Quality Insights
Quality Payment Program Support Center

Understanding Social Determinants of Health from a Health Equity Perspective: Transcript from Live Session

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Laurie Fink: Good afternoon, everyone, and welcome to today's webinar: Understanding Social Determinants of Health from a Health Equity Perspective. My name is Laurie Fink and I am a Communications Specialist with Quality Insights and I'll be serving as the host for today's session.

Laurie Fink: Before we get things started, I would like to remind everyone that you entered today's webinar in a listen-only mode. The phone lines will remain muted throughout the session, but if you have any questions for our speaker, please submit them using the chat or the Q&A features on the right of your screen. We will not be hosting a formal Q&A at the end of the presentation, so if you do have any questions, please send them our way and we will get back to you with answers via email.

Laurie Fink: So now, without further ado, I will hand things over to today's speaker, Jean Drummond, who is the President of Healthcare Dynamics International. Jean?

Jean Drummond: Yes, very well. Thank you so very much. I appreciate the opportunity. First of all, I'd just like to thank Dr. Berg and certainly Mrs. Cochran for their visionary leadership and understanding the importance of such a critical topic. As I look at a recent *Harvard Gazette* article stating in 2016, the United States spent nearly twice as much in healthcare as any other high income country, yet we have poor population health outcomes.

Jean Drummond: I think this is a very fitting statement to just kind of open up our presentation here that was in the Harvard Gazette in March of this year, at a time when certainly, when our health care expenditures exceed over 17% of our gross domestic product, that we talk about understanding the social determinants, particularly from a health equity perspective.

Jean Drummond: So if we can go to the next slide, there. Certainly, I am Jean Drummond. I am delighted to be with Healthcare Dynamics International. We are a cavalry of clinicians, analysts, studying really healthcare policy and driving healthcare policy strategies at the practice level, on the ground level with clinicians that are serving vulnerable populations. That is truly our passion.

Jean Drummond: But I want to really just jump right on in to our presentation here today, and just kind of give a highlight of, what are the social determinants? So we speak of social determinants, particularly of health. Social determinants of health are literally conditions where individuals were born, where we grow, live, work, play, where we age. And actually, I added in "play" there, because that is a very important part. Where we walk, where we may go to the movies, where we entertain, and where we purchase things.

Jean Drummond: It's very important and these, the social determinants of health are really responsible for many of the health inequalities. When we think about the push for patient and family engagement, and engaging our patients more and decision making, it's these social factors that often impact a patient's ability to either self-manage or drive or support their shared decision.

Jean Drummond: So clearly, when we think about the Harvard Business Review has talked shares that health disparity is estimated to be over 35 billion in excess. It's 10 billion in illness-related loss productivity, and then another 2200 billion in premature health.

Jean Drummond: So I intentionally lay the economic, the business case before you because it's very important that we understand the ... and we look at the social determinant data so that we can support some of the root causes that are really affecting population health.

Jean Drummond: So if you could go to the next slide for me. So in terms of our learning objectives, it our hope that at the end of this session, that you are able to identify some of the different social determinants, look at how these inequities impact these social determinants, form a working knowledge of health equity, and understand some of the resources that may be available, and to identify how you can take this very important information and make an impact on your community.

Jean Drummond: I also would like to share a very important resource. It's a historical resource, but very important. It was called, "Crossing the Quality Chasm Report." It was a report from the Institute of Medicine that identified equitable care as one of the six core aims in high value healthcare systems. Again, that's "Crossing the Quality Chasm." It's a dated document, but very, very applicable to our work at this time as we move forward to our value-based reimbursement system.

Jean Drummond: So if you would kindly go to the next slide there for me. So we think about the social determinants of where we look, we look at the childhood experiences. Where are the children playing? Is it a safe area, the neighborhood? We know that poor neighborhoods lead to poor schools, and so that's very important. When we look at particularly the research and know that the family income there in West Virginia is the third lowest in the nation, at $41,253.With minimum wage at $8.75, it would require a family to work 53 hours in order to afford a one-bedroom home.

Jean Drummond: Education. When we look at Delaware, 30% of their population has graduated with bachelor's degrees. In West Virginia, it's 18%. This is very important, and we know that there is a direct correlation. Research shows Americans with more education live longer, have healthier lives than those with less schooling. These links are very complex, but it's linked to better jobs, higher salaries, and just more resources to ensure that you are eating healthier foods or able to access your medication.

Jean Drummond: Your social support. We know that isolation is now linked to cardiovascular health. Your employment, the ability to have more jobs, your community, and also we know access to healthcare in rural and low-income areas, there's also typically less access to healthcare professionals.

Jean Drummond: So when we look at this, we see these are many of the social norms - the culture, the social practices, the economic policies - that are really driving many of these social determinants. So we kind of oftentimes refer to the social determinants as the cause of the cause, because of its upstream and certainly downstream impact.

Jean Drummond: So if we can move forward to the next slide here, and I appreciate certainly the clinicians that are on the line from the different states that Quality Insights certainly serves, and understanding as we're all moving towards the quality payment program and understanding the many challenges that we have around driving quality, it's important that we understand the population that we're serving, and are able to not only collect first the social determinants, but then also to drive the social determinants.

Jean Drummond: I've had opportunities of being with clinicians in their practices, and they say to me, "Jean, the challenge for me is that I have a diabetic and I've given her prescriptions. I've recommended certain diets." But I may not know that she just lost her job, or that she may not have access to food, or that her daughter is in a domestic violence circumstance and now she has had to move in, and my Medicare beneficiary who's on a limited income is now having to share her meager food substance for now three other individuals that are moving in her family.

Jean Drummond: So as we look at these different things, that it's very important to address these social factors because they do impact clinical outcomes. And also, as we understand what their social determinants are, we can help to integrate that into their care coordination plan. We understand they live in a food desert. We will be able to understand they may not have access to all the healthy foods, or whatever culture they may be, how they cook in their home.

Jean Drummond: It helps us to adopt population-specific needs. If we know that 20% of your practice is suffering from food insecurity, maybe there's an opportunity to identify food banks in that community and provide a flyer on the front desk that the medical assistant, not necessarily the physician as we work the top of our license, can provide that to the patient.

Jean Drummond: Also, another quality improvement strategy that began back in 2017 at a Massachusetts hospital was called the collection of REAL data. And "REAL" is an acronym that starts for race, ethnicity, and language data. In 2009, the Institute of Medicine declared that this should be a best practice that should be done throughout all hospitals and healthcare systems, so that it can help you better to risk stratify, which again, is very important when we think about success in the MITS or the APM program.

Jean Drummond: It helps to close some of the gaps, promote health promotion. We know that we want to decrease smoking. Higher smoking is correlated with lower education. That's very important, as well as the management of chronic diseases. We talked about diabetes and particularly, I know according to West Virginia Health Statistics Center, diabetes is 34.1 per 100,000. So the United States is 21.2.

Jean Drummond: We can also share some of these other statistics in other states and demonstrating the importance of how we are managing these chronic conditions, as well as looking at the obesity rate, which is 35.7 to the nation's 28.9. So these are critical factors, again, that impact the social determinants of health.

Jean Drummond: So let's go to the next slide, if you will. And this slide, I really want to spend some time on because it has so many factors that sometimes we may not think about, but I think that it's imperative as we move towards more of our team-based collaborative care, as we bring in our nutritionist and our behavioral health and try to provide for the whole patient, that we can think more broadly across these determinants of equity.

Jean Drummond: So if we think about access to food, in Louisiana, one out of six suffered from hunger. That's critically important. In other states, 28% of the population in West Virginia consumes a soda, or others may call it a pop, a day. So how are we having access to affordable, healthy, local food? It's interesting also when we look at two of the top nine worst urban food deserts, are in Louisiana, it's New Orleans, and Camden in New Jersey, two of the states that Quality Insights serves.

Jean Drummond: When we think about the access to health and preventative services, it's critical. People need to understand what prevention is, especially if you have individuals that are coming from other countries that do not embrace that concept in their own country around prevention.

Jean Drummond: When we think about access to recreation, and parks and natural resources, we're looking at a fourth of the population in 2016 in West Virginia was noted as not participating in leisure time or physical activity.

Jean Drummond: Think about transportation, and safe and affordable housing. 89% of households are on federal rental assistance. 49% are on low-income and pay more than half

of their income in rent. So here, again, is going to have an impact on their ability to have improved health outcomes.

Jean Drummond: We also have safe and supportive community for early childhood development. We know the data that speaks of early childhood development and nutrition, economic prosperity and equitable justice system, fair wages, and as I think I mentioned earlier, the minimum wage, and also clean and sustainable natural environments.

Jean Drummond: Looking at some data from the Environmental Work Group in Delaware in 2016, I'm concerned about the quality of the water in Delaware. And so here again these are determinants that impact the healthcare. The quality of education, we've spoken of, strong, vibrant communities. Communities that certainly have individuals that have jobs and they have safe walking places. Crime is reduced, is a determinant, as well as civic engagement and community connections.

Jean Drummond: You may not think about this, but the social cohesion or your civic participation is also noted as another determinant. We were looking at some recent data about family structure now and how over 25,000 children in West Virginia are now raised by their grandparents, and there's another interesting one that I found around the access to emerging technology.

Jean Drummond: Think about that. Everyone has a cell phone, or at least most. The internet and media - we know that the electronic self-record is so very important in terms of our ability to report quality data under the quality payment program. And so certainly having access to strong broadband is important.

Jean Drummond: Also, it's very important, I'd like to draw your attention to another resource they wish to access, and that is that healthypeople.gov has really highlighted the importance of health equity and the social determinants in terms of much of the ... as we move forward with a healthier nation.

Jean Drummond: So if we can, I'd like to move onto the next slide, that really kind of shows here, a visual around equity versus equality, demonstrating how some individuals may start off maybe in a wheelchair, but they may need accommodations. And so how across our country, do we ensure that the gap that people need, to ensure that they have healthier opportunities and have access to good jobs and homes and schools?

Jean Drummond: How do we, as healthcare providers, help to write that prescription, help to support our patients so that we can achieve not only healthier social determinants, but healthier physical determinants, such as the natural environment, our built environment? These are other areas that there's further research as it relates to this particular area.

Jean Drummond: So as I'm talking about the community, I'd like to turn to the next slide. You may say to me, "Jean, I'm a physician. I'm a nurse practitioner. I'm a clinician. I'm a

surgeon. I don't know where to go get the food or to provide the transportation. I went to medical school, so how do I address this? How do I embrace this work, because ultimately I realize that it can have an impact on my patients that have hypertension?"

Jean Drummond: And also there's a major link between opioid use and overdose and social determinants. There's a major report that we just saw in [inaudible 00:17:12] that relates that, and knowing the statistics that we have within our states as well as nationally related to opioids, it's very important that we try to address some of these social determinants.

Jean Drummond: So the next slide, there is a resource that we're happy to share with you, and it's a couple of actually resources. One is the Healthy People 2020, and also I'm happy to give ... CDC has a number of resources that they actually have toolkits that they are providing to communities, to healthcare systems, to support them in addressing their social determinants, as well as a [CBI 00:17:52] I'm happy to share with you. We have a tool that helps collect the social determinants in the ambulatory care settings. We're also testing it in hospital settings, so we're happy to provide that for you.

Jean Drummond: But once you identify and begin to collect this data, then how do you incorporate this data into real-time care coordination, and then be able to offer the patient, before they leave your practice, a solution towards addressing or closing this gap? This can be done through Aunt Bertha, as you see there. Aunt Bertha actually makes it easy. You just put your zip code there, and she is able to bring up resources related to food, health and housing, and even employment programs.

Jean Drummond: And so there are several resources, again, that we're trying to provide for clinicians, so that as you gather your team together, whether your team just may be your front desk receptionist, your nurse, so that we can bring these resources to you so that you can then provide these local-based resources in the different states or communities that you reside.

Jean Drummond: So I'd like to leave in action, if we might, with the next slide, if you would. And just kind of thinking about, how might having this data on your patient's social determinant condition affect your care coordination for your patient? We are presently working with practices where they have been asking patients around food, housing and medication.

Jean Drummond: And it's been incredible because we've been able to share information back with the practice. Some of the patients are actually living in a car. They were evicted from their homes, and they're living in their car. And because they were living in their car, they were unable to get their medications because they had no stable address.

Jean Drummond: And so, we were able to one, help them to get an address that we could get them their Medicaid card so that they could receive their prescriptions. So we oftentimes find that patients just don't have one social determinant, but they often have sometimes two or three more, and just having a patient-centered approach that you're able to help really can make a difference in your patient's life.

Jean Drummond: How can you incorporate this data collection? We are certainly working with ERM systems that you can collect it. Some systems already have questions, but making sure that you are addressing the questions, the responses are very important.

Jean Drummond: We have iPads. Some offices use iPads. And last but not least, I certainly wouldn't recommend this, but it's a start, it could be a paper-based system where at least you're able to, in a very small way, begin to collect it. Because I realize this can seem quite daunting, but we really can focus it may be on one or two social determinants. We need to find out if there's food insecurity for patients at each practice or if there's housing or even health literacy issues.

Jean Drummond: We think about health literacy. We think about not only language and individuals, their level of attainment of education related to their literacy, but also English as a second language. So that's very important, that you are ... Oftentimes patients will just kind of shake their head and say they understand when they really are unable to read the document that you may be sharing with them.

Jean Drummond: So you might say, "Well, Jean, I really don't think that food insecurity is common among our patients." Well, nothing proves that better than the data, and so being able to maybe collect some of that data. You might even think about a recent patient that you've had or case that ... Tracking this morning, I was listening to the surgeon's general of our country talking about diabetes, and he was speaking about how you find individuals oftentimes, they run out of the food at the end of the month, and you have a higher incidence of hypoglycemia or patients coming in to the emergency room because the 28th of the month, they run out of food. They may still take their insulin, but they don't have the food, and so you have a higher incidence of emergency room visits.

Jean Drummond: So is there a way that a bag of groceries could have helped with this? Well, there's also a program that we're familiar with at the FDA. It's called the means program, and if there's an interest in developing a clinical pantry in your practice, where literally there's this program where there's extra food that this organization will send to your doctor's office food for you to be able to write a prescription for your patient.

Jean Drummond: So think about that in terms of a wholeness approach. A patient comes to see you for their regular visit. They visit at the end of the month and they're able to stop by the front desk and get a bag of groceries to help them until their next paycheck may come. And then ultimately, you can look at the resources that are

in your community that can help to address. You'd be surprised ... We've been in rural communities. We've been in urban communities ... at the outpouring of just good will of nonprofit organizations, churches, firehouses, rural farmers markets. Many communities are very willing to bring the farmers into areas that are known as food deserts.

Jean Drummond: So as I bring this to a close, I say to you that as we continue to move, as our nation continues to move forward, to exhaust innovative solutions, to improving our healthcare systems, to improve our chronic conditions and to live healthier lifestyles, I say that let's envision an alternative future. Let's navigate so many different drivers. We have patient drivers. We have policy. We have technology. We have market drivers. Look at Amazon, and how Amazon is moving into this realm of being able to deliver healthcare right in your living room. That we really look within and develop collaborative partnerships, so that we truly can improve the health of our local population, of our community, and ultimately our nation as a whole, as we seek to address the social determinants of health. Thank you so very much.

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