Introduction to Social Determinants of Health in Long-Term Care

Table of Contents

[Welcome 1](#_Toc78357695)

[Introduction to Social Determinants of Health in Long-Term Care 1](#_Toc78357696)

[Resources 1](#_Toc78357697)

[Objectives 1](#_Toc78357698)

[Disclaimer 1](#_Toc78357699)

[Lesson 1: Overview 1](#_Toc78357700)

[Definition of Social Determinants of Health 2](#_Toc78357701)

[Definition of Social Determinants of Health (cont.) 2](#_Toc78357702)

[DHS: Social Determinants of Health 2](#_Toc78357703)

[OLTL: Additional Factors 2](#_Toc78357704)

[What Do You Think? 3](#_Toc78357705)

[Lesson 2: DHS’s Social Determinants of Health and the Role of SCs and DSPs. 3](#_Toc78357706)

[Childcare Access and Affordability 3](#_Toc78357707)

[Childcare Access and Affordability (cont.) 3](#_Toc78357708)

[Working with Childcare Access and Affordability 4](#_Toc78357709)

[Clothing: Emergency Assistance 4](#_Toc78357710)

[Working with Clothing Emergencies 4](#_Toc78357711)

[Working with Clothing Emergencies (cont.) 4](#_Toc78357712)

[Employment 5](#_Toc78357713)

[Working with Employment 5](#_Toc78357714)

[Working with Employment (cont.) 5](#_Toc78357715)

[Financial Strain 5](#_Toc78357716)

[Working with Financial Strain 6](#_Toc78357717)

[Food Insecurity 6](#_Toc78357718)

[Food Insecurity (cont.) 6](#_Toc78357719)

[Working with Food Insecurity 7](#_Toc78357720)

[Working with Food Insecurity (cont.) 7](#_Toc78357721)

[Health Care/Medicine Access & Affordability 7](#_Toc78357722)

[Health Care/Medicine Access & Affordability (cont.) 8](#_Toc78357723)

[Working with Health Care/Medicine Access & Affordability 8](#_Toc78357724)

[Housing Insecurity/Instability/Homelessness 8](#_Toc78357725)

[Working with Housing Insecurity/Instability/Homelessness 8](#_Toc78357726)

[Working with Housing Insecurity/Instability/Homelessness (cont.) 9](#_Toc78357727)

[Transportation 9](#_Toc78357728)

[Working with Transportation 9](#_Toc78357729)

[Working with Transportation (cont.) 10](#_Toc78357730)

[Utilities: Emergency Assistance 10](#_Toc78357731)

[Working with Utility Emergencies 10](#_Toc78357732)

[Knowledge Check 11](#_Toc78357733)

[Lesson 3: OLTL: Additional Factors 11](#_Toc78357734)

[Childhood Experiences 11](#_Toc78357735)

[Childhood Experiences (cont.) 12](#_Toc78357736)

[Working with Childhood Experiences 12](#_Toc78357737)

[Diversity 12](#_Toc78357738)

[Diversity (cont.) 13](#_Toc78357739)

[Diversity: Gender Identity & Sexual Orientation 13](#_Toc78357740)

[Working with Gender Identity & Sexual Orientation 13](#_Toc78357741)

[Working with Gender Identity & Sexual Orientation (cont.) 13](#_Toc78357742)

[Diversity: Cultural Perspectives 14](#_Toc78357743)

[Working with Cultural Perspectives 14](#_Toc78357744)

[Diversity: Race 14](#_Toc78357745)

[Working with Race 14](#_Toc78357746)

[Diversity: Disabilities 15](#_Toc78357747)

[Working with Disabilities 15](#_Toc78357748)

[Working with Disabilities (cont.) 15](#_Toc78357749)

[Education & Literacy 16](#_Toc78357750)

[Working with Education & Literacy 16](#_Toc78357751)

[Working with Education & Literacy (cont.) 16](#_Toc78357752)

[Healthy Behaviors 17](#_Toc78357753)

[Healthy Behaviors (cont.) 17](#_Toc78357754)

[Working with Healthy Behaviors 17](#_Toc78357755)

[Healthy Eating 17](#_Toc78357756)

[Exercising 17](#_Toc78357757)

[Medication 18](#_Toc78357758)

[Summary 18](#_Toc78357759)

[Social Supports & Engagement 18](#_Toc78357760)

[Working with Social Supports & Engagement 18](#_Toc78357761)

[What Do You Think Now? 18](#_Toc78357762)

[Course Summary 19](#_Toc78357763)

[Lesson 4: Conclusion 19](#_Toc78357764)

[Congratulations! 20](#_Toc78357765)

# Welcome

## Introduction to Social Determinants of Health in Long-Term Care

Welcome to the Office of Long-Term Living’s (OLTL’s) Introduction to Social Determinants of Health in Long-Term Care. The goal of this training is to educate Service Coordinators and direct service providers about Social Determinants of Health, review barriers to addressing Social Determinants of Health with program participants and apply the learning to the long-term care environment.

## Resources

Many website links are mentioned in this module. To ensure that the links remain accurate and active, we have placed them in a separate document on this website.

Whenever a link is available in the Resources Document, the following bar will be displayed in the training module, usually at the bottom of your screen.

## Objectives

The goal of this course is to raise awareness of Social Determinants of Health in order for individuals to identify opportunities for further development of their knowledge and skills.

After completing this module, you will be able to:

* Identify Social Determinants of Health and their significance in long-term care.
* List actions you can take to work with Social Determinants of Health in service planning and monitoring.
* Describe barriers to addressing issues with program participants.

## Disclaimer

Please note that this course covers sensitive topics. If any of these topics are a triggering event, you can skip to a different topic using the “Menu” tab on the left of the screen. In addition, it’s important to remember that every day is different. Our own experiences can sometimes influence our perspectives. It is important for all of us to be mindful of our own implicit biases, preferences, and recent experiences in every interaction we have with program participants. This will ensure the participant has a truly person-centered experience.

# Lesson 1: Overview

Let’s start by defining Social Determinants of Health and exploring the layout for this module.

## Definition of Social Determinants of Health

Social Determinants of Health are environmental and societal factors that impact health outcomes. The World Health Organization describes Social Determinants of Health as the conditions in which an individual is born, grows, lives, works and ages. These often-interrelated factors, though not medical in nature, can have a significant effect on health and long-term care outcomes.

## Definition of Social Determinants of Health (cont.)

Though it is important for Service Coordinators (SCs) and Direct Service Providers (DSPs) to be aware of these factors, they should not make assumptions about the specific situations. They should have person-centered discussions, noting that these issues could affect the success of the person-centered service plan. Service planning, service delivery and plan monitoring are participant-directed. Each plan reflects the individual participant’s goals and preferences. The SC is there to stimulate conversation, being aware that Social Determinants of Health can have effects on the outcome.

## DHS: Social Determinants of Health

Different organizations describe and categorize Social Determinants of Health in different ways. All health research organizations agree on the basics, though. The list we’ll work with in the next lesson are the topics identified by the Department of Human Services (DHS). This alphabetical list includes:

* Childcare Access and Affordability;
* Clothing: Emergency Assistance;
* Employment;
* Financial Strain;
* Food Insecurity;
* Healthcare/Medicine Access & Affordability;
* Housing Insecurity;
* Transportation; and
* Utilities: Emergency Assistance.

## OLTL: Additional Factors

The list we'll work with in Lesson 3 focuses on additional factors identified by OLTL and long-term care professionals in the Commonwealth that can affect participants' health. This alphabetical list includes:

* Childhood Experiences;
* Diversity;
* Education and Literacy;
* Healthy Behaviors; and
* Social Supports and Engagement.

## What Do You Think?

Before we continue with the course content, let’s see what you think about Social Determinants of Health.

Of the Social Determinants of Health and additional factors we just listed, which one do you think is the most important? Why?

Please pause.

Thank you for your response. There is no one right answer. As you work with an individual, you will learn how important each determinant is to them.

# Lesson 2: DHS’s Social Determinants of Health and the Role of SCs and DSPs.

Now let’s look at the Social Determinants of Health as identified by DHS and the role of Service Coordinators and Direct Service Providers in addressing them with each individual. The topics are presented in alphabetical order, beginning with Childcare Access and Affordability.

## Childcare Access and Affordability

Access to affordable, quality childcare is a social determinant of health for both the child and parents. Parents who lack access to quality childcare can experience higher levels of chronic stress, which affects their physical and mental health. Children who lack opportunities for quality childcare in their early years may experience lifelong consequences, including but not limited to, lower educational attainment, lower income jobs, higher risk of behavioral health issues and shorter lifespans.

Children who are unsupervised could be unsafe; however, supervision is not enough. Quality childcare involves the provider engaging with each child throughout the day. Research has shown a correlation between the number of words that children hear from birth to age 3 and their educational attainment by the third grade.

## Childcare Access and Affordability (cont.)

Families who are vulnerable may have insufficient financial resources to pay for quality childcare. Other barriers can include transportation, updated immunizations and physical locations of childcare facilities. If families cannot access or afford formal childcare, they may need to rely on informal supports to provide at least some supervision to keep their children physically safe. Families in crisis may not even have access to informal supports and may be forced to leave their child unsupervised and unsafe.

## Working with Childcare Access and Affordability

Childcare is usually a high priority for individuals. The most common barriers are affordability, availability, eligibility, and transportation. Affordable childcare can be a challenge for many of the parents we serve. It is important to be aware of local options, especially those that offer financial assistance. Availability is another challenge. Childcare may not be available during the hours that are needed by the family, or there may be a waiting list. Eligibility for childcare may center on whether a child can be accepted by the provider due to age or immunization status. Finally, transportation may be an issue depending on the geographic location of available childcare providers.

In working with families, it is critical to have a thorough understanding of childcare options in the local area, including costs and eligibility for the different options. The Internet can be an important tool. There are local sites in most areas that provide comparisons of different childcare options. Finding the best fit can be a challenge and may require families and their support team to be creative. It is essential to understand not only local resources available, but also the key questions to ask about eligibility and the supports families may need to ensure that their children can immediately access childcare when it becomes available.

For more information and key questions to ask providers, check the Resources Document for the link to “5 Steps to Selecting a Child Care Provider” page on the DHS website.

## Clothing: Emergency Assistance

Now, let’s look at the next Social Determinant of Health: Clothing. Having an adequate wardrobe may not be the first thing to come to mind in terms of participant health and safety. Pennsylvania has four specific seasons that can feature extremes of heat, cold, rain and snow. A lack of temperature- and weather-condition-appropriate clothing can pose immediate risks to health and safety. Without a winter coat, trips to the corner store can result in colds, flu or worse. The same applies for a lack of rain gear. Extreme heat, especially in the absence of air-conditioning, poses threats of heat exhaustion, dehydration and other risks to participant health.

## Working with Clothing Emergencies

Because of these threats to health and safety, Service Coordinators are expected to follow program guidelines in working with questions of clothing. This could be a more sensitive topic than “utilities,” but it is vital that Service Coordinators have the conversation.

## Working with Clothing Emergencies (cont.)

Service Coordinators are expected to use culturally competent, person-centered interview skills to assess the situation and provide needed assistance. If the individual does not have adequate outer wear for inclement weather and clothing to adapt to extremes of heat and cold even inside, the Service Coordinator is expected to work with the participant to acquire clothing and have a plan for its cleaning and storage. Service Coordinators should be knowledgeable about all community services and programs that provide clothing assistance.

For more information on finding resources, please review the Resources Document associated with this training..

## Employment

The next Social Determinant of health is employment. Individuals who participate in Community Health Choices (CHC), OBRA, Living Independence for the Elderly (LIFE), and Act 150 may be unemployed, especially if their long-term care needs are a result of a new situation such as a life-changing injury or unexpected worsening of a chronic condition. Pennsylvania’s Employment First initiative is competitive, integrated employment for any program participant who wants it. OLTL provides services and supports for those individuals who want to work while receiving long-term services and supports. This is not a work requirement. It is an opportunity for program participants to receive the financial, social and health benefits of paid, integrated, competitive employment without losing their benefits.

## Working with Employment

Service Coordinators are required to discuss employment options with participants during the initial planning phase and as part of their quarterly updates. If an individual expresses interest, Service Coordinators refer them to the Office of Vocational Rehabilitation for support and to their local County Assistance Office to explore the ramifications of working under MAWD, the Medical Assistance for Workers with Disabilities program.

## Working with Employment (cont.)

Employment services include: Benefits Counseling (to ensure participants are in financial compliance with other programs and do not lose benefits due to work), Career Assessments (to determine likely courses of action in terms of a participant’s knowledge, skills, experience and preferences), Employment Skills Development (to add specific skills participants may need to secure a job in their preferred area), Job Finding (to support the search and application processes), and Job Coaching (to support participants as needed once they have secured competitive, integrated employment).

For more information on service definitions, Service Coordinator responsibilities, provider responsibilities and processes, please review the Resources Document associated with this training, specifically on how to access Employment online training.

## Financial Strain

Financial strain is the next Social Determinant of Health. Income level affects health outcomes. This is because financial stability influences not only the ability to pay for health services, but also many of the other social determinants. For example, poverty negatively impacts access to health services, educational opportunities, employment opportunities, access to flexible transportation options, and the ability to live in their neighborhood of choice. Intergenerational financial instability and its associated stressors could have significant impacts on children. These impacts could be carried into adulthood.

## Working with Financial Strain

Clearly, individuals who participate in public programs like those offered through OLTL could be economically insecure. If an individual qualifies for Medicaid, they are in lower income brackets at the time they are enrolled. Something for Service Coordinators to consider is how long the individual has been economically insecure. Is this a new condition? How long have they felt the stress of living in a low-income household? How has this affected their overall health? Have they had access to preventative care? If they are new to economic distress, have they been educated on all programs and services available to them? Are they aware that employment is an option for public program participants? Service Coordinators can make referrals to federal, state and local programs so that participants can be more secure.

For more information on working with financial strain, please review the Resources Document associated with this training.

## Food Insecurity

Food insecurity is another major Social Determinant of Health. One in ten individuals in Pennsylvania struggles with food insecurity. Food insecurity includes a range of situations that affect health outcomes. People who are unable to afford or access sufficient food are vulnerable. These individuals may need to rely on food donations or getting help from family and friends. They may not be eligible for the Supplemental Nutrition Assistance Program (SNAP) or may have run into barriers accessing the program. If these informal supports fall through, they may go hungry. Other individuals may be in crisis. Individuals who miss meals or go hungry are considered “in crisis” and need immediate intervention.

## Food Insecurity (cont.)

There are two essential aspects to food security on which we’ll focus: affordability and access. Clearly, low-income individuals are more likely to be vulnerable. Unexpected bills, increases in rent or utilities, or a lowering of income can force individuals to prioritize their spending on items other than food.

In addition to the challenges of affording food, people can experience challenges accessing food. Individuals who lack needed transportation or have limited mobility may not be able to get food sources outside of walking distance. Adding to this challenge is the possibility that supportive programs, such as food banks, may not be physically close enough to the individual for them to access.

## Working with Food Insecurity

Ensuring that individuals can afford and access proper nutrition is essential to maintaining health. It is essential to talk about the situation and discover all the barriers that people face in feeding themselves and their families. If the challenge is affordability, there may be some relief to be had from the SNAP program. People may need assistance signing up for the program and learning how to use it. It is important to keep in mind that SNAP is intended as a supplement, not a full food budget. Individuals may need assistance cobbling together various sources of nutritional support in addition to public programs. Other sources may include local food banks and other nonprofit organizations focused on providing food to individuals in need.

The other common barrier is access. A common conversation would include talking about where individuals shop for food and how they get there and back. In this case, explore transportation options with the individual. Depending on costs, grocery delivery service may be available as well.

## Working with Food Insecurity (cont.)

Other barriers may exist in the home. Though it may be an uncomfortable conversation, it is important to start a conversation about food preparation and food storage, if the individual is open to it. People may lack the means to freeze or refrigerate food. This would limit their options and possibly increase their food budget. Others may not have the experience and equipment to prepare meals. If the individual is interested, explore accessing kitchen supplies and education. It is important to be person-centered in these conversations. How people choose to eat is up to them.

For many individuals, affordability is the main barrier, but it may not be the only barrier. In working with food insecurity, be sure to have an open, complete, and person-centered conversation about all aspects of how the individual would like to improve and maintain household nutrition.

## Health Care/Medicine Access & Affordability

The next Social Determinant of Health that we will cover is access and affordability relating to health care and medicine. Access to health services applies to two main concerns: participants’ knowledge of services available and removing barriers to receiving those services. Some program participants may not have been accessing all available care, especially preventative care. Many of us put off dental or ophthalmological visits due to a perception that these are less critical issues. They are not less critical. Non-acute health services can affect overall health, such as preventing or identifying more serious conditions. For example:

* A lack of preventative dental care can affect the ability of people to eat healthy food. Severe dental conditions also can affect heart health.
* A lack of preventative vision care can affect an individual’s overall health.
* A lack of preventative behavioral health care can lead to severe outcomes up to and including hospitalization, facility placement or even suicide.

## Health Care/Medicine Access & Affordability (cont.)

A lack of access to basic and preventative health services has a human cost and poses a financial burden to the public health system. A lack of investment in health access and preventative services leads to greater costs treating severe outcomes. This puts an undue financial strain on the public health system.

How did we get here? Many people have not had dental, vision or behavioral health insurance coverage in their employer-defined health plans. Other people may find it difficult to find health service providers in their areas. Further, based on past experiences, some individuals are reluctant to go to doctors. All of these dynamics make it difficult to access effective health services and preventative care.

## Working with Health Care/Medicine Access & Affordability

Service Coordinators are responsible for discussing with participants all health services available to them and helping to remove barriers that participants face in accessing these services. Service Coordinators need to know how to access providers in their areas and assist participants in getting set up with services. Transportation to and from appointments can be an issue. Service Coordinators work with participants to determine the least costly and most appropriate form of transportation available and assist participants in signing up for transit services. Service Coordinators use their motivational interviewing skills during regular participant contact points to follow up on the success of visits and participant satisfaction with outcomes. Direct care workers can also follow up during the regular conversations they have with participants.

For more information on access to health services, please review the Resources Document associated with this training.

## Housing Insecurity/Instability/Homelessness

Finding affordable, accessible housing is a challenge in most states. Pennsylvania is no exception. Challenges beyond the basics of affordability and accessibility are access to transportation routes, security of housing, payments and cost. Once housing is secured, issues of the physical environment may arise. Common environmental issues include pest infestation, hoarding, lack of common assistive devices (such as raised toilets and grab bars), lack of temperature control and smoking while using oxygen. Each of these issues can pose a risk to participant health and safety. Service Coordinators are required to engage on these issues in a person-centered manner to manage and resolve the health and safety risks.

## Working with Housing Insecurity/Instability/Homelessness

CHC includes services for housing and pest eradication services. Service Coordinator responsibilities also include addressing issues related to security, transportation, finances and physical environment. Service Coordinators may receive calls from participants who are to be evicted. They can work with participants and their landlords to avoid losing housing. They are also expected to be aware of environmental issues in their initial planning sessions. Service Coordinators can ask how participants feel in terms of the safety of their situation. They can ask to see kitchens, stairs and bathrooms to assess how safe these areas of common fall risk really are. They can educate participants on their rights as renters and landlord responsibilities for safety and security.

## Working with Housing Insecurity/Instability/Homelessness (cont.)

DSPs and their care workers are also responsible for participants’ health and safety. Care workers are in the participant’s home on a regular basis. They can be the “front line” in identifying environmental safety issues. If providers can intervene immediately to solve the issue in a person-centered manner, they do so. If they cannot, Service Coordinators can become involved to develop a plan with the participant to make the living environment safer. In either case, provider staff should keep Service Coordinators up to date on the situation.

For more information on working with housing, especially on how to access the Housing online training, please consult the Resources Document associated with this training.

## Transportation

Another crucial Social Determinant of Health is transportation. Long-term services and supports and person-centered service plan goals that require transportation may include medical appointments, grocery shopping, social engagements, employment, religious services, visits to day programs and other rides necessary for participants to reach their goals. Unfortunately, transportation is a common barrier for individuals with long-term service and support needs. In some cases, an individual’s physical capacity does not allow them to drive anymore. They must rely on public transportation or volunteer transportation. Some physical conditions require extra care in using transportation. And in some areas of Pennsylvania, transportation options are limited. In addition, the time of day in which transportation is required may not line up with the available options in the county in which the participant lives. For example, for individuals seeking and maintaining integrated competitive employment, their work hours may not align with available public transportation options in their county. Distance can also be an issue in rural counties. Even participants living in counties with extensive public transportation options can have difficulty meeting their individual needs. In all cases, appropriate transportation must be provided for participants to meet their plan goals.

## Working with Transportation

So, how are the decisions made in terms of what kind of transportation works best in each situation to meet participant needs? Let’s start with the types of transportation based on need. There are two basic types of transportation that apply to person-centered service plans: non-emergency medical transportation (NEMT) and non-medical transportation. Emergency medical transportation by ambulance is also available for participants.

Non-emergency medical transportation can include doctor visits, dialysis, therapies and other scheduled medical services. Non-medical transportation meets participant needs such as grocery shopping, employment and other non-medical trips. Different programs support each type and need. And different entities coordinate and pay for transportation depending on the type and need. For example, CHC-MCOs contract with transportation brokers to coordinate non-medical transportation. CHC-MCOs also contract with transportation brokers to coordinate certain non-emergency medical transportation. In other programs, transportation services may be contracted directly with transit agencies or may be provided by the program. Depending on the participant’s need and reason for transportation, different programs and payers can be involved.

## Working with Transportation (cont.)

In terms of the mode of transportation that works best for participants, there are several options. Some participants can use public transportation such as bus service to go to non-emergency medical appointments. Others may rely on volunteer transportation. Depending on age and physical capability, participants may use demand response shared ride services. The decision in terms of the most appropriate mode can also be based on multiple factors such as whether the participant can travel alone, where the participant is being transported to, and which entity is responsible to provide the transportation. For example, a dialysis patient who can ambulate independently could use shared ride transportation through the Medical Assistance Transportation Program for appointments within their home county. Whereas a dialysis patient who cannot ambulate or use a wheelchair may need stretcher service coordinated and paid for by the CHC-MCO. Each decision is person-centered and tailored to the individual.

For additional resources on transportation, please review the Resources Document associated with this training.

## Utilities: Emergency Assistance

Another area critical to the health of program participants and essential to a safe living environment is the presence of utilities: water, sewer, electricity, gas and others. Utilities provide water for drinking, cleaning and cooking. Sewer services ensure that waste disposal is immediate. Power utilities like electric and gas ensure that environmental conditions are healthy (heating and cooling) and that appliances work to keep food and medications at safe temperatures. Utility failures present an immediate risk to individuals whose medications must be refrigerated and a mid-term risk to those whose physical conditions cannot adapt to extremes of cold or heat.

## Working with Utility Emergencies

Because of the risks to health and safety, Service Coordinators are expected to work with participants who have lost service or have a pending shutoff. Service Coordinators are encouraged to have knowledge of local utility providers, the specific providers of each participant and contact information for emergency assistance within utility companies. Utilities who serve participants with health conditions should not be able to cut off services without thorough review. Service Coordinator responsibilities include working with participants to restore or prevent shutoffs, assisting them with return to services and developing a plan to prevent shutoffs in the future. This could be assistance with setting up budget plans with utilities and financial management support depending on the reason for the shutoff—lack of funds or simple failure to send a check.

For more information on working with utility emergencies, please review the Resources Document associated with this training.

## Knowledge Check

Now take a moment to answer these review questions.

1. Which of the following factors are common barriers to obtaining childcare? (Select all that apply.)

Affordability

Availability

Eligibility

Transportation

Please pause.

The correct answer is that all four of these factors are common barriers to obtaining childcare.

2. True or False? If a participant does not own the appropriate clothing to deal with inclement weather, the Service Coordinator should insist that the participant only leave the home during ideal weather conditions.

Please pause.

The correct answer is False. The SC is expected to work with the participant to acquire appropriate clothing. SCs should be knowledgeable about all community services and programs that provide clothing assistance.

3. True or False? Income level can affect health outcomes.

Please pause.

The correct answer is True. Financial stability can influence not only the ability to pay for health services, but also many of the other social determinants of health.

# Lesson 3: OLTL: Additional Factors

Now let’s look at some additional factors identified by OLTL and long-term care professionals that can affect participants’ health. These topics are presented in alphabetical order, beginning with Childhood Experiences.

## Childhood Experiences

Childhood experiences could stay with us for life and could affect decision-making, planning and outcomes in long-term care. Participants who have experienced childhood trauma may not see the world through the same prism as those who had an uneventful upbringing.

Service Coordinators and direct care workers can encounter issues of mistrust, distancing, aversion to touch and resistance to receiving services that require caregivers to perform certain tasks. Each participant may manifest trauma in different ways. Negative experiences as adults with physical and behavioral health services can exacerbate childhood trauma.

## Childhood Experiences (cont.)

The stress of financial strain may be felt by everyone in the household. This could stay with people for their entire lives and affect health-care decision making. Other stressors from childhood can include the sense of a lack of safety, and mistrust depending upon their experiences with authority figures. In severe cases, childhood trauma could be based on emotional, physical or sexual abuse. These memories and experiences could affect behavior for the rest of a person’s life. The situation may be exacerbated if there are no immediate behavioral health supports.

## Working with Childhood Experiences

First, Service Coordinators and providers should be familiar with trauma-informed coordination and care. Specialized training and approaches are needed to work with these issues. Second, although Service Coordinators and providers need to be knowledgeable of triggers and likely behaviors of individuals who experienced childhood trauma, they cannot make assumptions and must follow specialized interview and communication guidelines and approaches to build trust and work with the individual in the most appropriate way.

To locate additional resources related to trauma-informed care, please consult the Resources Document associated with this training.

## Diversity

Now, let’s take a look at diversity. The DHS vision is to see all Pennsylvanians living safe, healthy and independent lives, free of discrimination and inequities. DHS’s mission is to assist Pennsylvanians in leading safe, healthy, and productive lives through equitable, trauma-informed, and outcomes-focused services while being an accountable steward of commonwealth resources.

Service Coordinators and providers strive to meet every participant’s preferences.

Diversity of perspective, background, experience, and knowledge can lead to more dynamic organizations, better ideas, and better outcomes. Reaching optimal diversity can be difficult to attain. It is easier to surround ourselves with people just like us. A lack of diversity not only hampers organizations, but it can also exclude people from full engagement as employees or participants. Therefore, there are rules in place to ensure the most basic level of diversity, which is nondiscrimination.

Diversity is an issue that affects all aspects of health care access, health care delivery, and long-term services and supports. In this training, we are focusing on diversity in terms of participant preferences in receiving services in four areas: gender, culture, race and disability.

## Diversity (cont.)

By law, every provider organization is required to recruit and retain quality employees to deliver services to program participants without discrimination based on age, race, creed, color, national origin, ancestry, marital status, sexual orientation, gender identity, or disability. Providers must comply. Compliance training is required of all providers.

Now that we've discussed hiring and managing employees, let's turn to how we work with issues of diversity in delivering person-centered services.

## Diversity: Gender Identity & Sexual Orientation

Gender and sexual orientation could affect individual and Service Coordinator interactions in many ways. We’re focusing on two in this training: programmatic requirements and person-centered support as needed. In terms of programmatic requirements, these issues are part of non-discrimination requirements in the program. In addition, program forms now include an option for individuals to have their gender reflected accurately. “What are your preferred pronouns?” is a person-centered way to address this. Sexual orientation can become an issue in terms of how long-term care services are provided. For example, in shared living environments, LGBTQ+ individuals could experience discrimination or harassment from other residents. Industry professionals, including Service Coordinators, are expected to provide culturally-competent, person-centered support in working through these situations.

## Working with Gender Identity & Sexual Orientation

The first thing Service Coordinators can do is build and maintain trust with participants. Make sure that participants know that they can call if they experience difficulties. Part of being person-centered is respecting privacy. If an individual does not disclose private issues, that is their choice. The person-centered path is to ask open questions and listen effectively. “How are things going in your new living situation?” “What’s the best part?” “What do you like least?” “How can we make it better?” It is especially important with sensitive issues of gender identity and sexual orientation to explore and manage our own past experiences and potential biases as well as to remain open and person-centered throughout the process.

## Working with Gender Identity & Sexual Orientation (cont.)

Another consideration that Service Coordinators and providers encounter has to do with preferences on service plans. Program participants may express a preference for a specifically gendered care worker. For example, a female participant may prefer (or demand) that her personal assistance services (PAS) be provided by a female. On its face, this may seem like discrimination. Service Coordinators need to take the next step in a person-centered manner to discover the reasons behind a preference that seems to be discriminatory. Using phrases such as “Help me understand your preference” or “What led you to this preference?” can give the Service Coordinator a fuller understanding of the individual. Preferences should be honored if the provider network has individuals available who meet the participant’s request (or demand). The challenge arises if no care workers that fit the participant’s preference are available. At this point, the reasoning behind the preference can help us in finding an alternative. Perhaps a male PAS worker could perform all duties that do not require touch and be supplemented by a female PAS worker for duties that do require touch.

For more information on working with gender and sexuality, please consult the Resources Document associated with this training.

## Diversity: Cultural Perspectives

Cultural issues can affect the success of the service plan. Individuals’ cultural preferences must be honored. Cultural issues can manifest in multiple ways, such as nutrition (for instance, foods preferred and dietary restrictions), housing (such as the desire to live with individuals of their own cultural background) and direct care worker (for instance, preference for a male/female worker or preference for a worker familiar with their culture).

## Working with Cultural Perspectives

Cultural competence is part of a person-centered approach. Without making assumptions, Service Coordinators can ask questions to discover what cultural preference a participant might have. “What special skills or background would you prefer in a direct care worker?” Those preferences for how a participant receives care are documented in the service plan and shared with direct service providers. If a provider cannot match the cultural preference of a participant with their workforce, Service Coordinators can discuss a participant-directed model with the participant.

For more information on cultural competence, please review the Resources Document associated with this training.

## Diversity: Race

Issues of race in long-term care can manifest in a participants’ preferences for direct care workers. Participants can express a preference for a care worker from a specific race, but providers may not be able to accommodate these preferences.

## Working with Race

How can Service Coordinators navigate issues of race in planning and service delivery? First, Service Coordinators must maintain a person-centered approach, making no assumptions and being aware of their own experiences and potential biases. Service Coordinators could ask about what led the participant to this preference as long as the questions are free of judgement and the participant has the option not to answer. Service Coordinators must also be candid with participants. If a participant expresses a narrow set of racial parameters for their preferred care workers, they may find themselves without a provider if none of the provider workforce fits this. Service Coordinators can discuss a participant-directed model if agencies cannot fulfill a participant’s preference.

For more information and resources in working with issues of race, please review the Resources Document associated with this training.

## Diversity: Disabilities

SCs and provider staff have training and experience on how to provide services to individuals with disabilities.

However, depending on their biases, fears or past experiences, SCs and provider staff could act in a way that could be nonproductive, even if well-intentioned. Common examples of this can include:

* Physically assisting an individual to ambulate when the individual can (and prefers to) move independently,
* Speaking very slowly and/or loudly to an individual who is older or who uses mobility devices when the person does not have a hearing or cognitive issue, or
* Performing a task without first checking for input about what works best for the person.

These behaviors could damage rapport, create mistrust and lead to a breakdown in the relationship between the SC/provider staff and the individual.

## Working with Disabilities

Having a disability is part of an individual’s identity, along with other elements such as race, gender identity, culture, life experiences and others. It is important for workers who interact with people with disabilities to ensure that their interactions:

* Reflect the diversity of an individual’s background and experiences;
* Focus on an individual’s abilities, not just their disabilities;
* Acknowledge an understanding of an individual's disabilities;
* Honor an individual’s personal preferences; and
* Create an environment of mutual comfort, rapport and respect.

## Working with Disabilities (cont.)

How do we do this? Ask questions and actively listen. Avoid assumptions, especially when working with a participant for the first few times or when performing tasks for the first time. Check in with them in terms of their preferences in regard to how to provide them individualized services.

Questions that can open these conversations include:

* How would you like me to work with you?
* How would you like me to . . .?
* What is your experience with . . .?
* What is the best way for you . . .?

And, as a best practice in listening, take time to confirm what you heard. This ensures that you heard it accurately. You can preface your confirmation with: “I want to get this right, what I heard is. . .” or other phrases that put the responsibility for receiving the correct information on the SC or provider staff.

## Education & Literacy

Now, let’s take a look at education and literacy. There are exhaustive studies correlating education levels to longevity and positive healthcare outcomes. Since that is beyond the span of control of Service Coordinators and public programs, we are going to focus on specific areas of education and literacy in which Service Coordinators can provide person-centered support when it is requested.

Let’s start with education. At a basic level, Service Coordinators provide education about health care, long-term care, transportation, public programs and navigational techniques when needed and requested for participants to reach their goals. It may not stop there, though. Participants may express an interest in returning to school, learning new skills or earning a certification. Service Coordinators provide person-centered support to assist participants in reaching their individual education goals.

Literacy can come into play in various forms. There is the issue of basic literacy in the participant’s language of choice. Some individuals may be more or less literate in different languages. It is the responsibility of the Service Coordinator to communicate in the language preferred by the participant. There are also issues of healthcare system literacy, computer literacy, form-completion literacy, financial literacy and others.

## Working with Education & Literacy

As with all aspects of long-term care, Service Coordinators start with person-centered conversations about education and literacy, taking into consideration each individual’s preferences, starting point, environment and expressed capabilities. In terms of education, Service Coordinators are there to assist with referrals and to help participants remove barriers to the participant’s education goals. Barriers could include transportation, cost, technological resources or current expressed levels of literacy. In terms of literacy, Service Coordinators are required to provide interpreter services, forms and documents in the language and mode preferred by the participant. Beyond that, if participants express an interest, Service Coordinators can assist them in finding and using services to improve any aspect or type of literacy in any area.

## Working with Education & Literacy (cont.)

Local resources are available in many areas to improve language, technological and financial literacy. Service Coordinators can also support participants in identifying and removing barriers to accessing these services. Common barriers can include transportation to classroom activities and availability and accessibility of technology resources to access online educational opportunities.

For more information on overcoming barriers and working with literacy, please review the Resources Document associated with this training.

## Healthy Behaviors

Healthy behaviors are another additional factor. How can participants improve their overall health? By increasing healthy behaviors—such as, eating better, exercising and taking medications—and decreasing unhealthy behaviors—such as, smoking, excess alcohol consumption and unwanted isolation.

Take a moment to think about these healthy and unhealthy behaviors. Think about how you can talk with participants. Are there opportunities on the service plan to help participants who choose to increase their healthy behaviors? What are some barriers they may run into?

## Healthy Behaviors (cont.)

It can be difficult for many of us to stick to healthy behaviors in the best circumstances. It can be even more difficult for individuals who experience physical, behavioral, logistical and financial barriers to integrate healthy behaviors into their lives. For example, people with physical disabilities may need assistance seeking out adapted exercise programs. People with behavioral health conditions may not be as open to taking medication. In addition, transportation and the ability to pay for services can add additional barriers to reaching healthy behavior goals.

## Working with Healthy Behaviors

Service Coordinators and direct care workers educate participants in a person-centered manner about how healthy behaviors can help them reach their goals. They also support participants in removing barriers to integrating healthy behaviors into their lives if they choose to do so.

Take a moment to read about ways Service Coordinators and direct care workers can educate participants.

### Healthy Eating

Some participants may choose to focus on healthy eating in their person-centered service plans. Service Coordinators can refer participants to a registered dietician as a start. Service Coordinators can also address other barriers such as accessible kitchens, transportation to supermarkets, cooking and washing supplies, and others.

### Exercising

Some program participants may choose to incorporate exercise as part of their person-centered service plan. Service Coordinators and providers can assist participants in finding individualized services that meet their specific physical needs and capabilities. It is up to the individual to decide how and when they will integrate these activities into their lives.

### Medication

Medication management affects health and safety. Service Coordinators discuss the challenges of taking medications, refer people to physicians as necessary and offer options for individuals to stay on track—cueing services, special packaging, and others. Service Coordinators must monitor the success of medication management interventions and try other options if the initial plan does not work.

### Summary

For more information on health and wellness resources and strategies, please review the Resources Document associated with this training.

## Social Supports & Engagement

The next additional factor focuses on social supports and engagement. Engagement with others and strong social and familial support can be predictors of overall health. Social engagement has been found to be useful to assist in the prevention and management of depression and other behavioral health issues. It can be difficult for some individuals to remain engaged in the community as their situations change. In addition, we all have different perceptions of what is effective for us in terms of how engaged we are with others. Natural extroverts may welcome this conversation with enthusiasm. Natural introverts may be less open to talking about this.

## Working with Social Supports & Engagement

Service Coordinators are responsible for addressing social supports during planning and during regular participant contacts. Service Coordinators can start the conversation about this in a person-centered manner by asking open-ended questions about how the participant feels regarding their level of engagement. For example, a Service Coordinator could start a conversation by asking, “What are things that you’ve enjoyed in the past that you no longer do?” Based on the answer, Service Coordinators could ask participants to expand on their answer and discuss their individual situation to further the conversation. Service Coordinators are also responsible for assisting participants in removing barriers to engagement. Barriers could include accessibility in group activities, transportation availability and knowledge of local opportunities. Service Coordinators can learn about local resources and be ready to educate and refer participants to opportunities.

For more information on finding resources and overcoming barriers, please review the Resources Document associated with this training.

## What Do You Think Now?

Before we continue with the course content, let’s see if your opinions about Social Determinants of Health have changed.

Now that we’ve reviewed all the Social Determinants of Health and additional factors, in which area(s) do you think your approach will improve as it relates to working with participants in a person-centered manner?

Please pause.

Thank you for your response. Be sure to spend some time exploring additional resources for each of the Social Determinants of Health you encounter on a regular basis.

## Course Summary

Public health organizations have varying lists of Social Determinants of Health. This module focused on specific areas that can have impacts on participants in Pennsylvania’s long-term care programs. It is critical to the success of participants’ plans that Service Coordinators be aware of the importance of Social Determinants of Health and additional factors and how to work with participants in a culturally-competent, person-centered manner.

# Lesson 4: Conclusion

Now that we’ve completed the course content, take a moment to complete this brief knowledge check to see what you’ve learned.

1. Fill in the blank. Social Determinants of Health are \_\_\_\_\_\_\_\_\_\_ factors that impact health outcomes.

Environmental

Societal

Both environmental and societal

Please pause.

Social Determinants of Health are environmental and societal factors that impact health outcomes.

2. True or false? In terms of literacy, participants must be able to read English-language forms and documents.

Please pause.

The correct answer is False. Service Coordinators are required to provide interpreter services, forms and documents in the language and mode preferred by the participant.

3. True or false? Participants can improve their overall health by increasing healthy behaviors and decreasing unhealthy behaviors.

Please pause.

The correct answer is True. Increasing healthy behaviors and decreasing unhealthy behaviors is a great way for participants to improve their health.

4. True or false? Direct Service Providers who are not able to accommodate participants’ caregiver preferences in caregiver assignments may explore the participant-directed model.

Please pause.

The correct answer is True. If a provider is not able to accommodate preferences, a participant-directed model may be explored.

# Congratulations!

Congratulations! You have successfully completed the Office of Long-Term Living’s Introduction to Social Determinants of Health in Long-Term Care online training course.

If you have read the contents of the entire module, go to this [webpage](https://oltl.deringconsulting.com/oltl-social-determinants-of-health-training/) to register your completion of this module.