Treatment has minor role in health outcomes

By Dana Beezley-Smith, Ph.D.

As healthcare providers grapple with the Affordable Care Act's call to reduce costs while improving quality, they're running into a roadblock: Most clinical improvements are out of their hands.

Professional services are estimated to drive only 10 percent to 20 percent of health outcomes, according to Sanne Magnan, M.D, Ph.D, senior fellow at HealthPartners Institute, a Michigan-based healthcare and insurance provider. Health-related behaviors, socioeconomic factors and environmental factors – called the Social Determinants of Health or SDoH – are responsible for the rest, she says.

Providers need to think beyond clinical care, says Thomas Kottke, HealthPartner's medical director for well-being.

The company has since 2015 surveyed its patients and members on seven domains thought to influence well-being and thus medical outcomes – "emotional functioning, physical functioning, career satisfaction, adequacy of financial resources, social/interpersonal relations, community support and meaning and purpose."

Survey data are used "to identify and address the conditions that create the highest burden of disease" and are compared with individuals' medical records to see, for example, if they're adopting healthy habits.

HealthPartners is one of many organizations across the country collecting SDoH information to monitor population status, track individual behaviors and study disparities.

But it was the Institute of Medicine that recognized the benefits of the ACA in documenting patients' SDoH in a more granular fashion, "with electronic health records as a unifying nervous system."

According to the World Health Organization, SDoH represent "the conditions in which people are born, grow, live, work and age." Such circumstances are seen as "shaped by the distribution of money, power and resources at global, national and local levels" and are the primary cause of health inequities.

Efforts to address heath disparities build upon provisions of the ACA that required federal documentation of Americans' race, ethnicity, sex, gender identity, primary language and disability status to research and determine solutions for underserved and minority communities.

In 2016, the Obama administration created an ACA-funded program, the Accountable Health Communities Model, requiring participants to screen Medicare and Medicaid beneficiaries for social needs and link them to community programs.

States are increasingly encouraging or requiring health systems and managed care organizations (MCOs) to create partnerships with community-based programs to identify and address unmet needs (e.g., housing instability, food insecurity, utility needs, interpersonal violence, social and transportation needs).

In New York's Medicaid program, providers in value-based payment arrangements must implement at least one SDoH intervention and contract with one local agency such as a housing organization or a food bank.

Tufts University School of Medicine researchers studied a variety of SDoH assessment tools and found 15 core domains: culture/religion, demographics, economic indicators, education, employment status, family/living arrangements, functional status, healthcare access, health-related behaviors, language, material hardship, mental health, social support, trauma/violence and veteran status.

Health-related indices measure alcohol, caffeine and tobacco use, secondhand smoke, physical activity, sexual activity, diet, safety, use of bike helmets, seat belts, and smoke detectors, baby-proof environments, gun ownership, driving safety and screen time. Trauma/violence subdomains include intimate partner violence, trauma, and physical, sexual, mental and child abuse.

While some psychologists may have concerns about sharing such personal details, that door was cracked open in 2015 when the country adopted the WHO's detailed ICD-10-CM system. The Z codes in particular were intended to capture contact with health services and factors that influence health status, including Z55-Z65 codes that specifically identify potential socioeconomic and psychosocial health hazards.

Z codes target nonclinical circumstances such as Hostility toward and scapegoating of child (Z62.3), High-risk bisexual behavior (Z72.53), Personal history of self-harm (Z91.5), Encounter for mental health services for victim of child sexual abuse by parent (Z69.010), and Discord with counselors (Z64.4), neighbors (Z59.2) or workmates (Z56.4).

UnitedHealthcare, the American Medical Association (AMA) and the Association of American Medical Colleges recently recommended expanding Z55-Z65 codes to report on circumstances such as "Can hardly ever count on family and friends in times of trouble (Z60.83)" and "Inadequate social interaction – limited to once or twice per week (Z60.82)."

"The industry needs to make better use of the established ICD-10 Z codes in place, including documentation of the SDoH by the entire inter-professional care team," says Ellen Fink-Samnick, MSW, owner of consulting company EFS Supervision Strategies. "Organizations are hemorrhaging wasted dollars by not addressing the SDoH."

The National Association of Community Health Centers launched a new national effort called "The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) to standardize SDoH assessment and interventions. The AMA also lists five other toolkits for medical practices.

While SDoH documentation was originally restricted to physicians, community health workers, college student volunteers, case workers, social workers, nurses and therapists may now report conditions. PRAPARE developers recommend clinical staff members collect data through interviewing called "empathic inquiry" to increase individuals' willingness to voluntarily divulge sensitive information.

Other data sources include wearable health device feedback, credit card records, smartphone apps and location information and social media postings.

Last December, Facebook's health team wrote for the *Journal of the American Medical Association* that "social network data in combination with increasingly available digital healthcare data… could lead to novel, more nuanced understanding of social and behavioral variables."

Michael Golinkoff, Ph.D., senior vice president of MCO AmeriHealth Caritas acknowledges that mental health providers have concerns about privacy in SDoH data collection. But, he told FierceHealthcare, times have changed.

Privacy laws such as HIPAA and 42 CFR Part 2 were developed at a time of paper records and greater mental health stigma and may now need to be revisited.

"As we come to appreciate how intertwined everything is, we realize that not being able to share data actually leads to bad outcomes."

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