ACTION 2.1

Social determinants screening should include risk factors, such as adverse childhood experiences (ACEs), trauma, poverty, and homelessness, and protective factors, such as resources that would help families and children recover from difficulties and exhibit resilience.

SCREEN CHILDREN & FAMILIES for SOCIAL DETERMINANTS OF HEALTH and CONNECT THEM to APPROPRIATE SERVICES

Social determinants or drivers of health are the conditions in which people are born, grow, live, work, and age. The conditions of children's neighborhoods, homes, and child care have a strong influence on their health, development, and school success. Children living in families with low incomes face many obstacles to healthy cognitive and emotional development, such as parental unemployment, housing instability, inadequate nutrition, and toxic stress. Screening for social determinants of health helps to identify families and children who need access to preventative formal and informal developmental supports.

WHAT WE KNOW

The **social determinants of health have been shown to have a larger significance for health than either access to healthcare services or genetic factors**. Because differential access to the social determinants of health is the primary driver of racial, ethnic, and socioeconomic health disparities, screening for them and directly connecting families and children in need to services is a crucial step in working towards health equity. Historical and contemporary practices restricting access to housing, education, wealth, and employment for members of communities of color places individuals and their communities at greater risk for poor health outcomes.

SOCIOECONOMIC FACTORS ALONE ACCOUNT FOR APPROXIMATELY 47% OF HEALTH OUTCOMES, while health behaviors, clinical care, and the physical environment account for 34%, 16%, and 3% of health outcomes, respectively.

Several studies in recent years have shown that these social and structural factors—from education, race, social support, and poverty—**contribute to over a third of deaths in the US in a given year**.

Dive Into the Data

Access to quality housing is a key factor influencing health and overall wellbeing. The **Pathways Data Dashboard** indicates that 50% of households in Pitt County are cost burdened, with this data broken down for other counties and disaggregated by race and ethnicity.

WHAT WE NEED

Given the complex and multi-layered nature of the social determinants of health, collaboration across sectors, such as transportation, education, housing, and healthcare, and across various organization types, such as government agencies, private industry, and community-based organizations, are needed to create positive change. These collaborations must also extend across scales–local, state, tribal, and national levels. Each of these sectors, organization types, and scales have differing reach and capabilities in connecting families and communities to supportive services.

HOW TO SUPPORT

It is important for legislators and those implementing health policies to have information based on screening for the social determinants of health so they can make targeted investments in supportive resources and services in communities with the greatest need. Coupled with this, there is increasing need for guidance regarding the development and use of linguistically appropriate screening and referral services to keep equity at the forefront and narrow gaps in access to services.

Thankfully, there are several **successful evidence-based interventions, addressing the social determinants of health**, that improves immediate and long-term health and wellbeing outcomes.

Social determinants of health—from housing to education to food security—are key drivers in health inequities, and have more of an impact than factors including clinical care to overall health.

Below is a short list of several interventions that can interact with each other to significantly change the course of a child's life. Increasing access to:

- Education and training needed to increase income
- Tax credit and supplemental income support for low-income and disabled individuals
- Affordable housing that is safe and stable
- Affordable and reliable transportation to work, school, and health care facilities
- Affordable, healthy food
- Case managers who can coordinate care across for those managing complex challenges

INITIATIVES WORKING IN THIS AREA

Wake Connections is a coordinated intake and referral system that matches young children (prenatal-5) and their families in Wake County with home-based and group services that best fit their needs. Wake Connections includes 12 partner programs focused on areas including parenting skills, child development, pregnancy and postpartum support, school readiness, behavioral health and resource linkage. One online application allows a family to be screened for eligibility for multiple services and matched with the best fit program.

Healthy Steps is an evidence-based, interdisciplinary pediatric primary care program designed to promote nurturing parenting and healthy development for babies and toddlers particularly in areas where there are persistent inequities for families of color or with low incomes. A child development professional, known as a HS Specialist, connects with and guides families during and between well-child visits as part of the primary care team.

Child Care Health Consultants (CCHCs) are health professionals with expertise in child and community health who work collaboratively with early educators to promote healthy and safe environments for children, staff, and families in child care. Located in about 38 counties across NC, they provide technical assistance, professional development, and coaching and serve as liaison between the child care provider, the family and the child's health care provider to identify needs as early as possible and connect families to services.

Visit the Pathways Action Map to learn more.