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NEO QI Hub
NORTHEAST OHIO QUALITY IMPROVEMENT HUB

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AHEAD Podcast 9 – The Opportunity for Primary Care to Identify and Address Social Drivers of Health

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to the AHEAD Initiative podcast series focused on sharing evidence-based practical strategies to improve diabetes outcomes and advance diabetes health equity. I'm Dr. Michael Konstan from Case Western Reserve University School of Medicine and I serve as the principal investigator for the Northeast Ohio Quality Improvement Hub, a collaboration of Western Reserve University with Northeast Ohio Medical University. The Northeast Ohio QI Hub is funded by the Ohio Department of Medicaid and provides quality improvement infrastructure for primary care clinics in our region. We hope you enjoy today's ahead initiative podcast.

Anne Gaglioti: Welcome to our Achieving Health Equity and Diabetes or AHEAD podcast series for the Northeast Ohio Quality Improvement Hub. My name is Dr. Anne Gaglioti and I am the co-lead of the equity and engagement team for the Northeast Ohio QI Hub. I'm a practicing primary care physician and health equity researcher and I serve as an associate professor of family medicine at Case Western Reserve University and the Metro Health System. I'm delighted to talk with Dr. Chris Mundorf and Dr. Bode Adebambo today about a topic we are all deeply invested in, the social drivers of health. Chris Mundorf is the chief strategy officer at Better Health Partnership, a health improvement collaborative in Northeast Ohio focused on advancing health equity and practice transformation across the region. Dr. Bode Adebambo also co-leads the equity and engagement team and serves as an associate professor of family medicine at Case Western Reserve University and the MetroHealth System. She is an expert in health disparities and a practicing family physician. Thanks so much for talking with me today, Chris and Bode. I'm excited to get started.

Bode Adebambo: I'm excited to be here with you both.

Chris Mundorf: Likewise. I think it's going to be a great conversation.

Anne: First off, Chris, can you talk about what the social drivers of health are and some of the terminology associated with this work that primary care clinicians listening today might come across?

Chris: Social drivers of health are the contextual conditions where people and family live, work, play, and worship. Some examples are our ability to access healthy food, have healthy relationships and be safe. These factors account for 80% of our health and well-being, while

access to high quality health care only accounts for about 20% of our health for most people. You hear many terms used when talking about social drivers of health. Some terms you might hear used are health related social needs, social drivers of health, social determinants of health, and social risks. Often these terms are used interchangeably with overlap. For example, social determinants of health addresses the upstream underlying social and economic conditions such as economic stability while health related social needs are the immediate needs of the individual such as food and transport. At Better Health Partnership we have chosen the term social drivers of health because well we feel this language emphasizes that these are modifiable factors.

Anne: Thanks so much Chris. Bode, can you talk a bit about why social drivers of health are important for our AHEAD collaborative in our efforts to eliminate diabetes disparities in Northeast Ohio?

Bode: Absolutely. Exposure to social risk disproportionately affects minoritized groups, people living in rural and remote areas and contributes to health disparities in diabetes. The reason there is unjust exposure to social risk for these groups is related to the structural drivers of health or the historical systemic imbalance in power that one group has over another.

Anne: So, Bode, what is the impact of social drivers of health on the health of individuals and the community?

Bode: Social drivers impact multiple areas that are often classified into specific domains. Healthy People 2030, the United States Department of Health and Human Services initiative for health promotion and disease prevention describes five domains. The first one, economic stability: steady employment promotes economic stability and decreases poverty. Investing in resources such as job programs and child care can improve the likelihood of steady employment and increase economic stability. The next domain they talk about is education access and quality. Literature shows that people with higher education are more likely to live longer and healthier. Unfortunately, there are some groups of people that live in areas with poorly performing schools, poor access to early childhood education, and continue to have barriers to a college education. The third domain, healthcare access and quality. All people should have access to quality health care to achieve their full potential for health. This may mean increasing insurance coverage and access to screening and preventive care such as occurred with Medicaid expansion. The fourth domain, neighborhood and built environment. Safe housing and communities with access to parks promote physical activity and have been shown to decrease violence. The fifth domain, social and community context, encourages relationships, connections, and community support, which has a positive impact on health and well-being. These domains are related to and impact one another. By working to provide resources in each domain it can improve the overall health of the people in the community.

Anne: Thanks for describing that Bode. Do other categories of social drivers of health exist and how do social drivers of health relate to patients and patient care?

Bode: Other categories that are sometimes mentioned are transportation, civic participation, stress, discrimination, violence, language and literacy skills. The categories can comprise

economic and social circumstances that impact the health outcomes of an individual. An individual that doesn't have these resources in their community is at a disadvantage and has poorer health outcomes and a lower life expectancy.

For example, we can think about the case of a theoretical patient, John. John is a 50-year-old man who completed high school and got a job working in construction. He was recently diagnosed with diabetes and treated with metformin and oral medication. His blood sugars improved in the first month but have been persistently elevated in the second and third month without a medical reason. He doesn't smoke, drink alcohol, or use other substances. Further interviewing revealed that he lost his job of 10 years 5 weeks ago, so he lost his health insurance. With his bills piling up, including the inability to pay his rent, he takes his medication intermittently to make the pills last longer. He also cannot complete the preventive test ordered by his doctor due to the cost. He has no symptoms related to diabetes and his wife and children are emotionally supporting him through this. His initial assessment is a 50-year-old man without significant past medical history with a diagnosis of uncontrolled diabetes. So, Anne, when you take a holistic view of the patient what social drivers or risks might you consider?

Anne: Well, listening to that case, some of the social drivers that I might think about would be economic stability, healthcare access, and health literacy. Without employment, he has limited access to healthcare coverage, which will make it difficult for him to receive his medications or attend his visits. And he has a high school education without college, and so that may limit his opportunities to secure another position. If we were ordered to revise the assessment, we might say that John is a 50-year-old man without significant past medical history with uncontrolled diabetes due to financial insecurity and possible housing insecurity. Short-term, we might consider screening for social needs. Think about cost appropriate medications and tests if the patient is willing to do that. Think about consulting social work or financial services. In the longer term, we might consider a referral for housing assistance or connecting him to a workforce training program. This assessment that incorporates the health-related social needs gives you a more patient centered holistic view of the person's circumstances. Bode, can you talk a little bit about how social needs that impact health get identified in a healthcare setting?

Bode: Social needs can be identified in various ways and by different members of the healthcare team depending on how it's set up in your office. A commonly used method of screening is screening everyone or a subset of patients for social needs. And this can happen in settings such as the office of a healthcare provider via electronic platforms such as MyChart, outreach by health insurance companies, by institutions or offices to specific at-risk populations. The best method for screening is yet to be determined and the method utilized will depend on the resources and processes in the individual office or healthcare facility. Ideally, all individuals should be screened. However, the best intervals for screenings is unclear. Social needs can also be identified during an office encounter when the usual response to treatment is not occurring. So, a red flag could be raised like the example above. Other red flags could include missed appointments, unexplained symptoms such as unexplained weight loss, gaps in the patient's medical history or if the patient expresses any concerns.

Anne: Thanks Bode for that overview of the clinical aspects. Chris, when we talk about screening for social risks in a clinical setting, what screening tools are useful and how are these usually implemented in practice?

Chris: Thanks, Anne. Well there are several social risk screening tools that are available. Sometimes the tool is designated by the health system or is built into the electronic health record. The National Association of Community Health Centers has developed the PREPARE tool, which stands for Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. One of the health systems in the collaborative uses a screening tool that aligns with the requirements from the Centers for Medicare and Medicaid Services or CMS based on the accountable health communities' health related social needs screening tool and includes several domains including food security, transportation needs, interpersonal safety, housing instability, utility difficulties, digital connectivity, financial strain, physical activity, stress, social connectedness, housing problems, education, and employment. This screening tool can be accessed in the AHEAD diabetes QI clinical toolkit found at neoqihub.org.

Anne: I'm always struck by how those screening domains are really incredibly comprehensive and connecting people to care for all of those social needs requires a really robust network of community resources. So, Bode, when a patient has a positive screen for a social need what are some ways that that social need can be addressed?

Bode: Well Anne, how people are connected to care for social needs varies across practices, health systems and communities, but it's important to know that identifying a social need for a patient can absolutely influence developing a tailored care plan for patients at the primary care clinician or primary care team level. For example, if a patient screens positive for financial strain, this might prompt a conversation between the patient and their primary care clinician about the affordability of their medications. They might then decide to implement a care plan that includes switching medication to combine medications to reduce co-pays or selecting a generic alternative if a patient is on a branded medication.

Anne: That's a really great point, Bode. Sometimes if someone has a positive screen for a social need, that information can be helpful to the care team beyond the act of connecting someone to social care. Besides using the screening tool to develop a personalized care plan for a patient, how else are primary care practices connecting people to social care? Chris?

Chris: Well, in our work at Better Health Partnership around screening and referral for social needs, we have talked with the health systems in Northeast Ohio to understand their practices around this. This was part of our work on the CMS funded accountable health communities project. One pathway to connect people to social care is through United Way 211. When a patient has a positive screen, they are connected to a care navigator through the United Way. The navigator speaks to the patient about their needs and provides referrals and offer support with navigating the process of connecting with different organizations. Another way patients are connected to care is through the electronic platform called Unite Us. This platform is the digital solution that automates referrals for positive social needs screening and connects people to care through a network of community-based organizations that acknowledge and resolve the

referrals through the same platform. One feature of the Unite Us platform is that it allows the health system to track whether or not the referral was closed or resolved by the community-based organization. Although it is important to know that this approach does not have a person helping the patient navigate referrals and a resolved referral can mean different things. For example, a resolved referral might mean that the patient declined help from the organization, that the patient received services, or that a patient was unreachable after several contact attempts.

Anne: Based on what's been shared today, I think it's safe to say that the process of screening and referral is complex. Chris, what are some of the common barriers to connecting people to care for social needs?

Chris: Good question. Well, various institutions have performed assessments to barriers connecting people to care. For example, the Institute for Hope at Metro Health have been very successful screening patients through the patient portal of their electronic health record. They've screened over 42,000 people in the last year. However, they also ask a question on their screening tool that asks people if they are interested in receiving assistance or a referral to connect them to social care. And a vast majority of those that screen positive for social needs decline referrals. They have done some inquiry with patients as to why this is through a follow-up question. And the most common response is that the patient doesn't believe that the help will be effective. Another barrier is infrastructure or availability of services to meet needs. For example, many people struggle with unstable housing in our community. But there is very little affordable housing available for people regardless of the acuity of the need. So that capacity issue comes up. There are many barriers we can talk about, but the last one I'll mention is that navigating and coordinating the referral process can be intense and difficult for patients who are often dealing with multiple social risks. This is one place we've seen the effectiveness of navigation.

Anne: Thanks for fleshing out some of those complexities. Chris, Bode, how is health related social need screening information used by a practice or a health system?

Bode: Something to think about is that during a patient visit, the provider synthesizes information to come up with a medical differential diagnosis and treatment plan. And it's important to integrate both the social and the medical to obtain a holistic and patient centered view of the patient's health. Once the social needs are identified, the diagnostic codes called Z-codes can be entered alongside the medical diagnostic codes, added to the problem list and an assessment and plan outline that includes their health related social needs. It is likely that this Z-code may also be used in the future by CMS for risk adjustment for health systems that serve socially complex populations. In addition to capturing the social complexity of the patient served by the practice, it allows a holistic view of a person's well-being.

Anne: Thanks, Bode. Chris, when you think about best or promising practices to link individuals to social care, what comes to mind and how do these models work?

Chris: I think the most promising models that have shown impact on health outcomes and the potential for closing gaps in persistent health disparities like those we see among people with diabetes in Northeast Ohio are those models that incorporate a relationship. Laura Gottlieb, a national expert in this arena at the UCSF SIREN or Social Interventions Research and Evaluation Network and her colleagues recently came out with an important article that proposes a new causal or mental model for understanding the mechanisms that underlie the effectiveness of screening and referral for social needs. These pathways go beyond simply identifying need, making referral, resolving a need, and improving help. They include connecting people with social services, but also with the person who is helping them navigate these services. Someone like a community health worker or care navigator who is a source of healing relationship for the person. We also know that this process of screening and referral for social needs can be a pathway to other needed health care services and more tailored care by a patient's health care team to mitigate the challenges that they may be facing.

Anne: Those are such important points, Chris. I really loved that article by Gottlieb that came out in the Milbank Quarterly in January and how it highlighted the importance of relational knowledge and whole person care to connect people to what they need when they need it. I think those concepts are really key to advancing equity. As we mentioned at the beginning of our conversation, social context is the driving force behind 80% of our health. And as a primary care physician, I want to be able to hold space and care for a patient's whole self. And social risk or social needs screening and referral is an important way to understand people in the context of their communities, their family systems and in the context of their structural and social drivers. Thank you both so much for this conversation about screening and referral for social needs and for your dedication to working in this space.

Bode: Thank you both. It's been a great conversation.

Chris: Yes, it has been great to be here with both of you to talk about this important topic.

Anne: And thank you again for listening to the AHEAD podcast. As always, please find more resources on NEOQIHub.org. That's neoqihub.org or subscribe on your favorite podcast platform so you never miss an episode.

[Voiceover] Michael: This concludes today's AHEAD Initiative podcast. To learn more about the Northeast Ohio QI Hub, visit NEOQIHub.org. The Northeast Ohio QI hub is part of the regional quality improvement hub project funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. Views stated in this podcast are those of the presenters only and are not to be attributed to the Ohio Department of Medicaid or to the federal Medicaid program.

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