Implementation of Interventions Targeting 'Social Determinants of Health': State of the Science

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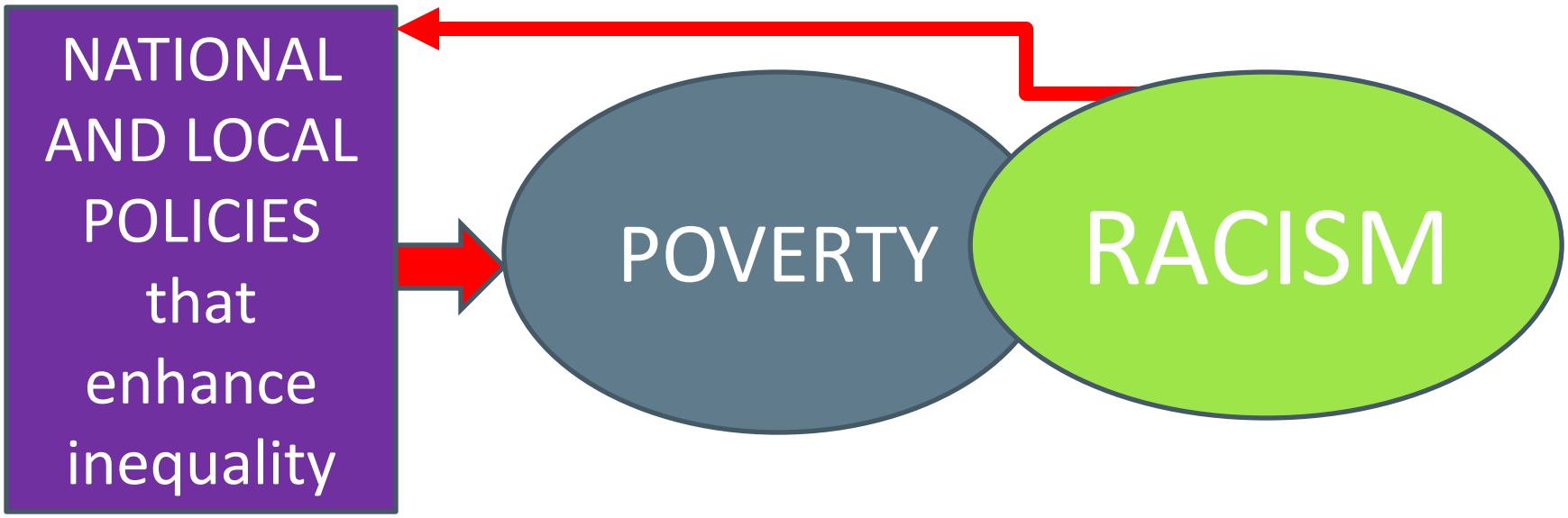
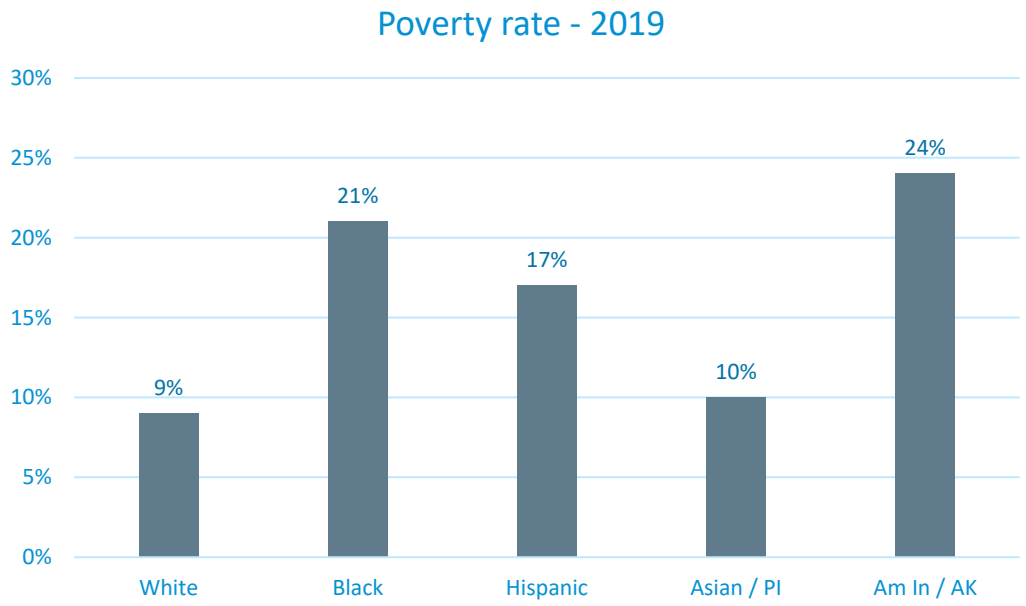
Why do most social determinants of health exist?



How are poverty and racism related?

- As a result →

- And … poverty-related social risks are 2-2.5x more prevalent in **black and Hispanic** people than non-Hispanic whites



https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/

In sum …

- Poverty → most social risks
- Racism creates more poverty in some racial / ethnic minority groups → disproportionately impacted by social risks
  - Racism also impacts health on its own
- Prejudice / discrimination → similar impacts in other minority groups, e.g., transgendered people
- This underlies health inequities / disparities

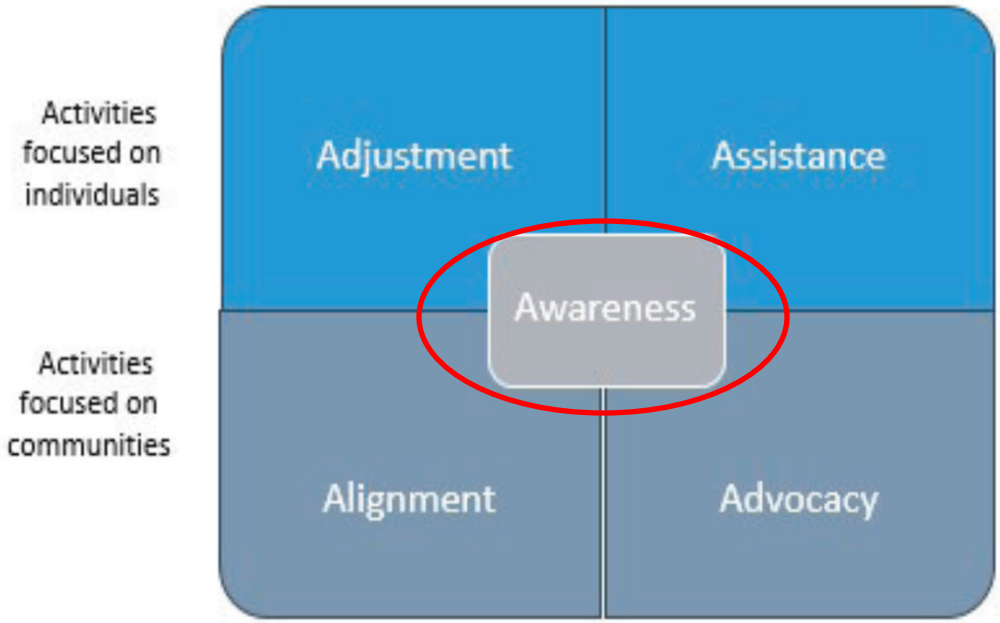
Social risks impact health … now what?

- **What can be done by healthcare systems?**
  - Note: Ongoing **debate** about whether this is the purview of healthcare
- **What are useful health information technology tools?**
- **How can these activities be implemented?**

Barriers to implementing *any practice change*

- **Staff** turnover / staffing
- Developing, adopting new **workflows**
- No **champion** (or wrong champion)
- No **leadership** support
- Inadequate **resources** / competing **priorities**
- **Right information** to right person at right time
- Workload / **overload**

2019 NASEM Report



Awareness – role of HIT and implementation barriers

- Health system **leadership** must buy in
- Concern: **resources** are limited; is it impactful enough to justify investing?
- Organizational **culture** related to social risks
  - Not my job
  - Social needs can't be addressed by health care settings
  - Addressing these needs does not help patients
  - I already know my patients' needs
  - Don't have time

- **Why screen if I can't refer** – discomfort / not prepared (!!!)

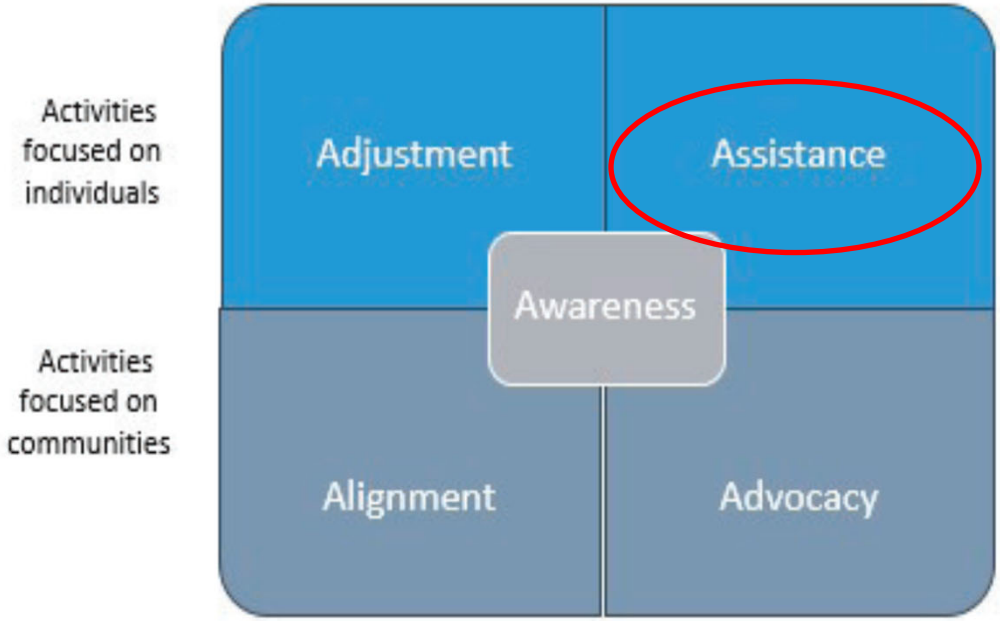
Awareness – role of HIT and implementation barriers

- Who, when, how (which tool?)
- Strategy and structure
  - E.g., planning, testing integration, workflows, communication, external partners
- Infrastructure
  - Enough clinic staff to conduct related tasks?
  - EHR tools adequate to support tasks?

Awareness – role of HIT and implementation barriers

- Collecting / documenting social risk data - commonly via screening with data entry by clinic staff
- Other HIT approaches could entail:
  - **Portal** pre-encounter? → not all patients have portal accounts
  - **Tablet** at check-in? → not all clinics have / can manage tablets
  - **Texting**? → not all clinics can bulk text; not all patients text

2019 NASEM Report



Assistance – role of HIT and implementation barriers

- Emerging evidence: **internal** and / or **external** assistance referrals *can* → modestly improved health outcomes
  - Includes several systematic reviews
  - Consider acceptance barriers
- National hypertension guidelines recommend assistance activities
  - E.g., referring food-insecure patients to food assistance programs

Assistance – role of HIT and implementation barriers

- **How to refer when social risk is reported?**
  - **Staff** must know local CBOs - **which** available, who they serve; or
  - Clinic-created EHR-integrated list of service agencies must be **updated**

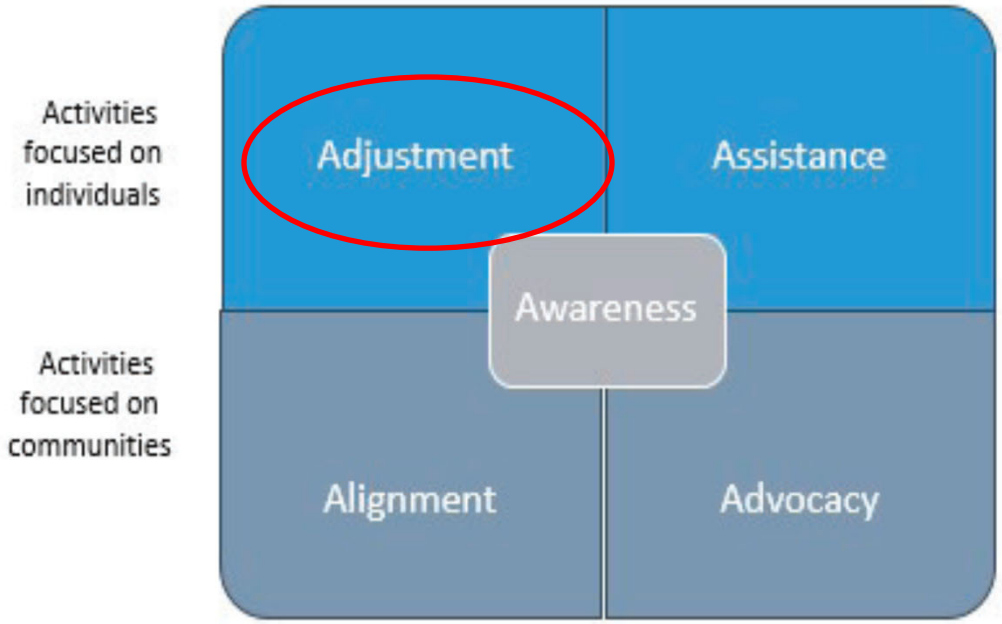
- **Or SSRLs …**
  - Can be too **costly** for clinics serving patients with social risks
  - Low-cost SSRLs only accessed **outside** of EHR
  - **EHR-based** SSRLs
    - Involve multiple steps / **clicks**
    - Present referral **options** so user needs to know how to choose
    - Referral-making tools separate from documentation tools
  - CBOs unable to 'close the loop'
  - May require **duplicate** data entry
  - CBOs may want to work with **only one** interface

Assistance – role of HIT and implementation barriers

- Patients offered assistance interventions in health care settings **do not always accept them**
  - Our team:
    - 79% of CHC patients with reported social risks declined referrals
    - Varied by # positive domains, gender, race / ethnicity (in submission)
    - <50% of integrated care patients with reported social risks declined referrals (in submission)
  - Others:
    - Food insecurity referral acceptance: 21-90%
    - Housing insecurity referral acceptance: 12-20%

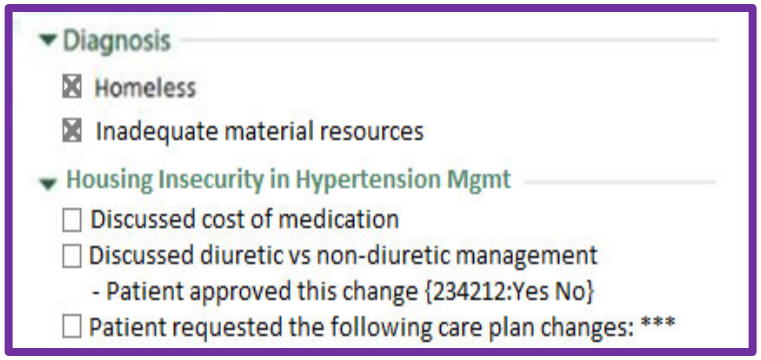
De Marchis et al. *JABFM.* 2020;33:170-175

2019 NASEM Report



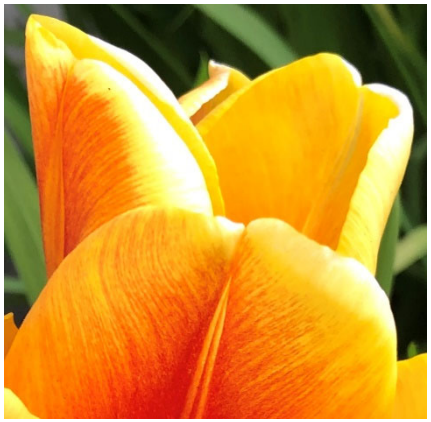
Adjustment – role of HIT and implementation barriers

- How to *adjust care* to account for social risks?
- How do providers use social risk data to adjust care?
- When social risk data does not come with related recommendations, data used inconsistently
  - E.g., in one private setting in <25% of cases
- Barriers to uptake of adjustment strategies?!!!



Adjustment – role of HIT and implementation barriers

- **Adjustments might include:**
  - Unstable housing / restroom access: Non-diuretic anti-hypertensives
  - Food / housing insecure: Metformin rather than insulin
  - Transportation insecure: Options for follow-up care (e.g., telehealth visits, home BP monitor, same day labs/visits, don't require appointment, customize follow-up plan)
  - Options for lower-cost medications
  - Housing insecure: 28-day insulin supply (max time with no refrigeration)
  - Prioritize meds, determine which essential, forgo the rest



Barriers to implementing social risk-related activities might be addressed if:

- Demonstrate **utility** of collected data
- Establish protocols, **workflows**; start small, test; be **flexible**
- Identify, support clinician **champions**
- **Engage** staff in planning, iterating SDH processes
- Needed **infrastructure**, staffing in place first
- Demonstrate **leadership** support
- Certification or **regulation** (PCMH / meaningful use)
- External **motivators** (Grant programs, CCO / ACO, APM)
- REASONS for screening are clearly communicated

ASCEND study 5-step implementation process

SDH screening adoption step	Project month	Led by	Tasks needed for this step	You will receive the following resources to help with this step
Step 1. Create a 'SDH Team.'	1-2	Clinic Leader-ship	Obtain leadership support for SDH screening. Identify a clinician champion (CC) for SDH screening adoption. Identify a project champion (PC); this may be the CC if desired. Give the champion(s) dedicated time for SDH efforts, including contact with study team.	• Leadership orientation guide to social determinants of health • Draft email from leadership to staff • List of SDH references / resources
Step 2. Identify clinic goals	1-2	Clinic Leader-ship / PC & CC	Identify your clinic's goals for SDH screening (why you want to do SDH screening, what you will do with SDH screening results, which patients you want to screen, how this screen-ing fits your clinic's vision, etc.). Your goals may be to adapt or scale up your existing SDH screening efforts.	• Recommendations for identifying your clinic's goals • Decision tool • Support from OCHIN Implementation Support Team
Step 3. Create a 'SDH Plan.'	1-2	PC & CC	Create a workflow plan to meet your clinic's targeted SDH collection goals, and (if desired) SDH action. Create a rollout plan and a plan for tracking your clinic's SDH screening adoption.	• Examples of SDH data collection / review / action workflows • Workflow planning tool • Guides & training on using EHR's SDH Tools • Support from OCHIN Implementation Support Team

ASCEND study 5-step implementation process

Step 4. Train clinic staff in the 'SDH Plan.'	3-4	PC	Orient clinic staff (e.g., at a staff meeting, via email, etc.).	• Orientation / training materials that the clinic can use to train new staff
	Ongoing	PC	If changes are made to the plan, orient staff to the changes.	
	Ongoing	PC	Train new staff as needed.	
Step 5. Roll out, then iteratively revise the 'SDH Plan'	3-6	PC & CC	Roll out your planned SDH workflow.	• Rollout planning tool • Guide to testing and revising workflows • Monthly reports on SDH data collection rates • Support from OCHIN Implementation Support Team
			Demonstrate your clinic can run SDH screening rates.	
	Ongoing	PC	Use SDH screening rates/workflow review to improve adoption of your SDH Plan.	• A tracking tool to help you monitor your implementation progress

Examples of decision tools: Goals

Step 2: Decision Tool

Use the next few pages to help set your clinic's goals. This important step will help guide you through the next 6 months of SDH implementation support.

Identifying your clinic's goals for SDH documentation will help you decide:

1) Which patients to screen for SDH
2) Which SDH to screen for, and how often
3) How your clinic intends to use the collected SDH data.

The Implementation Support Team can help you think about how to answer each of the questions below.

a. **Why do you want to screen your patients?**

Review these potential uses for SDH data; **check those that apply** to your clinic's goals **and mark a number** corresponding to how much of a priority each use is at this time. If your goals for SDH screening change, consider whether / how that affects which patients you screen, how often, and for which SDH.

1. To provide contextual information that could impact individual patients' treatment plan	
☐	**Inform treatment, care planning; know what is affecting patients** E.g.: Change homeless patient's rx to one that doesn't require refrigeration **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**
☐	**Identify & make needed social service intervention referrals** E.g.: Refer patient with diabetes, who lacks healthy food, to food bank **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**
2. To use social needs in population health management and targeted outreach efforts ("Segmentation" of your patient population)	
☐	**Enable targeted outreach to vulnerable patients** E.g.: Identify patients with transportation barriers (e.g., those in communities with little public transportation), and refer them to transportation assistance **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**
☐	**Prioritize management of complex patients** E.g.: Community Health Worker identifies patients with social needs for care management program **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**
3. To understand areas of need in your clinic / community	
☐	**Support organizational changes - Identify needed staff, allocate resources** E.g.: Ensure that a social worker is available to address patients' experience of relationship violence; use SDH data to decide where to locate a new Community Health Worker staff position **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**
☐	**Support development and capacity building in the community - Provide data for advocacy** E.g.: Inform local government about need for housing resources **Priority: Low** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **High**

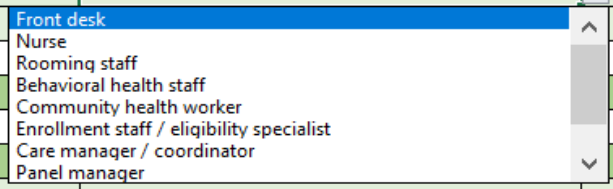
Step 2: Your Clinic's Goals for Working with ASCEND

Thank you for identifying your clinic's goals for starting or expanding SDH screening. We will help you meet these goals! Please help us understand your goals for working with the ASCEND Implementation Support team over the next 6 months.

Check which of these goals apply to you (select as many as apply)	Please describe
☐ 1. Develop or refine workflows / processes for: Does this process need to be developed or refined? If refined, please add any relevant information.	
☐ a. Social determinants data collection. Example: We want to refine our workflow for social determinants data collection. At present we are not screening as many patients as we would like.	
☐ b. Social determinants data entry into Epic.	
☐ c. Referring patients with social needs to services to address those needs.	
☐ d. Adapting care plans to address patients' social needs.	
☐ 2. Expand our workflow to additional teams, patients, etc. Example: We are now screening only patients seen by one team. We want to expand to all clinic patients.	
☐ 3. Integrate the EHR's SDH tools into our workflows.	
☐ a. Use the EHR tools to: Assign an SDH questionnaire to the patients we want to screen.	
☐ b. Use the EHR tools to: Track our SDH screening rates.	
☐ c. Use the EHR tools to: Flag patients targeted for SDH screening.	
☐ 4. Obtain buy-in about SDH screening ...	
☐ a. From clinic leadership	
☐ b. From clinic staff	
☐ 5. Use information about patients' social needs to make clinic decisions (e.g., staffing, community partnerships, etc.)	
☐ 6. Other – please list	

Examples of decision tools – workflows

5	**1**	**Who and when will the SDH data be collected:**		
6	1a	Who will collect SDH data?		
7	1b	When will SDH data collection occur during visit?		
8				
9	**2**	**How will SDH data be collected?**		
10				
11	**3**	**If data collection method is MyChart:**		
12	3a	Which patients will be batch emailed?		
13	3b	How often will patients be asked to complete screening?		
14	3c	Who will be responsible for batch email?		
15	3d	How often will batch emails be sent?		
16				
17	**4**	**If data collection method is on paper:**		
18	4a	When (in workflow) will SDH data be entered in EHR?		
19	4b	Who will enter SDH data in EHR?		
20	4c	How often will SDH data be entered in EHR?		
21				
22	**5**	**If data collection method is a tablet:**		
23	5a	Who will oversee distribution/collection of tablet(s)?		
24	5b	When (in workflow) will SDH data be entered in tablet?		
25				
26	**6**	**If data collection method is patient entry directly into EHR:**		
27	6a	Who will secure Hyperspace and show patient how to complete screener?		
28	6b	Who will file patient data to flowsheets?		

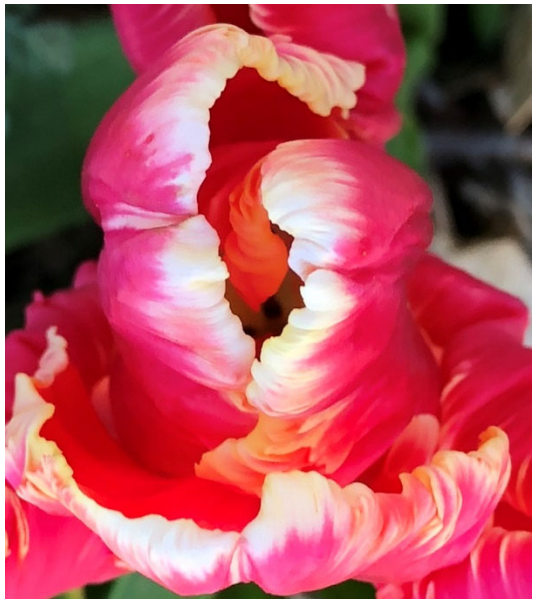


Why screen if we can't refer?

- Social risks should be considered in care decisions.
- Some clinics report that this screening yields previously unknown information and can inform care planning.
- Social risk data can be used to assess needs in your community.
  - This can help clinic leaders advocate for resources, develop community partnerships, and target investments.
- Some clinics use social risk data to adjust payment rates or to convince funders to cover non-billable services.
- Try to ensure that staff and patients understand ***why*** social risk data are being collected!
- Check out: https://www.orpca.org/initiatives/empathic-inquiry

Next steps - research

- Which social risks impact which outcomes?
- Pathway? → e.g., more impact on … risk? healthcare access?
- Which approaches to addressing social risks are effective for which patients?
- Why do patients decline assistance? Should we address this? How?



Next steps - research

- How best to screen (workflows, staffing)?
- Which screening tools? How often?
- Impact on care relationships - providers / patients? Potential *harms* of social risk screening?
  - Mistrust, stigma
  - Others?
- Best practices for social service referrals
- How best to adapt care plans to address needs
- ***What are we missing???***

[Poverty] is basically a political problem, whose radical solution will require a return to distributive justice. Why write about it in a medical journal? Because doctors [AND NURSES] are also citizens; they have opportunities to observe and perhaps to mitigate the effects of poverty; and they should be, in Virchow's words, "the natural advocate of the poor."

– Douglas Andrew Kilgour Black, 1913-2002 (thanks to Perm. J. Fall 2018)

Addressing social risks in medical settings is a band-aid, but it's better than doing nothing.

- Me

Thank you! Questions?

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