Centers for Disease Control and Prevention’s Social Determinants of Health  
Public Health Use Case Workgroup for Chronic Disease Prevention  
Personas and Story Document

**Purpose:** To illustrate the feedback received from workgroup members on the directional alignment of the persona candidates and story. This is closely connected to a consensus-based set of use cases that will have broad applicability, feasibility, and desirability for public health purposes.

**Note:** Revisions are highlighted in yellow.

**Personas Candidates:**

<table>
<thead>
<tr>
<th>Jessica, Case Manager</th>
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| **Age:** 33  
**Education:** Master of Social Work  
**Family Status:** Married and living with spouse  
**Employment:** Lakeview Social Service Non-profit Organization (CBO) located near Sunville Community Health Center (FQHC) |
| **Preferences:** She loves engaging with members of the community she serves and working with local community leaders and like-minded organizations.  
**Challenges:** Her organization has seen an influx of referrals during COVID-19 and is struggling with the capacity to serve those in need. As her organization establishes more partnerships, staff must log into multiple systems that are not integrated with their case management platform escalating the administrative burden.  
**Goals:** She strives to be an advocate for people in need and help them access services to improve their overall health and well-being. She wants to work towards an easier way to receive and respond to referrals from various organizations, allowing her to spend more time with her clients. |

<table>
<thead>
<tr>
<th>Kevin, Care Coordinator</th>
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| **Age:** 48  
**Education:** Licensed Clinical Social Worker (LCSW)  
**Family Status:** Single Parent of 2 children ages 13 and 16  
**Employment:** Sunville Community Health Center, a Federally Qualified Health Center (FQHC) located in Forest County |
| **Preferences:** He enjoys engaging with his patients directly to identify and address health and social needs.  
**Challenges:** He cannot maintain increasing care coordination needs due to limited resources for rising patient numbers with food insecurity and other economic hardships escalated by or resulting from the COVID-19 pandemic. He struggles with locating health and social support services for his patients because the resource lists are outdated. He finds it hard to be efficient and effective in his work as he collects and documents patients’ SDOH needs in the FQHC’s EHR system.  
**Goals:** He wants to identify patients’ SDOH needs, resources, programs, and/or services to address their health and well-being. He works toward referring patients to needed health |
### Kevin, Care Coordinator

and/or social services and tracks these referrals to monitor their outcomes.

### Claudia, Public Health Analyst

| Age: 29 | Education: Master of Science in Data Analytics |
| Family Status: Not married, without children | Employment: Forest County Department of Health |

**Preferences:** She loves analyzing data, identifying trends, and engaging with community stakeholders to understand community needs, strengths, available resources, gaps in services, and strategizing to find solutions.

**Challenges:** The lack of consistent and timely data related to social services, programs, or resources in the community makes it harder for Claudia to evaluate community needs and deploy evidence-based interventions.

**Goals:** She aims to conduct a community health needs assessment to identify the health and social support gaps of individuals and communities, specifically surrounding diabetes care, as she has witnessed the impact of diabetes and other chronic conditions on family members.

### Victor, Public Health Program Director

| Age: 55 | Education: Master of Public Health |
| Family Status: Married with one child in college | Employment: State Department of Health’s Diabetes Program Director. **Forest County is located in his state.** |

**Preferences:** He enjoys building partnerships with stakeholders across the health ecosystem and learning about innovative solutions to challenging problems. He does not want to let “perfect” be the enemy of good.

**Challenges:** His department is short-staffed, and leadership has been focused on the pandemic response. The data he reviews is limited in helping him identify what community resources are available or are required to address his population’s growing social needs.

**Goals:** He wants to help advance and deploy the needed interventions, social services, programs, and/or resources to address SDOH needs and health disparities, especially for those at risk for, or managing, diabetes.

### Makayla, Project Officer

<p>| Age: 38 | Education: Master of Science in Public Administration |</p>
<table>
<thead>
<tr>
<th><strong>Makayla, Project Officer</strong></th>
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<tbody>
<tr>
<td><strong>Family Status:</strong> Married with a 3-year-old child</td>
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<td><strong>Employment:</strong> CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Division of Diabetes Translation</td>
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<td><strong>Preferences:</strong> She loves to work with grant awardees on implementing public health programs across the US. She recognizes the importance of establishing performance and outcome measures to achieve goals.</td>
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<td><strong>Challenges:</strong> Given the diversity of her awardees, it is challenging for Makayla to make recommendations about available social services, programs, and resources at the community level. CDC does not have granular-level data across all SDOH domains to help guide program decisions and identify the needed resources to support her awardees.</td>
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<tr>
<td><strong>Goals:</strong> She wants to help all her awardees be successful, disseminate best practices, facilitate meaningful peer-to-peer connections, and help reduce health disparities among those at risk for, or diagnosed with, diabetes.</td>
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**Story**

- Claudia’s county Department of Health established a Public and Environmental Health Advisory Board, a citizen group to advise the Department of Health and County Board of Supervisors on community concerns and emerging public health issues.¹
- During a recent meeting, Kevin, a care coordinator at one of the county’s Federally Qualified Health Centers (FQHC), indicated that his FQHC is seeing a rise in levels of food insecurity among its patient population. He is worried about his patients, especially those with, or at risk for, diabetes. Jessica, a case manager from Lakeview Social Service Non-profit Organization (CBO), is also seeing a similar rise in levels of food insecurity and other social needs among her community members.
- Claudia’s county Department of Health will be kicking off a community health needs assessment (CHNA) soon. As part of the CHNA, the county will conduct key informant interviews with clinical and community providers, community leaders, and advocates and hold focus groups with county residents.
- The CHNA will help identify and prioritize community needs and issues through systematic and comprehensive data collection and analysis. In preparation for the assessment, Claudia’s team will identify various data sources that can help them assess the county’s needs, along with the qualitative data they will obtain through interviews.
- According to the Public and Environmental Health Advisory Board’s feedback regarding social needs and food insecurity, Claudia believes her team could leverage aggregated social risk screening data from FQHCs and clinical and community providers. She is aware of the national initiative, the Gravity Project, that is developing data standards to capture and exchange social risk and social needs information.
- Claudia calls Jessica, Kevin, and other clinical and community providers, to establish an understanding of screening tools and SDOH data collection in her local community. She finds that some organizations use electronic social risk screening tools and conduct e-referrals.

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- Claudia learns the regional health information exchange (HIE), which receives and exchanges data from most of the county’s clinical providers, has recently started collecting standardized SDOH-related data across some clinical and social services providers.
- Given the county’s data landscape and limited resources at her county Department of Health, Claudia’s team believes it worthwhile to receive SDOH-related data from clinical and community organizations via the regional HIE to support the CHNA.
- After further research and review, Claudia’s county Department of Health develops an initial partnership with the regional HIE and signs a data use agreement (DUA) that permits the county to use HIE data for the CHNA. The DUA specifies that the data will be encrypted.
- Claudia’s county Department of Health receives the data from the HIE and assesses it for completeness and quality. This assessment includes understanding the type of available SDOH data and the reason for missing data (e.g., data is incomplete, missing patients’ SDOH screening assessments, bias in data collection, and/or providers not conducting SDOH screening assessments).
- One of the first concerns Claudia’s team assesses is the burden of food insecurity among people with, or at risk for, diabetes in their county. This information is paired with data on types of interventions, social services, programs, and/or resources already implemented for individuals within the zip code(s) served to address specific SDOH.
- Meanwhile, Victor, who works at the state’s Department of Health, is assessing the state and CDC-funded diabetes programs. The results of his assessment will be included in the state’s continuation application for their cooperative agreement supported by CDC’s Division of Diabetes Translation (DDT). DDT funding supports programs and activities to prevent or delay the onset of type 2 diabetes and improve health outcomes for people with diabetes. These activities may include support for addressing individuals’ social needs.

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2 Clinical providers can also include providers affiliated with Department of Defense, Veterans Health Administration, and Indian Health Services.
3 Additionally, it is imperative to acknowledge that state, tribal, local, or territorial (STLT) health departments can share data and information back to community members, providers, and other stakeholders that would benefit from aggregated SDOH data.
Victor understands the state can use CDC’s DDT funding to provide grants to a broad and diverse range of organizations that support the delivery of evidence-based programs to prevent and manage type 2 diabetes.

Additionally, the state’s Medicaid Program is participating in a Delivery System Reform Incentive Payment (DSRIP) program and other all-payer value-based care initiatives that encourage or mandate the documentation of SDOH-related health assessment/diagnoses using nationally recognized standards ICD-10 Z-codes.4

Given the recent COVID-19 pandemic and its economic ramifications, Victor wants to address food insecurity levels in areas of the state where the burden of diabetes is highest. He also wants to determine if CDC-recognized organizations are offering the National Diabetes Prevention Programs (National DPP), Lifestyle Change Programs (LCPs), or other diabetes self-management and education programs in these areas.

To begin his assessment, Victor wants data that includes a) the number of people who have, or are at risk for, diabetes by zip code and b) how many people are food insecure by zip code.

Victor learns a regional HIE can provide limited but timely data on the burden of diabetes and food insecurity by zip code for certain geographic regions in the state.

Victor acknowledges that it is important to understand both the resources and needs in a geographic area to determine what gaps and overlaps exist.

Similar to the county Department of Health, Victor’s state Department of Health develops an initial partnership with the HIE and signs a DUA that permits the state to use the data.

The HIE data, along with data from other clinical and community providers, supplemented with existing Medicaid claims data (Z-codes), gives Victor a more robust and comprehensive view of what is occurring across the state. He overlays this aggregated data with the state’s DDT-funded program data by zip code to identify which areas in the state to prioritize.

Victor is aware that this method does not give him complete data on all persons in the state. However, he appreciates the data as the most robust, standardized, interoperable, and timely SDOH-related data he can leverage to help understand the burden of diabetes and food insecurity to support resource allocation effectively.

● Victor wants to understand the type of SDOH data sent from the clinical providers, community providers, HIE, and the state Medicaid Agency. He aims to determine why data is incomplete, missing patients’ SDOH screening assessments, and/or providers not conducting SDOH screening assessments. This assessment helps Victor identify missing population groups and possible data collection bias due to incomplete data.

● Victor learns that not all SDOH assessments are coded using nationally recognized standards. He works with the clinical providers, community providers, and the HIE to learn which screening questions and responses have not been mapped to these code sets. With this knowledge, Victor engages stakeholders to develop a plan to address the gaps.

● Victor disseminates his analysis of SDOH data to others in the state (e.g., HIE, county departments of health, providers, payers, CBOs, and other state leaders) to help inform stakeholders to make data-driven decisions, develop and implement programs and allocate resources.

● Makayla is a CDC DDT Project Officer for Victor’s state. They often touch base to discuss the DDT-funded programs and share promising practices they see in the field.

● Victor informed Makayla of the SDOH data analysis findings, which leveraged clinical, social, community, and claims data to better understand food insecurity among people with, or at risk for, diabetes in his state.

● As the Project Officer, Makayla wants to ensure that all awardees leverage data to better assess and monitor their programs based on CDC cooperative agreement requirements.

● DDT is encouraging its awardees, as well as CDC-recognized lifestyle change programs, to implement food insecurity strategies to track and report the number of individuals with diabetes by demographic factors (e.g., race and ethnicity). These individuals have been identified with food insecurity as a social risk factor and the awardees will set target outcomes to reduce household or individual food insecurity. (*Based on recent SDOH measures and guidance from NCCDPHP).

● CDC is committed to achieving health equity and has developed an SDOH framework to describe the center’s vision and approach to addressing the fundamental causes of health disparities in five priority social determinants of health: Built Environment, Nutrition Security, Community Clinical Linkages, Tobacco Free Policy, and Social Connectedness.
CDC has specified outcomes, measures, and associated data sources for each of the five priority SDOH areas. This will be intended for use in routine grantee data reporting to monitor progress and demonstrate the impact of programmatic investments.

Makayla and her team provide technical assistance and support to her awardees and LCPs to assess SDOH activities that support diabetes prevention and management strategies. Awardees and LCPs report on performance measures related to the SDOH strategies and report on individual and community level social risks associated with health outcomes.

Once her team receives awardees’ and LCPs progress or evaluation reports, DDT analyzes the data to assess progress toward their targets.

These data are aggregated to assess population trends and identify innovative practices. Makayla and her team will disseminate the summary data and any analytic results (e.g., reports, dashboards, benchmarks) to all program awardees, LCPs, national and public health partners, DDT, and other federal leadership to help inform data-driven decisions.