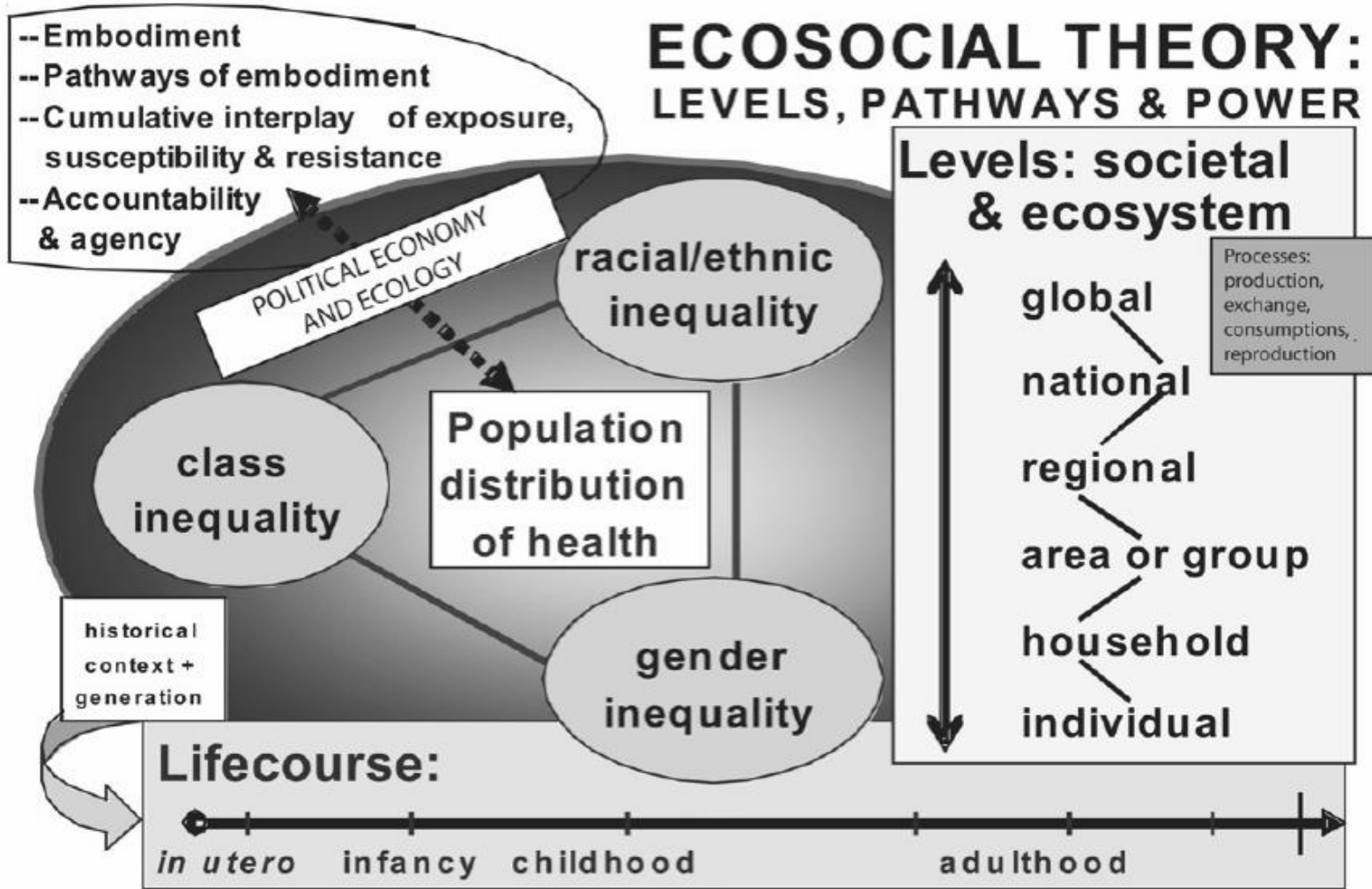# *Addressing Social Determinants of Health*

*Belinda Pettiford*
*Women's Health Branch*
*NC Division of Public Health*

September 23, 2019

# Health is complicated…



Nancy Krieger

Societal Level | Community & Policy Level | Individual & Family Level

Pro-Equity Policies

Affordable Housing
Safe Neighborhoods

Good Paying Jobs
Quality Education

Access to Healthy Foods & Physical Activity

Incarceration  Obesity

Address Structural Racism and Privilege

Healthy Environment

Access to Transportation

Access to Healthcare

Low Birth Weight

Homelessness
Untreated Mental Illness

Health Problems

**Political structures & institutional practices that assure fairness & opportunity for all**

**Social, economic, & physical conditions that allow people to reach their full potential**

**Services for individuals and families to treat problems**

Reference: Healthy People 2020

# Social Determinants of Health

*Social determinants of health are conditions in the environments in which 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. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place."*

# Health equity is more than the absence of health disparities



CREATING HEALTH EQUITY
Inputs may need to be different to achieve equal outcomes

This is Equality    This is Equity
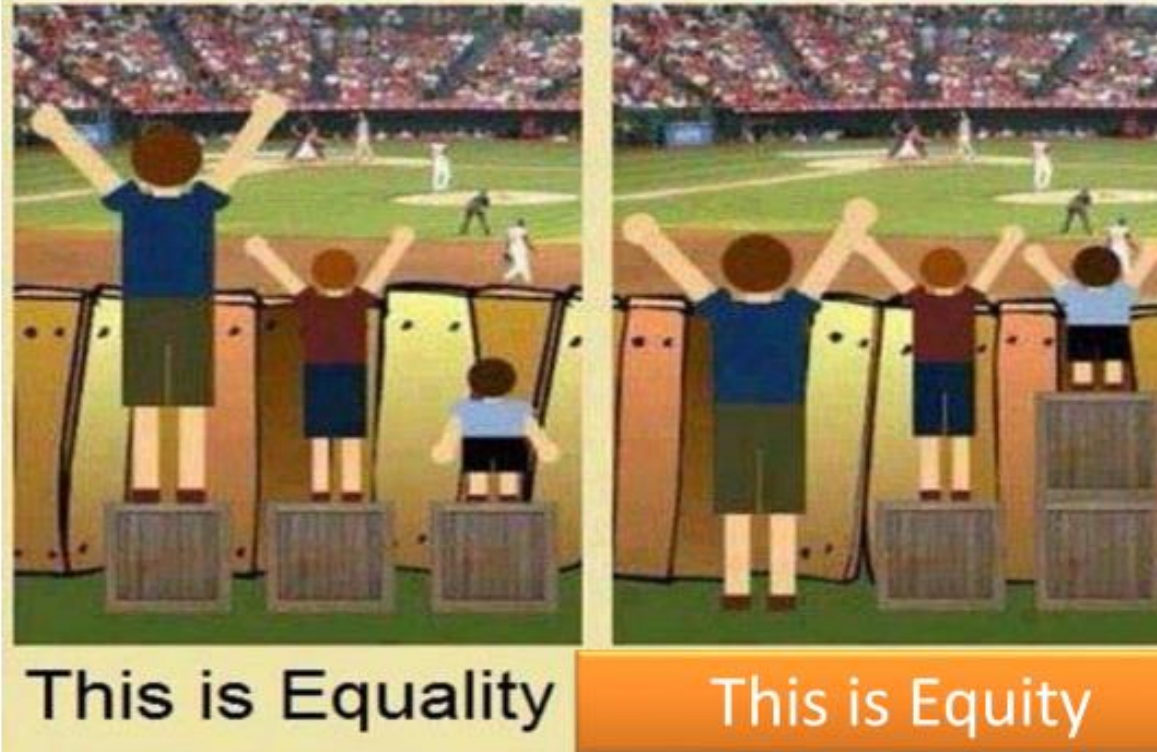
MDCH, Health Equity Learning Labs 2013, provided by Hogan, V., Rowley, D., Berthiaume, R. and Thompson, Y, University of North Carolina at Chapel Hill. Adapted from http://indianfunnypicture.com/search/equality+doesn%27t+mean+justice

## Health equity is every individual having access to the resources and opportunities that promote good health.
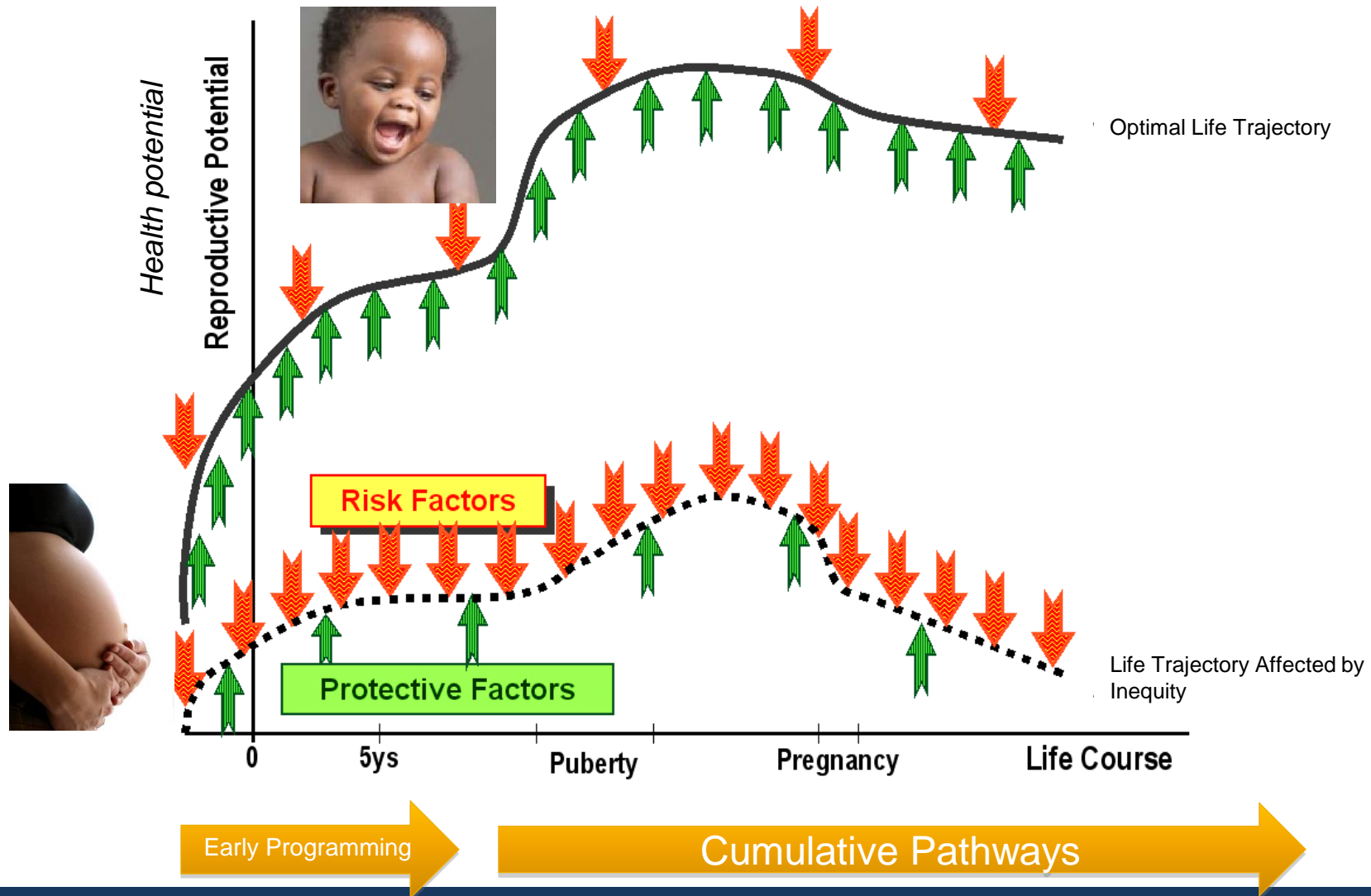
# Health Equity

*The opportunity for everyone to have good health.*
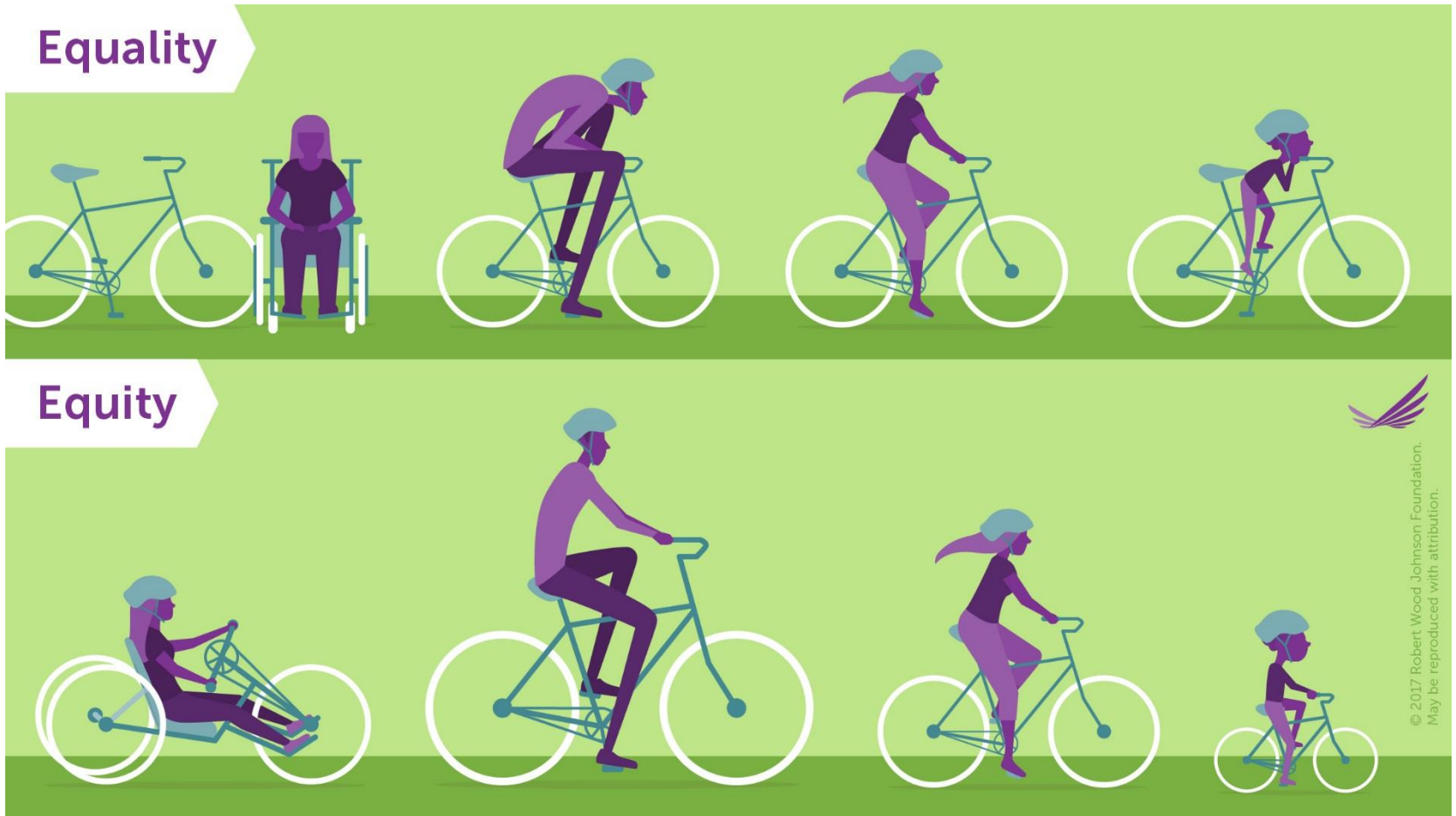


**Reference:** NC Office of Minority Health and Health Disparities North Carolina Equity Report 2018
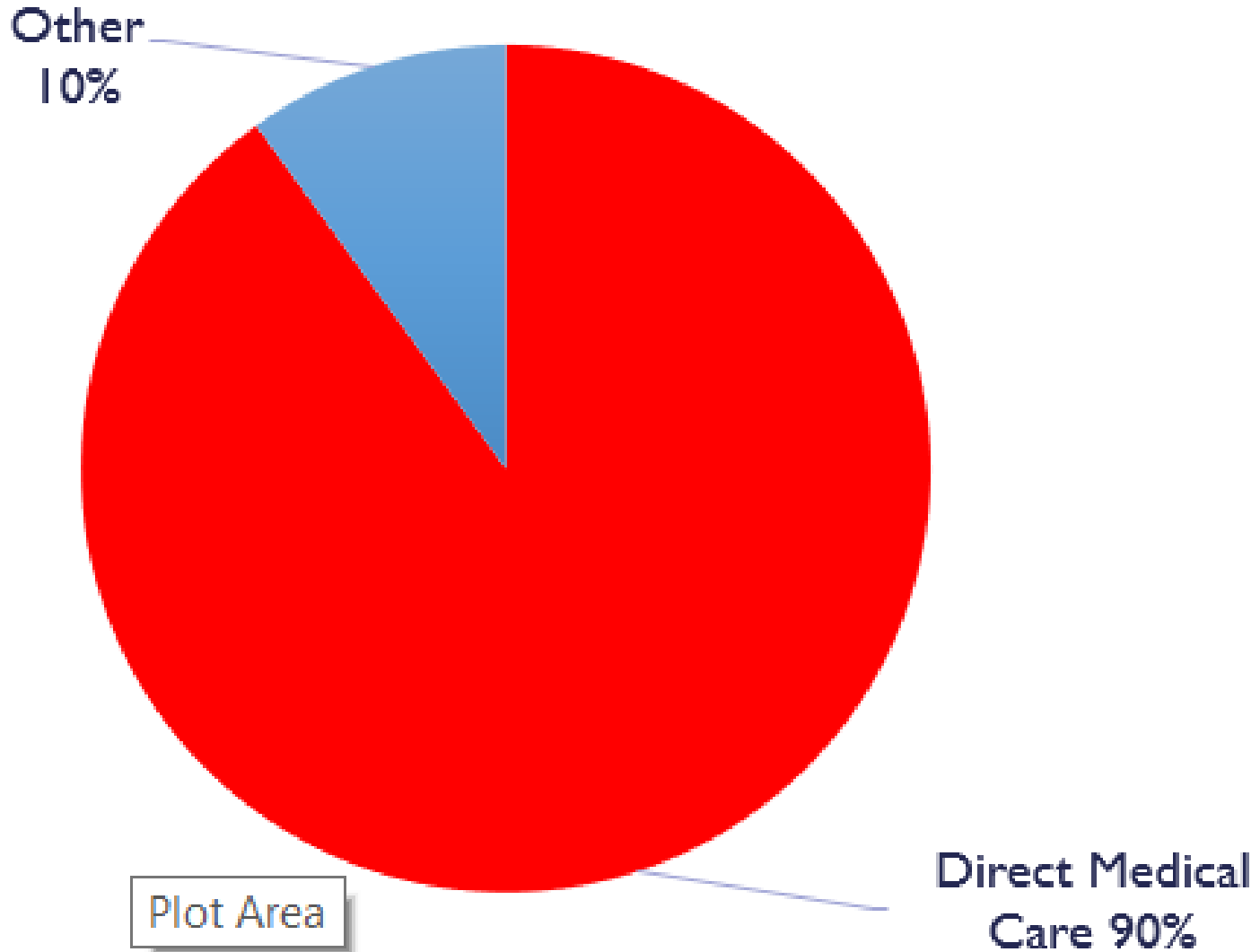
# Life Course Approach



Optimal Life Trajectory

Life Trajectory Affected by Inequity

Health potential

Reproductive Potential

Risk Factors

Protective Factors

0    5ys    Puberty    Pregnancy    Life Course

Early Programming

Cumulative Pathways

# Socio-Ecological Model

Health Care Spending

Other 10%

Direct Medical Care 90%

Plot Area

# Drivers of Health

- Behavioral Patterns 40%
- Health Care 10%
- Environmental Exposures 5%
- Social Circumstance 15%
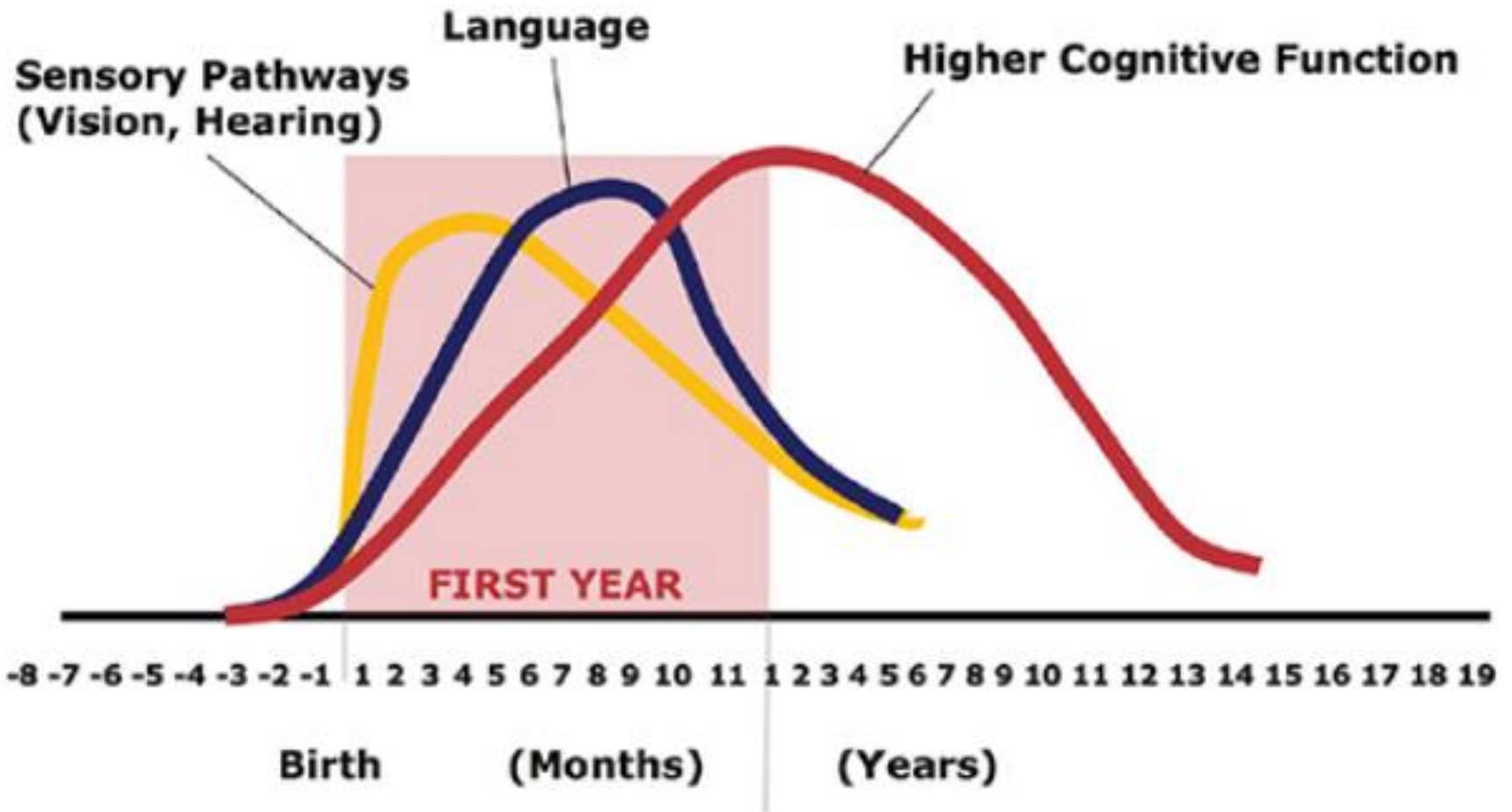- Genetic Predisposition 30%
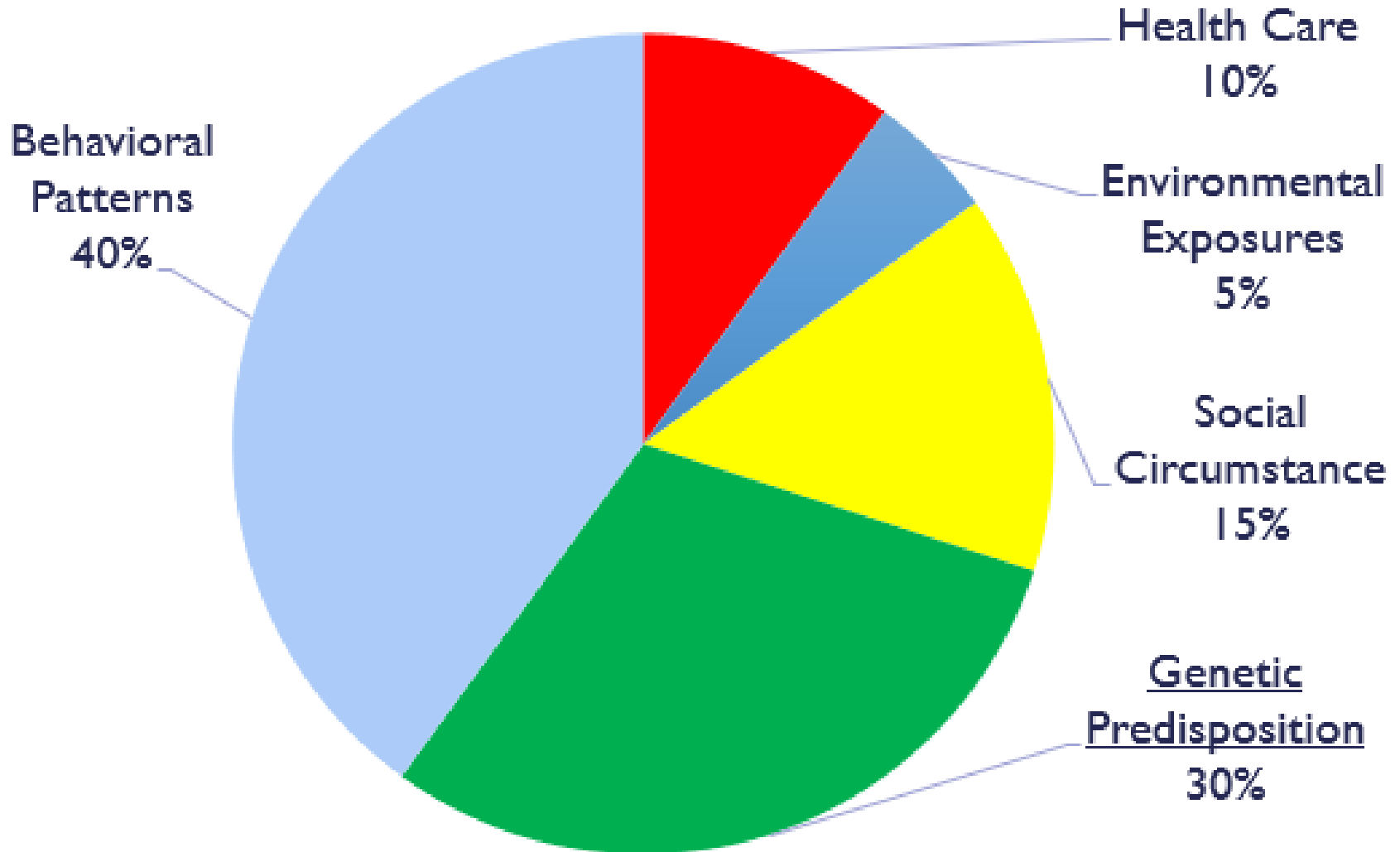
# Early Brain and Child Development

# Human Brain Development
## Neural Connections for Different Functions Develop Sequentially

Language

Sensory Pathways
(Vision, Hearing)

Higher Cognitive Function

FIRST YEAR

-8 -7 -6 -5 -4 -3 -2 -1 1 2 3 4 5 6 7 8 9 10 11 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19

Birth          (Months)          (Years)

# Humans do not develop in isolation

# Early Childhood is a Time of Rapid Brain Growth



1 week    3 months    1 year    2 years    10 years
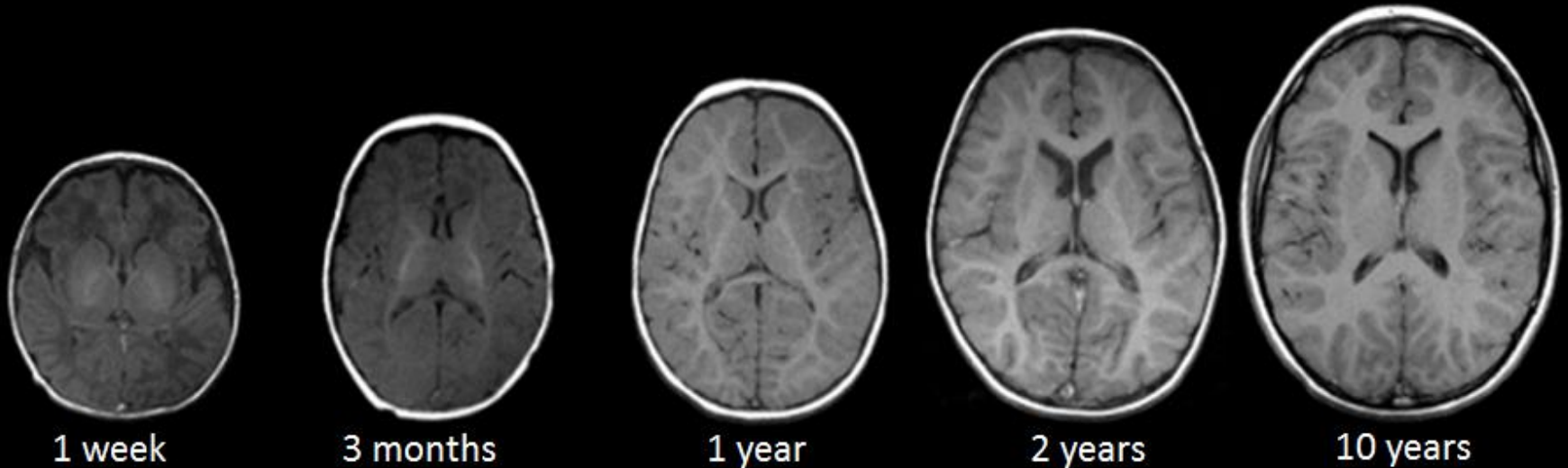
MRI scans of human brain development

T1W

# Levels of Stress

**POSITIVE** — Brief increases in heart rate, mild elevations in stress hormone levels.

**TOLERABLE** — Serious, temporary stress responses, buffered by supportive relationships.

**TOXIC** — Prolonged activation of stress response systems in the absence of protective relationships.

Center on the Developing Child, Harvard University
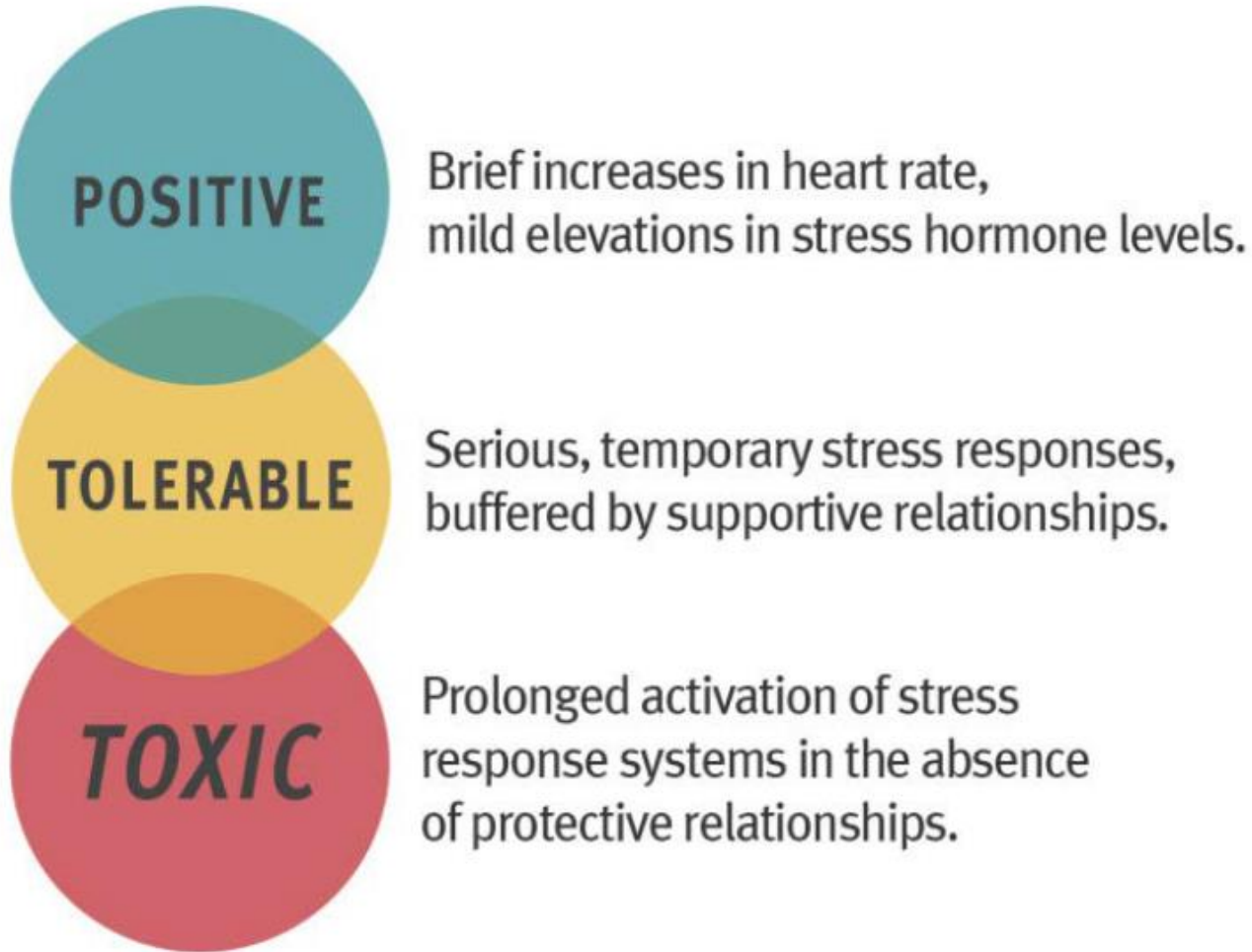
# Lifespan Impacts of ACEs



Critical & Sensitive Developmental Periods

Adverse Childhood Experience
MORE CATEGORIES – GREATER IMPACT
Physical Abuse, Sexual Abuse
Emotional Abuse, Neglect
Witnessing Domestic Violence
Depression/Mental Illness in Home
Incarcerated Family Member
Substance Abuse in Home
Loss of a Parent

Genetics
Experience triggers gene expression (Epigenetics)

Brain Development
Electrical, Chemical, Cellular Mass

Adaptation
Hard-Wired Into Biology

Chronic Disease

Psychiatric Disorders

Impaired Cognition

Work/School
Attendance, Behavior, Performance

Obesity

Alcohol, Tobacco, Drugs

Risky Sex

Crime

Poverty

Intergenerational Transmission, Disparity
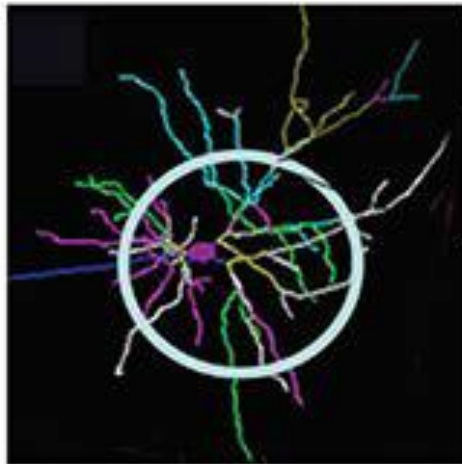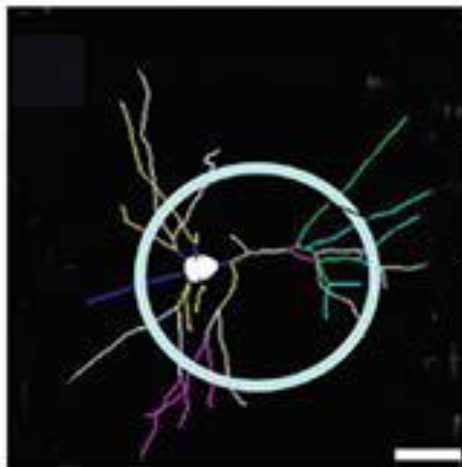
# Persistent Stress Changes Brain Architecture



Normal
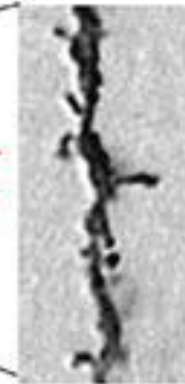
Typical neuron—
many connections

Toxic stress

Damaged neuron—
fewer connections

Prefrontal Cortex and Hippocampus

Center on the Developing Child, Harvard University

# Toxic Stress in Early Childhood



3 Year Old Children

Normal          Extreme Neglect
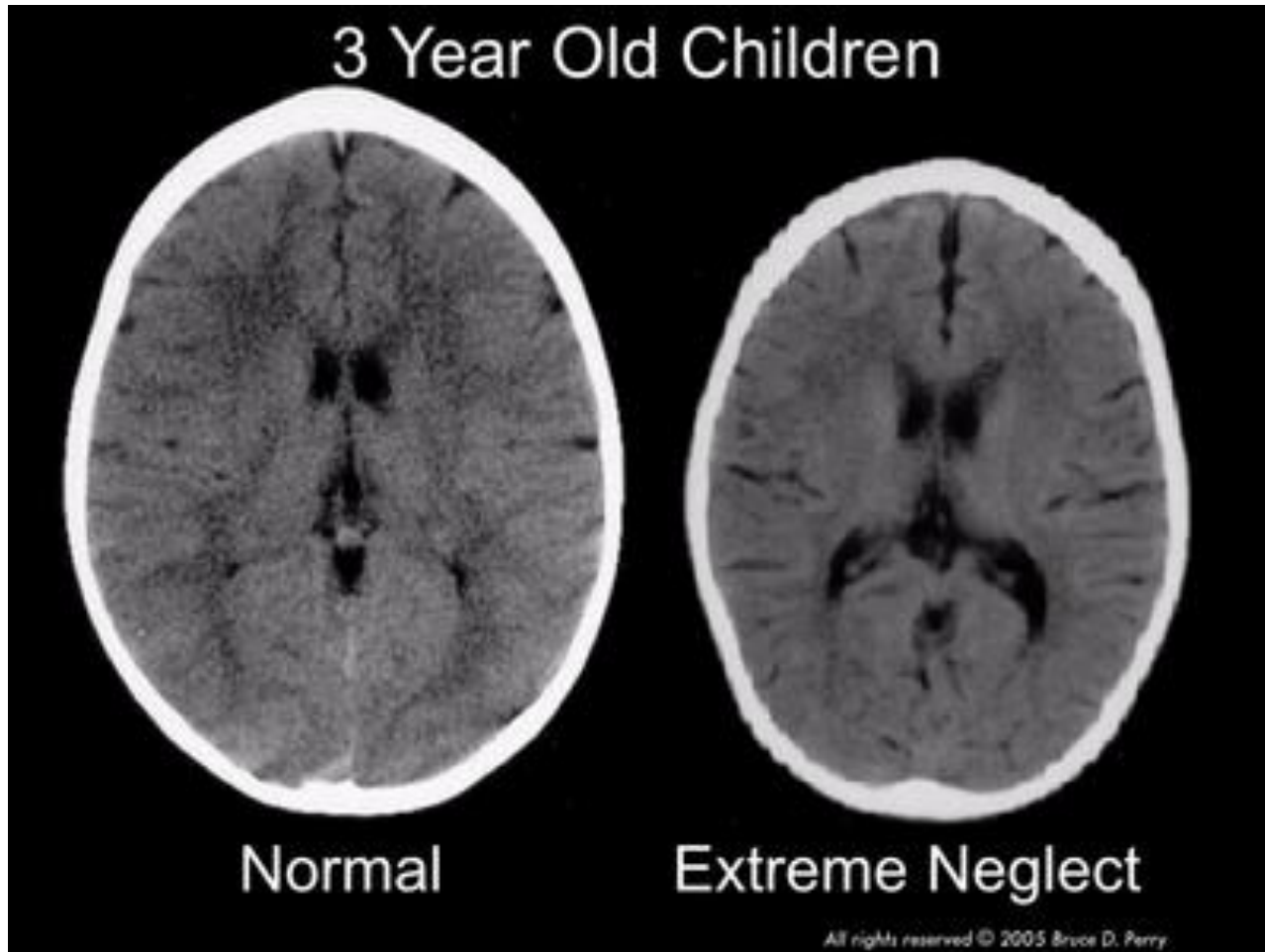
# Threats to Healthy Brain Development

- Lack of Stimulation/Neglect

- Poverty

- Poor nutrition (e.g. iron deficiency anemia)

- Unstable Housing

- Environmental Toxins (e.g Lead)

- Adverse Childhood Experiences/Toxic Stress

# Interpersonal Trauma/Adverse Childhood Events - ACEs

**Research Article**

## Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

### The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

**Collaborative effort between Kaiser Permanente and Centers for Disease Control and Prevention**

# Adverse Childhood Experiences (ACEs)

Traumatic or stressful live events experienced before age 18

**Childhood abuse**

- **Physical abuse**
- **Sexual abuse**
- **Emotional abuse**

**Household dysfunction**

- **Household member who was depressed, mentally ill, or suicidal**
- **Alcohol or drug abuse in household**
- **Incarcerated household member**
- **Violence between adults in the household**
- **Parental divorce or separation**

# Trauma/ ACEs increase risk of behavioral, physical and mental health issues
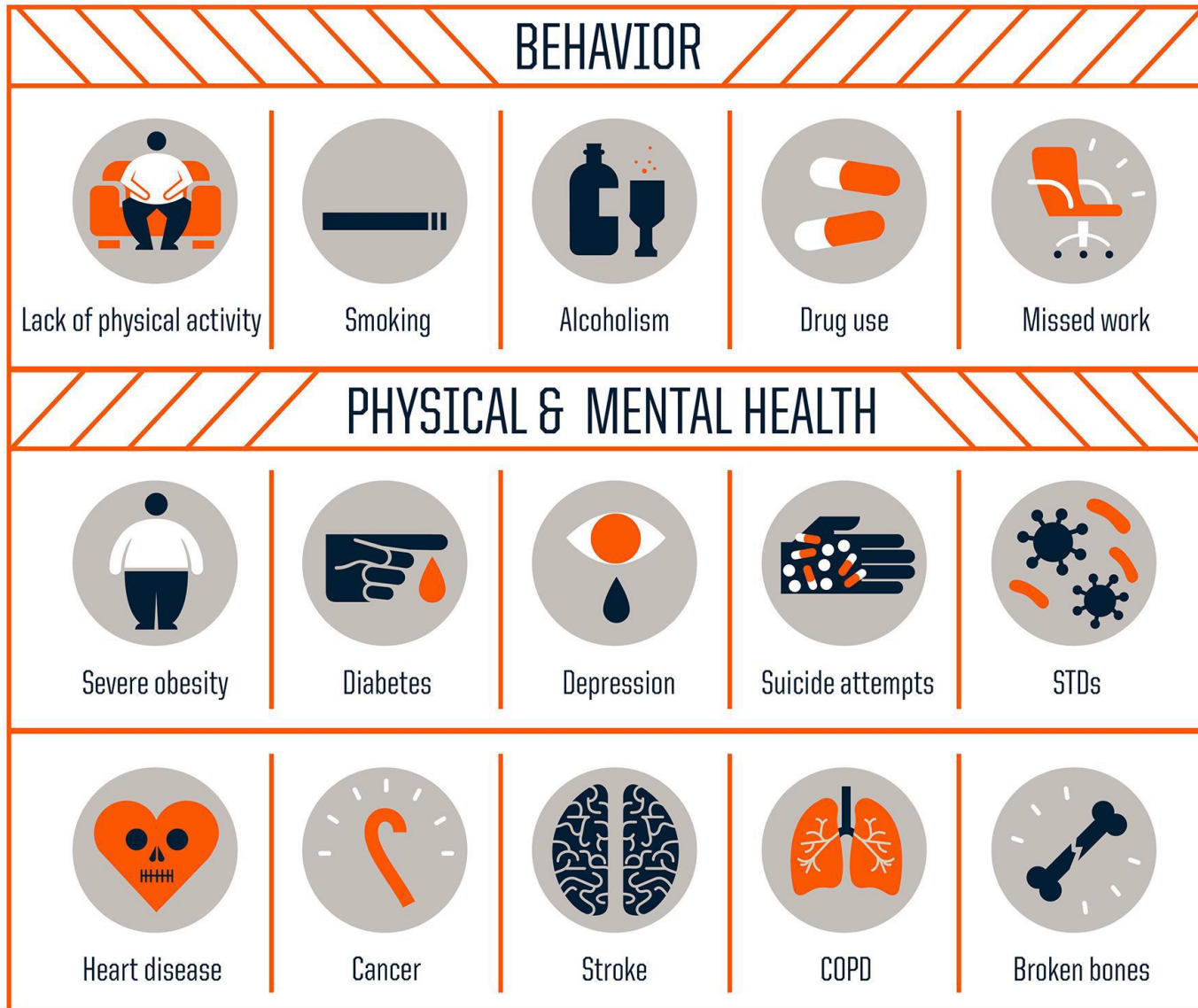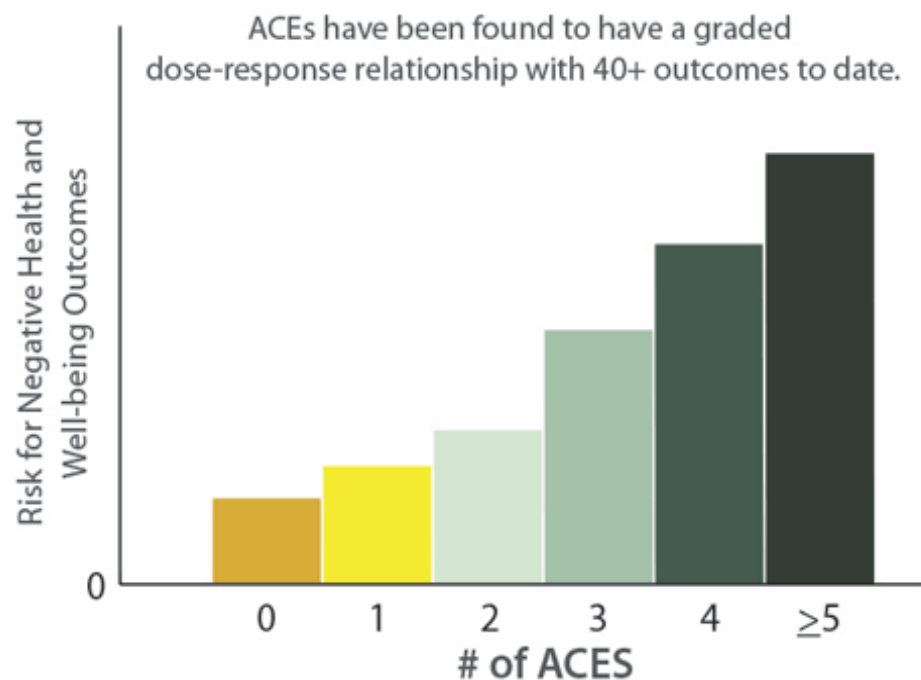
# ACES can have lasting effects on….

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)

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

Risk for Negative Health and Well-being Outcomes

# of ACES

0    1    2    3    4    ≥5

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

# The Pair of ACEs

## Adverse Childhood Experiences

Maternal Depression

Emotional & Sexual Abuse

Substance Abuse

Physical & Emotional Neglect

Divorce

Mental Illness

Incarceration

Domestic Violence

Homelessness

## Adverse Community Environments

Poverty

Discrimination

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

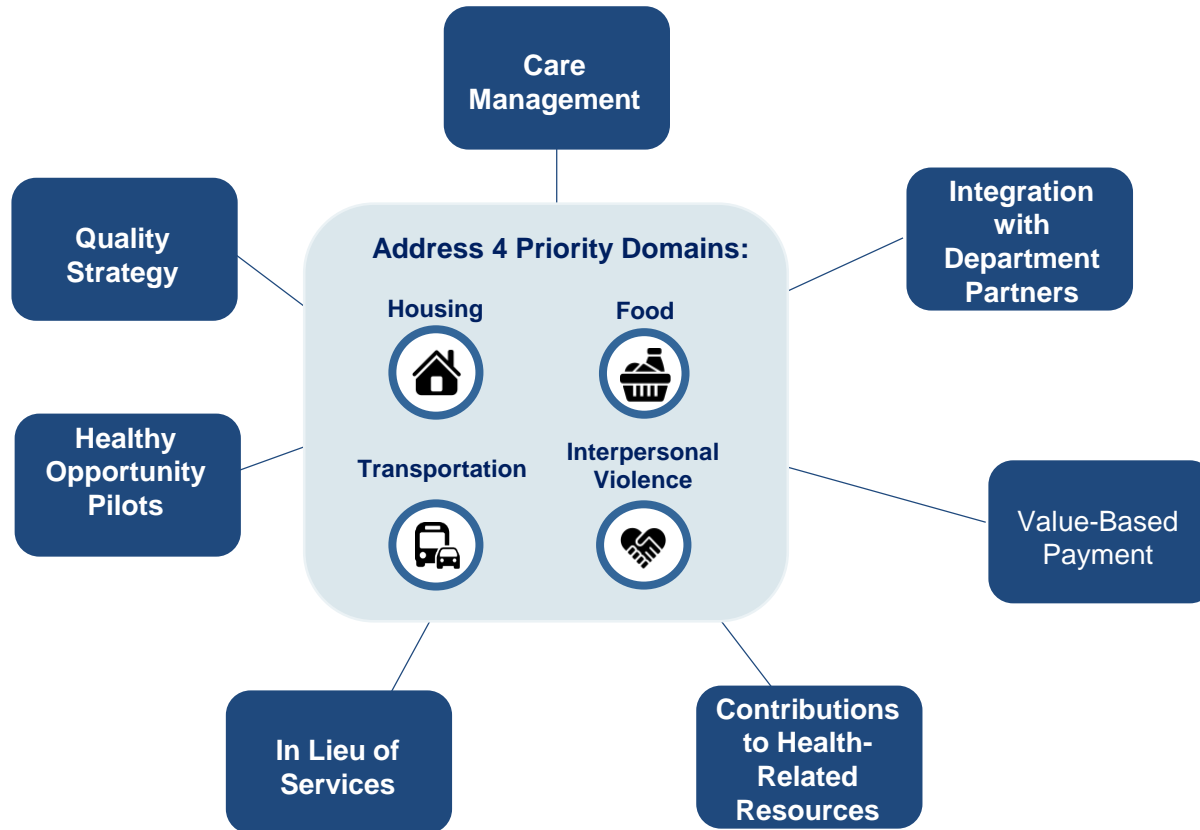Poor Housing Quality & Affordability

Violence

Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

## North Carolina's Vision for Medicaid Managed Care

**"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health."**

# Requirements



**Care Management**

**Integration with Department Partners**

**Quality Strategy**

**Address 4 Priority Domains:**

Housing

Food

Transportation

Interpersonal Violence

**Healthy Opportunity Pilots**

Value-Based Payment

**In Lieu of Services**

**Contributions to Health-Related Resources**

# Screening Questions

- Developed by Technical Advisory Group
- Drew from validated and commonly used tools (e.g PRAPARE, Accountable Health Community)
- Routine identification of unmet health-related resource needs
- Statewide collection of data
- Implementation
  - Public Review
  - Fall 2018 Pilot testing in 18 clinical sites and telephonically (n=804)
  - Ready Providers/Systems adopting
  - Encouraging everyone to use for all populations
  - Launch of Managed Care
    - PHPs Required to Include in initial Care Needs Screening

### Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

| | Yes | No |
|---|---|---|
| **Food** | | |
| 1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? | | |
| 2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more? | | |
| **Housing/ Utilities** | | |
| 3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)? | | |
| 4. Are you worried about losing your housing? | | |
| 5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? | | |
| **Transportation** | | |
| 6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? | | |
| **Interpersonal Safety** | | |
| 7. Do you feel physically or emotionally unsafe where you currently live? | | |
| 8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone? | | |
| 9. Within the past 12 months, have you been humiliated or emotionally abused by anyone? | | |
| **Optional: Immediate Need** | | |
| 10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today. | | |
| 11. Would you like help with any of the needs that you have identified? | | |

# What is NCCARE360?

**NCCARE360** is the first statewide coordinated network that includes a robust repository of shared resources and a shared technology platform to connect healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

**NCCARE360 Partners:**

# Infrastructure and Elements across all populations

| | |
|---|---|
| **Hot Spot Map** | • GIS map of social determinants of health indicators at census tract level |
| **Screening** | • Statewide Standardized Screening Questions |
| **NCCARE360** | • Statewide coordinated network with shared technology platform |
| **Workforce Development** | • Community Health Workers, Permanent Supportive Housing |
| **Aligning Enrollment** | • Coordinating enrollment across programs e.g., Medicaid, WIC, SNAP |

# Healthy Opportunities

- **All North Carolinians should have the opportunity for health**

- **Access to high-quality medical care is critical to a person's health, but up to 80% of a person's health is determined through social and environmental factors and the behaviors that are influenced by them**

- **NC DHHS is focusing on improving the health and well-being for all North Carolinians by tackling the foundational drivers of health**
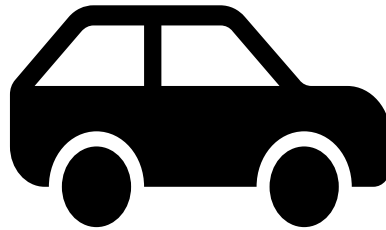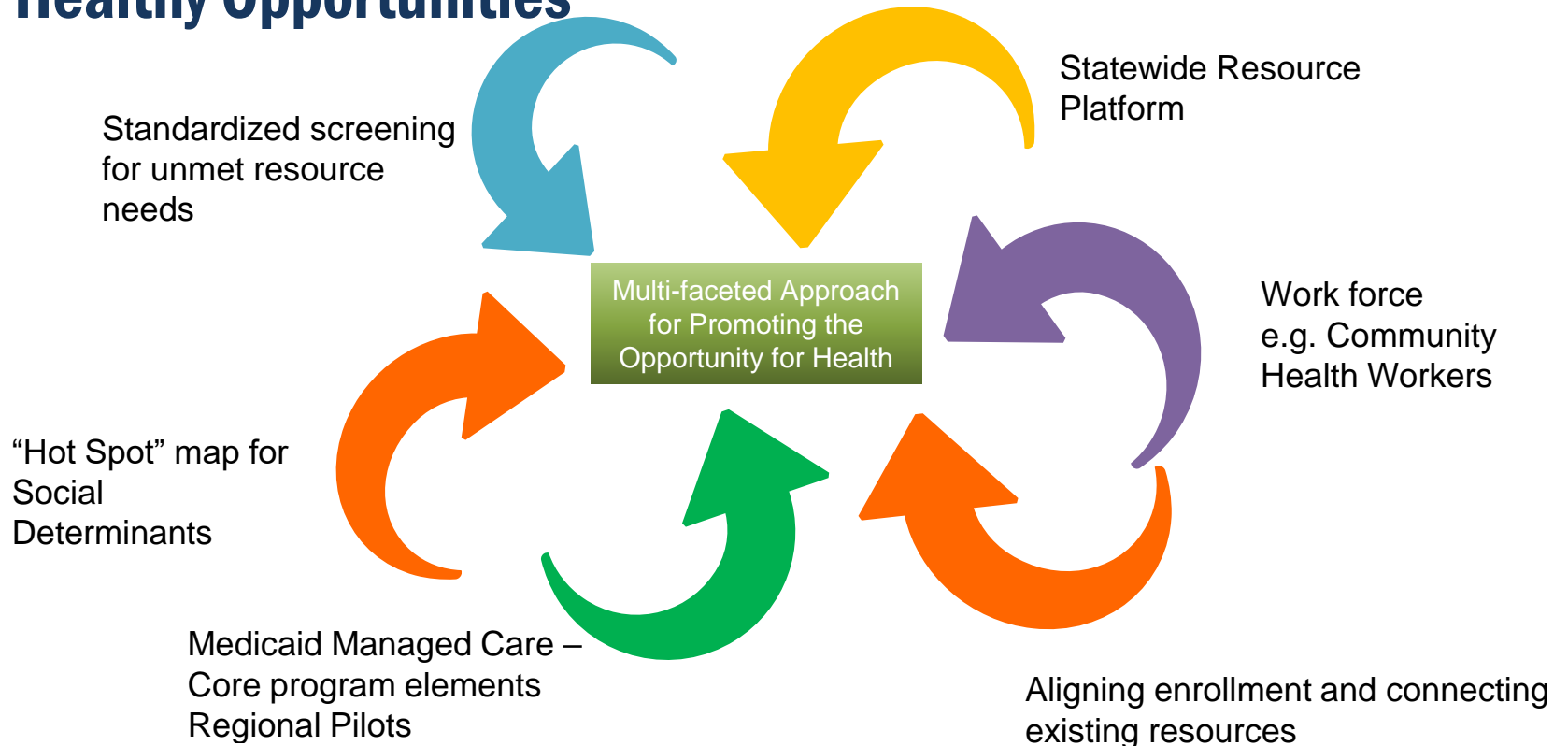
# Priority Domains
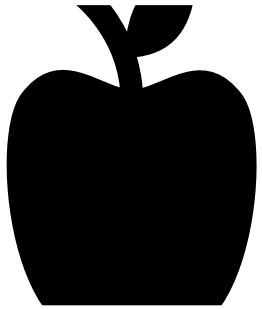
Food Security

Housing Stability

Trans-portation

Inter-personal Violence

# Creating the Statewide Framework and Infrastructure for Healthy Opportunities

Standardized screening for unmet resource needs

Statewide Resource Platform

Multi-faceted Approach for Promoting the Opportunity for Health

Work force e.g. Community Health Workers

"Hot Spot" map for Social Determinants

Medicaid Managed Care – Core program elements Regional Pilots

Aligning enrollment and connecting existing resources

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

# "Hot Spot" Map

- Statewide map now live: http://www.schs.state.nc.us/data/hsa/
- GIS/ESRI Story mapping of 14 SDOH indicators with a summary statistic
- Displays geographical health & economic disparities

| Social and Neighborhood | Economic | Housing and Transportation |
|---|---|---|
| % < HS Diploma | Household Income | % Living in Rental Housing |
| % Households with Limited English | % Poverty | % Paying >30% of Income on Rent |
| % Single Parent Households | Concentrated Poverty | % Crowded Household |
| Low Access to Healthy Foods | % Unemployed | % Households without a Vehicle |
| Food Deserts | % Uninsured | |

**Early Childhood Action Plan**

# GUIDING PRINCIPLES

- **Brain and developmental science** serve as the foundation for the Action Plan

- **Children and families** are at the center of our work

- Builds upon and expands **existing strengths and partnerships**

- Goals are **ambitious and achievable**

- Focus is on **all** of North Carolina's children reaching their full potential, intentional about **eliminating disparities**

- Reflects the values of **transparency, good stewardship, and accountability**

# North Carolina Early Childhood Action Plan - Vision

All North Carolina children get a healthy start and develop to their full potential in safe and nurturing families, schools and communities.
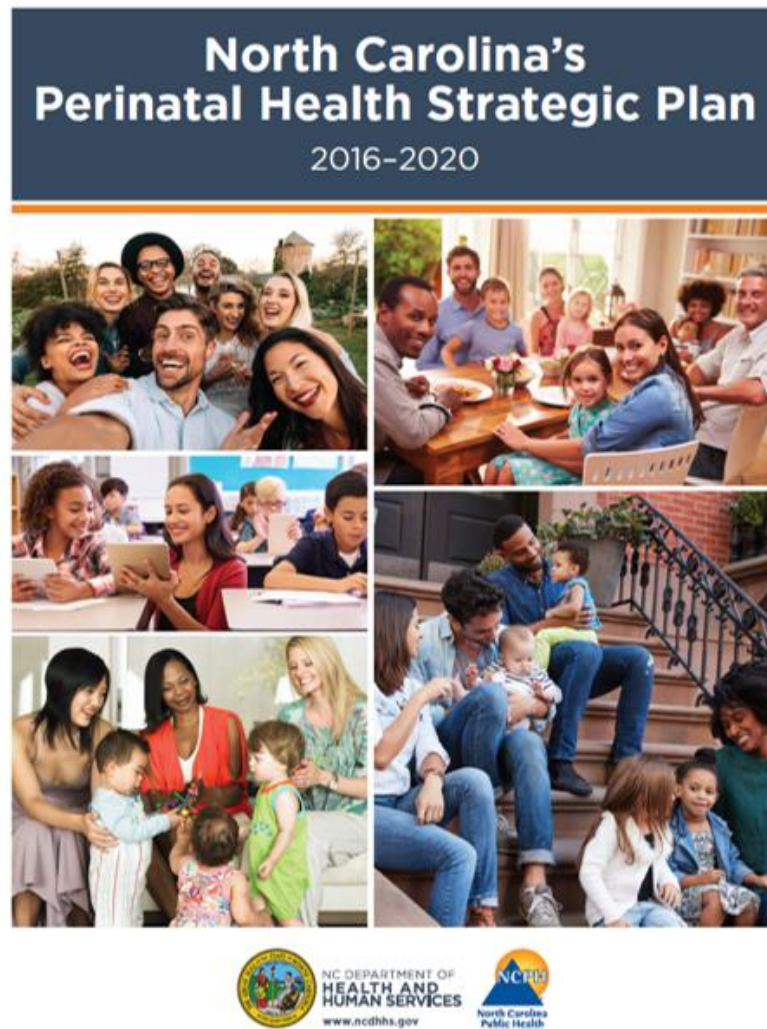
1) **Healthy and Safe:** Children are healthy at birth and thrive in safe environments that support their optimal health and well-being

2) **Nurtured**: Children grow confident, resilient and independent in stable and nurturing families, schools and communities

3) **Learning and Ready to Succeed:** Children experience the conditions they need to build strong brain architecture and school readiness skills that support their success in school and life

# Early Childhood Action Plan

# The Perinatal Health Strategic Plan

- **Framework is based on the "12-Point Plan to Close the Black-White Gap in Birth Outcomes: A Life-Course Approach" developed by Lu, Kotelchuck, Hogan, Jones, Wright, and Haflon**

- **Broader focus encompassing infant mortality, maternal morbidity and mortality; and the health of women and men of childbearing age**

- **Data driven and focused on the best evidence available**

- **Infused throughout with issues of health equity and social determinants of health**



North Carolina's Perinatal Health Strategic Plan 2016-2020

# North Carolina's Perinatal Health Strategic Plan
## 2016–2020

The North Carolina Perinatal Health Strategic Plan (PHSP) addresses infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age.

The PHSP framework was adapted from the "Closing the Black-White Gap in Birth Outcomes: A Life-Course Approach" (2010) by Drs. Michael Lu, Milton Kotelchuck, Vijaya Hogan et al to "reduce Black-White disparities in birth outcomes using a life-course approach" (Lu, et al 2010) which "conceptualizes birth outcomes as the end product of not only the nine months of pregnancy but the entire life course of the mother before the pregnancy" (2010). The PHSP supports the Healthy People 2020 Approach to Social Determinants of Health (SDOH), reflecting five key areas of SDOH (Figure 1).

The 12-point plan is divided into three goals, comprised of four points per goal. In 2017, the PHSP Team voted on priority strategies noted by an asterisk (*).



Figure 1 Healthy People 2020 Approach to Social Determinants of Health

| Goal I. Improving Health Care for Women and Men | Goal II. Strengthening Families and Communities | Goal III. Addressing Social and Economic Inequities |
|---|---|---|
| • Provide interconception care to women with prior adverse pregnancy outcomes* <br> • Increase access to preconception care* <br> • Improve the quality of prenatal care* <br> • Expand healthcare access over the life course | • Strengthen father involvement in families <br> • Enhance coordination and integration of family support services <br> • Support coordination and cooperation to promote reproductive health within communities* <br> • Invest in community building and urban renewal | • Close the education gap* <br> • Reduce poverty among families <br> • Support working mothers and families <br> • Undo racism* |

The PHSP team meets every two months. The four PHSP work groups (Community and Consumer Engagement, Data and Evaluation, Communications, and Policy) meet more often. The PHSP strives to find alignment and collaboration opportunities with other initiatives occurring in the state. This includes connecting with consumer, community, and organizational partners to share and evaluate the plan. By eliminating inequities, we will improve the overall well-being of our state's individuals and communities.

*For more information on the Perinatal Health Strategic Plan or to join the planning team, contact: Jasmine Getrouw-Moore, MPA Perinatal Health Strategic Plan Program Consultant • 919-707-5682 • PHSPquestions@dhhs.nc.gov*

# A Call to Action: Data Demonstrating Inequities in North Carolina



**1 in 5 children** live in households that lack consistent access to adequate food (2015)

*Source: Feeding America. 2018 Child Food Insecurity Module (2016 data).*

**45% of renters** are cost burdened by spending more than 30% of their income on rent (2016)

*Source: Joint Center for Housing Studies of Harvard University tabulations of US Census Bureau, 2016 American Community Survey 1-Year Estimates.*

4th grade Black and Hispanic public school students are **less likely** to score proficient in reading (2017)

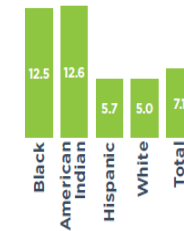| | |
|---|---|
| Asian | 54% |
| White | 52% |
| Black | 22% |
| Hispanic | 22% |
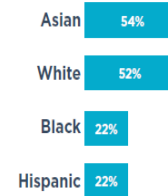
*Source: 2017 Reading State Snapshot Report. North Carolina. Grade 4. Public Schools.*

Black infants are **2.5 times** as likely to die than white infants (2017)

### NC Infant Mortality Rates per 1,000 live births

| Black | American Indian | Hispanic | White | Total |
|---|---|---|---|---|
| 12.5 | 12.6 | 5.7 | 5.0 | 7.1 |

*Source: NC State Center for Health Statistics, 2017 Infant Mortality Report, Table 3.*

Youth of color are **more than 2.5 times** as likely as white youth to have complaints filed against them by law enforcement or other citizens (FY 2015-16)

*Source: NC Department of Public Safety Juvenile Justice 2016 Annual Report.*

**NC Department of Health and Human Services • Division of Public Health • Women's Health Branch**
whb.ncpublichealth.com • NCDHHS is an equal opportunity employer and provider.
200 copies were printed at a cost of $103.31 or $0.516564 each. • 3/2019

# Goals and Points

## North Carolina's Perinatal Health Strategic Plan
### 2016–2020

The North Carolina Perinatal Health Strategic Plan (PHSP) addresses infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age.

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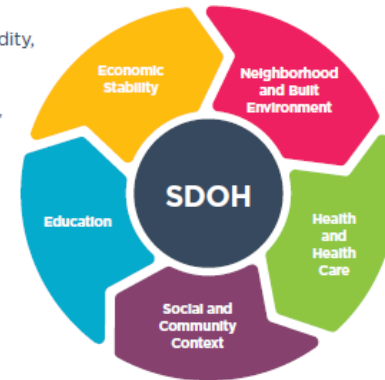
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# Goal 1 – Improve Health Care for Women and Men

| |
|---|
| **Point 1. Provide interconception care to women with prior adverse pregnancy outcomes** |
| 1A. Support healthy pregnancy intervals through access to **effective methods of contraception**, including increased access to **Long-Acting Reversible Contraception (LARC).** |
| 1B. Provide **care coordination/case management/home visiting services** that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management and access to health care. |
| 1C. Assure women are **transitioned from different points of care** and have access to postpartum/primary/well woman care including access to ongoing health insurance coverage and a medical home. |
| 1D. Provide **outreach to all providers who care for children** (pediatric and family practice clinics, community settings, etc.) to ensure women are receiving interconception care services. |
| 1E. Increase **quality and frequency of risk assessment** at the postpartum clinic visit. |

# Goal 1 – Improve Health Care for Women and Men

**Point 2.  Increase access to preconception health and health care to women and men**

2A. Expand the college-based **Preconception Peer Education (PPE) Program** to reach additional women and men in colleges, universities, graduate schools, community colleges and adult learning programs.

2B. Integrate **preconception health care and messages** into primary care for women of reproductive age.

2C. Integrate the use of **evidence-based curriculum with adolescent and young adult population** in educational and community settings.

2D. Implement the **North Carolina Preconception Health Strategic Plan and Supplement**.

# Goal 1 – Improve Health Care for Women and Men

## Point 3. Improve the quality of maternal care (includes prenatal, labor, delivery and postpartum care)

3A. Expand the use of **evidence-based models of prenatal care**.

3B. Provide **evidence-based clinical standards in prenatal care** (e.g., early elective deliveries, cesarean rate, 17P, tobacco cessation, hypertensive disorders, gestational diabetes, mental health, substance abuse, intimate partner violence, perinatal mood disorders, etc.)

3C. Improve access to and utilization of **first trimester prenatal care**.

3D. Provide **care coordination/case management/home visiting services** that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management, perinatal mood disorders, and access to health care.

# Goal 1 – Improve Health Care for Women and Men

**Point 3. continued - Improve the quality of maternal care (includes prenatal, labor, delivery and postpartum care)**

3E. Ensure that all pregnant women and high-risk infants have access to the appropriate level of care through a **well-established regional perinatal system**.

3F. Promote access to **comprehensive breastfeeding support services** including medical lactation services.

3G. Provide **evidence-based culturally competent patient education** and anticipatory guidance.

# Goal 1 – Improve Health Care for Women and Men

**Point 4. Expand healthcare access over the life course for all**

4A. Promote access to and utilization of the **adolescent well visit**.

4B. Promote access to and utilization of **evidence-based preventive health services**.

4C. Increase access to and utilization of **medical homes**.

4D. Provide **affordable, comprehensive insurance coverage**.

4E. Promote access to and utilization of **immunizations** according to the American Committee on Immunization Practice guidelines.

4F. Provide **evidence-based culturally competent patient education** and anticipatory guidance.

# Goal 2 – Strengthen Families and Communities

**Point 5. Strengthen father involvement in families**

5A. Promote **parenting and co-parenting skills** and responsible strategies

5B. Improve/develop guidelines for the **inclusion of men in preconception, prenatal, and interconception health services**

5C. Use **evidence-based strategies to promote healthy family relationships**.

5D. Promote the **role of fathers to change the culture**.

# Goal 2 – Strengthen Families and Communities

**Point 6. Enhance coordination and integration of family support services**

6A. Promote **agency and community coordination** in providing services

6B. Decrease fragmentation in the service delivery system to **reduce burden on families**.

6C. Improve **family and community driven service provision**.

# Goal 2 – Strengthen Families and Communities

**Point 7. Support coordination and cooperation to promote reproductive health within communities**

7A. Promote **reproductive life planning**.

7B. Expand **community stakeholder involvement and community engagement** in service design and implementation.

7C. Promote utilization of **breastfeeding friendly policies and services** in local communities.

7D. Promote utilization of **evidence-based strategies to prevent all forms of violence and promote coordinated community response**.

# Goal 2 – Strengthen Families and Communities

## Point 8. Invest in community building

8A. Create and improve **transportation systems** and **infrastructure**.

8B. Support **capacity building** in areas of **concentrated disadvantage**.

8C. Improve environments to **support healthy living**.

8D. Create and promote local employment opportunities that provide at least a **livable wage**.

8E. Improve **civic participation** through building community networks

# Goal 3 - Address Social and Economic Inequities

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| **Point 9 – Close the education gap** |
| 9A. Promote and increase access to **higher education**. |
| 9B.  Increase high school and post high school **graduation rates**. |
| 9C. Expand **race/ethnic/gender diversity representation** in schools (administrators, faculty, and staff) . |
| 9D. Promote and increase access to **early childhood education**. |
| 9E. **Disrupt the school to prison pipeline**, beginning with pre-school. |

# Goal 3 - Address Social and Economic Inequities

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| **Point 10 – Reduce poverty among families** |
| 10A. **Learn, collaborate, and partner** with organizations, agencies, and institutes that **focus on poverty reduction**. |
| 10B. Formulate and/or enhance ways that **data can be collected to comprehensively track on how living in poor or near poor homes and communities affects health outcomes** over the life course. |
| 10C. Recommend and support legislation of a **livable wage and equity in compensation**. |
| 10D. Standardize **poverty reduction strategies** into systems, services, and programs. |

# Goal 3 - Address Social and Economic Inequities

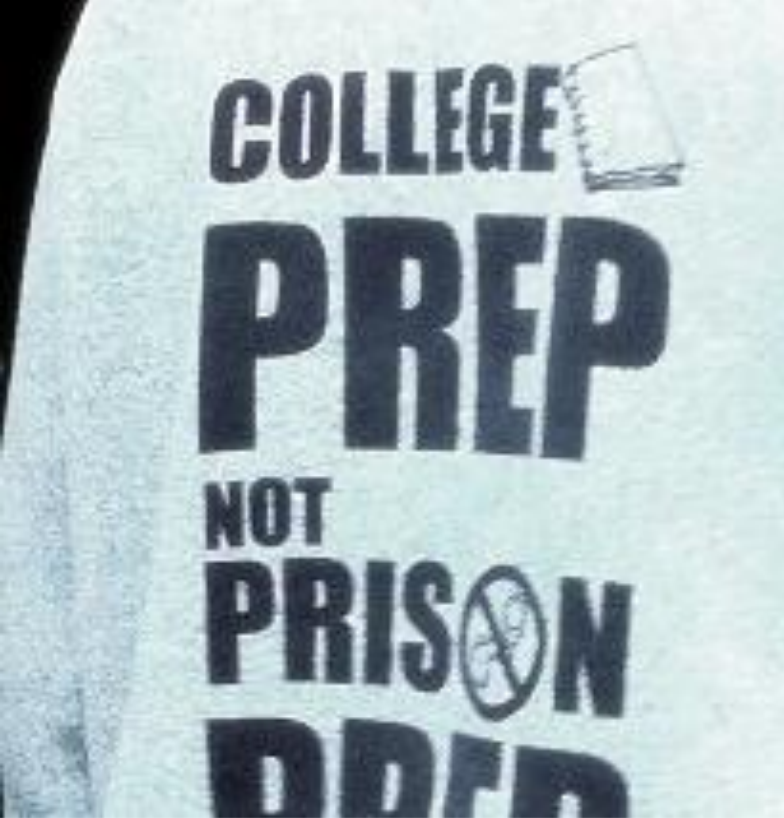| Point 11 – Support working mothers and families |
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| 11A. Create and expand **paid parental and sick leave policies**. |
| 11B. Increase affordable, available, and accessible **high quality child care**. |
| 11C. Increase **support for breastfeeding**. |
| 11D. Create **safe work place and incarceration environments** for women. |

# Goal 3 - Address Social and Economic Inequities

| Point 12 – Undo racism |
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| 12A. Infuse and incorporate **equity in the delivery of health services**. |
| 12B. Promote **high quality training about institutional and structural racism** and its impact on poor communities and communities of color. |
| 12C. Modify and **change policies and practices to address institutional and structural racism**. |
| 12D. Promote community and systems **dialog and discussion on racism**. |

# Protective Interventions: Building Resilience



Significant Adversity

New Protective Interventions

Healthy Developmental Trajectory

Supportive Relationships, Stimulating Experiences, Health-Promoting Environments

Adapted from Center on the Developing Child, Harvard University