

# The Social Side of Health Impacts Outcomes

By Joanne Kaldy

There are many factors that influence a person's ability to recover and stay healthy and safe after they leave a post-acute and long-term care facility and return home. A program at PALTC22, "Social Determinants of Health: A Practice Imperative for Promoting Health Equity and Quality in PALTC," identified how practitioners can connect with community and other resources to ensure a smooth care continuum and prevent patients from avoidable readmissions and emergency department visits.

Social determinants of health (SDOH) include economic and social conditions that influence individual and group differences in health status. More specifically, the Healthy People 2030 report defined these as "conditions in the environments where 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" (<https://health.gov/healthypeople>).

## The (Five) Ties That Bind

"There are many elements that can contribute to a patient's outcomes," said Mamata Yanamadala, MD, MBBS, an assistant professor at Duke University School of Medicine in Durham, NC. However, there are five established domains of social determinants: education access and quality, economic stability, health care access and quality, social and community context, and neighborhood and built environment (<https://health.gov/healthypeople>).

All these issues can have a domino effect on other areas. For instance, Dr. Yanamadala noted, "One in 10 people are living in poverty. And poverty often limits people's access to food, transportation, and other supports and services." She stressed the importance of not underestimating the impact of social connections on health. She explained, "For one, the impact of loneliness is equivalent to smoking 15 cigarettes a day."

The community where patients live and receive care can make a difference. As Diane Sanders-Cepeda, DO, CMD, senior medical director at UHC E&I Retiree Solutions in Cooper City, FL, said, "In thinking about our residents, we need to consider what's happening in our facilities and the challenges they face." She noted that ZIP codes tell us a great deal: where someone lives is linked to transportation, housing, income, education, and food access. The ZIP code of a facility also can speak volumes about issues such as social and institutional inequities, living conditions, behaviors, and health outcomes.

It also is important to understand where a resident has come from and where they will be going after discharge. As Dr. Sanders-Cepeda said, "You have to think about the neighborhood and community the person will go to." Unhealthy eating and lack of access to

fresh foods; crime, drug, and alcohol abuse; and lack of family or social connections all can impact individuals' ability to continue their recovery and stay healthy.

There are several impact points where SDOH should be addressed in PALTC, Dr. Sanders-Cepeda said. These include on admission and discharge, at transitions, and in subacute rehabilitation, long-term care, and palliative/hospice care. "We need to go beyond just asking what social determinants of health might impact the individual to considering why," she said.

## All About Assessments

Dr. Sanders-Cepeda noted that there are three different approaches to assessing SDOH, which can be found in the 2020 "Social Determinants of Health: Resource Guide" from the National Committee for Quality Assurance (NCQA) (<https://bit.ly/3vkLjwi>):

- Strength-based assessment — focusing "on measuring a patient's positive or protective factors that help them take actions toward improved health."
- Risk-based assessments — "more commonly used in medical settings," capturing "individual characteristics associated with poor health outcomes."
- Needs-based assessment — gauging "individuals' immediate unmet needs based on their preferences and priorities."

There are several SDOH assessment tools, such as the Montefiore 10-Question SDOH Survey. This is a simple list of yes/no questions that inquire about patients' confidence that they will have a stable place to live in the coming months and can meet their needs for childcare or care for an older family member, a need for legal help, their ability to pay utility bills, and more.

"Several practitioners may have responsibility for SDOH assessment," said Dr. Yanamadala. These can be conducted in several ways, including verbally in person, verbally remote, in writing (the person fills out an assessment in the office before an appointment, online, or via mail), or at a kiosk or on a tablet.

According to the NCQA resource guide, studies have found that "patients are increasingly open to being asked about their social needs in clinical settings." As Dr. Yanamadala said, "They understand that these questions are important and have an impact on outcomes." She pointed to a recent study conducted across 10 sites in nine states that was summarized in the NCQA resource guide which found that patients:

- "Know the importance of assessing for social risks."
- "Understand the connection between social risks and overall health."

- "Feel that patient-centered implementation of social risk assessment is important."
- "Recognize there are limits to health care's capacity to address or resolve social risks."

In addition to talking with patients, Dr. Yanamadala stressed that "it's important to engage family members and other stakeholders and get input from them." It also is key, she said, to seek other sources of data including formal assessments, electronic health records (EHRs), and claims data. She also referred to Dr. Sanders-Cepeda's comments and said, "Use the ZIP code as a proxy to understand patients' likely SDOH and social risks."

SDOH data can be captured in EHRs using validated tools. At the same time, the availability of SDOH data in the EHR can help clinicians link their patients to community resources. However, Dr. Yanamadala said, there are several logistical barriers to incorporating SDOH in EHRs, "including lack of knowledge and consensus, resource differences between social services and health care organizations, lack of multi-sector collaboration, and difficulties with current technology systems" (*Ann Intern Med* 2018;168:577-578).

Additionally, some Minimum Data Set (MDS) data may correlate with SDOH, including:

- Section C (Delirium)
- Section D (Mood)
- Section E (Behavior)
- Section G (Functional Status)
- Section I (Active Diagnoses)
- Section K (Swallowing/Nutritional Status)
- Section M (Skin Conditions)
- Section N (Medications)
- Section P (Restrains and Alarms)

It's not enough to collect data and information. Dr. Yanamadala stressed, "It is important to understand the impact of cultural humility." This means understanding that someone can never really know what another individual — one who resides in a different social and cultural universe — feels, thinks, or experiences.

In addition to physicians, other members of the care team can help assess SDOHs. For instance, the social worker plays a significant role. As Dr. Sanders-Cepeda said, "SDOH doesn't need to be assessed at one time and only by the physician."

## Social Prescribing

Just as practitioners prescribe medications and therapies, there also are opportunities for "social prescribing." As Robert Russell, MD, medical director at CommuniCare Health Services in Lafayette, IN, observed, "This presents an opportunity for health professionals to view patients through a social lens" and understand how various factors

impact their health and well-being. The key to effective social prescribing, he suggested, is asking patients "What matters to you?" instead of "What's the matter with you?"

At its best, social prescribing can connect and integrate social and community care and support with medical and clinical care, connect individuals with activities of personal interest, and help them with complex health and social needs. It also can address mental, psychosocial, socioeconomic, physical, and cognitive issues and community well-being, and help build community and a sense of belonging, increase sense of purpose, develop more control over well-being, increase peer support, and reduce physician/emergency department visits and health inequities. It is, he said, a holistic, strength-based approach to health that is co-created and community-led.

Social prescribing, Dr. Russell stressed, focuses on empowerment, resilience, and wellness rather than illness and deficits. 

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## Prognostication

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accumulation of geriatric syndromes means that, overall, prognostically, the patient is at higher risk," Dr. Bednarczyk said. "We need to assess: are we seeing any signs or symptoms that might indicate that the patient is getting closer to the end-of-life trajectory, such as ... edema or anasarca, unexplained tachycardia, or dyspnea?"

Helpful tools, she said, include the Clinical Frailty Scale and the ePrognosis website, the latter of which includes the well-known Palliative Performance Scale as well as several validated indices/calculators that can be used to estimate the mortality risk for specific populations. (For instance, the Mitchell index estimates six-month survival for an individual with advanced dementia.)

Edward Gometz, MD, CMD, said during the session that he sometimes shares the tools he has used during family meetings. "I explain [to families] that these are tools that are oftentimes used to help us with this really hard job of prognosticating," he said.

It is never too early to initiate goals of care conversations, he reminded session participants. "And goals of care should be revisited frequently." 

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