Addressing Social Determinants of Health (SDOH): Beyond the Clinic Walls

Improve health outcomes by addressing social determinants of health

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How will this module help me understand the impact of social determinants on health and develop an action plan to create a healthier patient population by addressing social determinants?

1. Eight STEPS to engage your practice in addressing social determinants of health
2. Answers to commonly asked questions
3. Key resources to understand the topic, create awareness and facilitate implementation of strategic initiatives
4. Real examples of how other organizations are addressing social determinants of health
Introduction

Social determinants of health (SDOH) are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems that shape the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. Also known as social and physical determinants of health, they impact a wide range of health, functioning and quality-of-life outcomes.

There are six common domains of SDOH, shown in the chart below:

1. Economic stability
2. Neighborhood
3. Education
4. Food
5. Community/social support
6. Health care system

Table 1. Six common domains of social determinants of health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Provider availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Support systems</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Discrimination</td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
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<td></td>
<td>Quality of care</td>
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Historically, the practice of medicine has focused primarily on diagnosing and treating specific clinical conditions. As medical knowledge evolves and our health care system shifts to more value-based and population-focused medicine, the medical community is beginning to take a more comprehensive approach to patient care. Practices are looking beyond the clinic walls to understand how patients' social and physical environment impacts their health. Over two decades of research indicates that SDOH have up to a six-fold greater impact on health than clinical care. Addressing SDOH requires collaboration across multiple sectors, including but not limited to medical care, public health and social service providers.

Q&A

How do SDOH impact health?

Non-medical determinants such as the environment, health behaviors and social factors are greater contributors to premature death than quality of health care (Figure 1). For example, poor air quality in the home due to mold, pest infestation or pollution will have an adverse impact on an individual's respiratory health. The resulting asthma,
allergies, cough, and headaches will impact overall quality of life. If the individual cannot remove him/herself from the housing condition, the health issue will likely persist despite medical treatment.

Figure 1. Impact of Different Factors on Risk of Premature Death

In 2003, the World Health Organization (WHO) suggested a list of ten SDOH, while the CDC and Healthy People 2020 identify five key areas of social determinants. Defining a discrete list of SDOH is less important than recognizing that there are interactions among social determinants that create an even greater impact on health than any one social determinant alone. For example, people living in poverty-stricken areas often have issues with education, housing, unemployment and stress. This confluence of negative SDOH and its effect on health status is often reflected in disparities in life expectancy based on zip code.

The profound impact of these factors can persist across generations and drive health inequity based on race, ethnicity, and socioeconomic status, effects that can be visualized on a map of life expectancy—a few miles can translate into a significantly shortened lifespan (Figure 2).
You can explore disparities in life expectancy in other places in the U.S. at https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html

Not only do social determinants influence health outcomes, they can also have an impact on a practice's clinical outcomes, financial sustainability and resource allocation decisions, as well as on the overall health of communities and the health care system. As the nation moves toward value-based care, expanding our health care focus to include SDOH is increasingly necessary to achieve improved outcomes.

Eight STEPS to engage your practice in addressing social determinants of health

1. Understand and engage your community
2. Engage key leadership
3. Assess your readiness
4. Select and define your plan
5. Assess SDOH at the patient level
6. Link patients to SDOH resources
7. Evaluate and refine
8. Celebrate your success
Understand and engage your community

Begin by understanding the health needs of the communities you serve. It is likely that you have already seen the impact of SDOH among your patients. In addition to listening to the perceptions of the communities served, there are multiple resources available in every community to learn more about the health of different groups. A good place to start is by reviewing your local Community Health Needs Assessment (CHNA). Federally tax-exempt hospitals are required to conduct a CHNA every three years. Hospitals conduct a CHNA in collaboration with local public health departments along with community input. This report is posted on the website of each hospital and includes information about the population that the hospital serves, identifies disparities, and prioritizes health issues of concern. If you are in a community practice with patients seeking care across multiple hospitals, it may make sense to sample a few CHNA reports to further define the needs of your patient population. The assessment can be easily accessed online by typing your organization’s name and “Community Health Needs Assessment” into a search engine.

Example: Rush University Community Health Needs Assessment

Q&A

**What is a Community Health Needs Assessment (CHNA)?**

A CHNA, also referred to as a community health assessment (CHA), refers to a state, tribal, local or territorial health assessment that identifies key health needs and issues of a particular community through systematic, comprehensive data collection and analysis.  

**How are community health assessments determined?**

Community health assessments use such principles as:

- Multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation
- Proactive, broad and diverse community engagement to improve results
- A definition of community that encompasses a significant enough area to allow for population-wide interventions and measurable results, and includes a targeted focus to address disparities among subpopulations
Maximum transparency to improve community engagement and accountability

Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation

Evaluation to inform a continuous improvement process

Use of the highest quality data pooled from, and shared among, diverse public and private sources

What specific questions should I explore regarding SDOH?

Look for specific data on community demographics, health trends, services and resources.

1. **Incidence of chronic illness** – understand the prevalence of obesity, diabetes, asthma, and other chronic diseases within your service area and pay close attention to disparities that exist for different subpopulations or different locations

2. **Hardship Index** – review hardship indices by community and understand the impact of crowded housing, households below poverty, unemployment for those over age 16, lack of high school diploma, population under 18 and over 64, and per-capita income

3. **Health Coverage Profiles** – understand the percentage of insured and uninsured patients in your community by age and ethnicity

4. **Find sources of information for SDOH** such as unemployment, graduation, poverty, food insecurity, etc.

Where can I locate important population health data, other than our CHNA?

Local and state public health departments, as well as the U.S. Department of Health and Human Services, provide information by county on health outcomes, behaviors, access to care, social factors and the physical environment through resources such as County Health Rankings and Roadmaps.

Community Commons is another resource that provides a wealth of data in easily generated maps of specific, self-defined communities. Population-level data can be shared with faculty, staff, and leaders throughout the institution. Understanding the needs of your particular patient population will better equip your organization to meet the needs of the community.

### Engage key leadership

Addressing SDOH is an essential strategy to improve the health of a population. Support from key leadership, such as a Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), and Chief Medical Information Officer (CMIO), is recommended. Key leadership provides the necessary financial and staffing resources needed to implement programs and initiatives. They can also assist in removing any administrative or logistical barriers. For a smaller scope of intervention, such as an individual department within a larger institution, secure the support of the department Chair or for an individual practice, the practice manager.

Many practices and health systems have seen the positive impact of addressing SDOH, both financially and in terms of patient health outcomes.

**Case:**
Houston’s Patient Care Intervention Center (PCIC) focused on 39 patients who had at least ten emergency room visits or four hospital admissions over the previous year. With an emphasis on care coordination, these patients received social assistance, a chaperone at primary care appointments and additional focused interventions. Over the course of six months, the total health care costs of the 39 patients were reduced by $1.3 million dollars (Figure 3).
By sharing success stories from other practices and linking the needs of your community to the health of the organization, you will be better equipped to make the business case for assessing SDOH to key leadership.

### Assess your readiness

Before selecting a specific initiative, assess your organization’s readiness to implement.

**Q&A**

*How can I engage my team and foster a supportive culture to address SDOH?*

Understanding our own internal biases can be an important first step in fostering a supportive patient-provider relationship and practice culture. We are all human and shaped by our unique experiences and circumstances. As a result, we may form judgments and perceptions about which we may not be consciously aware.
Consider having your team take the Project Implicit Tests. This resource offers 14 different implicit association task (IAT) tests that identify potential biases related to attributes such as gender, skin tone, and religion.

By acknowledging and exploring our individual biases, we are better equipped to create and be a member of an engaged and empathetic team, which ultimately results in a high level of cultural competency.

By understanding the available resources within your organization, you will be able to select an appropriate SDOH initiative. An assessment can help you identify:

- **Gaps in process** – Does your practice or organization have the infrastructure to implement a specific program?
- **Financial needs** – What financial resources are available from your practice, organization, community, or state to support SDOH initiatives? The amount of available funds often determines the size and scope of the SDOH project selected.
- **Staffing needs** – Does your practice or organization have the necessary staff? Or will you need to engage community health workers, or recruit a pharmacist or social worker? Is there a champion who can help spearhead the project and sustain the effort?
- **Existing supportive resources** – Does your community, region, state or federal government have existing requirements or resources specifically targeted for your project of interest?

How can I tell if my organization is ready to address SDOH?

- **Focus** – Think about one priority patient population served by your organization and one health-related social need that impacts that population. For example:
  - Adults with diabetes and food insecurity
  - Children with asthma and substandard housing
  - Elders with cognitive impairment and social isolation
- **Assess** – Keeping a specific population and a specific social need in mind, assess your capability to address them across 10 domains (Figure 4).
Conducting a readiness assessment can help your practice or organization determine where to begin in launching an SDOH initiative. For example, if your CHNA identified obesity as an area of need, yet your state is already focusing on healthy lifestyle initiatives to reduce incidence of obesity, a readiness assessment might determine that an intervention focusing on obesity is an optimal place to start due to existing resources and support.

4 Select and define your plan

There are many SDOH and each can influence one another. However, it is best to begin by selecting one area of focus for your SDOH initiative.
A. Select a social determinant
B. Choose a health outcome to track
C. Define your target patient population
D. Consider what type of practice setting best describes your clinical practice.

- Physician Practice
- Federally Qualified Health Center (FQHC)
- Hospital/Health System

**Figure 5. Example of a Federally Qualified Health Center (FQHC)**

<table>
<thead>
<tr>
<th>Social Determinant of Health</th>
<th>Food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Screening Metric</td>
<td>% of patients reporting food insecurity</td>
</tr>
<tr>
<td>Target Patient Population</td>
<td>Dual-eligible patient population</td>
</tr>
</tbody>
</table>

The practice setting will play a key role in determining the size and scope of project implementation. Will you deploy a system-wide initiative or begin with a subset of your patient population?

There are many ways to address a SDOH, depending on the size and capacity of the organization. For example, a small practice might screen for a SDOH and refer patients to community organizations for assistance. A larger practice might employ a social worker to navigate the community referrals with patients. A larger organization, such as a hospital or academic medical center, might screen, refer, navigate, develop new services if there are gaps in the community (e.g., patient education activities and farmer’s markets for access to fruits and vegetables), and contribute to community policy considerations, for example, supporting local parks and neighborhoods to combat physical inactivity and smoke-free campuses throughout the community.

Below is an example of a quality matrix, which can help you identify different potential initiatives for a specific population and SDOH, based on level of intervention and level of prevention.
As you define your plan, leverage quality improvement methods, such as Plan-Do-Study-Act (PDSA) or Lean concepts.

- Identify who will be on your SDOH team
- Downloadable tool: Workflow Implementation Guide - NAHC
- Orient practice staff to metrics and goals
- Map out your workflows and what roles each team member will play
- Identify and communicate your plan with your community partners and resources

**Q&A**

Who should be a part of the SDOH team?

As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team. This requires clear guidelines on roles and responsibilities.

Once a need is identified, enable a team member to automatically provide or refer resources to meet that need. Try to avoid adding another step to existing processes, such as a physician-generated order or referral.

Team members and their responsibilities will depend on your practice size and structure, and may include staff additions if current staff may already be overburdened. Consider including patient navigators, social workers, care coordinators and community health workers to help with this effort. Those assisting with this work and referrals should add this directly to the patient chart as an action plan.
Assess SDOH at the patient level

Once you have resources to address needs, start to assess a portion of your patient population for the selected SDOH at an individual patient level. This is recommended regardless of the practice setting or social determinant selected. By implementing a screening process into your workflow, you will quickly begin to understand what is important to the patient and identify social determinants that may be impacting their health status.

Q&A

Should I start by screening all patients who have an appointment?

No, you can begin to screen a smaller population such as dual-eligible patients, a certain age group, or those with a specific diagnosis such as asthma, diabetes, chronic pain, or obesity.

As you begin to screen and accumulate important information about your patients and their SDOH, it can be valuable to incorporate this data into the patient’s electronic health record (EHR). Many EHR vendors provide the functionality to embed a screening tool into the clinical workflow. Incorporating an SDOH screening tool during the pre-visit planning process or during the patient visit is a great way to gather patient information and connect the patient with his/her needs and wishes. By understanding what matters to the patient, you can be more effective in designing and linking that patient to a care plan.

Below are some common free screening tools for care teams:

- **PRAPARE - Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences Implementation and Action Toolkit** – sponsored by the National Association of Community Health Centers, PRAPARE was designed to create and implement a national standardized patient risk assessment protocol to assess and address patients’ SDOH as well as tools to respond to SDOH data. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers’ Uniform Data System (UDS). Additionally, freely available PRAPARE EHR templates exist for eClinicalWorks, Epic, GE Centricity, and NextGen.

- **PCAM – Patient-Centered Assessment Method** – The University of Stirling and The University of Minnesota developed the PCAM to assess patient lifestyle behaviors, mental well-being, social environment, health literacy and communication and care coordination needs. The PCAM has its origin in the Minnesota Complexity Assessment Method (MCAM), a resource developed to bring a broad range of aspects of health into patient assessments, including physical health, mental health, social support, social needs, health literacy and engagement with services. The PCAM resource contains a section focused on actions that can be taken to address the needs and issues identified in the assessment as well as the level of service coordination needed to ensure referrals can be practically
accessed by the patient. There is no cost to obtain a license to use PCAM and the developers are committed to maintaining it as a freely available resource.

- The EveryONE Project\(^9\) – The American Academy of Family Physicians (AAFP) has developed an initial screening toolkit to help physicians recognize and respond to various social factors that affect their patients' health. The toolkit includes screening questions that have been tested, validated, and purposefully assembled to reveal the health hurdles that patients are facing. The screening toolkit also includes a description of a team-based approach to screening for SDOH, along with supporting resources and tools to help family physicians plan next steps to address deficiencies. AAFP also offers a community-level SDOH toolkit. This resource includes tools to determine whether a practice is ready to begin intervening after assessing SDOH needs, as well as how to assess community needs to best deliver appropriate referral resources. The community-level SDOH toolkit also includes strategies for developing partnerships with local social and behavioral health providers to support a screening and referral process. The toolkit and resources are free to use.

- AHCM – Accountable Health Communities Health-Related Social Needs Screening Tool – CMS has developed a 10-item screening tool to identify patient needs in five different domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). Clinicians and their staff can use this short tool across a spectrum of ages, backgrounds, and settings, and it is sufficiently streamlined to be incorporated into busy clinical workflows. As with clinical assessment tools, results from this screening tool can inform a patient’s treatment plan, as well as make referrals to community services.

- OCHIN, a nonprofit health information and innovation network, integrated SDOH tools into Epic. The SDOH health flowsheet developed by OCHIN facilitates the entry of patient-reported SDOH information in the EHR that is not already collected in other places, such as demographics or social history. Additionally, the data collection tools are designed to be flexible so that anyone on the care team can enter data.

### Link patients to SDOH resources

Once you have identified patients who have screened positive for your selected SDOH need, the goal is to link the patient to appropriate resources. Providing the patient with a list of resources can be beneficial, but taking a
more active role in arranging a resource alongside the patient and following-up to ensure benefits were accessed is likely to have a much larger impact. Examples of SDOH resource connections might include:

- Referrals to local food banks and food pharmacies
- Vouchers for bus and subway transportation
- Providing a mobile food pantry at a clinic location

It is important to think about how this “navigation” could be accomplished in the practice setting. There are models using students (Health Leads and Case Western Reserve University’s Patient Navigator Program) and community health workers as parts of the medical team to extend the reach of physicians and nurses.

Take advantage of the 211 – Essential Community Services Program. By simply dialing “211”, callers are routed to referral specialists who can help match individuals to available resources and oftentimes will make a direct referral to an organization that can provide assistance. This resource is available throughout the country.

Q&A

What types of referrals may be offered by 211?

- **Basic Human Needs Resources** – including food and clothing banks, shelters, rent assistance, and utility assistance
- **Physical and Mental Health Resources** – including health insurance programs, Medicaid and Medicare; maternal health resources; health insurance programs for children; and medical information lines, crisis intervention services, support groups, counseling, and drug and alcohol intervention and rehabilitation
- **Work Support** – including financial assistance, job training, transportation assistance and education programs
- **Access to Services in Non-English Languages** – including language translation and interpretation services to help non-English-speaking people find public resources (foreign language services vary by location)
- **Support for Older Americans and Persons with Disabilities** – including adult day care, community meals, respite care, home health care, transportation, and homemaker services
- **Children, Youth and Family Support** – including child care, after-school programs, educational programs for low-income families, family resource centers, summer camps, and recreation programs, mentoring, tutoring and protective services
- **Suicide Prevention** – referrals to suicide prevention help organizations. Callers can also dial the following National Suicide Prevention Hotline numbers, which are operated by the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services:
  
  - 1-800-SUICIDE (1-800-784-2433)
  - 1-888-SUICIDE (1-888-784-2433)
  - 1-877-SUICIDE (1-877-784-2432) (Spanish)

Are there resources to find local treatment facilities, support groups and community-based organizations for individuals and family members facing mental and/or substance use disorders other than suicide?

Yes, the Substance Abuse and Mental Health Services Administration (SAMHSA) operates a free, confidential National Helpline 1-800-662-HELP (4357), also known as the Treatment Referral Routing Service, that is available 24 hours a day, seven days a week and 365 days a year to help with treatment referral and information (in English and Spanish) for individuals and families facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups and community-based organizations. Callers can also order free publications and other information.
Are there other products or services that specialize in linking SDOH patients to needed resources?

Yes, as technology and digital health applications continue to evolve, many organizations are creating social referral platforms to assist providers and patients. Many of these platforms are in early phases of implementation, and range in cost from free services to more comprehensive EHR solutions.

Some of the available linking sources include online platforms and tools that assist in connecting individuals to community resources by leveraging comprehensive data analytics on resource referrals, e-prescriptions, engagement and beyond:

- NowPow
- Purple Binder
- Pieces

Another great free resource is Aunt Bertha, a search engine specializing in locating local resources and services.

Evaluate and refine

Throughout the implementation phase of your SDOH initiative, it is important to refine and enhance your workflows. Discuss with your team and patients to learn what is working and what needs to change. If you discover that your screening method isn’t occurring as consistently as it should, examine the process to see if you can identify a better way to screen more patients. The solution may be as simple as training one extra staff member on administering the questionnaire during rooming.

Celebrate your success

As you continue to refine your workflow, celebrate your successes. Share patient stories and best practices with colleagues across your organization and community. By sharing your stories, you may inspire other practices to implement your model, which will help to scale and sustain the initiative, as well as improve the health outcomes of many more patients across the community.

Conclusion

With a step-wise approach, healthcare professionals and systems can address SDOH in order to improve health outcomes, improve care quality, lower costs and enhance joy at work for health care providers across the organization. As hospitals and clinics expand their role in creating healthy communities, it will be essential to address the SDOH for their patients where they live, work and play.
AMA Pearls

Be thoughtful in determining your target population for intervention.
Trying to address too large of a patient population or including too many SDOH initiatives at one time could dampen the impact of your initiative. Targeted, specific and focused is best.

Take the time to adequately develop and train staff to address SDOH initiatives.
Understanding implicit bias and assumptions is critical to ensuring open and productive communication with patients from all backgrounds.

Build and sustain strong partnerships with external stakeholders.
It is far more important to partner with expert community-based organizations than to build new services that may be redundant and competitive.

STEPS in Practice

Addressing Social Determinants of Health in Richmond, VA: A Case Study

In Greenville, SC, Bon Secours St. Francis Health System is leveraging “mission tours” to shine a light on the needs of the community and how their health system plays an integral role. Bon Secours St. Francis is a faith-based organization committed to serving the urban poor, as well as an extended community of rural poor in the surrounding areas of Greenville. The social safety net in South Carolina is rather thin, and the state did not agree to Medicaid expansion under the Affordable Care Act, resulting in many uninsured and underinsured in the surrounding region. Because Bon Secours St. Francis is a faith-based institution, they turn no one away and in many instances are often the first medical provider that patients may have seen in years. Patients often present with advanced illness despite public messaging regarding the importance of screening and proactive management of complex health problems, resulting in a rather complex patient population that urgently needs care.

Culture and faith play a key role in the attitude towards health care in the region. It is often difficult to discern if these attitudes toward patient's own health care are a direct result of their spiritual beliefs, or a comforting alternative response to a health care system that has in large part neglected them and their needs. Bon Secours St. Francis strives to address these needs by educating their leadership and taking them out of their personal cultural comfort zone. They aim to help leadership understand how their local “consumers” engage the health care system and how the health system makes care available to them. This education happens through a cultural tour of the community offered by the staff in the Bon Secours St. Francis Mission office. These tours are offered to leaders, both administrative and medical, within the system. They are not mandatory and everyone has the opportunity to take advantage of the outing or not. Each tour consists of a guide from the Mission office and three to five system leaders. By keeping the groups as small as possible, one can observe interactions at the community sites without the tour becoming disruptive or the unintended focus of the location’s events.
The first stop on the tour is to the free dental van that parks outside local mercy centers on particular days. The dentist and her staff manage individuals and families, many of whom have long-standing dental issues and no routine dental care. In many cases, the dental issues exacerbate chronic medical conditions which are often already under poor control. By positioning itself in the parking lot of the mercy center, the dental van increases its visibility and accessibility to individuals with otherwise limited transportation options. The mercy center itself is a unique place. It functions as food bank as well as a social and activities center for many of the community's homeless. Bon Secours St. Francis also embeds a social worker in this otherwise independent faith-based organization, which is affiliated with a well-attended contiguous local church.

The next stop is to another church, one that serves nearly 2,500 Latino families. This house of worship serves an immigrant community of limited means and one unlikely to reveal itself to the scrutiny of a formal health care institution given recent trends in immigration policies. Understanding these patients' needs, Bon Secours St. Francis embeds a bilingual nurse and bilingual social worker into space provided by the church, where medical and social services are delivered on site in comforting, non-threatening surroundings.

The final stop of the mission tour is at a center that provides day care and developmental therapies for children with a variety of chronic medical conditions. The center aims at enhancing the quality of the lives of the children and freeing up parents for other responsibilities to work and family. Bon Secours St. Francis has also invested in an activities area for the center in support of its mission.

At the completion of the tour, health system leaders are left with a more intimate understanding of their community, its needs and the role that Bon Secours St. Francis plays in caring for the patients in their community who have limited access to care. In addition to the Mission office, Bon Secours also employs a population health staff and has several employees in various churches, community centers, schools and free medical clinics where social services and primary medical care are provided. Despite these efforts, Bon Secours St. Francis recognizes there still remains much work to be done. There are still areas in which there are no outposts for community management of health. Urban populations are denser, and one can interact with more people in a smaller space with fewer staff than one can in more rural areas. Implementation of programs in rural settings requires a completely different approach, which is not as developed as that for programs targeting the urban underserved. However, Bon Secours St. Francis continues to practice mission and is hopeful about the improvements that can be made in the future for their patient population.

Addressing Social Determinants of Health in Burbank, CA: A Case Study

Situated across the bay from San Francisco in Alameda County is Hayward Wellness Center (HWC), an outpatient clinic that serves a diverse community as a Federally Qualified Health Center (FQHC) within the county health system. The clinic is a vital part of the community, providing health care services to a largely underinsured and low-income population. The health of the community is deeply impacted by a number of social determinants, such as housing, transportation and education. All of these factors play a role in the health status of the clinic's patients, but chief among these health-related social needs (HRSNs) is food insecurity.

HWC began working to train all providers and staff on how to use food as medicine to address chronic medical conditions like hypertension, diabetes and obesity. The clinic developed produce prescriptions, identified community resources, formed partnerships with a local urban farm to develop an on-site “food farmacy,” developed cooking group medical visits and assisted patients in obtaining food stamps. The model relied on clinical judgment to trigger the cascade of interventions to help. Screening for food insecurity at the patient level was inconsistent and sparse, resulting in low numbers of referrals for food resources to community partners.

It was then that HWC decided to partner with HealthBegins to assist in putting together an Upstream Quality Improvement campaign that could improve the efficiency and quality of their clinical-community partnerships and care for their food-insecure patients. HealthBegins helped HWC to align their food insecurity efforts with their health system's specific Medicaid-driven strategic priorities. They then helped HWC to refine their food insecurity screening practices using the Hunger Vital Sign™, revise workflows and define care team roles. Finally, HealthBegins introduced the concept of Community Health Detailing™ to accelerate the clinic's Upstream Quality Improvement campaign and increase the adoption of new HRSN-related behaviors and workflows among
clinicians and care teams. Community Health Detailing™ is adapted from traditional Academic Detailing, in which educators ("detailers") deliver key messages that are tailored to a clinician's learning needs through a series of brief, semi-structured, on-site visits. Unlike traditional detailing methods that rely on professionals with technical healthcare expertise to serve as educators, the educators in the Community Health Detailing™ model are staff from medical and non-medical community-based organizations and/or community residents with lived experience dealing with HRNS.

Once they launched their Community Health Detailing™ Campaign to improve care for food-insecure patients, HWC quickly saw impressive results. In just over three months, HWC screened over 3,800 patients for food insecurity (a 94 percent screening rate.) More than one in five of these patients (21 percent) screened positive for food insecurity using the Hunger Vital Sign™. Not only were patients in need identified, but referrals for community support increased as well. In the year prior, HWC had sent 35 referrals for patients needing food support or resources. After the Community Health Detailing™ Campaign launched, HWC clinicians and care teams generated 550 food resource referrals in over three months, a nearly 16-fold increase.

This early success, accomplished in such a short period of time, has inspired HWC leadership, clinicians and staff to look for other opportunities to better meet the HRSN of their community through Upstream Quality Improvement. HealthBegins actively supports healthcare systems across the country to deploy Upstream Quality Improvement strategies, campaigns and tools to make meaningful, rapid progress to improving care and the social determinants of health.

Addressing Social Determinants of Health in Dallas, TX: A Case Study

Across the Northern Texas communities of South Oak Cliff, Garland, Pleasant Grove and West Dallas, one innovative team is making a difference. With the ever-changing reimbursement landscape, more and more clinics are focusing on serving populations with commercial insurance in order to cover costs and maintain a level of profitability. MD Medical Group, however, has taken the opposite approach and is focusing on serving patient populations that are almost exclusively covered by Medicaid, are uninsured or self-pay. In fact, MD Medical Group’s payor mix is comprised of approximately 70 percent Medicaid and 18 percent uninsured or self-pay patients. Providing care to patients living in these communities can be a daunting venture, but MD Medical Group seems to have cracked the code. In 2007, MD Medical Group received $1.5 million to invest in technology, staffing and infrastructure to provide care for the region's low-income patient population. Thanks to innovative leadership and a sense of mission, they have been able to accomplish a great deal.

This generous infusion of funding led MD Medical Group to begin testing workflows to enhance care coordination and, ultimately, patient health outcomes. Approximately 73 percent of the patients that MD Medical Group serves are children on Medicaid. Because of this robust pediatric population, the clinic decided to focus on initiatives aimed at improving health outcomes for children. After assessing common areas of need across clinics, MD Medical Group decided to focus on addressing pediatric asthma. Many of MD Medical Group’s pediatric patients reside in housing environments with risk factors for allergies and asthma. Living in these environments often results in a higher incidence of asthma, as well as more frequent visits to the emergency department. Further complicating the situation was the fact that the majority of these patients are insured under Medicaid yet less than 40 percent of specialists in Texas accept new Medicaid patients.

All of these factors combined motivated MD Medical Group to take matters into their own hands. They started with assessing their current protocols for treating asthma. This review quickly showed that across physicians, there was an immense amount of variability in treatment protocols. MD Medical Group understood that to be successful they would need to standardize their asthma protocols and treat consistently across their patient population. In addition to standardizing treatment protocols and developing clinical pathways, MD Medical Group also invested in their own technology. The clinic purchased new equipment, such as pulmonary function testing machines and spirometers. They also added an asthma specialist to the care team to conduct one-hour educational sessions for parents and patients. During the session, the asthma specialist would review the child’s chart, tests and living conditions, as well as teach parents how to use an inhaler and proactively recognize and avoid asthma attacks. With “Asthma Champions” stationed at multiple clinic locations, the treatment adherence rate went from 29 percent to 60 percent. Word that MD Medical Group was offering this educational resource quickly spread through the community and other parents began calling to join the sessions as well. Not only did
adherence rates improve, but a local health plan also took notice. Parkland Hospital Health Plan found patient outcomes for MD Medical Group were significantly better than surrounding providers. Parkland tracked 10 patients over a short period of time and found that since the implementation of MD Medical Group’s Asthma Pathway Program, they had realized a cost savings of over $750,000.

No question, MD Medical Group is making a difference in their community. Their innovative approach is not only reducing the cost of care, but also enhancing the quality of life for so many of their patients.

Addressing Social Determinants of Health in the Bronx NY: A Case Study

Ask patients “what matters to you?” to uncover social determinants of health

When patients are engaged with their health care decisions, it can greatly improve the treatment and outcomes of chronic conditions such as type 2 diabetes and hypertension. Through health coaching, a team-based approach, physicians and their teams can help patients become active participants in their care. One health care collaborative has incorporated health coaching that goes beyond just asking “what’s the matter?”

At the Montefiore Hudson Valley Collaborative (MHVC) partner organizations, health coaching means asking, “What matters to you?” MHVC is a network of organizations including hospitals, Federally Qualified Health Centers (FQHCs), primary care providers, skilled nursing facilities, and behavioral health and substance use providers in New York’s Hudson Valley. Together, they work to improve outcomes and reduce costs as part of the NY State Delivery System Reform Incentive Payment Program.

Network partners at MHVC committed to begin asking patients in diverse clinical settings, “What matters to you?” (WMTY) to uncover the social determinants of health and identify priority concerns the patient is dealing with. Engagement requires asking what matters, listening attentively to what the patient says and collaboratively designing care plans that address what is most important to the patient.

The AMA’s STEPS Forward™ collection of practice improvement strategies offers a health coaching module to guide physicians and their teams. Depending on the state, health coaches can include registered nurses, licensed practical nurses, medical assistants (MA), health educators and community health workers.

Damara Gutnick, MD, an internist and medical director at MHVC, first tried WMTY by asking the question to a few of her patients. She was amazed at how shifting the question from “What’s the matter?” to “What matters to you?” opened up the conversation. It also saved her time because she quickly identified the real issues that were most important to her patients.

“It’s changing the dialogue and the feeling in the room [when we] think about what we can do together rather than what barriers are getting in the way,” Dr. Gutnick said.

Uncover the patient’s needs, goals

Asking, “What matters to you?” helps to connect what is really important to the patient, what the bottom line is and what the driver is for them.

“Asking this question opens up the discussion about what is important to the patient, it allows you to meet them where they’re at and incorporate what really matters to them into their care plan,” Dr. Gutnick said.

For example, a patient with poorly controlled diabetes and high blood pressure who is also at risk of losing their housing may not be particularly worried about taking their insulin—they’re thinking about where they’re going to sleep that night. A “patient-centric” care plan might then include linking the patient to a community-based organization that can help them address their housing needs. Managing the diabetes is of course important, but the priority is addressing what matters to them first.

“You have to recognize that the goal [the patient] might want to set may not be directly related to their medical condition, and look a little bit further at the connections that can be made to other resources to address what is really important to them,” Dr. Gutnick said.
The question goes beyond just asking—it's listening to what patients say and applying it to their care plan.

“If you see a patient in the emergency room and give them seven referrals, chances are they won't follow up with any, but if you give them one that is important to them—and the reason why they came to the emergency room in the first place—you're probably more likely to have them follow up,” she said. “Really think about what it means from the patient's perspective to manage all this work, to manage these referrals and manage their personal life, as well as their health.”

Engage the team, improve workflow

Addressing the patient’s concerns begins with team-based care. Implementing health coaching that puts WMTY into practice begins with a passionate person who is ready to perform.

“What is really amazing about this question is you don't need a lot of training to implement it—anybody can ask the question,” Dr. Gutnick said. “It can be the patient care person, the doctor, the care manager or even someone on the phone for pre-visit planning.”

Implementing WMTY does not require significant resources. It may, however, require workflow changes.

For example, a hospital will first engage its staff to see it finds the WMTY approach meaningful and worthwhile. Once the team is on board, it's important to find an appropriate place within the workflow. If the goal is to ask every patient at admission, designate a person to ask the question, distribute the sheets, etc. Whether it's a nurse, an MA or even a physician, ensuring at least one person asks and shares the information learned is important.

“What people have been telling me is once they’ve started and they see the impact, it's easier to get other colleagues and staff on board—the leadership of organizations we are working with have shared that it's easy to spread the WMTY campaign because staff immediately feel the difference in the dynamics of the conversation when they address “what really matters” to their patients. It brings joy back into work because this is why many of us went into healthcare in the first place,” said Dr. Gutnick.

Physicians and their teams can visit the STEPS Forward module to learn more about health coaching and what it takes to recruit, train and mentor coaches.

Several modules have been developed from the generous grant funding of the federal Transforming Clinical Practices Initiative (TCPI), an effort designed to help clinicians achieve large-scale health transformation through TCPI’s Practice Transformation Networks. The AMA, in collaboration with TCPI, is providing technical assistance and peer-level support to enrolled practices by way of STEPS Forward resources. The AMA is also engaging the national physician community in health care transformation through network projects, change packages, success stories and training modules.

Learning Objectives:
At the end of this activity, you will be able to:
1. Define social determinants of health and how they can impact an individual's health
2. Identify how best to understand the health needs of your community and ways to engage community members to improve their overall health
3. Describe how your practice can select and define a plan to begin addressing social determinants of health
4. Explain the different tools available to screen patients and how your practice can link patients to these resources

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