Webinar: The Influence of Social Determinants of Health on Diabetes Health Disparities

February 5, 2020

Virginia Diabetes Prevention Program Annual Networking Meeting
Today's Objectives

9 Describe the social determinants of health (SDOH) and their impact on health and diabetes outcomes;

9 Discuss the role of the Community Health Worker in addressing SDOH;

9 Explain the role of Community Health Workers within health care teams to promote a holistic approach to chronic disease management;

9 Provide examples of Community Health Workers currently addressing SDOH to impact persons with chronic diseases such as diabetes;

9 Describe the social determinants of health (SDOH) and their impact on health and diabetes outcomes;
POLLING STATION
The Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

-World Health Organization (WHO)

http://www.who.int/social_determinants/en/
The Social Determinants Can Be Cyclical
Determinants of Health

Social Determinants of Health:
- Education
- Income
- Work environment
- Housing
- Food
- Social support and capital
- Neighborhood environment

Behavioral Determinants of Health:
- Physical activity
- Eating Habits
- Tobacco
- Sexual practices
- Alcohol and other substances
- Drug use
- Drug use

Individual Determinants of Health:
- Age
- Genetics
- Sex
- Knowledge
- Attitudes
- Beliefs
- Attitudes
- Beliefs

Determinants of Equity:
- Racism
- Xenophobia
- Classism
- Sexism
- Ableism
- Homophobia
- Heterosexism
- AIDS
- Place of residence

Determinants of Health

Source: Virginia Department of Health
Health Inequities

A type of difference in health that is closely linked with social or economic disadvantage.

Physical disabilities differences.

Health inequities negatively affect groups of people who have experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, or geographic location. Other characteristics include socioeconomic status, gender, mental health, sexual orientation, or socioeconomic status differences.}

Health Inequities

U.S. Dept. of Health and Human Services
Health Equity

“Health equity means that everyone 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.”
DETERMINANTS OF POPULATION HEALTH

Physical Environment
- Environmental quality
- Built environment

Socio-Economic Factors
- Education
- Employment
- Income/inequality
- Child poverty
- Family/social support
- Community safety

Health Care
- Access to care
- Quality of care

Health Behaviors
- Tobacco use
- Diet & exercise
- Alcohol use
- Unsafe sex

Source: Authors’ analysis and adaptation from the University of Wisconsin Population Health Institute’s County Health Rankings model ©2010, http://www.countyhealthrankings.org/about-project/background
Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes,
Less than high school (12.6%),
High school (9.5%),
More than high school (7.2%)
To address race disparities in diabetes, policymakers should address problems created by concentrated poverty (e.g., lack of access to reasonably priced fruits and vegetables, recreational facilities, and health care services; high crime rates; and greater exposures to environmental toxins). Housing neighborhoods and development policies in urban areas should avoid creating high-poverty neighborhoods. To address race disparities in diabetes, policymakers should address problems created by concentrated poverty (e.g., lack of access to reasonably priced fruits and vegetables, recreational facilities, and health care services; high crime rates; and greater exposures to environmental toxins).
Community Health Workers: One Strategy for Creating Economic Opportunities & Improving Health
A COMMUNITY HEALTH WORKER IS...

A community health worker is a frontline public health worker who is a trusted member of and/or has unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to a range of activities such as outreach, community education, informal counseling, self-sufficiency through a range of activities such as increasing health knowledge and building individual and community capacity by increasing health knowledge and competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and competence of service delivery, social support and advocacy, and improving the quality and cultural competence of services and the community to facilitate access to professional health services and the community. A community health worker is a trusted member of and/or has unusually close understanding of the community served.

How CHWs Care Teams

Support service agencies and health care organizations.

Within diabetes care, CHWs are a bridge between clinics and...
CHW is a Professional Classification

- Patient/Peer Navigator
- Peer Counselor
- Lay Health Advisor
- Health Coach
- Outreach Advocate
- Outreach Worker
- Peer Advocate
- Peer Leader
- Community Health Advocate
- Community Health Representative
- Community Health Navigators
- Promotora/ Promotora de Salud
- Linkage to Care Coordinators

... And many more
(a) providing culturally appropriate health education and information;
(b) linking people to direct service providers, including informal counseling;
(c) advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity; and

Who are CHWs?

Virginia Definition

Who are CHWs? – Virginia Definition
Scope of practice & Core Competencies for Virginia

- Community Health Concepts and Approaches
- Service Coordination and System Navigation
- Health Promotion and Prevention
- Advocacy, Outreach and Engagement
- Communication
- Cultural Humility and Responsiveness
- Ethical Responsibilities and Professionalism

- Participatory Research
- Community-Based Support
- Care Coordination/Management
- Service System Access and Navigation
- Health Promotion and Coaching
- Community Mobilization and Outreach

Virginia
WHY CHWs?
Social Determinants

- Lack of transportation
- Lack of mental health resources
- Access to healthy foods
- Health literacy
- Secure housing
- Access to specialty care
- Access to primary care
- Reluctant to seek health and social resources due to stress and lower self-confidence
- Lack of mental health resources
- Lack of transportation
CHWs are an essential element of self-management programs and community linkage.

Leaders of self-management programs or serve in a supporting role.

Providing post-program and ongoing support for patients.

Forging linkages and facilitating referrals.

Engagement in community-clinical linkages such as:

Facilitating motivational interviewing to discover patient needs.

Sharing linguistically appropriate health education materials.

Conducting motivational interviewing to discover patient needs.

Following up on referrals to ensure that appointments are kept and patients are receiving provider recommended care.

Forging linkages and facilitating referrals.

Forging linkages and facilitating referrals.

Connecting patients to provide ongoing personal support.

Connecting relationships with social workers.

Forging linkages and facilitating referrals.

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Roles for CHWs in Diabetes Management

- Working with diabetes/healthcare teams to identify and overcome cultural barriers to self-care or behavior change
- Encouraging referrals to certified DSMES and CDC-recognized lifestyle change programs
- Gaining insight into cultural understandings of prediabetes and diabetes and educating community members about these conditions
- Utilizing culturally connected strategies to ensure that individuals understand the information provided by diabetes educators and other healthcare professionals
- Participating in data collection, program evaluation, and continuous quality improvement initiatives
- Utilizing culturally connected strategies to facilitate effective self-management of health
- Providing ongoing support to connect people with prediabetes or diabetes to community resources that address social determinants of health
- Building strong community connections through advisory boards and multi-sector coalitions to inform healthcare providers about community needs, barriers to care, and facilitators for healthy behaviors
- Serving as a bridge between people with diabetes, the diabetes/healthcare team, and the healthcare system
- Collaborating with the diabetes/healthcare team to assist people with prediabetes or diabetes build effective self-care behaviors
- Supporting culturally informed referrals to diabetes/healthcare teams to address lifestyle changes to daily routines around healthy eating, being physically active, managing stress, and other self-care behaviors
- Serving as a bridge between people with diabetes, the diabetes/healthcare team, and the healthcare system
Role of the Community Health Worker

Teaching recipes and showing healthy food options
Daily diabetic logs/food diaries
Facilitate Diabetes Prevention Program
Organize Diabetes Awareness Events
Perform risk screenings
Facilitate community outreach events
Facilitate monthly support groups in PCMHs
Provide administrative support for diabetes educators
Attend office visits with patients
Follow with patients who need extra support, reinforce self management
Building trust to overcome barriers
Leading by example
Serve
Building partnerships and advocating for the clients and community that we
Health Literacy
Recommendations for Diabetes Educators and other Health Professionals

- Recognize how CHWs can transform practice and advance health equity
- Acknowledge the unique skills that CHWs provide
- Support CHWs as valuable members of team-based care while offering DSMES services and lifestyle behavior change programs
- Provide ongoing mentorship, support, and direction to CHWs

Community Health Workers' Role in DSMES and Prediabetes
Recommendations for Diabetes Educators and Other Health Professionals

**Community Health Workers' Role in DSMES and Prediabetes Care Settings**
- Build awareness about the need for opportunities to sustainably finance CHWs in health care.
- Support statewide efforts to integrate CHWs and build the CHW workforce.

**Support CHWs in Their Education, Skill Building, and Professional Development**
- Support CHWs in their education, skill building, and professional development.
- Involve CHWs in AACE trainings, workshops, seminars, and events.

**Support Continuous Research That Explores the Roles, Contributions, and Effectiveness of CHWs**
- Support continued research that explores the roles, contributions, and effectiveness of CHWs.
- Work with CHWs to assess community needs and identify resources to improve self-care.

**DPP Services**
- Invite CHWs to participate in the design, implementation, and evaluation of the DPP services.
Centers for Disease Control and Prevention
Community Health Worker Strategies
Technical Assistance Guide for States Implementing American Association of Diabetes Educators
Community Health Workers Role in DSEM and Prediabetes

Resources
Thank you
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Contact us with questions:

Discussion