Webinar Q&A:
Social Determinants of Health: Current State of Affairs

Moderator Glen Mays with panelists Todd Wagner, Elizabeth Ford, Raj Srivastava, and Elena Rosenbaum

Is there a preference to using "Social Drivers of Health" vs. "Social Determinants of Health"? Are these interchangeable?
Dr. Ford: I tend to use Social Determinants of Health more out of habit, but I actually believe Social Drivers is probably more appropriate, as these circumstances may drive health outcomes, but shouldn't determine them.

Dr. Wagner: I have also heard people differentiate SDOH vs social risks.https://www.sbm.org/publications/outlook/issues/summer-2022/social-determinants-of-health-social-risks-social-needs-whats-the-difference-how-do-you-measure-them/full-article

What are the possibilities of local government public health agencies as Chief Health Strategists in serving as backbone support organizations?
Dr. Ford: In many regions, this is already happening! The challenge is that local public health operates differently depending on geography, capacity, financial resources, politics, and many other factors. Many local health departments are struggling to perform their required duties and may lack the manpower, funding, and/or IT support or know-how to support backbones in addition to their other responsibilities.

Dr. Wagner: We're seeing a lot of innovation at the state and local level. A weakness of this model is within the US migration. It would be more efficient to have state or national data backbones so that we're not inefficient at the local level due to being uninformed about new people in the local area.

Any strategy to make people participate in the surveys or in the sessions that help us collect data?
Dr. Rosenbaum: Data collection is done best where people are already using services or attending meetings. Also, people lose interest in being surveyed when they are asked the same questions over and over again. This is a major issue with demographic data collection, for example, and other screening/questions with the fragmentation in data and lack of visibility. Any strategy to improve data visibility and reduce redundant surveying is likely to improve the collection of information it is needed.

Are there any initiatives to provide SDoH support using a 2Gen framework?
Dr. Rosenbaum: Although health-related social needs (HRSN) screening is individual in the New York State Waiver, there are family considerations for the benefits. I agree that this family approach to SDOH support is necessary. It is particularly important to follow the outcomes of the whole family because giving mom the food or housing may impact a child's health outcome rather than (or in addition to) the mom's. However, this improvement may be missed if we are only measuring the mom's outcomes.

I wonder if we could clarify the difference between addressing SDoH (and their root causes – commercialism, racism, etc.) that are bigger issues and often generally need policy-related change, and health-related social needs – which are the individual health and social service needs showing because of the broader community-level SDOHs. So far, it seems that the closed-loop referral systems are mainly just addressing health-related social needs (downstream effort) as opposed to bigger SDOHs (upstream efforts)? (The housing example given may be one.)

Dr. Rosenbaum: Exactly, currently closed loop referral platforms and HRSN programs are addressing the downstream consequences of SDOH and their root causes. Community care hubs/backbones/social care networks can contract with organizations that address upstream SDOH (through policy, built environment, housing initiatives, etc.) but the work may be more at a community level or policy level, rather than individual and may not be captured in a closed loop referral platform.

Dr. Wagner: This gets quite philosophical and very hard to address succinctly in a brief email. Economist John Maynard Keynes said "The political problem of mankind is to combine three things: economic efficiency, social justice and individual liberty." I often think that many possible solutions, even policy solutions, help on one dimension, but come at the cost of another dimension.

I work for a large hospital system in Illinois and we are in the process of expanding screening for SDOH in our medical group settings along with our inpatient setting (CMS requirement). One of our barriers is adequate training

Dr. Rosenbaum: The Association for Clinicians for the Underserved has a JEDI initiative and they do SDOH training.

Dr. Wagner: Screening takes time, a systematic approach, referral resources, and trust. It is really hard to drop in screening without these four components. We're working on a separate study where we are trying to understand the time associated with screening, and while were not done yet, it appears more than you would expect.

I appreciate so much of what Elizabeth is saying and completely agree this is continuum, but how do we begin? What are some first steps?

Dr. Ford: I think the first step is Asset Mapping. So many communities aren't fully aware of all the resources available in their communities. We need to know what's available, hours of operation (i.e., Saturday and evenings), language capacity, public transportation access, provider capacity, etc.

I really encourage people to look at Michael Marmot's work. The whole idea of SDOH originated in the UK and their thinking is far advanced over how we are approaching the issue in the US.

Dr. Wagner: I would also point to the recent randomized controlled trial on universal basic income. https://www.nber.org/papers/w32711?utm_campaign=ntwh&utm_medium=email&utm_source=ntwg3

Even if the other "pockets" can't contribute with funding or providing services, like the education system, they can still be brought on as ADVOCATES knowing that addressing SDoH will benefit them too! Is that happening anywhere?

Dr. Wagner: Yes, this is happening in the mental health/schooling and the schools/gun education issues.