Screening for Social Drivers of Health: What Role Providers Play and Addressing Needs To Improve Patient Care

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University of California, Los Angeles, Integrated Substance Use and Addiction Programs

L.A. Care Health Equity Conference

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UCLA Integrated Substance Use and Addiction Programs
Division of Addiction Psychiatry

Financial Disclosures

- The following CME planners and faculty do not have relevant financial relationships with ineligible companies in the past 24 months:
  - Leilanie Mercurio, Provider Continuing Education (PCE) Program Manager, L.A. Care Health Plan, CME Planner.
  - Alex Li, MD, Chief Health Equity Officer, L.A. Care Health Plan, CME Planner.
  - Johanna Gonzalez, Project Manager II, Health Equity Department, L.A. Care Health Plan, CME Planner.
  - Marina Acosta, Manager, Health Equity Department, L.A. Care Health Plan, CME Planner.
  - Leah Mitchell, Health Education Project Liaison III, Health Equity Department, L.A. Care Health Plan, CME Planner.
  - Howard Padwa, Ph.D., Research Scientist, University of California, Los Angeles – Integrated Substance Use and Addiction Programs, CME Presenter.
- An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.
- Commercial support was not received for this CME/CE activity.

Learning Objectives

At the completion of the activity, learners can:

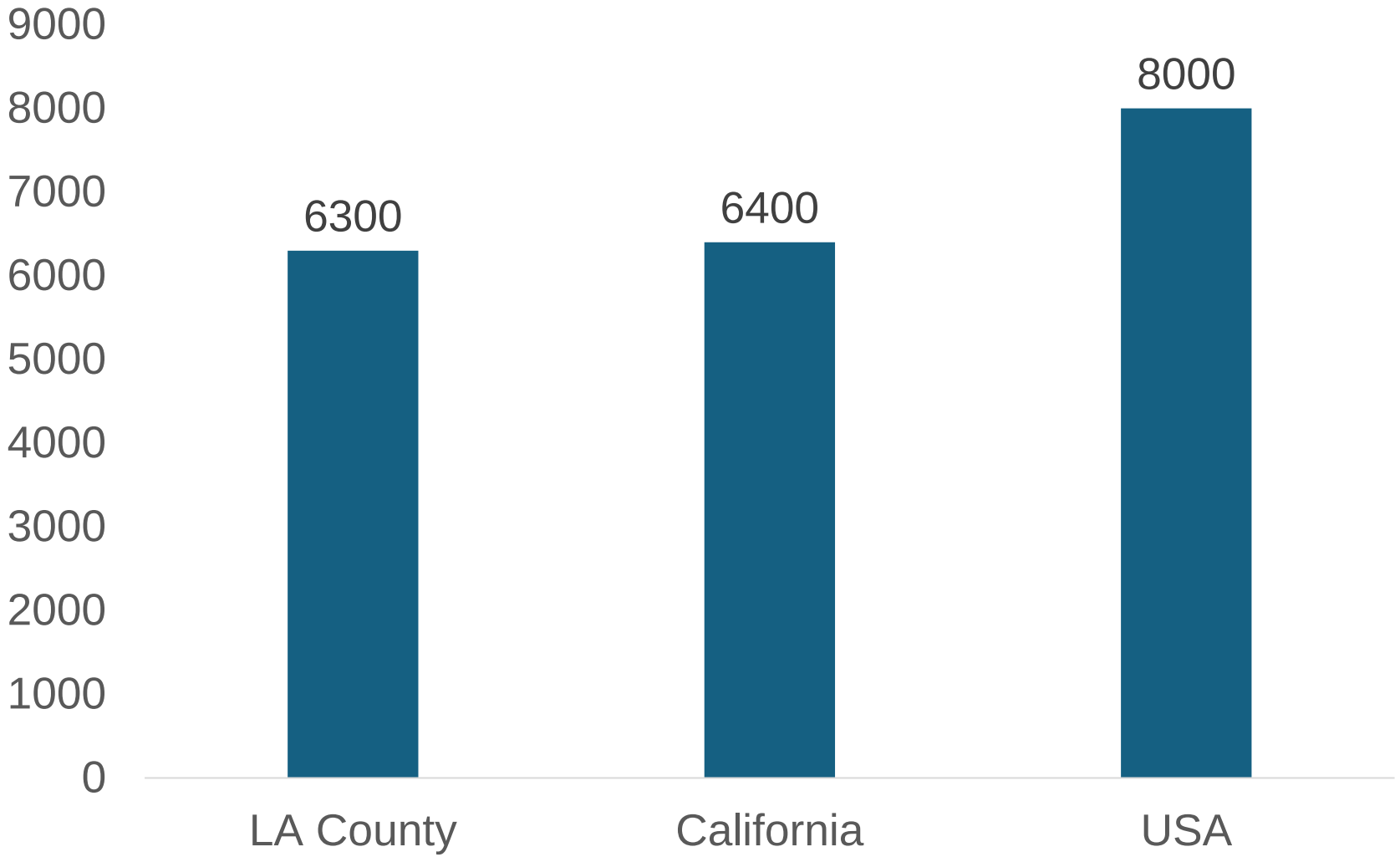
1. Identify at least two key social drivers of health (SDOH) impacting communities they serve.
2. List at least three ways that the short-term and long-term effects of SDOH can impact the health and well-being of the patients they serve.
3. Describe how knowledge of SDOH may impact clinical care and treatment planning.
4. Specify how medical providers can collect SDOH data and utilize it to improve clinical care.
5. Summarize services and supports available to address SDOH-related needs for patients in medically underserved areas.

Part 1

Social Drivers of Health (SDOH)

How Is Our Health in LA County?

- Premature Death – Measured as age-adjusted years of life lost before age 75 per 100,000 people.

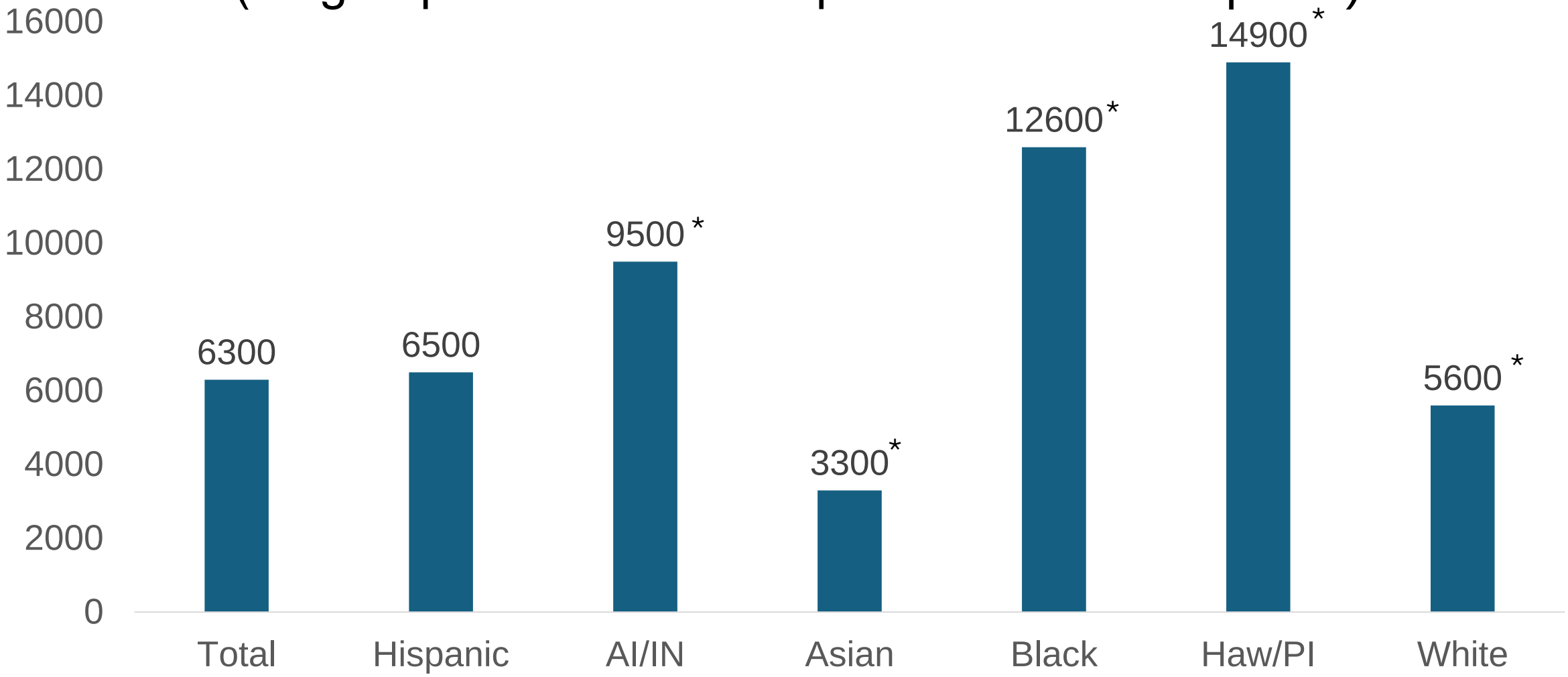


SOURCE: University of Wisconsin Population Health Institute (UWPHI), 2025

How Is Our Health in LA County?

Premature Death – LA County by Demographic Group

(All groups other than “Hispanic” are non-Hispanic)

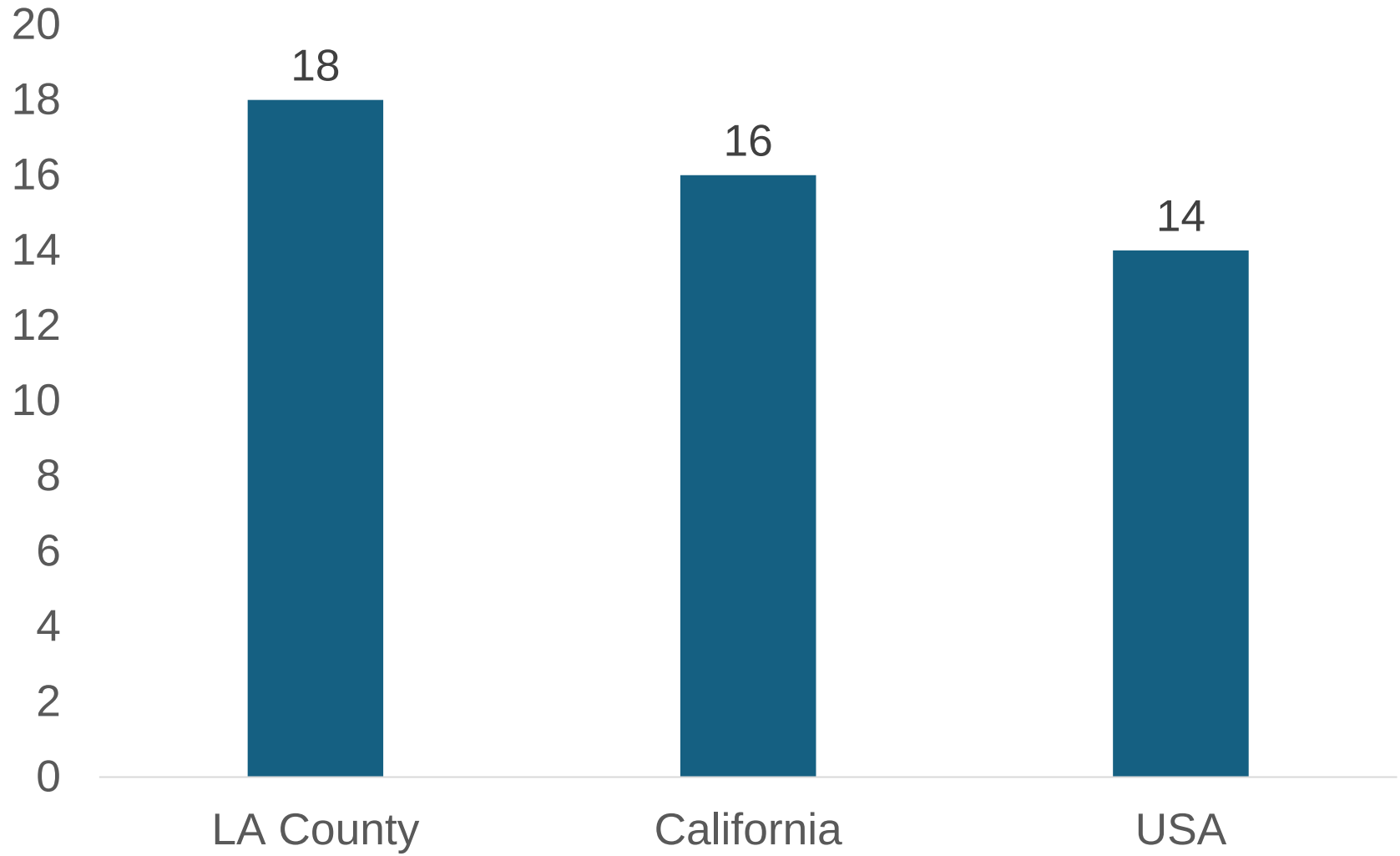


SOURCE: UWPHI, 2025

* Indicates statistically significant difference from total population

How Is Our Health in LA County?

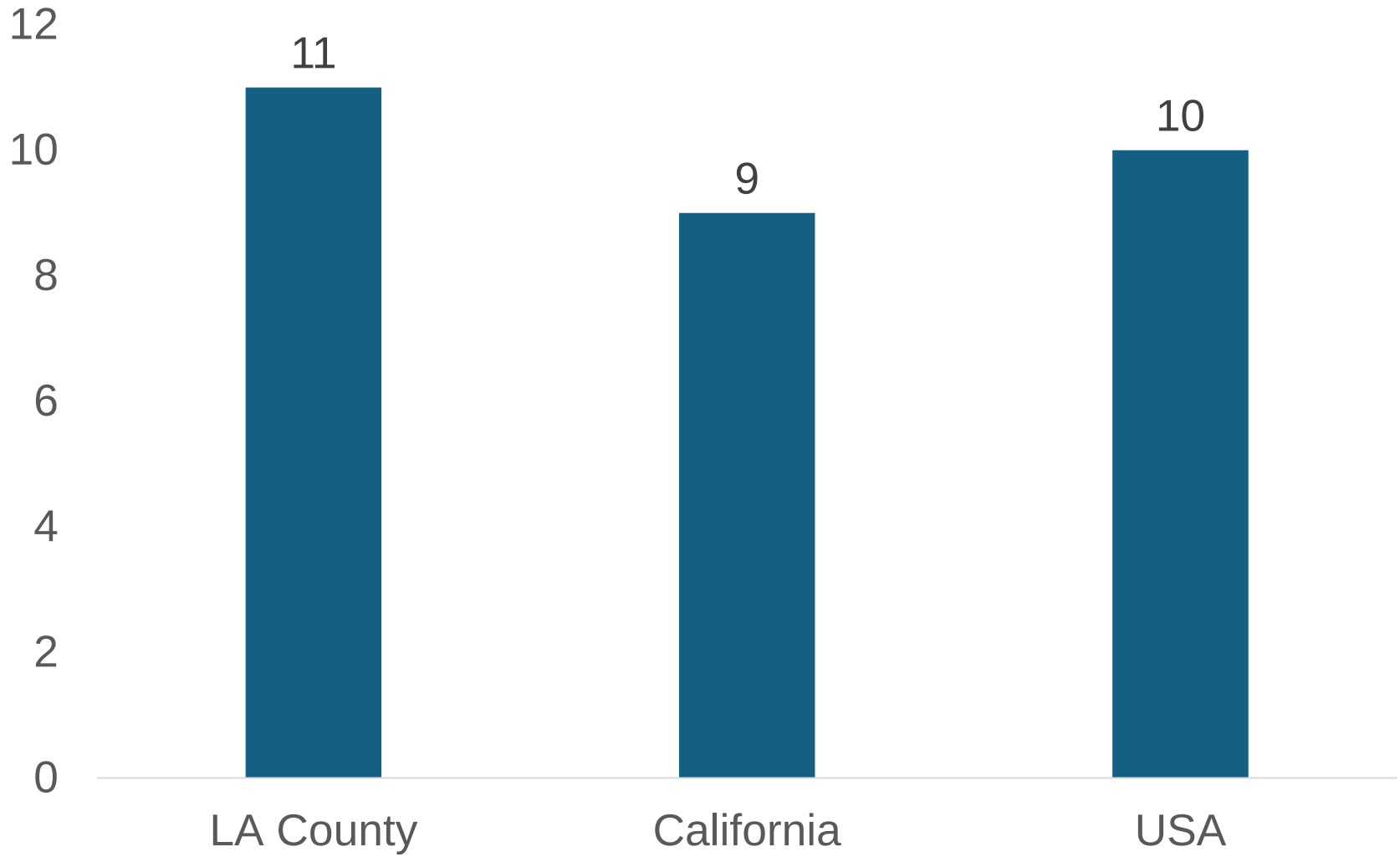
- Self-rated fair/poor health – age adjusted (%).



SOURCE: UWPHI, 2025

How Is Our Physical Health in LA County?

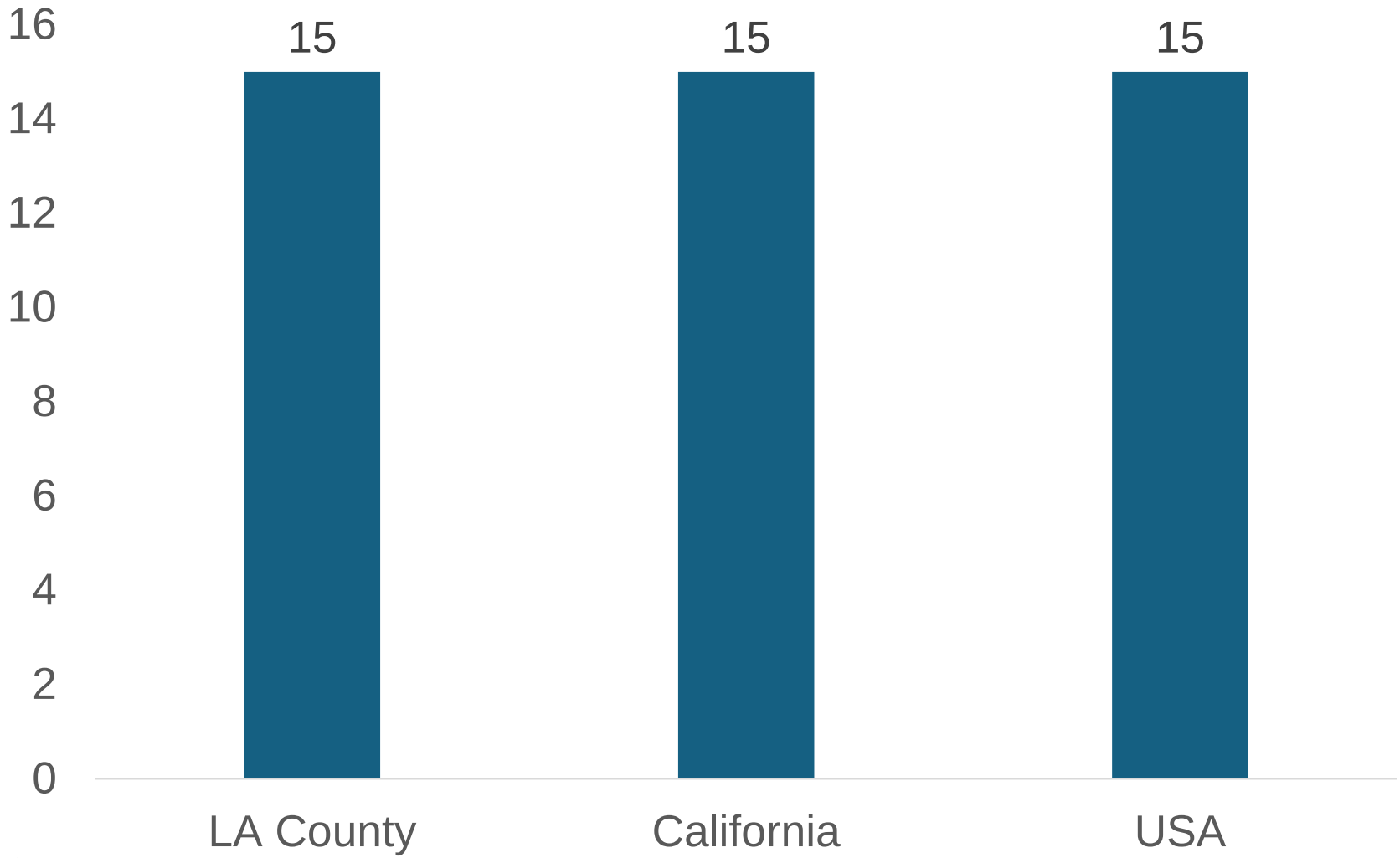
- Adults reporting frequent physical distress – poor health 14 or more of past 30 days (%).



SOURCE: UWPHI, 2025

How Is Our Mental Health in LA County?

- Adults reporting frequent mental distress – poor mental health 14 or more of past 30 days (%).



SOURCE: UWPHI, 2025

What Do We Mean By “Health”

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

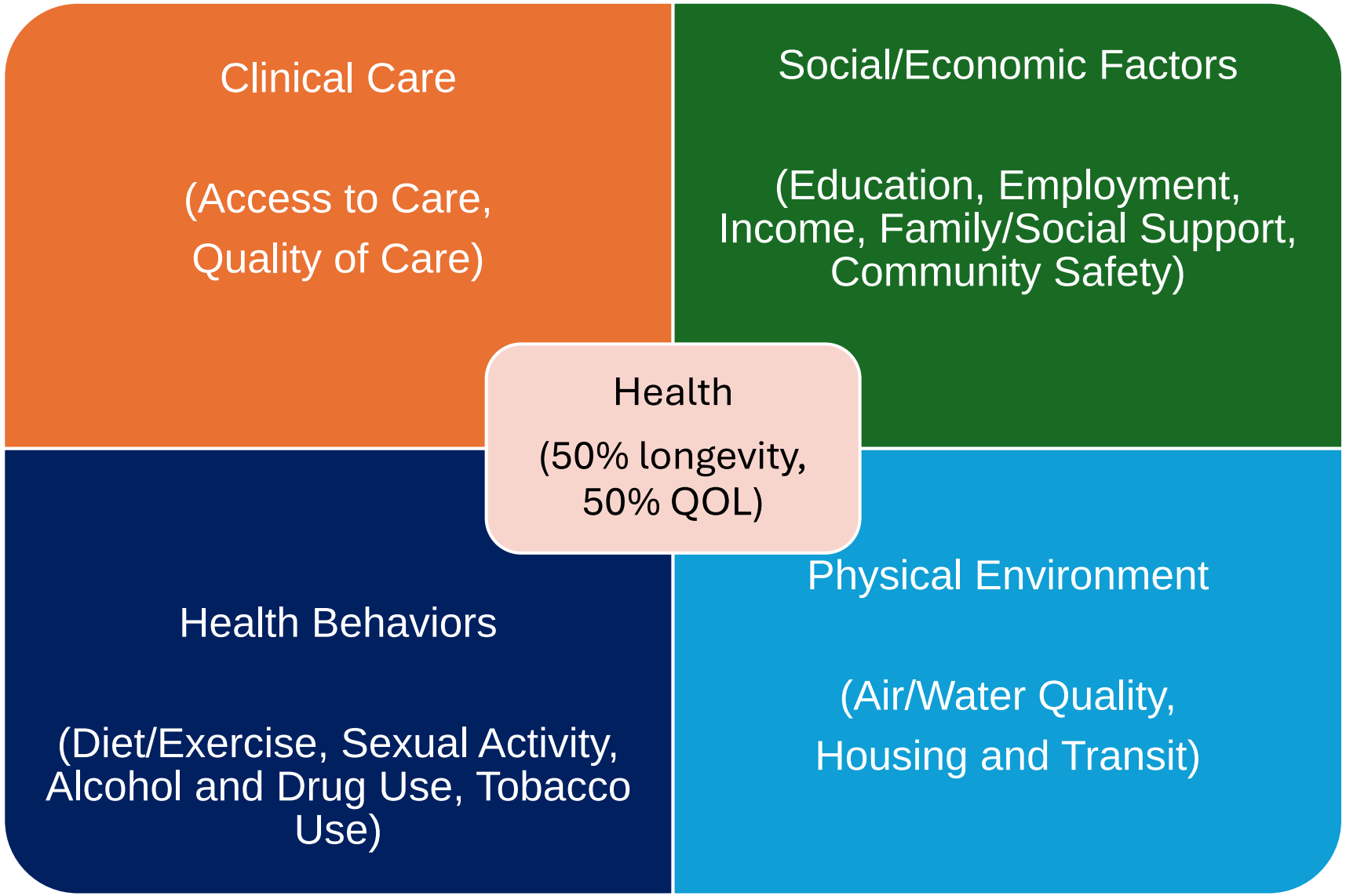
“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition.”

SOURCE: World Health Organization Constitution, cited in World Health Organization, 2020

What Impacts Your Health?

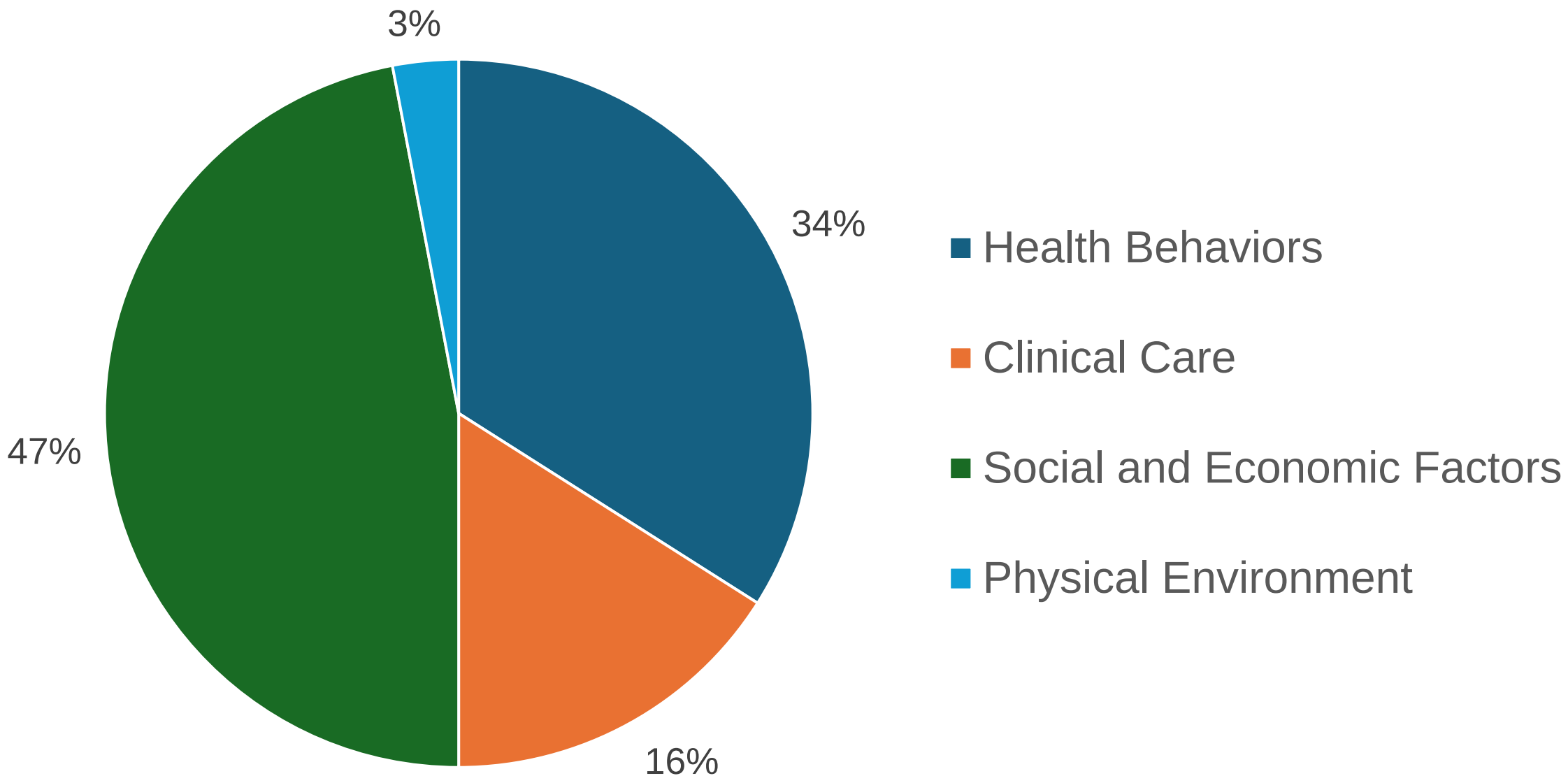
What Impacts Health?

In 2016 researchers analyzed health outcomes in all US counties across 45 states (excluded states with under 10 counties)



SOURCE: Hood et al., 2016

What Impacts Health?



SOURCE: Hood et al., 2016

Social Drivers of Health

- Social determinants of health are *"conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*

- The field is moving towards describing these as "drivers" instead of "determinants" to acknowledge our agency to improve health <u>despite</u> social barriers.

SOURCE: Department of Health & Human Services (DHHS), 2024; Halpin et al., 2023

What Are The Social Drivers of Health?

Higher education associated with better health outcomes and increased lifespan

Timely, quality health care improves outcomes

Air/water quality, violence, environmental risks impact physical and behavioral health outcomes

Access to healthy food, health care, housing are essential for health

Relationships promote/impede health and well-being

Social Determinants of Health
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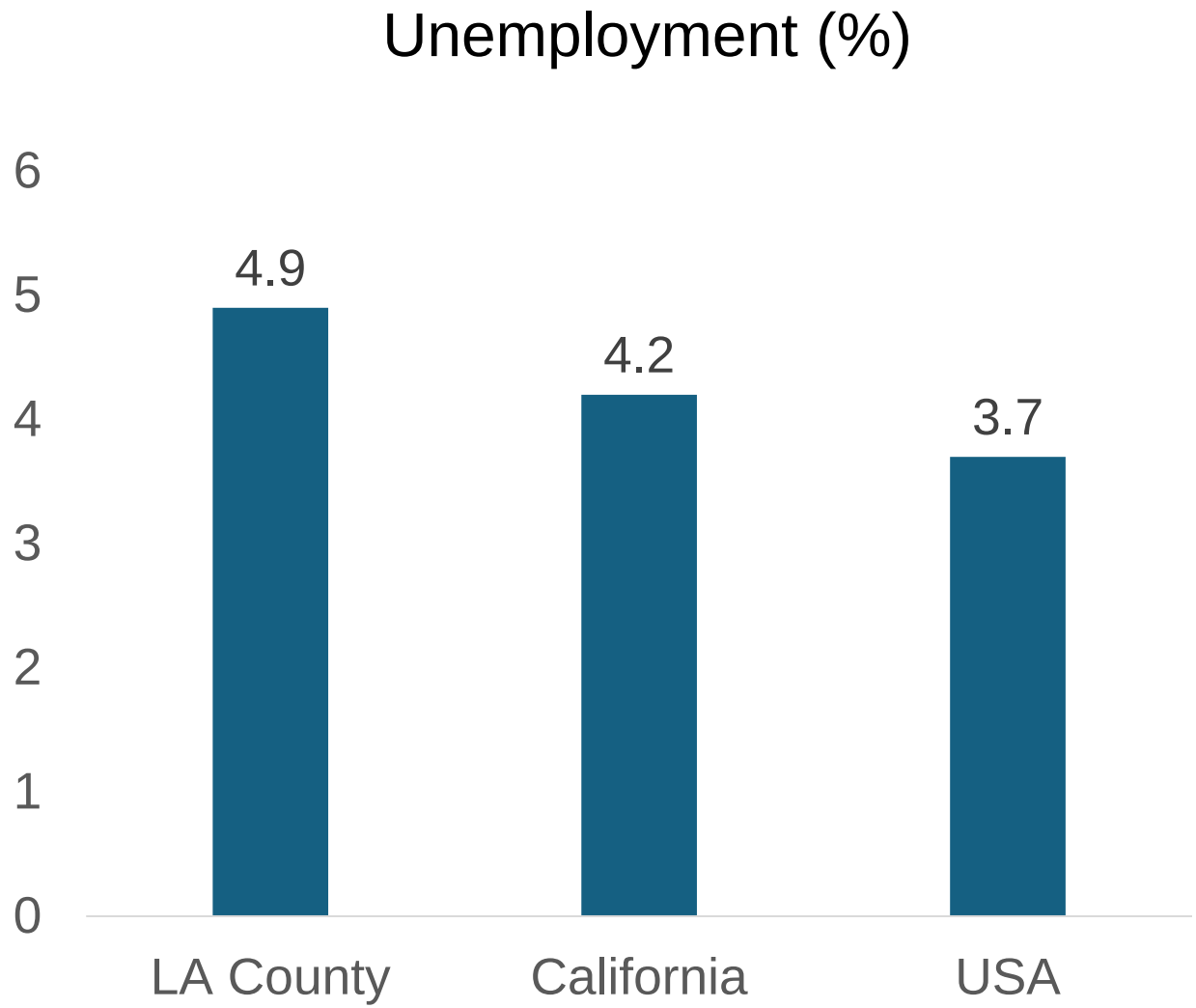
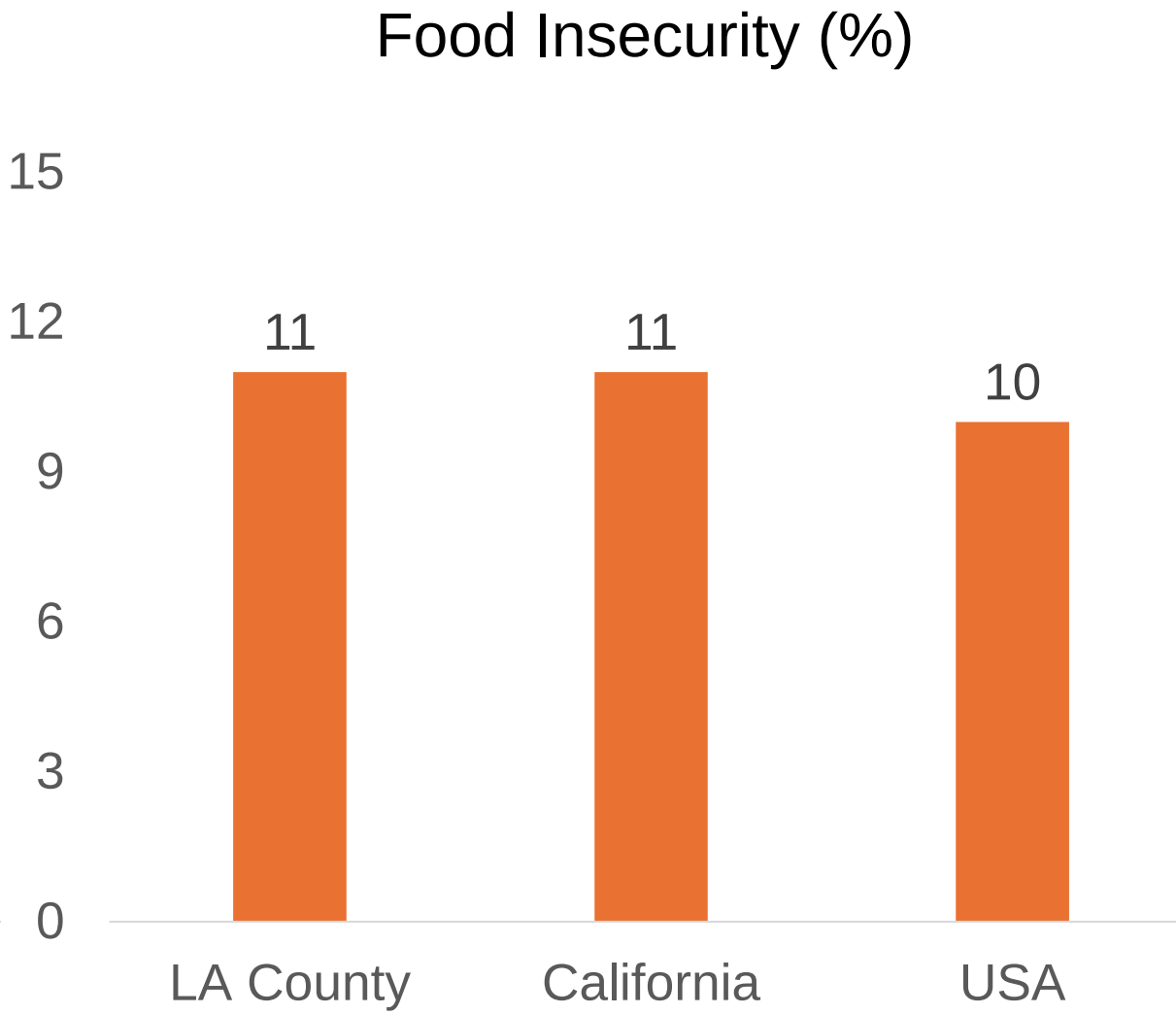
Healthy People 2030

Economic Stability in LA County





SOURCE: University of Wisconsin Population Health Institute (UWPHI), 2025

Education Access/Quality in LA County

School Funding Adequacy (Per Pupil)

SOURCE: UWPHI, 2025

Health Care Access (Population:Provider Ratio)

Provider Type	LA County	California	USA
Primary Care	1,330:1	1,230:1	1,330:1
Dentists	1,030:1	1,080:1	1,360:1
Mental Health	220:1	220:1	320:1

SOURCE: UWPHI, 2025

Neighborhood and Built Environment

% of Households with Severe Housing Problems:

- High Housing Costs
- Overcrowding
- Lack of Kitchen Facilities
- Lack of Plumbing Facilities

LA County	California	USA
32%	26%	17%

SOURCE: UWPHI, 2025

Neighborhood and Built Environment

Outcome	LA County	California	USA
Access to Healthy Food (Scale of 1-10)	8.3	8.6	7.7
Access to Park or Recreational Facility	98%	94%	84%
Air Particulate Matter (mg/m^3) (12.0 is decent)	13.4	7.1	7.4

SOURCE: UWPHI, 2025

Part 2

How Social Drivers Impact Health

Fetal Development

- Nutrition is the main driver of fetal growth.
  - Folate and folic acid
  - Calcium
  - Vitamin D
  - Protein
  - Iron
- Maternal nutrient availability, stress-related hormones, and inflammation impact metabolic systems and brain development.
- Combination of low income, low education, poor insurance, and poor diet associated with smaller gray and white matter volume.

SOURCE: Bloomfield et al., 2006; Herberg & Smyser, 2024; Mayo Clinic, 2025.

Childhood

- Nutrition
  - Essential for physical and brain development.
  - Hungry children have more trouble with education, social functioning.

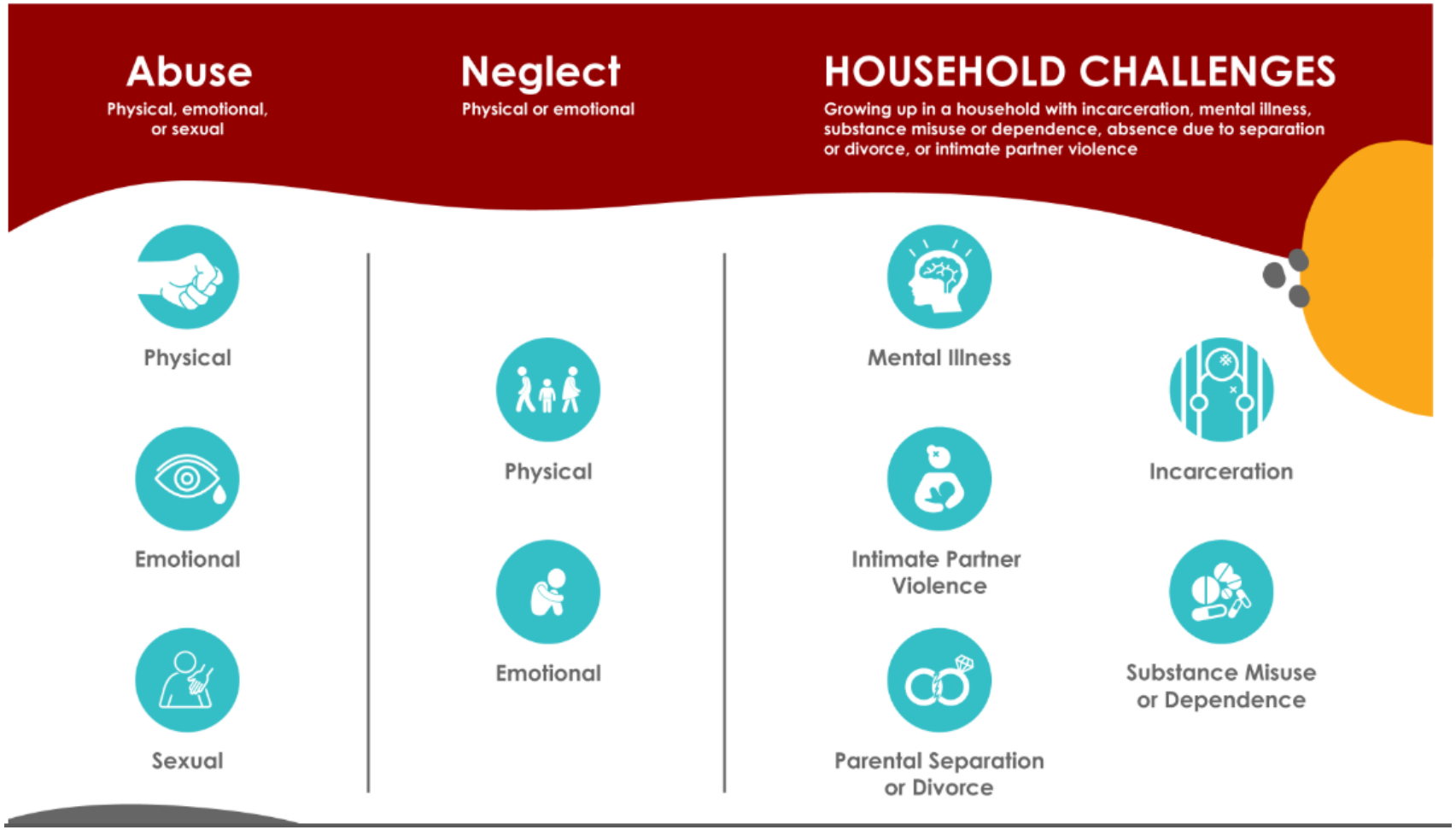
- Home environment
  - Housing conditions, neighborhood quality, caregiver stress impact children's cognitive functioning, social skills, and academic achievement.
  - Language acquisition and development associated with social environment.

- Environments that promote safe exploration help develop cognitive abilities, ability to assimilate information from one experience and apply it to other contexts.

SOURCE: Maggi et al., 2023

Adverse Childhood Experiences (ACEs)

- SDOH-factors can increase risk for Adverse Childhood Experiences (ACEs)



SOURCE: California Department of Health Care Services, 2025

Adverse Childhood Experiences (ACEs)

- ACE impacts are long-term
  - Can lead to maladaptive coping mechanisms, mental health problems, excessive alcohol and substance use.
  - Directly affect neurological, hormonal, and immunological development.

Condition	Increased Risk – 1 ACE	Increased Risk – 2+ ACEs
Harmful Alcohol Use	1.44	1.81
Illicit Drug Use	1.53	2.64
Smoking	1.23	1.74
Depression	1.34	2.69
Cancer	NS	1.25
Obesity	NS	1.23
Cardiovascular Disease	1.16	1.60
Diabetes	1.11	1.15
Respiratory Disease	1.29	1.90

SOURCE: Bellis et al., 2019

Adverse Childhood Experiences (ACEs)

- Multiple ACES increase risk even more.

Condition	Increased Risk 4+ ACEs
Overweight/Obesity	1.39
Cardiovascular Disease	2.07
Heavy Alcohol Use	2.00
Poor Self-Rated Health	2.24
Cancer	2.31
Liver/Digestive Disease	2.76
Smoking	2.70
Respiratory Disease	3.05
Anxiety	3.70

Condition	Increased Risk 4+ ACEs
Teen Pregnancy	4.20
Low Life Satisfaction	4.36
Depression	4.40
Problematic Alcohol Use	5.84
Sexually Transmitted Infections	5.92
Violent Victimization	7.51
Violence Perpetration	8.10
Problematic Drug Use	10.22
Suicide Attempt	37.48

SOURCE: Hughes et al., 2017

Adolescence

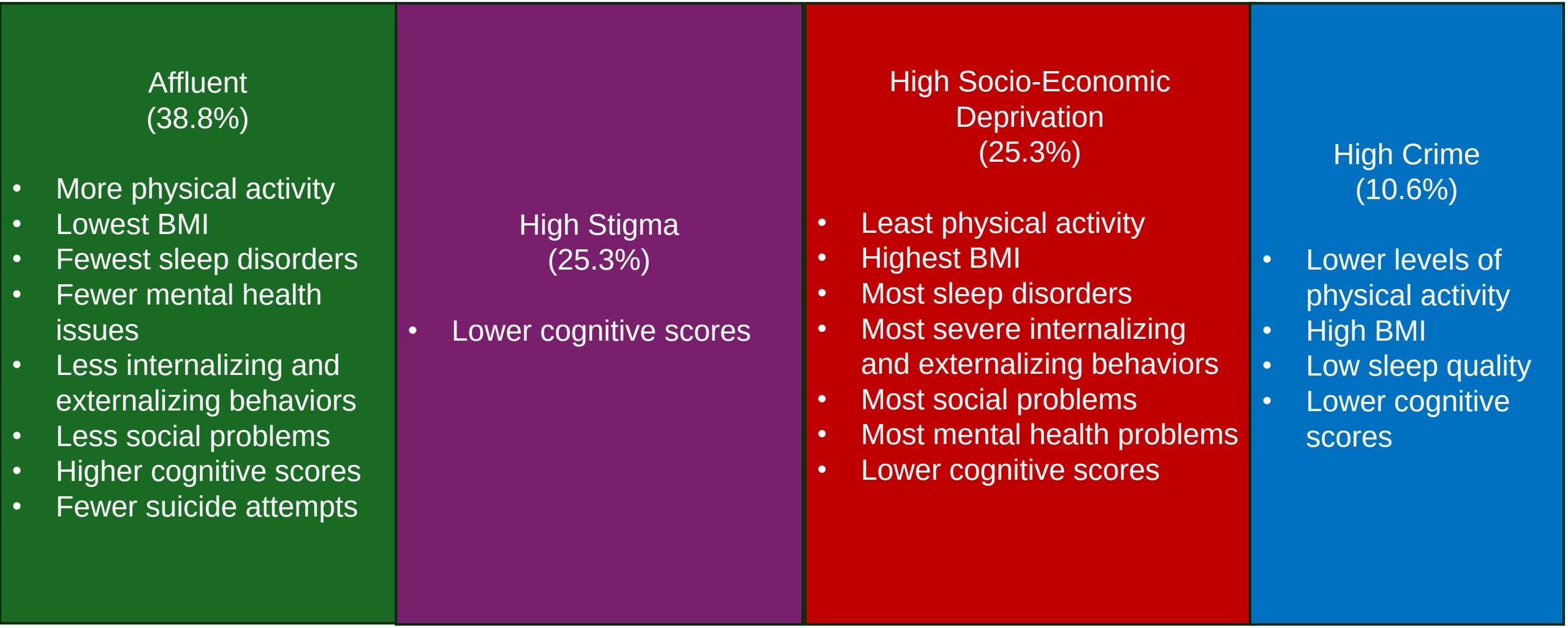
SOURCE: Xiao et al., 2023

- NIH Adolescent Brain Cognitive Development (ABCD) Study
  - Followed a racial/ethnically diverse sample of 10,504 9-10 year olds from 84 neighborhoods across the US from 2016-2021.
  - Found 4 SDOH patterns.

Affluent (38.8%)	High Stigma (25.3%)	High Socio-Economic Deprivation (25.3%)	High Crime (10.6%)
• High socio-economic status • Low structural stigma • Moderate crime rates • Good academic performance • Access to healthy food • Healthy environment • Moderate population density • Disproportionately White	• High bias and discrimination towards women and gender minorities • Low college enrollment • High pollution and heat exposure • Many lived in mobile homes or group settings • Low population density and walkability • Disproportionately White	• Low family income, home value • High unemployment, poverty • Poor math/reading proficiency • Highly dependent on public assistance • Experience high levels of racial/anti-immigrant discrimination • Disproportionately Black and Hispanic	• High crime and drug sales • Low educational attainment • High pollution • High population density • Crowded housing • Limited access to healthy environments • Disproportionately Hispanic

Adolescence

- Compared to other groups…



SOURCE: Xiao et al., 2023

Obesity and the Environment

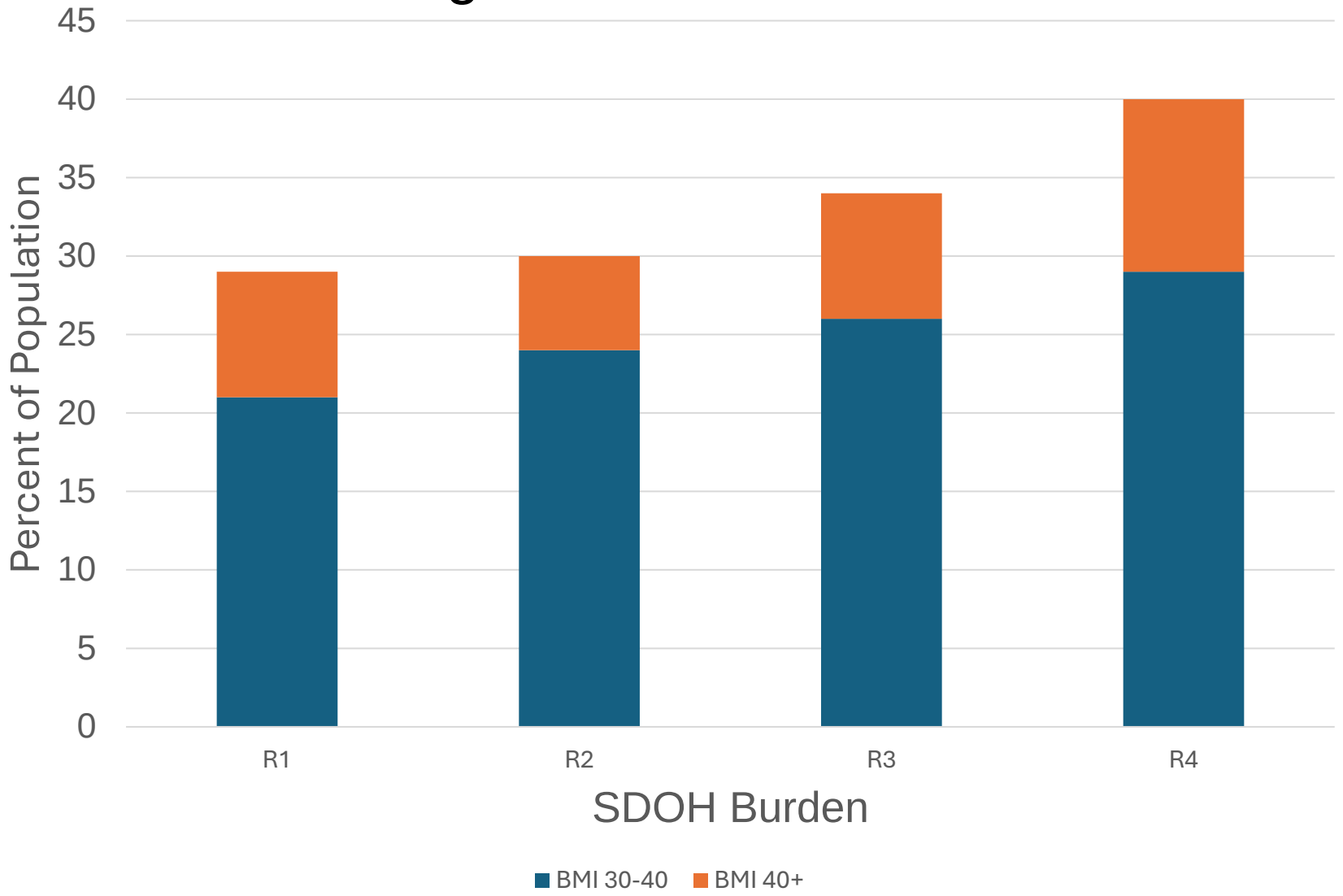
- Study of 10,763 middle-aged and older adults
  - Living near a grocery store associated 17% lower prevalence of obesity.
  - Living near a convenience store associated with 16% higher prevalence of obesity.

- Where are we missing the supermarkets?
  - Low-income areas have 75% of supermarket availability compared to middle-income areas.
  - Black neighborhoods have 52% of supermarkets available in White neighborhoods.
  - Hispanic neighborhoods have 32% of supermarkets available in White neighborhoods.

SOURCE: Jilani et al., 2021

Obesity

- 2013-2017 survey of 161,795 US adults assessed 38 SDOH domains, assigned SDOH burden from R1 to R4



When controlling for other factors, compared to R1, people in R4 had:

- 50% higher prevalence of BMI between 30-40.
- 70% higher prevalence of BMI over 40.

Middle-aged and non-Hispanic Black adults had higher obesity rates than their counterparts.

SOURCE: Javed et al., 2022

Diabetes

- Income
  - Compared to high-income individuals, middle income have 40% higher prevalence of diabetes, near poor have 74% higher risk, poor have 100% higher prevalence.
  - Differences in diabetes prevalence by income seem to be increasing.
  - For people with Type 2 diabetes, living below poverty level doubles risk of diabetes-related mortality.
  - For people with Type 1 diabetes, low income is associated with higher risk of diabetic ketoacidosis.
- Neighborhood
  - If you are poor, living in a poor neighborhood doubles the odds of having diabetes.
  - If you are not poor, living in a poor neighborhood still increases odds of having diabetes.
  - More walkable neighborhoods are associated with lower Type 2 diabetes prevalence.
- Environment
  - Air pollution associated with increased diabetes risk.

SOURCE: Hill-Briggs et al., 2020

Cardiovascular Disease

- Income under 150% FPL or less than high school education almost doubles risk of premature myocardial infarction and cardiovascular disease.
- 20-year changes in family income:

SOURCE: Jilani et al., 2021

Cardiovascular Disease

- Social Support
  - Study of 32,624 males over a 4-year period.
  - Compared to those with highest levels of social support, men with lowest levels of social support had **1.9 times** the risk for cardiovascular disease mortality and **2.21 times** the risk for stroke.

- Individuals who experience racism have elevated risk of hypertension.

- High social cohesion reduces risk of cardiovascular mortality.

SOURCE: Jilani et al., 2021

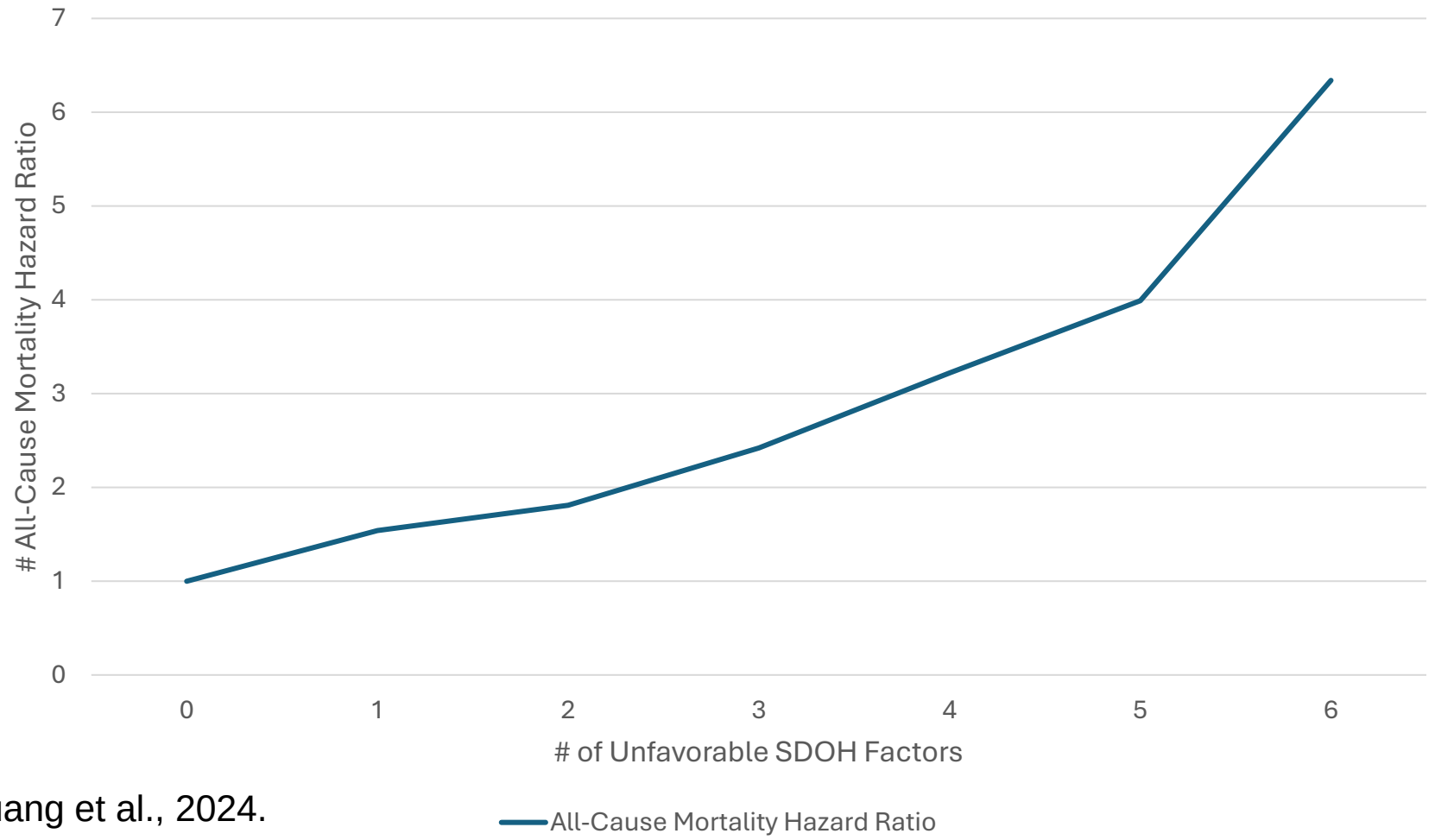
Cancer

- Second-hand smoke and other environmental toxins increase risk.
- Obesity—associated with up to 20% of cancer burden.
- Allostatic load—chronic exposure to fluctuating or elevated neuroendocrine responses to environmental stress associated with cancer-related risk.
- Health system disparities
  - Screening
  - Treatment

SOURCE: Syrnioti et al., 2023

Cancer

- Study followed 5,163 cancer survivors for 19 years.
- For cancer survivors, unemployment, lower economic status, and social isolation are associated with long-term cancer-specific mortality.



The more unfavorable SDOH factors, the greater risk of all-cause mortality.

SOURCE: Huang et al., 2024.

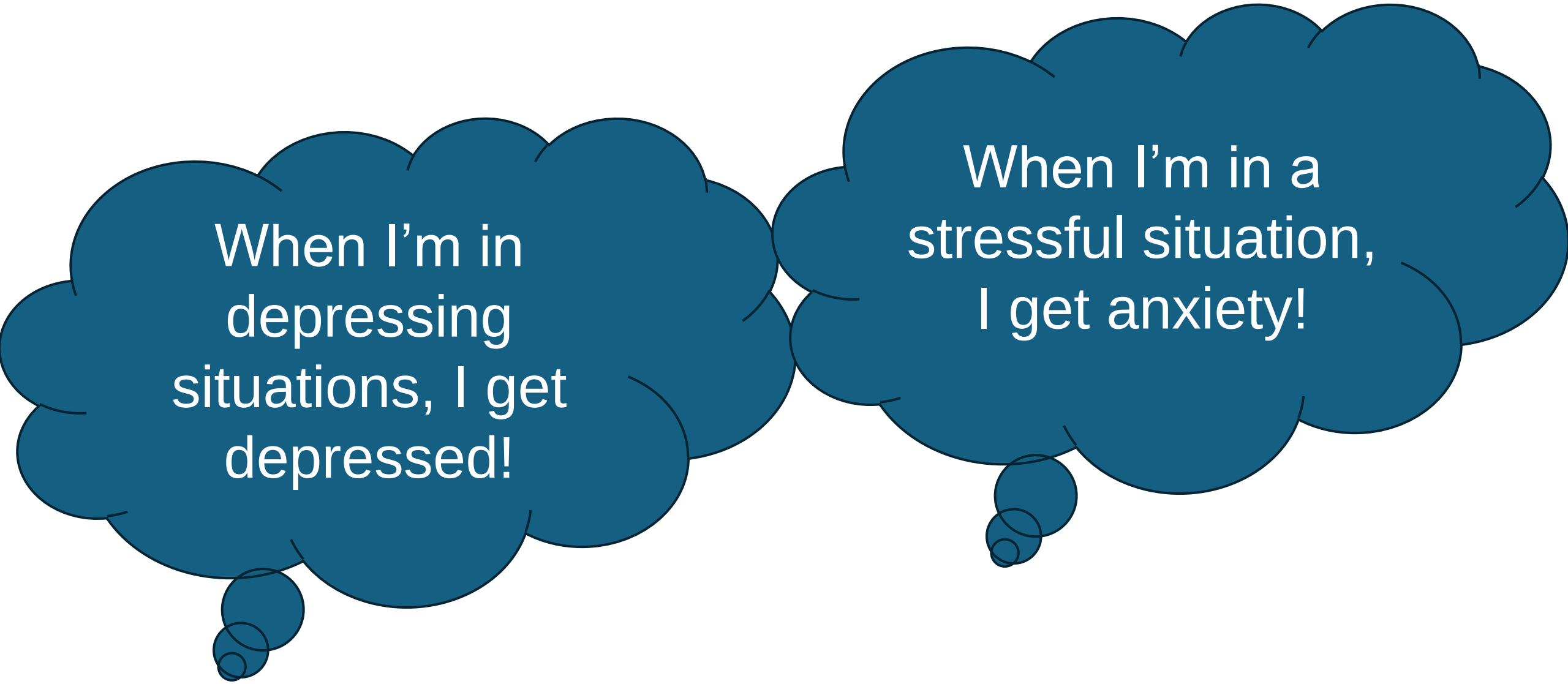
Mental Health

- Children growing up in disadvantaged environments are **2-3 times** as likely as their peers to experience mental health problems.

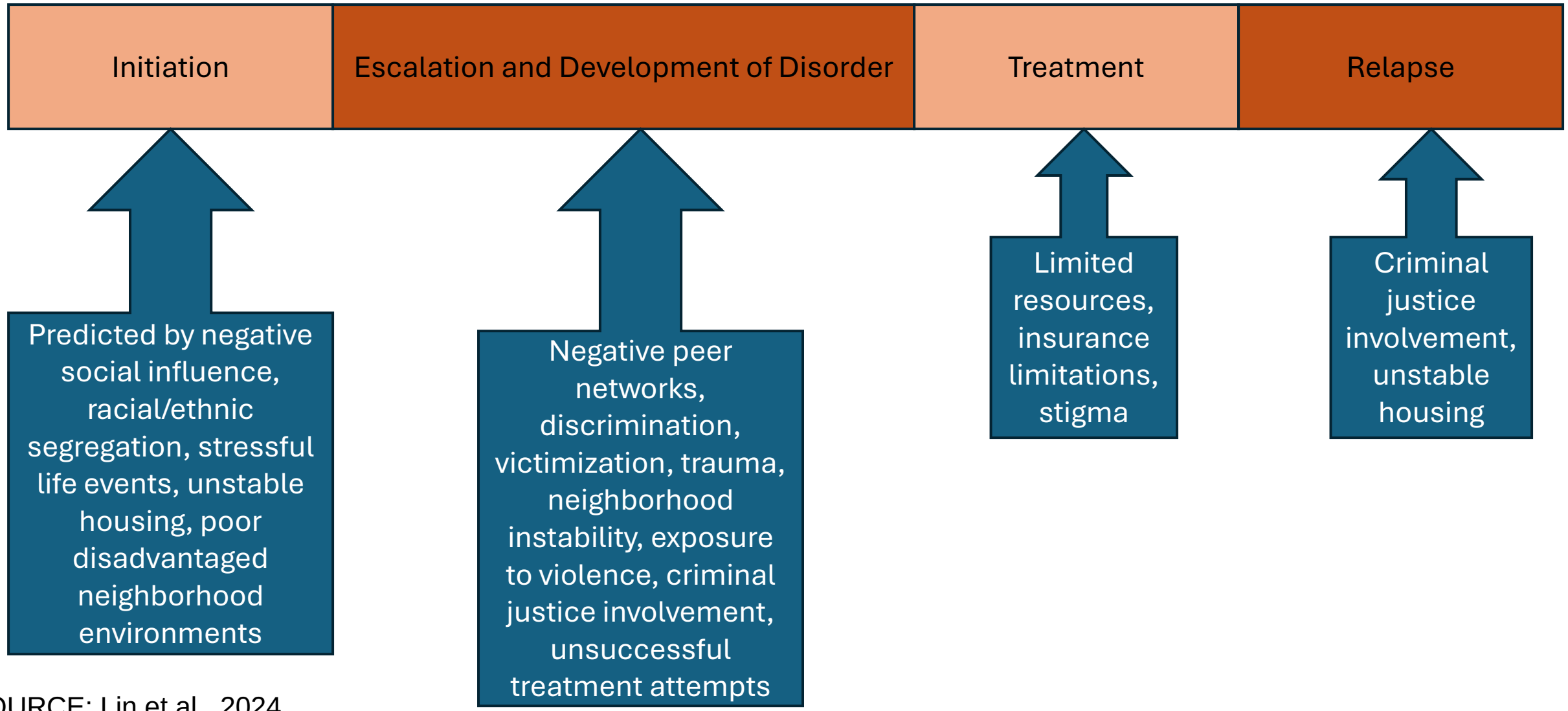
- Minoritized groups have **more symptoms of psychological distress** than White groups, but **lower rates of psychiatric diagnosis**.

SOURCE: Kirkbride et al., 2024.

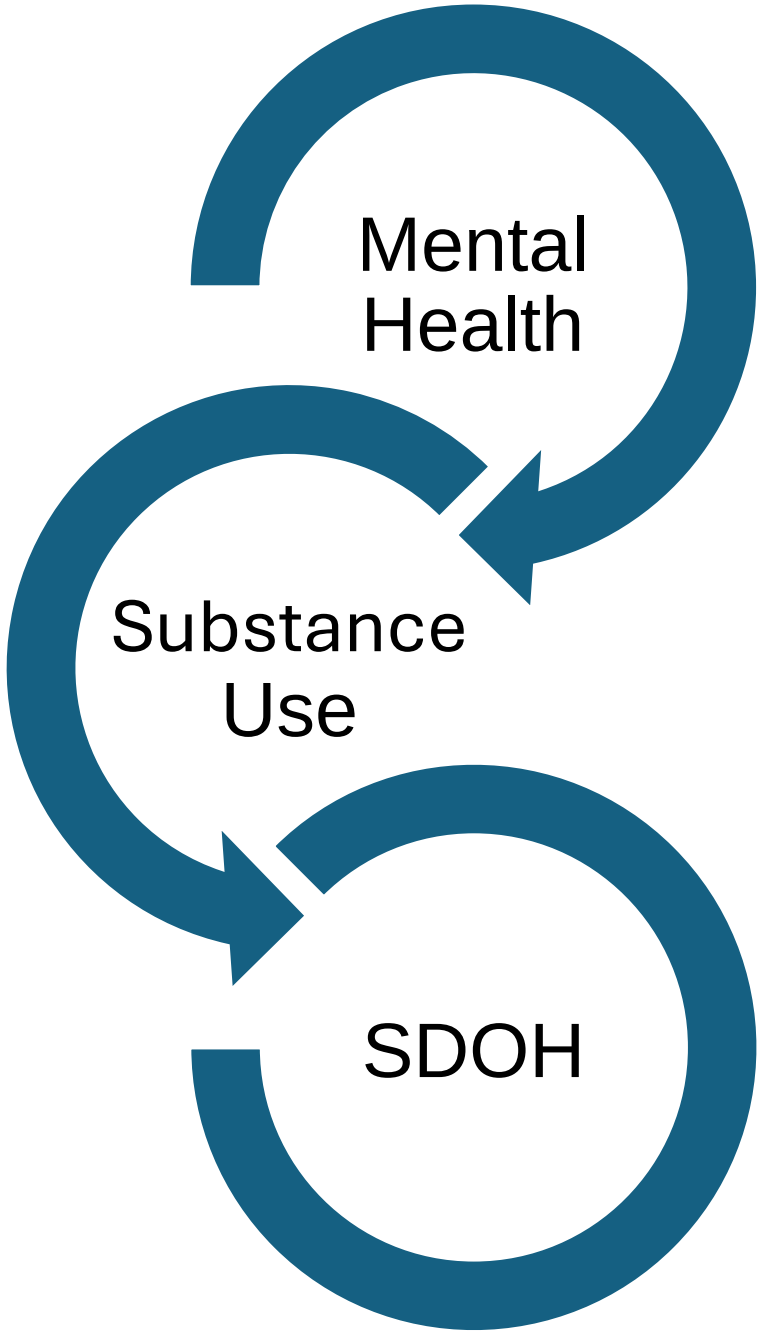
Mental Health



Substance Use Disorders



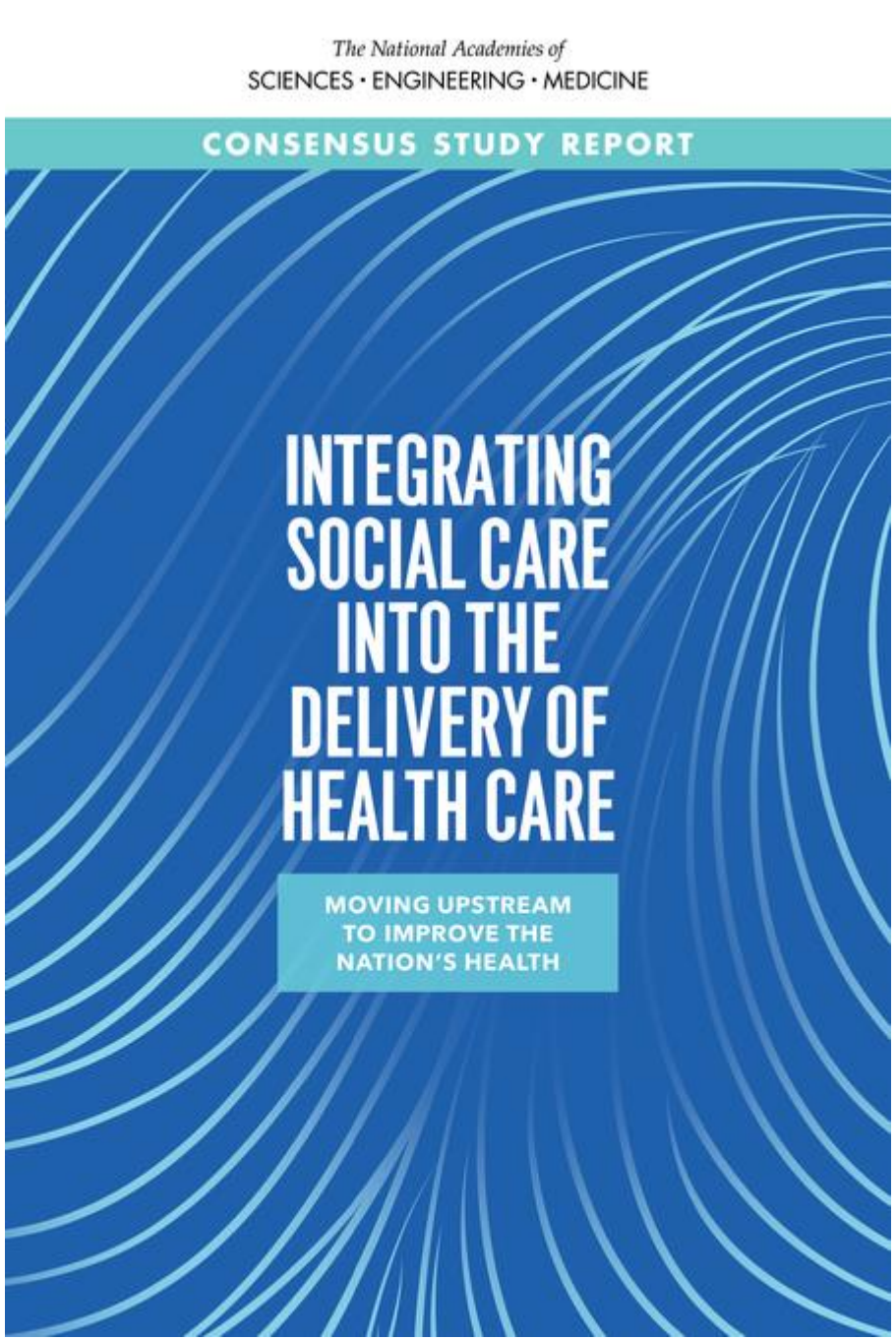
SOURCE: Lin et al., 2024.



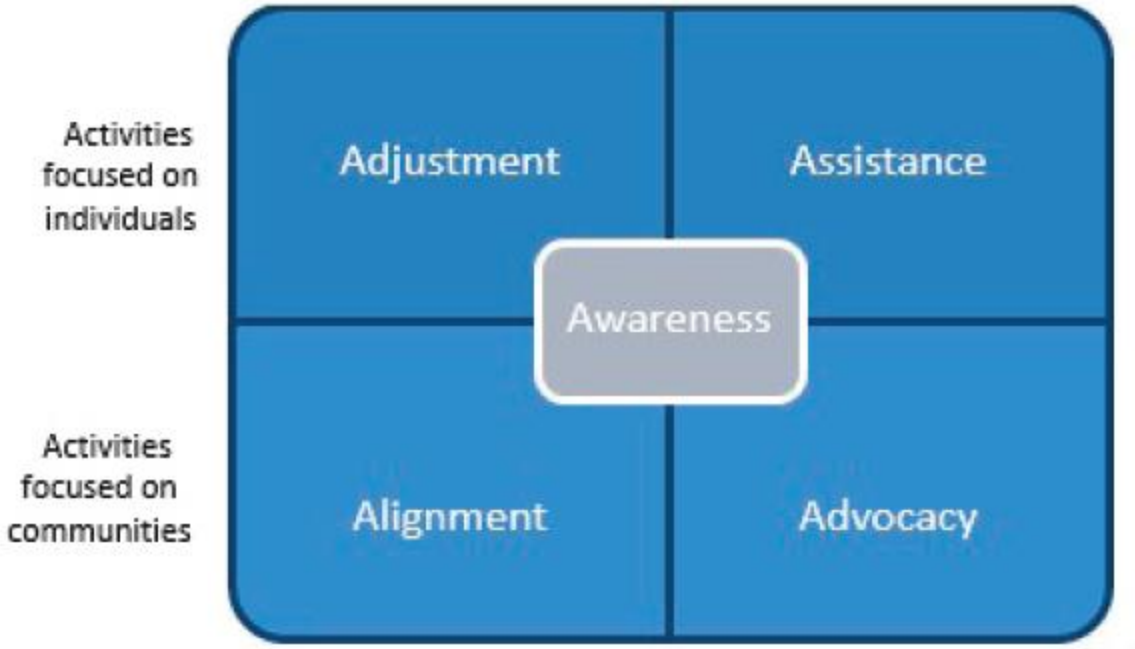
Because of their impacts on behavior and functioning, mental health and substance use disorders are often effects and causes of SDOH disadvantages.

Part 3

What We Can Do



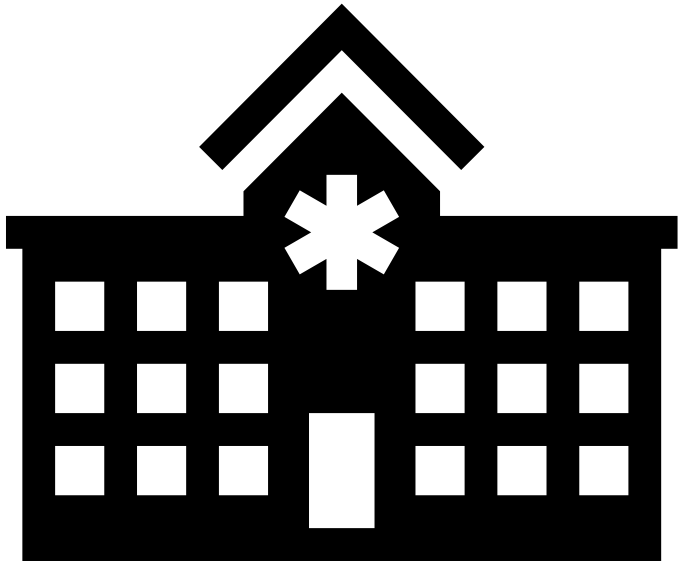
What Can Health Providers Do?



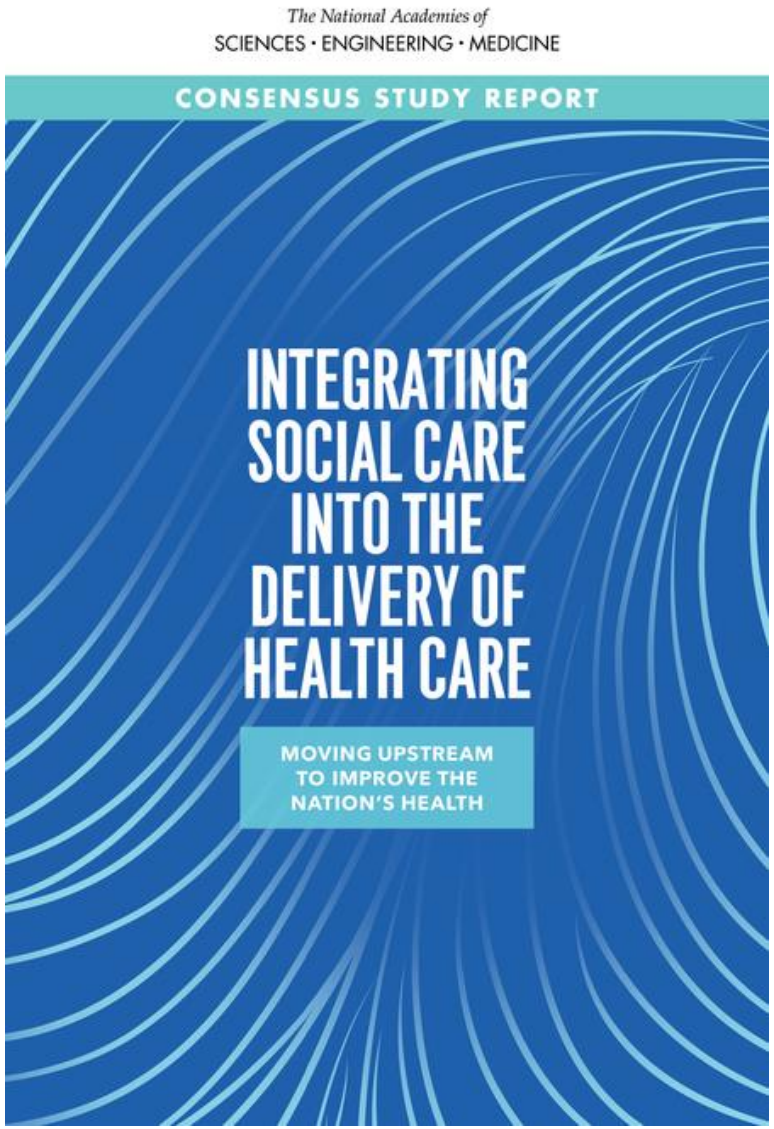
SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

Awareness

Identify social risks and assets of patients and populations



- Within your clinic
  - Use screenings, talk to individual patients to identify SDOH issues.
  - Screen clinic populations through surveys, interviews, focus groups, review of EHR.
  - Screen high-risk groups through surveys, interviews, focus groups, review of EHR.



Awareness

- Existing screening tools include:
  - AHC-Tool
  - HealthBegins
  - Health Leads
  - MLP IHELLP
  - Medicare Total Health Assessment Questionnaire
  - NAM Domains
  - PRAPARE
  - WellRx
  - Your Current Life Situation

SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

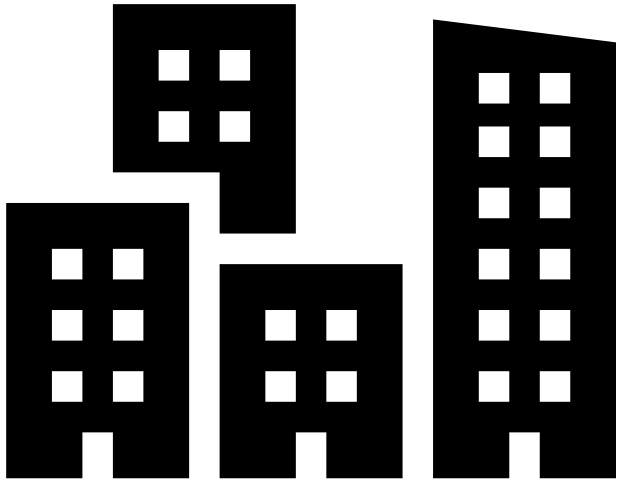
Awareness

- Or build your own screener!
  - You probably know the SDOH-related things that impact your patients.
  - Recommended to include domains related to demographics, financial strain, substance use, depression/stress, social connection, intimate partner violence.
  - Customize questions to meet local needs.
  - Providers are sometimes reluctant to ask about challenges they can’t help address.
  - It is good to have resources or referral channels related to domains you ask about.

SOURCE: Guise et al., 2017; LaForge et al., 2018

Awareness

Identify social risks and assets of patients and populations

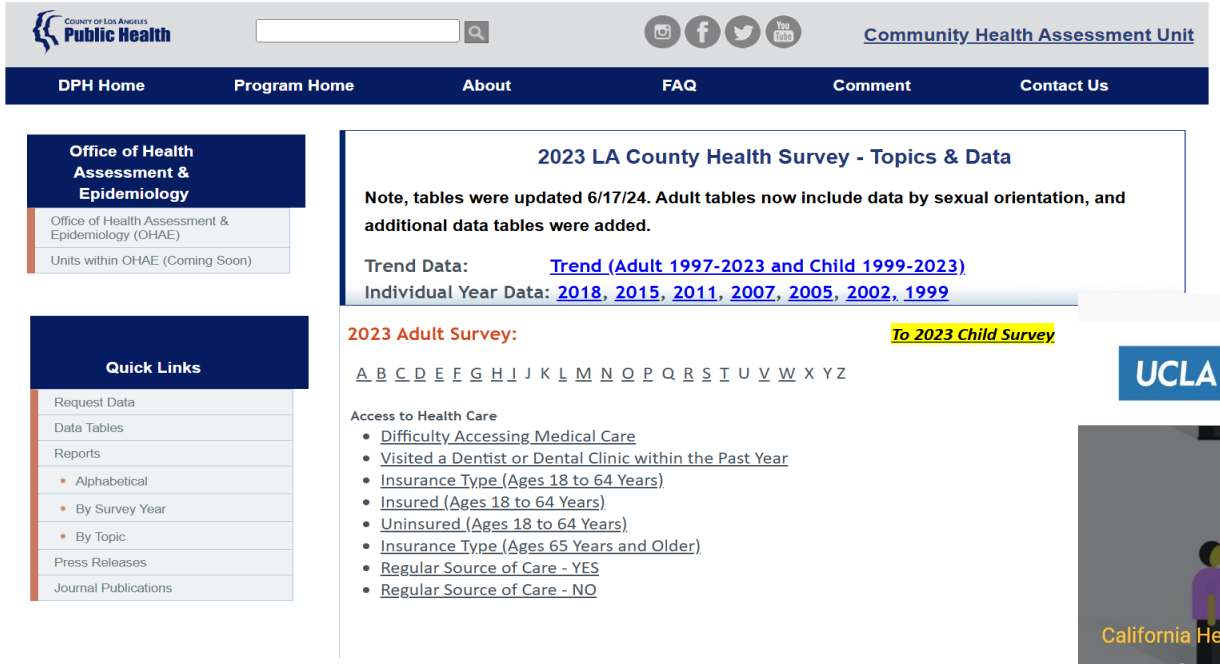


- In your community
  - Use community-level data.
  - Conduct community surveys or focus groups/interviews, particularly with at-risk groups.

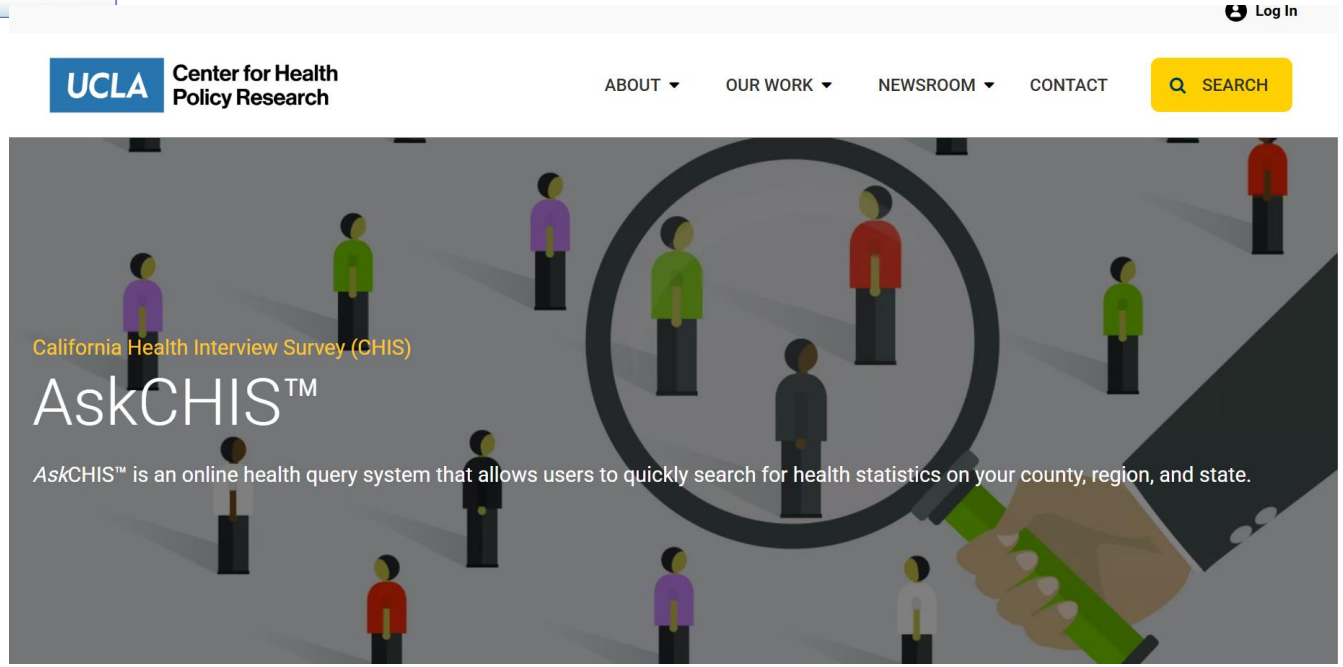
Awareness

Where is there community-level data?

LA County Health Survey
http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2023.htm



UCLA California Health Interview Survey
https://healthpolicy.ucla.edu/our-work/askchis



Adjustment

- Alter care to accommodate identified SDOH barriers
  - Deliver care in preferred language.
  - Have smaller patient ratios for patients with complex needs to allow for longer visits/consultations.
  - Open access scheduling.
  - Weekend or evening access.
  - Transportation
  - Telehealth

SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

Adjustment

Patient with diabetes receives food benefits	Change insulin doses near end of the month when benefits may run out
Patient recovering from ankle surgery is being harassed by a local gang	Instead of exercise at the park, recommend supervised indoor activities
Patient with opioid use disorder has trouble getting to methadone clinic each day	Consider take-home methadone options or buprenorphine

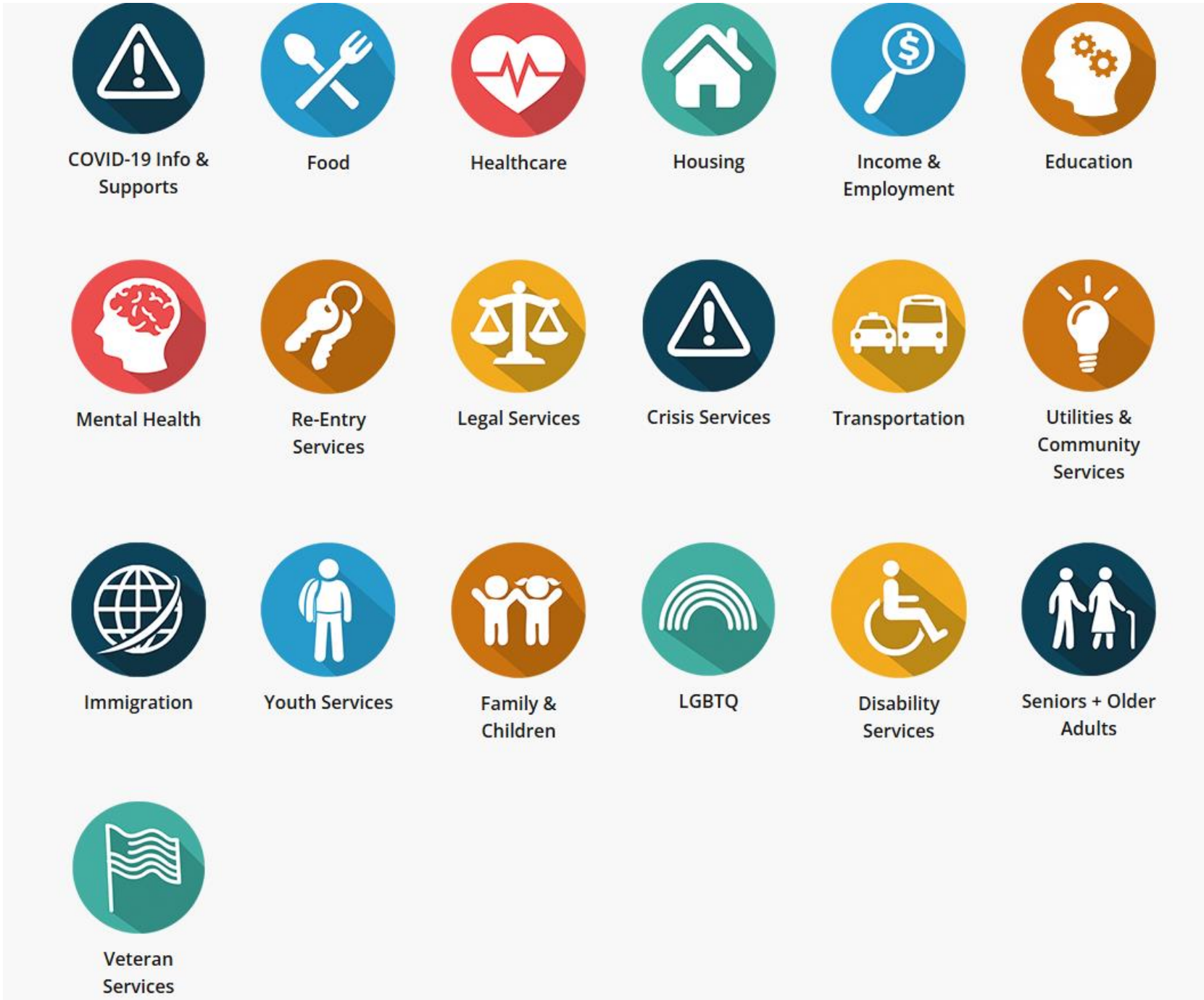
SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

Assistance
Light-Touch (one-time/ad-hoc)

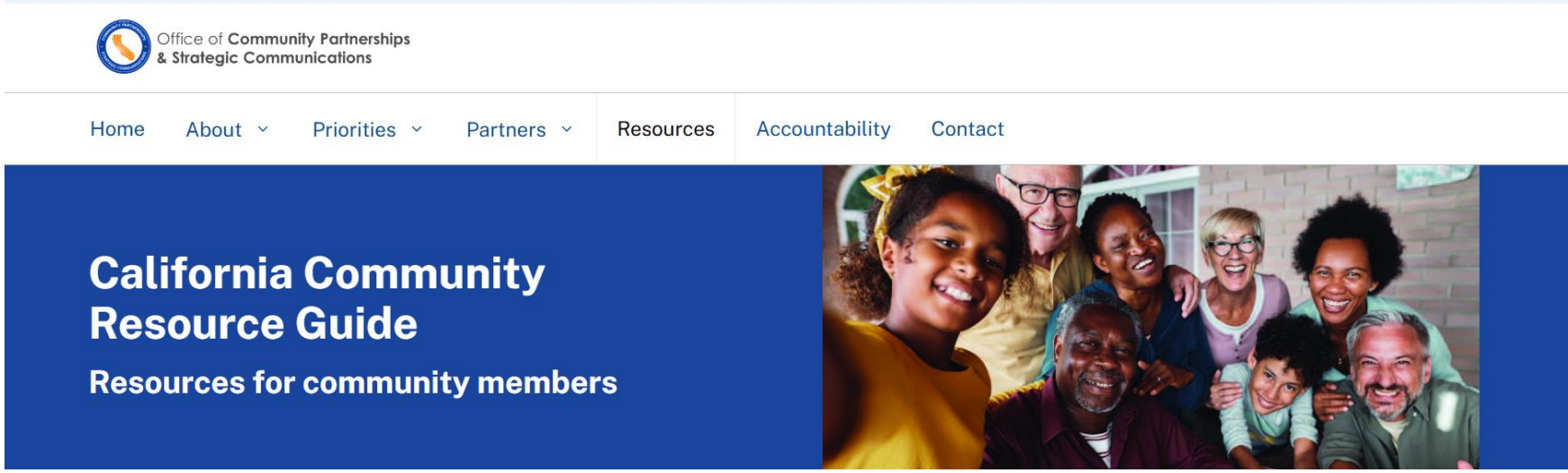
- Provide information about resources or specific programs that can address SDOH-related needs.
  - Medical-legal partnerships to address barriers to housing or benefits.
  - Eligibility counselors to enroll in Medicaid.
  - Social workers to help with bills or rent.

SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

What SDOH Assistance is Available for Patients in Underserved Areas in LA County ?



How Do I Navigate All These Services?

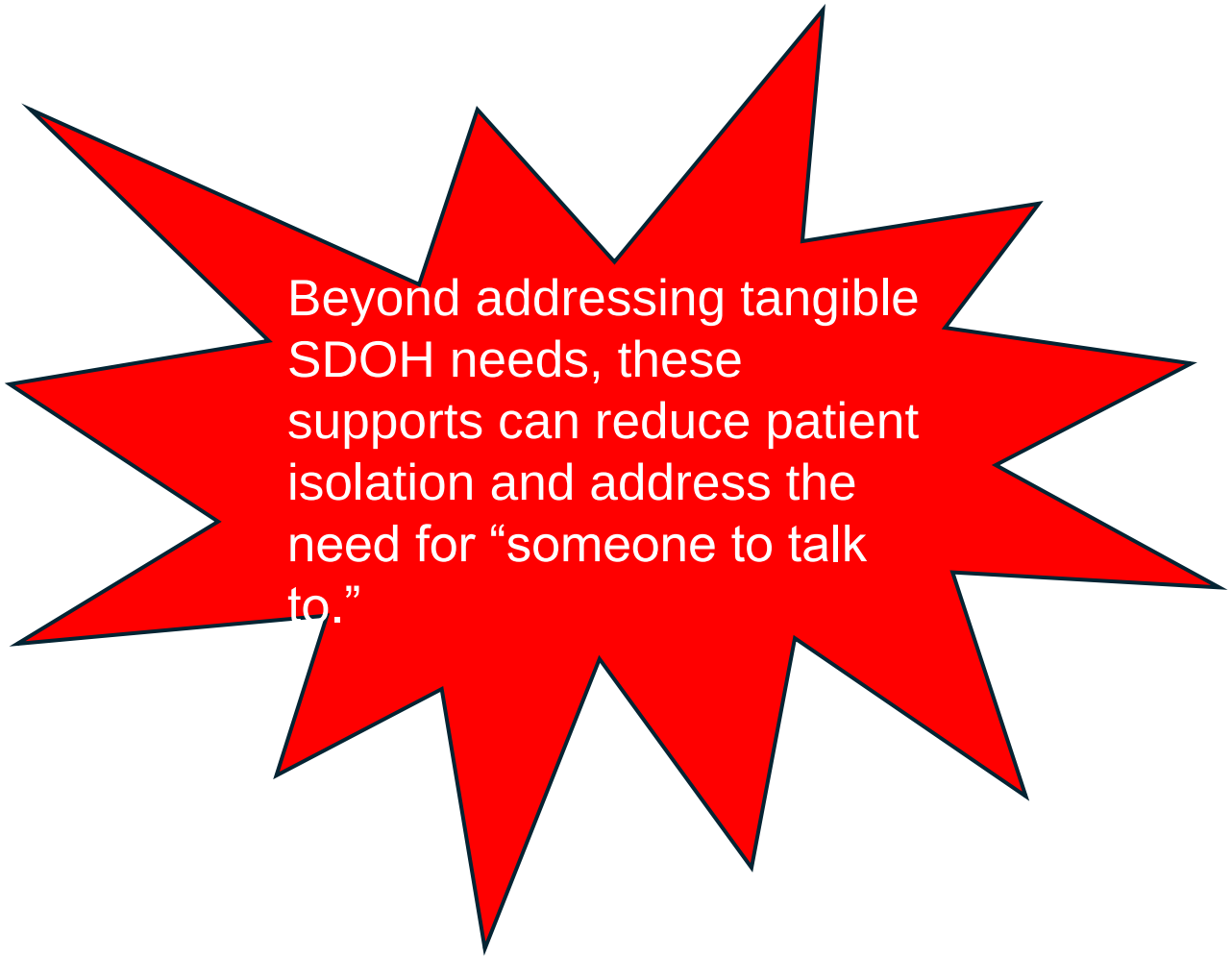


211 LA COUNTY
Help Starts Here

one degree

More Intensive Assistance

- Build relationships.
- Conduct comprehensive biopsychosocial needs assessments.
- Detailed care planning.
- Specialized interventions including ongoing case management, behavioral activation interventions such as motivational interviewing.
- Incorporate social workers, patient navigators, care coordinators, case managers, peers, and promatoras.



SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

SOURCE: California Department of Health Care Services (DHCS) – ND

Assistance: Medi-Cal Community Supports

- Under CalAIM, Medi-Cal Managed Care Plans (MCPs) can address SDOH to help beneficiaries avoid needing higher, costlier levels of care.

	**Housing Transition Navigation Services**	Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
	**Housing Deposits**	Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically-necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
	**Housing Tenancy and Sustaining Services**	Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.

SOURCE: DHCS – ND

Assistance: Medi-Cal Community Supports

	**Short-Term Post-Hospitalization Housing**	Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
	**Recuperative Care (Medical Respite)**	Members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.
	**Respite Services**	Short-term relief for caregivers of members. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.

SOURCE: DHCS – ND

Assistance: Medi-Cal Community Supports

	**Day Habilitation Programs**	Members who are experiencing homelessness, are at risk of experiencing homelessness, or formerly experienced homelessness, receive mentoring by a trained caregiver on the self-help, social, and adaptive skills needed to live successfully in the community. These skills include the use of public transportation, cooking, cleaning, managing personal finances, dealing with and responding appropriately to governmental agencies and personnel, and developing and maintaining interpersonal relationships. This support can be provided in a member's home or in an out-of-home, non-facility setting.
	**Nursing Facility Transition/ Diversion to Assisted Living Facilities**	Members living at home or in a nursing facility are transferred to an assisted living facility to live in their community and avoid institutionalization in a nursing facility, when possible. Assisted living facilities provide services to establish a community facility residence such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.

SOURCE: DHCS – ND

Assistance: Medi-Cal Community Supports

	**Community Transition Services/ Nursing Facility Transition to a Home**	Members transitioning from a nursing facility to a private residence where they will be responsible for their own expenses, receive funding for set-up services such as security deposits, set-up fees for utilities, and health-related appliances, such as air conditioners, heaters, or hospital beds.
	**Personal Care and Homemaker Services**	Members who require assistance with Activities of Daily Living or Instrumental Activities of Daily Living receive in-home support such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.
	**Environmental Accessibility Adaptations (Home Modifications)**	Members receive physical modifications to their home to ensure their health and safety, and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.

SOURCE: DHCS – ND

Assistance: Medi-Cal Community Supports

	**Medically-Supportive Food/ Medically Tailored Meals**	Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.
	**Sobering Centers**	Members who are found to be publicly intoxicated are provided with a short-term, safe, supportive environment in which to become sober. Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.
	**Asthma Remediation**	Members receive physical modifications to their home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, de-humidifiers, air filters, and ventilation improvements.

Alignment and Advocacy

- Alignment: Understand existing social assets in the community and deliver services that encourage synergies that simultaneously address health and social outcomes.

- Advocacy: Work with partner social care organizations to develop and promote policies that improve SDOH.

- Advocacy is not only trying to get more resources and does not need to be political—it can be for reform to transform systems and improve patient outcomes (e.g. Medicaid Waivers, BHSA).

SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

Alignment and Advocacy: Examples

- Collaborate with community-based organizations to provide healthcare, community case management, home-delivered meals, and caregiver respite to support aging adults and their families.

- Invest in low-income housing.

- Invest in your community!

Alignment and Advocacy: Examples

- Health systems have a lot of resources—use them!
  - Baltimore and Minneapolis: Costs of investing in cross-sector activities to improve the community (e.g. blight removal, housing/commercial development, fundraising) offset by savings in emergency department and hospital costs.
  - Healthcare Anchors: Leverage hiring, purchasing, investing, data collection capacity, and other assets to foster local community development.

SOURCE: National Academies of Sciences, Engineering, and Medicine (NASEM), 2019

Key Takeaway Points

- SDOH are key to health and health outcomes.
- SDOH and other characteristics of social disadvantage tend to cluster.
- The more SDOH/social disadvantages a patient has, the greater the risk.
- Though they cannot directly “fix” SDOH, health providers can help mitigate them and contribute to positive change.
- Innovations in Medi-Cal are creating new opportunities to address SDOH-related issues that have historically complicated patient care.

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Resources

- 211LA https://211la.org/
- California Department of Health Care Services, *Transformation of Medi-Cal: Community Supports*
- California Office of Community Partnerships & Strategic Communications, *Community Resource Guide* https://ocpsc.ca.gov/resources-guide/
- Los Angeles County Department of Public Health, *LA County Health Survey* http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2023.htm
- National Academies of Sciences, Engineering, and Medicine, *Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health* https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health
- Office of Disease Prevention and Health Promotion, *Healthy People 2030* https://odphp.health.gov/healthypeople

Resources

- One Degree – Los Angeles County https://chapters.1degree.org/los-angeles-county-ca/

- University of California Los Angeles, Center for Health Policy Research, *California Health Interview Survey* https://healthpolicy.ucla.edu/our-work/askchis

Thank You For Your Time!

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