Social Determinants of Health (SDOH) as Barriers to Quality Medical and Economic Outcomes. A case study

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RESEARCH

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ABSTRACT

Objectives: The first objective of this case study is to describe and analyze the experience of a young adult clinic patient exposed to negative Social Determinants of Health (SDOH), non-medical factors that affect medical, emotional, and economic well-being. The second objective is to suggest interventions that enhance the patient's ability to succeed economically and medically that are within the scope of the program.

Method: This is a single qualitative case study, of a 22-year-old female experiencing a variety of non-medical barriers. Our team evaluated semi-structured interviews, based content analysis and social work principles. The selected theoretical model focused on Social Determinants of Health and several aspects of Trauma Informed Care.

Results: The analysis of the patient's interview allowed the team to identify social determinant categories in agreement with the model variables. The impact of family of origin factors combined with minimal financial support and the demands of participation in academic classes were recognized in the adolescent's adjustment process. Social work and navigator interventions focused on education and support especially as it related to employment and clinic continuity.

Conclusion: The theoretical model of Social Determinants of Health combined with aspects of trauma informed care can contribute to understanding the needs of youth experiencing pervasive non-medical crises. Such approaches allow medical and social work interventions to moderate and mediate variables and promote economic success. The model proved to be suitable for future interventions for adolescents and young adults (AYA) experiencing similar situations.

Key words: Social Determinants of Health, inner city youth, access to care.

INTRODUCTION

Emerging evidence-based research suggests that, in addition to medical care, nonmedical factors affect health and the economic well-being of youth and young adults [1]. This school of thought, guided by the Social Determinants of Health (SDOH), considers broad based environmental issues and their impact that includes social and economic opportunities [1]. According to this approach, non-medical factors explain in part why some young adults are healthier and more successful than other youth. Moreover, social determinants not only include life conditions but also financial factors (lack of employment, under employment,

childcare and transportation issues) as well, which exert a powerful health influence over groups, among fragile or disadvantaged populations, especially adolescents and young adults. Braveman and OH [2] also posit that this recently emerging body of research suggests that social factors have a significant future impact on populations. This evidence does not deny that medical care influences health; rather, it indicates that medical care is not the only influence on health and suggests that the effects of medical care may be more limited than commonly thought, particularly in determining who becomes sick or injured as they age.

One selected component of SDOH, Adverse Childhood Events (ACEs) often begin early, are interconnected, and continue unless intervention occurs. ACEs also provide a useful proxy for a non-medical or hybrid influences with profound impact especially to trauma. Contemporary data [3] suggests that exposure to ACEs also compromises the development of resiliency and the associated mental health coping behaviours which affect subsequent life opportunities, educational attainment, and sexual decision making [4]. Merrick, et. al. [5] state that significant ACE exposure (defined as ≥4 ACEs) especially those related to sexual risks is negatively associated with future health [5] Recent research [5] suggest that generation X and later generations are more likely to report multiple adverse childhood events than people of the baby boomer generation. Hughes et al., [5] In their analysis of the 2019 Centers for Disease Control (CDC) risk surveillance system, found that Generation X was 1.67 times more likely to report four or more ACEs while millennials and Generation Z were over two times more likely. The prevalence of such factors often requires interventions based on a trauma informed care approach.

A sub-cohort of these patients is especially vulnerable. Minority low-income post-secondary youth often lack the economic resources necessary to compensate for these negative influences. Fortunately, some rely on their medical home as a portal to a variety of services to address these social determinants of health including meaningful employment. The scope of negative economic impact is significant. In Texas alone it is estimated that 14% of youth aged 14-26 years or 14% of the population have been unsuccessful in finding economically sustaining employment. Clinics that serve this population potentially have an added value as resource to also connect them to work and other positive social determinants of health. Of the various social determinants, employment, therefore, has been identified as a powerful driver of health for a couple of reasons. Several groups including The World Health Organization suggest that employment plays an important role in health establishment and maintenance. Employment also provides economic livelihood and family financial security. Moreover, in the United States employment is the primary vehicle for workforce health insurance. Access to meaningful work is especially important to vulnerable adolescent and young adult women.

This case study objective explores those non-medical factors identified in a clinic setting that function as barriers not only to the receipt of care but to economic stability. It will highlight the importance of linking health services to employment opportunities in this population. It will assess the role of family of origin in whether a client can transition to personal independence and job acquisition. The case study will also suggest client criteria that can maximize program resources to result in the desired outcome. It will conclude by describing and analyzing the degree of effort of program support for challenging cases and whether health institutions have the robustness to address the multiple challenges. Finally, it will suggest criteria to follow to assure that participants who are chosen to have a realistic potential for success.

METHOD

Study Design: This is a single case study, which is part of the qualitative type of paradigm, using content analysis related to a young adult's ability to manage a variety of SDOH factors as they impacted a transition to wellness and economic stability. The work was based on the Theories of Social Determinants of Health and Adverse Childhood Experiences.

Client demographic: Terry (not her real name) age 22, a high school graduate with perfect attendance, received her health care at an adolescent and young adult (AYA) clinic in the south western part of the United States. In addition to receiving primary and reproductive care she also received a referral for vision assessment and prescriptive glasses. As a clinic patient, she enrolled in the clinic's job portal program, Project Ascend, to receive an EKG certification via classes offered through a local community college, with tuition paid for by the program. An excellent student, she mastered all the EKG courses and is scheduled to complete her class certification test in the fall.

Family of origin issues: As an adolescent, Terry made the firm decision to break out of family's cycle of poverty and abuse. The status of her father is unknown, and is either in prison or deceased. Her mother is addicted to drugs. Her biological sister was awarded legal guardianship creating numerous problems for her including the inability to access her birth certificate, a prerequisite for a driver's license and a social security card. These personal identifications were significant barriers. Ascend staff assisted her in obtaining all three.

Because of family dysfunction, she also had an eviction felony and recent homelessness. Project Ascend found safe housing with apartment rent paid by a private donor through February 2024. Ascend found furniture and household items to furnish the apartment. To subsidize program support, Terry found a part time job.

Program components: To address the various SDOH, the client met regularly with all Ascend staff. Skills that were addressed included but not limited to resume writing, the creation and maintenance of a budget, checking on her progress at school and helping her navigate personal independence and all the responsibility that comes with life. She had no support system other than the clinic portal and its staff.

RESULTS

The analysis of the patient's interview allowed the team to identify social determinant categories in agreement with the model variables. The impact of family of origin factors combined with minimal financial support and the demands of participation in academic classes were recognized in the adolescent's adjustment process. Social work and navigator interventions focused on education and support especially as it relates to employment and clinic continuity. Major housing and personal identification challenges were successfully processes and managed because of program participation.

DISCUSSION

Minority low-income post-secondary youth often rely on their medical home as a portal to a variety of non-medical services to address social determinants of health including counselling. Unfortunately, such problems are seen by some as self-imposed without consideration of the age, circumstance or decision-making ability of youth. This is especially true with housing and eviction which have long term legal consequences. A strategic approach suggests that the nonmedical demographic concept of employment plays an important role in health establishment and maintenance for several reasons. Employment provides economic livelihood and family financial security. Moreover, historically, in the United States, employment is the primary vehicle for workforce health insurance. An additional long-term component for employing institutions is participation in a variety of financial benefits which often encourage youth focus on future financial security. In addition, some organizations will match contributions to retirement programs which can include health care components. This access to such added value factors embedded in meaningful work is especially important to vulnerable adolescent and young adults who have limited exposure to such financial products.

ACE variables in an inner-city youth seeking economic stability and describes the valuable role that a clinic portal can play for marginalized youth. A variety of

lessons can be learned from this analysis. First, it is often hard to mitigate the on-going negative influences of family of origin. As with the client in this case study, some relatives do not have the best interest of the family member at heart. Relatives commandeered the participant's birth certificate and social security number which impacted her ability to obtain a driver's license, a crucial form of identification. Second, due to lack of resources the client may be in survival mode and incapable of accurately assessing risk and ways to reduce it. In addition, collaborating institutions' staff may not understand the gravity of the situation which is often not revealed. This may limit various aspects of support, or an awareness of the issues involved as ACE issues are often complicated. Items such as transportation and day care are chronic barriers to program participation.

A corollary conclusion focuses on the criteria for initial enrolment into the program. Previous studies (Smith, et.al.) suggest that the impact of number of SDOH barriers, especially housing combined with transportation is cumulative and, in some cases, can be more than programs can successfully manage. The scopes of the issues that Terry had to overcome were significant. In retrospect if the staff, at client enrolment, had been fully aware of the depth of the issues, Terry probably would not have been enrolled. Her motivation and academic skills supported the decision to work through the issues with her. In conclusion, working with AYA is challenging and social acceptability of managing non-medical care of marginalized groups may require extra funding and commitment by agencies with the mission of maximizing client economic success.

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