The EveryONE Project

Advancing health equity in every community

AAFP

AMERICAN ACADEMY OF FAMILY PHYSICIANS

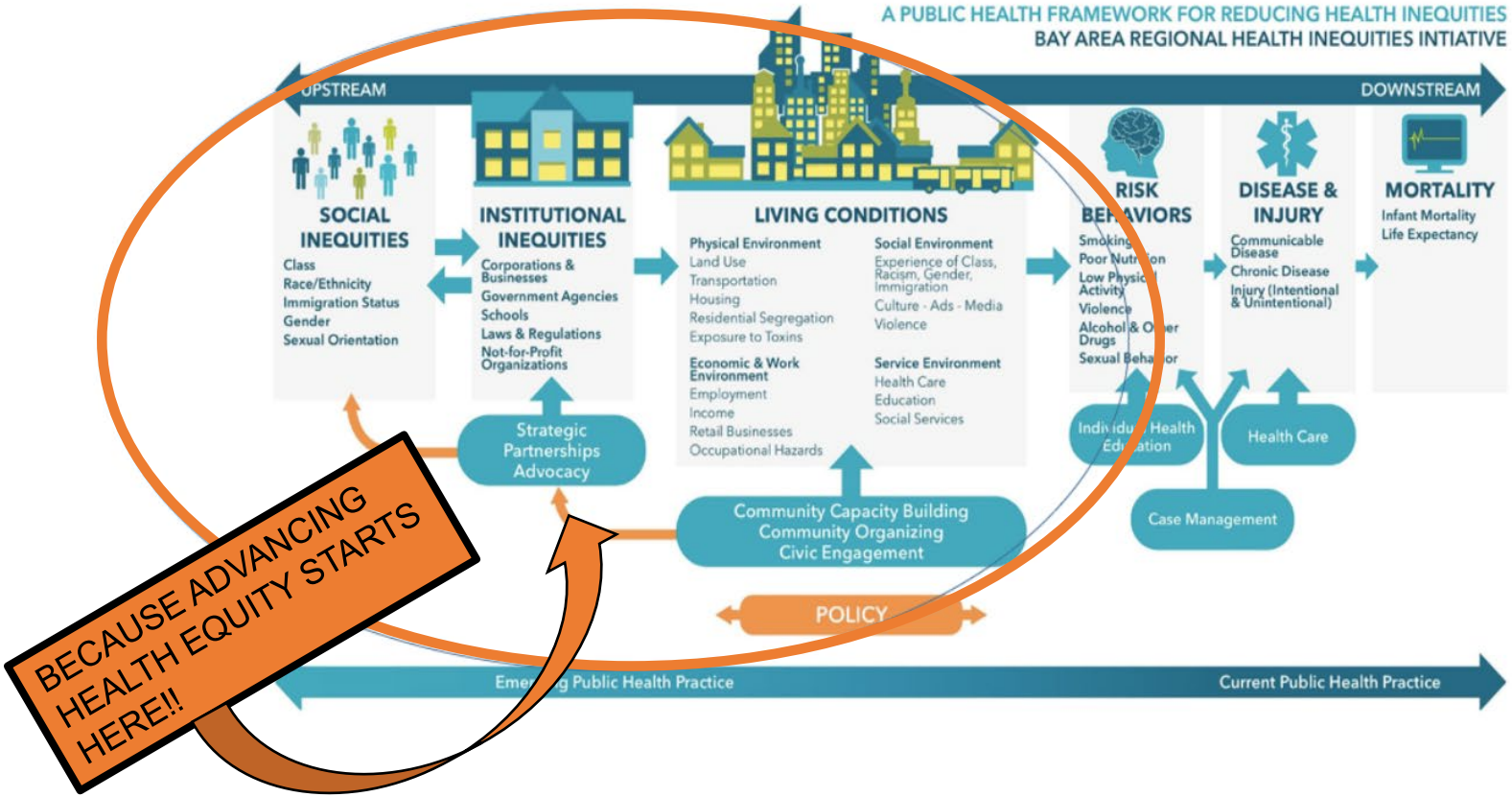
Learning Objectives

1. Understand how social and institutional inequities create health disparities for vulnerable populations

2. Communicate the AAFP's strategic priority and objectives of The EveryONE Project

3. Describe the available resources and how they can be integrated into clinical practice

4. Develop a plan for engaging your practice team and community



BECAUSE ADVANCING HEALTH EQUITY STARTS HERE!!

AAFP Strategic Priority

- The mission of the AAFP is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

- The AAFP aims to take a leadership role in addressing diversity and social determinants of health (SDOH) as they impact individuals, families, and communities across the lifespan and to strive for health equity.

Center for Diversity and Health Equity

Vision
Advance health equity and improve health for all

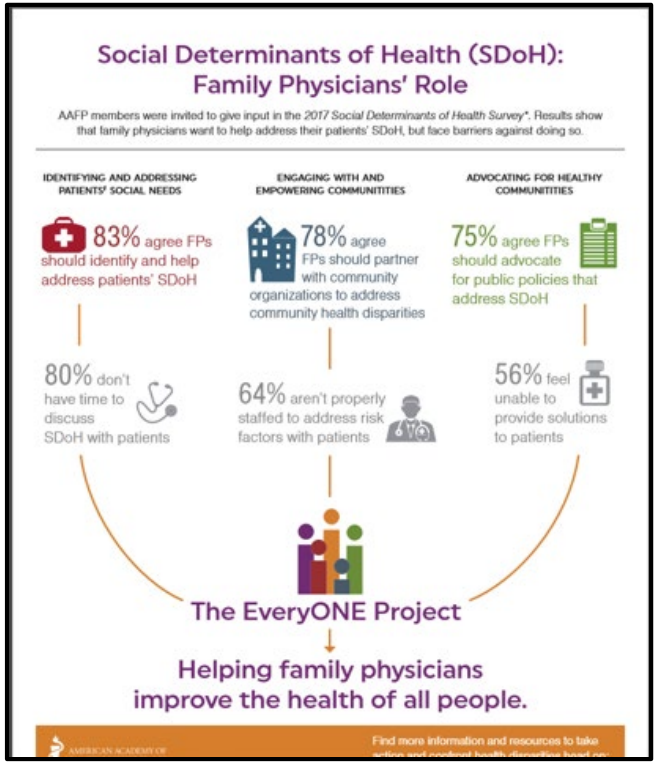
The EveryONE Project™

Mission
Take a leadership role in addressing diversity and social determinants of health as they impact individuals, families, and communities across their lifespan and to strive for health equity.

Focus Areas

- Workforce Diversity
- Advocating for Health Equity
- Education and Practice-based Resources
- Interdisciplinary Collaboration

2017 Social Determinants of Health (SDOH) Survey



About the Survey

- Purpose is to inform the AAFP of the prevalence of this issue among our members and the patients they serve
- Identifies
  - family physicians' perceptions of SDOH
  - activities of primary care clinics (screening, referral, advocacy)
  - barriers and needs
- Results (Available at www.aafp.org/everyone)
  - Four in 10 indicated this is either an 'essential' or 'high' priority issue
  - Nearly 60% are screening patients for SDOH and making referrals to social service resources
  - Family physicians are establishing high impact partnerships to address the issue with the help of:
    - community-based organizations (35%)
    - health insurers (13%)
    - philanthropic organizations (15%)

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AAFP

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The EveryONE Project TOOLKIT

Advancing Health Equity Through Family Medicine

As the primary providers of health care for America's underserved populations, family physicians see the impact of social determinants of health every day in their practice settings. The AAFP launched the EveryONE Project to promote diversiyt and address the social determinants of health, in an effort to advance health equity in all communities. This toolkit can help family physicians address social determinants of health in their practices and communities, to improve their patients' lives and help them thrive in a multitude of ways.

About Our Toolkit

- Screening*
- Practice Leadership
- Neighborhood Navigator
- Physician Advocacy
- Community Engagement
- www.aafp.org/everyone

With permission from the following:

- The National Association of Community Health Centers/Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)©
- Billioux A, Medicare C, Services M, et al. Standardized Screening for Health-Related Social Needs in Clinical Settings The Accountable Health Communities Screening Tool. 2017.
- Centers for Medicare & Medicaid Services. The Accountable Health Communities Health-Related Social Needs Screening Tool.; 2017. https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
- Health Leads. Social Needs Screening Toolkit. 2016. https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf

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Social Determinants of Health

GUIDE TO SOCIAL NEEDS SCREENING TOOL AND RESOURCES

"Why treat people and send them back to the conditions that made them sick in the first place?"
– Sir Michael Marmot

INTRODUCTION

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

Social determinants of health, as defined by the American Academy of Family Physicians (AAFP), are the conditions under which people are born, grow, live, work, and age. Factors that strongly influence health outcomes include a person's:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling)
- Early childhood social and physical environment, including childcare
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs. isolation)

Family physicians understand that it is important to identify and address SDOH for individuals and families to achieve optimal health outcomes and whole-person care. The challenge is operationalizing and implementing a large task with many factors into a busy practice environment in a manner that is actionable and practical.

The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

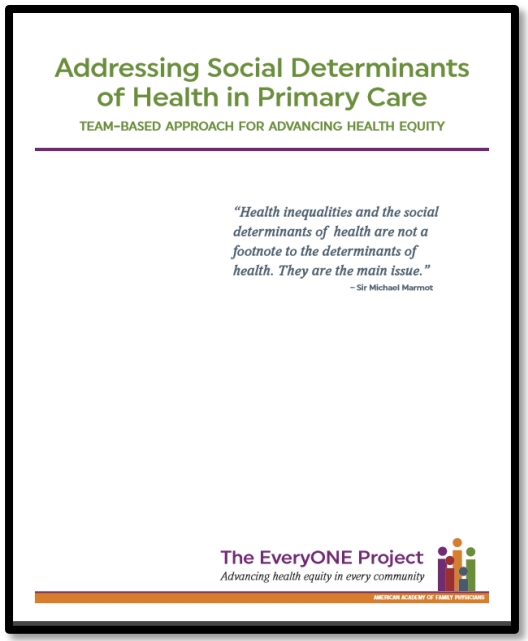
The AAFP is committed to helping you and your patients with a series of tools to use at the point of care by the practice team to quickly and efficiently screen your patients, act when needed, and link to community resources. All SDOH do not need to be addressed at one time, nor should this all be done by the family physician alone.

The AAFP is providing resources that you can customize to your individual practice, population, and community needs, and to help get you started. These tools are intended to be useful to you and your practice team. However, we acknowledge that not all practices have access to the same level of community resources and support.

Additional tools and resources will be developed to engage your care team and address SDOH factors that influence your patients' health outcomes.

TEAM-BASED CARE AND SDOH

As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team. This requires clear guidelines on roles and responsibilities. Team members and their responsibilities will depend on your practice size and structure, but may include:



Addressing Social Determinants of Health in Primary Care

TEAM-BASED APPROACH FOR ADVANCING HEALTH EQUITY

"Health inequalities and the social determinants of health are not a footnote to the determinants of health. They are the main issue."
– Sir Michael Marmot

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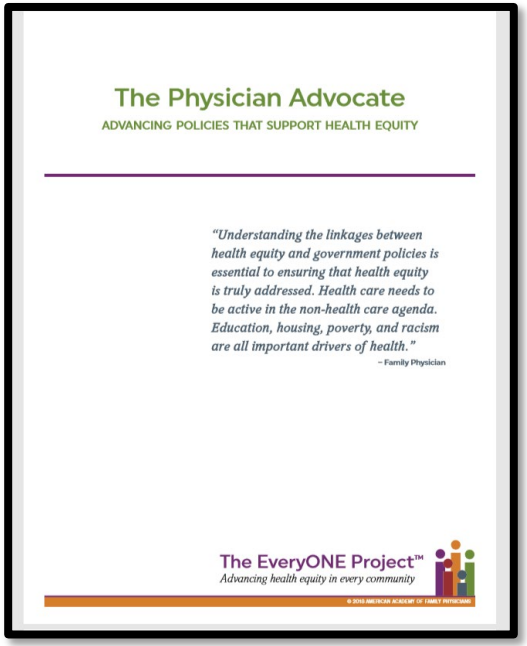

The Physician Advocate

ADVANCING POLICIES THAT SUPPORT HEALTH EQUITY

"Understanding the linkages between health equity and government policies is essential to ensuring that health equity is truly addressed. Health care needs to be active in the non-health care agenda. Education, housing, poverty, and racism are all important drivers of health."
– Family Physician

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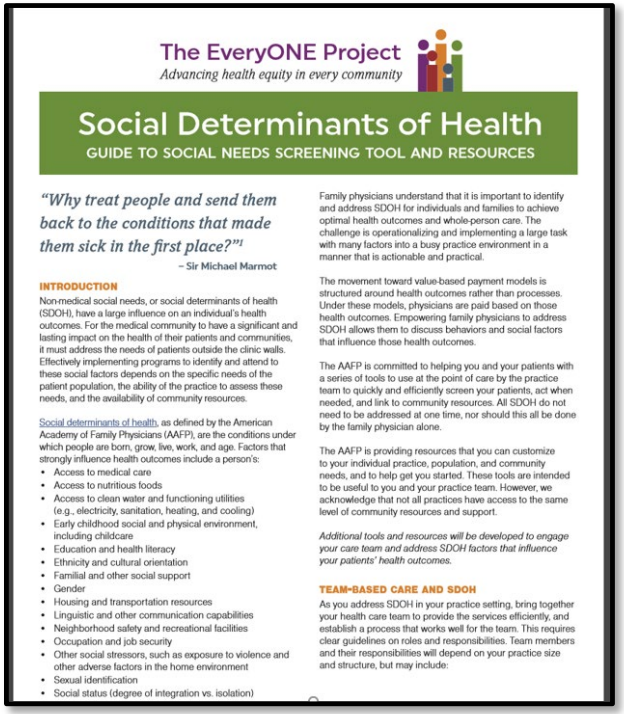
The EveryONE Project™

neighborhood navigator

Screening and Referral



The EveryONE Project
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Social Determinants of Health
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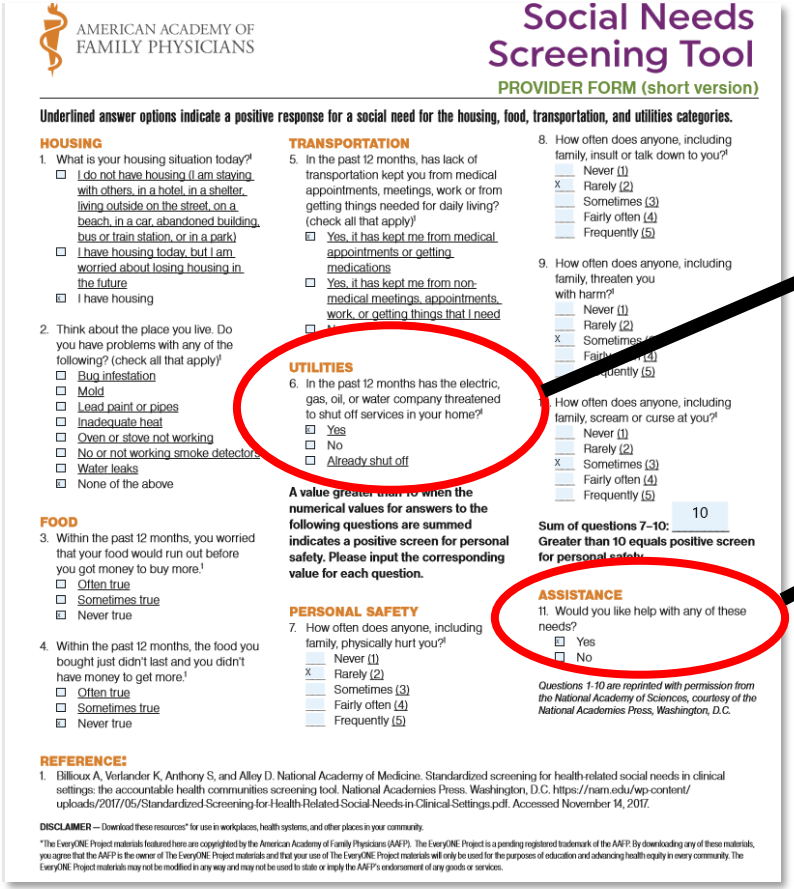
What's Inside

- Overview of the social determinants of health
- Role of the primary care team
- Description of core social needs
- Screening tools for patients and providers
- List of resources
- Published January 2018



AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PROVIDER FORM (short version)

Underlined answer options indicate a positive response for a social need for the housing, food, transportation, and utilities categories.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☒ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☒ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☒ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☒ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☒ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ [illegible]

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☒ Yes
   - ☐ No
   - ☐ Already shut off

A value greater than 10 when the numerical values for answers to the following questions are summed indicates a positive screen for personal safety. Please input the corresponding value for each question.

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ___ Never (1)
   - X Rarely (2)
   - ___ Sometimes (3)
   - ___ Fairly often (4)
   - ___ Frequently (5)

8. How often does anyone, including family, insult or talk down to you?[1]
   - ___ Never (1)
   - X Rarely (2)
   - ___ Sometimes (3)
   - ___ Fairly often (4)
   - ___ Frequently (5)

9. How often does anyone, including family, threaten you with harm?[1]
   - ___ Never (1)
   - ___ Rarely (2)
   - X Sometimes (3)
   - ___ Fairly often (4)
   - ___ Frequently (5)

10. How often does anyone, including family, scream or curse at you?[1]
    - ___ Never (1)
    - ___ Rarely (2)
    - X Sometimes (3)
    - ___ Fairly often (4)
    - ___ Frequently (5)

Sum of questions 7–10: 10 **Greater than 10 equals positive screen for personal safety**

ASSISTANCE

11. Would you like help with any of these needs?
    - ☒ Yes
    - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

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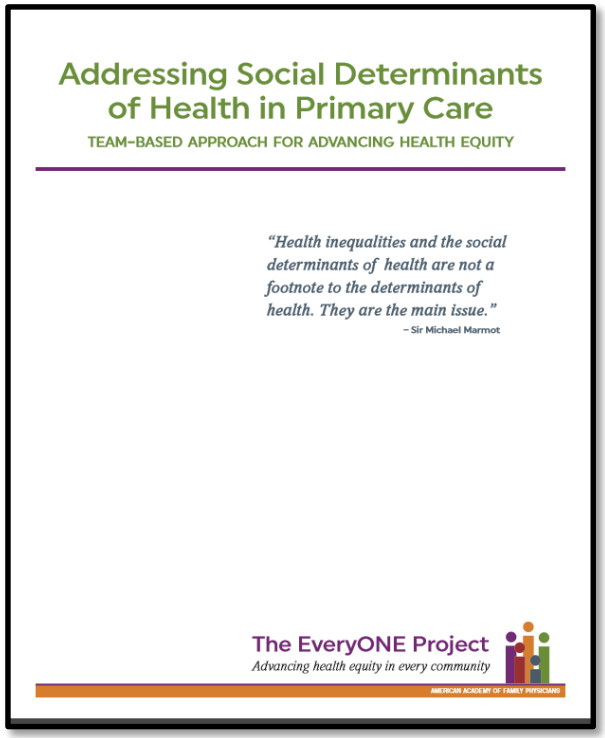
A Team-Based Approach



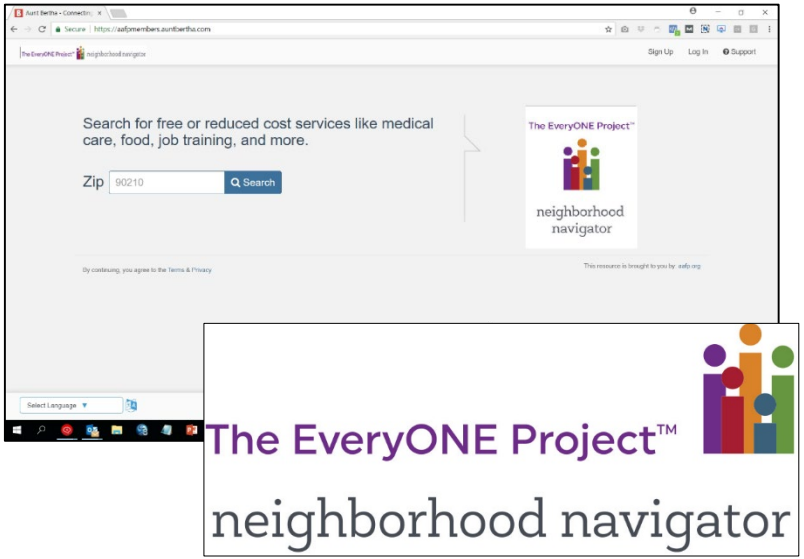
What's Inside

- Defining key SDOH terms
- Developing a culture of health equity
- Evaluating your current system
- Getting buy-in from stakeholders
- Creating an implementation plan
- Published April 2018

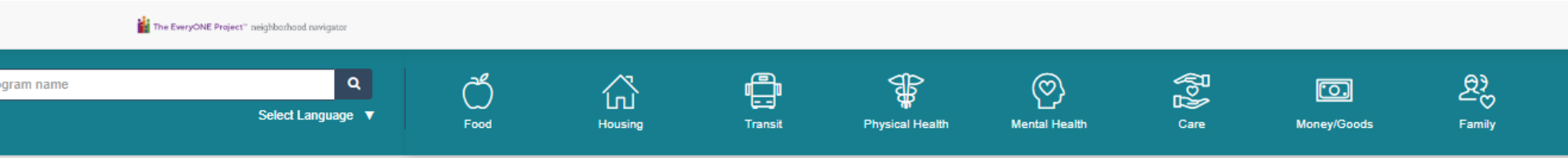
AAFP Neighborhood Navigator

- Launched July 2018
- Connecting people with programs and support in their communities
- Driving awareness of the tool to our members and the patients they serve through AAFP's patient facing website

neighborhoodnavigator.auntbertha.com



familydoctor.org



Over 140 Languages!

Find programs that serve people in Columbus, OH (43203)

Type a search term, or pick a category

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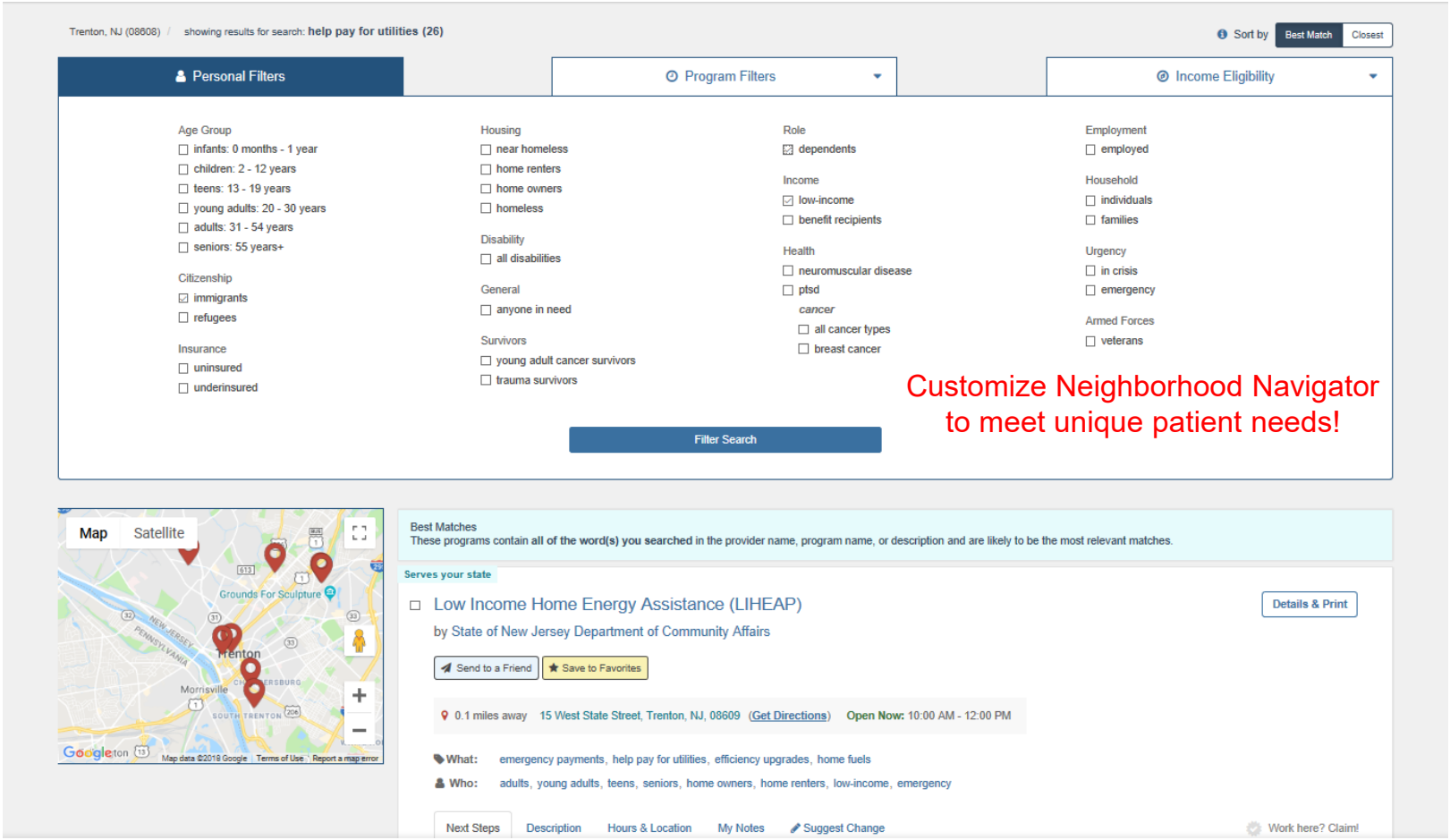
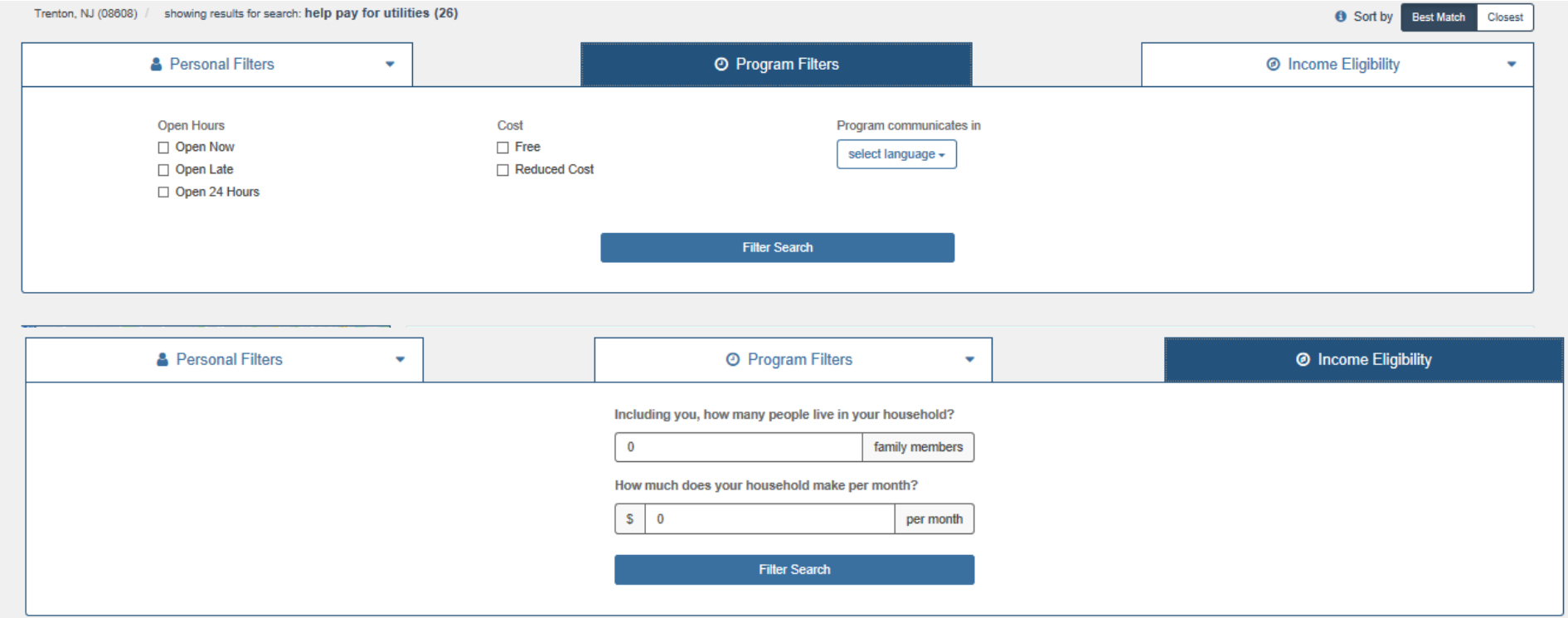
neighborhood navigator

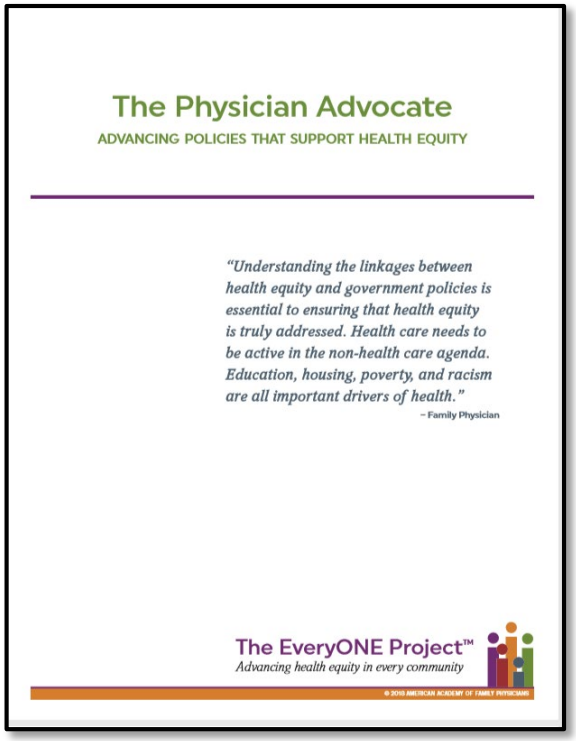
This data informs the development of AAFP educational content!


Trenton, NJ (08608) / showing results for search: help pay for utilities (26)
Sort by Best Match Closest
Personal Filters
Program Filters
Income Eligibility
Age Group
infants: 0 months - 1 year
children: 2 - 12 years
teens: 13 - 19 years
young adults: 20 - 30 years
adults: 31 - 54 years
seniors: 55 years+
Citizenship
immigrants
refugees
Insurance
uninsured
underinsured
Housing
near homeless
home renters
home owners
homeless
Disability
all disabilities
General
anyone in need
Survivors
young adult cancer survivors
trauma survivors
Role
dependents
Income
low-income
benefit recipients
Health
neuromuscular disease
ptsd
cancer
all cancer types
breast cancer
Employment
employed
Household
individuals
families
Urgency
in crisis
emergency
Armed Forces
veterans
Filter Search
Customize Neighborhood Navigator to meet unique patient needs!
Map
Satellite
Grounds For Sculpture
Trenton
Morrisville
Best Matches
These programs contain all of the word(s) you searched in the provider name, program name, or description and are likely to be the most relevant matches.
Serves your state
Low Income Home Energy Assistance (LIHEAP)
Details & Print
by State of New Jersey Department of Community Affairs
Send to a Friend
Save to Favorites
0.1 miles away 15 West State Street, Trenton, NJ, 08609 (Get Directions) Open Now: 10:00 AM - 12:00 PM
What: emergency payments, help pay for utilities, efficiency upgrades, home fuels
Who: adults, young adults, teens, seniors, home owners, home renters, low-income, emergency
Next Steps
Description
Hours & Location
My Notes
Suggest Change
Work here? Claim!

Search by Program Type or Income Eligibility



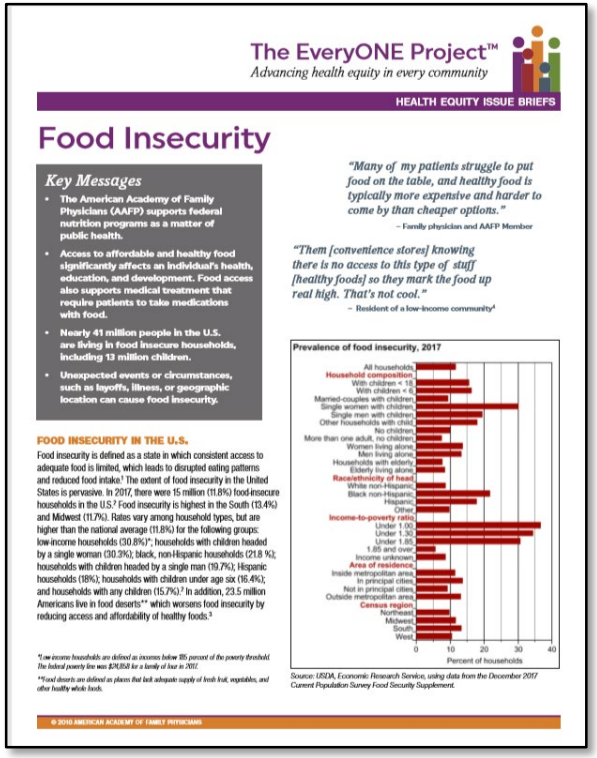
The Physician Advocate



What's Inside

- Learn about community health needs assessments and improvement plans
- Know the issues
- Organize a coalition
- Communicate and connect with elected officials
- Published October 2018

AAFP Health Equity Issue Briefs



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HEALTH EQUITY ISSUE BRIEFS

Food Insecurity

Key Messages

- The American Academy of Family Physicians (AAFP) supports federal nutrition programs as a matter of public health.
- Access to affordable and healthy food significantly affects an individual's health, education, and development. Food access also supports medical treatment that require patients to take medications with food.
- Nearly 41 million people in the U.S. are living in food insecure households, including 13 million children.
- Unexpected events or circumstances, such as layoffs, illness, or geographic location can cause food insecurity.

"Many of my patients struggle to put food on the table, and healthy food is typically more expensive and harder to come by than cheaper options."
– Family physician and AAFP Member

"Them [convenience stores] knowing there is no access to this type of stuff [healthy foods] so they mark the food up real high. That's not cool."
– Resident of a low-income community[4]

Prevalence of food insecurity, 2017

All households
Household composition
With children < 18
With children < 6
Married-couples with children
Single women with children
Single men with children
Other households with child
No children
More than one adult, no children
Women living alone
Men living alone
Households with elderly
Elderly living alone
Race/ethnicity of head
White non-Hispanic
Black non-Hispanic
Hispanic
Other
Income-to-poverty ratio
Under 1.00
Under 1.30
Under 1.85
1.85 and over
Income unknown
Area of residence
Inside metropolitan area
In principal cities
Not in principal cities
Outside metropolitan area
Census region
Northeast
Midwest
South
West

0 10 20 30 40
Percent of households

Source: USDA, Economic Research Service, using data from the December 2017 Current Population Survey Food Security Supplement.

FOOD INSECURITY IN THE U.S.

Food insecurity is defined as a state in which consistent access to adequate food is limited, which leads to disrupted eating patterns and reduced food intake.[1] The extent of food insecurity in the United States is pervasive. In 2017, there were 15 million (11.8%) food-insecure households in the U.S.[2] Food insecurity is highest in the South (13.4%) and Midwest (11.7%). Rates vary among household types, but are higher than the national average (11.8%) for the following groups: low-income households (30.8%)*; households with children headed by a single woman (30.3%); black, non-Hispanic households (21.8 %); households with children headed by a single man (19.7%); Hispanic households (18%); households with children under age six (16.4%); and households with any children (15.7%).[2] In addition, 23.5 million Americans live in food deserts** which worsens food insecurity by reducing access and affordability of healthy foods.[3]

*Low-income households are defined as incomes below 185 percent of the poverty threshold. The federal poverty line was $24,858 for a family of four in 2017.

**Food deserts are defined as places that lack adequate supply of fresh fruit, vegetables, and other healthy whole foods.

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HEALTH EQUITY ISSUE BRIEFS

Health in All Policies

Key Messages

- The American Academy of Family Physicians (AAFP) supports Health in All Policies as a strategy to improve population health and advance health equity.
- Government policies affect health. As such, policymakers should consider their health implications.
- Advocating for the Health in All Policies approach presents an opportunity for family physicians to engage policymakers and health officials in developing policies and legislation that benefit the health of patients, families, and communities.

GOVERNMENT POLICIES AFFECT HEALTH

Social determinants of health (SDOH) are the conditions under which people are born, grow, live, work, and age, and include factors which can affect health outcomes, such as socioeconomic status, education, employment, social support networks, and community characteristics. Social and economic factors have a larger impact on health (40%) than other factors, including behavior (30%), clinical care (20%), and environmental factors (10%).[1]

"Understanding the linkages between health equity and government policies is essential to ensuring that health is truly addressed."
– Family physician and AAFP Member

Government policies affect health by shaping the SDOH.[2] However, health outcomes are rarely considered when making social and economic policies.[3] To improve health considerations in public policy, the Health in All Policies approach was developed to provide policymakers with community input and evidence-based information to help them make decisions about how laws, regulations, and policies affect health outcomes and health equity.[4]

WHAT DOES HEALTH IN ALL POLICIES MEAN?

Health in All Policies refer to a collaborative approach that incorporates health considerations into policies that shape and influence SDOH. It aims to help policymakers make informed decisions about policies and services across all levels of government that will improve the health of the population.[5] The approach incorporates scientific evidence and community input to achieve this goal.[6] For example, a Health in All Policies taskforce may develop policy recommendations based on a review of current research on the topic and community engagement sessions held with the public.

In order to recommend effective policies, communities and public health advocates should ensure their Health in All Policies strategies:

- Promote health, equity, and sustainability;[4]
- Support collaboration across sectors;[4]

The circle graphic is adapted from the Health in All Policies framework from Healthiest Wisconsin 2020. It includes the potential partners, stakeholders, and community groups which can influence policies that impact health.

Health Equity Fellowship

AIMS

- Develop family physicians with the skills to translate the evidence into action
- Contribute to the creation of new knowledge
- Drive policy and system changes that produce equitable health outcomes

2019-20 Health Equity Grant Awards

- Ten AAFP Chapters
- Advance health in all communities
- Develop strategic plans for health equity in every state
- Build cross sector and interdisciplinary collaboration
- Build influence on issues of social justice

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA