CSMS-IPA 3d Quarter 2022 Newsletter

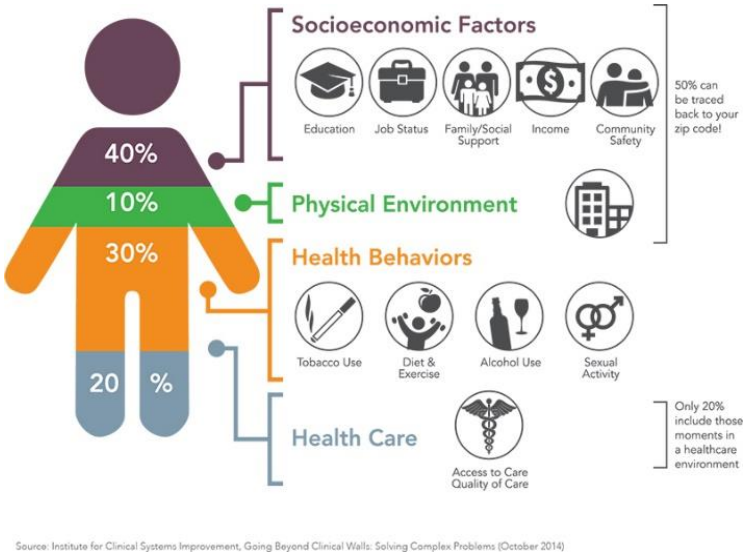
CMS-IPA, September 2022 Newsletter – Managing Social Determinants of Health (SDOH)

Why You Should Care about Social Determinants of Health (SDOH)

Are you convinced that good medical care and patient adherence are the only keys to good outcomes? If so, think again. Socioeconomic factors, known as social determinants of health (SDOH), influence health outcomes, and often, not for the better.

SDOH are the conditions in the environments where people are born, live, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. Differences in SDOH contribute to the stark and persistent chronic disease disparities in the United States among racial, ethnic, and socioeconomic groups, systematically limiting opportunities for members of some groups to be healthy. Centers for Disease Control (CDC March 29,2022)

Key Social Determinants of Health and Their Impact on Health Outcomes



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

See the examples below to better understand how SDOH can impact clinical outcomes.

- **May Garcia** - A 32-year-old mother of two reluctantly comes to the office because of her frequent severe migraines. She is oddly reticent about the timing of her migraine episodes. Eventually she reveals that she has migraines when her domestic partner threatens her with violence.
- **The Altman family -** Janna, Harry and Conal are all under age 10. All are overweight. An SDOH questionnaire reveals that the family suffers from food insecurity and purchases many high calorie foods from a local store where no fresh fruits or vegetables are available.
- **Jaretta Washington** - This 82-year-old woman with COPD, often has exacerbations of her illness. She has trouble managing her inhaler. She cannot get a spacer for her inhaler because it is not covered by Medicare and she can't afford it.

In each of these cases, social determinants of health, more than medical care, will determine clinical outcomes for each patient. Medical offices that address social determinants will provide far more comprehensive treatment for patients and will achieve a better patient experience. SDOH have a particularly big impact on preventive testing as rigid low wage job schedules, lack of transportation and being distracted by basic survival needs may be big barriers to getting mammograms, colonoscopies, etc.

Social Determinants of Health Assessment Tools

To effectively help patients in managing SDOH, medical practices should choose an SDOH assessment tool. A short tool that is optimized for poor readers is best. The practice must also create a workflow that starts with patients completing the assessment and ends with a referral to community resources and follow-up on referral results. SDOH assessment and follow-up should become a routine part of the annual visit or a part of shorter visits if there are signs that a social determinant problem exists.

Social Determinants of Health Screening Tools

There are a variety of SDOH screening tools. Many electronic medical records have them embedded. You can also use the tool in the CIGNA toolkit which was sent to all CSMS-IPA medical practices, or you can log into the CSMS-IPA website to access it. Other tools are listed in the "Resources" section at the end of this newsletter.

Health Literacy as a Social Determinant of Health

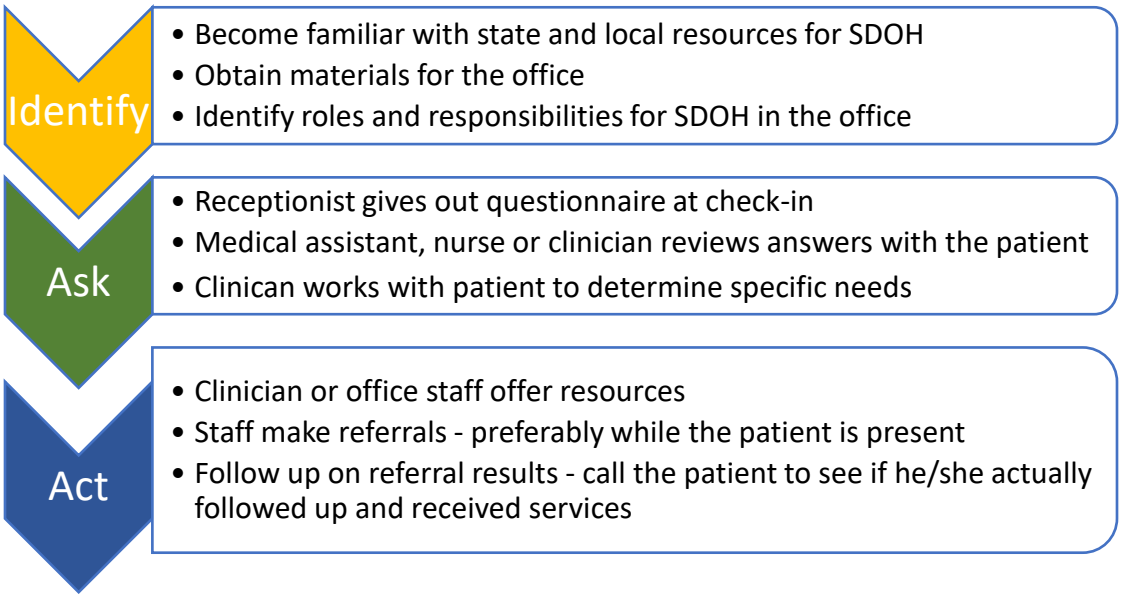
Health literacy is a key social determinant that is the root cause of many adherence problems. Patients who are not health literate may not understand their illness, treatment plan or medications. To assess health literacy use the following evidence-based question.

How confident are you in filling out medical forms by yourself?

- ✓ Extremely
- ✓ Quite a bit
- ✓ Somewhat
- ✓ A little bit
- ✓ Not at all

Any answer of **somewhat or below** indicates a possible issue with health literacy and subsequent issues with adherence to medical treatment plans.

Workflows for Addressing SDOH in Primary Care



How They Did it - A CMS-IPA Practice Tackles Social Determinants of Health

In a recent interview Lorie Owens, Practice Manager of Barochia Internal Medicine, described how the practice adopted a screening workflow for SDOH. Lorie describes this as: "Something new - with insurance companies adopting the idea that things beyond just medical care can keep you healthy."

The staff started by creating a one-page guide to local community resources. Lorie feels that 211 is the most useful of the resources. They then developed a one-page SDOH assessment form that was given out at appointments. Staff were quickly overwhelmed by managing the forms and eventually decided to use them only for annual visits.

Staff also created a single page community resource form to hand out. They found that patient embarrassment was a big barrier to resolving SDOH issues. Since this is a small practice, staff typically know patients and they use their personal relationships and communication skills to gently support patients in getting help. The staff always emphasize the confidentiality of the process. They are also careful not to push too hard as this can produce resistance.

The practice is taking a new direction on SDOH as their EMR incorporates the PRAPARE form. They hope to have patients complete the form on tablets and submit them electronically. This will save both time and money for the practice. Lorie feels that this process has been a good thing as it has uncovered some SDOH problems and provided patients with resources that they were not aware of prior to their visit.

Tips for Effective Management of SDOH

- Utilize local resources - Research or use staff knowledge of local food pantries, diaper banks, medical equipment loan closets, free transportation, domestic violence services and other resources. In the office, post a list with phone numbers. Town websites and senior centers are good sources of information.

- Test resources yourself - Investigate how easy they are to use, what they offer and how responsive they are to callers or online inquiries.
- Tread lightly in communicating about SDOH issues. Many patients are embarrassed by their lack of financial resources and other needs. Use active listening skills including open ended questions, reflecting back what you have heard and summarize.
- Emphasize that the whole process of SDOH referral and follow-up is confidential.
- Help the patient prioritize and set goals for resolving SDOH issues. Patients will not act if they do not see the SDOH issue as a priority or if they feel overwhelmed with day-to-day survival needs.
- Where possible, use a warm handoff to community resources. If the patient needs extra help, make a referral to the community resource while he/she is in the office.
- Follow up on the results of referrals. Call patients to see whether they have followed through on getting help. If not, problem solve with them and make another plan.
- Check on the status of SDOH issues at the next office visit.

Resources for Managing Social Determinants of Health (SDOH)

SDOH Screening Tools

The screening tools listed below can be adopted by any practice to uncover patient social determinants of health issues.

- *CIGNA Toolkit SDOH Tool - Sent to all practices and available in the password protected section of the CSMS-IPA website.*
- *The Accountable Health Communities Health-Related Social Needs Screening Tool - Centers for Medicare and Medicaid*
- *PRAPARE Assessment and Toolkit - National Association of Community Health Centers (https://prapare.org/)*
- *Social Needs Screening Tool - American Academy of Family Physicians*

SDOH Screening and Management Tools and Techniques

These articles provide practical information on screening for and managing SDOH.

- *Addressing Social Determinants of Health in Primary Care - Team-based approach for advancing health equity - American Academy of Family Physicians*
- *Social Determinants of Health – Guide to Social Needs Screening - American Academy of Family Physicians*
- *Social Determinants of Health- The Missing Link in Health Outcomes – Webinar slides (June, 2021) by Tess Lombard, M.D and Tammy Johnson King, RN, MSW, CCM*

Community Resources for Patients with SDOH Issues

These websites provide both state and national resources and benefits programs for patients.

- **211 Connecticut** (www.211ct.org) – A statewide call center with a huge variety of state resources A national resource database that can be searched by zip code.
- **Resources for Older Adults and Caregivers** from the Yale COACH 4M project is now available on the Yale Geriatrics website: https://medicine.yale.edu/intmed/geriatrics/agingresources/directory/
- **Benefits Check Up** (benefitscheckup.org) provides benefits information by zipcode. It also provides a toll free number that seniors can call for help finding benefits (1-800-794-6559)
- **Findhelp.org** is a national database of resources. Patients can enter their zipcode to identify local resources.