

# Addressing Social Determinants of Health in Healthcare Delivery

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**Meet Mr. Jones**



# CDC & Healthy People Definition

Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks



# Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

## Economic Stability

Employment

Income

Expenses

Debt

Medical Bills

Support

## Neighborhood and Physical Environment

Housing

Transportation

Safety

Parks

Playground

Walkability

## Food

Hunger

Access to  
Healthy Options

## Community and Social Context

Social  
Integration

Support  
Systems

Communication  
Engagement

Discrimination

## Education

Literacy

Language

Early Childhood  
Education

Vocational  
Training

Higher  
Education

## Health Care System

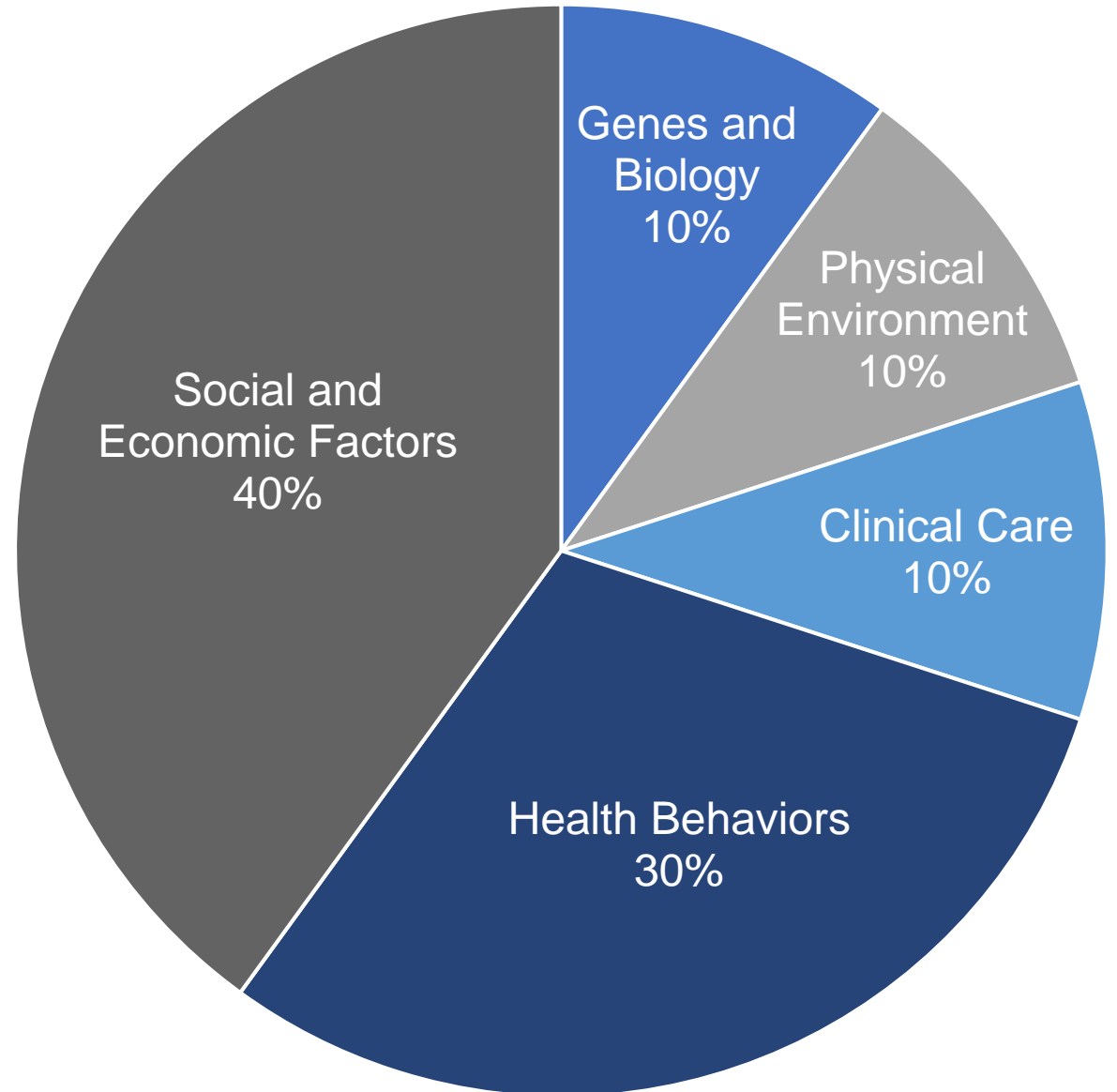
Health  
Coverage

Provider  
Availability

Quality of Care

Provider  
Linguistic and  
Cultural  
Competency

# Determinants of Health



# Traditional Disease Management



Prevention and therapeutic care activities



Education



Routine care

**1/3**

Of people with diabetes do not meet general targets for glycemic, blood pressure, or cholesterol control.

**It is not for a lack of health insurance.**

The Affordable Care Act significantly increased access to care for people with diabetes, with coverage rates at 90% for people 18-64 in 2016, and near universal coverage for those >65 years.



# SDOH and Chronic Disease



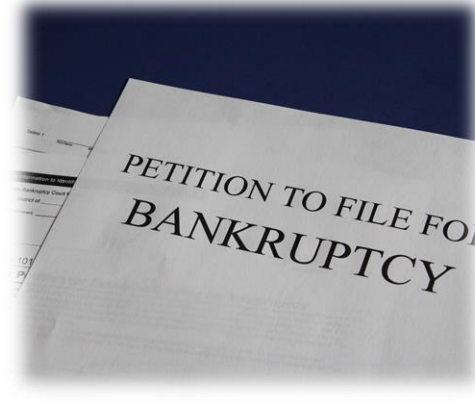
# Financial Toxicity- the Facts in Cancer



40 - 80% of cancer survivors **exhaust their savings** to finance medical expenses



Up to 34% of patients **borrow money** to pay for care



**Bankruptcy rates** among people with cancer are 260% higher



People with cancer who declared bankruptcy had a **79% greater mortality risk**

# Financial Toxicity- the Facts in Diabetes



Half of adults with diabetes report **financial stress**



Nearly a quarter experience **high out-of-pocket healthcare burden** and **food insecurity**



**Cost-related non-adherence** is between 20-40%

# Financial Toxicity- the Facts in Alzheimer's/Dementia



Friends and family  
**spend \$5,000/year**  
on loved ones with  
dementia



> 1/3 had to **reduce  
hours or quit their  
job**



13% **sold personal  
belongings** to make  
ends meet



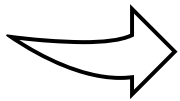
Half of the care  
contributors **dip into  
their savings /  
retirement funds.**

# Social Prescribing

Connecting patients to non-medical services to improve health and well-being



Screening for social needs



Referrals to community-based services



Supporting access to relevant services

# Origins

**Community-Oriented  
Primary Care**

**Affordable Care Act**

Incentives for treating the whole  
patient and testing new models

# Accountable Health Communities

Center for Medicare and Medicaid Innovation

Test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization



30

*participating  
organizations  
over a 5 year  
period*

*Evaluation forthcoming*

HealthAffairs

CULTURE OF HEALTH

By Leora I. Horwitz, Carol Chang, Harmony N. Arcilla, and James R. Knickman

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# **Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017-19**



# Evidence Gaps

Category	Opportunities for further inquiry
Measurement	Identifying and defining process and outcome measures
	Determination of differential intervention effects on certain patients, populations, or geographies
	Consideration of how social needs may link to biomarkers, health-care utilization, and costs
	Benchmarking cost-effectiveness of interventions against medical treatments/interventions
Intervention	Assessing different means through which screening occurs
	Identifying best practices for referrals to relevant resources
	Identifying best practices for community-partnership building, intervention codesign
	Patient or family view of social needs interventions in clinical settings
	Comparative effectiveness of existing interventions and different intervention strategies
	Relationship to advocacy for social safety net programs
Methodologic	Alternative epidemiologic study designs
	Use of implementation science, quality improvement methods



Consistent pattern across programs is that typically **fewer than half of those who screen positive for social risk factors are interested in receiving assistance** from the health system to help address identified risks

# Potential Sources of Discrepancy

## Validity of Social Risk Screening

Lack of psychometric testing of tools

Use of social risk screening as diagnostic tool

## Lack of Patient Interest in Assistance

Patient already getting assistance elsewhere

Patient does not prioritize social care during clinical encounters

# Guiding Principles for Social Needs Screenings



## Empathy

The ability to understand and share the feelings of another.



## Respect

Regard for the feelings, wishes, rights or traditions of others.



## Autonomy

The right of patients to make independent decisions about their care.



## Trust

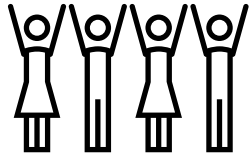
The reassuring feeling of confidence in the clinician.

# Guiding Principles for Social Needs Screenings



## Dignity

Sense of self-respect.



## Collaboration

Working with someone to create an outcome.



## Support

The act of helping or assisting someone.

# Guiding Principles for Social Needs Screenings



**Sensitivity**  
An appreciation of others' feelings.



**Cultural Competence**  
Being respectful and responsive to the health beliefs and practices of diverse population groups.



**Community-Engaged**  
The process of working collaboratively with community groups and members to address issues that impact the well-being of those groups.

# Guiding Principles for Social Needs Screenings



**Engage Community Stakeholders**



**Create a Safe Space for Conducting Screenings**



**Get Buy-In from the Patient**



# Guiding Principles for Social Needs Screenings



**Learn from the Patient**



**Train Clinicians and Care Team Members**



**Apply Cultural Humility Skills**



# Guiding Principles for Social Needs Screenings



**Identify Individual  
and Community  
Strengths and  
Assets**



**Develop Effective  
Documentation  
Processes**



**Develop Actionable  
Next Steps**



**Scale the Screening  
Process**

“...just because my hair is clean, I'm dressed in clean clothes, I'm driving a halfway decent car, **you make the judgment that I don't have a need...**”

“I don't know why I haven't called...I feel like it's just more me not wanting to, like, accept help from other people... **I just feel kind of bad or ashamed that I even need help** in the first place.”

“When I went around to various agencies in 2010, they all gave me the same list. And finally, at one place, I said, ‘I have the list. I don't need the list. I need the service.’ And I didn't qualify. I didn't qualify for anything because they were using last year's taxes...People say, **“Well, why don't poor people ask for help?” Because they don't think of themselves as poor people.** And to have to go ask for help and then have some[one tell you]...one social worker...did tell me...’You're too proud. You have to be humble.’ And I said, ‘No. I can be as proud as I want.’ So, **I'm not going to deal with people who see me as some poor creature.** I'm very competent...We have to change the attitude of the so-called helpers. So, if they change their attitude, maybe I'll go. But I'm not going to put myself through that again.”

“It’s frustrating, you know. **It’s like you feel like you’re asking for...stuff for free, but it’s not like you’re doing it because you want it for free.** It’s just you want to be able to take care of yourself so you’re not as much of a burden on everybody with your disease.”

“I don’t want to take away resources from somebody that might need them more than me and that might have less resources than me. **I would rather struggle than...take away somebody’s place that I feel needs it more than I do.**”

**Thank you!**