USING THE UDS MAPPER TO UNDERSTAND SOCIAL DETERMINANTS OF HEALTH ISSUES FOR HEALTH CENTER PATIENTS

WE WILL START 2 MINUTES AFTER THE HOUR

- Slides for today's webinar can be found in the Handouts section of the GoToWebinar attendee interface
- A link to today's captions can be found in the Questions/Chat section of the GoToWebinar attendee interface
  - Submit a question if you require assistance
USING THE UDS MAPPER TO UNDERSTAND SOCIAL DETERMINANTS OF HEALTH ISSUES FOR HEALTH CENTER PATIENTS
ACKNOWLEDGEMENTS

This work is supported by the Health Resources and Services Administration under contract HHSH250201800033G
Using the UDS Mapper to Understand Social Determinants of Health Issues for Health Center Patients

**GOTOWEBINAR ATTENDEE SCREEN**

- Open/close control panel with orange arrow
- Keep control panel open by clicking View and unchecking Auto-Hide the Control Panel
- Type questions into the question box (do not raise hand)
TODAY’S SLIDES

- Slides can be found in the Handouts section of the GoToWebinar attendee interface
- UDS Mapper webinars are recorded
  - Videos, captions, slides, and supporting materials (if any) will be available on the UDS Mapper website after the files have been processed
TODAY’S AGENDA

▪ Discuss the Social Determinants of Health and their relevance to health centers
▪ Highlight tools and techniques to select communities of interest in the UDS Mapper
▪ Demonstrate how to find relevant community data in the UDS Mapper and extract them from the system
▪ Finding user support after the webinar
WHAT IS THE UDS MAPPER?

▪ An online mapping tool developed to provide access to maps, data, and analysis using Uniform Data System (UDS) and other relevant data to visualize service area information for Health Center Program (HCP) awardees and look-alikes

▪ Compares HCP awardee and look-alike data to community/population data and shows spatial relationships between the program, community attributes, and other resources
WHO CAN USE THE UDS MAPPER?

▪ The UDS Mapper is open to everyone, not just HCP awardees and look-alikes

▪ To begin using the UDS Mapper all you have to do is register for a user name and password at www.udsmapper.org

▪ More than one person from an organization can have a login for the UDS Mapper
REGISTER FOR A NEW ACCOUNT

- Accounts are necessary to allow you to save data that you upload to the UDS Mapper
- Complete all required fields
- Type the text you see in the image
- Submit
In order to practice population health:

- **Define** who your population is
  - Examples: all people in X state or county
- **Measure** health outcomes on individuals within that population
  - Examples: mortality, morbidity
- **Examine** the distribution of health and **identify** disparities
- **Address** the disparities to improve population health
## INTEGRATING PATIENT CARE AND PUBLIC HEALTH

<table>
<thead>
<tr>
<th>Level of Intervention</th>
<th>Individual Patient Care</th>
<th>Public Health</th>
<th>Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject</td>
<td>Sally Doe</td>
<td>All people (usually limited in some way); may or may not seek clinical care</td>
<td>A group of people of whom some or all seek clinical care</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Patient history</td>
<td>Public datasets</td>
<td>Patient history including individual social needs</td>
</tr>
<tr>
<td>(potential sources)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Vital signs</td>
<td>Primary data collection</td>
<td>Vital signs/Clinical data</td>
</tr>
<tr>
<td>-</td>
<td>Clinical data</td>
<td>Clinical data</td>
<td>Public datasets</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Diabetes</td>
<td>Higher rates of diabetes in X population</td>
<td>Subset: All patients in group who are diabetic</td>
</tr>
<tr>
<td>Intervention</td>
<td>Treatment plan: eat healthier, exercise plan</td>
<td>Population intervention: access to farmers markets, exercise opportunities</td>
<td>Individual: Treatment plan including addressing social needs Group: Potential population intervention</td>
</tr>
</tbody>
</table>
COMMUNITY ORIENTED PRIMARY CARE (COPC)

- Define the community of interest
- Identify (health) problem to be addressed
- Develop and implement interventions
- Conduct ongoing evaluation

Note: All of these steps should involve the community
# COPC AND THE HEALTH CENTER PROGRAM

<table>
<thead>
<tr>
<th>COPC Steps</th>
<th>Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the community of interest</td>
<td>Funded service area</td>
</tr>
<tr>
<td>Identify problem to be addressed</td>
<td>Using community-level data, which services do we offer based on patient and community needs?</td>
</tr>
<tr>
<td>Develop and implement interventions</td>
<td>Provide those services in that service area</td>
</tr>
<tr>
<td>Conduct ongoing evaluation</td>
<td>Reassess:</td>
</tr>
<tr>
<td></td>
<td>a. Am I still serving the funded service area- do I need to expand?</td>
</tr>
<tr>
<td></td>
<td>b. Are the services we provide effective?</td>
</tr>
<tr>
<td></td>
<td>c. Are the services we provide what my service area still need?</td>
</tr>
<tr>
<td></td>
<td>d. Am I reaching the community members who do not come in as patients?</td>
</tr>
<tr>
<td>Note: All of these steps should</td>
<td>Community-based board of directors</td>
</tr>
<tr>
<td>involve the community</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All of these steps should involve the community
FIND SDOH DATA FOR COPC

- What is the income level in this neighborhood?
- Do most of the adults in this neighborhood have a high school diploma?
- What is the walkability of this area? Are there sidewalks? Are the parks, if any, usable?
- What languages are spoken in the area? What languages do my patients feel most comfortable using when talking about health needs?
CAPTURING SOCIAL AND BEHAVIORAL DOMAINS IN ELECTRONIC HEALTH RECORDS

Domains include:
- Race/Ethnicity
- Country of Origin
- Education
- Employment
- Financial Resource Strain (Food and Housing Insecurity)
- Health Literacy
- Stress
- Negative Mood and Affect (Depression and Anxiety)
- Dietary Patterns
- Physical Activity
- Tobacco Use and Exposure
- Alcohol Use
- Exposure to Violence
- Neighborhood/Community Compositional Characteristics
TWO TYPES OF SDOH DATA

Primary Data
- Asked directly of the patient
  - PRAPARE
  - Health Leads
  - Others
- Captured in some data system, perhaps the EHR
- Tied to the individual but could potentially be aggregated

Secondary Data
- Data that represent the area the patient lives in but may not necessarily represent the patient
- Likely not available in the EHR - must access via a separate data tool
- Linked to patient records via geography (ZIP Code, county, etc.)
WHAT DOES THIS DATA WORK LOOK LIKE?

▪ Gathering data about the community
  • Census data
  • Public health data
  • Windshield surveys
  • Direct data collection from community members
  • Direct data collection from patients

▪ Making the case for
  • Funding (grant writing)
  • Clinical program development
  • Connecting health center patients with services in the community
UDS MAPPER IS A DATA AGGREGATOR

- UDS Mapper contains relevant data for health center use
  - American Community Survey (U.S. Census Bureau)
    - Population demographics
    - Insurance status
  - Public health data
    - Behavioral Risk Factor Surveillance System (CDC)
      - Prevalence of diabetes, obesity, high blood pressure, no dental visit in the past year, delayed care due to cost, no usual source of care, smoking, binge drinking
    - Opioid-epidemic related data (CMS, CDC)
    - Low birth weight rate (HRSA)
    - Mortality (CDC)
DEMOGRAPHIC SDOH DATA IN THE UDS MAPPER BY ZCTA

From Census Bureau/American Community Survey

- Poverty/low-income
- Race/ethnicity
- Income level of the uninsured
- Age
- Non-employment
- Less than high school education
- Limited English proficiency
- Estimated one-year insurance status
- Disability status
POPULATION HEALTH SDOH DATA IN THE UDS MAPPER BY ZCTA

- Not all data are available from the source at the ZCTA level
- Some data in the UDS Mapper are estimated to the ZCTA level
- Sources: HRSA Area Resource File, CDC Wonder, CDC Behavioral Risk Factor Surveillance System (BRFSS)
  - Low birth weight rate
  - Age-adjusted mortality
  - Prevalence
    - Diabetes, obesity, high blood pressure, no dental visit in the past year, delayed care due to cost, no usual source of care, smoking, binge drinking
- Opioid epidemic related data are presented at the county level because they cannot be estimated to the ZCTA level
Conduct a COPC-like analysis for a health center using individual-level and community-level SDOH data

Assumes:

- Collecting personal SDOH (for this walkthrough we will assume you are using PRAPARE, but you could be using any assessment tool)
- Storing them in a database of some sort, and in this use case, we assume the data are tied in some fashion to patient address
- That you can aggregate the data by geography, specifically ZIP Code, and
- You are able to extract the data from your system in some way
USING THE UDS MAPPER TO UNDERSTAND SOCIAL DETERMINANTS OF HEALTH ISSUES FOR HEALTH CENTER PATIENTS

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Thank you for joining us for the webinar today. We will get started 3 minutes after the hour to ensure that everyone has an opportunity to connect to the webinar. For an actual live webinar, a link for closed captioning will be listed here.
UDS MAPPER AND FUNDED SERVICE AREAS

- UDS Mapper does not contain a list or a setting to view funded service areas
  - Health centers should know or can retrieve their funded service area from their HRSA EHB profile

- Select those ZIP Codes in the UDS Mapper
SELECTING ZCTAS

Use the Explore Service Area tool

- Search for your area on the map and then click directly on ZCTA on map
- Enter ZCTA or ZIP Code in the Search box and add directly
- Easily select many ZCTAs
  - Copy and paste a list of ZIPs/ ZCTAs from your spreadsheet
  - Select state or counties to add all ZCTAs in those areas
  - Use paintbrush to select all ZCTAs you cross with your mouse
- Selected ZCTAs will be covered in a black, dotted pattern and listed in the **Selected ZCTAs** box in the Explore Service Area tool.

- Click the **red X** next to the ZCTA number in the Selected ZCTAs box to deselect.
Main Maps

Choose a main map below to show either UDS data on health center patients, or total population (not just patient) statistics.

Begin by selecting a topic:

- Population Data
- UDS Data

Select an Indicator:
- No Main Map Selected

Poverty Level
- Pop. Poverty (%) 2013-2017
- Pop. Low-Income (%) 2013-2017

Race and Ethnicity

Population and Insurance Trends

Age

Social Environment

Uninsurance by Income Level

Not Served (Out Density)

Legend:
- States
- Counties
- ZCTAs

Pop. Low-Income (%) 2013-2017
- <15%
- 15 - 30%
- 30 - 45%
- 45 - 60%
- >60%

Using the UDS Mapper to understand social determinants of health issues for health center patients

www.udsmapper.org

UDS MAPPER MAIN MAPS TOOL

Compare to demographic thematic maps to see how the area it is in compares to others
UDS MAPPER POPULATION INDICATORS TOOL

- Compare your area to population health indicators
- Is your area one that exceeds the national average? State average?

USING THE UDS MAPPER TO UNDERSTAND SOCIAL DETERMINANTS OF HEALTH ISSUES FOR HEALTH CENTER PATIENTS
### BENCHMARKS TABLE

- Tool default is national average
- Benchmarks table in Tutorials & Resources contains state benchmarks
- Adjust the threshold to any number along the range
  - State average
  - Published number/goal
  - Clinical rate
COMPARE INDICATORS

Turn on more than one indicator to look for overlapping cold spots of need

- **Green areas**: at least 10% of population with less than high school education
- **Purple areas**: at least 15% of population with no usual source of care
- **Blended areas**: at least 10% of population with less than high school education AND at least 15% with no usual source of care

Because blended colors do not appear in the legend, we recommend you not turn on more than two indicators at a time, as colors will blend and may become confusing.
MAP FOR MAT INDICATORS TOOL

- Enables you to find high need areas based on opioid-epidemic related data
  - High need is determined by the user
- All data are displayed by county
All data from the Information Cards, Main Maps, and Population Indicators can be added to the Data Table.

Data can be exported.
## PRAPARE employment question:

11. What is your current work situation?

<table>
<thead>
<tr>
<th>Unemployed</th>
<th>Part-time or temporary work</th>
<th>Full-time work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I choose not to answer this question</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Table: PRAPARE Employment Analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>All Patients</th>
<th>Completed PRAPARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>15,503</td>
<td>4,258</td>
</tr>
<tr>
<td>Adults (#)</td>
<td>9,832</td>
<td>1,810</td>
</tr>
<tr>
<td>Adults (%)</td>
<td>63.42</td>
<td>42.5</td>
</tr>
<tr>
<td>Not Employed (#)</td>
<td>-</td>
<td>742</td>
</tr>
<tr>
<td>Not Employed (%)</td>
<td>7.5</td>
<td>41</td>
</tr>
<tr>
<td>Unemployed (#)</td>
<td>-</td>
<td>444</td>
</tr>
<tr>
<td>Unemployed (%)</td>
<td>4.5</td>
<td>24.5</td>
</tr>
</tbody>
</table>
### SDOH Data by Zip Code

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Not Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>48838</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>49503</td>
<td>250</td>
<td>95</td>
</tr>
<tr>
<td>49504</td>
<td>130</td>
<td>86</td>
</tr>
<tr>
<td>49505</td>
<td>64</td>
<td>42</td>
</tr>
<tr>
<td>49506</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>49507</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>49508</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>49509</td>
<td>97</td>
<td>88</td>
</tr>
<tr>
<td>49519</td>
<td>45</td>
<td>19</td>
</tr>
<tr>
<td>49548</td>
<td>89</td>
<td>39</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>742</strong></td>
<td><strong>444</strong></td>
</tr>
</tbody>
</table>

**PRAPARE Employment Question:**

11. What is your current work situation?

- Unemployed
- Part-time or temporary work
- Full-time work
- Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)
- Please write:
- I choose not to answer this question

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SELECT ONLY THE ZCTAS WITH HIGHEST NUMBERS

- Deselect the ZCTAs of your service area with smaller numbers of non-employed
- The remaining ZCTAs are the priority areas within your own service area
- Who can we partner with?
PREPARE DATASET

Make sure the sheet with the addresses is the first one in the workbook, especially if you have multiple sheets.
In Map My Data tool, select \textbf{Batch Entry}

- Browse for or drag and drop your file

- Make selections
  - Color code point based on
    - Will color points based on a column of information in your spreadsheet (this is where the name and type columns come in handy)
    - Maximum of 8 different colors
  - Name the dataset
    - Give it a name even if you are not planning on saving it
GEOCODE POINTS

- Click Geocode Addresses
- If you want to save the points to re-add to a future map, click Save
- Analyze resource location and need
- Augment services or create partnerships and referrals
User support is available throughout the UDS Mapper site.

Most of the help resources are found in the Tutorials & Resources section of the site.
THANK YOU!

If you have additional questions or feedback after the conclusion of this presentation, please use the Contact Us form provided on the UDS Mapper Site:

https://www.udsmapper.org/contact-us.cfm

or contact the Bureau of Primary Health Care:

https://www.bphc.hrsa.gov

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