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

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

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

PAVING THE ROAD TO HEALTH EQUITY

Health Equity is when everyone has the opportunity to be as healthy as possible.

Programs: Successful health equity strategies

Measurement: Data practices to support the advancement of health equity

Policy: Laws, regulations, and rules to improve population health

Infrastructure: Organizational structures and functions that support health equity

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.**”


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**

In the United States, national goals include eliminating health disparities, improving the health of all people, and achieving health equity (Healthy People 2020, 2020a). 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 (Brauman, 2014; Brauman 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 (Brauman, 2014; Brauman et al., 2011). Social factors such as poverty, minimal education, and lack of opportunity increase the risk of health disparities (Brauman & Gottlieb, 2014; Brauman 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, 2020b). 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?**

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

Janice Phillips. Survey conducted winter 2019 at Rush University Medical Center. Unpublished data.
Addressing SDOH as a team

... NO... IT'S YOUR JOB TO CLOSE THE DOORS...

ROLE CLARITY
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

**Patient Navigator**
- Health Risk Assessments (HRA)
- Scheduling transitions of care follow up appointments
- Arranging transportation assistance

**Care Manager - RN**
- Comprehensive Risk Assessments (CRA)
- Individualized Care Plans
- Explaining discharge instructions
- Medication and disease management education

**Care Manager - LCSW**
- Comprehensive Risk Assessments (CRA)
- Individualized Care Plans
- Motivational Interviewing and Patient Education
- Psychosocial needs
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)

**ACA Readmission**

- 13% External Network
- 11% MHN

**Patient Engagement**

**Inpatient Days/1000**

- Year 1 Acute Days/1000
  - External Network: 659
  - MHN: 568
  - 14% BETTER OUTCOME

- Year 2 Acute Days/1000
  - External Network: 772
  - MHN: 608
  - 21% BETTER OUTCOME

**ED Visits/1000**

- Year 1 ED Visits/1000
  - External Network: 907
  - MHN: 743
  - 18% BETTER OUTCOME

- Year 2 ED Visits/1000
  - External Network: 903
  - MHN: 750
  - 17% BETTER OUTCOME

**MHN ACO:**
- 71% COMPLETE

**External Network:**
- 31% COMPLETE

**130% BETTER OUTCOME**

Period: July 1, 2014 – Present
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

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:

<table>
<thead>
<tr>
<th>Percentage Reported</th>
<th>Activity Description</th>
</tr>
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<tbody>
<tr>
<td>100%</td>
<td>Patient engagement, obesity management</td>
</tr>
<tr>
<td>75%</td>
<td>Discussing risk reduction, making inpatient visits, delegating tasks, problem solving</td>
</tr>
<tr>
<td>50%</td>
<td>Administering risk appraisals, discussing nutrition, managing mental health conditions, managing chronic pain</td>
</tr>
<tr>
<td>25%</td>
<td>Arranging transportation, psychoeducation, end of life issues</td>
</tr>
</tbody>
</table>

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!

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