



Social Determinants of Health— an Employer Priority

**“HEALTH FUNCTIONS AS A KIND OF SOCIAL
ACCOUNTANT. IF HEALTH SUFFERS, IT TELLS US THAT
HUMAN NEEDS ARE NOT BEING MET.”**

— BRITISH EPIDEMIOLOGIST AND HEALTH POLICY EXPERT,
SIR MICHAEL MARMOT PID

ABOUT THIS REPORT

The Health Enhancement Research Organization (HERO) is a national non-profit dedicated to identifying and sharing best practices in the field of workplace health and well-being (HWB). HERO was established over twenty years ago to create and disseminate research, policy, leadership and strategy to advance workplace HWB, providing leadership of the nation's workforce. Much of the good work that HERO does is achieved through the efforts of its volunteer committees. This paper was produced by one such committee, the Healthy Workplaces Healthy Communities Study Committee (HWHC).

The HWHC Study Committee was created to explore the intersection between workplace well-being, community health, population health improvement and the value of public-private partnerships. This intersection of workplace and community health promotion and improvement represents a two-way street that has the potential to operate in a synergistic manner. To better define the mutually beneficial interconnectivity between healthy workplaces and healthy communities, the HWHC Committee has two areas of focus: 1) understanding employer and business implications of social determinants of health (SDOH); and 2) the expansion of the get-HWHC.org website to include supporting case studies from companies investing in community health. Each focus area has a dedicated workgroup to achieve stated deliverables.

CONTRIBUTORS

This report is a product of the HERO HWHC Study Committee. Development of this report and content was led by HERO staff and members of the HWHC Study Committee. Contributors to the report are listed alphabetically below.

Alexandria Blacker, MPH
Stephen Dion, MBA
Jessica Grossmeier, PhD, MPH
Kris Haugen, MPH
Rick Hecht, MFT, MBA
Elizabeth Markle, PhD

Les Meyer, MBA
Sarah Monley, MPH
Bruce Sherman, MD
Nicole Vanderhost, MA
Emily Wolfe, MSW, LCSW

For more information, contact HERO at:

Health Enhancement Research Organization
24 South Olive Street, Suite 301
Waconia, MN 55387
952-835-4257 | info@hero-health.org

TABLE OF CONTENTS

1 | About this report

4 | Executive Summary

5 | Introduction

6 | Relationship Between SDOH and Well-Being

7 | Impact of SDOH on Employees

9 | Relevance to Employers

10 | Implications for Well-Being Programming

11 | Relationship to Corporate Social Responsibility

12 | Action Steps for Employers

- Organizational Philosophy
- Work Cultural Environment
- Health and Well-Being Benefits
- Work Scheduling and Pay
- Work-Life Integration
- Work Physical Environment

15 | Conclusion

16 | Bibliography

EXECUTIVE SUMMARY

Modern workplace wellness programs began in the 1970s in response to a perceived shift in financial responsibility for health care from government to employer. While early wellness thought leaders advocated for a holistic approach to wellness that included dimensions such as mental, emotional and social well-being, many early wellness programs focused attention primarily on individuals' physical health behaviors. In the last 10 years, the motivation for and the approach to workplace wellness has shifted. Employers are motivated by the influence well-being has on intangible assets such as morale, productivity and retention. The scope of worksite wellness initiatives today extends beyond individuals' physical health to include dimensions of mental and emotional health, job satisfaction, social connectedness and financial well-being.

Workplace wellness is ever evolving, and that evolution includes cooperation between departments, collaboration between professional disciplines, and partnerships across industry sectors. Employers are exploring the properties of the places and institutions that all people depend on to be healthy and well with the understanding that there are social factors that lead to ill health and health inequities. Employers are discovering influences impacting their employee populations that the public health sector has known about for decades. They are learning, as hospitals and health systems have, that health suffers when medical care is provided in isolation from social services.

Health starts in families, in schools and in workplaces. It's not something people can get in a doctor's office. Sometimes referred to as vital conditions or social factors, social determinants of health (SDOH) have been the focus of the public health sector for decades. It has only been in the last two years that conference speakers, webinar facilitators, authors and writers have introduced employer audiences to the idea that social determinants of health and addressing health equity may make good business sense.

Employers seeking to establish health equity among their employee populations will benefit from this paper. The connection between SDOH and well-being is outlined based on the determinants that directly impact workers' health such as food insecurity and social isolation. An explanation of the impact determinants have on employees illustrates the interplay between how SDOH can influence employee performance at work and how employment can influence employees' SDOH. There is a description of this topic's relevance to employers that includes business performance and profitability. This paper introduces the implications SDOH have on well-being programming by providing examples from employers. Finally, employers will find specific actions they can take to address SDOH within their workforces.

INTRODUCTION

For more than thirty years, employers have tried to improve employee health through the development of worksite wellness initiatives, most notably interventions focused on physical health. While physical well-being is important, the results of employers' efforts have been underwhelming. American employees continue to struggle to maintain positive health status as evidenced by the growing obesity and chronic condition epidemics. These epidemics continue to impact American businesses in a variety of ways including productivity losses driven by absenteeism, presenteeism, turnover, health care, workers' compensation and disability costs.¹

The construct of well-being is complex and multi-faceted. While there are several definitions, the holistic Gallup model goes beyond physical well-being and includes career well-being, social well-being, financial well-being, and community well-being. The elements are interdependent, and people can be thriving, suffering or struggling in each element.²

Well-being influences business through employee engagement² because business is based on human potential. To improve employee well-being and thereby sustain

high-value business performance, employers must not only focus on individual behavior change in the physical well-being dimension. They must also remember that well-being is not bestowed by a doctor, a therapist or a health system. Rather, well-being is generated, sustained and diminished in the communities where people live, and by the relationships in their lives.

Sometimes referred to as vital conditions³ or social factors, social determinants of health (SDOH) are the conditions that shape and influence employee experiences: where they are born, grow, play, learn, work, and pray. They are the conditions that influence health and illness, and they have a profound impact on morbidity, mortality, and quality of life, which in turn have implications for productivity and performance. Examples of SDOH include: cultural norms; social support; education level; economic stability; the physical attributes of a community including air quality and access to clean drinking water; access to supermarkets and healthy food; reliable transportation; affordable, adequate, and stable housing; and good jobs that pay a livable wage.⁴

RELATIONSHIP BETWEEN SDOH AND WELL-BEING

While all social determinants may impact employee well-being, this paper highlights the following SDOH: location, financial instability, food insecurity and social isolation.

Location

Where individuals spend their time matters. Location influences access to food and transportation, safety and housing, employment and healthcare. One's ZIP code has been shown to have a greater impact on health and happiness than one's genetic code, including the length and quality of life.⁵ People living in impoverished neighborhoods, particularly racial minorities, experience increased exposure to environmental risks and are at a greater risk of illness. In America, adjacent communities can have life expectancies that vary by 20-30 years.⁶

Financial instability

Poverty has been linked to increased morbidity and mortality and has been shown to have significant health implications throughout the lifespan. Adults living in poverty have a higher incidence of diabetes, heart disease, stroke, obesity, depression, and premature death. They are more sedentary, smoke more, and are more likely to have unhealthy diets.⁷ Poverty not only has a negative impact on quality of life, it has been shown to reduce life expectancy by almost five years.⁸ A 2018 Gallup study found that 29% of Americans skip medical care because of finances, and half of those people report that it was for a serious condition.⁹ While smoking rates

nationally have continued to decline, they remain high among the poor. The rate of lung cancer is 18-20% higher for people who live in under-resourced rural areas. A Gallup study found a connection between income and weight for American women.¹⁰

Food insecurity

Research shows that good nutrition is critical to long-term health, yet finding food at all is a challenge for millions of people in the U.S. According to the U.S. Department of Agriculture Economic Research Service, food-insecure households are uncertain of having, or are unable to acquire, at some point during the year, enough food to meet the needs of all their members because they had insufficient money or other resources for food. Of the 11.8% (15 million) U.S. households that were food insecure at some point during 2017, 52% were full-time employed.¹¹

Social isolation

Loneliness has a significant impact on morbidity and mortality.¹² Loneliness impacts health outcomes in ways comparable to smoking, alcohol consumption, obesity, high blood pressure, and sedentary behavior.¹³ People who are lonely are at a greater risk of catching a cold, having a stroke, or developing heart disease.¹⁴ A recent 10-year study found that loneliness increases the risk of dementia by 40%.¹⁵ It reduces life expectancy comparable to smoking 15 cigarettes per day, and has been found to impact work productivity, creativity, reasoning, and decision making.¹⁶

IMPACT OF SDOH ON EMPLOYEES

SDOH influence employee behavior and the workplace can influence an employee's SDOH.¹⁷

The Centers for Disease Control and Prevention (CDC) notes that work is “a central part of people’s lives that affects the physical, psychological, and social well-being of workers and their families.” A person’s career can influence where they live, the type of housing, childcare and education they can afford, as well as the amount of time they can spend with family and accessing other needed resources.¹⁸ A person’s income is primarily determined by work, as well as one’s social prestige and opportunities for social connectedness, all of which relate to power. In fact, “work is the underlying measure of inequality in any definition of socio-economic health inequalities.”¹⁷

Many aspects of the workplace such as the work environment, compensation, job security, and demands may affect the health of employees.¹⁹ Additionally, socioeconomic status variables such as education, gender and racial and ethnic disparities contribute to the type of work people do, workplace conditions and income they earn.

Work environment

Particular benefits offered to employees have the potential to positively impact the health of employees. According to the U.S. Department of Labor, Bureau of Labor Statistics in 2017, 70% of civilian workers and 67% of private industry workers had access to health insurance, while 89% of state and local government employees had access.²⁰ Furthermore, additional benefits such as paid sick leave and maternity leave have been associated with a number of positive outcomes, such as protection from

unexpected medical costs and enhanced maternal and child health.^{21,22}

Reported workplace injuries can be an indicator of the conditions of the workplace.²³ Findings from the Robert Wood Johnson Foundation, indicate that workers are “more prone to injuries and illness if their job includes repetitive lifting, pulling or pushing heavy loads, poor quality office equipment, long-term exposure to harmful chemicals such as lead, pesticides, aerosols, and asbestos, or a noisy work environment.” Additionally, the job demands, lack of autonomy, workplace interpersonal conflict, evening shift work and working multiple jobs are reported sources of psychosocial stress.²⁴⁻³¹

Education

According to the Pew Research Center, among adults ages 25 and older, 23% of African American and 15% of Hispanic individuals have a bachelor’s degree or more education in comparison to 36% of white adults and 53% of Asians.³² Research has shown that those with less education tend to have “fewer employment choices” leading to positions “with low levels of control, job insecurity, and low wages.” This type of work is also far more likely to include roles that expose individuals to environmental toxins and that are physically strenuous.³³

Gender

Gender differences in the workplace highlight several disparities. Namely, “women are underrepresented at every level, and women of color are the most underrepresented group of all,” notes the 2018 LeanIn.Org and McKinsey Women in the Workplace study. These researchers argue that the most meaningful and

progressive way to close this gap is by focusing on hiring and promotions within organizations. The survey noted that “for every 100 men promoted to [a] manager [role], 79 women are” promoted, and due to this gender gap, men hold “62% of manager positions, while women hold only 38%.”³⁴ Other studies looking at Fortune 500 companies note that this percentage is even lower with women holding only 26% of executive or senior-level positions, only 21% of board seats and only 5% of CEO positions.³⁵ This gap grows larger when looking at women of color who hold only 3.9% of executive or senior level roles and only 0.4% of CEO positions in 2015.³⁶

The McKinsey report goes on to say that key factors, including microaggressions and sexual harassment, lead to an uneven playing field and less opportunities for women. Examples of microaggressions in the workplace include: having one’s judgment questioned in his or her area of expertise, needing to provide more evidence of one’s competence than others do and being addressed in a less-than-professional way. Both men and women report experiencing microaggressions, but female employees experience them at a higher rate.³⁴

Additionally, the 2017 U.S. Census reported that the income for women was 80.5% of their male counterparts.³⁷ Even though women tend to be overrepresented in lower-paying occupations such as healthcare, education and social services³⁸, regardless of industry, women earn less than men in their industry.³⁹ For example, a 2016 study found that female physician faculty earned a little over \$50,000 less than their male counterparts. A significant difference persisted even after controlling for a variety of factors including age, experience, specialty, and clinical revenue.⁴⁰ When considering racial differences, this gap widens even further with African American women earning 67% and Hispanic women earning 62% of what their White male counterparts earn.⁴¹ Much of this disparity is due to lower earnings in occupations that are comprised mainly of women, offer limited or no paid family leave or child care, and use discriminatory compensation and hiring processes.⁴²

Lastly, research is still needed to understand and address the specific disparities of the lesbian, gay, bisexual, transgender (LGBT) and gender nonconforming communities in the workplace. A 2014 research study from the Human Rights Campaign Foundation indicated that 53% of LGBT workers nationwide have to hide who they are in the workplace due to an unwelcoming work environment. This has impacts on broader employee engagement, retention and productivity with 17% of LGBT workers avoiding working with certain clients or customers, 27% avoiding certain people at work and 30% feeling unhappy or depressed at work. Positively, the study found that organizations with an inclusive environment for LGBT employees reported that one in four employees stayed with the organization specifically due to the workplace environment.⁴³

Race and ethnicity

Racial and ethnic disparities are also common in the American workplace. As previously noted, there are salary differences between men and women, but when considering racial and ethnic differences there are a variety of gaps. According to the Pew Research Center in a 2015 report, Asian men earned 117% as much as white men, with African American men earning 73% and Hispanic men earning 69% of what their White male counterparts earned.³² When considering those of the same education level, wage disparity still exists. “College-educated black and Hispanic men earn roughly 80% the hourly wages of white college educated men (\$25 and \$26 vs. \$32, respectively). White and Asian college-educated women also earn roughly 80% the hourly wages of white college-educated men (\$25 and \$27, respectively).”³²

In addition, according to the Centers for Disease Control and Prevention, African Americans are more likely to be employed in jobs where they are at a higher risk for injury or illness.⁴⁴ Furthermore, a study assessing occupational health disparities concluded that ethnic and racial minority groups are more likely to face workplace inequalities, which can lead to poor mental and physical health.⁴⁵

RELEVANCE TO EMPLOYERS

SDOH can impact employer business performance and profitability.⁴⁶ For example, stress “has been associated with increased risk for coronary vascular disease, obesity, diabetes, depression, cognitive impairment, inflammatory and autoimmune disorders, and reduced physical mobility and cognitive function at older ages.”⁴⁷ Furthermore, employee performance and productivity may be impacted by chronic conditions caused by SDOH. A Gallup poll from 2011 suggested that about 86% of full-time workers in the U.S. are above normal weight or have at least one chronic condition.⁴⁸ Compared with healthy workers, these employees miss an estimated 450 million additional days of work each year, costing more than \$153 billion in annual lost productivity. Workforce SDOH measures can also be evaluated in relation to business performance, including work quality, safety, efficiency, and customer satisfaction.

Today, employers are leaning toward value-based benefit design offerings that encompass SDOH. Emerging strategies focus on high-value services which decrease cost-related non-adherence, reduce health care disparities and improve the efficiency of healthcare spending without compromising quality.⁴⁹ Value-based benefit design requires a unified definition of value that includes elements of clinical effectiveness, patient personalization and patient perspective.⁵⁰

When the health care system partners with employers, providers, well-being vendors, consumers, local, regional and federal governments and community organizations, the effects of SDOH can be mitigated. The Population Health Alliance (PHA) is leading work to identify best practices and problem solve with members and the healthcare community to create and sustain cross-sector partnerships for health.⁵¹

Example of high-value service design

An example of partnership is at Geisinger Health System. Geisinger’s focus on food insecurity has led to a program called Springboard Healthy Scranton which empowers employees and patients to eat better and get healthier. Its innovative food prescription program, the Fresh Food Pharmacy™, helps patients sustain lifestyle changes by improving access to healthy foods and brings together community organizations including a hospital and local food bank.⁵²

In addition to value-based benefit design that considers employees’ SDOH, employers today are building workplaces that foster fulfilling employee experiences⁵³ and seeing how employees’ functional well-being and emotional intelligence intertwine with SDOH through a behavioral economics lens.⁵⁴

IMPLICATIONS FOR WELL-BEING PROGRAMMING

Beyond benefit offerings

Historically, employers have tried to improve employee health and well-being by focusing on the health care delivery system. Public health researchers have shown that comparatively small expenditures to address community based SDOH priorities can lead to significant reductions in overall healthcare costs.⁵⁵ Similar to employee well-being, public health seeks to assure conditions in which people can be healthy. Employers have traditionally focused on the workplace while public health practitioners focus on community efforts to prevent disease and promote health.⁵⁶ A recent report published by the Bipartisan Policy Center and de Beaumont Foundation asks employers to consider the question: “Is our community thriving, healthy, inspiring, and attractive to blossoming talent, or is it perceived as deteriorating, sick, and unsafe?”⁵⁶ How an organization answers that question will shape the approach taken towards public health promotion and SDOH interventions.

Several health systems have begun to address SDOH in partnership with the public health sector. For example, the Centers for Medicare and Medicaid Services has initiatives that require health plans to screen for social needs and provide referrals.⁵⁷ Private health plans are approaching SDOH by providing screening and referrals to social services, including housing support, nutritional assistance and integrated case management. Examples include:

- Anthem’s Healthy Generations initiative uses social mapping technology and analyzes public health data to provide a snapshot of the major health issues in each state, allowing the organization to target initiatives at the ZIP code level.⁵⁸
- Humana’s Bold Goal initiative creates

physician, non-profit, business and government partnerships to address SDOH like food insecurity, loneliness and social isolation.⁵⁹

- Kaiser Permanente has donated 200 million dollars to fight homelessness. The organization’s Total Health initiative focuses on health promotion policies and environmental changes to address the SDOH in neighborhoods and school settings, as well as screens patients for unmet social needs.⁶⁰
- L.A. Care Health Plan provides permanent housing for the homeless.⁶¹
- United Healthcare and the American Medical Association’s nearly two dozen ICD-10 codes trigger referrals to social and government services that connect patients directly to local and national resources in their communities.⁶²

Employer examples

In order to improve health and reduce health disparities, employers will need to follow the health systems’ lead by collaborating with community organizations and businesses to address SDOH. This work has begun at Walmart through vendor relationships with Even and Archangels⁶³, but other examples include:

- Financial well-being: Tom’s of Maine pays the lowest-paid workers more than 25% above a living wage.⁶⁴
- Housing: Housing Trust Silicon Valley, a nonprofit community development financial institution including Cisco, LinkedIn, and Pure Storage, has committed millions in support of affordable housing initiatives in the region.⁶⁵
- Food insecurity: Campbell Soup Company’s Healthy Communities campaign works to improve food security through a collective impact model by bringing together the disparate work of government, nonprofits and businesses to make the community healthier.⁶⁶

RELATIONSHIP TO CORPORATE SOCIAL RESPONSIBILITY

Investment in programs to address SDOH in addition to the needs of workers is now both a responsibility of good corporate citizenship and a key element of an enterprise talent strategy. Society expects organizations to play an increasing role in strengthening population health and well-being. Organizations are responding to these growing expectations, focusing primarily on employees and, in some industries, on customers. Levi Strauss and Target⁶⁷, Walmart⁶⁸ and PepsiCo⁶⁹ have extended health initiatives across their entire value chains to include suppliers, local communities, and the general public.

Anchor institutions are rooted in their communities, making them invaluable to local economies with the potential to lead community wealth building. The largest and most numerous of such anchors are

universities and healthcare systems. Over the past two decades, useful lessons have been learned about how to leverage the economic power of universities as they relate to targeted community benefits. The University of Southern California (USC), for example, has instituted a program to increase employment from neighborhoods immediately surrounding its campus. This is an impactful investment as recent reports have shown that “one out of every seven applicants for staff positions at USC was hired from the seven ZIP codes nearest the campus.”⁷⁰

Complex health challenges require cross-sector partnerships.⁵⁶ It is imperative for leaders from business and public health to address SDOH in a manner that will benefit both, in addition to the community.

ACTION STEPS FOR EMPLOYERS

For businesses, a compelling goal should be to optimize the value of workforce human capital. The impact of existing company practices on workforce health in all aspects of business operations must be considered, even in areas not traditionally viewed as affecting employee health. Once successfully implemented, “health in all policies and practices” can become a new organizational mantra, with measurable quantitative benefit.

Below is a representative list of where business leaders can begin to explore the extent to which their company aligns with promoting a healthy, high-performing workforce as it relates to addressing SDOH. This list is not meant to be exhaustive; instead, the intent is to prompt further internal analysis to identify other opportunities to better align workforce health and well-being with enhanced business performance objectives.

Organizational Philosophy

Socialize SDOH internally.

Educate business partners on financial management and health literacy. Train managers to recognize employees who are struggling with both mental and physical health issues or who are struggling with SDOH. Teach managers to be empathic and understanding, and encourage them to connect with employees to see if there is anything they can do to help. Worline and Dutton⁷¹ instruct managers to utilize appreciative inquiry to probe for life circumstances that may be contributing to performance issues. Notably, Gallup reports

that 70% of the variability in employee engagement is driven by the manager.⁷² Ensure that the organization’s mission supports employee health and well-being. Provide a livable wage.

- To what extent does the organization include its beliefs about the importance of its workforce human capital in its mission and/or vision statements?
- To what extent are the mission and/or vision statements operationalized in daily practice?
- Is employee engagement in work considered an important organizational priority? If so, how broad, rigorous and data-driven is the process to improve job satisfaction, engagement and retention levels?
- Are employees paid a fair living wage, particularly in geographic regions where the cost of living may be higher than national norms?
- Do supervisors receive formal management training to foster constructive working relationships with their direct reports? If so, is there a formal process for evaluating the effectiveness of these programs?
- Does supervisor training include raising awareness of SDOH and resources they can refer employees to?
- Does supervisor training include strategies for addressing performance issues that open the door to the ways SDOH may be influencing employee behavior?

Work Cultural Environment

Create policies and practices to support

health including leave policies that support employees in taking care of themselves and caring for others, including paid time off to go to doctors' appointments, subsidized public transportation and childcare.

- What workplace factors do employees identify that interfere with their ability to do their jobs well (e.g., high demand-low control environment, inadequate staffing, hostile peer environment)?
- How do employees describe their sense of job security? Do they feel they could be fired at any time?
- Is there a formal process by which workforce health and well-being is considered when implementing new corporate policies or practices?
- Do all employees have an opportunity for career advancement?

Health And Well-Being Benefits

Learn about employees and their struggles. Employers can ask employees directly which social services and programs would be most valuable to them. This may be done through focus group conversations or through formal employee surveying. Kaiser Permanente, for example, deployed an anonymous survey to measure employees' subjective well-being that included SDOH metrics.⁷³

Leverage existing vendor partners including employee assistance providers, onsite social workers, financial partners (i.e., 401k, insurance), and health plans to understand employee data with a SDOH perspective. Explore new vendor partners that may be able to provide SDOH data for program planning purposes. Internally, there may be human resources data such as ZIP codes and income levels that help identify target locations for intervention. Externally, public health records, area depravity indexes, medical carrier ICD-10 codes, and data aggregation services can help employers make informed decisions.

Lastly, teach employees how to use their benefits and locate providers in their

communities. Research and promote local resources that address various SDOH that are relevant to the employee population, including 211 assistance. Identify and communicate local transportation resources and aid to those who struggle to get to and from work and appointments.

- Have employers heard directly from employees and their family members as to what they value in available and desirable offerings to promote their health and well-being?
- Do all employees have equitable access to affordable benefits, with some type of wage-based subsidy for lower income earners?
- Do all employees have the ability to leave work without penalty to obtain recommended preventive care services, including cancer screenings?
- Are programs available to support the financial well-being of all employees?
- Are programs available to support the mental well-being of all employees?
- Do employees receive employer support to promote their financial well-being, either through retirement fund contributions or performance-based incentives or both?
- Are health plan partners addressing SDOH within their delivery system and in the community?
- Is the health plan offering SDOH screening and referral services for members, especially for food insecurity and adverse childhood experiences?
- Does the health plan support the local community where employees live, such as reinvesting funds to support the overall health and well-being of the community?

Work Scheduling and Pay

Review recruiting and hiring practices to incorporate new skills and perspectives, especially those of underserved populations including the formerly incarcerated.⁷⁴ Employers such as King's Kitchen⁷⁵ in Charlotte, NC, and Greyston Bakery⁷⁶ in New York employ previously incarcerated individuals with a goal to educate, train and ultimately end the

cycles of poverty that impact health status. Promote ongoing training to incorporate cultural competency and health equity into the culture.⁷⁷

- Do employers understand what employees desire in terms of equitable work scheduling and pay?
- Do all employees have predictable work schedules to ensure a steady source of income?
- Do all employees have access to regular pay – and do opportunities exist to facilitate access to emergency funds/ advance pay in the event of a financial crisis?
- Are work schedules involving shift work designed to promote/facilitate favorable health outcomes?
- Is paid sick leave available for all employees? Paid maternity/paternity leave?
- Is employee sleep disruption considered in travel planning for high-frequency travelers?
- Are there programs to support diversity and inclusion in hiring and promotion processes?

Work-Life Integration

Address behavioral health issues, especially stress and depression. Work to reduce stigma and create a culture where people are informed and feel safe to talk about these issues. Set up a confidential, safe setting where employees can meet with human resources, an onsite employee assistance professional, or an onsite social worker to help target local referrals. To address loneliness and isolation, consider surveying employees about the best way to engage together. Train managers to engage with their employees every day. The culture at work is key to creating social connections. Creating a culture

where people feel valued, cared about, and that supports kindness can help foster connections. For some employees, the kind word they receive from colleagues may be the only positive thing they hear all day, particularly if they are returning home to a dysfunctional environment.⁷⁸

- Do employers understand employee issues/concerns regarding work-life balance?
- Are employees given opportunities to propose flexible work arrangements within their teams or to their managers?
- What are employer expectations for the duration of the workweek in terms of hours per day and days per week?
- Are employees able to disconnect from all business communications without penalty during their 'off' time?
- Does the employer provide adequate resource support for employee lives outside of work, for example, to address caregiving concerns?

Work Physical Environment

Build a work environment that makes the healthy choice the easy choice. Create easy access to healthy food options, filtered water, a quiet room, a locker room with showers, and walking paths. Work may be the only time that employees have access to such things.

- Does the physical environment support a healthy workforce?
- Are healthy food options available and subsidized?
- Are stairwells well-lit and easy to use?
- Is physical activity or periods of rest for active jobs during paid work time (e.g., walking meetings or breaks) encouraged?
- Are potential workplace ergonomic issues being proactively addressed?

CONCLUSION

Health is a personal and national resource. It is what allows people to engage with life. Without mind-body-health-well-being, people cannot share in loving, enduring relationships with family and friends, contribute to their communities, or fully participate in work.⁷⁹ When people can maximize positive emotion, engagement, relationships, meaning and accomplishment they flourish.⁸⁰ Yet, as Dr. Sandro Galea explains, “Each of us is shaped by the conditions around us – the combination of place, time, power, money and connections, by what we know, and by the compassion of the people we encounter. And, importantly, our health depends on these things, too.”⁸¹ Therefore, there is a call to action to address SDOH in the workforce.

The Health Enhancement Research Organization (HERO) calls business leaders across the country to identify at least one action your organization can take in the next 12 months to address the social determinants impacting your employee population. In time, draft and contribute a case study to HERO for publication on the HERO and get-hwhc.org websites. Your ability to demonstrate how your organization is working to address SDOH for your employees can inspire other business leaders and motivate change throughout the country.

BIBLIOGRAPHY

1. Worker Productivity Measures | Model | Workplace Health Promotion | CDC. Cdc.gov. <https://www.cdc.gov/workplacehealthpromotion/model/evaluation/productivity.html>. Published 2019. Accessed May 29, 2019.
2. Rath T, Harter J. The Five Essential Elements of Well-Being. Gallup.com. <https://www.gallup.com/workplace/237020/five-essential-elements.aspx>. Published 2010. Accessed May 29, 2019.
3. Well Being Legacy | Conditions. The Vital Conditions. <https://www.wellbeinglegacy.org/vital-conditions>. Accessed June 21, 2019.
4. Determinants of Health | Healthy People 2020. Healthypeople.gov. <https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health>. Published 2019. Accessed May 29, 2019.
5. Graham GN. Why your ZIP Code Matters More Than Your Genetic Code: Promoting healthy outcomes from mother to child. Breastfeeding Medicine. <https://www.liebertpub.com/doi/10.1089/bfm.2016.0113>. Published 2016. Accessed May 29, 2019.
6. Evans G, Kantrowitz E. Socioeconomic Status and Health: The potential role of environmental risk exposure. Annual Reviews. 2002.
7. Khullar D, Chokshi DA. Health, Income, & Poverty: Where We Are & What Could Help. Health, Income, & Poverty: Where We Are & What Could Help | Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hpb20180817.901935/full/>. Published October 4, 2018. Accessed May 30, 2019.
8. Hunger and Health: The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being. Food Research & Action Center <http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf>. Accessed May 30, 2019.
9. Saad L. Delaying Care a Healthcare Strategy for Three in 10 Americans. Gallup.com. <https://news.gallup.com/poll/245486/delaying-care-healthcare-strategy-three-americans.aspx>. Published December 17, 2018. Accessed May 30, 2019.
10. Norman J. Low Incomes Tied to High Weight for Women, Not for Men. Gallup.com. <https://news.gallup.com/poll/244961/low-incomes-tied-high-weight-women-not-men.aspx>. Published November 21, 2018. Accessed May 30, 2019.
11. USDA ERS. Interactive Charts and Highlights. Interactive Charts and Highlights. <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/interactive-charts-and-highlights/>. Published September 5, 2018. Accessed May 30, 2019.
12. Threnhauser SC. Is Loneliness The Overlooked Social Determinant? OPEN MINDS. <https://www.openminds.com/market-intelligence/executive-briefings/loneliness-overlooked-social-determinant/>. Published January 30, 2018. Accessed May 30, 2019.
13. Holt-Lunstad J, Smith T. Social Relationships and Mortality Risk: A Meta-analytic Review. SciVee. July 2010. doi:10.4016/19911.01.
14. Killam K. To Combat Loneliness, Promote Social Health. Scientific American. https://www.scientificamerican.com/article/to-combat-loneliness-promote-social-health1/?utm_source=newsletter&utm_medium=email&utm_campaign=daily-digest&utm_content=link&utm_term=2018-01-24_top-stories. Published January 23, 2018. Accessed May 30, 2019.
15. Sutin A, Stephan Y, Luchetti M, Terracciano A. Loneliness And Risk Of Dementia. In-

- novation in Aging. 2018;2(suppl_1):966-967. doi:10.1093/geroni/igy031.3581.
16. Murthy V. Work and the Loneliness Epidemic. Harvard Business Review. <https://hbr.org/cover-story/2017/09/work-and-the-loneliness-epidemic>. Published September 5, 2018. Accessed June 1, 2019.
 17. Ahonen EQ, Fujishiro K, Cunningham T, Flynn M. Work as an Inclusive Part of Population Health Inequities Research and Prevention. *American Journal of Public Health*. 2018;108(3):306-311. <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304214>.
 18. Social Determinants of Health. Centers for Disease Control and Prevention. <https://www.cdc.gov/socialdeterminants/faqs/index.htm>. Published February 7, 2018. Accessed June 2, 2019.
 19. Social Determinants of Health. Social Determinants of Health | Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
 20. The Employment Situation. BLS. November 2017. https://www.bls.gov/news.release/archives/empsit_11032017.pdf. Accessed June 2, 2019.
 21. DeRigne L, Stoddard-Dare P, Quinn L. Workers without paid sick leave less likely to take time off for illness or injury compared to those with paid sick leave. *Health Aff (Millwood)*. 2016;35(3): 520–27.
 22. Burtle A, Bezruchka S. Population health and paid parental leave: what the United States can learn from two decades of research. *Healthcare (Basel)*. 2016;4(2):30.
 23. Robert Wood Johnson Foundation. Work matters for health; 2008. Brief No.: 4. Available from: <http://www.commissionon-health.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf>
 24. Shain M, Kramer DM. Health promotion in the workplace: framing the concept; reviewing the evidence. *Occup Environ Med*. 2004;61(7):643–48.
 25. Brooker A, Eakin JM. Gender, class, work-related stress and health: toward a power-centered approach. *J Community Appl Soc Psychol*. 2001;11(2):97–109. doi:10.1002/casp.620.
 26. O’Neil BA, Forsythe ME, Stanish WD. Chronic occupational repetitive strain injury. *Can Fam Physician*. 2001;47(2):311–316.
 27. Ross P. Ergonomic hazards in the workplace: assessment and prevention. *AAOHN J*. 1994;42(4):171–76.
 28. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. *Worker Health Chartbook*, 2004. Cincinnati (OH); 2005.
 29. Centers for Disease Control and Prevention. Adult blood lead epidemiology and surveillance—United States, 2003–2004. *MMWR*. 2006;55(32):876–79.
 30. Hager LD. Hearing protection. Didn’t hear it coming... noise and hearing in industrial accidents. *Occ Health Saf*. 2002;71(9):196–200.
 31. Nelson DI, Nelson RY, Concha Barrientos M, Fingerhut M. The global burden of occupational noise induced hearing loss. *Am J Ind Med*. 2005;48(6):446–58.
 32. Patten E. Racial, gender wage gaps persist in U.S. despite some progress. Pew Research Center. <https://www.pewresearch.org/fact-tank/2016/07/01/racial-gender-wage-gaps-persist-in-u-s-despite-some-progress/>. Published July 1, 2016. Accessed June 2, 2019.
 33. Berkman LF, Kawachi I, Theorell T. *Working conditions and health*. In: *Social Epidemiology*. New York: Open University Press; 2014. p. 153–181.
 34. Krivkovich A, Nadeau M-C, Robinson K, Robinson N, Starikova I, Yee L. *Women in the Workplace 2018*. McKinsey & Company; 2018. <https://www.mckinsey.com/featured-insights/gender-equality/women-in-the-workplace-2018>. Accessed June 1, 2019.
 35. Catalyst. *Pyramid: Women in S&P 500 Companies*. Research. <https://www.catalyst.org/research/women-in-sp-500-companies/>. Published May 1, 2019. Accessed June 2, 2019.
 36. Valentina Zarya, “Why There Are No Black Women Running Fortune 500 Companies,” *Fortune*, January 16, 2017, available at <http://fortune.com/2017/01/16/black-women-fortune-500/>.
 37. Data Visualization. 2018. <https://www.census.gov>.

- gov/content/dam/Census/library/visualizations/2018/demo/p60-263/figure2.pdf
38. Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity. U.S. Bureau of Labor Statistics. https://www.bls.gov/cps/cpsaat11.htm#TB_inline?height=200&width=325&inlineId=cps_program_links. Published January 18, 2019. Accessed June 2, 2019.
 39. Women's Earnings by Occupation. 2017. https://www.census.gov/content/dam/Census/library/visualizations/2017/comm/cb17-tps21_womens_earnings.pdf
 40. Jena AB, Olenski AR, Blumenthal DM. Sex Differences in Physician Salary in US Public Medical Schools. *JAMA Intern Med.* 2016;176(9):1294–1304. doi:10.1001/jamainternmed.2016.3284.
 41. Household Data Annual Averages. <https://www.bls.gov/cps/cpsaat37.pdf>
 42. IWPR. The Gender Wage Gap: 2017. IWPR; 2018. https://iwpr.org/wp-content/uploads/2018/03/C464_Gender-Wage-Gap-2.pdf. Accessed June 2, 2019.
 43. The Cost of the Closet and the Rewards of Inclusion. Human Rights Campaign Foundation; 2014. http://assets2.hrc.org/files/assets/resources/Cost_of_the_Closet_May2014.pdf. Accessed June 2, 2019.
 44. Centers for Disease Control and Prevention. CDC health disparities and inequalities report—United States, 2013. *MMWR.* 2013;62(3 Suppl):3–128.
 45. Okechukwu CA, Souza K, Davis KD, de Castro AB. Discrimination, harassment, abuse, and bullying in the workplace: contribution of workplace injustice to occupational health disparities. *Am J Ind Med.* 2014;57(5):573–86.
 46. Sherman BW, Stiehl E. Health Management in Commercially Insured Populations. *Journal of Occupational and Environmental Medicine.* 2018;60(8):688-692. doi:10.1097/jom.0000000000001344.
 47. Addressing Social Determinant Factors That Negatively Impact an Individual's Health. AJMC. <https://www.ajmc.com/newsroom/social-determinant-factors-can-negatively-impact-an-individuals-health>. Published August 20, 2017. Accessed June 6, 2019.
 48. Witters D, Agrawal S. Unhealthy U.S. Workers' Absenteeism Costs \$153 Billion. Gallup.com. <https://news.gallup.com/poll/150026/unhealthy-workers-absenteeism-costs-153-billion.aspx>. Published October 17, 2011. Accessed June 11, 2019.
 49. Fendrick M. Center for Value-Based Insurance Design (V-BID) | Institute for Healthcare Policy & Innovation. <https://ihpi.umich.edu/center-value-based-insurance-design-v-bid>. Accessed June 11, 2019.
 50. Mitts L. Slideshow: What is VBID (Value Based Insurance Design)? Families USA. <https://familiesusa.org/product/slideshow-what-vbid-value-based-insurance-design>. Published July 18, 2016. Accessed June 11, 2019.
 51. Population Health Alliance Quality and Research Committee. Social Determinants of Health and Health Disparities. 2018. <https://populationhealthalliance.org/wp-content/uploads/2018/07/PHA-Social-Determinants-Brief-July-2018.pdf>
 52. Springboard Healthy Scranton - Geisinger Health System. Springboard. <https://www.springboardhealthy.org/>. Accessed June 11, 2019.
 53. CECP, Imperative, PwC. Making Work More Meaningful: Building a Fulfilling Employee Experience.; 2018. <https://d0cb2f2608c-10c70e72a-fc7154704217aa017aa46150b-f00c30c.ssl.cf5.rackcdn.com/pwc-building-a-fulfilling-employee-experience.pdf>. Accessed June 11, 2019.
 54. Meyer LC. DIGITAL THERAPEUTICS: The Future of Behavioral Health. BPI Network; 2018. http://www.bpinetwork.org/pdf/DigitalTherapeutics_TheFutureofBehavioralHealth_LesCMeyer_BPI.pdf. Accessed June 12, 2019.
 55. Pruitt Z, Emechebe N, Quast T, Taylor P, Bryant K. Expenditure Reductions Associated with a Social Service Referral Program. *Population Health Management.* 2018;21(6):469-476. doi:10.1089/pop.2017.0199.
 56. Bipartisan Policy Center, de Beaumont. Good Health Is Good Business: The Value Proposition of Partnerships between Business and Governmental Public Health Agencies to Improve Community Health.; 2019. <https://www.debeaumont.org/news/2019/report-good-health-is-good-business/>. Ac-

- cessed July 8, 2019.
57. Artiga S, Hinton E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation; 2018. <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>. Accessed June 12, 2019.
 58. Healthy Generations. Anthem. <http://www.anthemcorporateresponsibility.com/healthy-generations>. Accessed June 13, 2019.
 59. Humana Bold Goal | Improving Community Health Together. Humana. <https://populationhealth.humana.com/humana-bold-goals/>. Accessed June 13, 2019.
 60. Improving community conditions. Kaiser Permanente. <https://about.kaiserpermanente.org/community-health/improving-community-conditions>. Accessed June 13, 2019.
 61. AHIP. Beyond the Boundaries of Health Care: Addressing Social Issues .; 2017. https://www.ahip.org/wp-content/uploads/2017/07/SocialDeterminants_IssueBrief_7.21.17.pdf. Accessed June 12, 2019.
 62. UnitedHealthcare and the AMA Collaborate to Understand and Address Social Barriers Preventing People's Access to Better Health. UnitedHealth Group. April 2019. <https://www.unitedhealthgroup.com/newsroom/2019/2019-04-02-uhc-ama-social-barriers.html>. Accessed June 12, 2019.
 63. Sherman B, Hoke D. Social Determinants Matter. Recording Information. <https://www.businessgrouphealth.org/event-calendar/social-determinants-matter/>. Accessed June 21, 2019.
 64. B Impact Assessment: Tom's of Maine. <https://s3.amazonaws.com/blab-impact-published-production/public/aRM67b-4S84h43iXNzwsp9mRRINOJahnUiiMnw0v>. Accessed June 12, 2019.
 65. Candid. Tech Firms Invest \$20 Million in Affordable Housing in Silicon Valley. Philanthropy News Digest (PND). <https://philanthropynewsdigest.org/news/tech-firms-invest-20-million-in-affordable-housing-in-silicon-valley>. Published November 29, 2018. Accessed June 13, 2019.
 66. Zellner S, Bowdish L. The ROI of Health and Well-Being: Business Investment in Healthier Communities. National Academy of Medicine. <https://nam.edu/roi-health-well-business-investment-healthier-communities/>. Published May 29, 2019. Accessed June 13, 2019.
 67. Worker Health and Well-being in the Supply Chain. shine. <https://shine.sph.harvard.edu/worker-health-well-being-supply-chain>. Accessed June 13, 2019.
 68. Walmart. Providing Access to Affordable, Sustainable and Healthier Food.; 2017. <https://corporate.walmart.com/2016grr/enhancing-sustainability/providing-access-to-affordable-healthy-food>
 69. Sustainable Farming Program. Pepsico; 2018. https://www.pepsico.com/docs/album/a-z-topics-policies/sfp-scheme-rules.pdf?sfvrsn=fb5b95cf_4. Accessed June 13, 2019.
 70. What is Community Wealth Building? Community. <https://community-wealth.org/>. Accessed June 13, 2019.
 71. Worline MC, Dutton JE. Awakening Compassion at Work the Quiet Power That Elevates People and Organizations. Oakland, CA: Berrett-Koehler Publishers; 2017.
 72. Adkins JHA. What Great Managers Do to Engage Employees. Harvard Business Review. <https://hbr.org/2015/04/what-great-managers-do-to-engage-employees>. Published April 2, 2015. Accessed June 13, 2019.
 73. Stiefel M, Gordon NP, Wilson-Anumudu FJ, Arsen EL. Sociodemographic Determinants of Health and Well-Being Among Adults Residing in the Combined Kaiser Permanente Regions. *The Permanente Journal*. 2019;23(18). doi:10.7812/tpp/18-091.
 74. ACLU. Back to Business: How Hiring Formerly Incarcerated Job Seekers Benefits Your Company. American Civil Liberties Union. <https://www.aclu.org/report/back-business-how-hiring-formerly-incarcerated-job-seekers-benefits-your-company>. Published 2017. Accessed June 13, 2019.
 75. The King's Kitchen Mission. The King's Kitchen. <http://kingskitchen.org/mission/>. Accessed July 17, 2019.
 76. Greyston: Open Hiring. Greyston Bakery. <https://greyston.org/open-hiring>. Accessed July 17, 2019.
 77. Centers for Disease Control and Prevention.

- A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. US Department of Health and Human Services; 2013. <https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf>.
78. Work and the Loneliness Epidemic. Harvard Business Review. <https://hbr.org/cover-story/2017/09/work-and-the-loneliness-epidemic>. Published September 5, 2018. Accessed June 13, 2019.
79. Meyer LC, Palliative Care Everywhere: A Conversation with Diane E. Meier, MD, FACP. Collective Impact of Palliative Care at Work, Home and in the Community. CMSA Today Magazine, Issue 3 2017 Digital. <http://www.nxtbook.com/naylor/CMSQ/CMSQ1117/index.php?startid=16#/16>. Accessed June 12, 2019.
80. The PERMA Model: Your Scientific Theory of Happiness. Positive Psychology Program. <https://positivepsychologyprogram.com/perma-model/>. Published May 24, 2019. Accessed June 13, 2019.
81. Galea S. Well: What We Need to Talk about When We Talk about Health. New York, NY: Oxford University Press; 2019.

