Emory Prevention Research Center

Implementing Strategies to Address Social Determinants of Health

Emory Prevention Research Center

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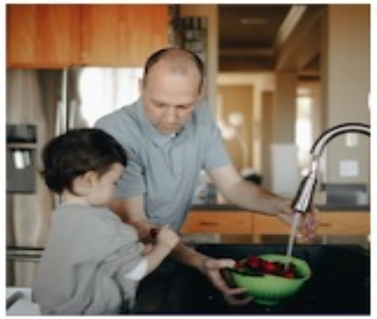
Agenda

1. Recap of the Social Determinants of Health (SDH)
2. General strategies to address SDH
3. SDH strategies from a rural health equity initiative
4. Way to address SDH in your organization





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Partnering with communities and leveraging research to prevent cancer and promote health equity

Prevention Research Centers (2019-2024)

Emory Prevention Research Center (EPRC)

- Core (CDC-funded) research focuses on cancer prevention & reducing health disparities related to chronic disease in **rural** communities
- Based in the Department of Behavioral, Social, and Health Education Sciences, Rollins School of Public Health, with strong connections to Winship Cancer Institute
- Funded by CDC from 2004-2014, and now again 2019-2024
- Strong partnership in **southwest Georgia** since 2004, building on Cancer Coalition of South Georgia's (now called Horizons Community Solutions) Board of Directors for our **Community Advisory Board** initially and prior study on smoke-free homes
- **Encourage and support SIP proposals to focus on southwest Georgia when appropriate**

RESEARCH

EVALUATION

TRAINING

COMMUNITY

DISSEMINATION

Training Symbols

1

Zoom Poll

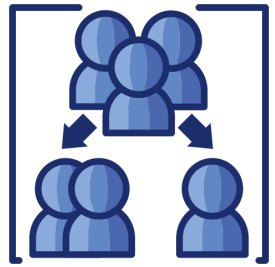
2

Annotate Feature

3

Video Clip

4



Breakout Room
OR
Chat

Learning Objectives

Discuss ways to address social determinants of health (SDH)

Describe guidance for addressing SDH in your organization

Chat: Agencies Represented

What is your organization or setting?

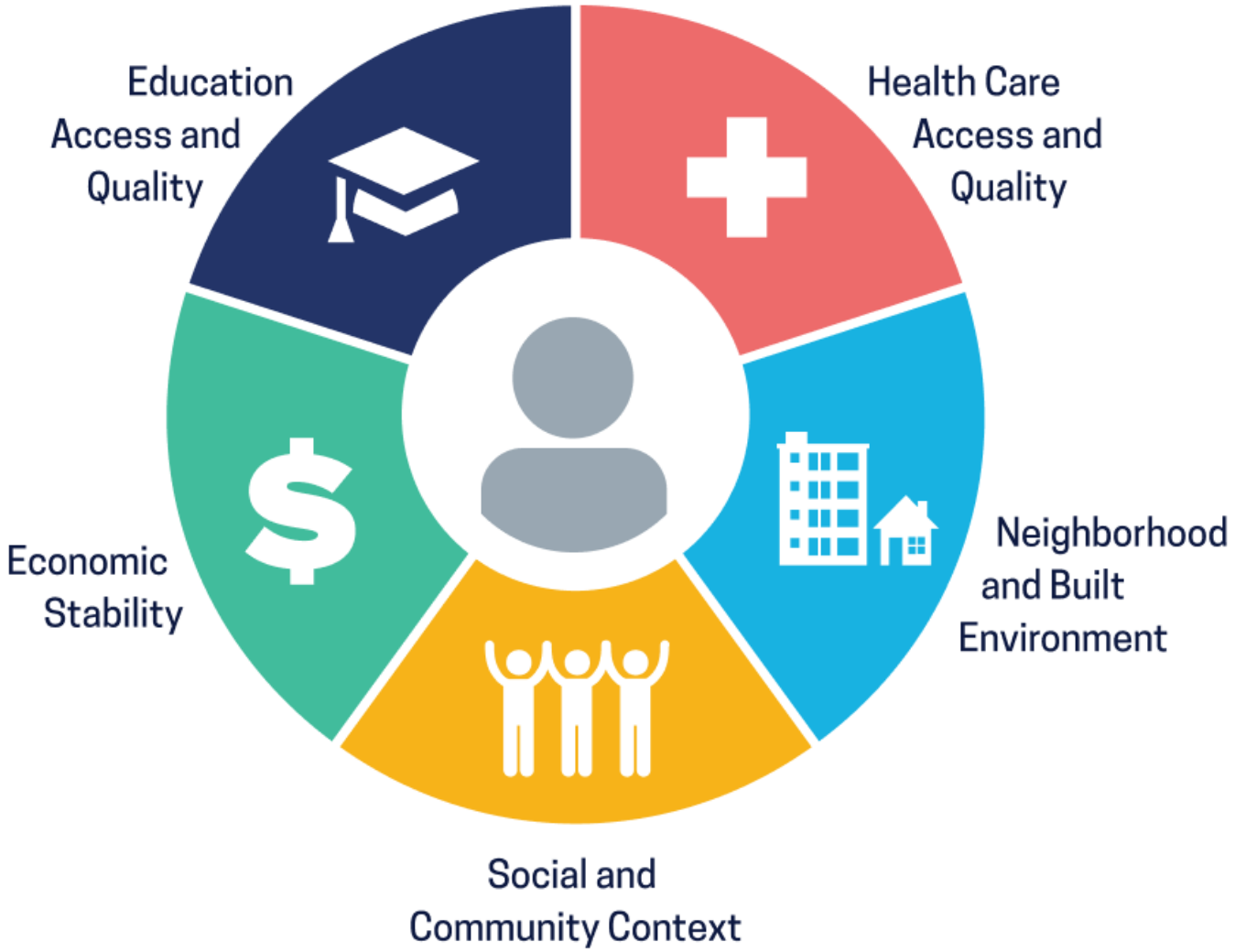
Recap of the Social Determinants of Health

What are Social Determinants of Health?

"The conditions in which people are born, grow, live, work, and age" and "the fundamental drivers of these conditions"

World Health Organization, Commission on Social Determinants of Health

Social Determinants of Health



Economic Factors

Poverty

Employment

Income

Income inequality

Housing/ transportation affordability

Child care access

Food security

Education Factors

Academic achievement (High school graduation)

Language and literacy

Early childhood education and development

Infrastructure and capacity

School environments

Health education

Health Care Access

Health care utilization & access

Health care infrastructure

Quality of care

Provider training

Public health program/services

Neighborhood/ Built Environment

Food environment and agriculture

Housing and transit (community-level)

Safety, crime, violence, and policing

Environmental conditions

Social Factors

Family/social support

Social cohesion/collective efficacy/social capital

Civic participation/ engagement/ governance

Social mobility

Discrimination/racism

Incarceration

Segregation

What social determinants of health issues you are seeing in your community?

Ways to Address Social Determinants of Health

Ways to Address SDH - Data

1

- Use data to discover the most important SDH to address for your project or community and create data graphs/reports
- This may include data stratification (e.g., separating out groups on characteristics such as race, income, age, location, etc.) or assessing the underserved or diverse communities to understand their needs
- Prepare plans to address SDH (e.g., health literacy – create/find materials in language, train lay health person, have bilingual staff)

2

- In planning interventions, consider barriers for participants or program delivery (e.g., transportation through gift cards/being in community/mobile unit, training of staff related to cultures)
- Plan ahead to build in funds/resources/partnerships can address some SDH earlier
- For example, local social services or 2-1-1 for community resources around assistance with utilities or rent

For Steps 1 (data collection) and 2 (barriers identification)

- In Part 1 of this training, we shared some tools for collecting social needs or SDH (access these materials at https://web1.sph.emory.edu/eprc/training/)

Tool	Items	Location
Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)	15	https://prapare.org/the-prapare-screening-tool
The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS)	10	The AHC Health-Related Social Needs Screening Tool (cms.gov)
North Carolina DHHS SDH Screening Tool	11	Screening Questions | NCDHHS

Existing Datasets

- PLACES

  https://www.cdc.gov/places/

- Datasets with SDOH data:

  https://www.cdc.gov/places/social-determinants-of-health-and-places-data/index.html

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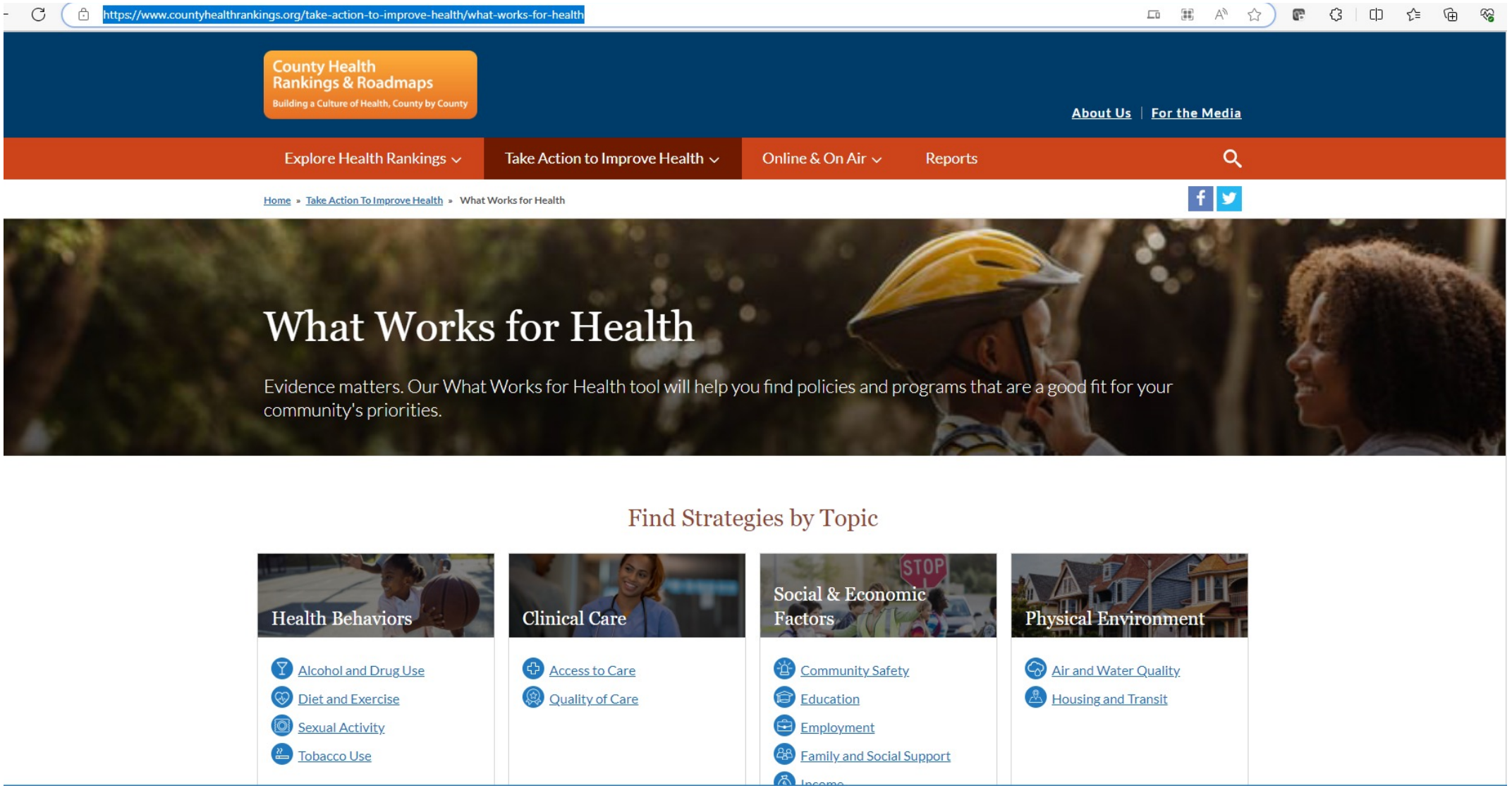
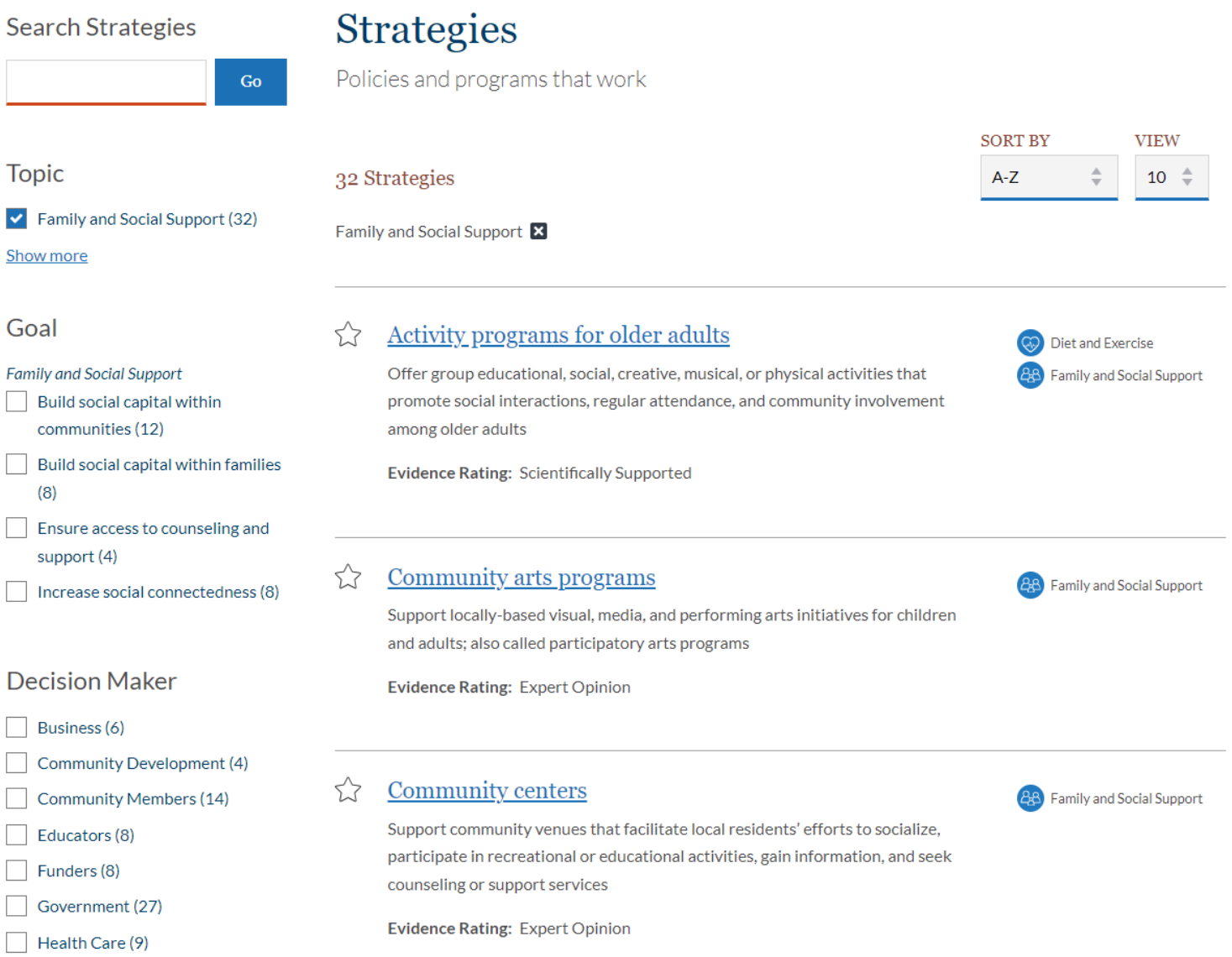
Resources - County Health Rankings – What works for Health



Choose Topic – Family and Social Support



Ways to Address SDH - Partnerships

3

- Partner with community organizations in your area
- They can bring other resources to your projects related to food access, jobs/placements, transportation, etc. depending on what you are finding in your community assessment
- Create resources lists or have clinic staff/navigators/ community health workers to help make linkages

4

- Partner with other sectors addressing priority SDH in your community
- Have people from transportation, business, social services or education sectors be on your planning or partnership teams

Ways to Address SDH

5

- Consider agency wide linkage or shared data or space (e.g., for access to public health services have one-stop/wrap around clinic services)
- This may include care coordination, navigators or community health workers to educate or address needs, or one centralized location to facilitate referrals

6

- Advocate for policies in your communities that can positively impact health (e.g., city/coalitions with green initiatives, city revitalization efforts, housing vouchers)
- Join community coalitions or initiatives addressing health/SDH issues in your area
- Advocate for funding for public health efforts

Equitably Addressing Social Determinants of Health and Chronic Diseases | CDC; Health Equity Resources (shvs.org)

THE TWO GEORGIAS INITIATIVE

PLACE MATTERS: ADDRESSING HEALTH EQUITY IN GEORGIA

SDH Strategies from a Rural Health Equity Initiative

The Two Georgias Initiative, 2017-2022

Place-based grant making program designed to:

- Expand access to quality healthcare
- Achieve greater health equity among rural Georgians
- Build community, organizational, and individual leadership

11 rural GA Community Coalitions ($70-100k)

- Included funding a local evaluator

5-year initiative

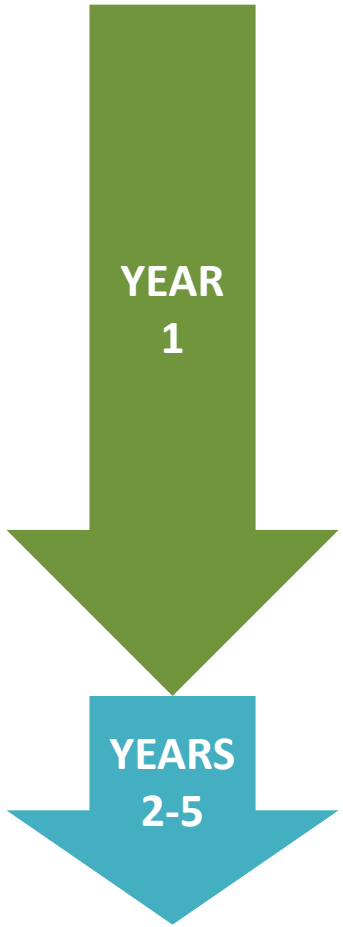
- Phase 1 (Year 1): Planning, 7/2017-6/2018
- Phase 2 (Years 2-4): Implementation, 7/2018-6/2021
- Phase 3 (Year 5): Sustainability, 7/2021-6/2022

Technical Support (management team)

- Coaching, evaluation, health equity experts

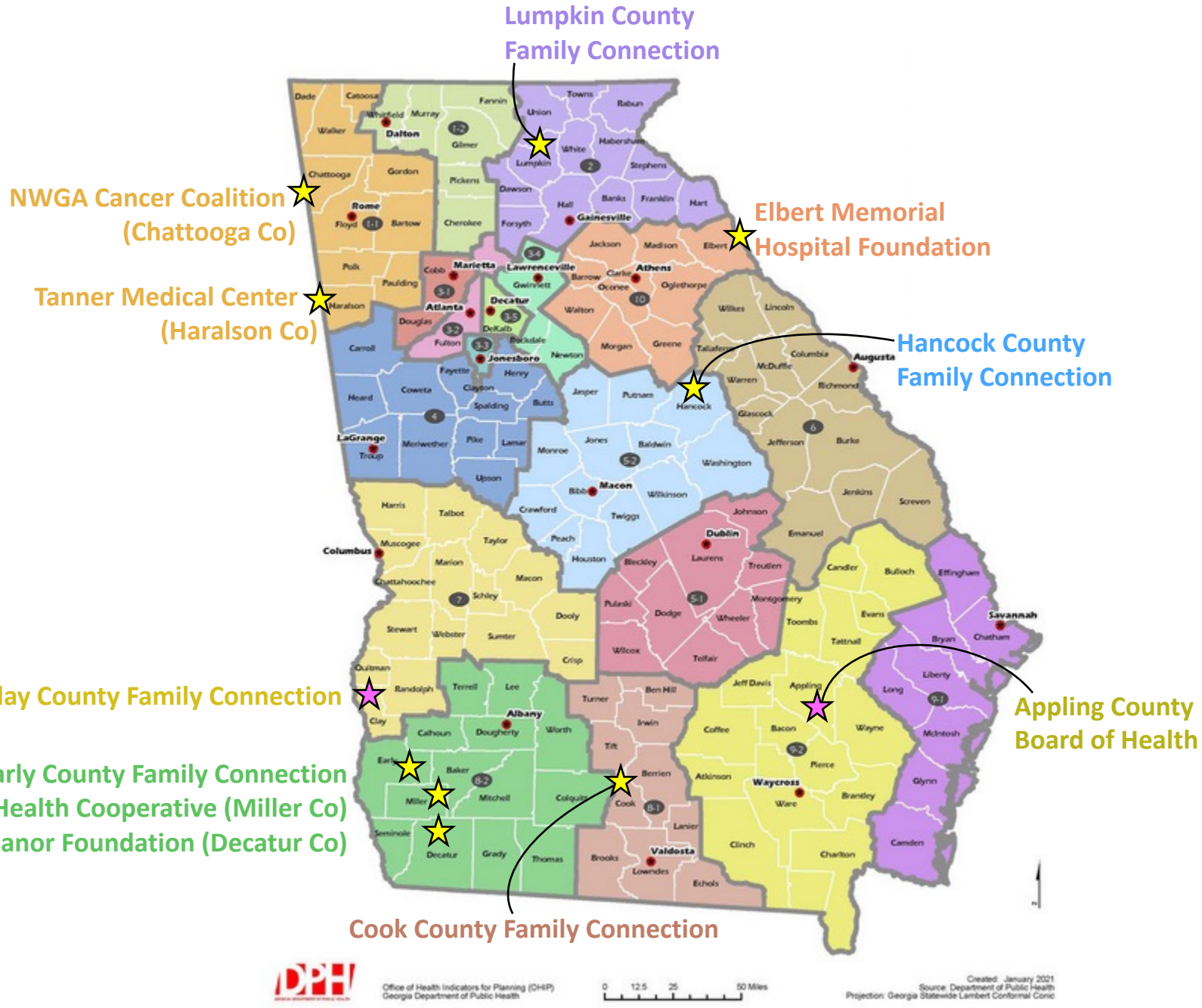
Coalition Activities

1. **Form a Community Health Coalition**
   - Diverse in terms of people and sectors represented
   - Formal leadership structure, bylaws, etc.
2. **Conduct a Community Health Needs Assessment**
   - Collect and analyze data on health status and related factors
   - Determine process for priority setting
3. **Develop Community Health Improvement Plan (CHIP) (including a local evaluation plan and logic model)**
   - Describe priority areas and plan to address
   - Collect baseline outcome evaluation data
4. **Implement, evaluate, and sustain CHIP**



Grantee Locations

COUNTY POPULATIONS ALL <35K
3 COUNTIES <10K



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Initiative Evaluation Design

Process and outcome focused questions

- Understand the process of addressing health inequities through Initiative
- What outcomes or changes result from these efforts

Mixed-methods data

- Use of qualitative & quantitative methods useful when single method is insufficient
- Help increase accuracy of measurement and certainty of conclusions

Use an equity lens throughout all steps in evaluation

- Assess what worked, for whom, under what conditions, and whether health inequities decreased, increased or remained the same
- Applied to logic model, design, instruments, analysis/interpretation, & dissemination

Data Sources for Identifying Strategies

Community change tracking tool

- Excel-based tool that tracked progress & key steps toward policy, systems, and environmental changes, reach to prioritized populations, unit of change, COVID-19 impact

Program documents

- Progress reports and annual local evaluation reports

Key informant interviews

- Local project directors, local evaluators, coalition members
- Barriers and facilitators to planning and implementation, dimensions of readiness and capacity to address health equity, effective strategies and impact on equity, sustainability, COVID-19 impacts

Other Evaluation Data Sources

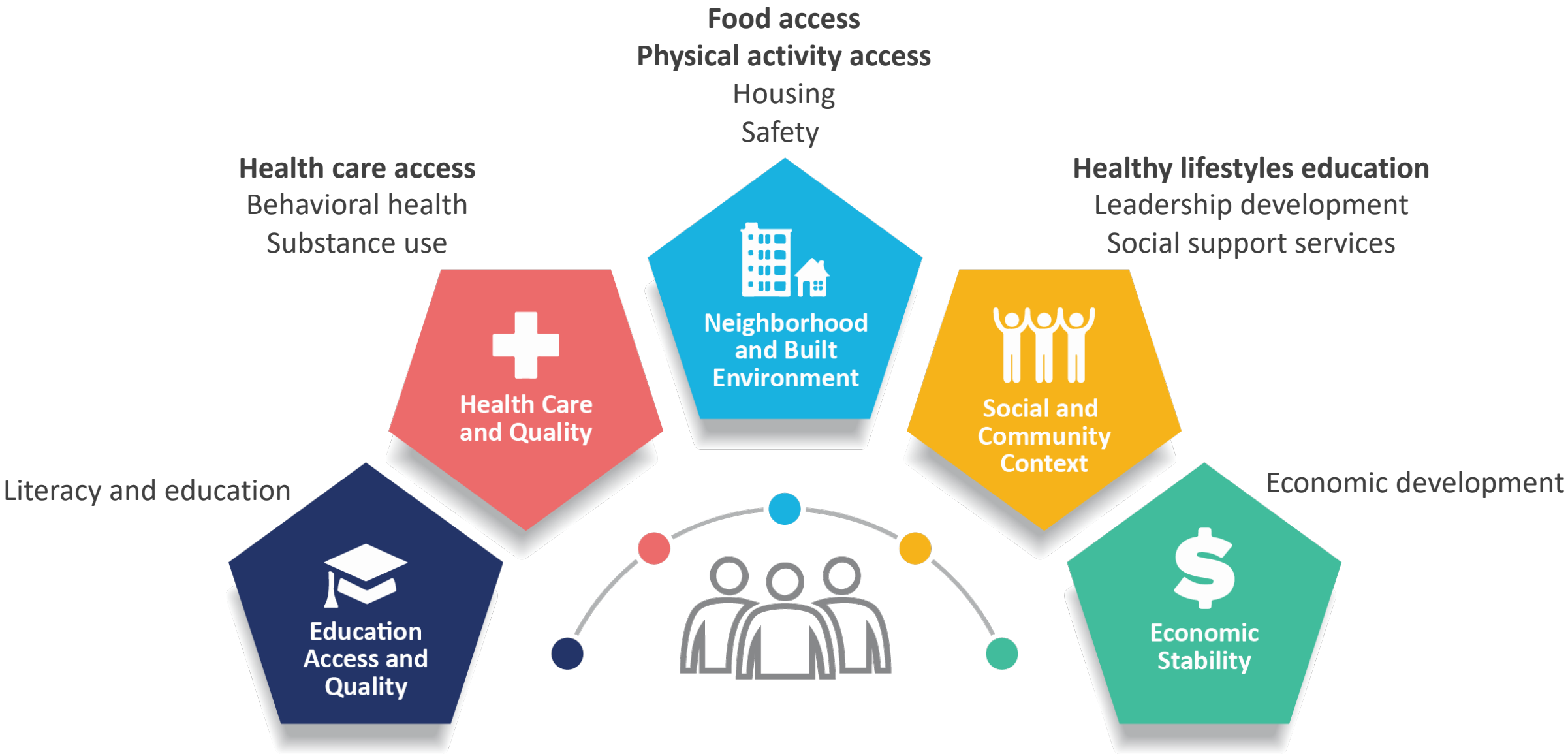
Coalition member survey

- Web-based survey of active coalition members (Year 2 n=236; Year 4 n=258)
- Coalition functioning (e.g., communication, decision-making), roles coalition members played, satisfaction, diversity by sector and demographics, community readiness, collaborative synergy, major community changes, COVID-19 impacts

Population based survey*

- Year 2: (n=2,788) County-specific surveys mailed to random households
- Year 5: Surveys mailed to baseline participants (n=1,421); in 3 counties mailed to new set of cross-sectional only households (n=428)
- Optional modules: food access/security, healthy eating, physical activity, health care access & use, social capital
- All survey modules: well-being, health status, healthy days, demographics

DOMAINS	# STRATEGIES	# COALITIONS IMPLEMENTING
Health care access	20	8
Healthy lifestyles education & nutrition guidelines and support	20	6
Physical activity access	19	8
Food access	19	8
Literacy and education	12	4
Leadership development	11	5
Behavioral health	7	4
Substance use	6	2
Economic development	4	3
Housing	3	3
Safety	3	2
Social support services	1	1



Graphic source: https://www.cdc.gov/publichealthgateway/sdoh/index.html

COOK COUNTY
FAMILY CONNECTION

https://www.youtube.com/watch?v=-HcNOVUhPbc&t=136s

Full videos are available at: http://www.twogeorgias.org/

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https://www.youtube.com/watch?v=q34FhqBwXKw&t=125s

Full videos are available at: http://www.twogeorgias.org/

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Health care access

Establish/strengthen referral system

Mobile health services/Telehealth

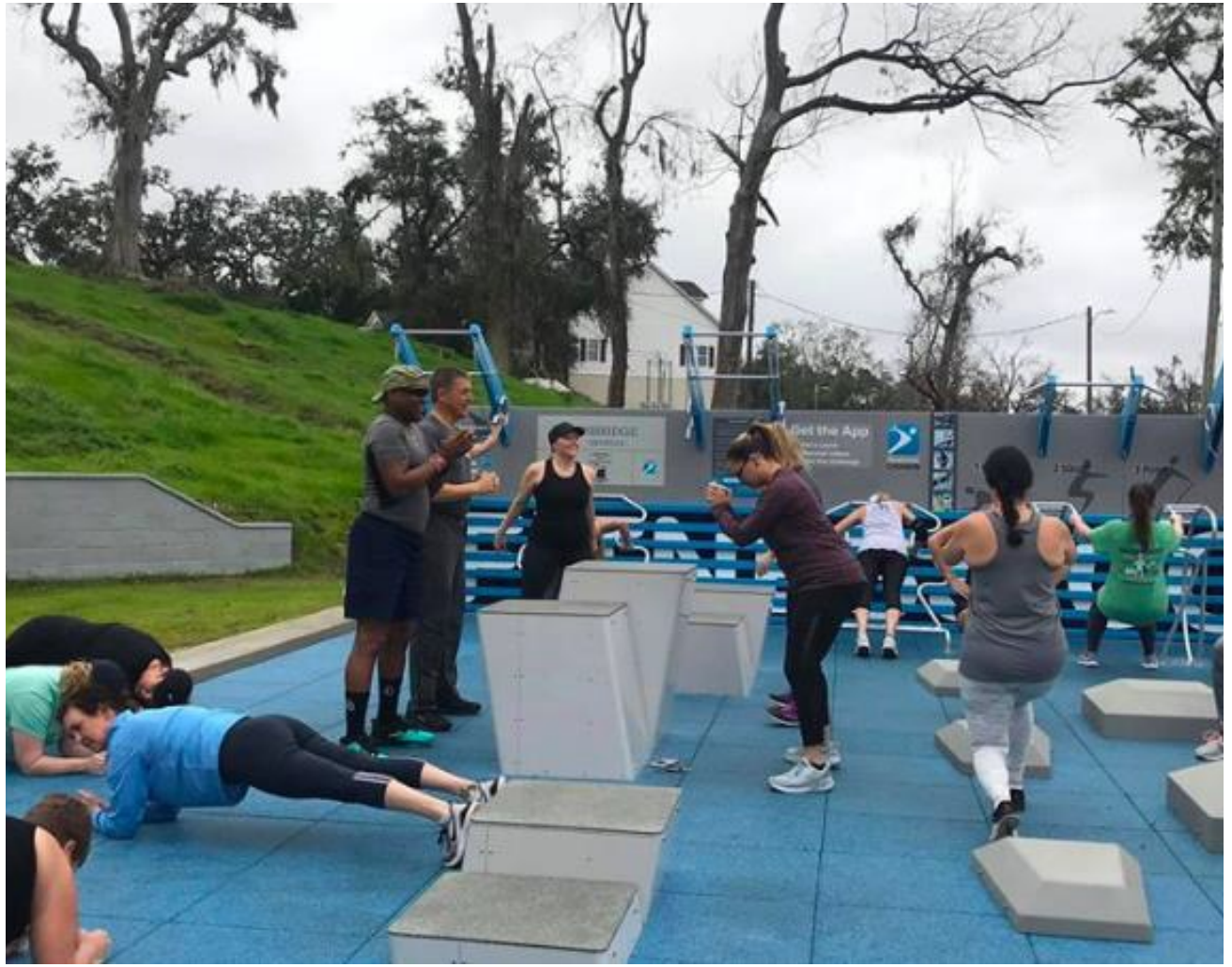
Other

Health Care Access Strategies	# Coalitions	Priority Population
Establish/Strengthen referral systems, including transportation		
Health screening/referral at community or navigation events	4	All, low-income
Community-clinical linkage referral system	2	Patients
Transportation support systems	2	All, low-income
Medical home & patient assistance programs to reduce emergency visits	1	All
Mobile health services/Telehealth		
Provide mobile/dental health services	2	Low-income, un/underinsured
Telehealth availability	1	Low-income
Other		
Community resource guide	2	All, low-income seniors, youth
Annual health fairs – general	1	Low-income
New clinic/pharmacy	1	All
Expand health care services among existing health partners	1	All
Provision of free and reduced cost prescription medications	1	Low-income

Physical activity access

Geographic access

Financial access



Physical Activity Access Strategies	# coalitions	Priority Population
Expand recreation activities/classes	5	All, mill workers, seniors, youth
Recreation facilities and courts improved	4	All
Improve or build walking trails & sidewalks (including lights)	3	All
Playground and play space improvements	3	Youth
Establish joint use agreements for school equipment use	2	All
Stipends/scholarships available for organized recreation	2	Youth, low-income
GEO-caching (outdoor treasure hunt using GPS coordinates)	1	All

Food access

New food sources

New food delivery systems

Food Access Strategies	# Coalitions	Priority Populations
Community gardens (churches, schools, etc.)	7	All, Low-income, Seniors, Youth, Faith
Mobile pantry/produce truck	4	All, Low-income, Seniors
Food pantry expansion	2	All
Gleaning & produce distribution	1	Low-income, Seniors
Farmers market vouchers	1	Seniors
Summer food backpack programs	1	Low-income youth
Youth empowerment greenhouse	1	Youth
Blessing boxes	1	Low-income

Other Domains

Safety

- SafeKids motor safety
- Life Alert buttons
- Safe Routes to School

Literacy & education

- Little libraries
- Childcare center quality ratings
- Head Start hours extended

Substance use

- Naloxone policy/training
- Smoke-free policy/ program
- Tobacco cessation referral network

Leadership

- Youth development/ empowerment trainings
- Career/ technical/ agricultural education in high schools
- Soft skills trainings
- Photovoice projects

Behavioral health

- School mental health clinics
- Screening/referral networks

Economic development

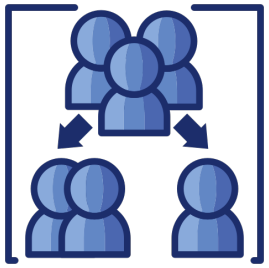
- Rural Zone
- Local flea market
- Workforce development with technical college

Housing

- Policies for safe & affordable housing
- Code enforcement
- Home repair program

Social support services

- Included in United Way catchment area



Breakout Session (3 breakouts)

1. Discuss a social determinant of health in your community

2. Choose one of the ways to address SDH and discuss how you may or are implementing this strategy

Guidance on Social Determinants of Health for your Organization

National Culturally and Linguistically Appropriate Services (CLAS) Standards

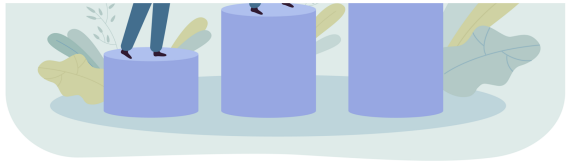
- Culturally and linguistically appropriate services are recognized as effective in improving the quality of public health/medical care and services

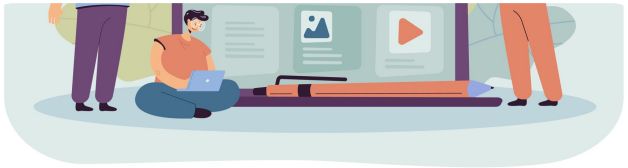
- 15 areas for self-review within our organization to address these areas

Principle Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

CLAS Standards - Think Cultural Health (hhs.gov)

National Culturally and Linguistically Appropriate Services (CLAS) Standards





Governance, Leadership, and Workforce

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

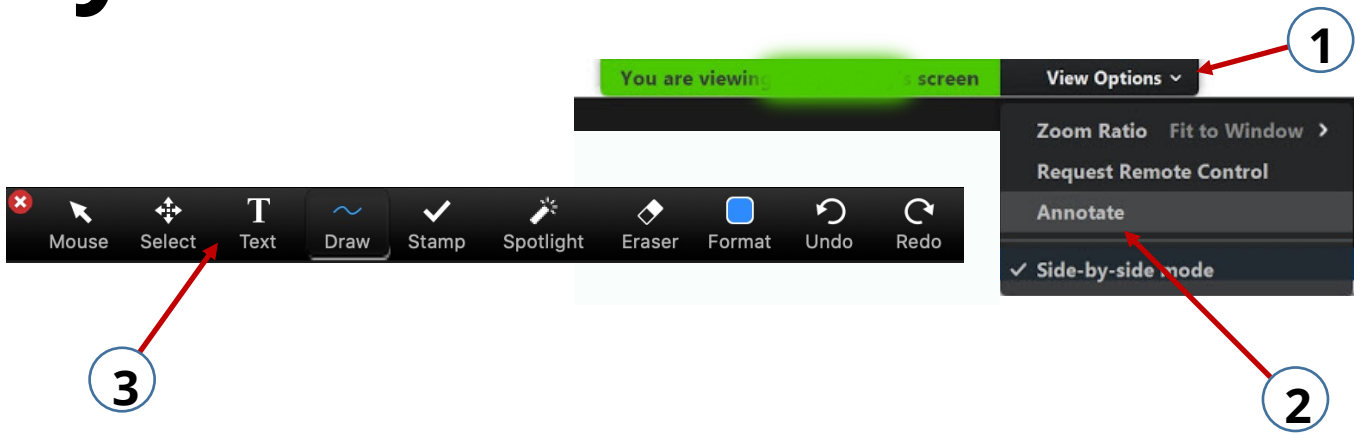
Engagement, Continuous Improvement, and Accountability

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

What does equity-based change in your community look like?

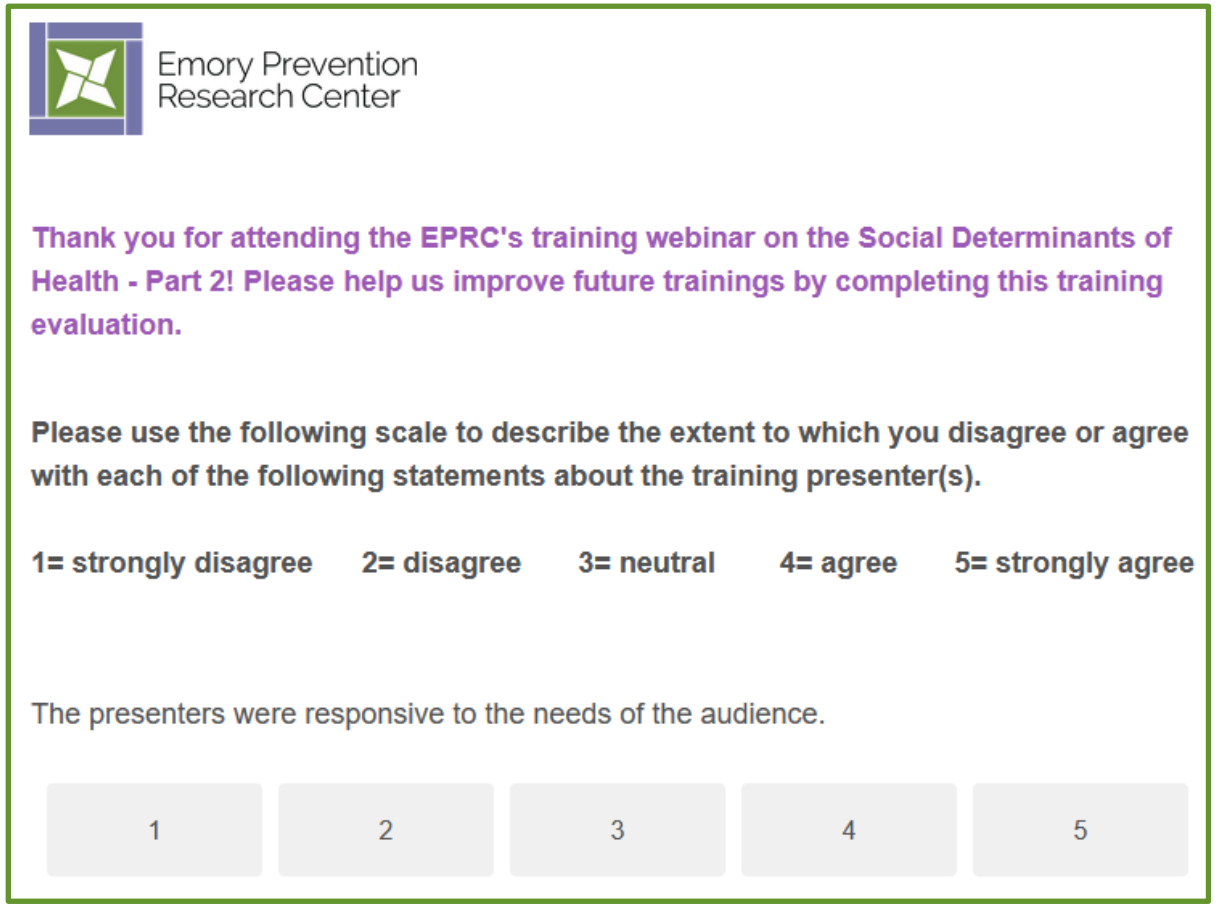


Let's Recap!

- There are many ways to address social determinants of health
- Some keys strategies are to collect SDH data from your community, form partnerships or coalitions to work together on identified needs, and advocate for addressing social needs and conditions that affect health
- The National Culturally and Linguistically Appropriate Services (CLAS) Standards offer guidance on assessing your own agency and the services offered related culture and language in your services

Training Evaluation

https://tinyurl.com/SDHpt2



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