

# **Advancing Social Determinants of Health**

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**Donna L. Washington, MD, MPH**

Professor of Medicine, UCLA Geffen School of Medicine

Director, Health Equity-QUERI National Partnered Evaluation Center, VHA

NASEM Workshop: Enhancing Care and Services  
for Mental Health and Substance Use Disorders

July 1, 2025

# Disclosures

- I have no actual or potential conflicts of interest in relation to this presentation.
- The views expressed are my own, and do not necessarily represent the position or policy of the Department of Veterans Affairs or of the U.S. government

# Social Determinants of Health

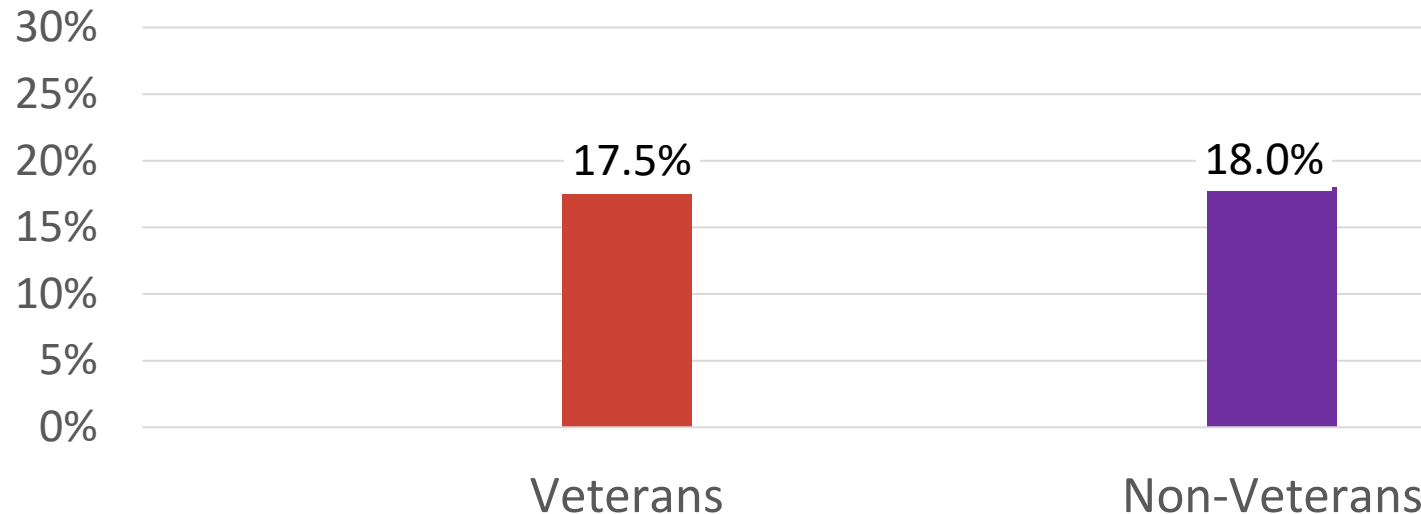
“The social determinants of health are the conditions in which people are born, grow, work, live and age, and the wider forces that shape the conditions of daily life.”

*World Health Organization*

# Department of Veterans Affairs (VA) Health System – Example of Care Model that Addresses SDOH

- One of the largest integrated health systems and learning health systems in the U.S.
  - > 9 million enrollees
  - > 1,000 sites of care
- High prevalence of mental health conditions and substance use disorders among VA users
- Health care and social missions
  - Eliminates insurance as a contributor to disparities

# Mental Health Condition Prevalence by Veteran Status and VA use\*



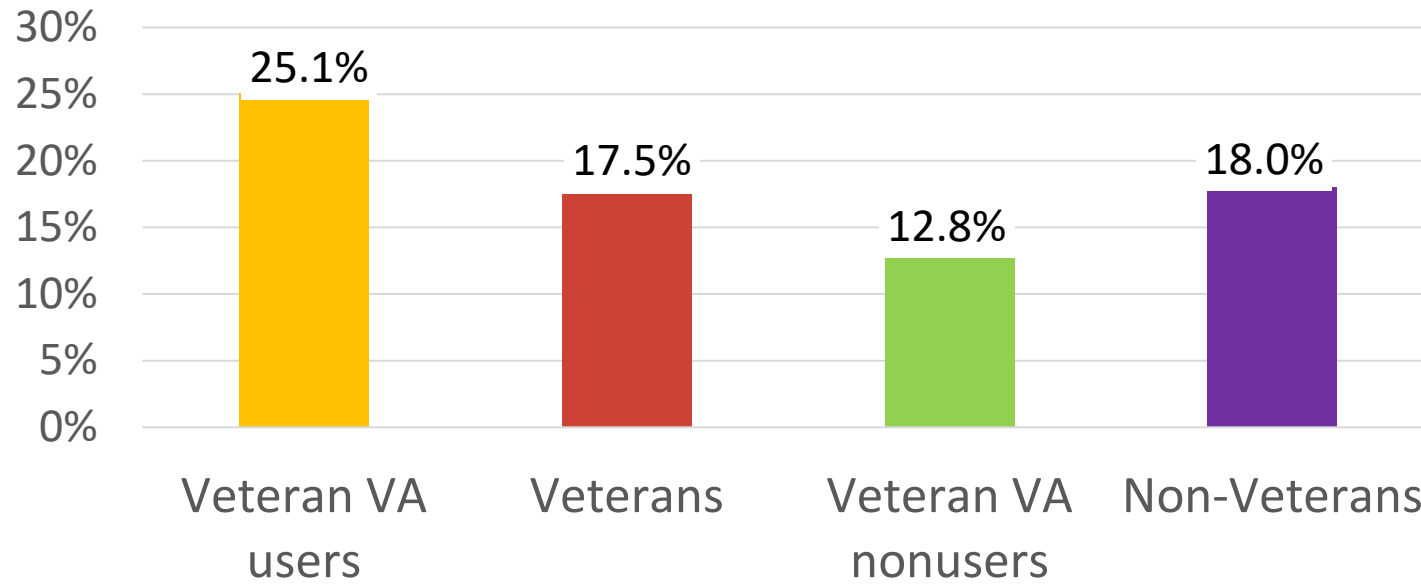
- Some conditions, e.g., suicide risk, and risk factors, e.g., homelessness, much higher in Veterans\*\*

Sources:

\*RAND analysis of MEPS 2006-2012 data. Eibner C, RAND Health, 2015.

\*\*Tsai J, Cao X. Association between suicide attempts and homelessness in a population-based sample of US veterans and non-veterans. J Epidemiol Community Health. 2019 Apr;73(4):346-352.

# Mental Health Condition Prevalence by Veteran Status and VA use\*



## SUD Prevalence in VA users: 13%\*\*

Sources:

\*RAND analysis of MEPS 2006-2012 data. Eibner C, RAND Health, 2015

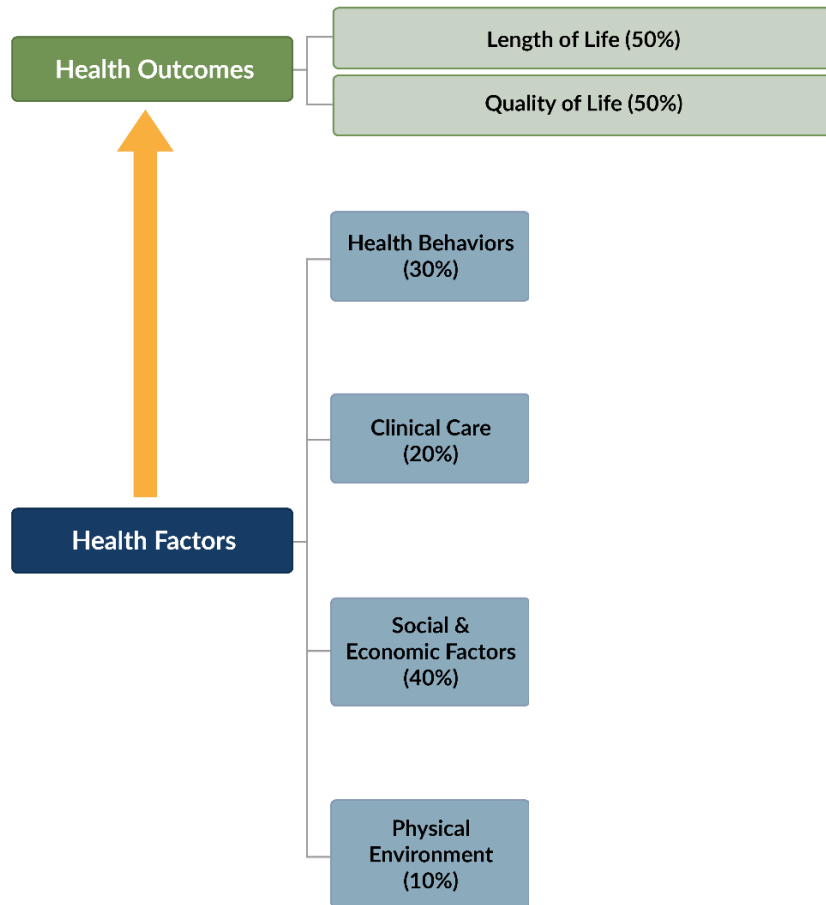
\*\*Hoggatt KJ, Harris AHS, Washington DL, Williams EC. Prevalence of substance use and substance-related disorders among US Veterans Health Administration patients. *Drug Alcohol Depend.* 2021 Aug 1;225:108791.

# Health Outcomes



*University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. 2014.*  
<http://www.countyhealthrankings.org/our-approach>

# Determinants of Health Outcomes



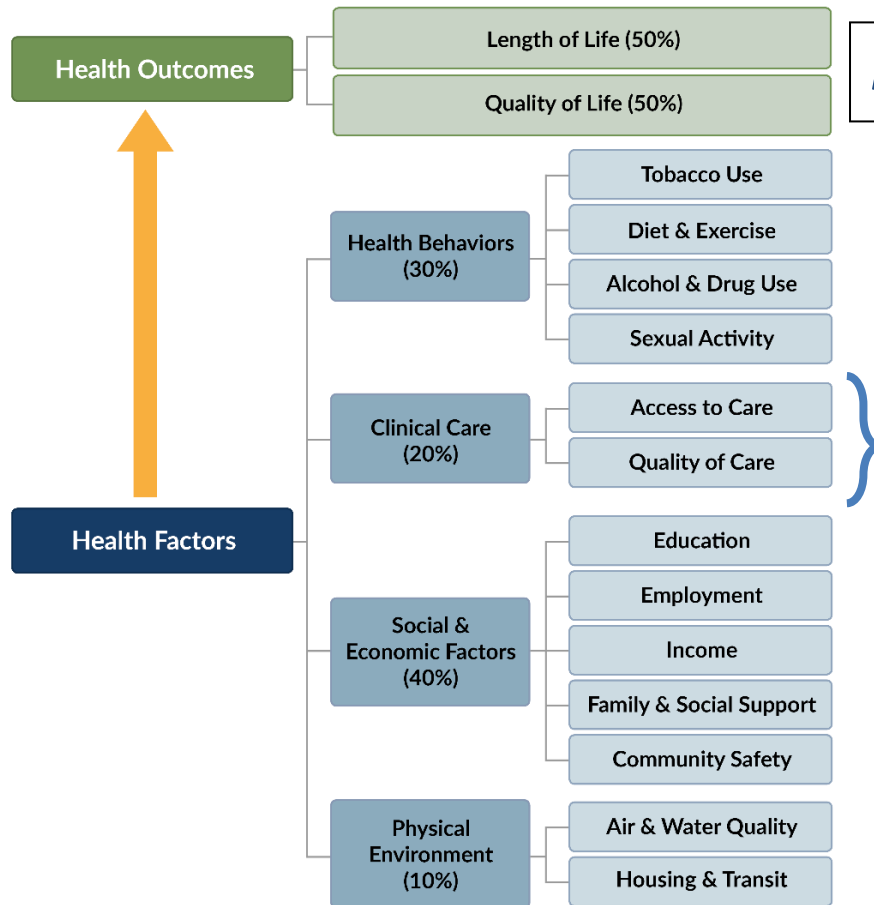
## Social determinants of health (SDOH)

Example: Wong MS,..., Washington DL. Assessment of exposure to environmental toxins and racial and ethnic disparities in COVID-19 hospitalizations among US Veterans. JAMA Netw Open. 2022 Jul 1;5(7):e2224249.

University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. 2014.  
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# Determinants of Health Outcomes



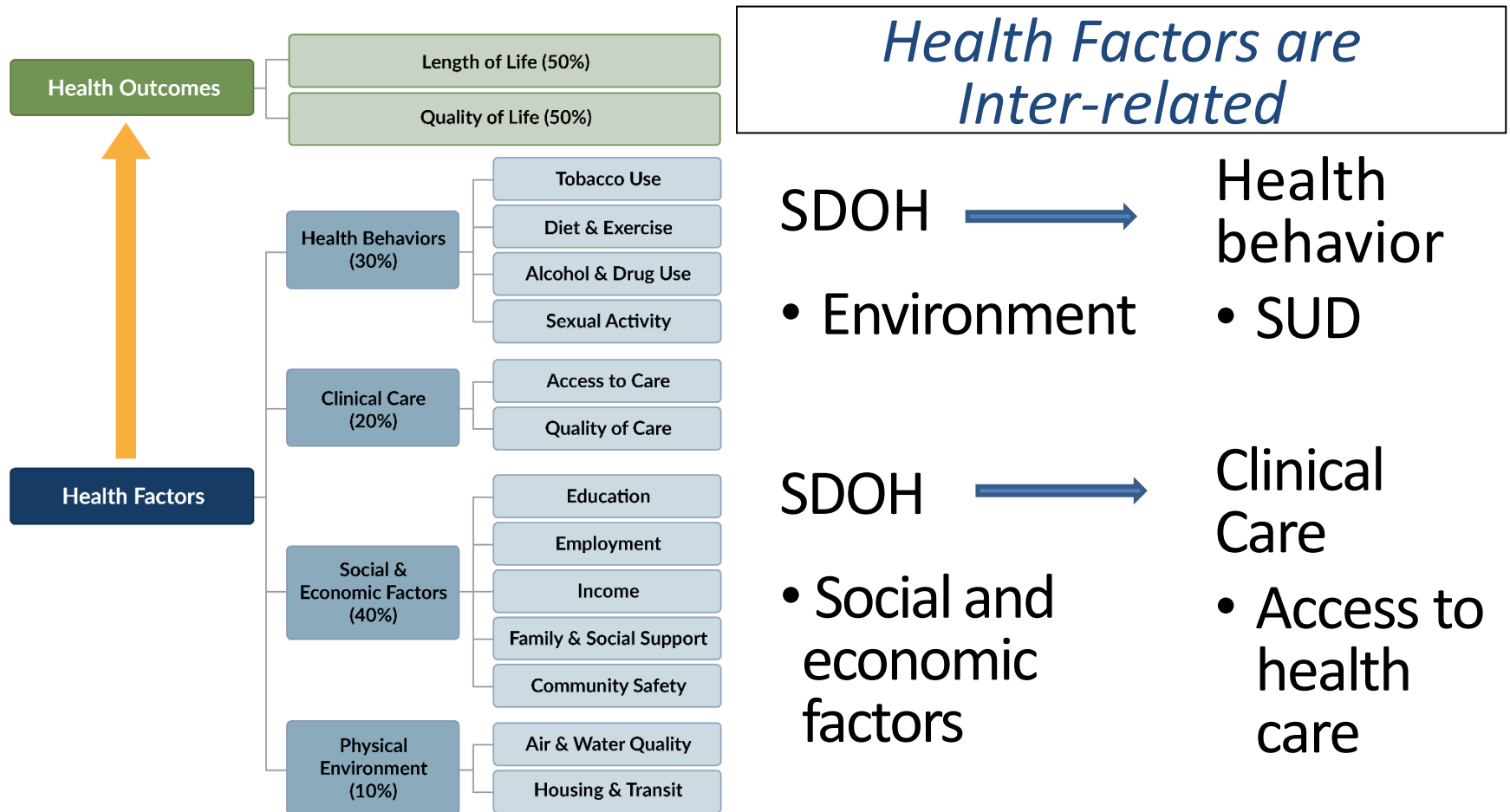
*Health Factors are Modifiable*

Example: Patients with a SUD diagnosis reported worse experiences for 8 of 12 patient experience measures, including access, provider communication, and information received

Source: Hoggatt KJ, ..., & Washington DL. Substance Use Disorder-Related Disparities in Patient Experiences of Primary Care. Health Equity. 2019 May 2;3(1):193-197.

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# Determinants of Health Outcomes



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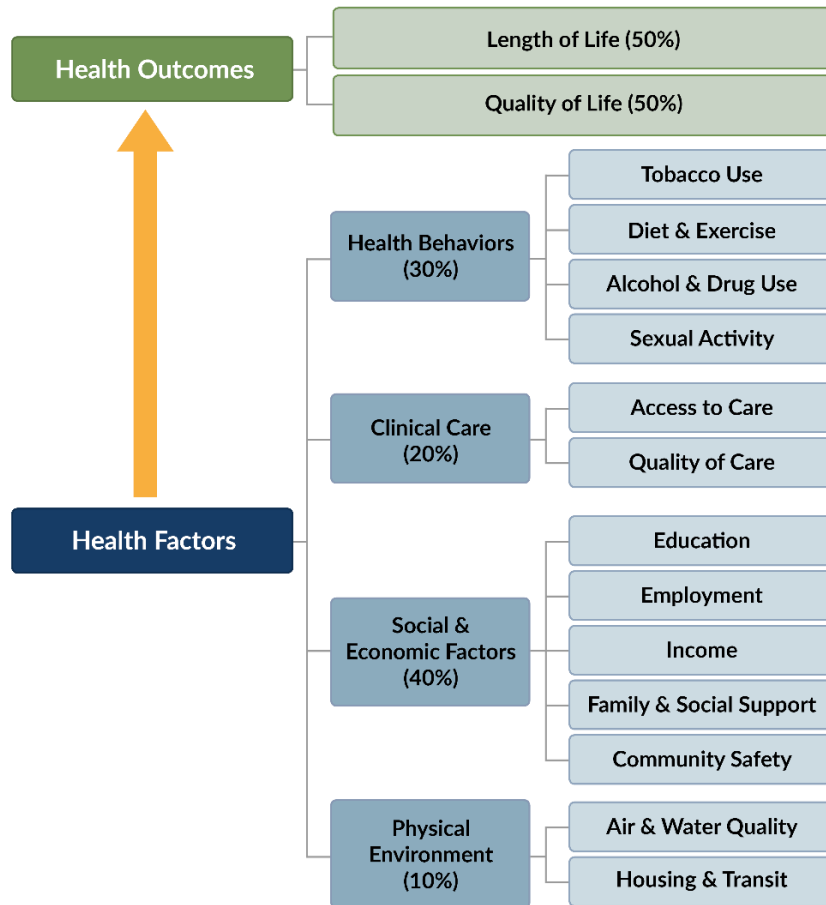
# Inter-related Health Factors

## Race, Poverty, and Mental Health Drive VA Colorectal Cancer Screening Disparities

*May FP, ..., Washington DL. Med Care. 2019 Oct;57(10):773-80.*

- Findings: overall colorectal cancer screening rate 81.5%
  - Lowest rates: American Indian/Alaska Native Veterans, individuals in lowest socio-economic status quintile, individuals with serious mental illness and those with SUD
  - Small advantage: Black, Hispanic, and Asian Veterans, older age groups

# Determinants of Health Outcomes



University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. 2014.  
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# Social Needs Screening and Interventions

- Screening for social needs in VA primary care settings (e.g., food insecurity)
- Quality Improvement initiative for more comprehensive screening and embedded linkages with resources: Assessing Circumstances and Offering Resources for Needs (ACORN)\*

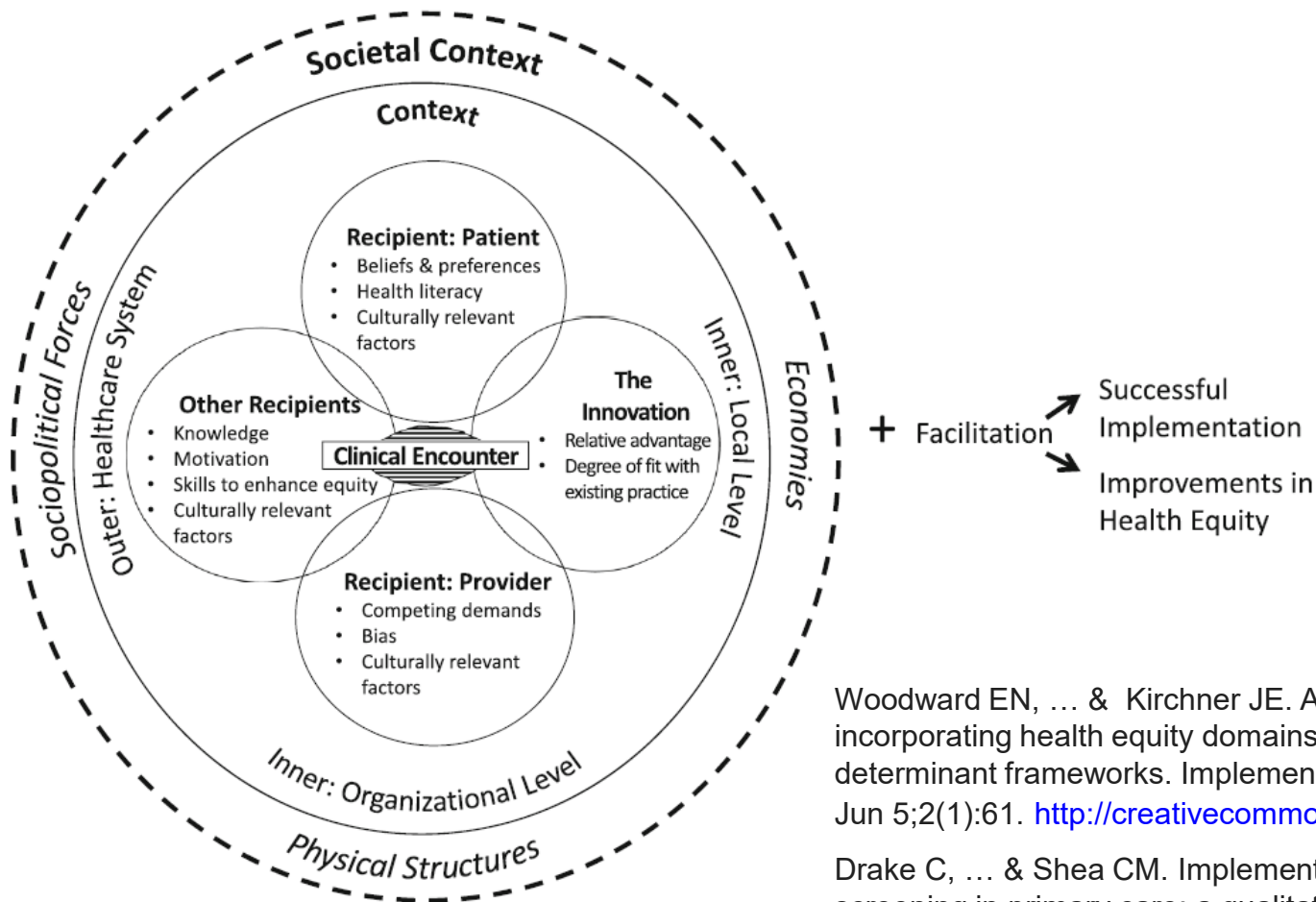
ACORN implementation, evaluation, and expansion supported by VHA Office of Health Equity.

\* Mitchell KM, et.al. Assessing Circumstances and Offering Resources for Needs (ACORN) Implementation Toolkit. U.S. Department of Veterans Affairs, June 2024. [https://www.va.gov/HEALTHEQUITY/docs/ACORN\\_Implementation\\_Toolkit.pdf](https://www.va.gov/HEALTHEQUITY/docs/ACORN_Implementation_Toolkit.pdf)

# Social Needs Screening and Interventions (continued)

- Tailor clinical setting for specific populations
  - H-PACT (Patient Aligned Care Teams) = Patient-centered medical home care delivery models for homeless-experienced Veterans
  - MH clinics with primary care and other services
- Direct delivery of social services
  - Housing for homeless-experienced Veterans

# Health Equity Implementation Framework



Woodward EN, ... & Kirchner JE. A more practical guide to incorporating health equity domains in implementation determinant frameworks. *Implement Sci Commun*. 2021 Jun 5;2(1):61. <http://creativecommons.org/licenses/by/4.0/>.

Drake C, ... & Shea CM. Implementation of social needs screening in primary care: a qualitative study using the health equity implementation framework. *BMC Health Serv Res*. 2021 Sep 17;21(1):975.

# Discussion