Social Determinants of Health Their Tie to Poverty and Health Equity

OneWorld
Community Health Centers, Inc.

Josie Rodriguez, Chief Diversity, Equity, and Inclusion Officer
OneWorld Community Health Center

Care for ALL PEOPLE

OneWorld
Community Health Centers, Inc.

Culturally Respectful, Quality Healthcare

VISION

To be an innovative leader, empowering individuals and creating healthier communities.

Culturally Respectful, Quality Healthcare

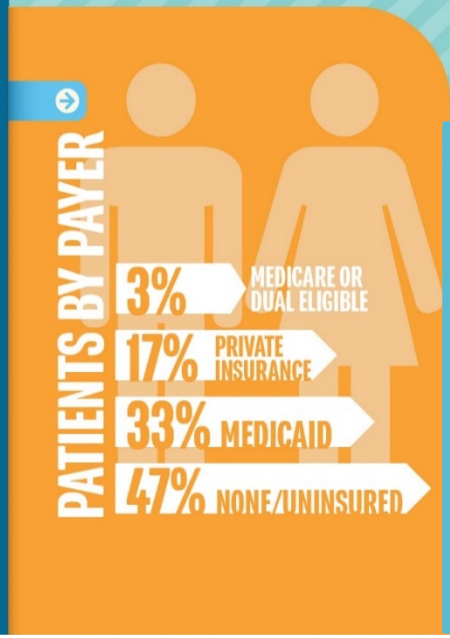
MISSION

OneWorld Community Health Centers, in partnership with the community, provides culturally respectful, quality health care with special attention to the underserved.

SERVICES & PATIENTS

CORE SERVICES

PATIENT SUPPORT VISITS	DENTAL VISITS	MEDICAL VISITS	VACCINE DOSES GIVEN	PRESCRIPTIONS FILLED	MENTAL HEALTH VISITS
18,647	20,401	121,064	125,112	136,126	10,401



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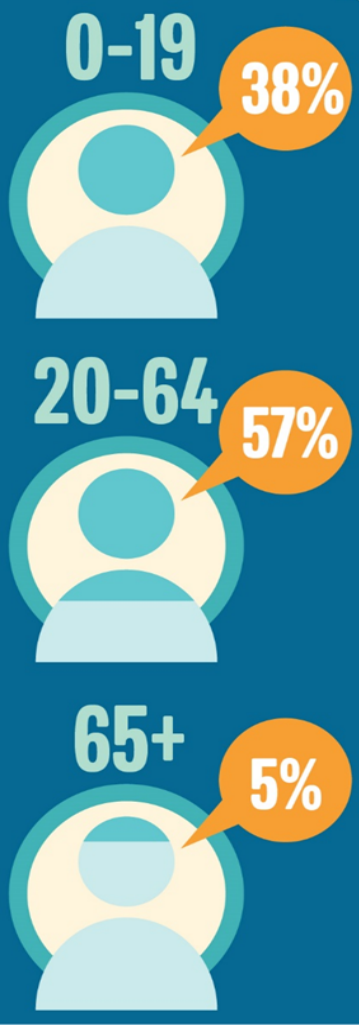
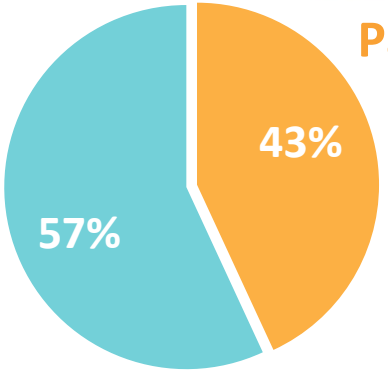
PATIENT DEMOGRAPHICS

PATIENTS BY AGE

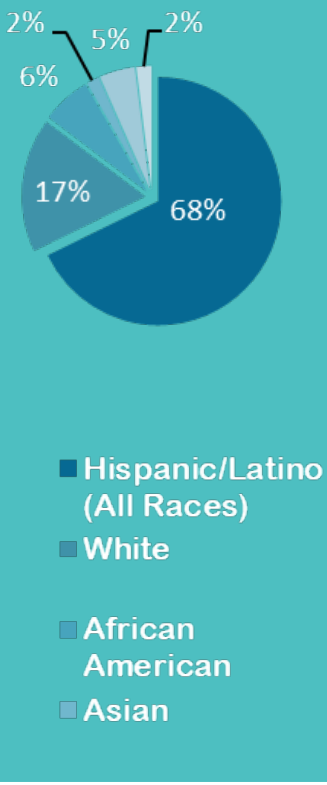


Patient Gender



PATIENTS BY % FEDERAL POVERTY LEVEL WITH KNOWN INCOME

Patients by Race & Ethnicity



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What does twice POVERTY look like?

$3,916 TAKE HOME PAY

-$1000	rent (median)
-$200	car payment (1 car)
-$100	car insurance
-$150	gas/repairs
-$900	food (thrifty budget/USDA determined for food stamps)
-$400	utilities
-$200	clothing/school
-$700	childcare
$3,470	

What's left for health care?

Culturally Respectful, Quality Healthcare

Health equity means that everyone has a fair and just opportunity to be healthier.

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.

-Robert Wood Johnson Foundation

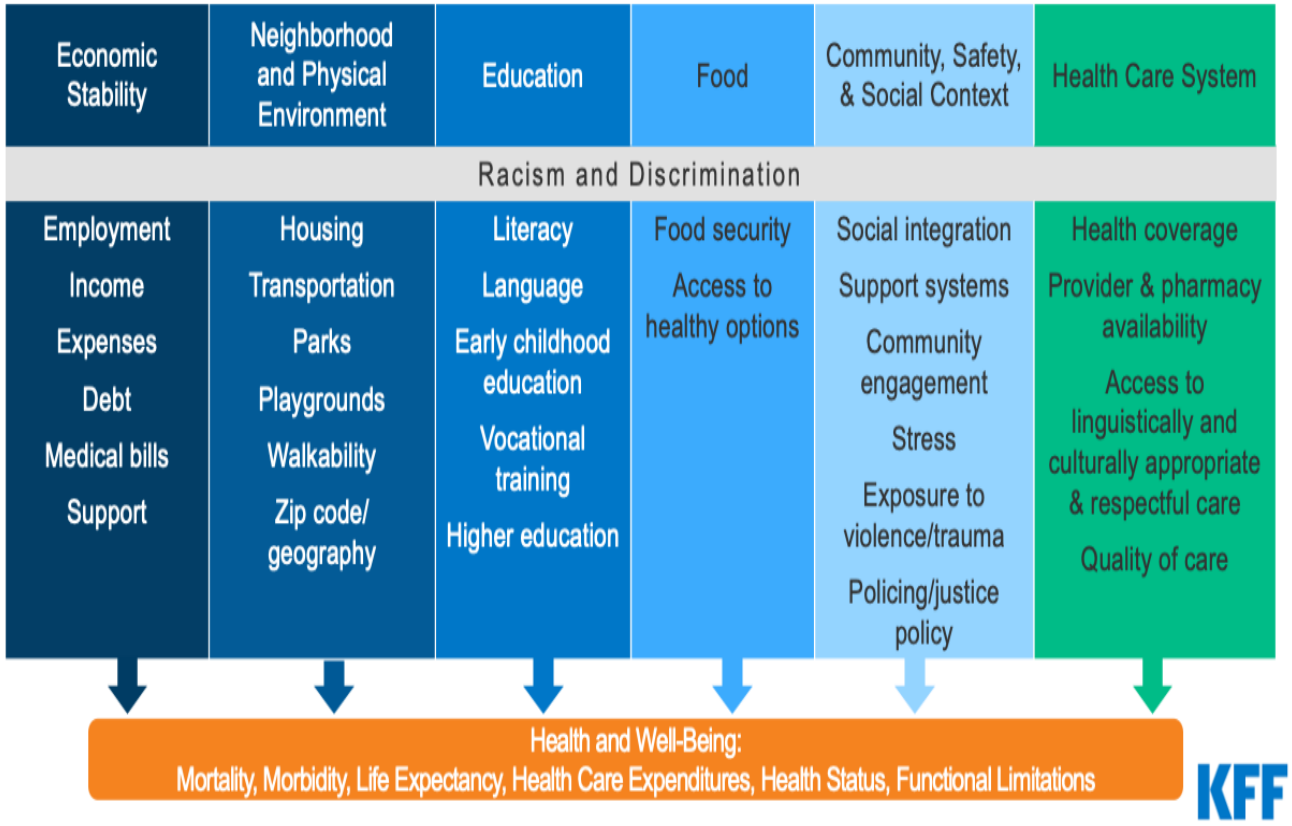
Health Disparity

"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Healthy People 2030: https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

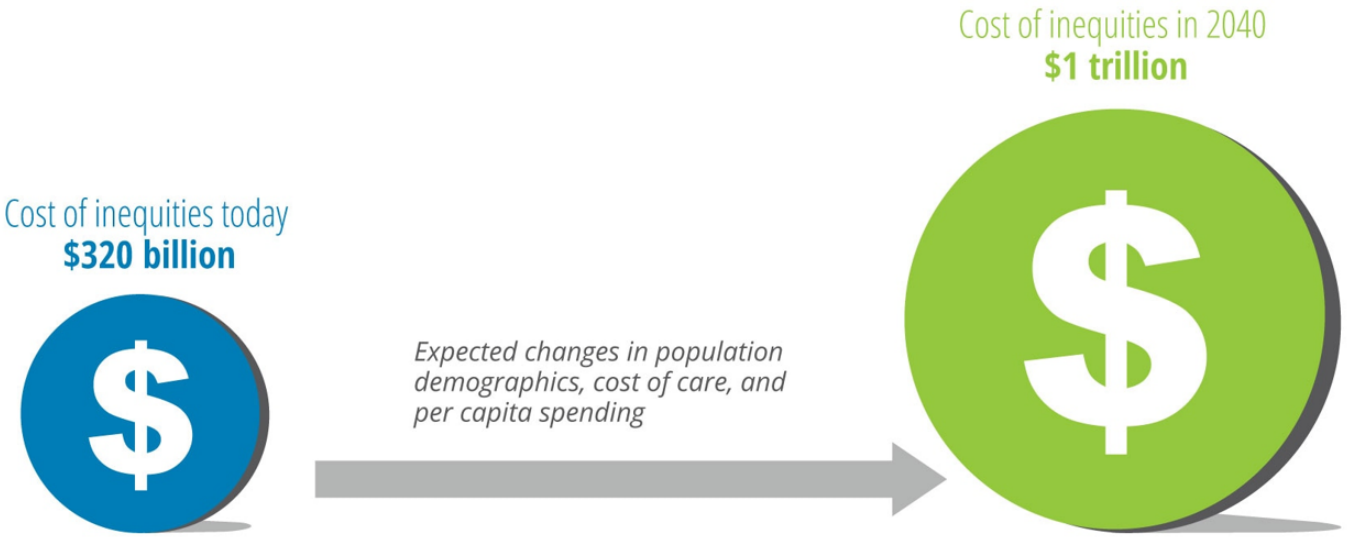
Health Disparities are Driven by Social and Economic Inequities



Kaiser Family Foundation: Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity
https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

How much do inequities cost us?

Modeling the cost of health inequities in 2040

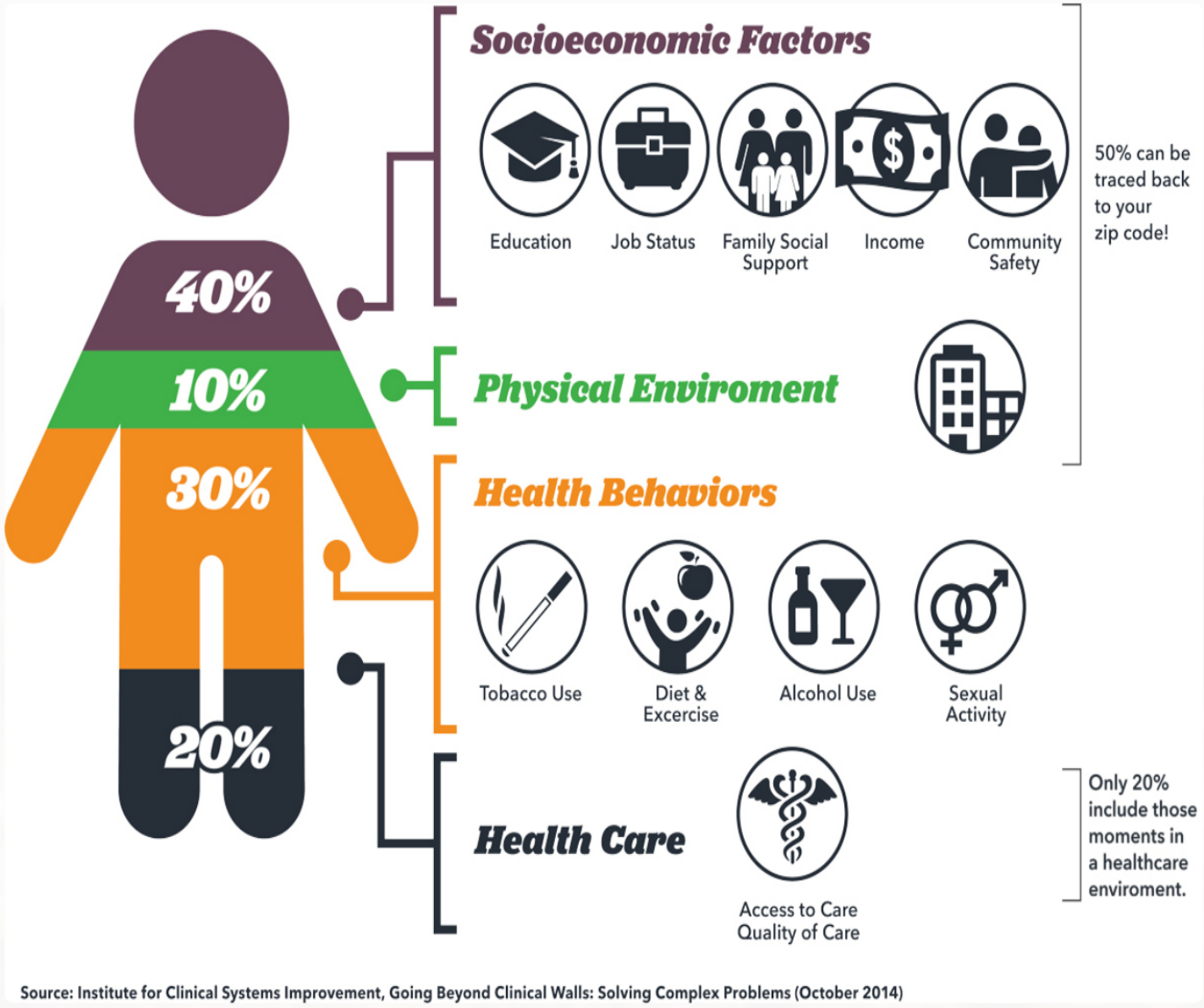


We initially focused on a set of disease states to establish a baseline for the costs potentially attributed to inequities and bias

Using the assumptions from these disease states and disparities research, we extrapolated to all other disease states

Note: All values are in US dollars.

Sources: Deloitte analysis.



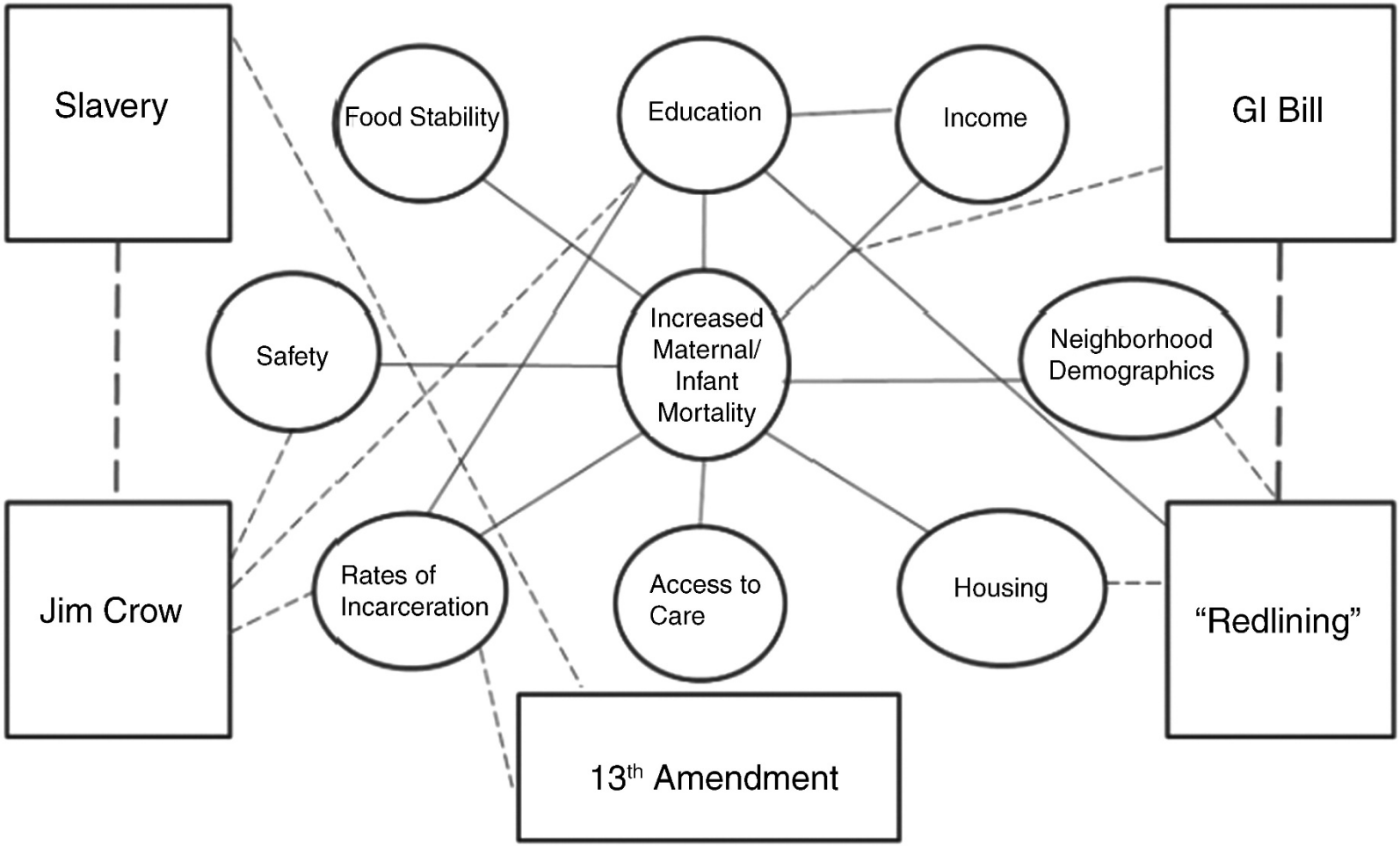
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Social Determinants Health are Impacted by Government Policies

The ECHO Project. https://www.echobh.com/sdoh/

WEB OF CAUSATION

STRUCTURAL and SOCIAL DETERMINANTS: IMPACT ON HEALTH



Restoring Our Own Through Transformation (ROOT). https://www.roottrj.org/web-causation

Social Determinants of Health

Employment

4.3x

African Americans were less likely to be unemployed at 11.2% of the population, compared to Whites at 4.1%.

Household Income

2.1x

American Indians reported the lowest median household income at approximately $25,700, compared to Whites at $55,100.

Poverty

American Indians were most likely to be living in poverty at 40.5% of the population, compared to Whites at 10.9%.

Education

3x

Hispanics (10.1%) were less likely to have more than a Bachelor's degree, compared to Whites at approximately 30%.

How do social indicators affect health?

The conditions where individuals live, work and learn can have a large and lasting effect on health. For example, poverty can limit an individual's access to healthy food options, and education and stable housing have long been linked to better health. Understanding these social determinants of health and how they affect certain populations is important to improving health outcomes for all groups.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: American Community Survey 2006-2015

Nebraska Office of Health Disparities & Health Equity

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Risk Factors for Low-Income Nebraskans

The likelihood of having health insurance and a personal physician increases as income levels increase.

Health Care Coverage

Approximately two of every five Nebraskans earning less than $25,000 annually did not have health care coverage.

Diabetes

2.3x

Nebraskans earning less than $25,000 were most likely to have been diagnosed with diabetes (12.3%), a percentage 2.3 times higher than that of those earning over $75,000 (5.4%).

Perceived Health Status

Approximately 30% of individuals who earned less than $25,000 annually perceived their health status as fair or poor.

Only 5% of individuals who earned more than $75,000 annually perceived their health status as fair or poor.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska BRFSS 2011-2015

NEBRASKA
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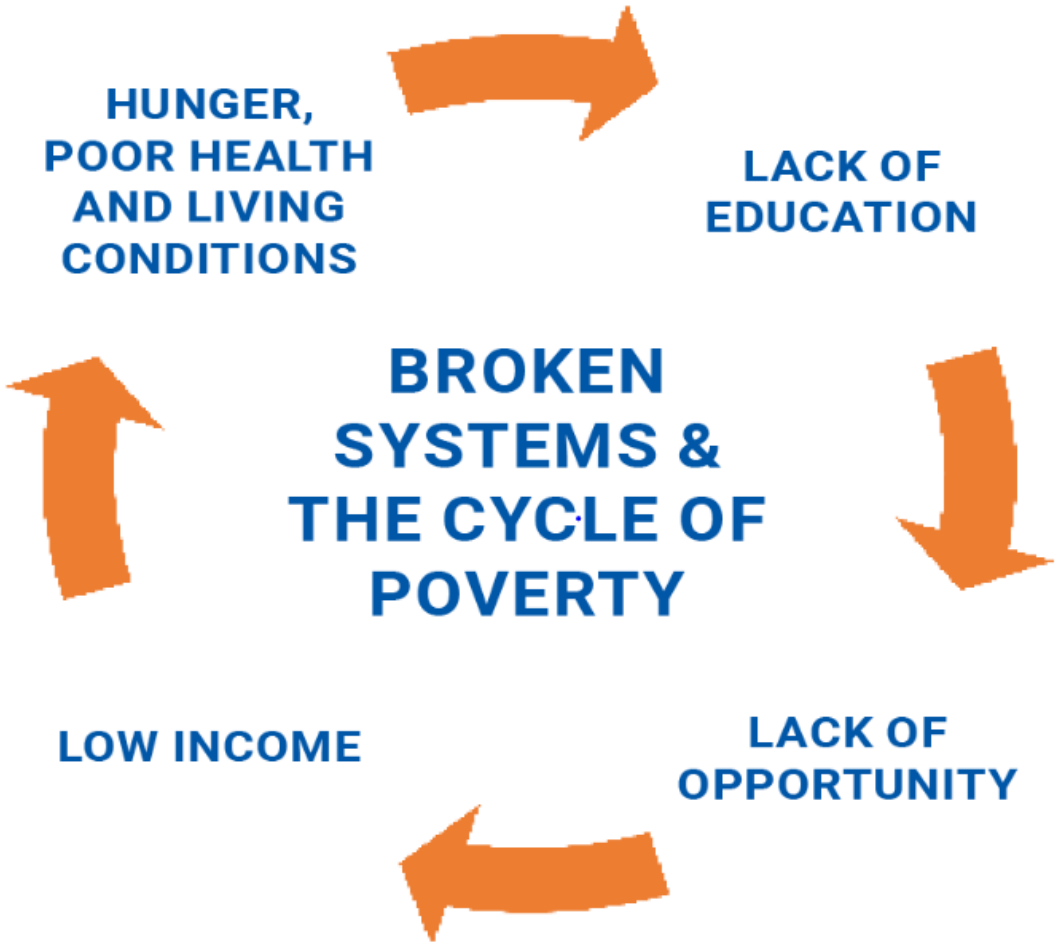
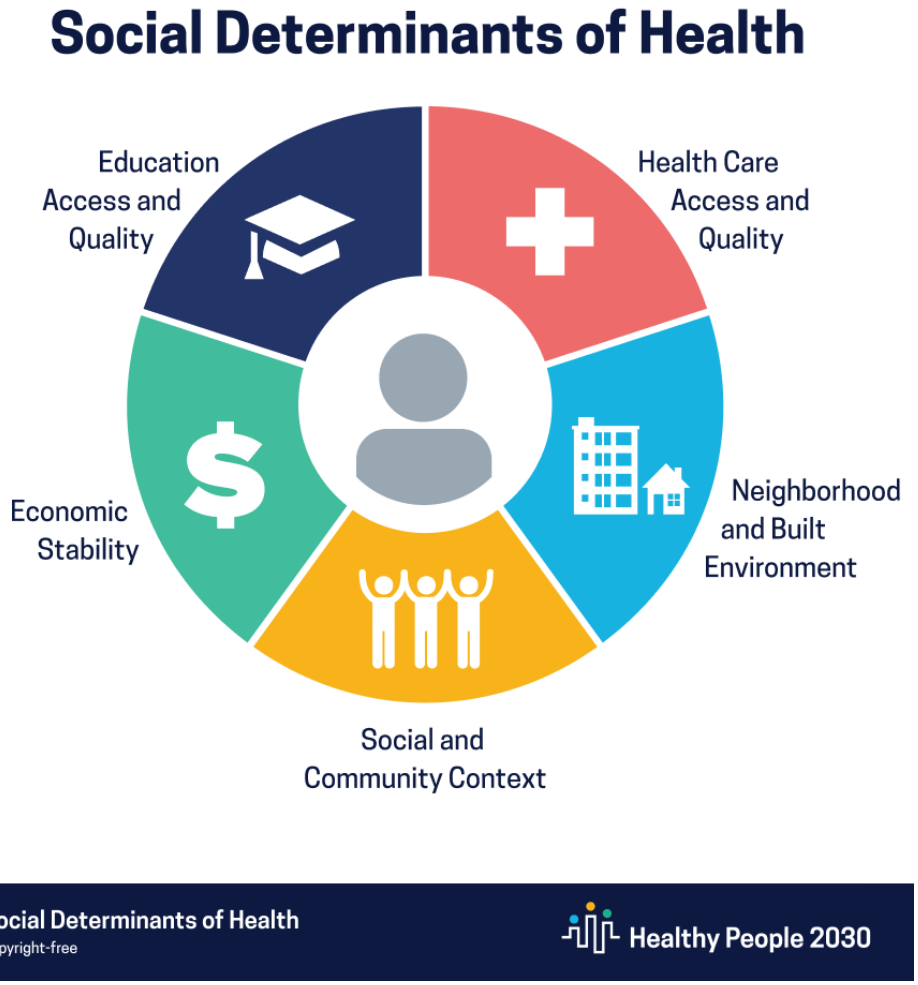
Is Poverty Connected to the SDOH?



Lubbock United Way: https://www.liveunitedlubbock.org/csreconomics



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Healthy People 2030 Objectives Related to Economic Stability/Poverty

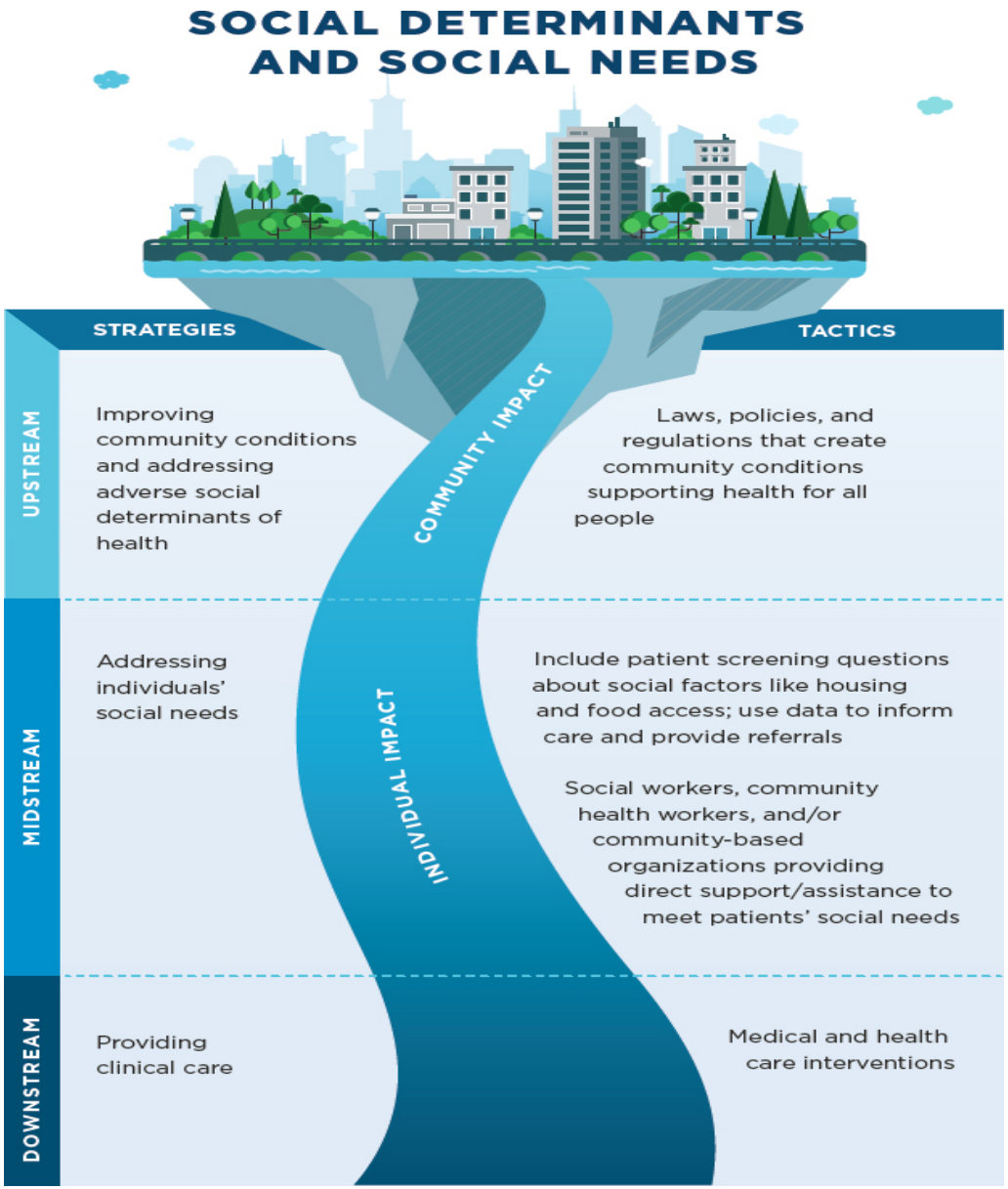
Reduce the proportion of adolescents and young adults who aren't in school or working — AH-09

Reduce the proportion of people living in poverty — SDOH-01

Increase employment in working-age people — SDOH-02

Increase the proportion of children living with at least 1 parent who works full time — SDOH-03

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health



National Academies of Sciences, Engineering, and Medicine. 2021. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25982.

WHAT IS HEALTH IN ALL POLICIES?

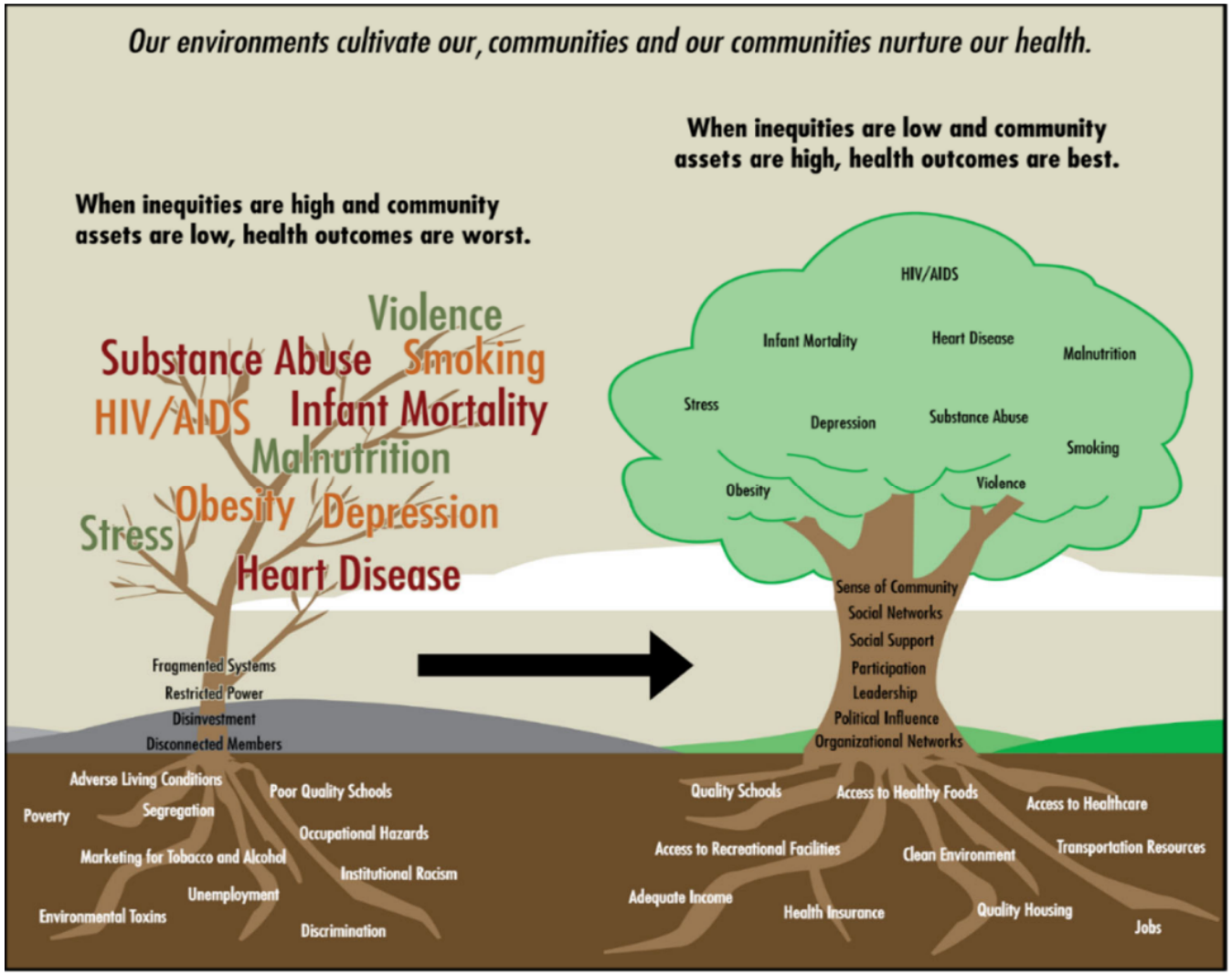
World Health Organization

Good health requires policies that actively support health

It requires different sectors working together, for example:

To ensure all people have equal opportunities to achieve the highest level of health

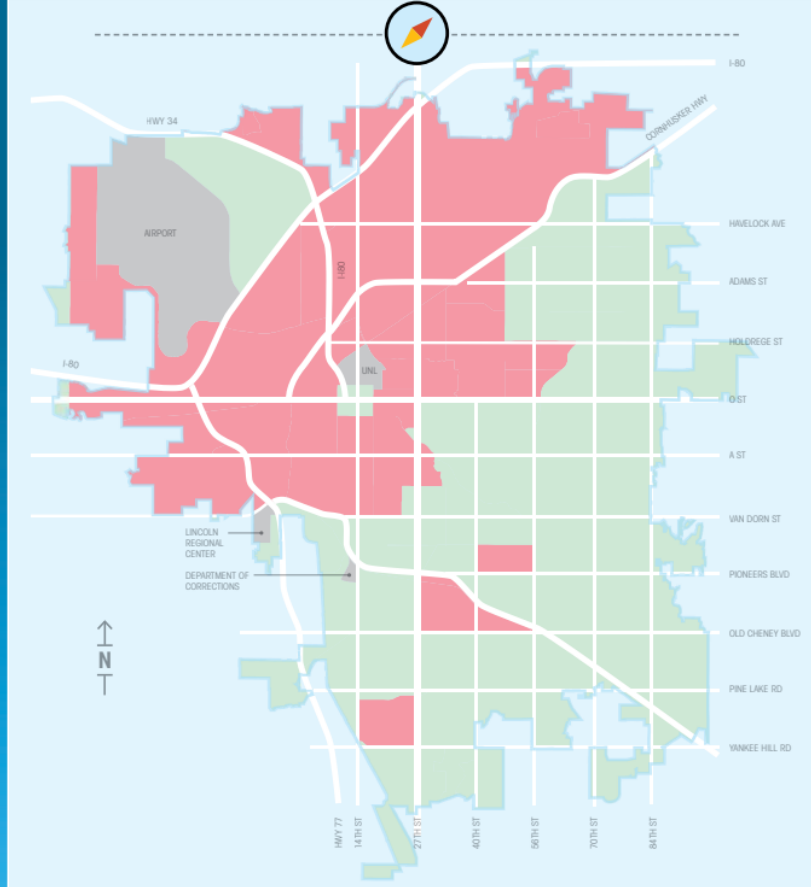
World Health Organization. https://cdn.who.int/media/docs/default-source/infographics-pdf/social-determinants-of-health/who_whatishiap_infographic_web-070220-2910a78a6-7e19-421b-a474-5cd23dea4b68.pdf?sfvrsn=a1ab17d0_1



Promoting Health Equity. A Resource to Help Communities Address the Social Determinants of Health. Retrieved from: https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf

Programs Addressing SDOH

- Nebraska Children and Families Foundation
  - Community Collaboratives, Bring up Nebraska, others initiatives
- Community Heath Endowment of Lincoln
  - zip code and census level data - identify the areas of most meet. Award funding to address needs.
- CDC Programs
  - Built environment and health
  - Childhood lead poisoning, early childcare and education
  - Partnerships to improve community health



Minority Population > 18.4%
Excluded
Current City Limits

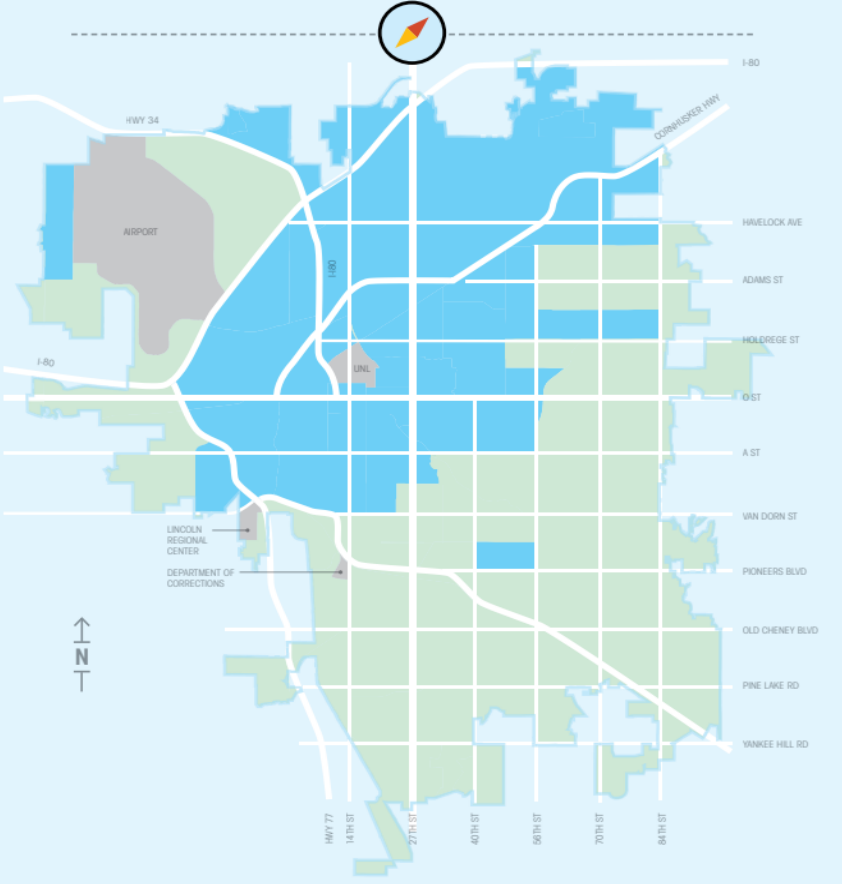
Minority Population* 2018

While the majority of the population identifies as White, Lincoln is becoming an increasingly diverse community. In 2000, the percentage of people who identified as Black, Asian, Native American, Hispanic, or Other was 13.3% of the total population, compared to 18.4% in 2018. This map highlights the census tracts where the percentage of people identifying as a racial minority or Hispanic exceeds the current community average.

** Includes all racial minorities and Hispanic population*

Data Source: U.S. Census Bureau
Map: Lincoln-Lancaster County Health Department (LLCHD)

COMMUNITY HEALTH ENDOWMENT OF LINCOLN IN PARTNERSHIP WITH LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
PLACE MATTERS COMMUNITY MAPPING PROJECT



Poverty > 13.1%
Excluded
Current City Limits

Poverty* 2018

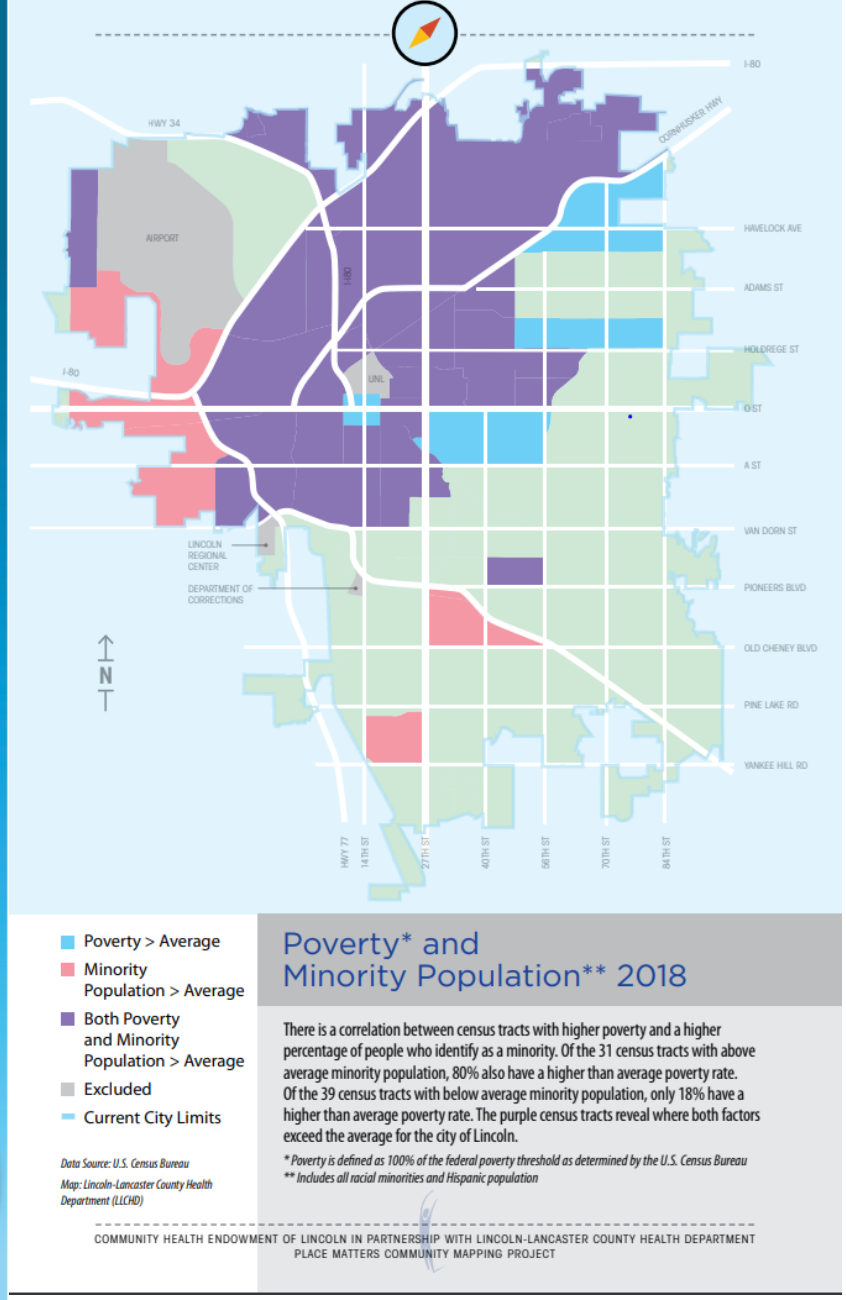
Poverty is often considered the 'cause of causes' and the most powerful predictor of disease and premature death. In 2018, the average poverty rate for the city of Lincoln was 13.1%. This map highlights the census tracts where the percentage of people living in poverty exceeds the community average.

** Poverty is defined as 100% of the federal poverty threshold as determined by the U.S. Census Bureau. In 2018, the poverty threshold for a family with two adults and two children was $25,465.*

Data Source: U.S. Census Bureau
Map: Lincoln-Lancaster County Health Department (LLCHD)

COMMUNITY HEALTH ENDOWMENT OF LINCOLN IN PARTNERSHIP WITH LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
PLACE MATTERS COMMUNITY MAPPING PROJECT

Community Health Endowment of Lincoln. https://www.chelincoln.org/placematters/



- Poverty > Average
- Minority Population > Average
- Both Poverty and Minority Population > Average
- Excluded
- Current City Limits

Data Source: U.S. Census Bureau
Map: Lincoln-Lancaster County Health Department (LLCHD)

Poverty* and Minority Population** 2018

There is a correlation between census tracts with higher poverty and a higher percentage of people who identify as a minority. Of the 31 census tracts with above average minority population, 80% also have a higher than average poverty rate. Of the 39 census tracts with below average minority population, only 18% have a higher than average poverty rate. The purple census tracts reveal where both factors exceed the average for the city of Lincoln.

** Poverty is defined as 100% of the federal poverty threshold as determined by the U.S. Census Bureau*
*** Includes all racial minorities and Hispanic population*

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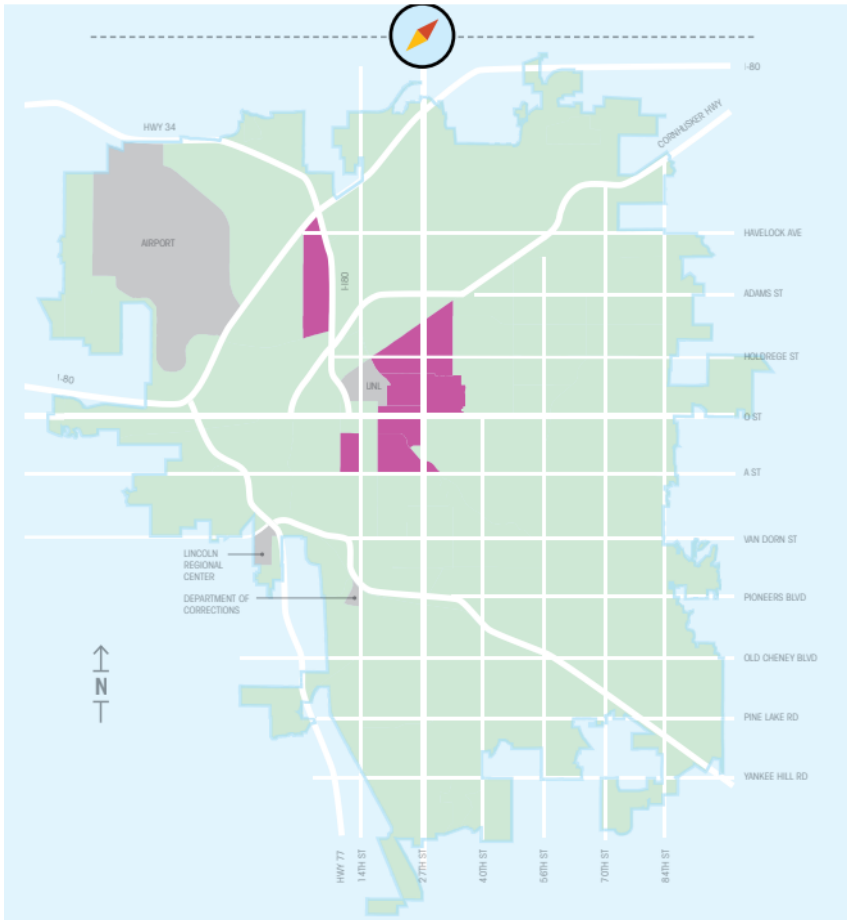
PLACE MATTERS COMMUNITY MAPPING PROJECT



- Poverty > 26.2% and Minority Population > 36.8%
- Excluded
- Current City Limits

Data Source: U.S. Census Bureau
Map: Lincoln-Lancaster County Health Department (LLCHD)

Poverty* and Minority Population** Concentration

The highlighted census tracts indicate where both the percentage of people living in poverty and the percentage of people who identify as a member of a racial or ethnic minority group are more than double their average rates for the city of Lincoln. This map identifies the areas of Lincoln where higher rates of poverty and race/ethnicity are most concentrated.

** Poverty is defined as 100% of the federal poverty threshold as determined by the U.S. Census Bureau*
*** Includes all racial minorities and Hispanic population*

COMMUNITY HEALTH ENDOWMENT OF LINCOLN IN PARTNERSHIP WITH LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
PLACE MATTERS COMMUNITY MAPPING PROJECT

Community Health Endowment of Lincoln. https://www.chelincoln.org/placematters/

Nebraska Programs Working to Advance Health Equity by Addressing SDOH

- More healthcare organizations collecting and using SDOH tools to integrate primary care and community/public health.
- Nebraska Public Health Departments
  - Community Health Workers/Promotoras to address SDOH
- Nebraska MCO contracts include SDOH requirements
- FQCH's work to address SDOH
- Many others …

OneWorld Social Work Program

- Prenatal and social work patients screened with PRAPARE 2.0 assessment tool.
- Provides education, information and resources, to assist in overcoming SDOH barriers.
  - Patients with multiple barriers are case managed so they can continue to work with the social work team as needed.

Patient Stories

- Patient with multiple chronic conditions, and pending disability.

- Provided specialized wheelchair for an 11 year old patient with developmental disabilities.

OneWorld Case Management Program

- Focuses on patients labeled as high risk, most on Medicaid.
- The patients enrolled in the program 30-180 days
- Program criteria:
  - A Behavioral Health Diagnosis/Concerns
  - A Chronic Disease
  - Little/No Support System
  - Frequent Avoidable ER Visits/IP Stays
  - SDOH Gaps
- Case manager
  - Completes assessment of needs (SDOH as well as physical), and works with patient on development of 1-2 SMART Goals
  - Educates on their conditions
  - Be a liaison/navigator for the health care system, and available resources
  - Contacts patient according to need (2-3 x week to 1 x month)
- Patients steadily progresses, decreasing utilization of healthcare and graduates from the program.


THANK YOU
merci
spasiba
kam ouen
gratzias
manana
mahalo
cheers
toda
grassie
thank you
danki
grazie
tak
kitos
hvala
welalin
gracias
mahalo
danki
thanks
takk
gracias
domo arrigato
merci
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thanks
na gode
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