Social Determinants of Health

Introduction

When caring for patients we should be aware of all factors that influence their health, wellbeing and how they care for themselves. The World Health Organization (WHO) defines social determinants of health (SDOH) as conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. This module will explore the social determinants of health and demonstrate how awareness of these in a patient's life can help direct care for optimal health.

Let's Explore SDOH

The World Health Organization groups determinants of health into three overlapping categories of physical, mental, and social factors and defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (https://www.who.int/hia/evidence/doh/en/) Healthcare providers are often more informed of the physical and mental determinants of health than the social determinants, yet these have just as much impact on health.

The Healthy People 2020 approach to social determinates of health outlines 5 key areas: economic stability; education; social and community context; health and health care; and neighborhood and built environment. Those who have access to the following have better health than those who do not: 1) economic stability (employment, income, and housing); 2) education (high school education, language fluency and literacy); 3) health and health care (access to care and information); 4) neighborhood and built environment (safe neighborhoods with access to healthy food and quality housing); and 4) social and community relationships (social relationships, engagement, and mutual trust).


https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Social inequities have long lasting effects on physical and mental health. Adverse childhood experiences (ACEs) such as traumatic events, abuse or neglect, social isolation, family violence, poor parent-child relationships, and significant losses affect children in ways that are not always obvious to the healthcare team. They may also include community violence and concentrated neighborhood disadvantages such as poverty, high unemployment rates and high-density substance use. Social inequities also affect adults across all of the social health domains. Traumatic events such as natural disasters, faith, racial or ethnic or even random violence shakes a community. In those situations, communities that have economic stability, education, access to care and social cohesion can mitigate some of the long-lasting effects. The most important place to begin is through social health promotion and prevention. Much work is being done to design neighborhoods that address social needs.

The Role of the Healthcare Provider: The Continuum of Care

Health Promotion. Health care providers have an important role in promoting social well-being and resilience. By understanding the populations/subpopulations that we serve, we can promote social well-being. We can refer to the appropriate social agencies, offer parenting education and promote positive social engagement. We can promote social well-being and therefore overall health and quality of life. This is especially important for children and adolescents whose brains have not yet developed the fixed personality traits and related behaviors of adulthood. The CDC Essentials for Childhood webpage provides a framework and resources for promoting safe, stable, nurturing relationships and environments for children. These include creating the context for healthy children and families through norms change, programs and policies. No matter what type of practice, health care providers can provide resources to improve social health literacy and connect families to available community resources.

Continuum of Care

http://www.parentslead.org/professionals/other-resources/continuum-of-care
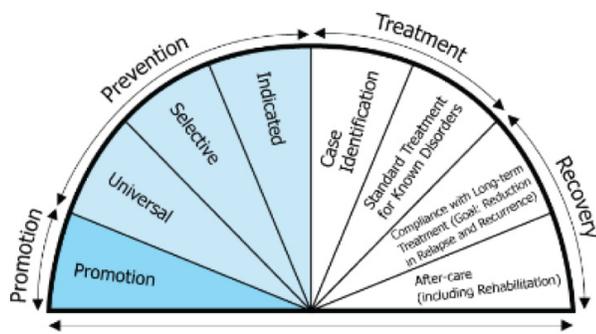
Prevention. Primary prevention of social health disparities can be practiced by healthcare providers. On the healthcare continuum, primary prevention involves screening for risk factors. Screening can be done to identify social health disparities that put individuals at risk for physical and mental health problems. The CDC includes a health inequity screening tool in its Putting SDOH into Action materials. Two additional useful social determinants screening tools include the Centers for Medicare and Medicaid (CMS) Health-Related Social Needs Screening Tool and the American Academy of Family Physicians (AAFP) Social Needs Screening Tool. The CDC webpage on Health-related Quality of Life (HRQOL) also includes screening tools for well-being.

The CMS Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool consists of 10 questions that collect information about living situation, food, transportation, utilities and safety. Screening questions include the following:

AHC-HRSN: https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

Think about the place you live. Do you have problems with any of the following?

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months

➤ Within the past 12 months, you worried that your food would run out before you got money to buy more.

➤ Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

➤ In the past 12 months, has lack of reliable 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?

➤ Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

➤ How often does anyone, including family and friends, physically hurt you?

➤ How often does anyone, including family and friends, insult or talk down to you?

➤ How often does anyone, including family and friends, threaten you with harm?

➤ How often does anyone, including family and friends, scream or curse at you?.

Secondary prevention follows the awareness, assessment, and screening for SDOH. If social domains of health are impaired, it is our role as health care providers to provide risk-reducing interventions appropriate to our scope of practice and to refer out for those we can't address. The overall goal is to address the challenges of an unequal world through socially inclusive health interventions (Luchenski et al., 2018; Marmot, 2015).

Specific aspects of your patient's life and environment that should be taken into consideration when planning care include:

Availability of resources to meet daily needs: including a safe living environment and access to nutritious food. There are food deserts in many large cities and even rural areas where fresh fruits and vegetables are not readily available.

Access to educational, economic, and job opportunities.

Access to health care services: services may be available but can be difficult to access secondary to insurance and/or cost concerns, limited transportation or decreased numbers of accessible providers especially within certain subspecialty areas. Accessibility to free preventative services along with tobacco prevention and cessation programs. Promote hiring of workforce in health care that reflects the population being served.

Quality of education and job training: based on geographic area, is quality of education or ability to train for employment available?

Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.

Transportation options – limited options makes employment difficult, access to health care more difficult.

Social support: from family and friends as well as the community as a whole.

Social norms and attitudes: discrimination, racism, and distrust of government.

Public safety: police and emergency services. Develop approaches to address enforcement of existing regulations and laws affecting health such as housing and health codes to prevent childhood lead poisoning and intervention programs to prevent violence against women and children.

Exposure to crime, violence, and social disorder: presence of trash and lack of cooperation in a community.

Socioeconomic conditions: concentrated poverty and the stressful conditions that accompany it.

Residential segregation

Language/Literacy: is information presented in a manner the patient can understand including language and reading level. Are there resources available for those who cannot read?

Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)

Culture: do individual or collective norms make adherence to lifestyle changes or health behaviors difficult.

Health disparities and SDOH are measurements in which we can use to assess for health equity. Health equity is the value underlying a commitment to reduce and ultimately eliminate health disparities as mentioned in the Healthy People 2020 objectives (US Department of Health and Human Services). It signifies that everyone has the opportunity to attain optimal health irrespective of disability, race, ethnicity, level of education, gender, sexual orientation, job or the neighborhood in which they live (Braveman et al., 2011). The recognition, screening, and intervention for SDOH can impact health and reduce disparities.

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