We Aren't Achieving Our Desired Result. Why Not Change Our Approach?

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Financial Relationship Disclosure

I have ***no*** financial relationships with any ineligible companies to disclose.

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Objectives:

At the end of the presentation, the participant will be able to:

1. Define and identify Social Determinants of Health (SDOH) and the 5 categories (domains).

2. Examine the consequences of not addressing unmet social needs.

3. Discuss the paths to incorporate SDOH into practice without diverting your attention from medical care.

Meet Patient Mr. P.F.

69 yo Caucasian male with Diabetes, Hypertension, Coronary artery Disease, Degenerative Disc Disease (cervical and lumbar), and Glaucoma

71.5” 231.6#
BMI: 30.14
136/68
HR 78
PHQ-2 neg
Hbg A1c 10.1

Re for visit: Ear Pain

Functional Assessment: decreased hearing and blurry vision

No advance directives

Independent living, works part-time, limited income, no reliable transportation

No CRCS

No PCV-23 or Influenza vaccination

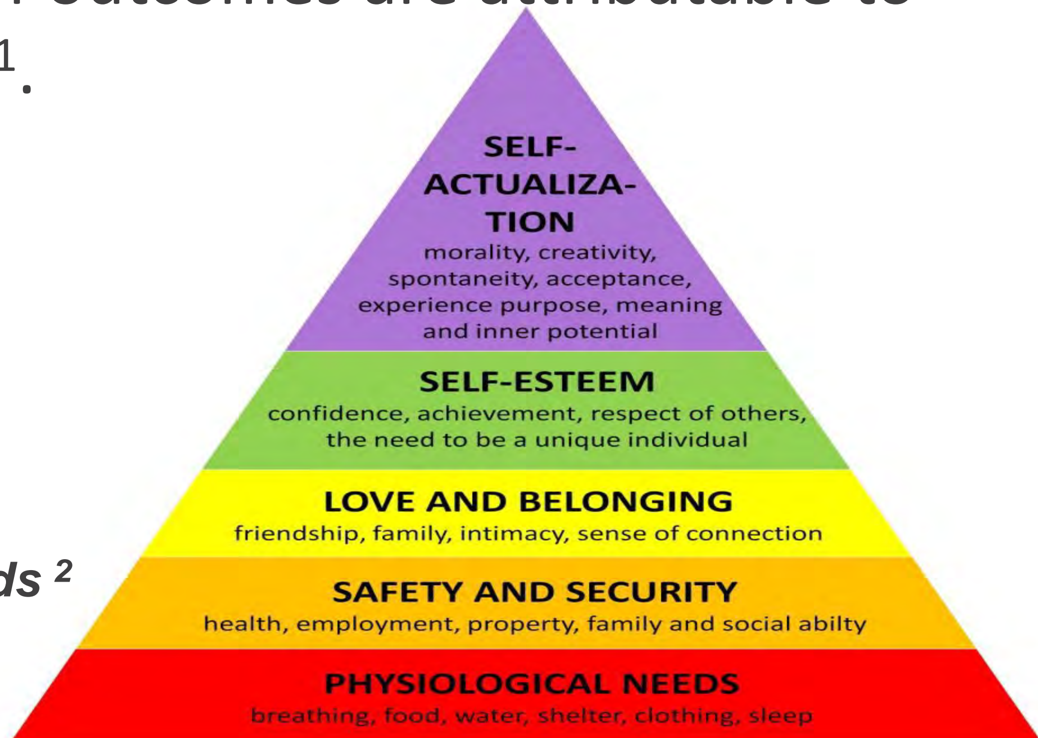
Allergy: Statins

Meds: Atorvastatin 20mg nightly, Isosorbide Mononitrate CR 30mg daily, Metformin 850mg twice daily, Diltiazem ER 300mg daily, Metoprolol 25mg twice daily, Effient 10mg daily, Humulin 70/30 25-35 U twice daily, *non-taking* Lisinopril 10mg daily

Define Social Determinants of Health

- SDOHs are the conditions in the environments in which people live, affecting a wide range of health, functioning, and quality-of-life outcomes and risks.

- Many people are surprised to learn that clinical care accounts for just 20% of health outcomes, while 80% of outcomes are attributable to social determinants of health (SDOH)[1].



Maslow's Hierarchy of Needs [2]

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The U.S. Department of Health and Human Services groups SDOH into 5 domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Addressing SDOH adequately can make the difference in whether someone lives a long and healthy life.

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Economic Stability

Ability for people to earn steady incomes that allow them to meet their health needs.

In the United States, 1 in 10 people live in poverty,[3] and many people can't afford things like healthy foods, health care, and housing.

Examples:

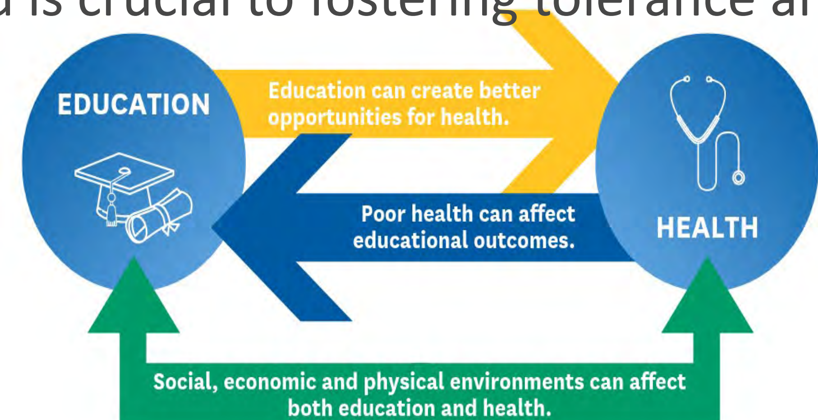
- **Food insecurity.** Someone lacking access to grocery stores with healthy foods is less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy.
- **Transportation.** Not being able to find transportation to the doctor's office means a disease in its early stage can go undetected until it gets to the point that health care options become more dire – not to mention more expensive.
- **Medication affordability.** Half of adults with diabetes perceived financial stress, and one-fifth reported financial insecurity with healthcare and food insecurity subsequently leads to cost-related non-adherence[4].

Education Access and Quality

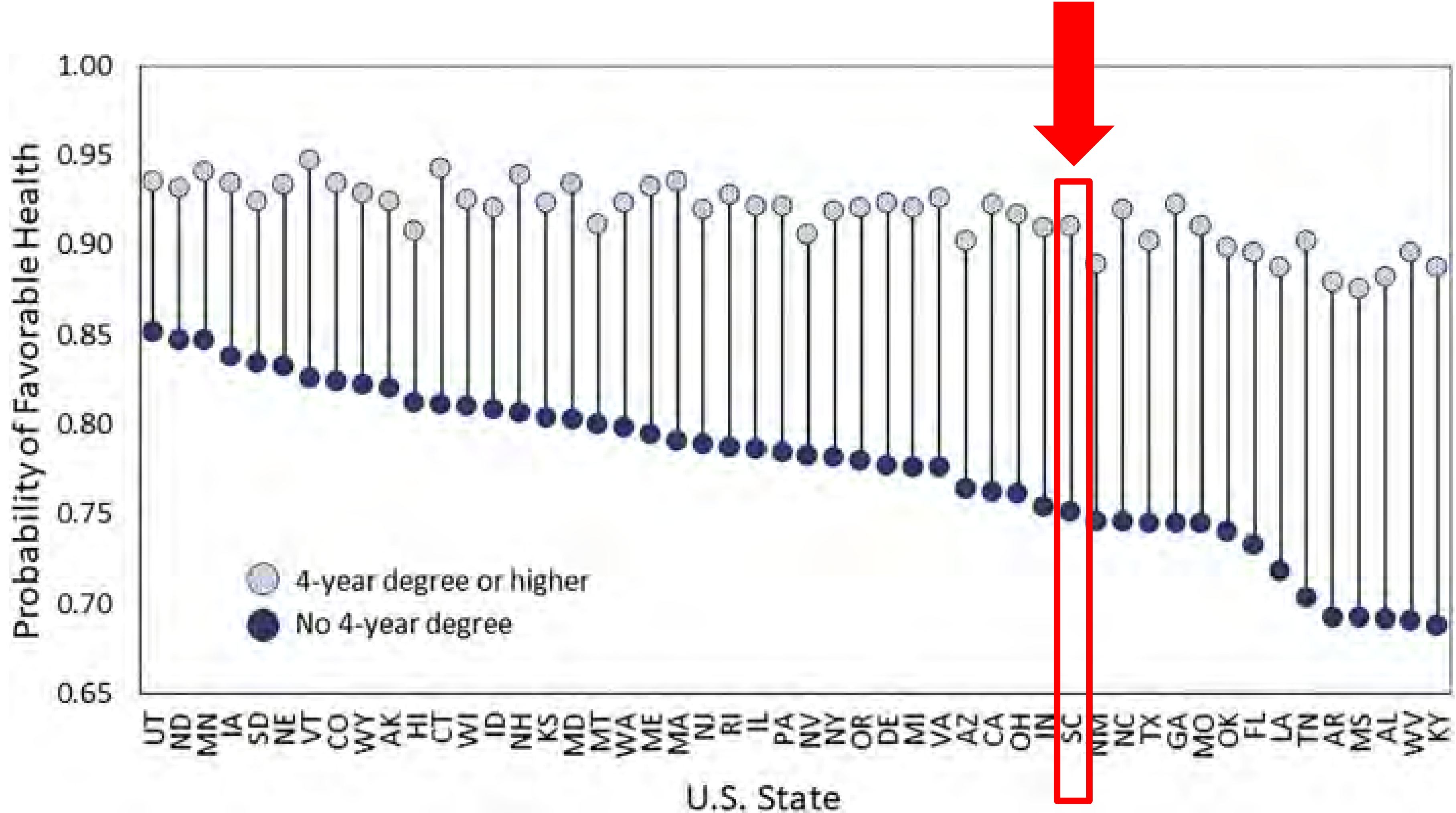
Ability to educational opportunities and help children and adolescents do well in school.

Why does education matter?

- **Less education is linked to lower income, which is linked to poorer health**.
- Adults with more education have better overall health, are less likely to develop morbidities and disability, and tend to live longer and spend more of those years in good health [5]
- Education enables upward socioeconomic mobility and is a key to escaping poverty. Education helps reduce inequalities and reach gender equality and is crucial to fostering tolerance and more peaceful societies.



Probability of reporting favorable health among adults ages 25–64 by U.S. state. Data are from the 2011–2018 BRFSS, include adults ages 25–64, and are adjusted for age, sex, and race-ethnicity differences between states. Adults who reported that their health was excellent, very good, or good are considered in “favorable” health, unlike those who reported that their health was fair or poor.



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Health Care Access and Quality

Access to comprehensive, high-quality health care services. Access to healthcare means having “the timely use of personal health services to achieve the best health outcomes.

Good access to care means having:

- Health insurance that facilitates entry into the healthcare system.
  - About 1 in 10 people in the United States don’t have health insurance.[7]
- Timely access to needed care.
- A usual source of care with whom the patient can develop a relationship.
- The ability to receive care when there is a perceived need for care.

Neighborhood and Built Environment

Access to neighborhoods and environments that promote health and safety.

The neighborhoods people live in have a major impact on their health and well-being.[8]

- neighborhoods with high rates of violence,
- unsafe air or water,
- exposures to things harm their health, like secondhand smoke or loud noises.

For example, providing opportunities for people to walk and bike in their communities — like by adding sidewalks and bike lanes — can increase safety and help improve health and quality of life.

Social and Community Context

Need for social and community support.

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being.

Social isolation. Loneliness is a common problem especially seniors, particularly as their spouse, friends or other loved ones pass. Loneliness and depression can result in a lack of motivation to take care of oneself.

More than 1 in 10 individuals in the adult population reported social isolation, and prevalence varied strongly with regard to sociodemographic and socioeconomic factors[9]. Social isolation was particularly frequent in disadvantaged socioeconomic groups. From a public health perspective, effective prevention of and intervention against social isolation should be a desired target as social isolation leads to poor health.

Mr. P.F.

Established cadence of visits every 4 weeks (many appts missed, high ER utilization for acute pain issues)

BMI 30 → 31 → 34

HA1c 10.1 → 10.3 → 10.5

Engaged Care Coach for chronic care management

1st Encounter: Discovered nonadherence to regimen due to fears of hypoglycemia. Also, disclosed to care coach he never completed diaries I gave him (blood sugar or food) because he could not write. Educated on the impact of some of his favorite foods was having on his blood sugar and given guidance how to balance eating them while avoiding blood sugar spikes.

Subsequent Encounters: Hbg A1c 6.6 (3 months), 100% feeling better without any more MSK complaints, able to work more and buy reliable transportation

Path to Incorporate: CenterWell/Conviva Centers Balancing patient load with SDOH.

Value-based care. Primary care is the single most impactful lever to improve population health, so it's critical that we structure care in a way that leads to the best possible outcomes. In our value-based model, we're responsible for the patient's overall health and well-being. Instead of simply offering *more* care, we strive to offer *more effective*, high-quality care.

- In practice, this value-based and team-oriented model is focused on **Access**, **Patient-Provider Relationships, *also termed Engagement***, and **Quality Care**.

- Our providers meet with patients for 50% longer than in a traditional practice (a typical visit might last up to 40 minutes) – to address all of the factors that might be affecting the patient's health and to answer the patient's questions. Doing so helps us understand the patient's lifestyle and health goals, so we can tailor a care plan to address their specific needs.

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Path to Incorporate: CenterWell/Conviva Centers

Balancing patient load with SDOH.

Activity centers. Our onsite activity centers offer seniors throughout the community, not just our patients, things like classes on health and fitness, healthy eating, gardening, etc., as well as other opportunities to socialize with their peers, such as movie night. We're even thinking of having genealogists come in to educate seniors on how to research their family tree.

Path to Incorporate: CenterWell/Conviva Centers

Balancing patient load with SDOH.

Care team. It's not all on the physician and advanced practice professionals.

Our care team includes nurses, pharmacists, social workers, behavioral health specialists, community health workers and referral specialists who can help patients find resources for transportation, financial assistance, housing and nutrition needs.

- The care team meets each morning to discuss the patients that we'll see that day and ways we can work together to provide high quality care.
- High-risk rounds to discuss the most as risk patients with the most at risk conditions.
- Deployment of community health workers to our unengaged patients
- Operational steps to avoid care fragmentation with referrals and specialist visits

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The Impact:

CenterWell's care model is proven to improve health outcomes and increase patient satisfaction.

CenterWell patients, that are Humana Medicare Advantage members, experience:

- More than a 30% decrease in avoidable hospital admissions.[10]
- More than 20% reduction in emergency department visits.[11]
- CenterWell patients are 25% more likely to have had a PCP visit.[12]

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Look for signs…. Ask the questions …. Find resources

1. Educate your team to look for signs
   - Arrival to clinic
   - Behaviors (missed appointments, frequent ED visits, **noncompliance**)
   - Appearance
   - Affect

2. Use SDOH screeners

3. Develop community resource guides
   - Greenville United Way 2-1-1

WellRX TOOL:

Social Determinants Screening Tool

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for **food**? ____ Yes ____ No
2. Are you **homeless** or worried that you might be in the future? ____ Yes ____ No
3. Do you have trouble paying for your **gas or electricity** bills? ____ Yes ____ No
4. Do you have trouble finding or paying for a ride (**transportation**)? ____ Yes ____ No
5. Do you need daycare, or better **daycare**, for your kids? ____ Yes ____ No
6. Are you without regular **income**? ____ Yes ____ No
7. Do you need help finding a **better job**? ____ Yes ____ No
8. Do you need help getting more **education**? ____ Yes ____ No
9. Are you concerned about someone in your home using **drugs or alcohol?** ____ Yes ____ No
10. Do you feel **unsafe** in your daily life? ____ Yes ____ No

- Feel unsafe at home
- Physically or emotionally hurt
- Prefer not to answer
- Injuries
- Physically or emotionally threatened
- Other:
- Neglect
- Made to feel afraid

11. Do you need help with **legal issues**? ____ Yes ____ No

In the last 6 months have you been at the Emergency Department more than twice? ____ Yes ____ No
If Yes, How many times? ________

In the last 6 months, have you been hospitalized? ____ Yes ____ No
If yes, How many times? ______

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