Chicago Town Hall: *Panel on Integrating Social Determinants of Health and Health Equity into Nursing Research*

June 7, 2019

Robyn Golden, LCSW

Associate Vice President of Population Health and Aging, Rush University Medical Center

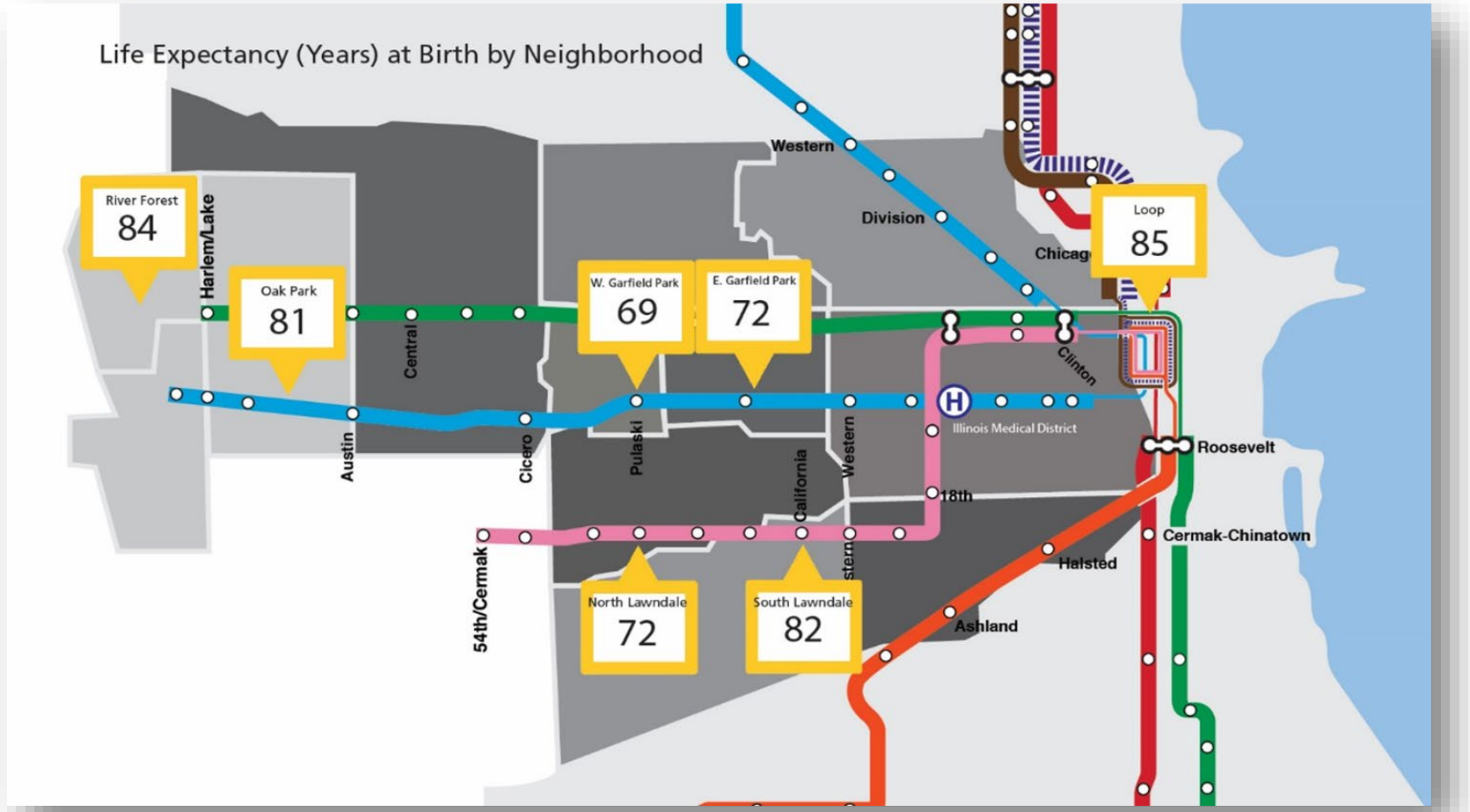
Co-Director, Center for Health and Social Care Integration

Robyn_L_Golden@rush.edu

RUSH

CHaSCI
Center for Health and Social Care Integration

Social determinants of health (SDOH): The new vital sign

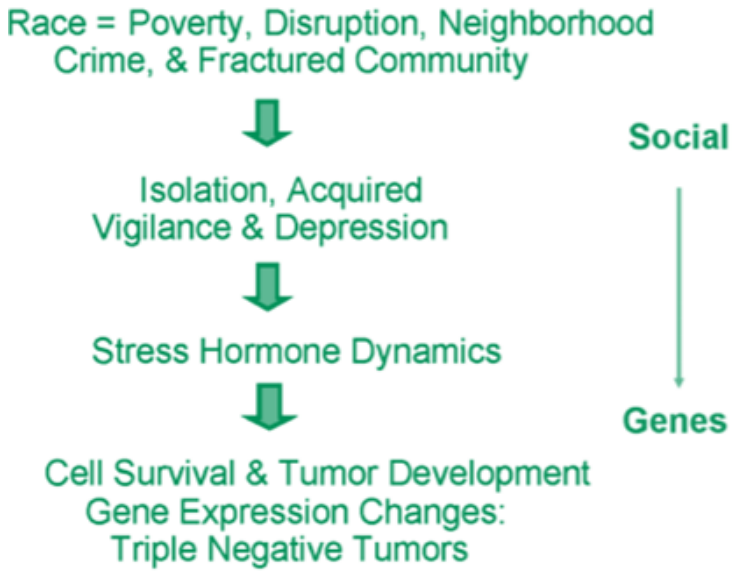


Source: The Death Gap: How Inequality Kills. David A Ansell, MD. https://www.press.uchicago.edu/ucp/books/book/chicago/D/bo25081418.html

Why the disparities?

- **Multiple factors contribute to inequitable outcomes → diverse disciplines needed to understand pathways and design& deliver interventions**

- **Example: a model for studying disparities in breast cancer rates and outcomes**

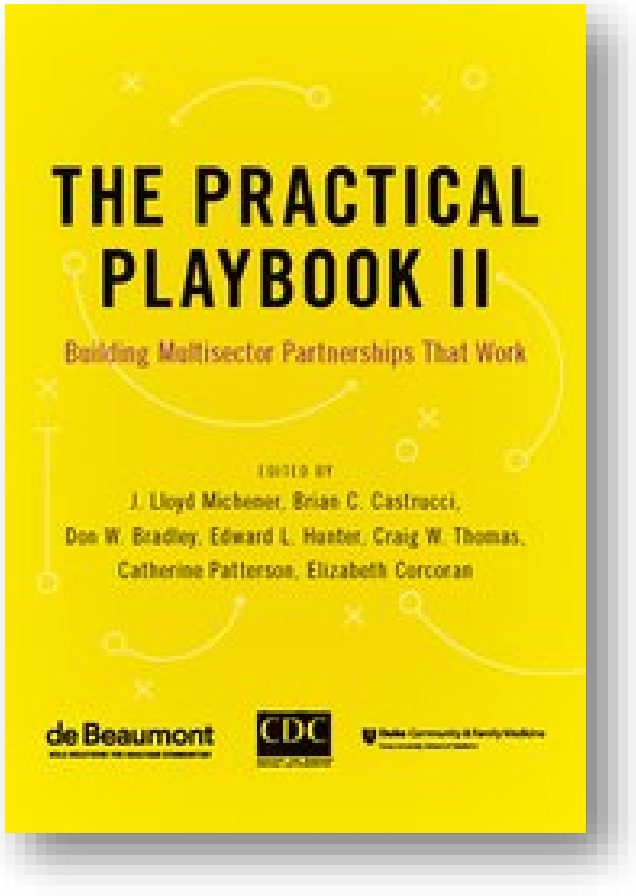


Sarah Gehlert PhD , Ann Murray , Dana Sohmer , Martha McClintock , Suzanne Conzen & Olufunmilayo Olopade (2010) The Importance of Transdisciplinary Collaborations for Understanding and Resolving Health Disparities, Social Work in Public Health, 25:3-4, 408-422, DOI: 10.1080/19371910903241124

https://www.cdc.gov/minorityhealth/publications/health_equity/index.html, https://journals.lww.com/jphmp/toc/2016/01001

Making health systems responsive to public health needs

- **The Practical Playbook: to become *socially accountable*, academic medical centers must:**
  - adapt health professions education and training to the local community's needs
  - define institutional objectives together with society
  - contextualize educational programs to improve local health outcomes
  - focus evaluations on impact
  - utilize partners as program assessors
  - graduate true change agents



https://www.practicalplaybook.org/

It takes a team

"Most successful chronic illness interventions include **major roles for nonphysicians."**

"Teams that cross practice or organizational boundaries may create communication and administrative nightmares, but are **essential for optimizing care for many patients."**

"Patient care teams in primary care have the potential to improve the quality of care for patients with chronic illness **if the roles of team members are clearly defined and explicitly delegated** and if team members are trained for their roles."

"To ensure effective clinical and behavioral management, **practice teams must have the necessary expertise, information, and resources to act rather than simply react.** The challenge then is to create a delivery system that **promotes productive interactions**."

Rothman AA, Wagner EH. Chronic illness management: what is the role of primary care?. Annals of Internal Medicine. 2003 Feb 4;138(3):256-61.
Wagner EH. The role of patient care teams in chronic disease management. Bmj. 2000 Feb 26;320(7234):569-72.

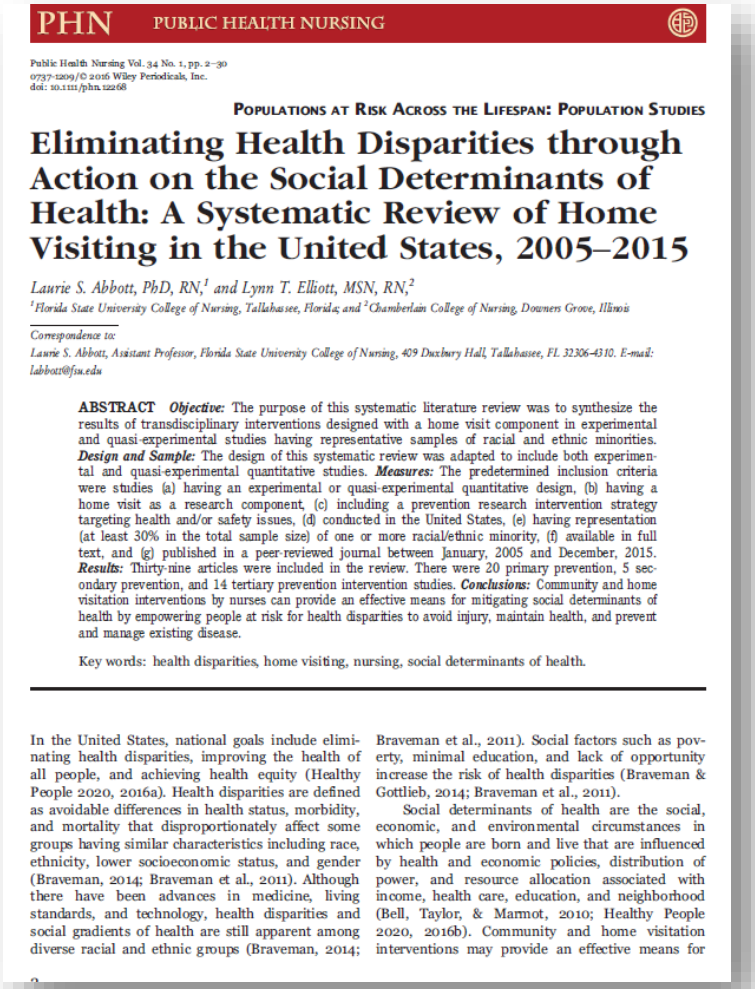
Identifying SDOH needs within healthcare settings

- **Survey of interprofessional clinicians about screening for and addressing social needs**
  - N = 258
    - 60% physicians, 16% pharmacists,13% nurses, 5% social workers from a large integrated health system in California (inpatient and outpatient providers)
  - Non-physicians were more likely than physicians to…
    - report that they were aware of resources to address social needs (64% vs. 45%, P=0.03)
    - think that social needs were an issue for most of their patients (90% vs. 76%, P=0.02)
    - endorse concerns that patients will feel uncomfortable answering questions about social needs (29% vs. 15%, P<0.01)

- **Many systems report using social workers and CHWs to screen for SDOH needs**

Schickedanz, A, Hamity C, Rogers, A, et al. Clinician experiences and attitudes regarding screening for social determinants of health in a large integrated health system. Med Care. 2019;57:S197-201. doi: 10.1097/MLR.0000000000001051.

Nurses and SDOH research



PHN PUBLIC HEALTH NURSING

Public Health Nursing Vol. 34 No. 1, pp. 2–30
0737-1209/© 2016 Wiley Periodicals, Inc.
doi: 10.1111/phn.12268

POPULATIONS AT RISK ACROSS THE LIFESPAN: POPULATION STUDIES

Eliminating Health Disparities through Action on the Social Determinants of Health: A Systematic Review of Home Visiting in the United States, 2005–2015

Laurie S. Abbott, PhD, RN,[1] and Lynn T. Elliott, MSN, RN,[2]
[1]Florida State University College of Nursing, Tallahassee, Florida; and [2]Chamberlain College of Nursing, Downers Grove, Illinois

Correspondence to:
Laurie S. Abbott, Assistant Professor, Florida State University College of Nursing, 409 Duxbury Hall, Tallahassee, FL 32306-4310. E-mail: labbott@fsu.edu

ABSTRACT ***Objective:*** The purpose of this systematic literature review was to synthesize the results of transdisciplinary interventions designed with a home visit component in experimental and quasi-experimental studies having representative samples of racial and ethnic minorities. ***Design and Sample:*** The design of this systematic review was adapted to include both experimental and quasi-experimental quantitative studies. ***Measures:*** The predetermined inclusion criteria were studies (a) having an experimental or quasi-experimental quantitative design, (b) having a home visit as a research component, (c) including a prevention research intervention strategy targeting health and/or safety issues, (d) conducted in the United States, (e) having representation (at least 30% in the total sample size) of one or more racial/ethnic minority, (f) available in full text, and (g) published in a peer-reviewed journal between January, 2005 and December, 2015. ***Results:*** Thirty-nine articles were included in the review. There were 20 primary prevention, 5 secondary prevention, and 14 tertiary prevention intervention studies. ***Conclusions:*** Community and home visitation interventions by nurses can provide an effective means for mitigating social determinants of health by empowering people at risk for health disparities to avoid injury, maintain health, and prevent and manage existing disease.

Key words: health disparities, home visiting, nursing, social determinants of health.

In the United States, national goals include eliminating health disparities, improving the health of all people, and achieving health equity (Healthy People 2020, 2016a). Health disparities are defined as avoidable differences in health status, morbidity, and mortality that disproportionately affect some groups having similar characteristics including race, ethnicity, lower socioeconomic status, and gender (Braveman, 2014; Braveman et al., 2011). Although there have been advances in medicine, living standards, and technology, health disparities and social gradients of health are still apparent among diverse racial and ethnic groups (Braveman, 2014; Braveman et al., 2011). Social factors such as poverty, minimal education, and lack of opportunity increase the risk of health disparities (Braveman & Gottlieb, 2014; Braveman et al., 2011).

Social determinants of health are the social, economic, and environmental circumstances in which people are born and live that are influenced by health and economic policies, distribution of power, and resource allocation associated with income, health care, education, and neighborhood (Bell, Taylor, & Marmot, 2010; Healthy People 2020, 2016b). Community and home visitation interventions may provide an effective means for

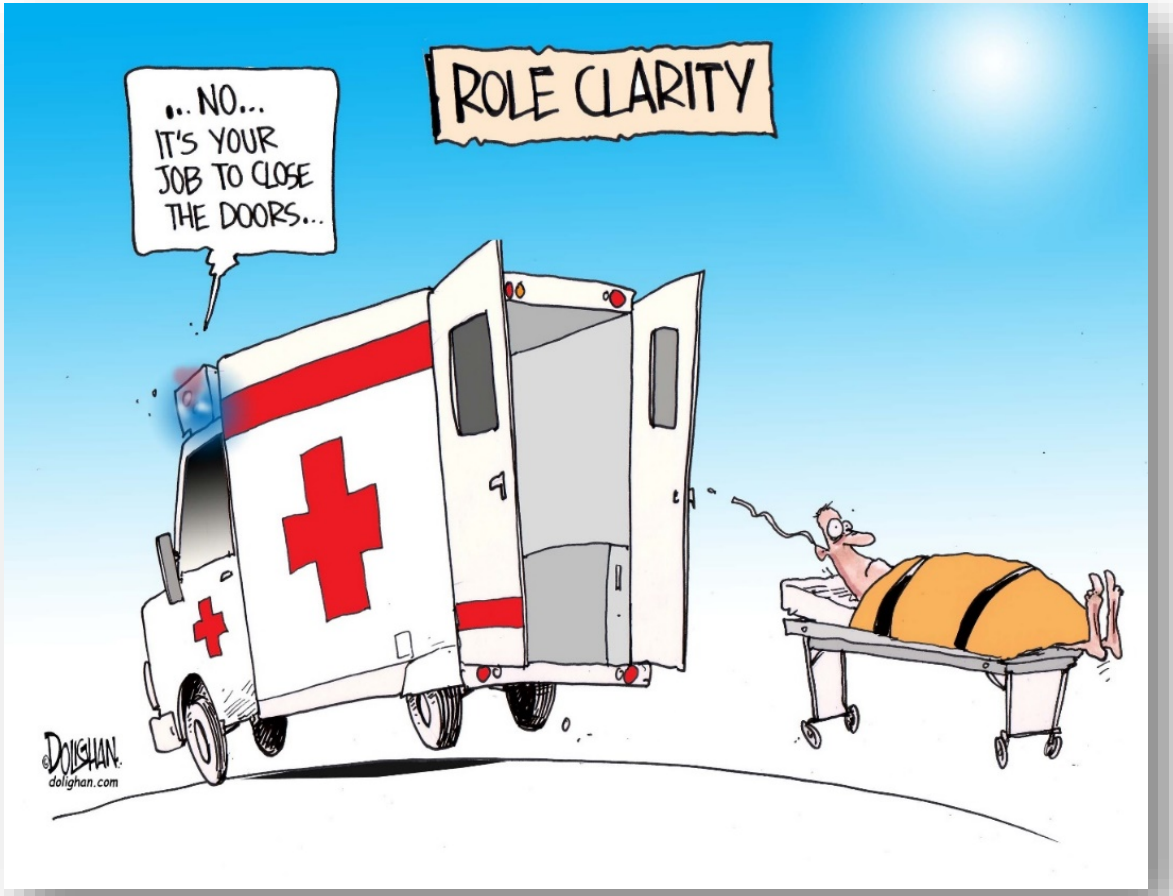
Bringing nurses to “the table”

- **Survey of Rush RNs (N=449): What are the barriers to addressing issues (SDoH) with patients in your care?**

• I believe that social work handles these types of issues	197 (43.8%)
• I believe that case management handles these types of issues	185 (41.1%)
• I don’t know how to address the issues if they are present	180 (40%)
• I think my patients would be uncomfortable if I asked	166 (36.9%)
• It takes too much time	120 (26.7%)
• I’m uncomfortable asking this type of information	113 (25.1%)
• There are other people in the organization who address these issues	91 (20.2%)
• Nurses should not be involved in these types of issues	20 (4.4%)
• I don’t think my patients have these types of issues	16 (3.6%)
• I don’t think these are important issues	1 (0.2%)

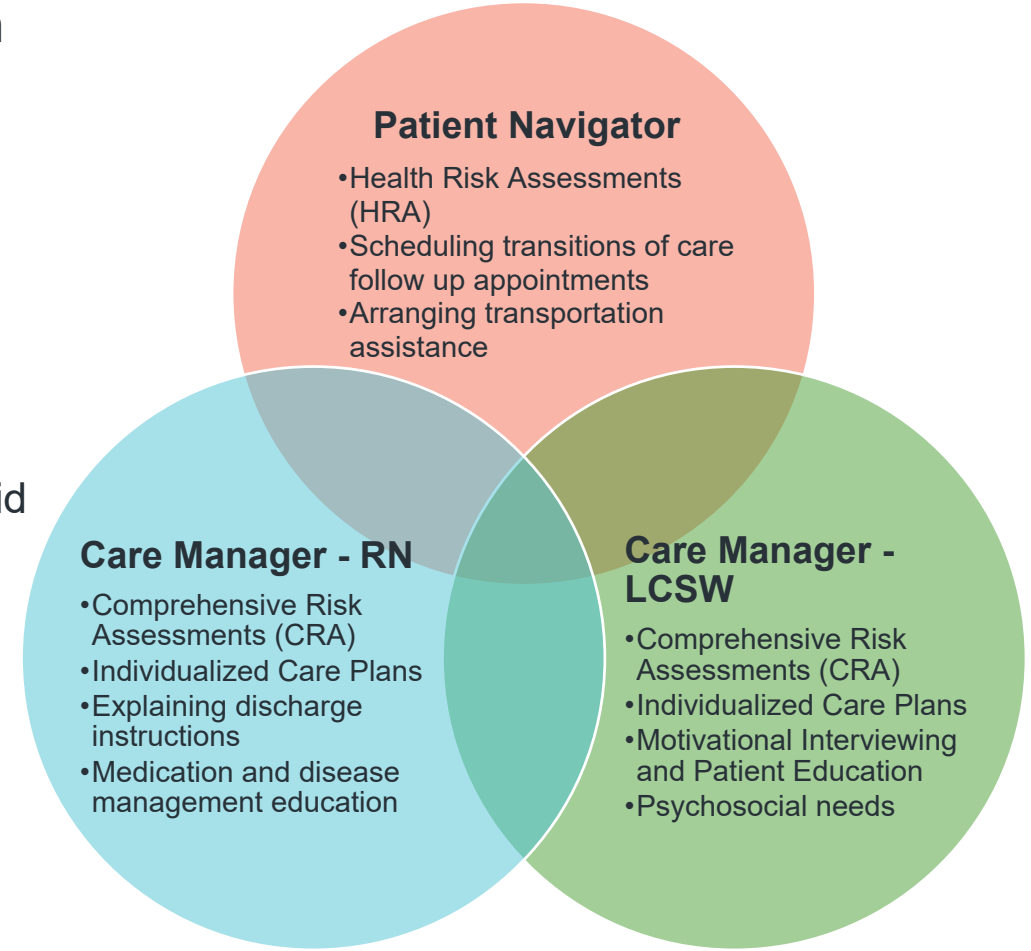
Janice Phlllips. Survey conducted winter 2019 at Rush University Medical Center. Unpublished data.

Addressing SDOH as a team



A “triad” approach to care management

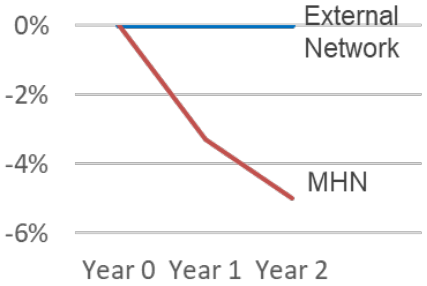
- **Rush’s Population Health team uses a triad model to provide care management for various value-based contracts**
  - SW, RN, and/or Patient Navigator
  - Based on client need
  - Pharmacist consultation
  - Includes playing a lead care management role within a Medicaid Accountable Care Organization



Contributing to improved outcomes across the Medicaid Accountable Care Organization

Total Cost of Care

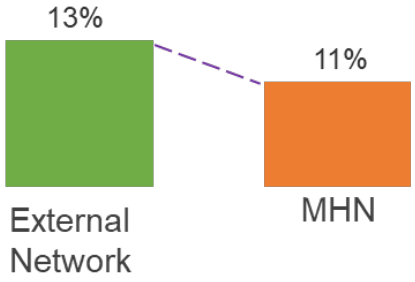
*The difference in cost of care for MHN versus other Medicaid patients in IL is **3.5%** in Year 1 and **5%** in Year 2 below trend*



5% LOWER COST
(risk adjusted)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care
Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population

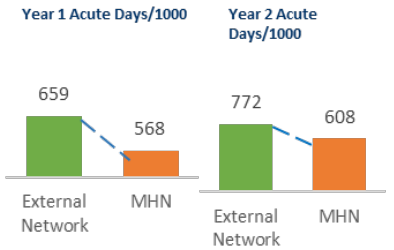
ACA Readmission



15% BETTER OUTCOME

ACA Utilization

Inpatient Days/1000



YEAR 1 Jul14–Jun15
14% BETTER OUTCOME

YEAR 2 Jul15– Jun16
21% BETTER OUTCOME

ED Visits/1000

YEAR 1 Jul14–Jun15
18% BETTER OUTCOME

YEAR 2 Jul15–Jun16
17% BETTER OUTCOME

Patient Engagement

MHN ACO:
71% COMPLETE

External Network:
31% COMPLETE

130% BETTER OUTCOME

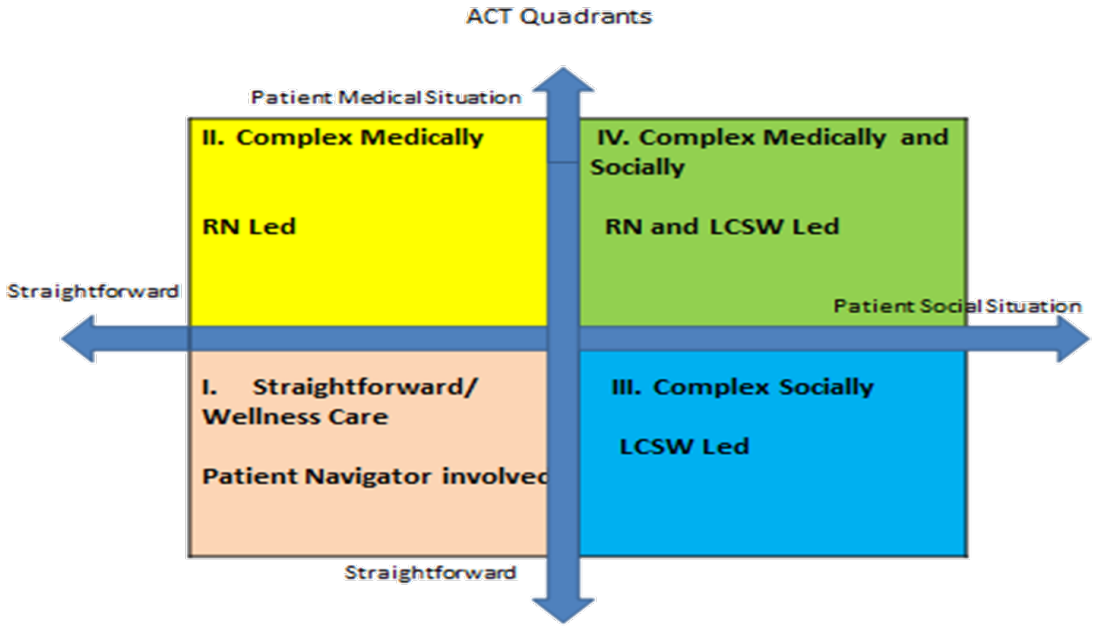
Period: July 1, 2014 – Present

RUSH

CHaSCI
Center for Health and Social Care Integration

Modeling out the triad's collaboration

- **"Activation and Coordination Team" (ACT) model**
  - Suggested protocol based on which quadrant patient is in
- **Hypothesis: by using assessments, we can efficiently identify who should be the lead care manager**



Source: Miller AM, Swartwout KD, Schoeny ME, Vail M, McClenton R. Care coordination to target patient complexity and reduce disparities in primary care. Public Health Nursing. 2019 Mar 20.

ACT triad care management: Who reports doing what?

- **Surveyed RN, LCSW, and patient navigators about care management activities performed in a typical work week (n=22)**

- **Activities that RNs reported performing always or often:**

100% reported always/often	**Patient engagement, obesity management**
75% reported always/often	**Discussing risk reduction, making inpatient visits, delegating tasks, problem solving**
50% reported always/often	**Administering risk appraisals, discussing nutrition, managing mental health conditions, managing chronic pain**
25% reported always/often	**Arranging transportation, psychoeducation, end of life issues**

Source: Swartwout, K., Vail, M., Miller, A. Schoeny, M., and Mclenton, R. (2017). Care Management Survey. Unpublished data.

A warning and call to action

- **To impact inequities on a population level, we must build evidence base needed to successfully sustain interventions in resource-limited settings**

"Future work must develop an evidence base about:

- the **professional skills and knowledge** that are required to address social needs successfully within health care settings;
- the **activities, tasks, and services addressing social needs** that directly result in improved outcomes;
- and the **patient risk factors that are most susceptible** to social support.

This level of specificity is required to support the development and refinement of models that are credible, replicable, and sustainable."

Source: Shier, Gayle, et al. "Strong social support services, such as transportation and help for caregivers, can lead to lower health care use and costs." Health Affairs 32.3 (2013): 544-551. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0170

Thank you!

Robyn Golden, LCSW

Associate Vice President of Population Health and Aging,
Rush University Medical Center

Co-Director, Center for Health and Social Care Integration

Robyn_L_Golden@rush.edu

www.chasci.org