Implementation of Interventions Targeting ‘Social Determinants of Health’: State of the Science

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Why do most social determinants of health exist?

- NATIONAL AND LOCAL POLICIES that enhance inequality
- POVERTY
- RACISM
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

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 improve 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?!!!

![Diagnosis](image-url)
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

<table>
<thead>
<tr>
<th>SDH screening adoption step</th>
<th>Project month</th>
<th>Led by</th>
<th>Tasks needed for this step</th>
<th>You will receive the following resources to help with this step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1. Create a ‘SDH Team.’</td>
<td>1-2</td>
<td>Clinic Leadership</td>
<td>Obtain leadership support for SDH screening.</td>
<td>• Leadership orientation guide to social determinants of health</td>
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<td>Identify a clinician champion (CC) for SDH screening adoption.</td>
<td>• Draft email from leadership to staff</td>
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<td>Identify a project champion (PC); this may be the CC if desired.</td>
<td>• List of SDH references / resources</td>
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<td>Give the champion(s) dedicated time for SDH efforts, including contact with study team.</td>
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<tr>
<td>Step 2. Identify clinic goals</td>
<td>1-2</td>
<td>Clinic Leadership / PC &amp; CC</td>
<td>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 screening fits your clinic’s vision, etc.). Your goals may be to adapt or scale up your existing SDH screening efforts.</td>
<td>• Recommendations for identifying your clinic’s goals</td>
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<td>• Decision tool</td>
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<td>• Support from OCHIN Implementation Support Team</td>
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<tr>
<td>Step 3. Create a ‘SDH Plan.’</td>
<td>1-2</td>
<td>PC &amp; CC</td>
<td>Create a workflow plan to meet your clinic’s targeted SDH collection goals, and (if desired) SDH action.</td>
<td>• Examples of SDH data collection / review / action workflows</td>
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<td>Create a rollout plan and a plan for tracking your clinic’s SDH screening adoption.</td>
<td>• Workflow planning tool</td>
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<td>• Guides &amp; training on using EHR’s SDH Tools</td>
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<td>• Support from OCHIN Implementation Support Team</td>
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</table>
## ASCEND study 5-step implementation process

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

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<tbody>
<tr>
<td>1</td>
<td>Who and when will the SDH data be collected:</td>
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<tr>
<td>2</td>
<td>How will SDH data be collected?</td>
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<tr>
<td>3</td>
<td>If data collection method is MyChart:</td>
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<td>4</td>
<td>If data collection method is on paper:</td>
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<tr>
<td>5</td>
<td>If data collection method is a tablet:</td>
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<tr>
<td>6</td>
<td>If data collection method is patient entry directly into EHR:</td>
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</tbody>
</table>

| 1a | Who will collect SDH data? | Nurse, Rooming staff, Behavioral health staff, Community health worker, Enrollment staff / eligibility specialist, Care manager / coordinator, Panel manager |
| 1b | When will SDH data collection occur during visit? |
| 3a | Which patients will be batch emailed? |
| 3b | How often will patients be asked to complete screening? |
| 3c | Who will be responsible for batch email? |
| 3d | How often will batch emails be sent? |
| 4a | When (in workflow) will SDH data be entered in EHR? |
| 4b | Who will enter SDH data in EHR? |
| 4c | How often will SDH data be entered in EHR? |
| 5a | Who will oversee distribution/collection of tablet(s)? |
| 5b | When (in workflow) will SDH data be entered in tablet? |
| 6a | Who will secure Hyperspace and show patient how to complete screener? |
| 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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