HHS Public Access

Author manuscript

J Public Health Manag Pract. Author manuscript; available in PMC 2024 April 02.

Published in final edited form as:

J Public Health Manag Pract. 2021 ; 27(5): 526–528. doi:10.1097/PHH.0000000000001410.

Public Health Approaches to Social Determinants of Health: Getting Further Faster

Karen A. Hacker, MD, MPH,
Centers for Disease Control and Prevention, Atlanta, Georgia

E. Oscar Alleyne, DrPH, MPH,
National Association of County and City Health Officials, Washington, District of Columbia

Marcus Plescia, MD, MPH
Association of State and Territorial Health Officials, Arlington, Virginia

In the wake of the significant health disparities in communities of color highlighted during the COVID-19 pandemic, a national commitment to address long-standing systemic health and social inequities has emerged. Addressing the underlying causes of poor health outcomes and inequity including poverty, education, housing, and access to affordable, quality health care can drive meaningful change. These social determinants of health (SDoH) are critical factors that can limit or enhance our opportunities to lead healthy lives.

During the pandemic, the federal government recognized the importance of income protection and wraparound services through the paycheck protection program and by providing funding to states to support housing and food security. Significant resources were also provided to support virtual learning in communities with limited access to computers and broadband. Recent funding has provided additional resources to enhance public health infrastructure and services. The Centers for Disease Control and Prevention (CDC) received funding to support an SDoH pilot program to provide grants to state, local, territorial, and tribal jurisdictions to develop plans to accelerate action to address SDoH. These plans have tremendous potential to help communities narrow disparities through multisector partnerships to address systemic and unfair barriers to practicing healthy behaviors.

Approaches to SDoH in the health care setting have focused primarily on connecting individuals to resources and services to fulfill their social needs[1] and developing data standards for SDoH information captured in electronic health records.[2] This individualized approach does not address underlying social conditions or lack of adequate access to basic resources in most communities.[3] These factors require complementary solutions nested in community engagement and collaboration. There is extensive literature on the processes of collaboration and the importance of addressing SDoH. However, more attention is needed to connect SDoH work directly to health outcomes, as well as to identify community

Correspondence: Marcus Plescia, MD, MPH, Association of State and Territorial Health Officials, 2231 Crystal Dr #450, Arlington, VA 22202 (pju3@cdc.gov).

The authors declare no conflicts of interest.

The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of CDC.

strategies for attaining these goals. This includes developing and sustaining multisector partnerships, braiding funding, community engagement in data gathering, and problem solving in communities directly impacted by the targeted SDoH.[4] To better understand which SDoH approaches result in positive health outcomes, we need to evaluate what types of local partnerships and roles are most likely to succeed, as well as how these practices can be supported by local, state, and federal policies and resources. This column describes a project to gather more information on successful approaches.

Starting in early 2020, CDC partnered with National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO) to identify multisector coalitions that have improved SDoH in their communities. Healthy People 2030 groups SDoH into 5 domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. Using these domains as a foundation, CDC's National Center for Chronic Disease Prevention and Health Promotion developed an integrated framework to address SDoH in areas with the greatest potential to impact chronic disease outcomes.[5] The *Social Determinants of Health—Getting Further Faster* pilot project focuses on the following SDoH areas:

Built Environment: Human-made surroundings that influence overall community health and individual behaviors that drive health.

Community-Clinical Linkages: Connections made among health care systems and services, public health agencies, and community-based organizations to improve population health.

Food and Nutrition Security: An economic and social condition characterized by limited or uncertain access to adequate and nutritious food.

Social Connectedness: The degree to which individuals or groups of individuals have and perceive a desired number, quality, and diversity of relationships that create a sense of belonging and being cared for, valued, and supported.

Tobacco-Free Policy: Population-based preventive measures to reduce tobacco use and tobacco-related morbidity and mortality.

Communities Making a Difference

ASTHO and NACCHO, through a competitive national application process, selected 42 community multisector partnerships and coalitions to participate in the project. Selection was based on criteria that focused on the structure of the multisector partnership and coalition, program design, availability of data to show success, and level of engagement of stakeholders.[6] Successful candidates demonstrated success implementing strategies in 1 or more of the 5 defined domains.[7] In addition to receiving targeted technical assistance around community coalition building and evaluation, the communities will participate in a retrospective evaluation to identify lessons learned about successful efforts to address SDoH.

The selected community partnerships and coalitions are primarily located in medium- to large-sized jurisdictions. Seventy-two percent are led by nonprofit community-based

organizations, with others led by a local health department (18%), a school or university (8%), or a health care organization (5%). Among partnerships and coalitions not led by a health department, 76% reported active participation from a local health department and 26% involved a state health department. At least 10 partnerships and coalitions are working in each of the 5 targeted domains, with several (48%) working in more than one. Fifty-five percent are focused on community-clinical linkages, 48% on nutrition security, 33% on the built environment, 31% on social isolation, and 26% on tobacco cessation. Fifty percent of partnerships and coalitions report they are implementing evidence-based interventions, and 57% report they are using culturally tailored interventions. The coalitions reported outcomes that include implementing smoke-free policies, making improvements in the built environment, increasing social connectedness, and improving the management of chronic conditions.

Documenting the Evidence Base for Social Determinants of Health

Considerable efforts are occurring at the local level to address policies, environments, and conditions that improve SDoH. These efforts build on the work of large federally funded programs, such as Racial and Ethnic Approaches to Community Health (REACH), and on a considerable number of efforts supported by private national foundations, such as the Robert Wood Johnson Foundation, the Kellogg Foundation, and the de Beaumont Foundation. As the nation invests resources in addressing SDoH, it is important to understand these efforts and build an evidence base of what works. The community partnerships and coalitions identified in this project provide leadership, experience, and outcomes to inform future efforts and funding opportunities. CDC, ASTHO, and NACCHO have partnered with RTI International to conduct an evaluation using a participatory, mixed-methods approach to synthesize reported outcomes and factors that contributed to coalitions' success. The evaluation includes a review of evaluation reports and other key coalition documents, a secondary analysis of administrative data, and discussions with coalition partners to gain a better understanding of key implementation strategies. Anticipated by late 2021, the findings will provide insights into community, coalition, and initiative factors that contribute to SDoH improvements.

We anticipate that successful efforts in these communities could help define the role of local and state health departments and CDC in advancing health equity by improving SDoH. This evidence may assist local health departments in shaping their own efforts to support community partnerships and address SDoH. As a result, they will be better positioned to educate local policy makers and engage community stakeholders. State health departments will be better equipped to prioritize how and where to provide resources, create supportive environments for local work, and introduce policy and systems changes with a more far-reaching population-based scale. CDC and other federal agencies can use the findings to further promote, expand, and foster an environment that supports collaboration of new partnerships and strategic approaches toward addressing SDoH and improving health outcomes.

Acknowledgments

The project described was supported by Cooperative Agreement no. CDC-RFA-OT18-1802 from the Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion.

References

1. Centers for Medicare & Medicaid Services. Medicare ACOs provide improved care while slowing cost growth in 2014. CMS Web site. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html. Published August 25, 2015. Accessed May 22, 2017.
2. The Gravity Project. Home page. https://thegravityproject.net. Accessed June 15, 2021.
3. Castrucci B, Auerbach J. Meeting individual social needs falls short of addressing social determinants of health. Health Aff. 2019. doi:10.1377/hblog20190115.234942.
4. Amobi A, Plescia M, Alexander-Scott N. Community-led initiatives: the key to healthy and resilient communities. J Public Health Manag Pract. 2020:25(3);291–293.
5. Healthy People 2030. Social determinants of health. https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Accessed June 1, 2021.
6. Leviton LC, Gutman MA. Overview and rationale for the systematic screening and assessment method. In: Leviton LC, Kettel Khan L, Dawkins N, eds. The Systematic Screening and Assessment Method: Finding Innovations Worth Evaluating. New Directions for Evaluation. Vol 125. Hoboken, NJ: Wiley and Sons; 2010:7–31.
7. Centers for Disease Control and Prevention. Social determinants of health community pilots recipients. https://www.cdc.gov/chronicdisease/programs-impact/sdoh/community-pilots.htm. Accessed June 1, 2021.