ADDRESSING OLDER ADULTS’ SOCIAL DETERMINANTS OF HEALTH

Grantmakers In Aging
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So happy to be here
“Social determinants of health have taken center stage in recent health policy discussions because of the growing focus on global payment, accountable care organizations, and other initiatives focusing on improving population health.”

-- Yale Global Health Leadership Institute

Social determinants, for example:
• Socioeconomic status
• Education
• Stress
• Early life
• Addiction
• Food
• Transport
• Work/Unemployment
• Social exclusion or support
• Physical environment
WHAT ARE SOCIAL DETERMINANTS OF HEALTH?
According to the World Health Organization (click), “Social determinants of health are the conditions in which people are born, grow, live, work and age.”

(click again) These conditions are shaped by the distribution of money, power and resources at global, national and local levels—sometimes termed ‘structural determinants’ of health inequities.”

(examples of SDH on next slide)
So what are some of those social determinants – conditions in which we are born, grow, live, work and age?

Social determinants, for example:
• Socioeconomic status
• Education
• Stress
• Early life (Adverse Childhood Experiences – ACEs)
• Addiction, other mental health concerns
• Food
• Transportation, other factors about physical environment related to mobility, environmental toxins, etc.
• Work/Unemployment
• Social exclusion or support
We all know that social factors impact health outcomes – and can think of the stories behind these statistics.

Psychosocial factors (things that contribute to, or deter, mental, emotional, social, and spiritual well-being) and environmental factors (things like access to public transit, public safety, access to healthy food, environmental toxins) impact health outcomes. Oftentimes such issues make physical symptoms worse and can also make it harder to follow a care plan. This leads to a lot of these issues presenting themselves in the doctor’s office or ED – not good for patient health outcomes, not good for the healthcare system.

Today we’ll be talking in more detail about some of this and looking at how this plays out specifically for older adults
Now we will begin to look individually at some important social determinants of health. The first we will talk about is the socioeconomic status (SES). SES refers to one’s social and economic circumstances.

We know that individuals with lower SES suffer more negative health outcomes. We also know that life expectancy is shorter for individuals with lower socioeconomic status.

Moreover, people across the SES spectrum have their SES status impact health outcomes. It isn’t just the poorest 20% of older adults whose SES impacts their health. We see differences in health outcomes among your average / middle-class patients compared with top 10% of income earners. As SES steadily increases, health outcomes also steadily improve – and vice versa. This concept is sometimes called the social or health gradient.

Another important consideration is that the impact of SES accumulates over one’s lifespan – leading to a greater cumulative impact for older adults. The longer an individual/family faces moving constantly against these factors, the greater impact stress has on them. We’ll discuss stress more specifically next and how this impacts us physically and mentally.
Stress is another social determinant of health. We know that stress responses are a natural, healthy part of life. Stress is also unavoidable; we all encounter it at certain points in daily life.

We also know that brief periods of stress hold no long term impact on our health. In fact, stress or an anxiety response can be healthy when they tell us when to leave certain situations, when a rapid change is needed, how to respond in certain situations. However, we also know that individuals that are exposed to chronic ongoing stress experience negative health outcomes, as we see on the right side of the slide.

What are some sources of stress that are often tied to social and structural factors?
- Lack of control
- Mental health issues
- Trauma
- Financial insecurity
- Safety – interpersonal, home (mobility), neighborhood
- Social isolation or Exclusion
- Discrimination
- Chronic health problems

Stress hormones affect health
- Adrenaline and cortisol
- Promote safety short-term
- Long-term exposure → neuron atrophy, memory impairment, immune system suppression
- Repeat elevation of blood pressure → cardiovascular problems
Frailty and other changes related to chronic conditions and aging
Social Exclusion is another social determinant of health. Social exclusion can take a number of forms such as hostility from one’s society/environment, discrimination, racism, unemployment, stigmatization due to illness/disability, incarceration or history of legal problems, or poverty.

It’s important to recognize that older adults’ core beliefs and conceptualization of self in relation to community is often built on experiences as child or young adult. So in terms of social isolation, childhood experiences (e.g. poverty leading to inability to participate in certain activities due to cost) or young adult experiences (not being able to participate in college due to caregiving duties or perception that a wife should not hold own friendships outside of marriage).
Individual and community-level isolation leads to poor social supports and higher rates of depression, which we know often contribute to more health complications. Exacerbation of health conditions often comes with changes in functional ability, pain or other symptoms, and a regimented care plan— which can themselves even further isolate someone.

Here are a few examples of groups with a history of social exclusion in the US who experience differential health outcomes and utilization of health care— African American, Latino, and LGBT individuals. Things like a historical mistrust of those in power, concerns about privacy, providers not being trained in providing culturally-competent and relevant care, and systems not being responsive to their care needs all contribute to this.
Now, looking at the opposite of social exclusion - Social Supports play a significant role in health.

Solid social networks are protective for health; they provide a system of concrete resources that are helpful for health care utilization (i.e., rides, help after surgery, accompaniment to an appointment, help with filling a medication pill box). We also realize that when one has those concrete methods of assistance, he/she “feels” a sense of assistance or accompaniment. So, the emotional fulfillment of support. Moreover, social supports often provide direct emotional support.

Again, when supports are lacking or when they are poor in quality, it can have the opposite effect. It can be an additional stressor for health maintenance or even a barrier. We see this lead to worsening mental health, affecting physical health and increasing isolation.

One dilemma that many individuals face however is the choices they face about social supports. In a medical setting we often hear about choices that are being made (older adult patient living with a financially abusive daughter). But we need to see that in the context of the additional social determinants they may be up against—perhaps that daughter is a full-time caregiver or the only family member.
left. Perhaps that daughter is the only way she can get to the doctor’s office. So what other factors is the patient facing in making a decision about what supports are “healthy”? 
Here is a graphic representation of social determinants impacting older adult health and wellbeing.

Economic instability or low health literacy often lead to behaviors that create or exacerbate medical conditions. Stress about paying your utilities due to economic instability can impact your quality of life by reducing your ability to focus on other things such as following a prescription regimen or connecting with social groups or family.

So, one might imagine that things such as health literacy and healthcare accessibility might be good targets for the health care and aging system to address.
Okay, so we recognize all of these social determinants... now, how are those playing into health and health care?
Okay, we just reviewed what some SDHs are and saw examples of how they can impact health. However, as this quote references, our society tends to emphasize an individual’s personal responsibility for their health outcomes.

Agency refers to the belief that individuals are agents proactively engaged in their own development and can make things happen by their actions.

But, we know the ability of an individual to have personal agency and control over some of their circumstances is connected to psychosocial and community-level factors. In order for policymakers and programs to improve health outcomes, it follows that they could help create conditions that are supportive of an individual making positive health behavior changes.

“Health is a prerequisite for full individual agency and freedom; yet at the same time, social conditions that provide people with greater agency and control over their work and lives are associated with better health outcomes.

One can say that health enables agency, but greater agency and freedom also yield better health. The mutually reinforcing nature of the relationship has important consequences for policy-making.”

- World Health Organization, 2010
If PCPs had the power to write prescriptions to address social needs, such prescriptions would represent approximately 1 out of every 7 prescriptions they write** — or an average of 26 additional prescriptions per week.

Physicians are not assessing for psychosocial issues because they do not feel confident in their ability to address these issues, and they do not know where to hand off to for social services.

Opening “Pandora’s box”
“What do I do if I find it?”

As a result, physicians often treat psychosocial issues as physical concerns.

This also happens in the inpatient acute setting where the priority is stabilizing a patient medically.

However, there is a whole system of community-based services and supports could be assessing and addressing psychosocial issues... for example...

Community-based organizations (CBOs)
Aging and disability network
Long term services and supports

The Institute of Medicine published recommendations for healthcare in Sept 2012 called: Community Links. These recommendations called for:

1. Assessing psychosocial issues
2. Delivering services in the community
3. Communicating these issues with medical team
When we talk about older americans health, there are lots of things to keep in mind

Heterogeneity of health status
Age-related physiologic changes
   Atypical disease presentations
Increased incidence of comorbidity (multiple chronic conditions)
   And, when already in hospital, higher rates of new infections, pressure sores
Mental health needs often ignored
Changes in functional ability
   Activities of Daily Living, Instrumental ADLs
Higher need of social supports
Different goals of therapy
Lack of differential diagnosis with cognitive issues

Also, older adults have an increased incidence of illness related to medical treatment, such as hospital-acquired infections and pressure sores
Mental health needs often ignored – and supports can be hard to find (low reimbursement rates, inadequate workforce)

Changes in functional ability
   Activities of Daily Living, Instrumental ADLs
Higher need of social supports
Different goals of therapy
Lack of differential diagnosis with cognitive issues
If we know social factors matter so much to health outcomes, and we’re concerned about rising healthcare costs and trying to improve the health and quality of life of consumers/community members, why are we spending so little on social care (less than any other country) and so much on health care (more than anyone else)?

On this graph, the US is in the middle – the smallest percent of GDP on social care (9%), biggest percent on healthcare (16%)
Let’s begin by thinking a bit about the kinds of care we can utilize. Preventive care is care that is aimed at preventing illness (shots, health education, screenings, labs). Routine care refers to things like check ups, doctors visits that are non urgent, tests done on outpatient level.

Acute care is care that is short-term and is more targeted towards a severe/specific illness or disease. This could include the ER, an inpatient hospital stay.

Acute care on the other hand is less predictable—there is less continuity with providers familiar with the pt
- due to this it can be a more stressful experience
- follow up is often lost in translation (explain d/c instructions and confusion)

- Shorter, more time-pressed visits in PCP setting
  - Clinical inertia
    - Lots of things to check off the list, EHR fields to complete
  - MD-centered communication
  - Diminished quality
    - Few geriatric-trained providers
    - Little time to address functional and cognitive abilities/changes
• Provider biases and less time to for discussion to correct them
  • Biases about adherence (often ignoring barriers to care plan adherence)
  • Biases about client beliefs/values/preferences

• Outcomes of this design for socially-disadvantaged patients:
  • Low patient understanding – little time for building up health literacy, clarifying diagnoses, or even knowing what to ask
  • Low satisfaction with care, leading to less adherence in the future
  • Less time for prevention and worse care for chronic disease
Alternatively, there are several advantages to comprehensive preventive care, such as:

- familiarity with your provider (the doctor you see gets to know you over time, know your history know your patterns)
- source of health education (when time is not as pressed we can get more health education)
- less stressful (we hear of less difficult visits when pts expect to be seen, when doctors anticipate the visit, and when the care is less urgent)
- planned follow up (person is told when to come back/what to do in the meantime and more time to ensure this is understood)
- connection to specialists (networks)—doctor can send you to someone he/she knows or even perhaps at the same facility
- co-location with other services (e.g. integrating outpatient therapists, mental health providers)
- Less expensive care setting (running tests in doctor’s office often cheaper for payer than in hospital setting)
ACA framed around the Institute for Healthcare Improvement’s triple aim - identify effective ways to delivery high quality, integrated care at a lower cost. This especially important for older adults, because they are the most expensive and complex.

Tilting the scales toward more comprehensive preventive care is one way that systems are doing this.
WHAT ARE CHALLENGES AND POSSIBILITIES AHEAD?
While we work toward the triple aim, we must recognize that many challenges that lay ahead for the US—especially through our lens of older adults.

**Health considerations for older adults**
- Multiple chronic conditions, increased difficulty with daily activities
  - Including Alzheimer’s Disease and Related Dementias
  - High rates of mental health issues, loneliness, and support needs
- Over reliance on—and lack of support for—family caregivers
  - Fewer family caregivers will be available in future for Boomers
  - ...and what about the future economic security of current caregivers?
- Prevalence of economic insecurity for older adults and families
  - → serious implications on access to quality food, housing, transportation
- Challenges faced by Medicare and Medicaid
  - Increasing per beneficiary Medicare costs coupled with decreasing number of workers per beneficiary paying in to Medicare trusts
  - Reliance on Medicaid for long-term care
  - Under resourced workforce for home- and community-based care

**Shortage of geriatric professionals**
- Across the board: MDs, mental health, dentists, direct care workers...

**Over reliance on—and lack of support for—family caregivers**
- Fewer family caregivers will be available in future for Boomers
  - ...and what about the future economic security of current caregivers?

**Prevalence of economic insecurity for older adults and families**

**Increasing costs to Medicare and Medicaid**
- Increasing per beneficiary Medicare costs coupled with decreasing number of workers per beneficiary paying in to Medicare trusts
Reliance on Medicaid for long-term care – not a good long-term solution for the country to depend on spending down to Medicaid

Increasing Medicaid costs cause some states reducing to reduce Medicaid service lines – increasing eligibility standards for in-home supports, taking out preventive oral health cleanings/exams

Under-resourced workforce for HCBS

- Training and supervision not always comprehensive enough

- Direct care workers – mandated overtime – good for workers, but may raise budget questions for some of these benefits
N3C definition of care coordination:
Integrate health and social services
Interdisciplinary
Involve range of providers – from PCP to PT to SW to direct care workers
Person and family-centered
Based on an assessment of individual’s preferences, needs, and strengths
Multicultural approach
Focus on: Medical, Social, Behavioral aspects, Communications

Care coordination included throughout ACA and also more recent legislation - Yet, challenges remain
Siloed care
Health and social service systems fragmented – different funding streams, eligibility rules, terminology, training programs
No IT interoperability across sites
Evidence for models that work, but we rarely spread or scale them up
Little payment incentives for care coordination \(\rightarrow\) little time is made for it
Payments for care coordination often not adequate given time intensity
E.g. $42 / month for Medicare “chronic care management” for patients with 2+ chronic conditions
Many providers still operating with volume-based care incentives
As a health system and in our Rush, we’ve learned that many things are important to successfully addressing social determinants of health in a healthcare setting:

Person- and family-centered services

Prevention and wellness strategies
  - Innovative models of care coordination
  - Attention to multiple chronic conditions
  - Attention to function, not just disease

More providers with skills & knowledge in aging

Collaborative team-based care
  - Seasoned clinicians across disciplines and sites
  - Improved interprofessional training and education

Community engagement and partnerships
  - Interoperability

So... What does it take?

- Person- and family-centered services
- Prevention and wellness strategies
  - Focus on function, not just disease
  - Attention to multiple chronic conditions
  - Innovative models of care coordination
- More providers with skills & knowledge in aging
- Collaborative team-based care
  - Seasoned clinicians across disciplines and sites
  - Improved interprofessional training and education
- Community engagement and partnerships
  - Interoperability
We’re seeing such programs be increasingly embraced by healthcare players – managed care companies paying for home modifications, doctor’s offices developing partnerships with aging network organizations. In this way, food, housing, and transportation are being used as medicine.

This is incentivized by the ACA’s requirement that non-profit hospitals complete Community Health Needs Assessments every three years, and come up with an implementation strategy. They are to have community stakeholders and community members involved in the needs assessment. This a clear opportunity for engagement with Aging Network sites, who long have been working in communities.

Increasing recognition of the needs of patients and families really has caused a strong focus on connecting patients with after-hospital care.
CMS doing lots to push innovation as well. They are aiming for 50% of their Medicare payments to be tied to value-based care or Alternative Payment Models by 2018

**Traditional Medicare (FFS)**
Medicare CPT billing codes for care coordination (Chronic Care Management, Transitional Care Management)
Value-based payments: Reimbursement adjustment for quality outcomes (e.g. readmissions), bundled payments for an entire episode (cardiac, joint replacements, others)

**Medicare Alternative Payment Models**
Risk-based contracts for hospital and ambulatory care, comprehensive primary care (e.g. Accountable Care Organizations)
MACRA passed by congress: new outpatient physician payment mechanism that incentivizes providing cross-setting care coordination, taking on risk;
CMS just released regulations to implement MACRA

**Accountable Health Communities**
Universal, comprehensive screening for health-related social needs in Medicare and Medicaid beneficiaries at participating clinical sites
Addressing needs tied to payment
Proposed regulations
Medicare reimbursement for care planning after dementia diagnosis
Changes to make PACE regulations more flexible \implies more community-based care for dual-eligibles
Another ACA concept of population health management comes in here – a concept that captures the efforts of how health care efforts can incorporate social factors in programming and how policies can also help move these efforts forward.

“Population Health” is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”.

It is an approach to health that aims to improve the health of a broader population – based on defining characteristics or geographies. Recognizes that disparities often exist within groups based on race/ethnicity, socioeconomic status (or social gradient), geography, gender, other characteristics.

Population health management is incorporating this recognition of these determinants, and implementing programs based on that in order to improve outcomes.
Aging Network CBOs

- **Roles of Aging Network Community-based Organizations (CBOs) expanding since ACA**
  - Transitional care contracts with hospitals and payers
  - Embedding CBO staff into primary care clinics
  - Managed Long-term Services and Supports (LTSS) contracts

- **Business Acumen**
  - Marketing, contracting, and valuation of CBO services for partnering with payers & providers
  - Two ACL technical assistance pilots (2013, 2015)
  - The Aging and Disability Business Institute

- **Proof of Concept**
  - Growing the evidence base for addressing social factors and integrating Aging Network staff into healthcare settings
  - Quality measure development to better capture impact and quality of home- and community-based services (NOF)
  - Need for further investments in data tracking, communication systems

*(NOF, 2016)*

*(In case you think background is needed)* **Aging Network CBOs provide range of home- and community-based services to older adults**

- Nutrition and meal delivery
- In-home homemaker services
- Legal services
- Caregiver supports
- Evidence-based chronic disease self-management programs
- Community case management
- Transportation

Payment reforms are providing a great opportunity for growing the roles and impact of CBOs. They have long provided a lot of important community supports, as I mentioned before - oftentimes with Older Americans Act funding or with Medicaid waivers.

Health reforms since the ACA have opened the door for expanded roles:
- Transitional care contracts with hospitals and payers
- Embedding CBO social worker into primary care clinics
- Contracts with MCOs for community-based LTC
A few key initiatives are happening to really strengthen this expansion of roles:

- Administration on Community Living in HHS recognized the need, ran two successful pilots that provided technical assistance for a couple dozen CBOs in marketing, contracting, and pricing CBO services for partnering with payers and providers. Many participating CBOs were able to secure contracts with MCOs.

- Big national players (n4a, ASA) have received funding from several foundations and ACL to fund a wide-reaching Aging and Disability Business Institute to support CBOs across country on learning more of the business acumen that it will take for them to be able to effectively have partnerships with the healthcare industry.

Other initiatives include:

- Growing the evidence base for addressing social factors and integrating Aging Network staff into healthcare settings (e.g. Bridge, AIMS).

- Quality measure development to better capture impact and quality of home- and community-based services (NQF).

- Investments in data tracking and communication technology are also helping CBOs be equipped to take on such new roles and collaborate with providers and payers – but more investment is needed.
In addition to the efforts to expand roles of CBOs and government-driven policies pushing health care beyond 4 walls, we’re also seeing policy advocates and funders help move the dial by:

- Looking at how to adjust payment for social factors (National Academies of Sciences, Engineering, and Medicine report on doing this in Medicare came out earlier this year)
- Funding projects such as analyzing the impact of changes thus far and developing care models (Commonwealth Fund portfolio)
- Developing more supports for informal caregivers (National Academies report, CARE Act)
- Making policy recommendations moving forward – how new administration can build on progress we’ve made, with practical ways to strengthen health care system and prepare for future needs
GRANTMAKERS AS CHANGEMAKERS
Grantmakers have tremendous impact in promoting innovation and evidence for service delivery & policy change

Especially important and transformative **right now**

- Increasing older adult population, and increasing diversity within it
- Fewer family caregivers and a direct care workforce in need of support
- State budget cuts and uncertainties in national politics
  - On top of an already underfunded Aging Network
- Changing roles for Aging Network given health reform
  - Need for support in redefining role, infrastructure development
  - Need for improved geriatric education across professions

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You recall the slide I showed earlier with this graphic of SDH impacting older adult health and wellbeing.

Many organizations and grantmakers have invested in programs that aim to mitigate such social factors from leading to adverse health outcomes. For example, for somebody living in food desert or an area where it is hard for them to get around, a mobile farmers market or meal delivery service may be critical for them being able to access foods that won’t exacerbate their diabetes or raise their blood pressure. These services and programs are essential for supporting people to age safely in the community.

**Examples of initiatives that reduce social factors’ impact on health:**
- Benefit enrollment
- Care coordination
- Health education
- Paratransit services
- Mobile farmers market
- Home modification services
The field of public health takes a step back from interventions and asks why it is that not all people have as hard of a time accessing healthy food or why other social determinants of health (or illness) are unevenly distributed. This uneven distribution of the social determinants stems from deeper human-caused structural factors – thus it is important to have programs and policies in place that also target those deeper factors, the roots of social determinants of health.
So, what are some of those structural determinants?

- **Governance processes and economic policies**
  - Taxation (Is it progressive or regressive? Progressive taxation takes a larger percentage from high-income earners than it does from low-income individuals. The opposite, regressive taxes, include sales taxes)
  - Minimum wage (If someone is working full time at minimum wage, are they earning a living wage?)
  - Enforcement of anti-discrimination laws
  - Social security (E.g. privatization of social security, which puts earned benefit at risk. Or, the cost of living adjustment, which is the formula used to determine how social security payments change with inflation; the formula chosen by gov’t has a big impact on seniors who rely on SSI solely for income.)

- **Social and public policies**
  - Affordable housing policies (Is government encouraging mixed development via grants, tax credits?)
  - Environmental policies (Are toxins being released into environment by nearby manufacturing plants? Can people who rely on drinking city water trust that it is safe?)
  - Transportation policies (Are public transportation corridors being developed through urban and regional planning? Is there another way for people without own car or with limited mobility to get around so they’re not socially isolated?)
• **Cultural and societal values**
  • Societal and cultural devaluation of some people (e.g. via racism, ageism)
    • → These implicit biases can lead to differential treatment in various settings, policies, and practices
  • Individualism (e.g. personal responsibility, pulling oneself up from your bootstraps, vs. collective thinking)
Here we see some examples of these societal level determinants when we think about aging:

- **Economic inequality**
- **Racism, Ageism** – two examples of cultural and societal devaluation of some people and privileging others. It’s important, for example, to look at how ageism manifests in differential treatment of older adults in different settings, in policies, and in practices - both currently and historically.
- **Lack of long-term care system** – why is it that such a system, which is in the public interest and would be a large public good, doesn’t exist? People rely on spending down to Medicaid for this. CLASS Act from the ACA was repealed in 2012 due to little belief that public would buy into it and insufficient and regressive taxation.
- **Politics of having two-tiered medical system** – which sometimes (especially historically) has prioritized free-market principles over rights of people. Medicare has generally been a solid rock for older adults, luckily. A few significant victories in this realm in the ACA for others- such as no pre-existing conditions keeping people out of health coverage.

Recognizing the role of structural determinants ON the social determinants and thus on health and wellbeing allows us to think about how we might try to intervene on these societal determinants (go to next slide)
Here we now see a range of interventions at different points in the process – including ones that try to prevent structural structures from turning into social factors that foster illness.

Here’s an example, in recognition that we don’t have a LTC system and that adult daughters often get tasked with non-skilled (and skilled) work helping care for their parents, sometimes having to take themselves out of the workforce. Some initiatives advocate for a caregiver tax credit or for credits toward building up social security, so that those family caregivers don’t hurt their future selves with reduced social security payments thus leading to economic insecurity.

**Examples that reduce societal factors’ impact on social determinants:**
- Caregiver tax credits
- Political movements, Community organizing, (E.g. Jane Addams Senior Caucus in IL, Black Lives Matter)
- Community-building initiatives (e.g. public-private partnerships)
- Affordable housing development
- Public awareness campaigns to combat ageism
- Advocacy for improved quality measures that help us get a sense of non-medical things impacting care, especially for dual-eligibles
Many ways grantmakers can help reduce social determinants’ impact on health outcomes

- Not easy issues to fix
- Can be hard to know what to prioritize
- The combination of all of our efforts is what is needed

I’ve already covered much of this – but wanted to put it here so you can see the spectrum of ways you can get involved.
“To reduce health inequities among older adults, we need to create supportive institutions and laws that create healthy environments for older adults, and make the healthy choice the easy choice for health behaviors... Diverse elders will be emotionally and physically healthier when they and their families make a living wage, have decent and affordable housing, and reside in safe and health-promoting neighborhoods in a society that values diversity.”

- Steven P. Wallace, Ph.D.

As we work to improve health outcomes for everybody in our country, we need to keep in mind the structural and social factors that help determine health and wellbeing.

(Steven P. Wallace, Ph.D., is the chair of and professor in the Department of Community Health Sciences at the UCLA Fielding School of Public Health, and associate director at the UCLA Center for Health Policy Research in Los Angeles, California.)
Thank you all for your important work
References