtual care implementation successes, challenges, and lessons learned to improve access to care. As part of the grant monitoring process, OVC awardees submitted 12 monthly reports and two biannual reports to describe key activities and progress made toward achieving OVC program objectives.

This brief highlights insights from OVC awardee efforts to advance health equity by identifying and addressing virtual care disparities within their health centers. During the first year of the OVC project, awardees reported:

- Implementing standardized protocols to screen for Social Determinants of Health (SDOH).
- Adopting virtual care strategies to enhance SDOH screening practices.

These efforts informed the tailoring of project activities to improve access to virtual care.

Measuring Patient Social Needs to Promote Equitable Virtual Care Delivery

Advancing health equity requires action to expand both the availability and accessibility of virtual care programs. Measuring health equity in virtual care, including assessing patients' unmet social needs, plays an essential role in supporting health centers to identify disparities and improve population health outcomes.[1] The sections below highlight OVC awardees' strategies and publicly available resources to support health centers in implementing measurement practices to improve community health via virtual care.

"Health equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality" HRSA.gov

Using SDOH Screening Tools to Address Unmet Social Needs and Improve Access to Virtual Care

SDOH, including conditions related to financial stability, education, health care access and quality, neighborhood environment, and community context, can impact patient health outcomes beyond individual-level clinical factors.[2] SDOH data illuminate existing social inequities and inform health center strategies in person-centered approaches to care.[3]

Most OVC awardees used standardized SDOH screening tools to assess patients' health-related social needs. The most common SDOH screening tools included: 1) Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE),[4] and 2) Accountable Health Communities Health-Related Social Needs Screening Tool.[5] For additional information about available SDOH screening tools, visit: Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu).

SDOH screening tools captured patient-reported information related to:[6]

- Demographics (e.g., race, ethnicity, age)
- Educational attainment
- Financial viability
- Physical activity
- Tobacco use and exposure
- Alcohol use
- Emotional health (e.g., stress, depression)
- Intimate partner violence
- Social connections and social isolation
- Neighborhood and community characteristics

Some OVC awardees added SDOH screening questions related to digital equity (e.g., patients' broadband access, internet availability, and comfort with technology), reflecting growing efforts to address the digital divide.[7] To learn more about digital equity by state, visit the Digital Equity Act Population Viewer released by the Census Bureau.

OVC awardees used insights learned from SDOH screening measures to:

- **Adapt virtual care approaches to align with patients' digital needs.**
  Example: Delivering virtual care devices to patients with limited transportation
- **Provide staff training to better serve patient populations.**
  Example: Refining staff training curriculum to increase staff awareness of common patient assets and barriers to virtual care
- **Partner with community-based organizations to make appropriate patient referrals or connections to resources to meet health-related social needs.**
  Example: Joining a health center learning collaborative and adopting their framework and metrics for addressing food insecurity and other SDOH impacting patients with diabetes

"[Patients] have connectivity issues with telehealth but cannot come to in-person appointments due to physical health and transportation concerns." ~OVC awardee

OVC awardees used virtual care technology to enhance SDOH screening processes.
Examples of OVC awardee SDOH screening challenges and opportunities for using virtual care technology to support SDOH screening within virtual care programs are provided in Table 1.

Table 1: Summary of SDOH Screening Challenges Addressed by Virtual Care Opportunities

SDOH Screening Process Description and Challenges	Virtual Care Opportunities to Address Screening Challenges
Timing Identify when patients are screened and time needed to complete screenings. **Challenges:** Difficulties integrating SDOH screening into clinic workflows and limiting patient burden; low completion rates for SDOH screening questions due to patient time constraints during health center visits	▪ **Accommodate patient schedules:** Asynchronous virtual care tools, such as mobile applications and patient portals, offer patients the ability to complete SDOH screening questions when convenient for them before, during, or after appointments. ▪ **Improve workflow timing and flexibility:** Virtual care technologies expand options for facilitating SDOH screening before or during appointments offering more opportunities to collect and respond to patients' SDOH data during patient visits.
Staffing and Data Collection Identify who administers the screening. Select appropriate format(s) to complete the screening. **Challenges:** Difficulties administering SDOH screenings due to staff shortages; screening facilitators' discomfort with asking sensitive SDOH questions or concerns that patients will not want to answer SDOH questions; inconsistent screening due to workflow challenges or assumptions made about patients SDOH needs **Tip: Providing staff training on communicating sensitive topics (e.g., trauma-informed care) and bias can help ensure staff are prepared to consistently ask screener questions to all patients.**	▪ **Accommodate patient preferences:** Offering multiple virtual care modalities for data collection provides options for patients to transition to different methods as needed. OVC awardees used audio-only phone calls, asynchronous virtual care portal messaging, and community kiosk services to collect SDOH screening data. ▪ **Leverage non-clinical staff:** Virtual care technologies provide greater flexibility for non-clinical staff (e.g., community health workers, patient navigators) to facilitate SDOH screening questions or for patients to complete self-administered SDOH surveys. ▪ **Reduce language barriers**: Virtual care tools such as patient portal messaging allow health centers to offer SDOH screenings in more languages, while reducing staff resources needed for translation services. ▪ **Increase SDOH screening completion rates**: Reminder messages sent to patients using short message service (SMS) texts or patient portals with hyperlinks to SDOH screeners can encourage patients to complete surveys.
Managing SDOH Screening Data Determine data management and analysis methods. **Challenges:** Limited staffing resources to abstract data entered in narrative provider notes, recorded on paper forms, or captured on digital forms not linked to electronic health records (EHR) prior to reporting; delays in accessing and interpreting data not initially captured in EHR.	▪ **Simplify data integration:** Many SDOH screening tools can be integrated into EHR systems to better coordinate data collection. Data standardization efforts, including the use of SDOH-related Z codes can help to improve SDOH documentation. ▪ **Streamline processes for interpreting patient data**: Some EHRs allow for filtering patient data by demographics, SDOH needs, and provider relationships to understand impact of SDOHs on health outcomes. ▪ **Automate data review:** Health centers may consider leveraging machine learning technology to identify indicators of unmet needs from provider notes.
Responding to Patient Needs Identified by SDOH Screening Implement strategies to address identified patient needs. **Challenges:** Limited staff time and capacity to address large volume of patient needs; uncertainty in health centers' jurisdiction to intervene. **Tip: Connecting patients with appropriate resources to address unmet social needs is important for sustaining patient trust and engagement in care.**	▪ **Improve capacity to connect patients with resources to address unmet social needs:** Video-based conferencing technology facilitates warm hand-offs to connect patients with support service providers (e.g., behavioral health providers) in other locations. Health centers may use asynchronous messaging technology to submit patient information needed to register them for social services. Mobile health applications can virtually connect patients with informational resources during and after care visits.

Additional Resources

- Health Equity Training Series for Health Professionals
- National Strategy for Digital Health
- Tools to Assess and Measure Social Determinants of Health - Rural Health Information Hub
- U.S. Census Bureau Digital Equity Act Population Viewer

References

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