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Identifying and Addressing Social Determinants of Health in a Primary Care Setting - Transcript from Live Session

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Laurie: Good afternoon everybody and thanks for joining us today for the Identifying and Addressing Social Determinants of Health in a Primary Care Setting webinar. I will now hand things over to today's presenter, Dr. Judith Singletary.

Judith: Good afternoon, my name is Judy and I'd like to welcome you to Identifying and Addressing Social Determinants of Health in a Primary Care Setting. The purpose of this webinar is increase awareness among primary care providers of the social determinants of health. Identifying and addressing social determinants of health contributes to improving health and health care for underserved individuals, communities, and population. We'll begin today's presentation with a brief review of the webinar's objective. Next, key terms will be defined such as health disparity, health equality, health equity, and social determinants of health. After those terms are defined, we'll briefly explore the current landscape of social determinants of health. As a part of that landscape, we'll review healthy people 2020 and its overarching goals relative to social determinants of health.

A few years ago, the Institute of Medicine, IOM, convened a committee to identify a core set of domains and metrics for social determinants of health. We'll review these measures and briefly discuss the benefits and implementation challenges of data collection. Next we'll take a look at a checklist for assessing social determinants of health in the primary care setting, and we'll explore some of the challenges of implementing those measures as a way to give voice to potential road blocks in the adoption phase. And finally resources will be provided so that you can take a deeper dive into issues related to social determinants of health after this presentation.

What can you expect to learn today? Well, at the end of this webinar, participants will be able to define the social determinants of health, differentiate the terms health equity, health equality, health disparity, and social determinants of health, identify concerns and challenges of social determinants of health. And discuss the collections of relevant data and measures in the primary medical care setting. Let's start by defining some terms. Once we hear a lot but may not be exactly clear on the meaning starting with health disparity. Health disparity is defined as the difference in health outcomes between groups within a population. These differences may be based on a number of factors including race and ethnicity. In general, ethnic minorities share a

disproportionate burden of disease and higher mortality rate when compared to life. Geographic location has revealed differences among rural and urban communities especially related to transportation to access care.

Difference is based on a socio economic status. Higher income patients are more likely to have health insurance, higher levels of education, and better health outcomes as compared to patients with low income. Gender, disparities in cardiovascular disease outcomes have been observed in women. Differences with respect to age because both the young and older populations are vulnerable groups. And social sexual orientation which has been linked to disparate outcomes in human papilloma vaccination, for example. However, the concept of health disparity may be best illuminated in the stories of workers in meat and poultry processing plants where the jobs are among the most dangerous in the United States, and where injury and death rates are several times higher than in other occupations. These are jobs that only the poor will take and increasingly are jobs filled by undocumented immigrants many of whom barely speak English.

One worker interviewed by the non-profit group, Human Rights Watch, said, "The meat processing line is so fast, there's no time to sharpen knives. The knives get dull and you have to cut harder, that's when it really starts to hurt and that's when you cut yourself. I cut my hand at the end of my shift around 8:30 at night. I went to the clinic the next day the 11:00 a.m. They gave me stitches and told me to come back at 2:30 before the start of my shift check. They told me to go back to work at 3:00, I never stopped working." Another man with fingers swollen said, "I hung the live birds on the line, grab, reach, lift, jerk without stopping for hours every day. Only young strong guys can do it, but after a time you see what happens. Your arms stick out and your hands are frozen. Look at me, I'm 22 years old and I feel like an old man."

A woman said, "I pull ribs with my fingers on the packing line. My fingers and nails are in constant pain because the company won't give us hooks to pull the ribs and they won't let us bring our own. We need hooks to pull the meat more easily and to avoid injury but they say that meat gets lost using hooks, and using fingers to pull them more, so, no hooks." Complaints from workers about conditions at processing plants are few because those who complain are usually fired or risk deportation. Although the conditions faced by meat and poultry workers are extreme, they illustrate how social class and ethnicity can leave individuals vulnerable to illness, injury, and even death.

This brings us to a discussion about the term health equality and health equity. These terms are often interchanged but it's important to understand that they do not have the same meaning. In fact, understanding how these terms are different is important to ensuring that patient needs are adequately assessed and met. Health equality involves treating everyone the same. It's true that equality aims to promote fairness but it can only work if everyone starts from the same place and needs the same help. In the image on the left, each person has the same support but as you can see because the heights of the crates are the same, there's not equal access to the fruit. Health equity on the other hand means that everyone has a fair and just opportunity to be as healthy as possible.

This requires removing obstacles to health such as poverty and discrimination. There are consequences which include powerlessness and lack of access to good jobs with fair pay, quality education and housing, space environment, and health care. In the image on the right, individuals are given different supports depicted in the graphic in the height of the crate. In that way, each has equal access to the fruit. Finally, let's turn attention to defining our topic, Social Determinants of Health. What are they and why are they so important? The World Health Organization defines social determinants of health as, “The conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels.”

Today, the need and value in addressing patients' social and environmental determinants of health is increasingly being recognized and integrated into the U.S. health care system. Just as providers routinely connect medically complex patients to medical experts, providers can also connect patients and families with social complexity to networks that can provide tools that will positively impact health outcomes. Because factors in our social environment are recognized as being so critical to determining health status and outcomes, it's important to understand the current landscape and thinking around social determinants of health. First, research shows that medical care alone is an insufficient determinant of health outcomes. In fact, medical care is estimated to contribute to only 10 to 20% of health outcomes. While the other 80 to 90% are accounted for by social determinants of health, and despite significant spending on health care, our health outcomes in the U.S. are among the lowest for developed countries.

Secondly, social determinants of health are influenced by both policies and programs and are associated with better health outcomes. Thirdly, new payment models are prompting interest in these determinants. Moreover, frameworks for integrating social determinants of health into clinical practice are emerging. And experiments and innovation are occurring right now at the local and federal level. Several new patient modes and innovative frameworks have been proposed including ones that capture social determinants of health, domains and the electronic health record or EHR which aligns with IOM recommendation. These innovations and efforts involve capturing patient information concerning such issues as transportation, food and housing, all of which have been found the key social determinants of health.

Here are some recent examples from the field of efforts to address social determinants of health through primary care. One staff at a behavioral health program in Camden, New Jersey realized chronic hunger with feeling the hyperactivity they witnessed on their young patients every day, they found ways to add breakfast and lunch to the schedule. Leaders at the city's health care network behind the program also discovered that these children were going home to empty pantries. So they partnered with the local food bank to create supper snack packs the kids could take home after school. The investment quickly led to better outcomes in the program and studies suggest the addition of healthy food is awfully likely to help these youngsters avoid obesity and chronic medical conditions down the road.

Nationally, we know that women in rural areas are less likely to breastfeed than those in urban areas. In rural underserved communities in the Arkansas Delta region, women face multiple societal barriers that hinder their ability to access breastfeeding support services. However, these barriers are being addressed through strategic partnerships with community groups, the health care community, and government by leveraging both internal and external resources to bring peer counselors to new moms in the Arkansas Delta region both at home and in the primary care setting. Another example involves health literacy, which we know to be a predictor of health status. In Michigan, the Kent County Health Department collaborated with public health graduate students from a local university to develop a multifaceted project that involves both the assessment of health literacy in the community and the creation of a provider toolkit.

The assessment is comprised of demographic questions, self-report questions, and skill-based items. The toolkit's focus is to address the most prevalent health literacy issues and their community, and to offer tips, tools, and resources for providers. Area clinics and community programs assist with the data collection efforts. Lastly in the St. Louis metropolitan area, despite the efforts of local public health agencies, health care providers, community based organizations, and many other partners and stakeholders, rates of chlamydia, gonorrhea, and syphilis are on the rise. In this community, people living in urban areas those under age 30 and African-Americans are at greatest risk for contracting STD. The county public health department went to work to help providers increase the percentage of cases that report race and ethnicity.

It also worked with providers to track other social determinants of health indicators such as access to care and socioeconomic status. They found that due to lack of health insurance coverage and lack of transportation, St. Louis residents often think STD services do walking clinics and hospital emergency departments. The city shored up its efforts to address the problem by embedding disease intervention specialists in clinics rather than in public health offices, and used patient navigators for sexual health services and to connect patients to insurance and other support services. These are just a few new and innovative examples of how stakeholders and local communities are working together to address social determinants of health.

HHS's Healthy People 2020 contains some overarching goals that address factors that contribute to our collective health and illness by calling for healthy places and support of public policies. Importantly, it places emphasis on the determinant of health. This blueprint also reflects the secretary's advisory committee on national health promotion and disease prevention recommendation by redirecting the attention from health care to health determinant. And by making determinants the primary focus of healthy people 2020 and health care a secondary focus. Similarly, in 2014, the IOM issued two reports based on a study who's findings reported this premise. That health care providers and health systems could more effectively influence patient and population health if they collect information on social and behavioral determinants.

They issued a second report entitled Capturing Social and Behavioral Domains and Measures in Electronic Health Record. This report identified domains and measures that captures the social determinants of health as a way to inform the development of recommendations for the meaningful use of the EHR. It pinpoints 12 measures and

considers the implications of incorporating them all into EHR. The authors of the report wrote, "Determinants of health have traditionally been the concern of public health, and have not been linked closely to clinical practice. However, if standardized social and behavioral data can be incorporated into patient electronic health records, those data can provide crucial information about factors that influence health and the effectiveness of treatment. Such information is useful for diagnoses, treatment choices, policy, health care system design, and innovations to improve health outcome and reduce health care costs.

Let's take a look at the 12 measures identified in the IOM report for incorporation in EHR. Note, that domains or measures are listed in alphabetical order. Those in the shaded area are once frequently collected in clinical settings while the domains are measures not in the shaded area are additional items not routinely collected in those settings. We'll briefly review each measure and the recommendations on how frequently the information about that measure should be collected starting with alcohol use. The report recommends that alcohol use should be assessed and followed up on appropriately at the initial encounter. Race and ethnicity also should be assessed at the initial encounter while it's recommended that a patient's residential address be verified at each encounter.

Tobacco use should be assessed and followed up on appropriately at the initial encounter, however, since it's tracked median income typically used as a proxy for socioeconomic status should be updated with any change of address. Depression should be assessed and followed up on appropriately at the initial encounter as should education and financial resource strain as well. Intimate partner violence should be assessed and followed up on at the initial encounter, and physical activity should also be assessed and followed up on at the first encounter as well. Lastly, the IOM report recommends that social connection and social isolation be screened for and followed up on at the initial encounter along with stress. So you can see from this listing that while only four measures are frequently collected in clinical settings, it's recommended that double that amount be collected in order for providers to get a clear picture of how social determinants of health are truly impacting their patient's health and wellbeing.

Some of the potential benefits of including social determinants of health measures in the EHR include more effective treatment as a result of documenting and observing trends and outcomes. More effective population management comes from aggregating patient data across multiple health information technology resources, and compiling the analysis of that data into a single actionable patient record. All of which enable care providers to improve both clinical and financial outcomes. An important benefit to including the recommended measures in the EHR include the potential for discovering trends through data aggregation and analysis which can inform treatment strategies and reveal opportunity to customize health care.

Of course, all of this is especially useful in safety net setting or practices with high risk patients. We're aggregating data but also greatly facilitate the ability to make referrals to community resources. Now the additions of social and behavioral measures to the EHR certainly have some challenges and implications for workflow and technological and financial resources. Some implementation challenges may include the fact that

many of the measures are subjective because they are self-reported which can potentially impact data accuracy, consistency, and missing data points. This also can be exacerbated by language limitation and literacy. Also additional levels of security may be required to protect patients' data. Ranking data could be another issue and might depend on the ability of your organization's data system to actually talk to one another.

An important consideration to keep in mind is the impact of such moves on resources. While the impact of additional resources on primary practices has not yet been truly quantified, it can be speculated that there could be additional staff required for additional workload on current staff along with resources needed for EHR build out to be able to capture social determinants of health measures. There may be staff needed for data collection and analysis and possibly for enhanced patient education as well. All of which should be considered beforehand in order to achieve the full benefits of implementation.

How do you know if you're ready to adopt social determinants of health assessments? Well, you can begin by asking three important questions, first, what is needed? Here you'd want to explore which tool best aligns with your organization's capacity to capture and address social determinants of health information. How will the data be recorded? Through EHR, Shared Care Plan, or maybe paper and pencil. What will be used to track referrals to community resources? And what relationships need to be established between providers and those community resources? Secondly, who will capture patient's social determinant of health data? In this case you'll want to consider which care team members will be responsible for administering the tool or will you do it electronically?

What training is necessary for administering the tool and collecting the data? How will care team members be made aware of available community resources? And how will they make connections to the organization? Lastly, how will patient social determinants of health data be used? Questions to explore include how the information will inform clinical practice and connections to meet social needs? How will organizations identify the types of information that will be shared between providers and community based organizations? How will the care providers handle obtaining patient consent? Transforming health care in the United States is an ongoing process. Health outcomes are not solely dependent on medical intervention, so we need to work together to understand the interaction between the social determinants of health and evidence-based medical interventions.

This important concept can inform the implementation of customized supportive measures which can lead to an equitable experience for vulnerable populations and patients. Albeit, the process is laden with unanswered questions relative to human intangible resources needed for integrating these new approaches into our delivery of health care. However, given the current landscape of identifying and addressing the social determinants of health, great strides have been taken to create easily adaptable tools such as the IOMs, social determinants of health measures. We can certainly learn from the early innovative experiences within the primary health care community. Finally, to continue the conversation about social determinants of health in your institution, you might start by revealing the assessment questions with your staff.

Now let's explore a few resources that may also help with this effort. It may be helpful to review this report. The Secretary's Advisory Committee on Health Promotion and Disease Prevention objectives for healthy people 2020. An opportunity to address the social determinants of health in the United States, which can be found on the healthypeople.gov website, or this paper by the World Health Organization's Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. This resource is also available online. You may want to look over the Office of Minority Health's report entitled, "National Partnership For Action, HHS Plan To Reduce Racial and Ethnic Disparity and The National Stakeholder Strategy For Achieving Health Equity," it can be accessed on the Office of Minority Health website.

Lastly, another great resource is the Surgeon General's *National Prevention and Health Promotion Strategy*. The National Prevention Strategy, America's Plan for Better Health and Wellness also found online. That brings us to the end of today's webinar. I'd like to thank you for participating in this presentation hosted by Quality Insights. If you have any questions or would like additional information on this topic, feel free to email or contact Quality Insights directly. A copy of the slide deck will be emailed to all participants today following the webinar. Thank you.

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