Private Practice: Attending to Business, episode ten—Social determinants of health in private practice
Featured topic and speakers

In the final episode of this mini-series, hosts Meghan and Taylor explore ways to assess social determinants of health (SDOH) at the patient level, link patients to resources, and define an SDOH plan for private practices.

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Resources

- [AMA STEPS Forward® module: Social Determinants of Health](#)
- [Health Equity & Health Disparities](#)
- [AMA STEPS Forward® Success Stories](#)

Hosts

- Meghan Kwiatkowski, private practice sustainability, AMA
- Taylor Johnson, physician practice development, AMA

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Transcript

**Speaker:** Hello, and welcome to the AMA STEPS Forward® podcast series. We'll hear from health care leaders nationwide about real-world solutions to the challenges that practices are confronting today. Solutions that help put the joy back into medicine. AMA STEPS Forward® program is open access and free to all at [stepsforward.org](http://stepsforward.org).

**Johnson:** Hello, and welcome to the final episode of Private Practice: Attending to Business, an AMA STEPS Forward® limited series podcast exploring the business side of private practice. In this series, we talk about how to navigate business operations and practice efficiency solutions to create a thriving and sustainable medical practice business. If you missed any of the episodes, I'd encourage you to go back and give them a listen.
I'm your host Taylor Johnson, manager of physician practice development at the American Medical Association, and I'm joined by my colleague and cohost Meghan Kwiatkowski, program manager of private practice sustainability, also at the American Medical Association. Collectively, we have two decades of experience in private physician practice and continue to support physician practices in our current work at the AMA. Before we start, I want to emphasize that this episode is for general informational purposes, and should not be relied on as medical, legal, or other professional advice. Listeners are always encouraged to consult a professional advisor for any such advice.

With some of the other topics we've discussed thus far, I want to offer a small preface to today's conversation by noting that social determinants of health are but one piece of a larger topic, in this case, health equity. The AMA has a Center for Health Equity and a number of resources available to delve deeper into this topic. We unfortunately don't have the time to cover all of that in just one episode, so we encourage our listeners to check out the AMA's website for additional details and for those resources that we do not touch on in the discussion today. And as always, we will link them in the podcast description for you.

With that said, let's start off today's discussion with the definition of social determinants of health. Meg, can you share that with us?

Kwiatkowski: Absolutely. So the World Health Organization defines social determinants of health, or SDOH, as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems that shape the conditions of daily life. They are also known as social and physical determinants of health and they impact a wide range of health functioning and quality of life outcomes.

An example of SDOH is the number of grocery and food options in a patient's area or the local housing policies and the availability of housing. These are not the same things as social needs, as social needs focus at the individual level and SDOH are more so at the community level.

Johnson: That's absolutely right. Social needs are things like access to healthy meals, a risk of eviction, or transportation to a doctor's appointment. It's an immediate need of an individual or family. I think it's important to note here that historically, the practice of medicine has focused on diagnosing and treating specific clinical conditions, but as medical knowledge has evolved and the health care system shifts to more value-based and population-focused medicine, practices are looking beyond their walls to understand how their patients' social and physical environments impact their health.

Meg, can you share a little bit about why this is and how social determinants of health impact health?

Kwiatkowski: Of course. So there is a really good infographic in our STEPS Forward® toolkit on social determinants of health that helps to explain this. It breaks out the impact of nonmedical determinants on the risk of premature death, and what it shows is that health is more than just medical care. To underscore this, we can look at the example which is given in the toolkit.

So say that there is poor air quality in a patient's home due to mold or to a pest infestation. This is detrimental to the individual's respiratory health. The resulting asthma or allergies, cough, headaches, that will impact their overall quality of life. And furthermore, if the patient can't remove himself or herself from the housing conditions, then that health problem will continue to persist despite the fact that they're receiving medical treatment.

In addition to influencing health and outcomes, Taylor, social determinants impact practices, clinical outcomes data, their financial sustainability, resource allocation decisions, and the overall health of communities and the health care system. As we move toward value-based care, expanding our health care focus to include social determinants of health is increasingly necessary, I think, to achieve improved outcomes.
Johnson: I completely agree. And now that we built the foundation for our discussion, let's shift our focus to ways that practices can address social determinants of health. As with any important initiative, the first couple of steps involve understanding and engaging your community, as well as engaging key leadership figures as appropriate.

It's incredibly important to understand the health needs of the community you serve. You've likely already seen the impact of social determinants of health among your patients, so a good place to start is reviewing your local community health needs assessment. This is also known as your CHNA. If your patient population seeks care across multiple hospital locations, you can sample a few of these reports to define their needs.

As far as leadership engagement goes, when you're in an individual practice, seeking your practice manager's buy-in and the physician owner's buy-in is really beneficial. For example, when I was in private practice, I worked in a subspecialty of ophthalmology, and I think it's a really common misconception that specialists can't have an impact on social determinants of health. We had to start thinking out of the box when exploring options of integrating social determinants of health into our practice. And the first way was expanding our reach into the community by attending community-based events to engage with patients and hosting educational sessions at community centers to inform members about how they can improve their eye health.

The second was including patients' family members more often as part of the team. So if the physicians felt that there was some sort of barrier between them and the patient, they would invite a member of the patient's family to review the treatment plan and help break down that barrier between the physician and patient for better outcomes. And now, this didn't always have to be that the family member was present in the office at the appointments. A lot of times the physician actually obtained consent from the patient to speak to a family member that they trusted, and so then the physician would call and have a discussion with the family member around the treatment plan and really made sure that the family was aware of everything that the patient needed.

Many practices have seen the positive impacts of addressing social determinants of health, both financially and in terms of patient health outcomes, and there are tools out there that can help practices calculate the return on investment for the intervention your practice is planning and offer a sustainable, data-driven approach.

So Meghan, what are some of the other things that practices should consider when addressing social determinants of health?

Kwiatkowski: So it sounds obvious but you really want to ensure, and be totally, totally confident, that your practice is ready to implement any kind of initiative. You really want to understand your own internal biases and your staff wants to do the same. You want to acknowledge and explore those. And by doing that, team members are then better equipped to create and to be a member of an engaged and empathetic team, which ultimately results in a high level of cultural competency. Conducting a readiness assessment can help your practice determine where you want to begin.

All that being said, choosing just one need in your patient population is best—even if the CHNA that you referenced earlier, Taylor, showed several areas of need—and will allow you to then select and define your plan. There are many ways to address a social determinant of health depending on the organization's size and capacity. So in a private practice, you might want to screen for select social determinants of health and refer patients to community organizations for assistance, whereas a larger practice might employ a social worker or a community health worker to navigate the referrals with their patient.

Johnson: And an important side note that I want to make. Meg, you've talked about quality improvement concepts in some other episodes, so I'll mention it here as well. It's a good idea to leverage quality improvement methods such as the PDSA, which is Plan Do Study Act or Lean concepts as you define your plan.
Kwiatkowski: That’s a great call out. So once we’ve gone through those first couple of steps that you and I have talked about, Taylor, what is next?

Johnson: So practices can begin assessing social determinants of health at the patient level. So they would incorporate screening tools into the workflow. In the social determinants of health STEPS toolkit, Meghan, that you referenced before, there’s a list of free screening tools for care teams.

And once patients who have unmet needs for your selected social determinant of health are identified, you can link patients to resources. So this would be providing patients with a list of resources that they would then contact and use, taking a more active role in engaging a resource alongside each patient, and following up to ensure each patient access the resource successfully is likely to have a much larger impact.

Kwiatkowski: Excellent point, Taylor. I do want to note: smaller practices, or really any practice that is worried about, you know what we’ve talked about so far, and that, you know, maybe they might not have the capacity to actively do the follow-up, can look to creative models to help extend the reach of their practice team. There are models out there that use students, or they use community health workers in this capacity that we’ve been touching on to accomplish this.

Johnson: I think that’s right. And it might seem overwhelming, but there are ways to get it done.

So as we start to wrap up this episode, the final few steps in this process include evaluating and refining the workflows as needed, but also celebrating success. Learn what is working, and what needs to change by talking with the rest of the team as well as the patients. If you discover that your screening method isn’t occurring as consistently as it should, examine the process to see if you can identify a better way to screen more patients.

Meg, any final thoughts on this or anything else we’ve discussed?

Kwiatkowski: A couple of things. I think first, I just want to note that, you know, all of the steps that you and I have touched on are covered in our STEPS toolkit that has been referenced throughout the conversation. And then also, by sharing success stories, those may inspire other practices to implement your model. So you know, when you talk about sharing the successes, you know what’s worked, what didn’t—practices who might not be at the same point in the journey, they may be inspired to implement your model or adapt it, and then that will help to scale and sustain the initiative and improve the health outcomes of many more patients across the community.

If practices are interested in sharing success stories around social determinants of health, they can contact the AMA STEPS Forward® team at the link in the podcast description.

Johnson: Thanks, Meg. So this episode covered social determinants of health and the impact on private practices. And we also gave some insights into methods to engage your community and create a plan to address social determinants of health in your practice.

The tools and resources mentioned in today’s episode are linked in the podcast description and available on the AMA website. CME is also available for this episode on the AMA's Ed Hub and linked in the podcast description. I’m Taylor Johnson and this has been a Private Practice: Attending to Business. Thank you for joining us throughout this series.

Speaker: Thank you for listening to this episode from the AMA STEPS Forward® podcast series. AMA's STEPS Forward® program is open access and free to all at stepsforward.org. STEPS Forward® can help put the joy back into medicine by offering real-world solutions to the challenges that your practice is confronting today. We look forward to you joining us next time on the AMA STEPS Forward® podcast series, stepsforward.org.
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