Social Determinants of Health: Improving Health and Decreasing Disparities

Breanna Lathrop, DNP, MPH, FNP-BC, RN

MEDBRIDGE

Disclosures

Financial

- None

Nonfinancial

- None

Learning Goals

- Define social determinants of health and their impact on health outcomes and disparities
- Recognize the relationship between social determinant of health interventions and long-term outcomes and return on investment
- Identify social determinants of health screening tools and strategies for use in the clinical setting
- Examine strategies for mitigating the impact of social determinants of health through program development and coordinated care networks
- Identify strategies to promote positive change and ongoing learning among team members regarding social determinants of health

Poll Question #1

Which best describes your organization's knowledge of social determinants of health?

A. We use a social determinants of health framework and feel we are able to address the social determinants most impacting our patients
B. We are actively addressing social determinants of health within our patient population but have identified additional learning needs and would like to grow our work
C. We care about social determinants of health, but resources and capacity restrictions have limited our ability to address them

Chapter 1

Why Address Social Determinants of Health?

The Cost of Inequity

- **Health equity:** everyone having a fair and just opportunity to live a healthy life[1]
- **Health disparities:** life expectancy varies by as much as 30 years between neighborhoods within the same city throughout the US[2]
- Reimbursement linked to health outcomes[3]

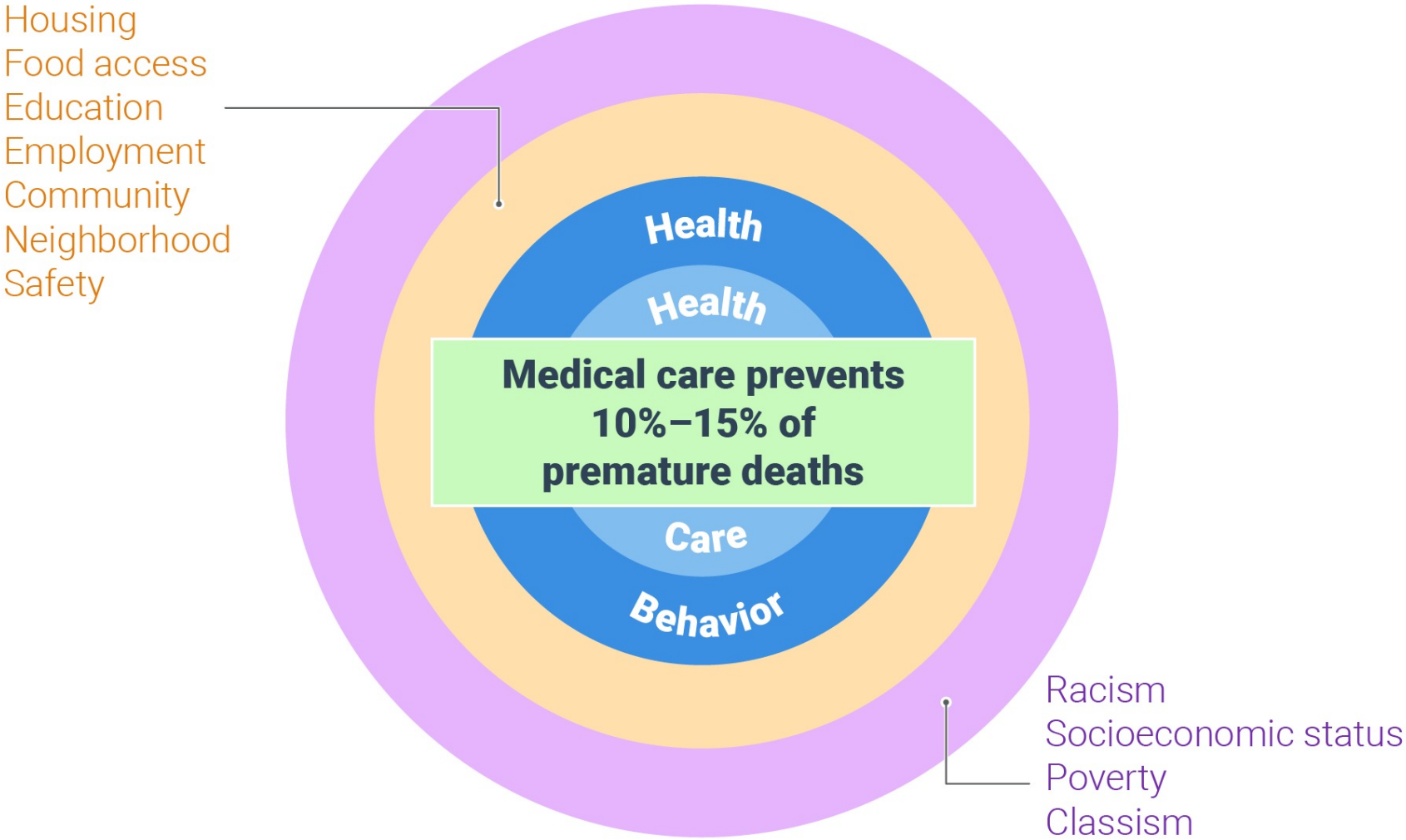
1. Braveman et al., 2017
2. NYU Langone Health, 2021
3. Taylor et al., 2016

Social Determinants of Health

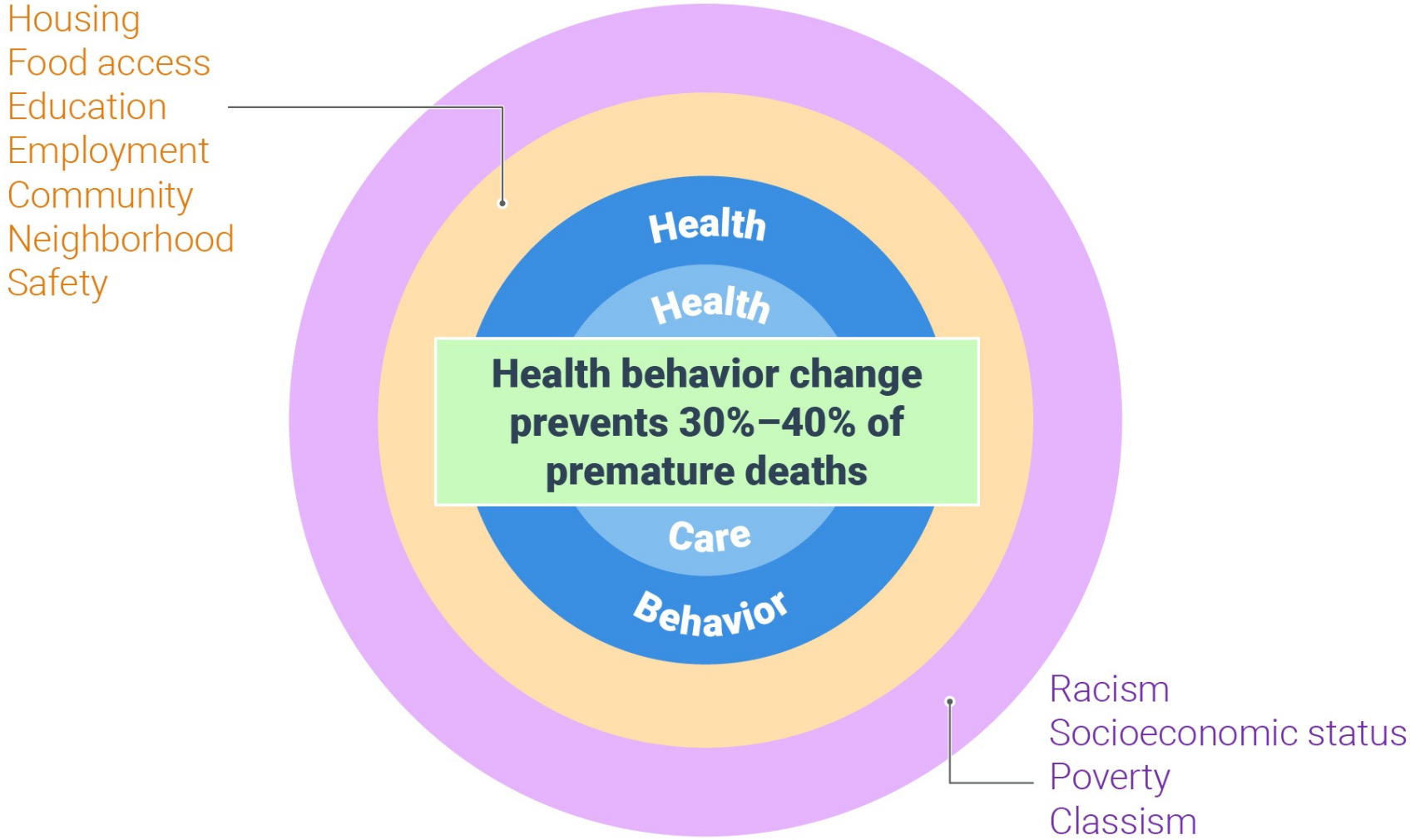
- Social determinants of health are the conditions in which people are born, live, work, grow, and age that affect health and quality of life, and the wider forces and systems that shape daily life, including policies, social norms, and political systems, influenced by the distribution of money, power, and resources[1]
- Negatively experiencing disparities in SDOH creates chronic stress[2, 3, 4]

1. World Health Organization, 2021
2. Steptoe & Marmot, 2002
3. Braveman & Gottlieb, 2014
4. Geronimus et al., 2015

Social Determinants of Health (cont.)



Social Determinants of Health (cont.)



SDOH and Health Disparities

- **Health disparities: preventable health differences that adversely affect disadvantaged populations[1]**
  - Disadvantaged populations systematically experience greater obstacles to health based on race, ethnicity, socioeconomic status, gender, disability, geographical location, and sexuality[2]
- **Associated with poverty[3]**
  - Increased risks for chronic disease and premature aging
- **Associated with racism[4–8]**
  - Differential exposure, diminished gains, weathering

1. US Department of Health and Human Services, 2020
2. Alvidrez et al., 2019
3. Marmot, 2017
4. Massey, 2017
5. William et al., 2016
6. Assari, 2018
7. Simons et al., 2016
8. Simons et al., 2018

SDOH and Health Outcomes

- **Social determinants interventions are associated with improved health outcomes[1]**
- **Interventions with notable improvements include housing, nutrition, income support, and care coordination/community outreach**
- **Promote improvement in overall population health[2]**
  - Reduce health disparities

1. Taylor et al., 2016
2. Adler et al., 2016

SDOH and Healthcare Costs

- **SDOH interventions can lower healthcare costs[1]**
- Decreased hospitalizations and readmissions
  - Unmet social needs linked to readmission and preventable hospitalizations[2,3,4]
- Decreased chronic disease burden
  - Potential to prevent and improve control
- Decreased ER utilization[5]

1. Taylor et al., 2016
2. Nichols & Taylor, 2018
3. Seligman et al., 2014
4. Abarje et al., 2008
5. Tsega et al., n.d.

The Challenge of Return on Investment

- **ROI on social investments is challenging**
  - New area of research[1]
  - Wrong pocket problem[2]
  - Length of time needed to measure[2]
- **Approaches for determining ROI**
  - Housing support, nutrition interventions, and case management/community health workers have strong evidence[2, 3]
  - Commonwealth ROI calculator
  - https://www.commonwealthfund.org/roi-calculator-app

1. Tsega et al., n.d.
2. Nichols & Taylor, 2018
3. Davison et al., 2020

Summary

- Social determinants of health are conditions, forces, and systems outside of the health care system that have a significant impact on health outcomes
- Social determinants of health create chronic stress, which causes maladaptive coping, premature aging, and changes to body systems
- Health disparities are rooted in systematic exclusion and discrimination, with poverty and racism correlating to poor health outcomes and decreased longevity
- ROI for SDOH interventions is emerging but strongly positive, particularly in the areas of housing, income support, nutrition, and care management

Chapter 2

A Framework for Social Determinants of Health Work

Organizational Culture and Awareness

- Commitment to individual and organizational change
- Ongoing staff education and facilitated discussion
- Mitigate the impact of implicit bias[1, 2]
  - Prioritize diversity and eliminate discrimination
  - Prioritize racial diversity at all levels of the organization
  - Create a work environment that promotes positive emotions
  - Perspective-taking: express empathy
  - Emphasize emotional regulation skills
  - Partnership-building: set goals with patients

1. van Ryan et al., 2011
2. The Joint Commission, 2016

Organizational Culture and Awareness

Promoting health equity within the clinician-patient relationship

- Organizational change supports and advances the work of clinicians

Video

Interview with Joanna Horst, DNP, RN, NEA-BC, Division Director: Clinical Innovation, Leadership, and Support at BAYADA Home Health Care

Measuring and Monitoring Health Disparities

Create systems to monitor and detect health disparities

- Health outcomes disparities
- Disparities in access and care received
- Social need disparities

Poll Question #2

Which is correct regarding providers who think social needs are as important as medical needs versus providers who are comfortable asking about social needs?

A. 80% say social needs are as important as medical needs, but only 40% of providers are comfortable asking about social needs
B. 60% say social needs are as important as medical needs, but only 10% of providers are comfortable asking about social needs
C. 90% say social needs are as important as medical needs, but only 20% of providers are comfortable asking about social needs

Screening for SDOH: Why?

- Identify the needs of your patients, and connect them to resources[1]
- Improve whole-person care[1]
- Correct diagnosis and relevant treatment plans[2]
- Improve understanding of community needs
- Identify gaps in current resources
- Design program and partnership interventions to meet needs[2]
- Encourage patients to understand the impact of their environment and history on their health

1. Andermann, 2018
2. LaForge et al., 2018

SDOH Screening Tools

- **Ready for use**
  - American Association of Family Physicians. Social Needs Screening Tool: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/physician-short.pdf
  - Center for Medicare and Medicaid Services. The Accountable Health Communities Health-Related Social Needs Screening Tool: https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
  - National Association of Community Health Centers. PRAPARE assessment tool: http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pd
- **Create your own**
  - Start with a few critical questions from an existing tool
  - Use a program designed to allow you to create a tool
    - Health Leads Screening Toolkit
    - https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Best Practices for SDOH Screening

- Integrate into existing workflow and EHR
- Incorporate into a wholistic assessment[1]
  - Avoid auto-referral systems
- Use a strengths-based approach[1]
- Use data to inform decisions and identify trends and disparities
- Create the roles and systems needed to address social needs communicated by patients

1. Garg et al., 2016

Staff Infrastructure for SDOH Interventions

- Use of dedicated positions able to facilitate referrals and social needs
  - Patient navigators/social support navigators[1]
  - Community health workers[2]
  - Care management/care coordinators
  - Social workers
  - Certified peer specialists
- Emerging, strongly positive evidence for improved outcomes and costs with care management and community health workers[3, 4]

1. Andermann, 2016 2. Garg et al., 2016 3. Tsega et al., n.d. 4. Taylor et al., 2016

Care Coordination

Strategies for addressing social needs

- Use existing coordinated care network platforms
  - Unite Us, Healthify, Aunt Bertha, NowPow
- Create local resource map[1]
  - Easy to access for providers
  - Patient handouts

1. Andermann, 2016

Cross-Sector Collaboration

- Build partnerships within and outside the health care system[1]
  - Community health workers, certified peer specialists, doulas, nutritionists, counselors, social workers
  - Lawyers, educators, faith leaders, employers, farms, coaches
- Cross-sector interventions
  - Housing: Housing First[2]
  - Home visiting: Nurse-Family Partnership[3, 4]
  - Food access: Food As Medicine[5]

1. Lathrop, 2020
2. Padgett et al., 2016
3. Adler et al., 2016
4. Thornton et al., 2016
5. Adermann, 2016

Summary

- Healthcare systems play a critical role in establishing a culture for health equity and mitigating the impact of implicit bias within the healthcare system
- Validated tools allow clinicians to understand the social determinants of health impacting their patients
- Resource mapping and care coordination networks link patients to resources outside of the traditional health care system
- Healthcare team members such as community health workers, certified peer specialists, and patient navigators can bridge medical and social services

Poll Question #3

Which best describes a comprehensive approach to addressing social determinants of health?

A. Screening for SDOH at every visit, and creating an automatic referral to a patient navigator for any positive screen
B. All-staff education and implicit bias training, SDOH screening during comprehensive assessments, and establishing a care coordination network
C. Initiating a health disparities task force, and screening for SDOH at annual exams

Chapter 3

Leadership and Change Management

Change Management

Build from your strengths

- Integrate changes into what the organization is already doing well
- Create spaces for processing and ongoing learning
  - Build in systems for feedback and sharing of experiences and learning
  - Share data and rationale for change
  - Communicate vision consistently and regularly

Leadership Beyond Healthcare

“While individual-level interventions are beneficial, characterizing them as efforts to address social determinants of health conveys a false sense of progress. These strategies mitigate the acute social and economic challenges of individual patients, but they do so without implementing long-term fixes.”

– Brian Castrucci and John Auerbach[1]

1. Castrucci & Auerbach, 2019

Advocacy for Change

- Sharing clinical experience can influence change
- Provide clinical support to strengthen other sectors
- Society-level changes that address SDOH[1, 2]
  - Early childhood interventions and education
  - Housing mobility program
  - Employee health and higher education
  - Income supports
- Engage in local decision-making processes

1. Marmot, 2017
2. Thornton et al., 2016

Summary

- Health inequities and disparities cannot be solved entirely within the healthcare system. System and policy change are also required.
- Engaging in advocacy can strengthen both healthcare delivery and other sectors that promote improved health outcomes

Chapter 4

Question and Answer Session

Bibliography

MedBridge
Social Determinants of Health: Strategies to Improve Health and Decrease Disparities (Recorded Webinar)
Breanna Lathrop, DNP, MPH, FNP-BC, RN

1. Adler, N., Cutler, D. , Jonathan, J,. Galea, S., Gly- mour, M., Koh, H., Satcher, D. (2016). *Addressing Social Determinants of Health and Health Disparities.* Discussion Paper, Vital Directions for Health and Health Care Series. National Academy of Medicine, Washington, DC. https://nam.edu/ wp-content/uploads/2016/09/addressing- social-determinants-of-health-and-health-dispari- ties.pdf.
2. Alvidrez, J., Castille, D., Laude-Sharp, M., Rosario, A., & Tabo, D. (2019). The National Institute on Minority Health and Health Disparities Research Framework. American Journal of Public Health, 109(S16-S20). https://doi.org/10.2105/AJPH.2018.304883
3. Andermann A. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ,* 188(17-18). DOI: https://doi.org/10.1503/cmaj.160177
4. Andermann A. (2018). Screening for social determinants of health in clinical care: Moving from the margins to the mainstream. *Public Health Review, 39*(19). doi: 10.1186/s40985-018-0094-7
5. Arbaje, A., Wolff, J., Oilu, Y., Powe, N., Andeson, G., & Boult, C. (2008). Postdischarge environments and socioeconomic factors and the likelihood of early hospital readmission among community-dwellign Medicare beneficiaries. *Gerontology, 48*(4), 495-504. doi: 10.1093/geront/48.4.495.
6. Assari, S. (2018)l Health Disparities due to Diminished Return among Black Americans: Public Policy Solutions. *Social Issues and Policy Review, 12(1)*: 112-145. https://doi.org/10.1111/sipr.12042
7. Aunt Bertha. (2019). https://www.auntbertha.com
8. Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. Public Health Reports, 129(suppl. 2), 19-31.
9. Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017) What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation.
10. Castrucci, B, &, Aurebach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. *Health Affairs Blog*. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/
11. Davison, G., Ferris, D., Pearson, A. *et al.* (2020) Investments with returns: a systematic literature review of health-focused housing interventions. *J Hous and the Built Environ 35,* 829–845. https://doi.org/10.1007/s10901-019-09715-6
12. Garg, A., Boynton-Jarrett, R., Dworkin, P. (2016). Avoiding the unintended consequences of screening for social determinants of health. *JAMA, 316*(8). 813-814. doi:10.1001/jama.2016.9282

13. Geronimus, A., Pearson, J., Linnenbringer, E., Schulz, A., Reyes, A., Epel, E., Lin, J., & Blackburn, E. (2015). Race/ethnicity, poverty, urban stressors and telomere length in a Detroit community-based sample. Journal of Health and Social Behavior, 56(2): 199-224. doi: 10.1177/0022146515582100
14. Healthify. (2019). https://www.healthify.us
15. LaForge et. al. (2018). How 6 organizations developed tools and processes for social determiants of health screening in primary care. *Journal of Ambulatory Care Management, 41*(1): 2-14. doi: 10.1097/JAC.0000000000000221
16. Lathrop, B. (2020). Moving toward health equity by addressing social determinants of health. *Nursing for Women's Health, 24*(1): 36-44. DOI https://doi.org/10.1016/j.nwh.2019.11.003
17. Marmot, M. (2017). The health gap: doctors and the social determinants of health. Scand J Public Health, 45(7):686-693. doi: 10.1177/1403494817717448.
18. Marmot, M. (2017). The health gap: doctors and the social determinants of health. *Scand J Public Health,* 45(7):686-693. doi: 10.1177/1403494817717448
19. Massey DS (2017). Why death haunts black lives. *Proceedings of the National Academy of Science*, 114, 800–802.
20. Nichols, L., & Taylor, L. (2018). Social determinants as public goods: A new approach to financing key investments in healthy communities. *Health Affairs, 37*(8). 1223-1230. DOI:10.1377/hlthaff.2018.0039
21. NowPow. (2019). https://www.nowpow.com
22. NYU Langone Health. (2021). City health dashboard. Retrieved from https://www.cityhealthdashboard.com
23. Padgett, D., Henwood, B., Tsemberis, S. (2016). *Housing First: Ending homelessness, transforming systems, and changing lives.* New York, NY: Oxford University Press.
24. Seligman, H., Bolger, A., Guzman, D., López, A., & Bibbins-Domingo, K. (2014). Exhaustion of food budgets at month's end and hospital admissions for hypoglycemia. *Health Affairs (Millwood), 33*(1):116–23.
25. Simons, R, Lei, MK, Beach, S, Philibert, R, Cutrona, C, Gibbons, F, & Barr, A. (2016). Economic hardship and biological weathering: the epigenetics of aging in a U.S. sample of black women. *Social Science & Medicine*, 150:192-200. https://doi.org/10.1016/j.socscimed.2015.12.001 2016
26. Simons, R. L., Lei, M.-K., Beach, S. R. H., Barr, A. B., Simons, L. G., Gibbons, F. X., & Philibert, R. A. (2018). Discrimination, segregation, and chronic inflammation: Testing the weathering explanation for the poor health of Black Americans. *Developmental Psychology, 54*(10), 1993–2006. https://doi.org/10.1037/dev0000511
27. Steptoe, A., & Marmot, M. (2002). The role of psychobiological pathways in socio-economic inequalities in cardiovascular disease risk. European Heart Journal, 23(1), 15.
28. Taylor, L., et al. (2016). Leveraging the social determinants of health: what works? PLoS One, 11(18). E0160217. https://doi.org/10.1371/journal.pone.0160217
29. The Joint Commission. (2016). Implicit bias in health care. *Quick Safety, 23.* Retrieved online at https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_23_Apr_2016.pdf

30. Thornton R, Glover C, Cene C, Glik D, et al. (2016). Evaluating strategies for reducing health disparities by addressing the social determinants of health. *Health Affairs (Millwood),* 35(8):1416-23. doi: 10.1377/hlthaff.2015.1357
31. Tsega, M., Lewis, C., McCarthy, D., Shah, T., Coutts, K. (n.d.) ROI Calculator for Partnerships to Address the Social Determinants of Health Review of Evidence for Health-Related Social Needs Interventions. Retrieved online at https://www.commonwealthfund.org/sites/default/files/2019-07/ROI-EVIDENCE-REVIEW-FINAL-VERSION.pdf
32. Unite Us. (2019). https://www.uniteus.com
33. U.S. Department of Health and Human Serivces. (2020). Disparities. Retrieved online at https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
34. Van Ryn, M., Burgess, D., Dovidio, J., Phelan, S., Saha, S., Malat, J., Griffin, J., Fu, S., & Perry, S. (2011). The impact of racism
35. William, D., Priest, N., Anderson, N. (2016). Understand associations between race, socioeconomic status and health: Patterns and prospects. *Heath Psychologi, 35(4)*: 407-411. doi: 10.1037/hea0000242
36. World Health Organization. (2021). Social Determinants of Health Retrieved from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1