

MEDICINE AND SOCIETY

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The Social Determinants of Health — Moving Beyond Screen-and-Refer to Intervention

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One afternoon in January 2021, in a community health center in south Providence, Rhode Island, Mr. D. buried his face in his hands and gently declared himself as good as dead. His mother, the center of his universe, had transitioned to hospice earlier in the week. Mr. D. was working as tirelessly as ever to meet all her needs, even as the goal of care evolved from keeping her alive to helping her die.

They had lived together in her subsidized one-bedroom apartment most of his adult life. In fact, she had added him to the lease just a few years earlier because of his dual role as son and caregiver. But his life was on the verge of being upended because the subsidized building where they lived was intended for elderly people and people with disabilities. Since Mr. D. was considered neither, he would have to relocate after his mother's death. His criminal record, race, and lack of income stared him in the face, as if daring him to so much as try to submit a housing application. He understood that his options for stable housing were severely limited.

Housing insecurity is one of the most common social risk factors affecting health in the United States,¹⁻⁴ and growing recognition of this fact has led some health systems to take a more active role in trying to address patients' housing needs.⁵⁻⁷ But the reality that housing insecurity is a condition caused by the dual and intersecting forces of racism and capitalism⁸⁻¹² makes housing advocacy and support daunting for health care systems and clinicians alike, since neither can single-handedly shift social policy. Health care systems that have found some success in using housing as a health intervention have been forced, in some sense, to bypass existing structures and

directly house their own patients by investing in housing stock or paying subsidies.⁵

Such direct investment is controversial,¹³ and a more common strategy is simply to screen patients for housing insecurity in clinical settings. A plethora of research on screening for social needs shows that it is generally well received by patients.¹⁴ Researchers have also investigated the impact of connecting patients who screen positive with external services. Recently, a solution that has generated substantial interest is off-the-shelf technology that enables health system staff to research community-based organizations and refer patients to them. For instance, patients who screen positive for housing insecurity may be electronically referred to a social service agency specializing in housing.^{15,16}

Although this approach is well intentioned and may work in communities with a highly organized and well-resourced housing services field,¹⁷ more often than not it means passing the buck to other entities — often community-based nonprofit organizations — that must contend with the realities of a housing system complicated by lack of affordable housing stock, lack of permanent supportive housing, stigma from landlords, and other problems. Research employing an implementation science framework to study social-needs screening has similarly found that the appropriateness of screening depends on the availability of community resources to address identified social needs.¹⁸ Furthermore, studies of the screen-and-refer approach, and anecdotal evidence from our health system and others, reveal that less than 25% of referrals generated by health systems to community-based organizations are pursued — including when closed-loop technol-

ogy is employed (so that both the referring organization and the responding organization access the same software).^{19,20} Thus, health systems will eventually have to grapple with the limitations of screen-and-refer strategies, especially as many begin to invest in off-the-shelf technologies meant to facilitate the process.⁶

But there are other paths that are immediately actionable, and immediacy is important to health systems that are eager to address health equity and antiracism. Health systems can play — and have played — important roles in high-level advocacy regarding systems-level policies involving sustained and cross-cutting efforts by health care organizations, legislators, advocacy groups, and others. But here we focus on the clinician as a “street-level bureaucrat” and consider how to patch — not fix — broken systems for patients by means of on-the-ground advocacy. As Elvin Geng describes the concept, a street-level bureaucrat is someone on the front lines who exercises “a tremendous amount of discretion in their decisions.”²¹ Geng explains, “when a patient is 15 minutes late for an appointment, we decide whether to squeeze them in or reschedule. . . . These decisions have particularly significant effects on people whose circumstances render them most vulnerable.”

The notion that clinicians should consider intervening to address social needs triggers resistance of many varieties, including objections that clinicians are inadequately equipped to fill this role. But clinicians are in fact uniquely equipped to address particular social needs — indeed, some resources can only be unlocked with their input. It is therefore the responsibility of clinicians, and by extension health systems, to understand the unique power they hold with regard to social care — a power that extends beyond screening and referral to on-the-spot intervention. Although this discretionary power should not be overstated (higher-level structural change is undoubtedly necessary), health systems have historically understated and underutilized their power to effect positive social change in their patients’ worlds.

THE ROLE OF CONTEXTUALIZED CARE

Clinicians have traditionally focused on biomedical aspects of care. But when they fail to understand and acknowledge the holistic context of a

patient’s life, they often set goals that are discordant with those of the patient.²² For instance, when a patient has a significant spike in glycated hemoglobin level because of numerous obstacles to managing health, and the patient cannot consistently take insulin, a clinician scrolling through the glucometer results may feel that the only tool available is to increase the insulin dose, even though the patient will still not be able to take it as prescribed. When the clinician makes this recommendation anyway, and the pattern continues for years, the patient may eventually stop showing up to appointments, feeling that if the clinician is unwilling to consider the patient’s most pressing priorities, there is no sense in engaging in care. Clinicians may feel disempowered by their lack of progress with such patients, yet they often continue to narrowly consider their other patients’ biomedical needs because they don’t know how to contextualize their care.

Contextualization is central to care provision because it broadens the clinician’s role from a strictly biomedical role to one that takes the whole patient into account. Contextualizing care provides both a conceptual framework and a practical, evidence-based strategy for identifying and addressing challenges that are relevant to planning care during a routine medical encounter; research has suggested that the number needed to treat to improve health outcomes with this approach is six.²³ Contextualization involves a four-step process: recognizing clues that patients are struggling with factors in their lives that complicate their ability to manage their care, asking high-yield questions, identifying opportunities to intervene, and incorporating the information into an individualized (i.e., contextualized) care plan. Remarkably, it has also been found not to lengthen visits.²⁴

In Mr. D.’s case, the clues were obvious. He was wan and on the verge of tears. “I’m going to lose my mother and I’m going to be homeless,” he told his physician. “I don’t know what to do.”

Before the physician shifted her gaze from the computer to Mr. D., she noticed that his glycated hemoglobin level had returned at 10.2%, a substantial bump from the previous quarter. She had entered the room intent on discussing diabetes control, but that agenda clearly wouldn’t align with Mr. D.’s goals. So she pivoted, choosing to contextualize care.

“Mr. D., I’m sorry. I know how much your

mother means to you. She is lucky to have such a caring and loving son.” She then sought to address the agenda she knew he would share: housing. “Do you want to stay in your mother’s apartment after she passes,” she asked him, “or would you rather move elsewhere?”

CLINICIAN INTERVENTION FOR THE PROVISION OF SOCIAL CARE

One reason clinicians often give for not attempting to elicit contextual information is that they feel doing so is futile — that they wouldn’t be able to help much anyway. The societal-level causes of structural racism, poverty, and other drivers of inequity can leave clinicians feeling helpless and resigned to focusing on the narrowly biomedical aspects of care. Yet many invaluable social resources can be unlocked for patients with the input and signature of a clinician. Unfortunately, information about these resources has not been integrated into either medical education or the current frameworks for antiracist medicine and health equity. The notion that clinicians should not engage in the provision of social care has meant that most U.S. clinicians never learn about the immense power that the federal and state governments have conferred on them.

A major exception is clinicians practicing at sites supported by a medical–legal partnership (MLP). As some of us have described, “MLPs entail embedding civil legal aid experts in the health care team in order to identify lapses in protection of patients’ civil rights and engage health care providers in appropriate interventions.”²⁵ MLPs have been shown to be effective in supporting patients with unmet legal needs, both in primary care and specialty clinical settings, such as trauma surgery and palliative care.^{26,27} But though they can improve various social outcomes and reduce acute care usage, MLPs can be resource-intensive and thus only serve a small percentage of the U.S. population.^{28–30} Disseminating the knowledge that MLPs bring to the health system about the power of medical documentation requires that clinicians learn about and embrace their own role in providing social care.

“Of course I want to stay in my mom’s apartment,” Mr. D. exclaimed. “It’s subsidized housing. I would be crazy to leave. You know I don’t have any income.”

As the physician nodded, she printed and

signed a standardized federal form intended for clinician use entitled, “U.S. Department of Housing and Urban Development (HUD) Verification of Disability.” The form had taken less than 3 minutes to complete and print.

She handed it to him. “Mr D., this form will allow you to stay in the apartment after your mother passes. As you know, I’ve supported your decision to apply for disability for years, but because you have not been awarded disability by the Social Security Administration, you are not currently qualified to live alone in the subsidized housing complex. By signing this form, I am using my clinical judgment to declare you disabled for the purpose of the U.S. Department of Housing and Urban Development because we know that there are many people like you who could benefit from disability benefits whom the Social Security Administration currently misses.”³¹

The model of care that this physician followed builds on the screen-and-refer approach by using a new paradigm that we call “screen and intervene.” In this enhanced approach, patients are screened for problems related to social and structural determinants of health, as they would be in the screen-and-refer model. But rather than providing eligible patients with a list of resources or referring them to a navigator (e.g., a social worker or community health worker) or community-based organization, the screen-and-intervene paradigm includes opportunities for direct intervention. Depending on the patient’s answer to a particular question, the physician can generate a solution to meet an identified social need. Resource lists and referrals remain part of the suite of solutions, as does referral to an MLP if one is available. But the playbook also contains solutions that empower the clinician to directly intervene to address patients’ concerns — so advocacy occurs at the level of the clinician–patient relationship. For instance, a patient’s answer may point a clinician to a purpose-built letter template that requires the clinician’s input and signature before being given to the patient. Clinician-generated documentation is already utilized by many health systems to support patients, does not require additional resources or personnel, and fits within the scope of clinicians’ skill sets.

At the conclusion of the appointment, Mr. D.’s physician logged into the electronic health record to complete the note for his visit. She noted that Mr. D. qualified as having a functional disability

and would be at risk for homelessness if he was not granted subsidized housing in light of the imminent death of his mother. To support her recommendation, she included an evidence-based dot phrase — a prewritten block of text that clinicians can quickly insert in the medical record (Table S1 in the Supplementary Appendix, available at NEJM.org) to describe the potential effects of housing insecurity and homelessness on Mr. D.'s overall health. Doing so enabled her to justify the time she'd spent completing the HUD form. She knew this intervention was at least as important for Mr. D. as any medication changes she could have made or health counseling she could have done that day.

MODELING A NEW PARADIGM IN OUR COMMUNITY

In Rhode Island, we have brought together people with relevant personal and professional experiences to develop and implement clinical programming, education, and research on the social challenges created by racism and capitalism. An important aspect of our work has been to empower and build the capacity of health systems to screen for and address the social determinants in which they can directly intervene. This approach can engage clinicians in directly supporting patients by deploying the often-untapped power of medical documentation. A lack of adequate paperwork is often used to justify denial of social services for which people are otherwise eligible, and clinicians can help patients get the necessary paperwork to document medical eligibility for services such as disability housing, prevention of utilities shut-off, disability income, improvement of housing conditions, prevention of incarceration, waiving of court fines and fees, and more (Tables S2 and S3).

As with any effort to address challenges rooted in social and economic inequities, there are limitations to the screen-and-intervene approach. Clinicians face increasing demands on the limited time available during patient visits — a problem that is often cited as a central barrier to expanding efforts to consider social determinants in health care settings.³² Although contextualizing care has been shown not to lengthen the visit itself,²⁴ it does require an initial investment of time by health systems to train clinicians in this approach and embed it in the practice

workflow. The hope is that this investment will save time and resources over the long term by addressing some underlying factors that impede people's ability to manage their health. In addition, even with a clinician's best attempts, the resources that patients urgently require — such as public housing units — may not be immediately available. As we've noted, high-level policy efforts are essential to allow patients to access certain resources — clinicians cannot single-handedly fix our patchy social safety net. Clinicians can, however, leverage the opportunities that this model of care provides to begin the intervention process, using their professional power to unlock needed resources. Such actions are key to the clinician's role as a street-level bureaucrat.

IMPACT ON PATIENTS

Mr. D. called the clinic a few days later in tears of joy. The management office at his subsidized housing complex had accepted and approved the form. They told him it was very helpful to have supporting documentation from a physician. His mother's death remained imminent, but he would no longer become homeless as a result.

Before hanging up, Mr. D. noticed his glucometer lying on the kitchen table, and with his worries about homelessness allayed, he considered his own health. "Can I make a follow-up appointment with my doctor?" he asked. "My sugars have been high, and I want to speak with her about how to get them under better control."

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