Social Determinants of Health
How Do I Ask and What Can I Do?

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Disclosures

None
Learning Objectives

At the end of this session, participants will be able to:

- Define the Social Determinants of Health
- Describe areas where they can act upon SDoH both inside and outside the clinic
Social Determinants of Health: Definition

- Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age that shape health.
# Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td>Zip code / geography</td>
<td></td>
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</tbody>
</table>

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Equality

The assumption is that everyone benefits from the same supports. This is equal treatment.

Equity

Everyone gets the supports they need (this is the concept of “affirmative action”), thus producing equity.

Justice

All 3 can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.
Impact of Social Determinants of Health

- **Socioeconomic Factors**
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- **Physical Environment**

- **Health Behaviors**
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- **Health Care**
  - Access to Care
  - Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Social and Medical Contributors to Disease (Galea, 2011)

U.S. Deaths in 2000 due to:

- Acute MI = 193,000
- Low education = 245,000
- Lung cancer = 156,000
- Low social support = 162,000
- Cerebrovascular disease = 168,000
- Racial segregation = 176,000
Life Expectancy at Birth in Seattle-King County 2018 (Boothe et al, 2018)
Don’t Even Want to Ask? You Are Not Alone!
Providers’ attitudes About identifying and addressing patients’ social needs--AAFP survey (2017)

- 83% agree FPs should identify and help address patients’ SDoH
- 80% don’t have time to discuss SDoH with patients
- 56% feel unable to provide solutions to patients
- 78% agree FPs should partner with community organizations to address community health disparities
- 64% aren’t properly staffed to address risk factors with patients
- 75% agree FPs should advocate for public policies that address SDoH
Benefits of Asking About SDoHs
(Andermann, 2018)

- Patients appreciate it and feel supported (Felitti and Anda and others)
- Providing whole-person care
- Reducing missed opportunities for diagnosis reducing “revolving door medicine” and recurrent emergency room visits by understanding underlying causes of the presenting health issues
- Providing more cost-effective care by intervening early and preventing hospitalization
- Increasing adherence to medication and improving health by prescribing medicines that patients can afford providing more trauma-informed care.
Patient Case Study

- 50 y.o Mexican immigrant mother of three with h/o of Diabetes, Obesity, Sleep Apnea and Heart Failure
Why is Maria in the clinic?

Activity: Draw out the causes and conditions of Maria’s chronic diseases
### SDoH INTERVENTION EFFECTS

#### Upstream and Downstream effects

<table>
<thead>
<tr>
<th>Upstream Intervention (leads to health equity)</th>
<th>Upstream</th>
<th>Patient</th>
<th>Downstream</th>
<th>Downstream intervention (leads to social gradient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy is revised in order to make drugs affordable and accessible</td>
<td>Health Policy</td>
<td>Patient would benefit from a new drug for chronic illness</td>
<td>Patient forced to use generic drug, not optimized</td>
<td>Patient pays for drug out of pocket or uses samples</td>
</tr>
<tr>
<td>Universal Health Insurance is installed</td>
<td>Health Insurance</td>
<td>Patient requires imaging for diagnosis</td>
<td>Delayed diagnosis due to inappropriate imaging</td>
<td>Patient pays or relies on personal insurance for imaging</td>
</tr>
<tr>
<td>Clean water and sanitation is ensured for all the population</td>
<td>Water systems</td>
<td>Patient lives in an area with unclean water</td>
<td>Patient infected</td>
<td>Patient relies on personal filters or water systems</td>
</tr>
</tbody>
</table>

*BMJ Case Reports*
MOVING UPSTREAM FROM BEHAVIORS TO POPULATION CHANGE

Upstream

Social Inequalities (race, class, gender)

Institutional Power (Govt., Business, Schools)

Midstream

Neighborhood conditions

Risky Behaviors (smoking, drugs, violence)

Downstream

Disease and Injury

Mortality
LEVEL OF INTERVENTION

UPSTREAM

STATE/NATIONAL

CLINIC

INDIVIDUAL

DOWNSTREAM
PRACTICAL INTERVENTIONS AT THE CLINIC LEVEL

► SDOH Interviewing
► SDOH Screening (SDOH-6 Screening Tool)
► SDOH integrated into EHR (Questionnaire & ICD 10)
► Train clinic staff and leadership
► Expand clinic services to meet SDOH needs
► Integrate Trauma Informed Care
► Interdisciplinary approaches to care using team based model/chronic disease model
► Expand referral and community resources
EXPANDED SERVICES IN THE CLINIC

- Navigators and Community Health Workers
- Medication Assistance
- Transportation
- Mobile Clinics/ER/Jail
- Reach out and Read
- Professional Interpreter Services
- Voter Registration
- Housing
THE EVERYONE PROJECT TOOLKIT

  - Building a team approach to addressing SDoH
  - Building cultural competency
  - Key aspects of health literacy
  - Addressing implicit bias
  - Tips on talking to elected officials
  - Links to resources
  - Social Needs Patient Action Plan
IMPACT OF SDoH AT THE INDIVIDUAL LEVEL
PERCENT OR AMERICANS WHO COULD COME UP WITH $400 IN AN EMERGENCY

- 26%
- 46%
- 66%
- 86%
ANSWER: 46%

Respondents who would completely pay an emergency expense that costs $400 using cash or a credit card that they pay off at the end of the month (by family income, race, and ethnicity)

IT IS TOUGH BEING POOR IN THE US

Federal poverty guidelines:
  For a family of four it is $25,750
  For a single person it is $12,490

Medicare is a federal program and consistent across all states
  Straight Medicare has no prescription benefit
  Medicare Advantage plans have prescription benefits, but have higher premiums

Medicaid is a state-federal partnership and eligibility and coverage vary widely
  Each state sets its own rules on things such as Medicaid Spenddowns
PRICE OF INSULIN OVER THE LAST DECADE

Insulin list prices over the last decade

- Levemir
- Novolog
- Lantus
- Humalog

Price at the start of 2009 vs. Current price in 2019

Sources: Truven Health Analytics; Bloomberg
ARE YOU OVERWHELMED YET?

► WHAT CAN AN INDIVIDUAL PROVIDER DO?
► A LOT, ACTUALLY
ASK SOME SIMPLE SCREENING QUESTIONS

► Are you working these days?
► Where are you living these days?
► How far did you get in school? Did you have any trouble with reading or math?
MAKE USE OF FREE ONLINE TOOLS

<table>
<thead>
<tr>
<th>Tool</th>
<th>Website</th>
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</thead>
<tbody>
<tr>
<td>One Degree</td>
<td><a href="https://www.1degree.org/">https://www.1degree.org/</a></td>
</tr>
<tr>
<td>Aunt Bertha</td>
<td><a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></td>
</tr>
<tr>
<td>211</td>
<td><a href="https://wa211.org/">https://wa211.org/</a></td>
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<tr>
<td>Health Leads</td>
<td><a href="https://healthleadsusa.org/">https://healthleadsusa.org/</a></td>
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REFER YOUR STRUGGLING PATIENTS TO A COMMUNITY HEALTH CENTER

- It’s what we were created to do--we won’t get mad