

Podcast episode transcript: Michelle Badore and Patricia Saleeby

Michelle Badore: Hi, and welcome to the Inside Angle podcast by Solventum. I am Michelle Badore. I am the manager of international clinical content development here at Solventum. And I have the pleasure of introducing Dr. Patricia Saleeby, who has earned a PhD in social work from the George Warren Brown School at Washington University, an MSSA in Nonprofit Management from the Mandel School of Applied Social Sciences at Case Western Reserve University, and a BA in Biology from Oberlin College.

Dr. Saleeby is the Department Chair in Sociology, Criminology, and Social Work at Bradley University. She is a recognized expert in the area of health and social care classifications, most notably for her involvement in the development and implementation of the World Health Organization's International Classification of Functioning, Disability, and Health, or ICF.

She co-chairs the WHO Functioning Disability Reference Group. She is a member of the PACIO and Gravity projects that focus on post-acute care, social determinants of health, and health interoperability.

Her work has been funded by the Centers for Disease Control and Prevention, the National Institute on Disability and Rehabilitation Research, the American Psychological Association, and the National Center for Health Statistics. She is a member of the Coalition for Social Work and Health, as well as the current editor in chief for the Journal of Health and Social Work.

Welcome, Dr. Saleeby.

Patricia Saleeby: Thank you so much, Michelle. It's an honor to be here.

Michelle Badore: So let's talk social determinants of health today. So as we know we're born, grow, live, work, and age, and our access to power, money, and resources influence our health outcomes more than genetic influences or health care itself. So this is something WHO reported on their [World Report of Social Determinants of Health](#). Can you comment on this and in its importance?

Patricia Saleeby: Absolutely. As you already articulated, social determinants of health are crucial because they significantly influence overall health and well-being. And when I mention health, I'm thinking and defining it very broadly.

So it's physical health, mental health, behavioral health, and so forth. And social determinants of health encompass essentially the conditions in which, as you mentioned, people are born into, where they live, where they work.

These are factors that can either promote good health or create barriers barriers or hinder good health. So they're essential for achieving health equity and improving overall health outcomes. And this is at an individual level, family or group level, community level as well. In terms of that report that you mentioned, to give a little bit of background, the World Health Organization established a commission on social determinants of health.

I believe it was back in 2005. And the intent or the aim was to determine what are those social factors that contribute to poor health and health inequities.

And after several years, and you mentioned that report, which was commissioned, I believe in 2008, they had three overall overarching recommendations. The first was how we were going to use social determinants of health to improve daily living conditions.

So not just health, but overall, because we know there are direct links between, for example, housing insecurity, food insecurity, crime, social economic status or poverty, with the daily living conditions and health. Two was to tackle that inequitable distribution of power, money, and resources, knowing that all three of those are essential to understanding what goes on in people's lives and inevitably also affect health.

And the third was to measure, understand the problem, and assess the impact of any actions that might be recommended from that particular commission.

Michelle Badore: Fantastic. Thank you. So I think I hear a lot of people are confused about SDoH and the acronym, what does it stand for? So I think it started with social determinants of health, as you know we've discussed already today.

And I think the U.S. has started to shift to call it social drivers of health to perhaps more accurately reflect The outcomes that are not predetermined, like social determinants just means like it's a certainty. So I think there's been a shift to social drivers of health, but now I'm hearing structural determinants of health being added. Can you help us understand that, please?

Patricia Saleeby: Sure, absolutely. Social determinants and social drivers, I think, are used interchangeably. I mean, I know they are used interchangeably. And the shift really represented the fact that these conditions, these social conditions, as we've mentioned, drive health care outcomes. They really influence, and I know determinants essentially, for many people, it's the same, but understand that these are drivers. Perhaps it's used more in the economic sectors of the world, but understanding that there are societal, economic, and political factors that intertwine, and this in turn is what shapes health outcomes.

In terms of structural determinants of health, which is relatively new, the idea is we want to move beyond just social factors and understanding that they exist, and we need to address them if we're going to actually achieve health equity and improve health outcomes. But understanding that it's not such an easy process because many of these things are embedded in our actual structural systems and things like poverty, inequality, discrimination, these all influence individual and population health outcomes. Because you have created these systemic barriers that are very difficult to break down. And you essentially have these social hierarchies, if you will.

And it's difficult, even if you're working at a macro level, which is a lot of what I do, to be able to redistribute resources, for example, or end inequality or inequitable policy inequitable policies that exist, perhaps in an institutionalized setting. So really difficult to be able to tackle these structures that inevitably impact health outcomes and the social determinants of health that also drive what we're seeing in terms of health equity and health outcomes.

Michelle Badore: Great. So examples of this could be things like the health of indigenous versus non-indigenous people of African descent throughout Americas, the Australias, things like that.

Patricia Saleeby: Absolutely. Those are population groups that might experience social and structural determinants of health to a greater extent. Everybody, regardless of your identities, your social identities, experiences, it can be done, it could be experienced, on a temporary basis, it could be experienced on a longer term basis.

But the idea of structural determinants really encompass those social and political structures that maintain or even promote the social hierarchical system and those inequalities that contribute to what we're seeing in terms of health inequities.

So structural determinants, for example, could be the way that your government in a particular country is structured. It can be and often is related to economic policies that are in place.

It can be regulations around distribution of resources. So these are things that are a little bit more difficult to tackle than for example, we have a food insecurity issue in our school and we know that once we identify perhaps what is contributing to it, we can perhaps more easily address that situation. But if it was embedded within that school district policies, it would be more difficult. We need both.

We need to address the low-hanging fruit, as they say, which would be more in line with social determinants and also the structural determinants of health to make more sustainable and longer-term outcomes achieved.

Michelle Badore: Great, great. So things like social norms, government policies, health care policies, regulations, all of these things need to be involved.

Patricia Saleeby: Correct. Absolutely. Yes. And we're looking at, that the interesting thing is that for years, we have different professions that have addressed this. So social work is absolutely one of those professions.

Now we have medical and healthcare care systems addressing it because we haven't achieved the health outcomes that we hope we would. There had to be something else. And so the missing piece of the puzzle really has become the social determinants of health. And now more recently, as we mentioned, the structural determinants of health until we're able to look at this and look at it across sectors and disciplines, we're not going to be able to address it correctly.

We can no longer just work within our siloed profession to make this happen. It will take collaboration. It will take cooperation. It will take communication between sectors and disciplines. And there are already good examples of this happening. When we're able to come together, we're able to actually achieve success.

Michelle Badore: Yes, there's so many different players in so many different care settings. Like you mentioned, the value of the social worker. Now we have other people addressing this as we need. you know It should be something throughout that care continuum. But we have community health workers. We have patient advocates. We have care navigators, referrals to community-based organizations, food banks and shelters, and the doctor themselves, the person who rooms them, you know assessments. There's so much across the care setting. So I'd like to start really with the value of the social worker. I think historically this has been there their role, guess.

I guess we need more role clarification because someone can always think, oh, the other person took care of this, collected this information, talked to the patient about it and and how to alleviate these inequities and and address their needs.

Patricia Saleeby: Absolutely. So social work has a longstanding history in helping individuals within their communities. So when we think about in the United States where we saw this happening, people like Jane Adams out of Chicago who created an organization called Hull House, understanding that we need to meet people where they're at.

She went out in the community and others who were women primarily, who were looking at dire circumstances in those communities and wanted to help. And she, at that point, we weren't calling it social work, but she played a key role in making sure those services were being met and then started advocating for social reform.

And that is where the start of our social work profession really began. So from the very beginning, we were addressing social determinants of health, and we have continued over decades to refine how we do that.

You mentioned some other important professions that are involved in looking at social determinants of health. Community health workers, we're seeing more community health workers help us provide resource and referrals to patients in healthcare settings, and with the community.

Social workers work with community health workers. We also take on that role or title of community health workers. So I think we're going to continue to see a very successful partnership in the future. Social workers are also patient advocates, but there's other people who are not social work trained who fulfill those roles. Same with care navigators, like for example, breast care navigators are very commonly used in healthcare systems.

So we're seeing some different titles that may or may not be an actual social work trained individual fulfilling those job roles. It may be others as well.

It will be interesting to see what the future holds. I think that we will need to determine a little bit more what role goes with what particular title, who is responsible for what, but ultimately what we're trying to do is improve health for individuals and communities.

Michelle Badore: Sure, sure. And we see this globally. It's not just the U.S., that role clarification that's being needed. This one puts it on that one. The other one puts it on this one. We don't know their training. We don't know their licensure, their credentialing. you know we just The doctor thinks before the patient gets to them that it's been addressed may or may not have been because someone who sees that patient before they get to the doctor may think this is a doctor's responsibility. So role clarification is pretty necessary, I think, everywhere.

Patricia Saleeby: Absolutely. Community health workers actually are more commonly used, I believe, outside of the United States. it was It's a more grassroots-oriented profession.

But here in the United States, we're seeing an increase and regulation around that particular job position. Social work has been heavily regulated for years. We have our Council on Social Work Education that maintains that all social workers must meet the basic competencies to actually be a social worker.

And in many states, you can't call yourself a social worker unless you have appropriate licensing. And that requires additional hours of training to be able to understand what the role entails and be able to effectively implement those job tasks.

Michelle Badore: Yeah, great information. So really, no matter where on the globe we are, really, we need the collaboration and we need learning to help create this paradigm that makes it everything equitable and accessible for everyone. Like physicians and other care providers, along

with community resources, which is important, need to help the patients navigate their social challenges.

Maybe they can't, they need assistance navigating, but the patients themselves have to take a part in this. Acting together, everyone, help prevent and alleviate some of those inequities before they get to the point that they're complex conditions. That can help everyone. We don't want to wait until the homeless person has to call an ambulance or have an ambulance called on them to go through the ED. We want to help them before it gets to this need, this state.

Patricia Saleeby: That's absolutely correct. And we're we're hearing more and more of those stories, which I think is why we're seeing the momentum around social determinants of health, because we know that for a sizable number of people, why they're actually going to emergency rooms, urgent care, why they're sick, if you will, is not because of a health reason It is because of something that falls under social determinants of health.

So if we're able to prevent this from happening, we're saving hundreds of thousands, probably millions of dollars to a healthcare system. We are saving thousands and hundreds of thousands of hours of time and burden upon our health and allied health workers.

Social prescription is something that we're seeing come into the U.S. It has been primarily coming out of the UK and other countries within Europe. But the idea that clinicians can prescribe not medicine, for example, and what you would find in a typical prescription, but they can do social prescriptions where they're able to identify and refer an individual patient to, as you mentioned, a community-based organization, to a social worker, they call it a link worker, but social workers fulfill that role in many countries, but the link worker to be able to address what is needed.

So it's an interesting take on what we would think of as a traditional prescription, but utilizing this. And interestingly, things related to social isolation and loneliness are things that can be socially prescribed. And we know that social connection is linked to improved health outcomes and reduced risk of early death. And that's something that has come out with a recent report out of WHO. So the idea of social prescriptions could be something that would take off in our country. I wouldn't be surprised if we don't see that happening.

Michelle Badore: That's so interesting. I love that. And like you said, the loneliness and isolation, that's huge. That's huge on outcomes.

Stepping back a little bit to the the expense of it all, not just helping people get what they need, but if we look at, you know, in the U.S. here where we are, we hear that like 5% of the population accounts for 50% of the spending.

I mean, that's large. Also, I know from Canada, their regulator said that almost 93% of their patients experiencing homelessness were admitted to the ED. And when they're homeless, they stay in the hospital twice as long with double the cost compared to the national average. I mean, saving money, you know that's important. Saving funding for something other than things that we can treat before it gets to that point, that's really big.

Patricia Saleeby: Absolutely. There was a report maybe five, maybe almost 10 years ago at this point. And the report indicated that about \$93 billion annually in terms of excessive medical care costs of things that were driven by social determinants of health.

So we if we were able to actually prevent and address those terms of health, that we could reduce those excessive medical care costs.

We could also, as we know, reduce the health disparities that lead to losses in productivity. So when you think about lost productivity, I think that same report mentioned it was around \$42 billion annually.

In terms of those losses associated with perhaps someone not being able to engage in their job and the workforce participation due to decreased output as a result of being being sick or having to go to the hospital, for example. So we know, and we when we look at, of course, health health inequities, there is a difference.

When you look at groups that identify as, you know, racial ethnic groups, cultural groups, persons with disabilities, and so forth. So we know that there are complications and there's differences and they're quite significant. between these types of groups. And that also relates to some of the social versus and the structural right determinants of health.

But if we can eliminate those inequities, those health inequities between these various population groups, we're probably going to look at greater input in terms of premature death. We're going to look at greater outcomes related to preventing illnesses, leading to also chronic diseases.

And that probably equates to in the trillions of dollars. So addressing social determinants of health really is an investment, and it's a cost-effective approach to how we might reduce our overall health care costs and how we actually can improve the health of our communities and our society at large.

Michelle Badore: Yes, at the same time, that's key.

So as we look to involve more community-based organizations like food banks and shelters, at least here in the U.S. and probably globally, you know these these resources, they're pinched. They have elevated needs. They have federal cuts.

So there's little resilience in and the system. We saw that here, the Department of Agriculture cut \$500 million from the Emergency Food Assistance Program. And you know this is with Feeding America and other large food banks that have meal programs, and you know not for profit.

These organizations are struggling now. And then with cuts, you know while there's an elevated need, it's a recipe for disaster.

Patricia Saleeby: Yes, indeed. It's very unfortunate. We're going to have to get creative and we're going to have to collaborate with one another. We're going to have to communicate.

We're seeing a lot of coalitions coming out of this, a lot of social movements, which very much aligns with social work. I think that's going to be important. And we also can we can share stories, right? Share our challenges, share our...you know, positive solutions or successes.

I think this is absolutely important. You know, there was a time I think years ago, working with a lot of nonprofit organizations where people didn't want to collaborate because there was a lot of competition, right, to go out going after those funds.

But I think the time has changed that we need to be more transparent and communicate that we are, in fact, having financial challenges. Looking to the foundations that are out there, private foundations, family foundations, they are stepping up.

They are stepping up to a fill the deficit, that gap that we're seeing being created by recent people. changes in legislation and regulations, things coming out of our administration at the federal and

state level. So understanding that nonprofit organizations are going to be taking, and they're already taking, really sizable budget cuts, how are we going to help them stay afloat? How are we going to help them sustain when on the other end, we're seeing increases in those so cases, the population groups of the clients being served and so forth.

So really important that we share those impact stories with one another. We start to pivot in terms of our fundraising strategies and looking to private giving as a source. And as I mentioned, these foundations are stepping up, we also need to engage our membership, our board members of these organizations, our key stakeholders, making sure that they're involved in key decision-making and so forth.

So we have to lead. Our nonprofit organizations have to lead with strategy, not just waiting and being reactive.

Michelle Badore: Yeah, true. Thank you. So this being such a global issue, you know we're all under the same sky. We have to address these factors, try to reduce these disparities, ensuring that all people have access to the care and the resources that they need to have their optimal health.

How do you see this going? How can we... measure, I'm just trying to get my arms around how big this problem is, you know, we could probably talk for hours and hours. This is a short podcast.

But like, how can we help measure this? Like, is it important? From what I'm thinking, we get the story in the documentation and then if we get it coded, we could know what we're dealing with. you know There's coding problems and disparities of coding, you know who uses what code set and all of that globally. But if we get it in the in the documentation and then we get it coded somehow, we could like measure it and trend it, analyze it somehow. And that's where I'm going with it. How do you think we could just wrap our hands around how big this problem is?

Patricia Saleeby: That's a great a great segue to what I had hoped we get to in this podcast because this is already being done. So many of us have had experience with electronic health records or the EMR, electronic medical records within a particular hospital or healthcare setting.

We're seeing this more and more because we're going digital, right? We're no longer having paper-based systems. But those systems don't necessarily communicate with one another, and they don't track that information, as you mentioned, related to social determinants of health.

But now we are building the system to enable to do this. There is something called FHIR, which is an acronym that stands for Fast Healthcare Interoperability Resources. It's that back end to all these digital solutions.

And that PACIO group and the GRAVITY group, that those two working groups that you mentioned, I'm involved with much more with the PACIO than GRAVITY. GRAVITY looks at social determinants of health and how we're going to actually build it into electronic health records. So they're taking social determinant of health as at a time and determining how we can systematically pull that in so we can actually capture that data, which is pretty remarkable.

The PACIO group, which is the acronym stands for post-acute care interoperability, We're looking at how we can pull in functional information, knowing that diagnosis alone tells us very little.

If someone, let's say Michelle, you and I have diabetes, we have the same ICD, which is the system, the WHO classification used for disease the same code, but our lives very likely are going to be very different. So we have to look at functioning and functional information. Now we have a

way to pull that into the electronic health record as well. And that we're we're linking it all to a terminology and classification called ICF, which is another WHO system that looks at functioning, disability, and health. It was something that I'm quite proud of.

As a PhD student at Washington University, I helped to develop it. And working with clinical professionals, working with persons with disabilities and other key stakeholders, we looked around the room and said, how are we building a functioning classification to work with that ICD system without looking at the environment?

And this is something in the late 1990s, something that predates what WHO later called social determinants of health. We built an entire section on the environment because there was no way to look at functioning and look at changes in functional status was without the environmental factors. So I'm quite proud of that, that history and that legacy, if you will, that has led to social determinants of health.

But it's important that we have the systems and now we have the technology that to be able to have it put into those records and to track it along the way. And I think that's going to be crucial that we can collect the data, we can measure it, and measure the interventions and the outcomes.

Michelle Badore: That's great. Thank you. I think this is a pretty good spot for us to stop for today, though I'd love to talk with you again about this.

Collect, track, measure, improve. That's key. Thank you.

Patricia Saleeby: Thank you so much for having me. It's been a privilege.