CHWs and Social Determinants of Health: How Far Upstream Are We Looking?

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2016 Unity Conference
Monday, July 18, 2016
2:30 – 3:45 p.m.
Atlanta, GA
Presenters

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Session Objectives

1) Describe risks associated with the growing emphasis on support for licensed clinicians as the primary CHW role.

2) Explain the distinction between linking people to services and transforming systems of oppression and inequitable resource allocations that underlie health disparities.
Health equity = heart of CHW identify and practice

• Improve health outcomes & reduce disparities for
  • Racially and ethnically diverse patients, clients, community members
  • Patients with—or at risk for—high cost, complex conditions
• Come from, understand communities they serve
• Core values based in equality, justice, empathy

❤️


Basis of CHW effectiveness

• Core roles and skills
• Home and community-based practice
• Relationships and trust based on shared life experience and unique community knowledge
• Core value in integrated health care teams
  • Connect people with health services
  • Navigate health systems
  • Promote adherence, care utilization
• Identify and address non-medical problems that underlie poor health
CHW Roles

National Consensus (C3 Project)

1. Cultural Mediation among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

5/27/16
CHW Core Skills

National Consensus (C3 Project)

1. Communication Skills
2. Interpersonal and Relationship-Building Skills
3. Service Coordination and Navigation Skills
4. Capacity Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Individual and Community Assessment Skills
8. Outreach Skills
9. Professional Skills and Conduct
10. Evaluation and Research Skills
11. Knowledge Base
CHWs help “address” SDOHs

“As the Affordable Care Act and other pressures push the health care system to move beyond the traditional provider-centric model to one that also addresses the broader social and environmental determinants of health, engaging CHWs as critically important members of the primary care team is one of the most important strategies available to us.”

“CHWs also serve as the intermediaries that link clinical services to practical actions in the community to address the social determinants of health. The information they glean about patients’ health status and their unique understanding of patients’ social and cultural barriers to health can be shared with the team, vastly improving care.”

Your thoughts?
“American Health Care Paradox:”
Highest spending for poor outcomes

- Highest per capital health care spending in the world
- Last among wealthy nations in outcomes, efficiency, equity
- 34th in life expectancy internationally
The IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost
Hope v. Reality in the ACA Prevention Logic Model

- Shared Risk
- Integration
- Care Coordination
- Community-Clinical Linkages
- Primary Prevention (SDOH)

Image: "SHOW ME THE MONEY!"
Person Centered “Upstream Medicine”

Assess Patient Needs → Refer to Community Services → Monitor Clinical Impacts

Clinical-Community linkages to address Social Determinants of Health:

Aspiration, not mainstream practice
“Upstreamists”

“...rare innovators on the front lines of health care who see that...health begins in our everyday lives, in the places where we live, eat, work, and play.”

“They see how policies that afford or deny opportunity, fairness, and justice can be reflected in patients’ faces as well as in their DNA.”

“The upstreamist considers it her professional duty not only to prescribe a chemical remedy but also to treat sickness at its source.”

Rishi Manchanda, The Upstream Doctors: Medical Innovators Track Sickness to its Source
Challenges for Upstreamists (Manchanda)

- Lack of provider socio-cultural competence
- Lack of provider diversity
- Fee-for-service based “financial ecosystem” that favors downstream health care over prevention
- Regulations and policies that prevent data sharing, practice innovation, and primary prevention.
Your thoughts?
How far upstream are we looking?

- What does it mean for CHWs to “address” the social determinants of health?
Health Care’s “Prior Claim” on Resources

- $3 trillion in total US health spending, 2014
  - 17.5% of GDP
  - $9,523 per capita

- 5 X higher than US military spending
  - $610 billion, 2014
  - 3.5% of GDP
  - $1,913 per capita

- > 30% of all health spending wasted — nearly $1 trillion per year
The Price We Pay

• Real Wages
• Education
• Housing
• Transportation
• Environment
• Infrastructure
• Social Services
• Arts

What else could we do with nearly $1 trillion/year?
In OECD, for every $1 spent on health care, about $2 is spent on social services.

In the US, for $1 spent on health care, about 55 cents is spent on social services.
Social Determinants of Health Inequities

- Racism
- Education
- Job Opportunity
- Socioeconomic Status
- Environmental Exposure
- Health Behaviors
- Access to Health Services
- Safe and Affordable Housing
- Reducing Violence
- Health Outcomes
Household Median Net Worth by Race, 2013

Net Worth is ASSETS minus DEBTS
(What You OWN minus What You OWE)

Source: Pew Research Center calculations of Survey of Consumer Finances mobile-use data. African Americans and Whites include only non-Latinos. (Dollar figures are in 2013 dollars.)

- **White**: $141,900
- **Latino**: $13,700
- **African American**: $11,000
CDC “Health Impact Pyramid”
Factors that Affect Health

Socioeconomic Factors

Changing the Context
to make individuals’ default decisions healthy

Long-lasting Protective Interventions

Clinical Interventions

Counseling & Education

Examples

- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation
- Fluoridation, trans fat, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

Smallest Impact

Largest Impact
Funding Disconnect

Chronic Disease

- 70% of US deaths, 2010
- 86% of US health care spending, 2010
“Super-utilizer” costs to Medicaid

% of Patients

94%

5%

1%

% of Cost

50%

22.7%

27.3%

Agency for Health Care Research and Quality
Triple Aim Imbalance

Population Health

Experience of Care

Per Capita Cost
Referrals to SDOH-related services are critically important, but...

- Inadequately available
- Unevenly distributed
- Losing ground in state and federal budget battles
- Not integrated into mainstream health care delivery
“Upstream Medicine” patient screening:
*If it’s not in the EHR, it’s not in HCR!*

Health Begins (Rishi Manchanda)

Health Leads: “We Care” BMC patient survey:
- *High School diploma*
- *Job*
- *Daycare*
- *Housing security*
- *Food*
- *Heat*

3. Do you always have enough food for your family?

[ ] YES
[ ] NO

If NO, would you like help with this?

[ ] YES
[ ] NO
[ ] MAYBE LATER

If yes, do you need food for tonight?

[ ] Yes*
[ ] No
Inadequate Housing

• More than $\frac{1}{4}$ of all renters in Greater Boston pay over half their gross income in rent.

• 44,000 people applied for 2,000 spots on the Austin, TX Section 8 wait list in 2014; avg. of 30 people placed monthly.
Inadequate public transportation

• 2/3 of community health center patients surveyed in Boston rely on public transportation to get to appointments.

• Average 49% missed an appointment in the last year due to poor bus or train service.

• Racial/ethnic disparities in missed appointments:

![Transportation by Race/Ethnicity](chart.png)
Inadequate legal services

• Civil legal aid community in Massachusetts turns away approximately 65% of income-eligible residents due to lack of resources.
Your thoughts?
Constraints on CHW upstream impact

• Limited availability of referral and support resources.

• Health system administrators may not support CHWs in home and community-based work.
Constraints

• Reality of work for many CHWs includes:
  • poor pay and benefits
  • insecure jobs
  • ill-defined roles
  • unlimited expectations
  • uneven supervision
  • lack of respect
  • toxic personal stress
Risk #1

Medicalization of the CHW role and marginalizing the effective work many CHWs do outside the health care delivery system.
Risk #2

Diminishing advocacy as a CHW core competency

• CHWs use advocacy as one of our core roles-skills to help clients and communities navigate systems

• CHWs must often confront institutional barriers to quality care within their own organizations.
Risk #3

Undervaluing CHWs in health care systems and financing.

• Limiting flexibility to address complex needs.
• Optional roles for CHWs within Integrated Care Teams?
• Allocation of savings that accrue from CHW effectiveness?
• Structural integration of funding for CHWs?
Risk #4

Placing excessive expectations on CHWs.

**Critical Distinction:**
Mediating ill effects of SDOHs for individuals and families by linking people to services ≠

Changing national, state, and institutional policies undergirding racism, poverty, and other foundations of structural inequality.
Risk #5

Diversion of focus from health system’s potential roles, responsibilities, and capacities to promote primary prevention and address underlying causes of structural inequality.
Achieving the Triple Aim requires Social Justice

World Health Organization “Marmot Principles”

- **Power, Money, and Resources**
  - Health Equity in all Policies, Systems, and Programs
  - Fair Financing
  - Market Responsibility
  - Gender Equity
  - Political Empowerment
  - Good Global Governance

WHO Commission on Social Determinants of Health, 2008
World Health Organization “Marmot Principles” (continued)

• Daily Living Conditions
  • Equity from the start, including education for girls
  • Healthy Places, Health People
  • Fair Employment & Decent Work
  • Lifelong Social Protection
  • Universal Health Care

WHO Commission on Social Determinants of Health, 2008
Change the Framework:

*Equity* in All Policies and Planning
Address Root Causes

• Promote and defend CHW advocacy and organizing roles.
• Address *economic and political drivers* of social determinants of health.
Organizing: Challenge for Us All

“Nothing about us without us!”
No Equity

No Triple Aim
No Organizing, No Progress

“Power concedes nothing without a demand. It never did and it never will.”

“If there is no struggle, there is no progress. Those who profess to favor freedom, and deprecate agitation, are men who want crops without plowing up the ground; they want rain without thunder and lightning.”

Frederick Douglass
1818-1895
Your thoughts?
Contact Information

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