

How social determinants of health impact health outcomes with Laura Zimmermann, MD

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Featured topic and speakers

In today's AMA Update, Laura Zimmermann, MD, interim division chief of general internal medicine at Rush University Medical Center in Chicago, discusses a step-by-step approach for physicians to address social determinants of health in their practice. AMA Chief Experience Officer Todd Unger hosts.

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Speaker

- Laura Zimmermann, MD, interim division chief, general internal medicine, Rush University Medical Center

Transcript

Unger: In this episode, we're going to discuss a step-by-step approach for physicians to address social determinants of health in their practice. I'm joined today by Dr. Laura Zimmerman, interim

division chief of general internal medicine at Rush University Medical Center in Chicago. I'm Todd Unger, AMA's chief experience officer also in Chicago. Dr. Zimmerman, it's a pleasure to have you here today.

Dr. Zimmermann: Thank you, Todd. It's a pleasure to be here.

Unger: You were recently featured on a webinar that was hosted by the AMA to help physicians address social determinants of health in their practice. And in that discussion, you started with a case study about a young woman you were treating that really helps to illustrate the importance of screening for social determinants. Why don't we just start by having you tell us a little bit more about that experience and why it's so important for physicians to make this a standard part of care?

Dr. Zimmermann: Absolutely. Yes, I had the pleasure in clinic of meeting a young woman, 43-years-old, who had a past medical history of asthma. She'd actually had a gradual weight loss over the year before I had met her and had been interacting with the medical system. She lost about 30 pounds.

It was unclear why she was up to date with her age-appropriate cancer screening over the course of the 12 months prior to our meeting. She had undergone a variety of tests for causes for weight loss, a variety of lab work, imaging studies, including ultrasounds, CTs of the chest, abdomen, pelvis. She'd also undergone endoscopy, so she'd had an upper and lower endoscopy. And basically, no underlying cause for the weight loss had been identified.

In speaking with her about this and about her thoughts on this, it came to light that she was actually having difficulty affording food. And she was an adjunct professor at a local community college teaching English. And so, I believe that because of some of the assumptions that we were making as a clinical team, it never really occurred to us to explore whether or not she was able to afford food.

And that turned out to be the underlying reason for her weight loss. And we were able to refer her to our care management team, and we were able to get her resources for supplemental nutrition and whatnot. The next time we saw her a month or two later, she had started to regain some weight. And she had no clinical evidence that there was anything else going on.

Unger: So literally not eating because she couldn't afford that.

Dr. Zimmermann: Absolutely, yes.

Unger: Wow. Well, Rush now has a comprehensive plan in place to address social determinants of health and has also used tools from AMA's STEPS Forward toolkit. While most physicians can see the importance of this work, many don't just even know where to begin. So why don't we start by saying, what is the first step in implementing a plan? And is this something that only a large health system can do or is this something that applies to smaller practice physicians or a single physician?

Dr. Zimmermann: Great questions. So this is something that yes, ideally a large health system can embark down this road and do a comprehensive program. But even those programs start small. It can start with one clinic. It can start with one physician.

The goal is to really define an intervention and an outcome and concentrate your resources, as limited as they may be, on that one intervention and outcome. Because the key to scaling any sort of intervention, particularly for social determinants of health, is demonstrating an impact. So one physician can absolutely do it.

The way to begin, if you're a large health system and you have you have contracts with Medicare, for instance, you do have to do a community health assessment as part of your obligations to Medicare. And so individuals can look to that. Those are published publicly. They're typically available online for large health systems. That's one way to utilize data that are already available for classifying the needs of your community that you're serving.

You can also go—you can start smaller. You can just go into the clinic. You can start surveying patients. You can start surveying providers. You can start surveying staff. You can see what are the needs that have come up in conversation in the clinic and at what frequency.

Unger: That's interesting. So after physicians have taken a step like this, I'm sure that a lot of folks need to get leadership buy-in. And the best way to do this is by, of course, showing return on investment. How do physicians do this and how do you show an ROI at Rush for this kind of work?

Dr. Zimmermann: Absolutely. So, again, you can start small. You can identify a small group of individuals. There's a great example that was actually published in the *New England Journal of Medicine Catalyst* in 2017. Dr. David Burke and his colleagues actually identified 39 individuals with housing insecurity. And they identified individuals who had been hospitalized multiple times, had had multiple ER visits.

They implemented interventions that addressed social needs. And they were able to show in a pre- and post-analysis a savings of \$1.3 million to the health system just within this group of 39 individuals.

Unger: Wow.

Dr. Zimmermann: Yeah, it's pretty amazing. So you can definitely start small and demonstrate a huge impact. Here at Rush, one particular example that I'd like to pursue coming up is looking at food insecurity in our patients with diabetes who are part of our Medicare Shared Savings plan. We have actually—so we've instituted screening for food insecurity within our clinics.

But we've also actually opened a food pantry onsite that serves our clinic patients. And one of the upcoming ways that I hope to show return on investment in this is by looking at our Medicare

population. We know that food insecurity is associated with poor diabetes control. And we know that our institution, like many others, is part of these value-based contracts where we're already looking at diabetes control amongst this population.

And so if we can show that when we screen these individuals for food insecurity, link them to resources, their diabetes control is actually better, that's a clear return on investment. So you basically want to—even as the individual physician you can do this. You can model projects where you're utilizing the data that are already being collected, the priorities already set forth for the institution, to make the case for return on investment and scalability.

Unger: You know, I've been thinking about this question since the case study you mentioned up front and the focus here on food and security. Is that just something that in, let's say, a normal interaction, the patient's just not going to share?

Dr. Zimmermann: Exactly. So really, part of the key to social determinants of health is meeting the patients where they're at. And this also—so there's two things, right? The person who is doing the screening or the person bringing this up has to have humility, nonjudgment. There has to be an understanding of meeting the patient where they're at.

And so also, it's very important as well that we do this systematically. Because, as in the case with our 43-year-old patient, we assumed she did not have food insecurity because of her job and the status that we associated with her job. And so it's really important for a person-centered approach to have almost universal precautions, just like we do for health literacy. There needs to be a systematic way that we're actually screening for these so that we are defeating our own biases and our own limitations in meeting the patients where they're at.

Unger: Now, to the point what you were talking about before, which is the food insecurity and diabetes treatment, is that the kind of you—call it laser focus that you need to have to really identify a particular approach population, define a plan? Is that what you mean by that kind of laser focus that it takes to make this work?

Dr. Zimmermann: Yes, that's a great example. If we say, OK, we're focusing on our Medicare MSSP participants who have uncontrolled diabetes, we are going to screen for food insecurity in this subpopulation of our patients, we are going to link them to this resource and then we are going to look at their diabetes control, that's your PDSA right there. That's your project. That's how you start. And then there are clear ways that you can scale that to other settings after you demonstrate success.

Unger: Talk a little bit about the other screening procedures you have at Rush in terms of social determinants. What else are you building in in that systematic approach that you talked about?

Dr. Zimmermann: Sure, absolutely. So, yes, we are taking a systematic approach. We're taking a team-based approach. There are actually multiple points at which the patients interact with the health system and they are opportunities to be screened.

So, for instance, we know about 30% of our patients in most of our primary care clinics are engaging with MyChart. And so the social determinants of health screener is actually embedded in the check in on MyChart. So the patients have an option to interact with it at that point.

We then also are putting in kiosks that have tablets in which the patients can interact in the waiting room and fill out the social determinants of health screener. They can do it in a very anonymous way. They can go to the kiosk. It's very private. And they can fill out the screener in that capacity.

We also have it embedded in the medical assistant grooming protocol. And so the medical assistants, if the patient has not completed the screening via MyChart, via the kiosk in the waiting room, there's an opportunity for the medical assistants to identify that and complete the screener. The medical assistants can then load the smart set. And then the physician can actually sign the smart set to route a referral to care management. And the care manager then reaches out to the patient.

So it's a very systematic approach. There's technology involved. There are multiple team members involved.

Unger: I'm a Rush MyChart user, so I'm going to look for that the next time I'm checking in. I'll know what's going on there.

Dr. Zimmermann: Excellent.

Unger: So once you use these systems and you identify a particular social determinant with a patient, what are some things that physicians can do immediately to make sure that doesn't fall through the cracks and it gets addressed?

Dr. Zimmermann: Absolutely. So if you're in a system where you don't necessarily have a smart set, you don't necessarily have a referral, it's not embedded in the HR, there's still more you can do. There's actually an organization. It's actually called 211.org. And in the United States you can call 2-1-1 and you can actually be connected to care managers that can address things like child care, food insecurity, housing insecurity, support to find work, mental health resources, a very comprehensive suite of resources that address social determinants of health.

Now, that phone number is contracted out in some places. And so if you call 2-1-1 and you don't get the organization, you can go online and you can also connect patients via email to that organization. So that's a first step, certainly. The other thing that physicians can do over time is develop relationships with community-based organizations in the area.

So over the years, we've partnered with a lot of different community-based organizations that serve our patients and communities. And one of my colleagues, Robin Golden, who is the head of social work here and has really spearheaded these efforts, made a comment recently that a lot of these organizations would love it if a physician called them. If you picked up the phone and you called the local WIC office or you called the local Catholic charities and you said, "I have this patient who has this need, how can I connect them?" That would be very powerful.

Now, do we all have time to pick up the phone and call on behalf of all of our patients? No. But that's where if you start small and you can demonstrate impact, demonstrate return on investment, you can ask for the resources. You can ask for the team to be able to set up those connections systematically.

Unger: Well, let's finish our conversation here on that very topic, which is time. We hear a lot of discussions about electronic health records, adding more questions to that, limited amounts of time that people have with patients. And then the kind of work that you're talking about there was kind of outside of the normal interactions with patients. How do you account for that time and the training that would be involved in people doing that?

Dr. Zimmermann: Absolutely, absolutely. So when starting small, you can utilize some of the time that's already set up. So you can utilize team meetings, staff meetings, clinic meetings—only a fraction of them. You don't want to take up the entire meeting with a new initiative.

But you can use those meetings to start to plant the seeds, share the mission, share the point of the project, get feedback on the project before you launch it. So utilizing some of those standing meetings is key. In terms of training, we've talked a bit about defeating our own biases, working around our own assumptions.

You can leverage some of the trainings that are already happening. So a lot of institutions are already doing things like diversity equity and inclusion training. And so you may be able to actually piggyback off of some of that. Or process improvement training that's being given to the staff, you might be able to repurpose or even build off of some of the trainings that are already there. And so that's a timesaver as well.

In terms of embedding the questions and the screening in the rooming protocol, for instance, it's very important to choose high-yield questions. So you want validated, short-form questionnaires that investigate these things. And in our social determinants of health webinar, we went through a variety of different resources to look for those questions. You want to pull those questions out and always use the short form so you're getting the biggest bang for your buck for your medical assistant's time.

Unger: And speaking of that webinar, definitely take a look at the full webinar featuring Dr. Zimmerman and her colleagues from Rush by clicking on the link in the description in this episode. And you can also find a link to the AMA STEPS Forward module, including a toolkit and other

resources.

Dr. Zimmerman, thanks so much for joining us today. It was an excellent discussion. I learned a lot. And we'll be back soon with another video and podcast soon. In the meantime, for all our videos and podcasts, go to ama-assn.org/podcasts. Thanks for joining us. Please take care.

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