USING THE FAMILY CONNECTS MODEL AS PART OF A STRATEGY TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

As defined by the Centers for Disease Control and Prevention (CDC), social determinants of health (SDOH) are the conditions in the places where people live, learn, work, worship, age, and play which affect a wide range of health, functioning, and quality-of-life risks and outcomes. SDOH include intangible factors such as political, socioeconomic, and cultural constructs, as well as place-based conditions, including accessible health-care and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthful food.

A few examples of SDOH:

- Income level
- Educational opportunities
- Occupation, employment status, and workplace safety
- Gender
- Racial segregation
- Access to nutritious foods
- Access to housing and utility services
- Early childhood experiences and development
- Social support and community inclusivity
- Crime rates and exposure to violent behavior
- Availability of transportation
- Neighborhood conditions and physical environment
- Access to safe drinking water, clean air, and toxin-free environments

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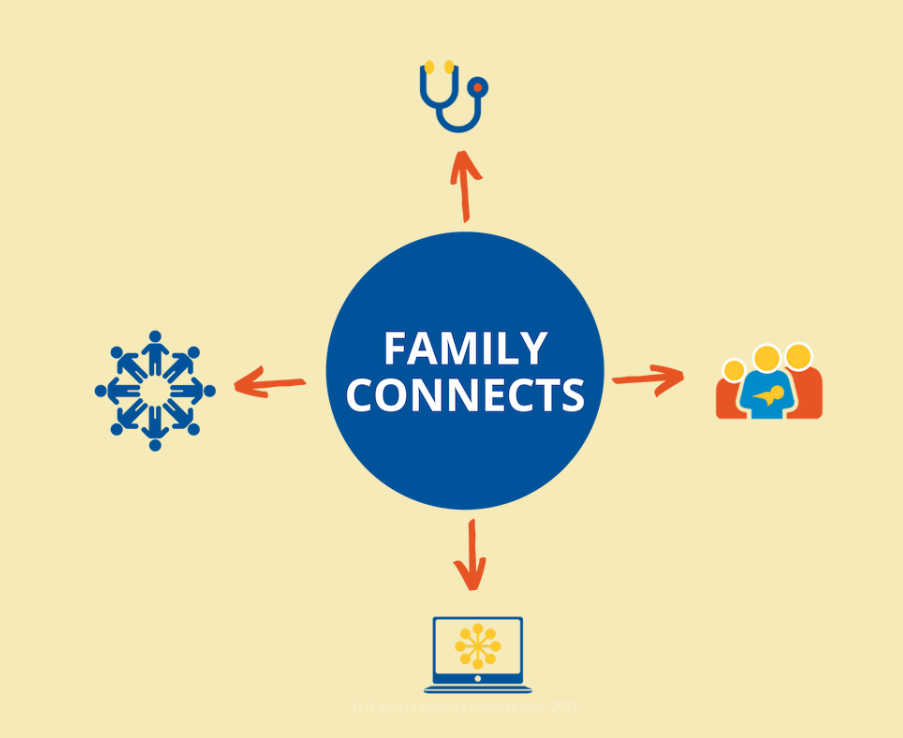
The World Health Organization notes that these tangible and intangible conditions are shaped by the distribution of money, power and resources at global, national and local levels. The SDOH are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between countries.

Increasingly, states and communities — along with health-care systems, clinicians and insurers — are seeking to move the health sector towards promoting health and reducing health inequities. This includes taking steps to assess social needs at the population-health level, including the development and use of standardized patient assessment tools that allow providers to collect patient-level data on the SDOH. Entities are also working together in developing innovative partnerships (with partners like local community-service providers) and holistic-care delivery models. The Centers for Medicare and Medicaid Services (CMS) has encouraged the development of accountable care communities to build a bridge between clinical services and community services. Regulations for managed care, the primary delivery system for people enrolled in Medicaid, have also recently been updated to support delivery system reform that drives person-centered care.

However, there is still much to be learned regarding the SDOH, especially the very complex intangible factors. And many barriers remain that limit the spread of successful clinical-community collaborations to address SDOH:

- Community resources are fragmented with no process for tracking and updating all available resources.
- Funding limitations limit the number of people who can be served.
- Connections to resources are not well-supported or followed-up.
- Gaps and challenges to accessing services are not examined from community members' perspectives, nor is there a mechanism for elevating identified needs and gaps in services.
- Data integration across systems used by clinicians and social-service providers is challenging, preventing a medical home from having access to relevant information.

There may also be barriers to obtaining consent to share information, either at a personal health-record or aggregate level.



The Family Connects model cannot remove all of these barriers, but it can:

- support the efforts within a state or community to align community resources;
- insure all referral information is detailed and current in real time;
- identify and elevate the social determinants for postpartum mothers and their newborns/families;
- deliver a warm hand-off to services;
- insure there is a feedback loop; and
- integrate with the data systems used by the community clinicians that form the families' medical homes (with patient permission).

Family Connects International (FCI) offers this evidence-based, population-health model that pairs engagement and alignment of community-service providers with a nurse-delivered family check-up in the home. The visit usually takes place within the first month after birth. FCI-trained, culturally responsive registered nurses visit any new family who desires it (Family Connects is completely voluntary), providing health check-ups and comprehensive assessments. Nurses are trained to build trust, offer supportive guidance, and navigate difficult situations. FCI provides the assessments, screening tools, and a data system that nurses use to link families with a direct connection to the specific community services that meet their individual needs and preferences.

The model includes trained community alignment specialists who partner with local stakeholders to develop and maintain a regularly updated and detailed guide to the resources within a community for families. Program staff follows-up with families to ensure that the community services they were referred to met their needs (and to take further steps if the connection was not successful).

The robust data system helps identify family needs that are not being met from available community resources, and the program's Community Advisory Board serves to elevate and advocate for new or supplemental resources that are needed within the community. With a family's consent, the nurse can follow up and share essential information with the family's medical home(s) to insure those providers have information about the home visit and referrals to social services.

Learn more on our website: www.familyconnects.org

Contact us to start the conversation: familyconnects@duke.edu

Sources

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