Facilitator Guide: The Social Determinants of Health

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<th>Learning Goals and Objectives</th>
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<td>1. Describe how the social determinants of health play a role in creating and perpetuating health disparities.</td>
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<td>a. Define five critical social determinants and their impact on health. <em>(Knowledge)</em></td>
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<td>b. Articulate how the three important components of Socio-Economic Status (SES) contribute to health disparities. <em>(Knowledge)</em></td>
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<td>c. Evaluate the impact of income inequality on health outcomes and life expectancy in the United States and abroad. <em>(Skill)</em></td>
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<td>2. Describe the local, state and federal programs that decrease the rates of poverty and mitigate the effects of poverty on child health in the US.</td>
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<td>a. Describe three federal income based programs that effectively decrease rates of poverty. <em>(Knowledge)</em></td>
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<td>b. Analyze the impact of educational and community based programs that invest in children and families long term to reverse the cycle of generational poverty and educational disparities. <em>(Skill)</em></td>
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<td>c. Explain how the funding mechanisms for education affect educational inequities between communities and nations and perpetuate the cycle of poverty. <em>(Skill)</em></td>
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This module is designed to cover the core principles of the social determinants of health as they relate to child poverty, health and well-being. The materials for this module are divided into three sections: Pre-Work, Interactive Case-based session, and optional Dig Deeper activities and resources. The Pre-Work and Interactive session materials make up the core of the module, while the Dig Deeper activities are designed for further exploration for individuals with interest or for programs who have more time to allot to this material.

1. **Pre-Work:** This consists of a breakdown of each section of the presentation with the related materials (video clips, articles). This is designed to be completed by learners to prepare them for the in-class presentation/discussion. Facilitators should review the Pre-work document so as to be able to discuss the material with their learners at the onset of the presentation.

2. **Presentation:** The facilitator guide serves as a guide with background information for the presenter for the slides and the cases. It aims to tie together the ideas and materials in the clips and articles.
   - a. Introductory Slides: Provide background on key concepts.
   - b. Cases: Allow facilitators to work with learners to apply newly acquired knowledge.

3. **Dig Deeper:** This section includes possible activities and further resources for facilitators, learners or programs that would like to go further in depth into these topics.
Presentation: Introductory Slides for Social Determinants of Health

Part 1: Definitions
Objectives Covered:
- Define five critical social determinants and their impact on health.
- Articulate how the three important components of Socio-Economic Status (SES) contribute to health disparities.

Facilitator’s Role
Outline:
- Present slides 1-8
- Engage learners in 1-2min discussion on their understanding of social determinants.
- Help learners identify a recent patient whose current health status is likely impacted by an unmet social need.

Guidelines:
Consider beginning this section by having the learners review what they know about the social determinants of health. Frame this session as an opportunity for the learners to think through recent patient interactions where unmet social needs may have contributed to the patient current health status.

What are the Social Determinants of Health?
The social determinants of health (SDH, SDOH) are the conditions or circumstances in which people are born, grow-up and age that affect their overall health, health risks, and quality of life. These individual circumstances are influenced by wider societal forces including economics and policy (cite WHO, HP2020). The social determinants of health can be categorized into several key domains. In the schematic from below the 5 domains are Economic Stability, Education, Social and Community Context, Health and Healthcare, Neighborhood and Built Environment. (Healthy People 2020).

Socio-economic status (SES) is a closely related concept to the social determinants of health. In particular, socio-economic status is defined as the combination of Income, Education, Occupation.

Walk through the initial slide possibly giving an example of each domain.

Videos:
- IN PRESENTATION - “Chad and Jeff”: Short video illustrating the impact of the social determinants on the lives of two young men: https://www.youtube.com/watch?v=_11xLlwKgWc
Part 1 Discussion options:
1) At the outset to review and identify social determinants:
   a. What are the traditional social determinants?
   b. What do you typically feel comfortable asking about? Why?
2) Facilitators may wish to prepare in advance their own experience where a social determinant impacted a patient’s health outcome. This should be brief to really serve as an opening for the learners to consider cases they have been involved in.
3) Intersection of Income, Education and Occupation as SES
   a. Do these 3 components typically come to mind with SES? Anything to add?

Part 2: Interactions
Objectives Covered:
- Evaluate the impact of income inequality on health outcomes and life expectancy in the United States and abroad.
- Explain how the funding mechanisms for education affect educational inequities between communities and nations and perpetuate the cycle of poverty.

Facilitator’s Role
Outline:
- Present slides (9-11)
- Have learners consider the basis for the differences in the effect of poverty on health for different groups of children.
- Engage learners in considering the systemic basis for health inequalities.
- Help learners identify their own biases.

Guidelines:
In this section we are going to look more deeply at the interactions between socio-economic status, health and well-being. In particular we are going to focus on the impact of inequalities in two important areas: income and education.

Income Inequality and Health
Income inequality is at the root of many forms of inequality related to the social determinants of health. Many studies have demonstrated clear links between income inequality and poor health outcomes. A 2008 report from the Robert Wood Johnson Foundation highlights the linear correlation between income level and child health that is seen across racial and ethnic groups (Figure 1). This linear correlation between low income and low health persists even when controlling for healthy vs. unhealthy behaviors in the home (Figure 2). To further explore the pathophysiology of the link between poverty and health, please review the Pathophysiology Module of the Child Poverty Curriculum.
Figure 1: Percent Children in Less than Very Good Health by Race/Ethnicity and Income Level (RWJ, 2008)

**Educational Inequality and the Cycle of Poverty**

Educational level has been consistently tied to numerous health outcomes for both children and adults both directly and via its impacts on occupation and income. In the United States, all children regardless of immigration status or income level are eligible for a free public education. Unfortunately, the funding available for that education varies substantially from district to district and state to state.

Most school districts in the US rely in large part on local property and income taxes to fund the schools. As a result school districts serving children with high rates of household poverty have less money to spend per student. This is in spite of the fact that children living in poverty often have greater educational needs and fewer resources to support education outside of the school. Because educational attainment is a key strategy for rising out of poverty, the net effect of this inequality in school funding is to contribute to a generational cycle of poverty. To further explore the interaction between educational inequalities and child poverty, please review the following resources.

Center for American Progress Report: The Stealth Inequities of School Funding:

**Part 2 Discussion options:**

1) Examine the bar graph
   a. Who fares the best? The worst? Thoughts on why?
   b. Any surprises?

2) Beyond the funding mechanism of education, what other institutional or systemic mechanisms currently in place perpetuate the cycle of poverty?
   a. Is there a way to change this process/mechanism?
   b. Are there ways to mitigate the effects?
Part 3: Interventions
Objectives Covered:

- Describe three federal income based programs that effectively decrease rates of poverty.
- Analyze the impact of educational and community based programs that invest in children and families long term to reverse the cycle of generational poverty and educational disparities.

Facilitator’s Role

Outline:

- Review slides (12-15)
- Help learners get an overview of the entitlement programs and their relative impact in lifting children out of poverty.
- Engage learners in reflecting on personal biases and/or misunderstanding of entitlement programs.
- Help learners identify local community programs that can serve as resources for their patients.

Guidelines:

In this section we will explore some of the ways that we can intervene in the cycle of poverty, both to raise children out of poverty and to mediate its effects when present. In particular we will focus on federal entitlement programs, educational and community based programs. We will begin with a brief overview of how poverty is measured for the purposes of program eligibility and national statistics.

Review the supplemental poverty measure:
http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-251.pdf

Federal Entitlement Programs

Three federal entitlement programs in particular - EITC, SNAP, and Medicaid/CHIP – have the potential to significantly impact the lives of children living in poverty and effectively lift those families above the poverty level. Social Security and Medicare are also federal entitlement programs that have had significant impacts in terms of raising seniors out of poverty, but are less applicable to children and will not be discussed in this section. The Temporary Assistance for Needy Families (TANF) program is another federally funded program providing benefits to needy families, which we will discuss briefly at the end of this section. Many other programs impact positively and negatively on a family’s financial resources.
**EITC**

The Earned Income Tax Credit (EITC) is a benefit for working people with low income who meet certain other requirements. In order to receive the credit, the parent must file a tax return and the credit will either reduce the amount they owe or provide a cash refund in the event that they do not owe any taxes. Eligibility is based on income and presence of a qualifying individual in the home. Children who are under 19 and not employed are married are considered to be qualifying children. Older children with permanent disabilities may also be considered to be qualifying. More information on eligibility visit the IRS Website: [http://www.irs.gov/Credits-Deductions/Individuals/Earned-Income-Tax-Credit](http://www.irs.gov/Credits-Deductions/Individuals/Earned-Income-Tax-Credit)

The average EITC amount for qualifying households in 2013 was around $2,000-$2,500 and varied by state ([http://www.eitc.irs.gov/EITC-Central/eitcstats](http://www.eitc.irs.gov/EITC-Central/eitcstats)). When counted as income, this amount was sufficient to lift 3.2 million children above the poverty level according to an analysis by the Center on Budget and Policy Priorities (CBPP) of the 2013 US Census data. When combined with the Child Tax Credit, the impacts are even higher as illustrated in the figure below. In addition to its direct effects on poverty, the EITC also promotes financial security for families by creating a system that rewards parents for working.

![Earned Income Tax Credit and Child Tax Credit Have Powerful Antipoverty Impact](image)

**Earned Income Tax Credit (EITC):**

- Basics on the EITC: [http://www.cbpp.org/research/policy-basics-the-earned-income-tax-credit](http://www.cbpp.org/research/policy-basics-the-earned-income-tax-credit)
SNAP

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, is a federally funded program that is administered by state or local agencies. To receive SNAP, someone in the household must be a U.S. citizen, U.S. national or have status as a qualified alien. The households must have limited countable resources and make no more than 100% of the Federal Poverty Level in net income. The Maximum monthly SNAP award is based on family size (see table on the USDA website linked below). However, the actual award takes into account the household net income and is calculated using the following equation: SNAP Award = Maximum Monthly SNAP Award– 30% Net Income. For example, based on 2015 data, a family of 4 with a net income of $1600/mo would qualify for SNAP as their income is below 100% of the FPL. Their maximum SNAP allowance based on the USDA table is $649. Their monthly award would be: $649 -0.3($1600) = $169. That is equal to $42 per person per month, or $1.40 per person per day.

Although a seemingly small amount, this additional resource has lifted many families out of poverty. According to US Census data, when SNAP benefits are counted as income, approximately 4 million households in 2012 rose above the FPL.

See the figure below from the Center on Budget and Policy Priorities to review the numbers of people lifted above the poverty line when SNAP benefits are added to their income over the last several years.

**Record Number of People Lifted Above Poverty In 2012 When SNAP Is Counted as Income**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of people lifted by SNAP</th>
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<tbody>
<tr>
<td>2015</td>
<td>2.0 million</td>
</tr>
<tr>
<td>2014</td>
<td>2.5 million</td>
</tr>
<tr>
<td>2013</td>
<td>3.0 million</td>
</tr>
<tr>
<td>2012</td>
<td>3.5 million</td>
</tr>
<tr>
<td>2011</td>
<td>4.0 million</td>
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Source: Census Bureau Data. Official Poverty Measures. Center on Budget and Policy Priorities (CBPP.org)


Medicaid/CHIP

Medicaid is an individual entitlement program that is federally regulated but state operated with joint federal and state funding. Benefits and eligibility can vary by state but are required to meet certain federal standards. The Children’s Health Insurance Program (CHIP) is a federal block grant matching funds program to allow states to cover children in families not eligible for Medicaid but who are unable to afford private health insurance (generally below ~200% FPL although this varies by state). States had many options in how to implement this program. For instance, they could use the funds to expand Medicaid to children at higher income
levels or could create a separately administered CHIP program. Eligibility for Medicaid and CHIP are tied to the Federal Poverty Guidelines and varies from state to state.

Although not directly included in the Supplementary Poverty Measure, the benefits provided by Medicaid and CHIP can substantially decrease out of pocket spending on medical expenses and thereby impact favorably on a family’s finances. While the impact is more complex to measure than other programs, one analysis by the Association for Public Policy Analysis and Management indicated that in 2010 Medicaid (including CHIP) kept 2.6 to 3.4 million people out of poverty, making it the third largest anti-poverty program in the United States after the EITC and SNAP. (Sommers and Oellerich: http://www.appam.org/assets/1/7/The_Poverty-Reducing_Effect_of_Medicaid.pdf).

**TANF**

The Temporary Assistance for Needy Families (TANF) program is funded with block grants from the federal government and operated by individual states. This program was enacted as a part of welfare reform. Program specifics vary from state to state but benefits may include: temporary cash assistance, childcare assistance, and job training/placement assistance. TANF is not truly an entitlement program in that eligible families are not guaranteed a benefit, and benefits are typically time limited and tied to requirements such as job-training. Eligibility and benefits vary widely from state to state.

**Educational and Community Based Programs**

In this section we will review a handful of educational and community based programs that invest in children and families and their long-term impacts on poverty and educational outcomes. There are many more programs than we will be able to cover in this section, and we encourage you to explore and investigate other programs in your own local community.

**Head Start and Early Head Start**

Head Start is a federal program run by the Department of Health and Human Services that provides early childhood education as well as nutritional and other services to low-income children and their families. The main goal of this program is to increase school readiness. Head Start serves children ages 3-5, after which time they transition to kindergarten in the school system. Early Head Start is an extension of this program that provides support to pregnant women, infants and toddlers up to age 3. Many studies have been done on the long-term efficacy of Head Start with somewhat mixed results. Early outcomes in terms of school readiness and early school performance are generally improved in children who have participated in Head Start. However, there is some evidence that the impact fades over time, perhaps related to the ongoing stress and impact of poverty in their lives. Other studies have indicated that the program none the less has long term benefits that outweigh program costs.
Nurse Family Partnership

The Nurse Family Partnership (NFP) is an evidenced-based community health program that pairs low-income first-time mothers with a registered nurse. The nurse visits the home throughout the prenatal period and for the first two years of the child’s life to provide education and support to the family. The NFP model has been well researched over the last three decades and has been found to lead to several important outcomes including improved maternal and child health, reduced subsequent pregnancies and increased intervals between births, increased maternal employment, improved school readiness, and improved economic self-sufficiency. For more information on the NFP, visit their website: http://www.nursefamilypartnership.org/

Reach Out and Read

Reach Out and Read (ROR) is a not-for-profit organization that promotes literacy and school readiness particularly in children from low-income communities. The program involves book distribution and literacy promotion strategies based out of the pediatric medical provider’s office. The ROR program targets the gap that exists in the exposure to language and reading in low-income children, with a goal of improving school readiness and educational outcomes later in life. Studies of the ROR program thus far have demonstrated success in terms of increased parental reading to children and improved scores on educational testing in the pre-school setting.

The Harlem Children’s Zone

The Harlem Children’s Zone (HCZ) is a non-profit organization that provides comprehensive support services to children and their families in central Harlem. Their “birth through college pipeline” model supported by an array of family, social service, health and community building programs. The goal of HCZ is to break the cycle of poverty through early intervention and continuous support that allows the children in the neighborhood to succeed along the educational pipeline through college and gainful employment. Early results show positive impacts on educational outcomes, particularly for students who attend the HCZ charter schools, although it is still too early to understand the full impact of this program on the ultimate goal of raising families out of poverty. The HCZ model has been replicated in many other cities and is the foundation for the US Department of Education’s Promise Neighborhoods program that began under the Obama Administration.

Part 3 Discussion options:
1) Discuss the activity assigned in pre-work and review the neighborhood-based programs in learners’ communities they found.
2) Name one new program or resource you learned about in this section.
   a. Why did you remember that one? What kind of impact is it having or does it have the potential to have on child poverty?
   b. Any thoughts on ways to revamp a program or a new program that could help lift children out of poverty?
3) Will having a better sense of these programs and resources change the way you approach patients and their families during a visit? Are you likely to ask about whether families are enrolled in these programs? Why or why not?
Case-Based Discussion

Case 1: Mary

Explores SDH factors in case of an child with developmental delay

Reflection #1

What additional information might have been helpful to Dr Robinson in developing a plan of action for Mary and her family?

In order to assess a patient’s ability to follow-up with any clinical recommendation and adhere to recommendations, their social context needs to be explored. We suggest using a “social determinant screener” for this purpose. There are currently multiple validated ones, just choose one that fits your practice needs.

Similar to the traditional review of systems, these questions are used selectively in a focused, problem-oriented manner. In this case, the following questions would be helpful:

- Where does Ms. Jones live?
- What is her economic and employment status? (if she works during the day, is there someone who can answer the phone and schedule an appointment?)
- Can she take a day from work to take her daughter to a hearing test? If not, does she have a support network?
- What is her literacy level? Can she follow written instructions on how to get to the hospital?
- Are there significant stresses in her life that may affect her ability to follow through with the plan such as housing problems, domestic violence, and substance abuse, among others?
- Does she know what Early Intervention is?

When addressing social determinants it is imperative that we explore with our students the relationship between zip code and health. What follows is a way to engage your students in doing so.

Many of the factors that affect a child’s opportunity to develop into a healthy and productive adult are tied to the neighborhoods in which they live. One way of looking at these factors together is using the Child Opportunity Index (Acevedo-Garcia, 2014). This index combines information from 19 different indicators across three domains: Educational, Health and the Environment, and Social and Economic to produce a relative measure of opportunity across neighborhoods in a metropolitan area. Take a moment to explore your own city or nearby metropolitan area using the Child Opportunity Index Map:

http://www.diversitydatakids.org/data/childopportunitymap

For more information on the Child Opportunity Index, read the following article:

Important facts to know

- The Early Intervention Program is part of a national effort initiated by Congress in 1986 through the passage of the Individuals with Disabilities Education Act (Public Law 99-457). The law created an entitlement to a wide range of rehabilitative services for infants and toddlers from birth until age 3. Early Intervention is a comprehensive interagency program that supports infants and children with developmental delays through provision of needed therapies and case coordination. As a federal entitlement program, these services are universally available at no cost to the family.

Reflection# 2

- At this second visit, what are potential reasons that Ms Jones did not call EI to schedule an appointment for her child to have a hearing test?

- Would there be a role to address caregiver’s motivation, activation and understanding of the issue at hand

When a patient does not follow through on previously discussed recommendations and agreed upon scheduled appointments, a provider should initiate a model of patient-centered interviewing to assess the patient’s perspective on the issue. This model allows a provider to explore non-adherence in a nonjudgmental way. When teaching, we refer to this process as developing a differential diagnosis of compliance.

We have adapted the Trans-theoretical Model for behavior change as shown in Table 9.2 to help identify when the patient is in his/her thinking and to guide the clinician’s efforts. Based on this model, Ms. Jones appears to acknowledge that Mary’s speech is different from other children and to accept that this is a problem that needs to be addressed. Furthermore, she has expressed a desire for help. However, it would have been helpful for Dr. Robinson to explore her understanding and motivations in more detail.

Using the Trans-theoretical model to explore non-adherence:

- Does the patient identify the issue/behavior?
  - Does the mother think that her child talks less than other children?

- Does the patient identify a problem?
  - Does the mother think there is anything wrong with the child’s speech development compared with other children her age?

- Does the patient desire a change?
  - Does the mother wish to get help for her child’s speech delay?

- Does the patient feel confident that he or she can make a change?
  - Explore the barriers to obtaining the services.
Important facts to know

Motivational interviewing technique is a communication strategy that has been shown to be effective in helping patients modify addictive behaviors and is increasingly being applied in a variety of clinical settings. The goal of motivational interviewing is to understand what the motivational state of the client is at the time and to act appropriately. Motivational interviewing is characterized by eliciting motivation from the client, not trying to impose it from the outside. It has been defined as a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Resolving ambivalence is a key to motivational interviewing. When people move into the contemplation stage, when they are thinking about changing vs. not changing, balancing out the pros and cons, they are more susceptible to real change. However, a helping professional who starts pushing behavior change at the client at this stage will meet resistance. It is the client’s task, not the counselor’s, to identify and resolve his or her ambivalence. What the client needs at this point is help listing pros and cons and a nonjudgmental, encouraging professional who really listens. The client determines whether their current behavior is consistent with their goals and then makes choices to move him or herself. The counseling style is generally a quiet, supportive, and eliciting one. In this setting, effective patient education requires more active listening than talking. The therapeutic relationship is more like a partnership than one of expert/recipient, and good provider–client rapport is crucial for success.

To complement motivational interviewing-based interviews, confidence and importance rating scales are often useful. The scales are used during or at the end of the visit, when a provider might ask: “On a scale of 1 to 10, how important do you feel it is to follow the plan we discussed?” (For example: to take this medicine or to go to this appointment) “And how confident do you feel that you can do this?”(For example: remember to avoid these foods or find your way to the appointment)

Finally, if the patient is ready, give advice and facilitate an appointment for the patient to make the change

Reflection #3

- What does Ms. Jones confusion about giving oral medication in the ear indicate?

The improper placement of liquid antibiotic into the ear, instead of the mouth, indicates that Ms. Jones has trouble comprehending dosing instructions; either the medication instructions were improperly given/read or they were not read at all. At this point, it is important to consider the patient’s health literacy level. According to Healthy People 2010, health literacy is defined as “the degree to which individuals have the capacity to obtain, understand, and process basic health information and services needed to make appropriate health decisions.” Studies have demonstrated that individuals with low health literacy have poor health status, communication problems with providers, poor knowledge of their disease states and medication regimens, increased hospitalizations, and problems with medication adherence. The ability to read medication labels and follow their instructions, to fill out insurance forms, and to navigate the medical system all require high levels of reading and numerical skills. To address these problems, specific communication tools have been developed
and demonstrated to be effective in improving patients’ understanding of medication instructions and prescribed treatments. Two highly regarded and well-evaluated communication tools are: the “Teach Back Method” and visual aids/pictorials.

When using the Teach Back (or Playback) Method, the provider asks the patient to restate in his/her own words the directions that have just been given. This method encourages the clinician to take responsibility for the patient’s understanding of instructions. In this case, Dr. Robinson might have asked: “In order to make sure that I explained this to you well, could you please tell me how you are going to give this medication to Mary?” Not surprisingly, literature has also shown that, when pictorials are combined with written or oral instructions, patient understanding of how to take medications is increased. Finally, limiting the quantity of information given at each clinical interaction and repeating instructions are always useful in improving understanding.

Reflection #4

- Why did it take 3 months and 3 visits to learn that Ms. Jones cannot read?

Health professionals rarely screen for illiteracy. Providers often associate illiteracy with poor, immigrant patients who do not speak English. Since Ms. Jones is not physically or demographically identified as an immigrant or non-English speaker, Dr. Robinson did not initially consider illiteracy. In fact, she may have been uncomfortable asking about reading ability because she did not want to insult her patient, thus jeopardizing the doctor–patient relationship.

There have been a number of studies that have evaluated providers’ ability to identify illiteracy in their patients. For example, in one study, doctors correctly identified only one-third of their patients with low literacy. Not surprisingly, illiterate patients are often adept at hiding their inability to read. One study asked patients in a public hospital who had difficulty reading, “Who knows you have difficulty reading?” Sixty-seven percent of these patients never told their spouses, 19% had never told anyone, and more than 75% said they had never brought anyone who could read with them to the hospital or doctor’s office.

According to the Institute of Medicine, nearly half of all American adults, 90 million, have difficulty understanding and acting upon health information. Examples of illiteracy can be seen in populations beyond immigrants and U.S. born citizens and across boundaries of race, socioeconomic status, age, and sex. Because nonreaders tend to hide their handicap very well, health care providers and health care facilities often fail to notice, if they are looking for it at all. Special care to screening and attention must be given to patients who cannot read so that they, together with their providers, can take control of their health and the health of their families. Strategies must be put in place to assist in the identification of illiterate patients as they present for care so that their providers can deliver appropriate, efficient, and high-quality health care.
How can patients who have low literacy be identified?

As noted above, it can be very difficult to identify patients with inadequate literacy because of embarrassment over the subject.

How could this case have been handled better to improve understanding and address patients with inadequate literacy?

Health care systems need to develop processes and multiple points to identify truly illiterate patients as they enter the medical setting. Had Ms. Jones’ illiteracy been identified when she presented for care, Dr. Robinson would have spent significantly less time on this issue, and the child’s receipt of needed services would have been expedited. During the family’s first and second visits, the quality of care provided by Dr. Robinson would have been improved had she explored the social context. In her review, she might have elicited the many barriers to care: illiteracy, lack of ability to navigate public transportation, long work hours, and lack of an answering machine. Providers, who are inevitably rushed and primarily forced on giving care and not discussing health, do not always have time to follow the lines of questioning suggested in this case. Frequently, subsequent visits highlighting situations when a patient returns without having followed through with a plan of care afford additional opportunities for providers to engage and access tools essential to delivery of quality care to vulnerable patients.

Finally, the key to high-quality patient care is patient-centered communication characterized by emphasis on respectful, active, nonjudgmental listening skills, and exploration of a patients understanding, desire, and ability to follow through on clinical management plans.
Case 2: Barbara

Explores the economic realities for a low-income family and their eligibility for key programs

Reflection #1:
- What is Barbara entitled to?
- What are key factors to know in order to answer this question?
  a. What state does she want to live in?
  b. Federal Poverty Level: What is it? How is it determined?
  c. What is Barbara’s health status?
  d. What are Barbara’s current sources of income?

Entitlements:
Entitlements are a Federal right based on income. The money/benefit goes directly to the individual. Eligibility criteria are state dependent. There are about four hundred of them.

Examples of entitlements:
- Temporary Assistance to Needy Families (TANF)
- Supplemental Security Income (SSI)
- Supplemental Nutritional Assistance Program (SNAP) - Food Stamps
- Women, Infants, & Children (WIC)
- Section 8 Housing
- Medicaid
- SCHIP

Access to entitlements:
- Varies from state to state
- In a study comparing various sites, New York had the most cumbersome process to obtain welfare benefits (TANF/SNAP/Medicaid)
- New York required many steps in the process including fingerprinting, photographing, home visits, daily 5 day a week job searches
- Application form much longer than other states (18 pages vs. 6 pages in Seattle)
- New York better at having translated applications (9 languages) than some states only in English

Federal Poverty Level (FPL):
- Determined by US Department of Health and Human Services:
  o http://aspe.hhs.gov/poverty/15poverty.cfm
- 2015: $24,250 for family of four (Individual- $11,770)
- Different entitlements are based on percentages of FPL
- Immigration status:
  o States determine which entitlements illegal immigrants are eligible for. For example, in New York State illegal immigrants are eligible for WIC and SCHIP.
  o There are some exceptions as outlined in www.socialneedsrx.org
Reflection #2:

- Barbara wants you to write a letter that documents her need. What is your reaction?

Access to Resources Impacts Health Outcomes/ Social Determinants of Health
http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

- It is well-documented in the medical literature that access to key resources – food, housing, fuel assistance – directly & significantly impacts health outcomes. These are the new health “vital signs”
- Children less than 3 years old whose families need but do not receive help paying their gas or electric bills are 30% more likely to be hospitalized.¹
- Children who experience “food insecurity” – uncertain or limited supplies of nutritious food – are 30% more likely to be hospitalized by age three.²

Reflection #3:

- What is meant by “Welfare”?
- What are some of the programs that comprise “Welfare”?

Welfare benefits can fall under multiple different program umbrellas, all of which require certain elements of eligibility to acquire and maintain payments. These programs are cash assistance (TANF), the child support program, child care, energy or utility assistance, food assistance, medical assistance, and vocational rehabilitation services.
http://www.welfareinfo.org/programs/

“Welfare to Work” began in 1996. Welfare reform law’s key goal was to place greater emphasis on work while continuing to provide a safety net to families with children that are unable to work because jobs are not available or they are addressing a personal or family crisis.

Regulations and restrictions do vary from state to state for obtaining welfare benefits through welfare programs. Below is an overview of general requirements of welfare programs. The goal is that recipients are working towards one day leaving the program which is why there is a focus on job training and skill development. For example, in New York State, there is a lifetime limit of sixty months.

Eligibility Requirements of Welfare Programs:

- A basic lack of gainful employment opportunity through either lack of places of employment or lack of job skill.
- A commitment to self-sufficiency is necessary before any potential recipient can begin to receive benefits. Heads of household must enter into an agreement they will become self-sufficient within a certain timeframe.
- A commitment to cooperation must be signed by the heads of household that they will comply with and continue all regulations and requirements while receiving aid.
- Dependent children must be living in the household. There are some very few exceptions, but generally all dependents must be within the home.
- All minors must be attending school during school days.
• All minors and dependents must be fully and appropriately immunized.
• The recipient must be 18 years of age.
• You must be a legal and permanent resident of the state to which you are applying.
• You must be a citizen of the United States or a qualified non-citizen legal resident, (restrictions apply).
• A commitment to complete accuracy and honesty during the program.
• All monetary resources must be divulged. This includes cash within the home, in checking or savings accounts and items of value in possession such as jewelry or electronics.
• A household financial budget must be created and adhered to.

What are some of the programs that comprise “Welfare”?

Temporary Assistance to Needy Families (TANF)

TANF is cash assistance that is available to bring income into households where there is minimal or none. The purpose of the TANF program is to allow income into the homes so that children, elderly or other dependents can be cared for. The criteria for these welfare benefits are that the heads of household are working to obtain job training which will enable them to leave the welfare programs. TANF is run by States and is funded by Block Grants. TANF block grants provide flat funding and this does not increase in response to increased need. Another problem is that states now use a much smaller share of the diminished funds they receive for cash assistance to poor families than they did in earlier years. States shift substantial portions of these funds for other purposes.

Supplemental Nutrition Assistance Program (SNAP)/ Food Stamps

SNAP is the US government benefits program that provides funds to lower-income Americans and qualified resident aliens in order to purchase the foods necessary to supplement their diet. The eligibility is based on total income in the household. There are web-based charts to determine eligibility by zip code. http://www.snap-step1.usda.gov/fns/ SNAP benefits were switched from coupons to Electronic Benefit Transfer (EBT) cards in all states. Every month benefits are replenished on the card. Most food stores accept EBT. Recipients like this better than the old coupons/vouchers as there is less stigma. It look like debit card.

• Uses:
  • Food or food products
  • Seeds or food-producing plants

• Exemptions:
  • Alcohol and tobacco
  • Hot foods
  • Vitamins and medicines
  • Pet foods
  • Any non-food item
Women, Infants, Children Program (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program - serves to safeguard the health of low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating including breastfeeding promotion and support, and referrals to health care.

http://www.fns.usda.gov/wic/about-wic

Supplemental Security Income (SSI)

Social Security Income was enacted in 1972 to care for elderly or disabled Americans with limited resources. Children are eligible for SSI through the disability route. It is a monthly added income to help supplement the families’ available resources. The majority of SSI funds come from a general revenue fund of the US Treasury, but is run by the Social Security trust funds (i.e. Federal government dollars). Eligibility is based on age, disability status and income. Low income elderly (>65 years of age), or people with blindness or disability are eligible.

For children, income eligibility is based on %FPL and how many workers are in the family. In addition, an applicant must be either an American citizen or in a specific category of documented immigrant.

There are income and asset limitations that are factored into the income calculator.

http://www.ssa.gov/ssi/

State Children’s Health Insurance Plan (SCHIP)

SCHIP is the State Children’s Health Insurance Plan. It was enacted as Title XXI of the Social Security Act as part of the Balanced Budget Act of 1997. Is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. In New York, SCHIP is called Child Health Plus. Child Health Plus is a program that began in New York in 1991 as a solely state-funded program for health care expansion, and was actually one of the models for the federal SCHIP program.

The monthly premium is dependent upon the family income. For example, in New York, there is no monthly premium for families whose income is less than 1.6 times the poverty level. Families with somewhat higher incomes pay a monthly premium of $9, $15, $30, $45, or $60 per child per month, depending on their income and family size. For larger families, the monthly fee is capped at three children. If the family's income is more than 4 times the poverty level, they pay the full monthly premium charged by the health plan. There are no co-payments for services under Child Health Plus, so families don’t have to pay anything when their child receives care through these plans.

Eligibility: state dependent
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Reflections:

- *Can families survive on TANF and SNAP alone?*
  - In many states, TANF and SNAP do not lift families out of deep poverty (50% of FPL)
  - In all states, TANF maximum benefit levels for a family of 3 are less than half the FPL and less than the HUD Fair Market rent for a 2-bedroom apartment
  - Examples of TANF and Food Stamp benefit as percent of Federal Poverty Line
    - New York: 80%
    - New Jersey: 62%
    - Alabama: 48%

- *How do families survive?*
  - Food pantries and other private source of aid
  - Undocumented help from the father, other family and friends
  - Other sources such as cash jobs (e.g./ babysitting, home cleaning)

- *What can we, as providers, do?*
  - Empower patients by providing access to information
  - Encourage families to apply (food stamps, welfare, SSI)
  - Encourage families to be timely in reapplication
  - Document the need for services and follow-up
  - Referral to Social Work, local Community Based Organizations
  - Write an advocacy letter

Please Note: the information and statistics given here are used to illustrate how entitlements work in the lives of our patients. Entitlements change frequently as political leadership and funding change. Please use the websites provided to find the most up to date information.
References:


Kuehn K.C. Quick ways to recognize and cope with illiteracy. *American College of Physicians, April 2000.*


