Linking Patients to Non-Medical Supports

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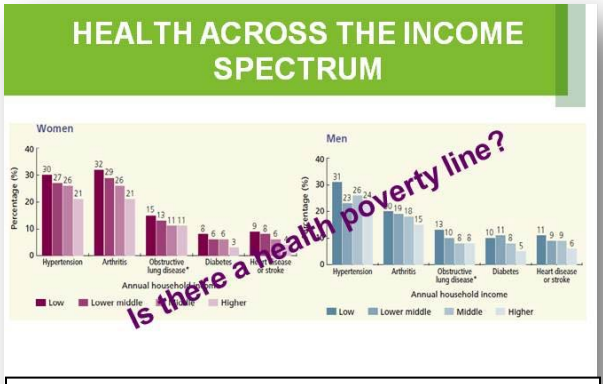
Patients who are low-health literate experience devastating disparities in health due to unmet social needs. Unmet social needs are the "blind side" of health care according to findings from a Robert Wood Johnson Foundation (RWJF) survey released in December 2011. Of surveyed physicians, 85% believe that addressing social needs is as important as addressing medical needs. Some of these unmet social needs include access to adequate income, employment, nutritious food, transportation, and safe housing. Jane Lowe of the RWJF, states that "… physicians are sending a clear message: the health care system cannot continue to overlook social needs if we want to improve health in this country."

These unmet social needs reflect the "conditions in which people are born, grow, live, work and age," according to the WHO. Dr. Gary Bloch, a Canadian family physician, points out that these conditions affect people's income, and income has a progressive inverse relationship with disease rates, as illustrated in the chart on the right. He contends that there is no discrete poverty line.



Dr. Gary Bloch, "A Program of Health Provider Action in Poverty: Learnings." Presentation to the Disparities National Coordinating Center's Community Engagement Affinity Group. January 21, 2014.

In fact, a January 2013 article in Health Affairs analyzed administrative data on patients hospitalized for hypoglycemia in California. Comparative data for low-income and high-income patients reveal that admissions for hypoglycemia were higher for those in the low-income group. For low-income hospitalized patients, the "risk for hypoglycemia admission increased 27 percent in the last week of the month compared to the first week…" The authors conclude that this difference suggests "exhaustion of food budgets" at the end of the month. Patients with diabetes face increased risk for hypoglycemia if there is a disruption in the balance between food intake and medication dose for glycemic control. Hospitalizations for hypoglycemia, however, did not differ among patients in the high-income group, between the first and last weeks of the month. In addition, admissions for appendicitis, a condition not sensitive to food intake, were similar throughout the month in both income groups.

Elderly Medicare beneficiaries are especially vulnerable to hypoglycemia since many are poor and have multiple chronic conditions, including diabetes. A detailed report on the extent of poverty among seniors at the national and state levels has been compiled by the Census Bureau. Unlike the official poverty measure, its supplemental poverty measure deducts health expenses from income and adjusts for regional cost of living differences. Nationally, while the official poverty rate is 9%, it is 15% in the supplemental measure. In 12 states the supplemental poverty measure is twice as high as the official poverty measure. Below are examples of how a

health care provider in Ontario, Canada, a hospital in Chicago, IL, and the state of New York are addressing unmet social needs.

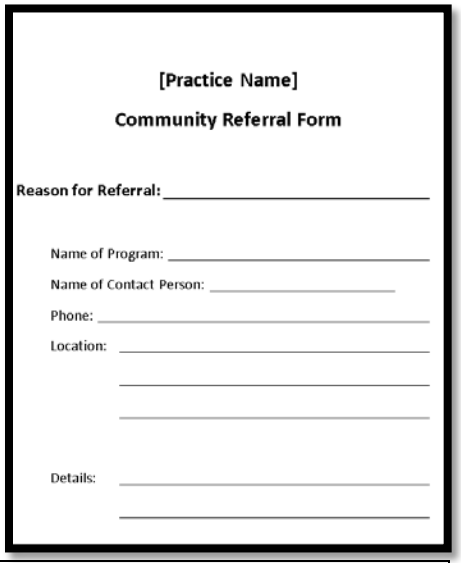
The Canadian provider is Dr. Gary Bloch, who sees poverty as a disease and prescribes for poverty as he does for any other disease. He points out that health and income go hand-in-hand. People at the lower end of the income spectrum not only carry greater disease burdens, including higher rates of heart disease, cancer, diabetes, and mental illness, but also have worse outcomes. (Watch this video).

But when income improves, so does health. Dr. Bloch states that "income is a powerful determinant of health – more so than many medications I prescribe." He screens every patient in his practice for poverty, takes poverty into account in assessing health risks, and links patients to income enhancing services, including preparation of tax returns.

Sinai Health System in Chicago, Illinois, formed its disease-management team in 2011 with the goal of reducing hospital readmissions by helping patients better manage their chronic conditions. The team quickly discovered that to meet their health objectives they needed to meet some of their patients' unmet social needs. For one patient it meant getting the landlord to fix the elevator in her housing complex so that she wasn't house bound, providing medication assistance, arranging for transportation for doctor visits, and assisting her with paperwork to move to another senior housing complex. According to Tamara Dubowitz from RAND Corporation, "some extremely large studies have shown engaging in health behaviors, like diet and exercise, and even our blood pressure, is affected by conditions in our home, neighborhood and workplace environment. Ultimately, putting our resources into (improving) these things will give us a better bang for our buck."

New York has embarked on an innovative program that views "housing as health care." It is addressing the social determinants of health as it relates to the housing and associated supportive services needs of its unstably housed, homeless, and selected institutionalized Medicaid beneficiaries. Homeless populations, for example, face many health risks and are among the highest users of the most expensive form of health care: inpatient hospitalizations. New York has recognized that "lack of upstream investment in social determinants of health probably contributes to exorbitant downstream spending on medical care in the United States." To curb spending and improve lives, New York has embarked on this "boundary-crossing experiment" aimed at improving health by addressing the unmet social needs of its most vulnerable residents. It has allocated $86 million for supportive housing in its 2013-2014 Medicaid budget.

Although this ambitious housing approach requires changes in policy and funding priorities, health care practices and hospital systems can address patients' unmet social needs with tools from the Health Literacy Universal Precautions as well as those developed by Dr. Bloch. Tool #18 (Link Patients to Non-Medical Support), Tool # 19 (Medication Resources), Tool # 20 (Use Health and Literacy Resources in the Community) and Tool #6 (Follow-up with Patients) offer a plethora of information for implementation and tracking of progress. Tool #18 offers approaches for assessing patients' needs, developing a list of community resources, and creating a referral system for non-medical services. For example, one suggested service is the training and certification of a staff member as a Notary Public to expedite processing forms. Tool #19 offers ways to assist patients with costs associated with taking their prescribed medications. It is a well-known fact that some patients cut back on their medications simply because they cannot afford them. This tool guides practices in assisting patients to get the medications they need.



[Practice Name]

Community Referral Form

Reason for Referral: _____

Name of Program: _____

Name of Contact Person: _____

Phone: _____

Location: _____

_____

_____

Details: _____

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Appendix, Health Literacy Universal Precautions Toolkit, 2010..

For example, pharmaceutical companies offer medication assistance to low-income patients. Some patients may have drug coverage under their health insurance plan but not know it. In such cases, it might simply be a matter of informing them to bring their insurance cards when they go to the pharmacy for medications. Other patients may need referrals to an agency capable of helping them apply for Medicaid or Medicare Part D. Tool #20 deals with connecting patients to health and literacy resources in the community. These resources may include diabetes classes, smoking cessation programs, weight management programs, exercise/fitness program, stress management programs, adult literacy, and English-as-a-second language programs. When medical practices refer patients to a particular assistance program, it is important to verify follow-through on those referrals using Tool #6 (Follow-up with Patients). While any designated staff (from nurses, to receptionists, to volunteers) may do the follow through with a recommendation if physicians prescribe or make the recommendations for patients to connect with community resources.

So, we've seen three examples of approaches to address unmet social needs in the context of health care delivery. They all illustrate the principle that taking good care of patients requires efforts that go beyond the conventional boundaries of medicine. While the New York housing approach would take some time to replicate, the other two approaches are immediately available for use by any provider, health practice, or hospital system.

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