SDOH: Developing an Upstream Mindset

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Road Map

- The Problem with a Treatment Only Mindset
- Social Drivers of Health Data
- Scripting for Social Drivers of Health Screening
- Break Out – Discussion of Care Pathways

Allegory

Generational Trauma

ACES

- About 64% of adults in the US reported at least one ACE before age 18.
- Nearly one in six (17.3%) adults reported 4+.
- 3 in 4 high school students reported one or more.
- 1 in 5 experienced 4+.
- 1.9 million heart disease cases and 21 million depression cases could have been avoided by preventing ACEs.
- Preventing ACEs could reduce suicide attempts among high school students by as much as 89%, prescription pain medication misuse by as much as 84%, and persistent feelings of sadness or hopelessness by as much as 66%.

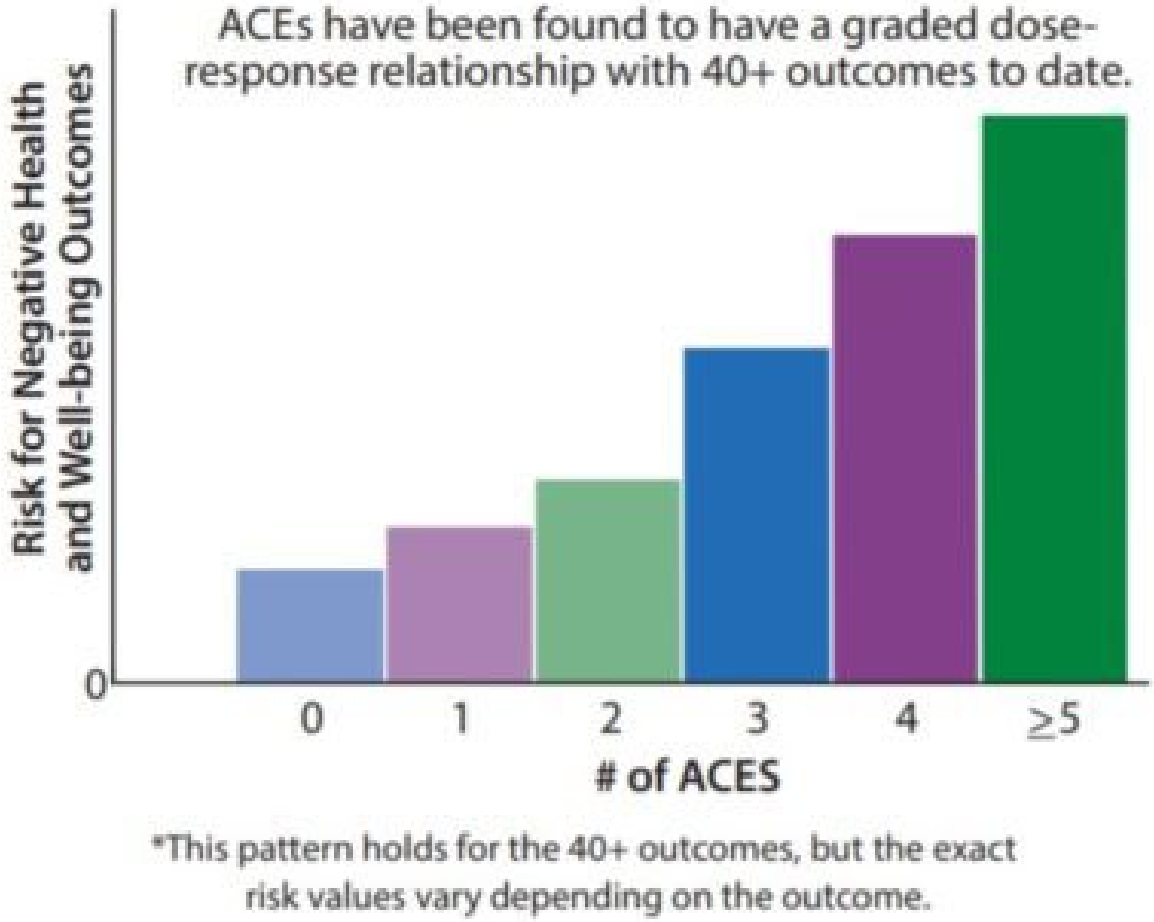
About Adverse Childhood Experiences | Adverse Childhood Experiences (ACEs) | CDC

ACEs can have lasting effects on...

Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

Behaviors (smoking, alcoholism, drug use)

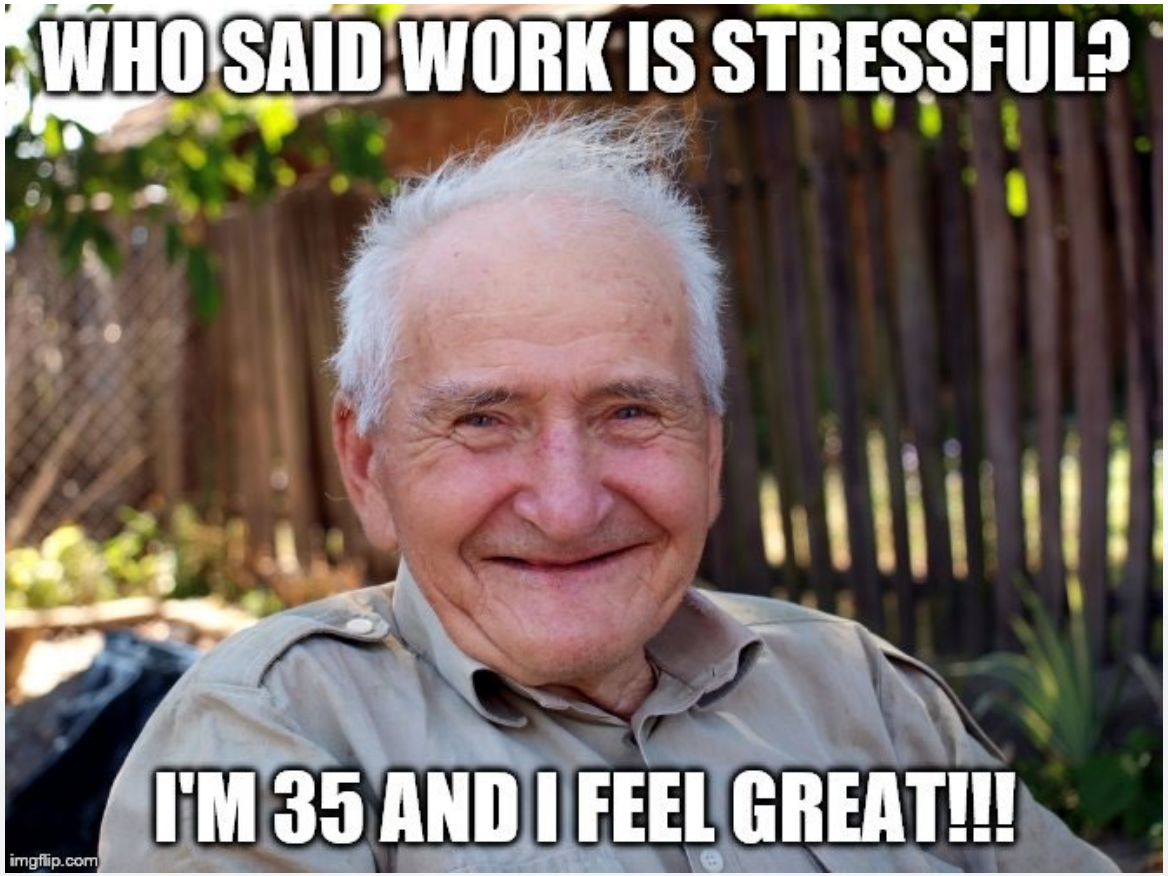
Life Potential (graduation rates, academic achievement, lost time from work)



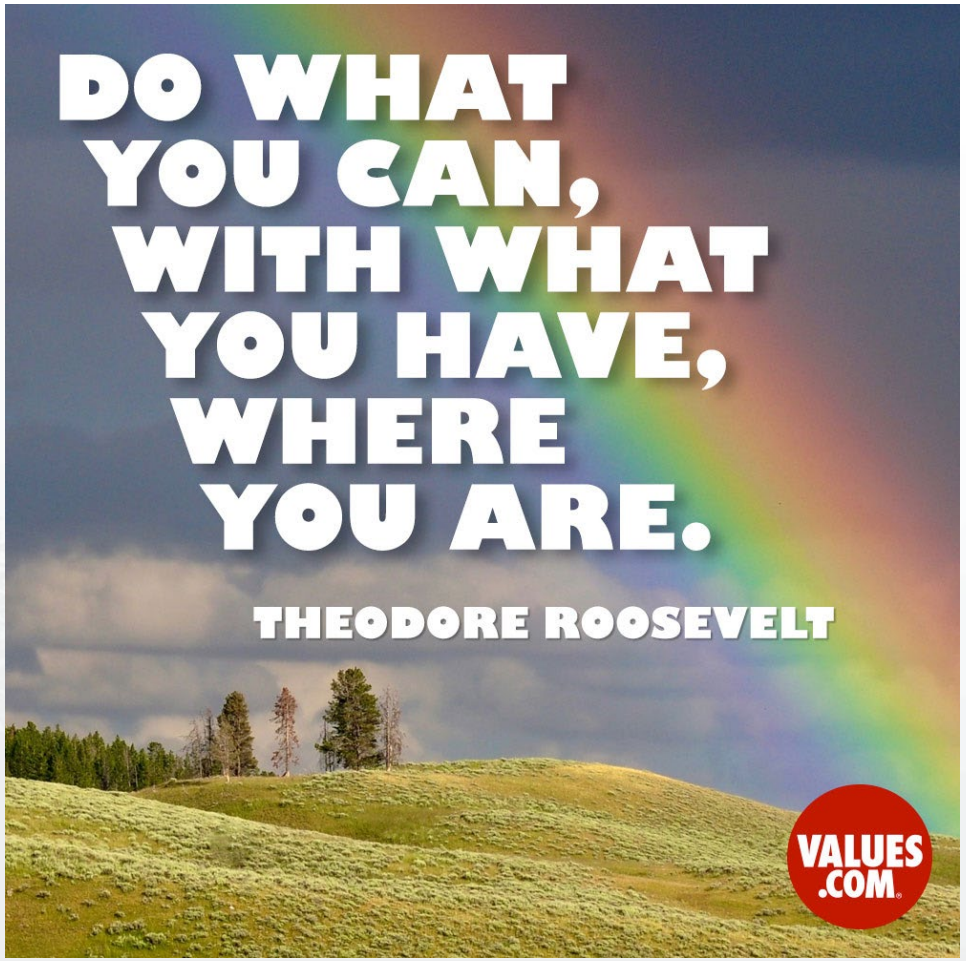
*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.

Meanwhile…

- More and more babies are being thrown in the river – or even born in the river…
- And fewer people are entering healthcare and helping professions.



Side Note



- We need both Top-Down Social Change
- And Bottom-Up Advocacy and Mobility!
- For our purposes, we will do what is in our power to do the best Community Health Work with what we do have.

standup

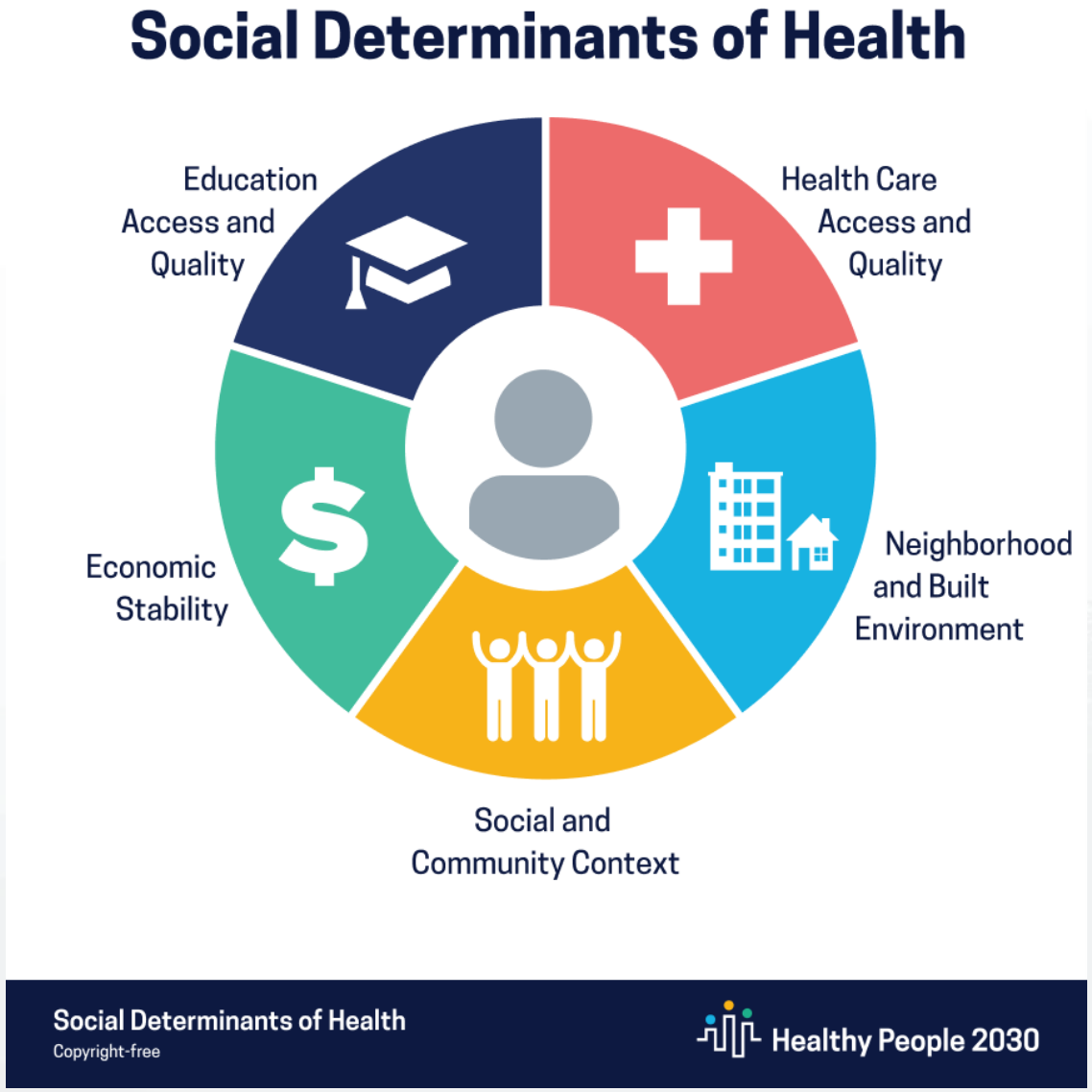
> Much of what we call personality is not a fixed set of traits, only coping mechanisms a person acquired in childhood.
>
> - *Gabor Mate*

Survival Skills

- People have great survival skills.
- The brain is wired to keep us safe!
- How we get our needs met.
- What we have learned about the world and how to navigate this.
- What we have learned about accessing healthcare, dental care, behavioral healthcare, etc.

SDOH

"The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."



Some Data:

- 1 in 10 Americans lives in poverty.
- About 1 in 10 Americans don’t have health insurance and are unlikely to engage in primary care services.
- About 41% of women and 26% of men experienced sexual violence, physical violence, or stalking by an intimate partner during their lifetime.
- Loneliness increases risk of heart disease by 29% and the risk of stroke by 32%. (The equivalent of smoking 15 cigarettes per day)
- According to the Surgeon General, 1 in 2 adults have measurable levels of loneliness.
- Over 61 million women and 53 million men have experienced psychological aggression by an intimate partner in their lifetime.
- According to Zillow, the current average home value in Montana is $463,962…

Normalize

- Given the data, we need to educate and screen our patients for Social Drivers of Health.
- So that we can provide assistance when it is needed.
- And educate our patients that we are available if ever we are needed.
- When we educate people about Social Drivers of Health and resources, then even if they were not able to tell us today, they have access to knowledge.

The SDOH Tools

- There are many screeners for assessing Social Drivers of Health
  - PRAPARE
  - AHC-HRSN
  - THRIVE
  - The EveryONE Project
- And regardless of the screener you use, the preferred method for gathering SDOH is Empathic Inquiry

Empathic Inquiry

- A culturally humble, compassionate conversation using motivational interviewing skills to screen for social drivers of health
- Is patient-centered, nonjudgemental, sensitive and empowering
- The interviewer is direct in explaining the reasons for screening and uses active and reflective listening to connect and communicate

Spirit of MI

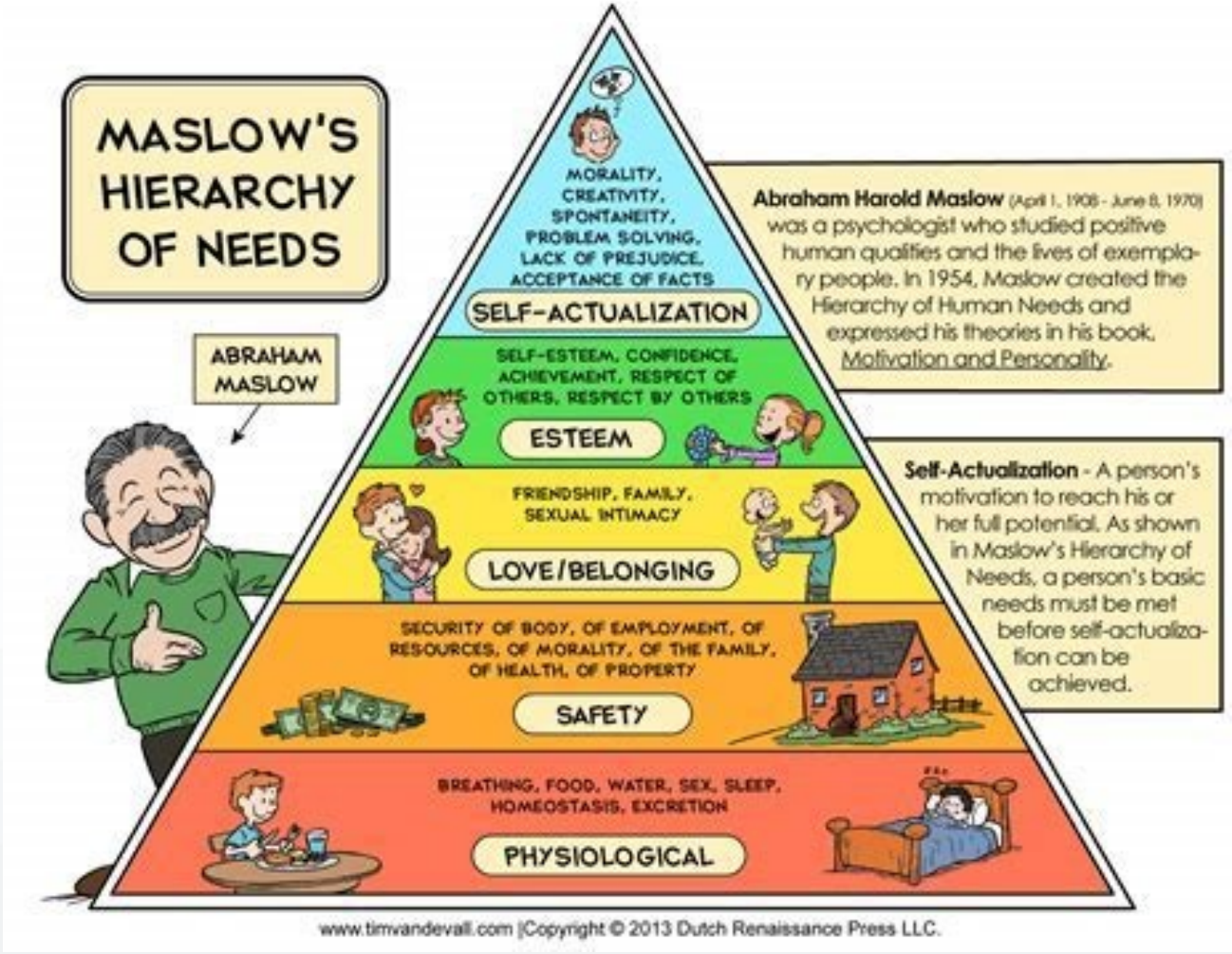
- Partnership
  - People are experts on themselves, and if they are the ones wanting to change, you need THEIR expertise!
- Acceptance
  - Belief that people have inherent worth and do not need to earn or prove that they deserve respect.
- Compassion
  - A commitment to support positive growth that is in the best interest of your patient.
- Empowerment
  - Helping people realize and use their own strengths and abilities.
  - *Adjusted in the 4th Edition to emphasize the importance of people's own strengths, motivations, resourcefulness, and autonomy.*

Step 1: Permission

Introduce yourself and your role.

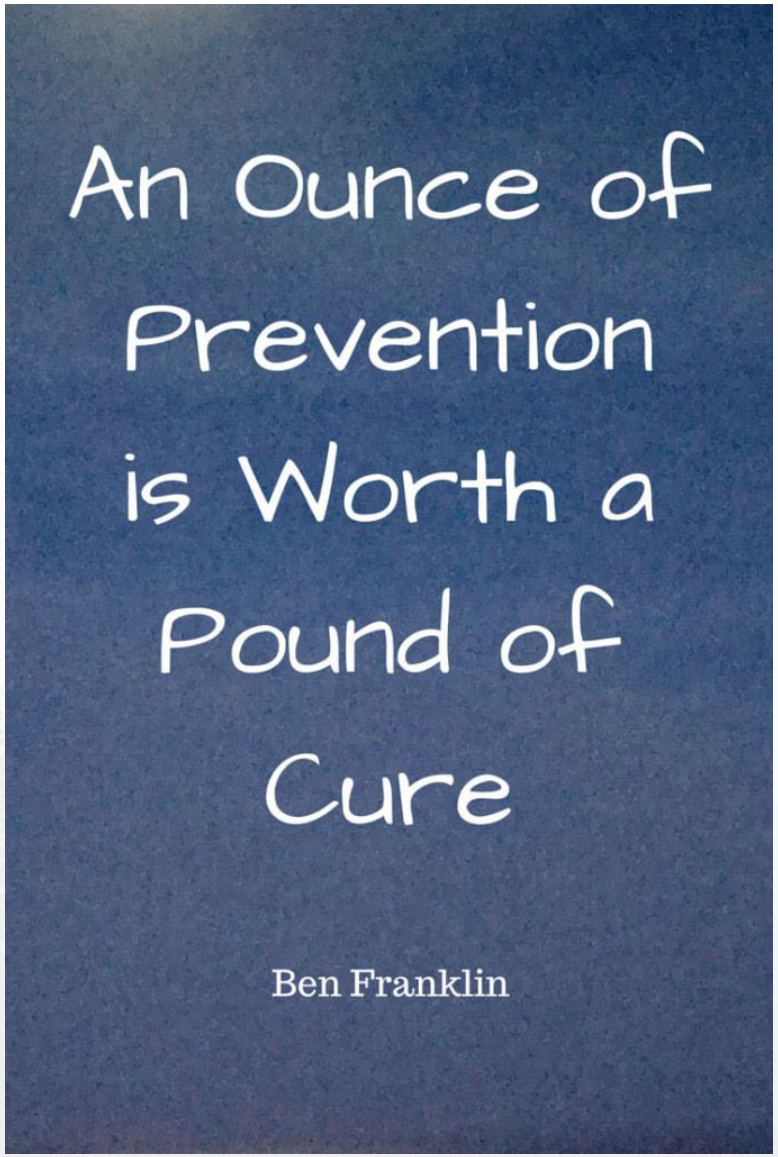
"My name is Jamie and I am the CHW on your care team. My job is to talk to patients about their physical needs and educate them about resources that might be helpful in their situation because we know that access to certain physical resources impact health care. Have you ever heard of the research behind social drivers of care? Would it be ok if we have a quick conversation about your access to the social drivers of care? This will only take about 10 minutes."

"Some of these questions may feel sensitive, and it is ok to let me know if you don't feel comfortable answering."



What if they say no!

- “Ok, no problem. Thank you so much for your time today. This is my name and number. If something comes up and you need extra support related to resources like food, transportation, paying utilities, insurance, work, childcare, or other physical needs, please give me a call!”



Normalize

- To get upstream, we MUST normalize discussing social drivers of care!
- That means asking questions and educating patients.
- If 1 in 2 people in our country are lonely, and loneliness impacts health the same as smoking 15 cigarettes a day, then CHW's should be REALLY busy!

Step 2

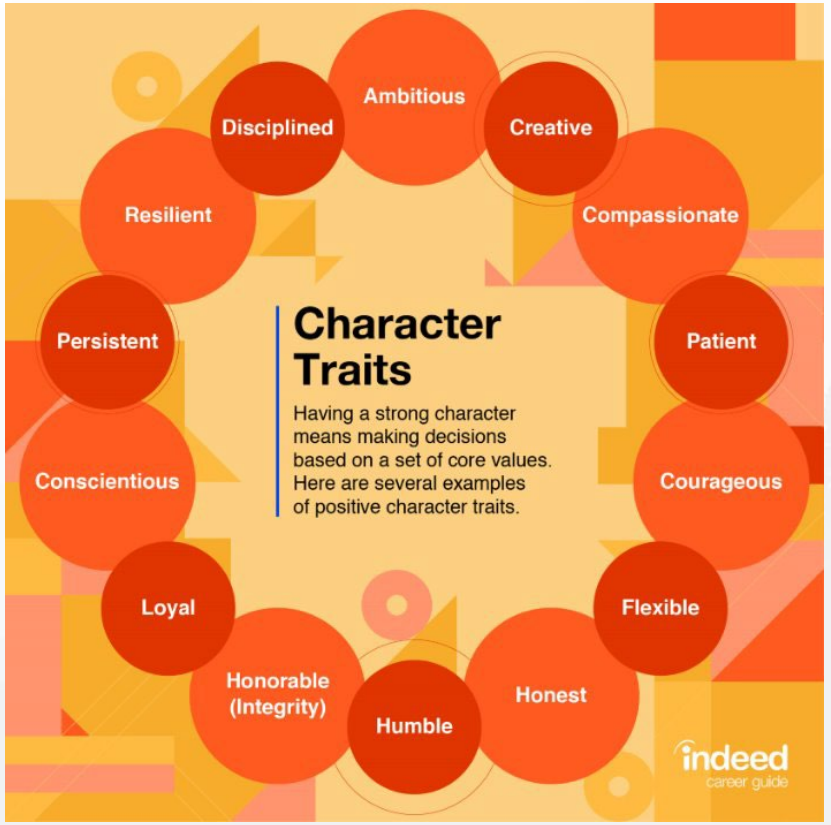
- *"Before we get started, do you have any questions or comments for me?"* (Maybe they already know what they need…)
- Open Ended Questions:
  a. *"What, if any, bills are you worried about this month?"*
  b. *"What are your concerns about accessing resources you need?"*
  c. *"Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?"*

Step 3: Active and Reflective Listening

- Show understanding through attentive non-verbal listening cues, including eye contact and body language as appropriate.
- Express understanding through reflective listening.
  - *"You are tired of bouncing between houses."*
  - *"Getting help with your electricity bill sounds like the highest priority."*
  - *"That must be really hard. Thank you for sharing. Can I tell you what I know about the kinds of foods you eat – or don't eat? (Ask) The amounts and kinds of foods you buy are important for your health and affect how you feel. (Offer) Have you ever noticed that? (Ask)"*

Step 4: Affirmations

- Provide affirmations of patient's strength and resilience.
  - *"You have worked hard to make ends meet. You are clearly resourceful and creative."*
  - *"It takes a lot of strength to get through such a tough situation."*
- *Be Authentic!*
- *Remember:*
- Affirmations can evoke change talk and confidence!



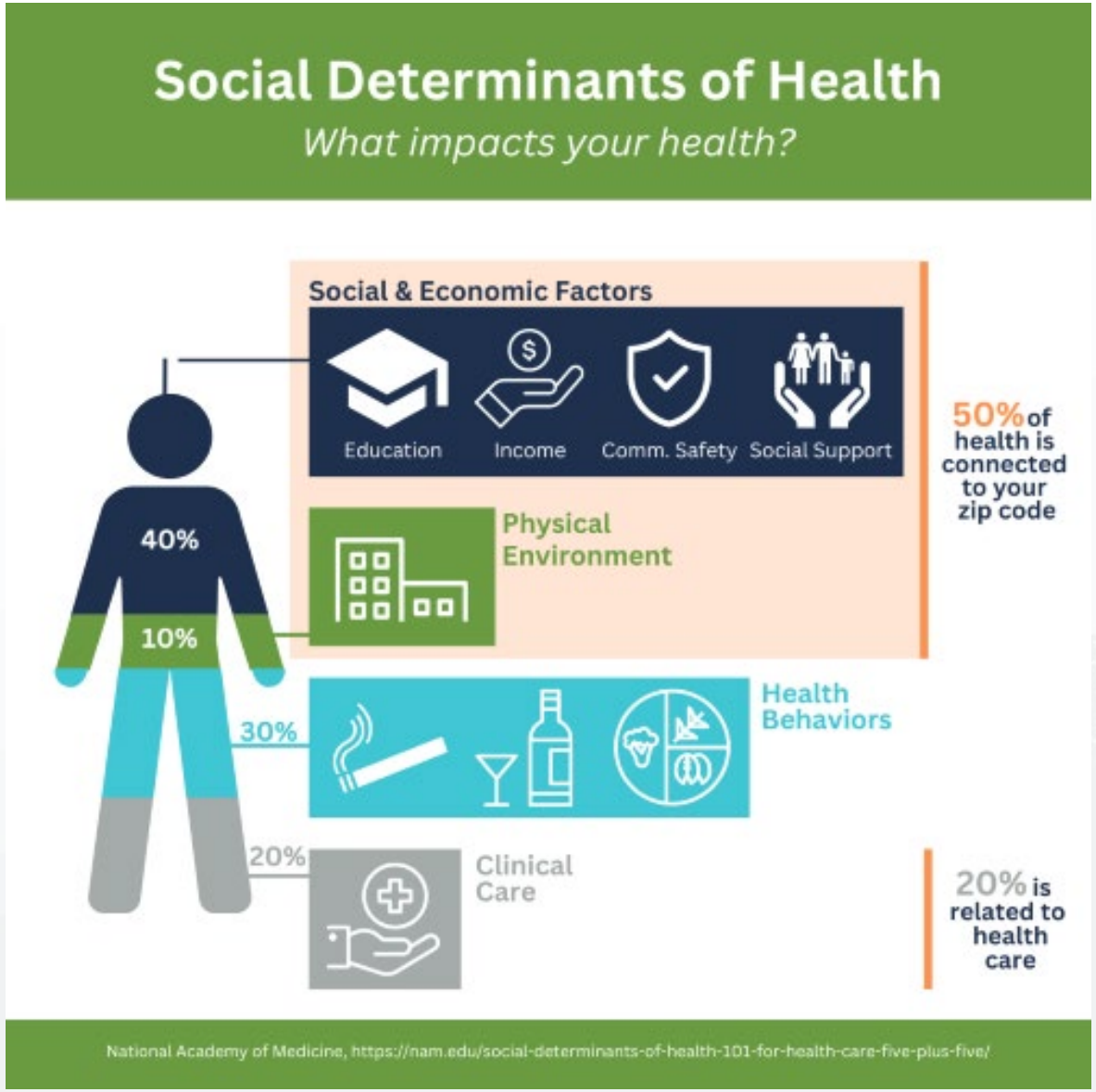
Finally: Summarize

- *"We've talked about a few different things that you've been experiencing, trouble paying your rent and having enough food for your family. You're also feeling kind of lonely and disconnected. It sounds like getting access to food is the most important right now. Is that right?"*
- *"I'd like to refer you to an organization in the community that can help. How do you feel about that?"*
- "I think that would be ok – thank you."
- *"Thank you for sharing with me. I appreciate your openness and I'm hopeful we can find help. This will be a step toward improving you and your family's health."*
- *"Can we schedule a phone call or in person follow up to make sure that we are on track with helping you access the Food Bank?"*

Care Pathways

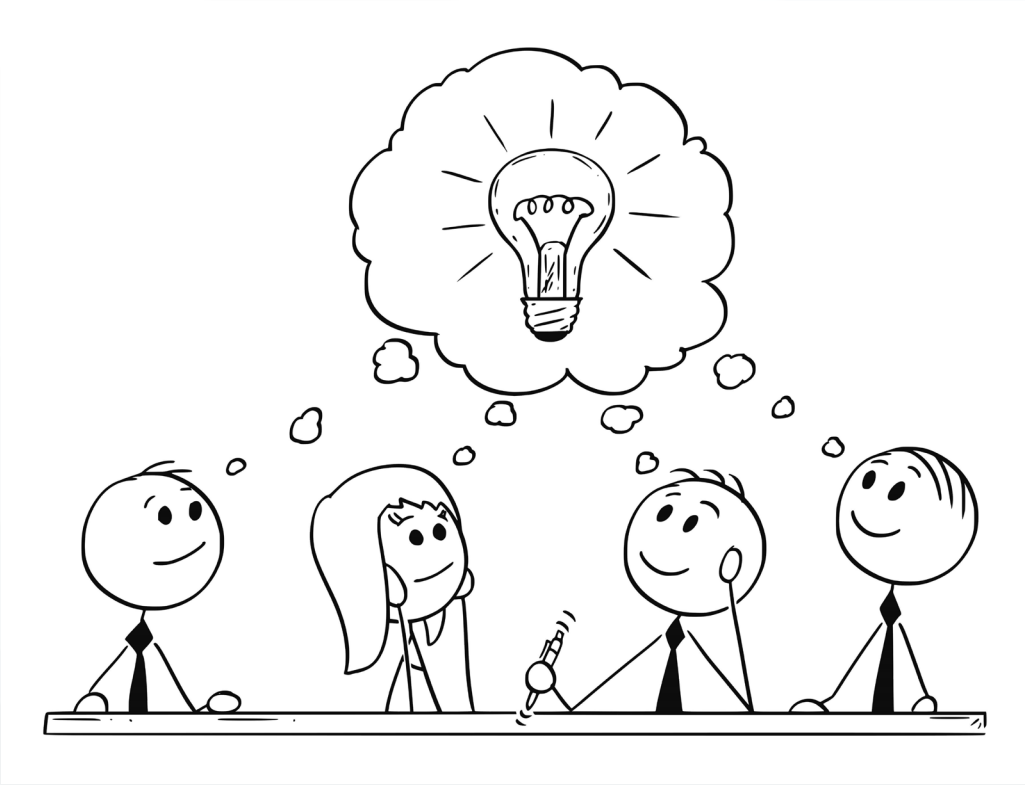
- Who should we screen for SDH?
  - EVERYONE
  - Screening is meant to be preventative as well as identify risks.

- Normalize that just like BH and SUD are part of healthcare, (and blood pressure and A1C) so are SDOH



Break Out

- Now that you've learned a bit about SDOH, consider how are you using SDOH in your setting?
- Is that adequate?
- If not, what could you do in your context to implement and increase screening?



Next Week

Wednesday, November 13th 9:00-10:00

Session 5: Finding Focus

You've built rapport, connected with resources, and are using the Spirit of MI. Your patients love you, but they still can't seem to stay on topic or set an explicit goal. Now what? In this session, we will work on helping our patients to set targeted, individualized goals.

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Resources:

- Resources | Adverse Childhood Experiences (ACEs) | CDC
- Social Determinants of Health - Healthy People 2030 | odphp.health.gov
- Income and Poverty in the United States: 2018
- About Intimate Partner Violence | Intimate Partner Violence Prevention | CDC
- Montana Housing Market: 2024 Home Prices & Trends | Zillow
- Our Epidemic of Loneliness and Isolation
- Social isolation, loneliness can damage heart and brain health, report says | American Heart Association
- Loneliness is at epidemic levels and it's killing Americans
- Health Partners on IPV + Exploitation
- Empathic Inquiry - Oregon Primary Care Association