Thank you for attending today’s training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services.

**Presented by:**
Darlene Jenkins, DrPH, Senior Director of Programs, National Health Care for the Homeless Council (NHCHC) and Roni Morales, Social Health Advocate Lead, Mountain Family Health Centers

**Live Broadcast Date/Time:**
Thursday, August 8, 2019
11:00AM–12:00PM Mountain Time / 12:00–1:00PM Central Time

**Event Overview:**
Health starts in homes, schools, workplaces, neighborhoods, and communities through the social determinants of health (SDOH). The World Health Organization (WHO) defines the social determinants of health as “the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.” The social determinants of health are primarily responsible for health disparities, which WHO defines as “unfair and avoidable differences in health status.” This webinar will present an introduction to the social determinants of health for community-facing staff and offer some strategies for these staff to address them from their positions at health centers.

**Learning Objectives:**
Through this session, participants should be able to:
1. Define the social determinants of health.
2. Explain why considering social determinants of health is important.
3. Identify strategies to address social determinants of health from your position at your health center.

**CONTENTS**

Page 2: CHAMPS Archives
Descriptions CHAMPS & CCHN
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CHAMPS ARCHIVES
This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit [www.CHAMPSonline.org/events-trainings/distance-learning](http://www.CHAMPSonline.org/events-trainings/distance-learning).

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally funded Community, Migrant, and Homeless Health Centers so they can better serve our patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, and the benefits of CHAMPS Organizational Membership, please visit [www.CHAMPSonline.org](http://www.CHAMPSonline.org).

DESCRIPTION OF CCHN
The Colorado Community Health Network (CCHN) represents the 20 Colorado Community Health Centers that together are the backbone of the primary health care safety-net in Colorado. For more information about CCHN, please visit [www.CCHN.org](http://www.CCHN.org).
SPEAKER BIOGRAPHIES

Darlene Jenkins, DrPH, was born and reared in the Mile-High City of Denver, CO. Although Darlene has lived in Nashville, TN for 13 years, so still considers Denver “home.”

Since 2009, Darlene has been on staff at the National Health Care for the Homeless Council, and currently serves as the Senior Director of Programs for the organization. Before her tenure at the Council, Darlene served as the Director of Disparity Elimination for the Tennessee Department of Health addressing health disparities with a focus on the social determinants of health.

Darlene received a Bachelor of Science degree in Clinical Dietetics from Loma Linda University, her Master of Public Health degree from the University of Michigan and Doctor of Public Health specializing in Community Health Sciences, Maternal/Child Health, and Women’s Health from the University of Illinois at Chicago. She is a Registered Dietitian, Certified Health Education Specialist and has a Graduate Certificate in Non-Profit Management.

Darlene has conducted research and have published work in the areas of mental health, alcohol and substance use among women who are homeless; and health care utilization by individuals experiencing homelessness.

Veronica “Roni” Morales is Social Health Advocate Lead for Mountain Family Health Centers in Glenwood Springs. Through her trainings at Colorado Prevention Center, Patient Navigator Training Collaborative, and Colorado Center for Nursing Excellence she coaches and supports clients to find quality health and self-awareness. Roni is passionate about helping medically underserved clients understand and navigate our complex health system in an effort to improve health outcomes, client care and experience. She has a strong and unique connection with clients through advocating on their behalf, her cultural competence, deep listening, and powerful storytelling. She believes in empowering others thru opportunities of self-discovery for wholehearted healing and living. Roni inspires individuals to explore and embrace courage thru their vulnerability and owning their story. She has been with Mountain Family Health Centers for 8 years.
O&E DISTANCE LEARNING SERIES PART 1
SOCIAL DETERMINANTS OF HEALTH 101
FOR COMMUNITY-FACING STAFF

Thursday, August 8, 2019
11:00AM – 12:00PM MT / 12:00-1:00PM CT
COMMUNITY HEALTH ASSOCIATION OF MOUNTAIN/PLAINS STATES (CHAMPS)

www.CHAMPSonline.org
COLORADO COMMUNITY HEALTH NETWORK (CCHN)

www.CCHN.org
PRESENTED BY

DARLENE JENKINS,
DrPH, MPH, CHES
Senior Director of Programs
National Health Care for the Homeless Council
(NHCHC)

RONI MORALES
Social Health Advocate Lead
Mountain Family Health Centers
Glenwood Springs, CO
LEARNING OBJECTIVES

Define the social determinants of health.

Explain why considering social determinants of health is important.

Identify strategies to address social determinants of health from your position at your health center.
HOW MANY PEOPLE ARE WATCHING THE EVENT AT YOUR COMPUTER, INCLUDING YOURSELF?

Submit your answers using the Questions Box.
ARE YOU CURRENTLY WORKING IN YOUR ROLE AT YOUR ORGANIZATION?

• Yes
• No
IS YOUR ORGANIZATION CURRENTLY SCREENING FOR SOCIAL DETERMINANTS OF HEALTH?

Yes
No
I don’t know
IF YOU ANSWERED YES TO THE PREVIOUS QUESTION, WHICH SCREENING TOOL(S) IS YOUR ORGANIZATION UTILIZING?

• Accountable Health Communities Model
• Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)
• Something specific to your organization (self-created)
• Other
• I don’t know
Social Determinants of Health
The What and The Why

Darlene M. Jenkins, DrPH, MPH, CHES
August 8, 2019
National Health Care for the Homeless Council

NATIONAL NONPROFIT

ESTABLISHED IN 1986

25 YEARS NATIONAL COOPERATIVE AGREEMENT WITH HRSA

TRAINING AND TECHNICAL ASSISTANCE TO HRSA SUPPORTED HEALTH CENTERS, PCAS, HCCNS

WORK ACCOMPLISHED THROUGH COLLABORATIONS, NETWORKS AND COMMITTEES
Objectives of Presentation

- Define Social Determinants of Health (SDH)
  - What are the SDH?
- Why is it important to address them?
What is Health?

Health is a dynamic state of complete physical, mental, spiritual, (economic) and social well-being and not merely the absence of disease or infirmity.

Source: World Health Organization
What Determines Health?

- **Health Behaviors**
  - Tobacco Use
  - Diet & Exercise

- **Health Care**
  - Access to Care
  - Quality Care

- **Social & Economic Factors**
  - Education
  - Employment

- **Physical Environment**
  - Air & Water Quality
  - Housing & Transit

- **Genetics**
  - Age, Sex Hereditary Factors

Source: County Health Rankings, RWJF 2014
Society is Structured Like a Ladder

Source: Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in The US- MacArthur Foundation
What are the Social Determinants of Health (SDH)?

Conditions that impact our health and well-being: the circumstances which we are born, grow up, live, work and age.

_________________________________

“Where we live, learn, work and play can have a greater impact on how long and how well we live than medical care.”

Hippocrates, 4th Century BC
<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
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<td>Community engagement</td>
<td>Provider linguistic and cultural humility</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
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<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td>Stress</td>
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<td>Support</td>
<td>Walkability</td>
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<td>Zip code, geography</td>
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</table>

Source: Beyond Health Care: The Role of SDH in Promoting Health and Health Equity Henry J. Kaiser Family Foundation, 2018
Patient with Bed Bug Bites
Examples how SDHs (Economics) Affect Health

- We treat kids with asthma but send them back to a home with mold.
- A dad faces high blood pressure and fatigue from a two-hour commute because his family can’t afford a home closer to work, and his kids miss his help with homework and his bedtime stories.
- A new mom ends up having her “home visit” on the street because her landlord evicted her so he could raise the rent.
What we Know

- Health is more than health care, and health does not start at the health center.
- Health is tied to the distribution of resources and starts in the conditions in which we live, work, and play.
- Our zip code may be more important to our health than our genetic code.
- The choices we make are shaped by the choices we have.
- “The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Geoffrey Rose, The Strategy of Preventive Medicine
How is your understanding now with the concepts of the social determinants of health?

• Good, I get it and I am ready to move forward.
• I kinda get it, but still have questions.
• I don’t get it, you lost me.
Why Address the SDH?

Focusing on the SDH Gets to the Root of the Cause.

Let’s Focus on – What is Causing This?
Moving “Upstream”

Source: PRAPARE, NACHC #SDOH
Managed Health Care Organizations

**Kaiser Permanente Launches Full-Network Social Determinants Program**

Kaiser Permanente is planning to equip all of its providers with technology tools to help address the social determinants of health.

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**UnitedHealthcare's Investments in Affordable Housing to Help People Achieve Better Health Surpass $400 Million**

Investments have helped build 40 communities in 18 states resulting in more than 6,500 new, affordable housing units and support services to help people who have health care needs.

3/8/19

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**Anthem’s Social Determinants Benefits Package Boosts Medicare Enrollment**

Bruce Japsen
Senior Contributor (D)
Healthcare
I write about healthcare business and policy

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**Quality | Access | Justice | Community | nhchc.org**

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**NATIONAL HEALTH CARE for the HOMELESS COUNCIL**
“AT UNITEDHEALTHCARE, WE UNDERSTAND THAT SOME OF THE GREATEST BARRIERS TO BETTER HEALTH ARE NOT CLINICAL ISSUES, BUT RATHER SOCIAL AND FINANCIAL BARRIERS, SUCH AS ACCESS TO SAFE AND AFFORDABLE HOUSING,” SAID ELLEN SEXTON, CEO OF UNITEDHEALTHCARE COMMUNITY PLAN OF WISCONSIN. “WE ARE PARTNERING WITH OTHER SOCIALLY MINDED ORGANIZATIONS THAT UNDERSTAND THE VALUE OF GOOD HEALTH, AND HOW PUBLIC-PRIVATE PARTNERSHIPS LIKE THESE CAN SUCCEED IN HELPING MAKE A POSITIVE IMPACT IN OUR COMMUNITIES.”

UNITEDHEALTHCARE, WHICH EMPLOYS 11,000 PEOPLE IN WISCONSIN AND SERVES THE HEALTH CARE NEEDS OF NEARLY 1.7 MILLION PEOPLE STATEWIDE, HAS INVESTED $384 MILLION TO BUILD MORE THAN 70 AFFORDABLE HOUSING COMMUNITIES IN 16 STATES, HELPING CREATE MORE THAN 3,400 AFFORDABLE HOMES FOR INDIVIDUALS AND FAMILIES. THE INVESTMENTS, WHICH INCLUDE $12 MILLION IN WISCONSIN, ARE PART OF THE COMPANY’S EFFORTS TO REDEFINE HEALTHY LIVING BY HELPING ADDRESS SOCIAL DETERMINANTS, LIKE ACCESS TO AFFORDABLE HOUSING, THAT AFFECT PEOPLE’S HEALTH AND WELL-BEING.

“WORKING TOGETHER WITH OUR EQUITY PARTNERS UNITEDHEALTHCARE AND MINNESOTA EQUITY FUND, IS HELPING MEET A CRITICAL NEED WITHIN THE MADISON COMMUNITY TO HELP PROVIDE FAMILIES WITH QUALITY, AFFORDABLE HOUSING WITH SUPPORTIVE SERVICES,” SAID CHRIS LAURENT, SENIOR VICE PRESIDENT OF CINNAIRE.
“At [Kaiser Permanente](https://www.kaiserpermanente.org), we recognize we can’t optimize our members’ health without improving the health of their communities—and we will never optimize community health unless we improve individual health. That’s why we’ve committed resources and convened partnerships to meaningfully go beyond health care to impact social needs and community conditions to improve health for all.”

Bechara Choucair, Chief Community Health Officer at Kaiser Permanente
Schools Are Addressing SDH
Hospital are Addressing SDH

Social Determinants Screenings Cut Hospital Admissions by Nearly 30%

Screenings helped providers refer Medicaid patients to community health services, which then addressed the social determinants of health.
Three Reasons Why Health Centers Should Address the Social Determinants of Health

TO PROMOTE HEALTH EQUITY
TO PROVIDE HOLISTIC PATIENT CENTERED CARE
TO DOCUMENT NEEDS OF CLIENTS TO FOSTER PARTNERSHIPS AND FUNDING OPPORTUNITIES
To Promote Health Equity

Source: Robert Wood Johnson Foundation
“Health equity means that everyone (regardless of race, gender expression, age, social economic status, class, or sexual orientation) has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

Source: Robert Wood Johnson, 2017
**Equality**

Equality = Sameness
Giving everyone the same thing

Only works if everyone starts from the same place.

**Equity**

Equity = Fairness
Access to the same opportunities

Must first ensure equity before equality can be enjoyed.

Source: Image Adapted from Saskatoon Health Region, 2014
To Provide Holistic, Patient Centered Care
Patient

- Poverty
- Bankruptcy
- Unemployed or Underemployed
- Socially Isolated
- Literacy challenges
- Mental health issues
- Prior history of homelessness/currently homeless
- Transportation issues
- Food
- Insecure
- Domestic violence
- Language
- Prior history of incarceration
- Substandard, Unsafe Housing
- Unsuccessful transition from military
- Adverse childhood experiences (ACEs)
- Stress
- Substance use disorders
- Uninsured or Underinsured
- Domestic violence
- Discrimination
- Cognitive Impairment/undiagnosed TBI
- Uninsured or Underinsured
- Food Insecure
SDH Must be Considered to Prescribe Correct Care Plan(s)

Need to know
- If client is food secure
- If client has refrigeration, stove
- If client is living in a safe environment (personal safety and hygiene)
- Need to know if patient has transportation
- Need to know about literacy, health literacy and numeracy issues
- If client has social network, assistance

Instead of asking, “What’s wrong with you, ask – “What happened to you?”
To Document Needs to Foster Partnerships and Funding Opportunities
Policy Responses to Address Social Determinants of Health

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<thead>
<tr>
<th>Social Determinant</th>
<th>Service Response</th>
<th>Policy Response</th>
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|                    | • Provide direct medical care  
|                    | • Connect to specialty care  
|                    | • Coordinate care  
|                    | • Facilitate prescription drugs & other needed services  | • Expand eligibility for health insurance & reduce barriers to care  
|                    | • Finding a bed or program placement  
|                    | • Help filling out housing applications  
|                    | • Provide housing support services  
|                    | • Help negotiate with landlord on behalf of vulnerable client  | • Fund Affordable Housing Trust Funds (or other programs designed to increase supply of housing)  
|                    | • Help connect to SNAP program  
|                    | • Create a medically tailored food pantry  
|                    | • Teach healthy eating habits  
|                    | • Start a community garden, greenhouse  | • Remove barriers to eligibility for SNAP/increase benefits  
|                    |                       | • Address food deserts/food swamps/“healthy food priority areas”  
|                    |                       | • Partner with schools to ensure healthy, accessible breakfasts & lunches  |
## Policy Responses to Address Social Determinants of Health

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>Service Response</th>
<th>Policy Response</th>
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<tbody>
<tr>
<td></td>
<td>• Provide legal aid/expungement services</td>
<td>• Expand diversion programs</td>
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<td></td>
<td>• Help client meet P&amp;P requirements</td>
<td>• Broaden legal aid capacity</td>
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<tr>
<td></td>
<td>• Help client successfully navigate diversion programs</td>
<td>• Ensure comprehensive health services within justice settings</td>
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<td>• Help with job applications/resumes</td>
<td>• Establish constructive re-entry policies</td>
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<td>• Practice interviewing skills</td>
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<td></td>
<td>• Teach good employment habits</td>
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<td></td>
<td>• Connect client to adult education</td>
<td>• Increase wages to better align with housing costs</td>
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<td></td>
<td>• Ensure child/youth health screenings to enter school</td>
<td>• Remove barriers to employment</td>
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<td></td>
<td>• Ensure transportation/access for homeless students</td>
<td>• Ensure accessible, reliable transportation options</td>
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<tr>
<td></td>
<td>• Expand adult literacy/GED/other programs</td>
<td>• Expand adult literacy/GED/other programs</td>
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<td></td>
<td>• Invest more resources in successful K-12 programs located in underserved areas</td>
<td>• Facilitate trauma-informed curricula in schools</td>
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<td></td>
<td>• Increase funding for higher ed, vocational &amp; trade schools</td>
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</table>
Final Thought

If we don’t evolve from treating sickness to creating a culture of wellness for and with communities then we will not be doing our job as healthcare leaders effectively.

Joseph Gave, Chicago, IL
Resources

- [https://www.commonwealthfund.org/roi-calculator](https://www.commonwealthfund.org/roi-calculator) – Commonwealth Fund
- Social Determinants of Health Case Studies, Association for Prevention Teaching and Research
- [Unnatural Causes…. is inequality making us sick](https://www.commonwealthfund.org/roi-calculator) (California Newsreel)
- Center for Diversity and Health Equity, The Everyone Project, American Academy of Family Physicians
- County Health Rankings and Roadmaps – RWJF and University of Wisconsin
- Screening for Social Determinants, Center for Health Care Strategies
- Building Healthy Places, Cincinnati Hospital Case Study, Crosswalk Magazine
- Advancing Health Equity by Addressing Causes of Homelessness, Homestretch
Resources

Contact Information

Darlene M. Jenkins, DrPH, MPH, CHES, Senior Director of Programs

djenkins@nhchc.org

Website: www.nhchc.org
Accountable Health Communities Model 
Resources and Workflow 

RONI MORALES SOCIAL HEALTH ADVOCATE LEAD | CHAMPS SOCIAL DETERMINANTS OF HEALTH 101
What is AHCM?

AHCM is a federal project designed to test if screening patients for social needs, providing them with resources and community care coordination can reduce healthcare cost, reduce emergency room visits, and improve patient’s health.

Patients who screen positive for social need will be referred to organizations in the community.

Patients who have been to ER two or more times and have screened positive for social needs will get in person care coordination support.

Our GOAL is to improve health and the quality of the delivery of healthcare to our communities.
MFHC AHCM Workflows

- Clinical Workflow
  - Front Desk Staff
  - Medical Assistants

- Care Coordination Workflow
  - Complex Care RN and SHA
    - Care Coordination
    - Case Management
MFHC AHCM Clinical Workflow
Resources
QUESTIONS?

Type any questions into the chat box at the bottom of the screen.
THANK YOU!

Please fill out the event evaluation here:
https://www.surveymonkey.com/r/OEDL2-SupportingOE
Preparing for Open Enrollment 7: Outreach to Specific Populations
Thursday, August 29, 2019
11:00AM-12:00PM MT / 12:00-1:00PM CT
Click here for more information and to register.

Self-Care: Resiliency and Burnout Prevention
Thursday, September 19, 2019
11:00AM-12:00PM MT / 12:00-1:00PM CT
Click here for more information and to register.