Taking Action on Social Determinants of Health

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How Healthcare Systems Move Toward Health Equity

Burdened by persistent health disparities and escalating healthcare costs, healthcare systems across the U.S. are well aware of the limitations of healthcare provision. Massive life expectancy gaps between neighborhoods in the same city[1] and higher rates of all-cause mortality among Black Americans compared to white[2] have challenged healthcare systems to move beyond discussions of quality healthcare provision to that of health equity.

Health equity requires all individuals to have a fair and just opportunity to live a healthy life,[3] and reaching this goal will require healthcare systems to take action and implement models that identify and address social determinants of health. Clinicians and other frontline healthcare workers are already addressing the downstream impact of social determinants but often lack the tools, resources, and organizational support to take a more upstream approach.

Leveraging a model that integrates social determinants of health will also be integral to successful value-based care and can decrease healthcare costs by decreasing ER utilization, hospitalization, and readmission. Value-based models incentivize positive outcomes over volume of care—with as much as 70 percent of non-modifiable variation in health outcomes attributable to social determinants of health, healthcare organizations lacking a SDOH framework will struggle to keep up.[4] Healthcare organizations in value-based care models will need to dig deeper than standard medical data and, instead, effectively integrate data sources that measure SDOH to provide holistic treatment to each individual.

By addressing patients' social needs and changing the systems that facilitate inequity, healthcare organizations have the potential to close health disparity gaps, improve health and wellbeing, and stabilize healthcare costs. This white paper offers practical steps and resources for healthcare systems to better understand and address social determinants of health, improve the lives of their patients, and promote health equity.

Understanding Social Determinants of Health

Social determinants of health are the conditions in which people are born, live, work, grow, and age that affect health and quality of life, as well as the wider forces and systems that shape daily life. These can include policies, social norms, and political systems, all influenced by the distribution of money, power, and resources.[5] Medical care alone prevents only about 10% of premature death, but another 30 to 40 percent of premature death[6] can be prevented by health behavior change.[7] Health behavior is also influenced by SDOH, meaning 50 percent of premature death is driven by social

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factors outside of the traditional medical system, including food access, housing, employment, education, transportation, built environment, and neighborhood safety. These factors also influence medical care and health behaviors. Disparities in all of these social determinants are the result of larger forces, including racism, classism, and poverty. Social determinants of health are not simply risk factors, but directly correlate to ongoing health status[8] and have been shown to increase the risk of chronic diseases such as hypertension and heart disease as well as decreased life expectancy.[9, 10]

Healthcare interventions that address social determinants of health improve patient health outcomes and reduce readmissions.

Intervention and programming around housing, nutrition, income support, and care coordination and community outreach have consistently demonstrated improvements in health outcomes.[11] Addressing social determinants of health can reduce readmissions, keeping people home and limiting additional exposure and medical interventions.[12, 13, 14]

One successful example of housing intervention programming is Pathways Housing First, which was created in response to frequent emergency room utilization by people experiencing homelessness in New York City. In this strategy, people are given immediate permanent housing and the support systems they need to maintain housing, such as mental health counseling, psychiatry, and medication-assisted treatment, are built around them.[15] The New York Housing study found that Housing First participants were less likely to spend time homeless and less likely to be hospitalized for psychiatric illnesses.[16]

Addressing social determinants of health also decreases health disparities.

Health disparities are preventable health differences that adversely affect disadvantaged populations on a systemic level.[17] Inequities in social determinants such as housing, employment, food access, and education drive health disparities in the clinical setting. Racism is a particularly critical social determinant of health. The weathering hypothesis explains that people of color experience chronic stress as a result of racism, resulting in chronic inflammation and illness.[18] Black Americans are more likely to experience adverse environments such as poverty and toxin exposure due to America's history of segregation (differential exposure)[19] and less likely to benefit from programs designed to provide resources and improve health (diminished gain).[20] Interventions aiming to improve health equity must be centered around people of color and address racism and bias.

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Creating an Action Planning Framework

Although critical to improving health outcomes, transforming a healthcare organization to meaningfully address social determinants of health and promote health equity is a challenging and ongoing process. The work starts internally by creating a culture that is inclusive, patient-centric, and collaborative, as well as establishing processes for monitoring health disparities, mitigating the impact of implicit bias, and evaluating impact. Next, healthcare systems must respond to social determinants affecting the health of their patients by identifying and meeting social needs. Finally, healthcare systems need to invest in ongoing transformative policy and structural changes, and engage in advocacy to address the systemic forces driving inequities in health and social determinants. This framework provides tools to begin work in each of these areas.

Organizational Culture and Evaluation

Action around social determinants of health cannot only occur at the leadership level. Each team member at all levels of the organization must be engaged. To succeed, they will need to learn not only how they can promote health equity in their work, but also how they may be inadvertently working against it.

Educate employees about social determinants of health and bias.

Dedicate time and resources to educating employees about the impact of SDOH and the organization's vision for improved impact and comprehensive care. Allow employees to contribute their experience and feedback to this ongoing process. This can take the form of asynchronous continuing education learning, regular workshops on specific topics such as understanding the health impact of homelessness or substance abuse resources, or templated guides to help clinicians understand their role in identifying SDOH and connecting patients with resources.

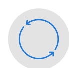
The work starts internally by creating a culture that is inclusive, patient-centric, and collaborative, as well as establishing processes for monitoring health disparities, mitigating the impact of implicit bias, and evaluating impact.

Given the health disparities across racial lines and the influence of racism on social determinant inequities, healthcare systems must discuss and create mitigation strategies for implicit bias. Implicit bias describes subconscious attitudes and stereotypes that affect understanding, decision-making, and actions.[21] Implicit bias is as pervasive among healthcare providers as the general population and extends across not only race but ethnicity, socioeconomic status, mental health, substance abuse, and other domains.[22] Most concerning, it is a cause of disparities in the quality and appropriateness of care provided. Healthcare systems can mitigate the impact of implicit bias through awareness efforts such as workshops, training, education, and implicit bias testing.[23]

Empathy and perspective building have also been shown to mitigate bias and improve healthcare quality.[24] Increasing clinician and staff empathy requires intentionality and ongoing support. Organizations can encourage empathy through helping clinicians monitor their cognitive load and promoting positive emotions in the workplace.[25]

Create systems of evaluation to regularly identify disparate health outcomes between groups of patients.

Monitoring social determinants of health is challenging, requiring the use of non-health data systems.[26] Information is commonly sourced from federal agencies such as the US Census, USDA, and EPA, which provide data on a range of socioeconomic and environmental risk factors. However, healthcare systems can monitor for differences in services provided and outcomes by race, ethnicity, gender, language, and socioeconomic status. Regular review and action planning around disparities identified within the healthcare system can promote change, uncover bias, and improve health outcomes.



Engage the community in regular feedback, needs assessment, and decision-making.

Healthcare systems can solicit community and patient input through community needs assessment, patient satisfaction surveys, qualitative evaluations, and focus groups, and by establishing community advisory boards or patient advisory boards. With this in mind, strategies for patient and community engagement must center on building trust within the community, communicating clearly and honestly the role of the healthcare system in addressing health disparities.[27] One common strategy used by nonprofit hospitals is to conduct a community health assessment (sometimes known as community health needs assessment), which refers to "a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis."[28] These can also be used as a way to assess the health of communities and to design strategies and policies to address SDOH that are tailored to the community you serve.

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Identification and Response to Individual Needs

While achieving health equity requires both systemic and policy change, healthcare systems directly impact the health of their patients by identifying social needs and linking patients to services and resources to meet those needs. Discussions about social determinants of health can help patients understand the connection between their environment, past experience, and their current health.

Adopt routine screenings for social determinants of health.

Screening for social determinants of health during office visits assists the clinician in identifying needs and providing resources, improves whole person care, and promotes correct diagnosis and relevant treatment plans.[29] Over time, this data allows healthcare systems to better understand the needs of their community, identify gaps in resources, and design collaborations and interventions to meet those needs.[30] Multiple, validated screening tools, listed below, exist to help collect this information. Clinics can create their own by using selected questions from these tools or designing one of their own through a tool such as the Health Lead Screening Toolkit. Common questions that appear in leading screening tools involve housing, transportation, utilities, personal safety, food, and offers for assistance in any of these areas. Some SDOH screening questions include:

- What is your housing situation today?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
- In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

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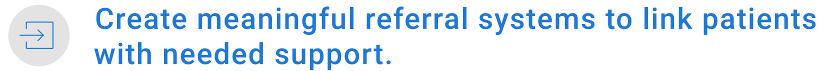
HELPFUL SCREENING TOOLS

Association of Family Physicians' Social Needs Screening Tool

Center for Medicare and Medicaid Services' Accountable Health Communities Health-Related Social Needs Screening Tool

National Association of Community Health Centers' PRAPARE Assessment Tool

Organizations can also improve utilization by integrating SDOH screening into the established workflow and electronic medical records system. All questions and conversations around social determinants of health should prioritize respect and trust building. This is best accomplished by incorporating screening into holistic care, explicitly asking patients about what services would be helpful and obtaining permission to refer, and using a strengths-based approach.[31]



Create meaningful referral systems to link patients with needed support.

To respond effectively to social determinants impacting patients' health, healthcare systems must have an evolving resource list beyond referrals within the healthcare system. Resource mapping involves the creation of modifiable resource lists, which clinicians can use to route patients to social supports such as housing assistance, legal services, food access and delivery, and transportation assistance.[32] Provider guides and patient handouts allow clinicians to provide resources during care planning in partnership with the patient versus referring all social needs into social work or case management. This practice helps normalize discussing social factors during medical visits and promotes partnership and trust building. Healthcare systems can also invest in coordinated care networks such as those listed below. As with resource mapping, these platforms provide search functions for identifying social service organizations and facilitate cross-sector communication and collaboration.

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COORDINATED CARE NETWORKS

Aunt Bertha

Unite Us

Healthify

NowPow

Structure your team to help provide patients with ongoing support.

Striving for improved health outcomes amidst systemic inequities is difficult and overwhelming for individual clinicians and healthcare systems, and patients with complex medical and social needs require ongoing support and collaboration with the healthcare team. Creating positions within the team to specifically facilitate this work can benefit both the patient and healthcare team. Patient navigators or social support navigators can be employees or volunteers who are trained to assist patients in navigating resources, making calls, and facilitating referrals.[33] Community health workers can both connect patients to local resources as well as deliver health and educational services directly to patients in their home.[34] Certified Peer Specialists use their lived experience with mental health concerns and/or substance abuse to assist and support peers experiencing similar challenges.[35] Care management programs, including social work and care coordination, have been shown to improve health outcomes.[36]

Systemic Change for Health Equity

Meeting the social needs of patients, while important, is not equivalent to addressing social determinants of health.[37] Systemic, policy, and social change is required, much of which occurs outside of the healthcare system. However, healthcare systems can promote upstream movement, addressing root causes of health disparities and poor health outcomes in a variety of critical ways.

Healthcare systems can take a more holistic view of health and prioritize cross-sector collaboration, creating interventions that address systemic barriers and inequities.

Cross-sector collaboration includes educators, employers, faith leaders, community leaders, lawyers, farmers, and social service organizations, stretching healthcare systems to value external partnerships as much as interdisciplinary collaboration within the healthcare system.[38]

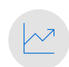
Creating positions within the team to specifically facilitate this work can benefit both the patient and healthcare team.

SDOH interventions in the areas of housing, nutrition, income support, and care management have also been consistently linked to improved health outcomes.[39] The following are examples of successful cross-sector interventions addressing SDOH:

- The Nurse-Family Partnership brings nurses into the homes of first-time moms to provide education and support during pregnancy and for the first two years of the child's life.[40] The program has reduced child injuries, decreased incarceration rates for mothers, and created greater work-force participation of mothers.[41]
- Food prescription programs are increasing in frequency and designed to foster access to healthy food and healthy behavior change. These interventions require collaboration between prescribing clinicians, nutritionists, and food providers. Programs range in approach and food distribution method, but have been linked to improved glucose control[42] and decreased food insecurity.[43]

Healthcare systems can engage in power sharing to facilitate interventions most desired by and helpful to the individuals and communities impacted by them.

Whether designing individual treatment plans, educational programming, or community interventions, prioritize community capacity building—defined as enabling all members of the community to develop skills and competencies that allow them to control their own lives.[44] Helping patients gain health knowledge and utilize resources, as opposed to only providing resources, creates ongoing health benefits. Patient advisory boards and governance models that invite patients and non-medical community members to participate in envisioning, planning, and advising foster responsive and inclusive programming and service delivery.



Clinicians and healthcare systems can influence policy change that promotes equitable access to resources and services for improved community health.

Advocacy does not have to be political. Policies should examine the broader implications of their decisions and consider health, equity, and sustainability when evaluating policy options.[45] Transportation, housing, zoning, and education policy all have an impact on health. Healthcare workers can share their knowledge and expertise to inform decision-makers of the health impacts of policy decisions. Healthcare systems can also encourage clinicians and healthcare teams to participate in advocacy, whether joining local advisory boards, testifying in committee hearings, or directly communicating with lawmakers. When healthcare systems allow employees the space and support needed to engage or directly support advocacy efforts, they move further upstream in their work.

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Sustaining Social Determinants of Health Models and Change

Addressing social determinants of health to decrease health disparities and improve health outcomes is ongoing, emerging work. Sustaining this commitment to growth and change will require both financial and organizational sustainability. Given the historical underfunding of preventive care in the U.S., and the cross-sector nature of SDOH interventions, organizations will need to consider return on investment over a longer period of time and leverage billing and grant opportunities to fund SDOH interventions.

To mitigate this impact, healthcare system leaders can create models of ROI that plan for the cost savings to be realized 1 to 5+ years after initiation.[46] This can be helped by maximizing billing options by billing for integrated care, group classes, nutrition consults, certified peer specialist visits, and other services that address social determinants of health. Using data from SDOH screening and community health assessments as well as cross-sector partnership can also help to create strong grant applications. Preventing readmission with discharge planning that encompasses SDOH can also result in substantial cost savings. Unmet social needs have been linked to increased ER utilization and hospitalization,[47, 48] and subsequent readmissions within 30 days of hospitalization can result in financial penalties for hospitals and average $14,400 per readmission.[49]

Advancing health equity starts within the healthcare organization, and will require a shared vision built around addressing SDOH within the organization, engaging all employees in the process with space for learning and processing. In order to sustain commitment to this growth and change, leaders will need to understand that this work is emergent, and the change process must be responsive to both the needs of patients and employees. Effectively addressing social determinants of health will be ongoing and challenging work—but if we continue to leave these systemic factors unacknowledged, the greater cost to the wellbeing of our patients and the communities we serve is something we truly cannot afford.

Preventing readmission with discharge planning that encompasses SDOH can also result in substantial cost savings.

Endnotes

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How MedBridge Helps Address Social Determinants of Health

Providing employees with ongoing education and training about the impact of social determinants of health can help foster a more equitable healthcare environment for the patients and communities they serve.

MedBridge produces evidence-based, expert-led education for providers and patients on the social determinants of health and implicit biases to help decrease health disparities, improve outcomes, and reduce readmissions.

Social Determinants of Health Education

Achieve a deeper understanding of SDOH and their impact on health status with relevant tools and resources for screening and mitigating their impact on patient populations.

Addressing Health Disparities and Outcomes

Assessing and Addressing Social Determinants of Health

Assessing Social Determinants of Health: Roleplay Demonstration

Additional Provider Education

Diversity and Inclusion

Gain a deeper understanding of potential cultural differences in your patients and learn what steps you can take to prevent bias in healthcare.

Readmissions and Transitions of Care

Stay proactive about increased readmission rates associated with SDOH with evidence-based education on transitions-of-care solutions and prevention strategies.

Patient Management and Education

Chronic Condition

Our chronic condition series provides engaging educational videos to empower patients to effectively manage common chronic conditions associated with SDOH.

Related MedBridge Products

Continuing Education

Thousands of accredited courses across multiple disciplines and specialties help improve training, engagement, and outcomes.

Patient Education

Help patients quickly and comprehensively understand their diagnosis and rehabilitation plan with engaging education.

Learning Management System

Remediate gaps in knowledge by seamlessly creating, assigning, and tracking staff education.

Patient Adherence Tracking

Identify behavioral patterns and barriers to adherence to help boost patient satisfaction and improve clinical outcomes.

About the Author

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