

Addressing Patients' Unmet Social Needs: Checklists Are a Means, Trust Is Foundational

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Recent events, including the COVID-19 pandemic, the death of George Floyd, and the establishment of the Black Lives Matter movement, have highlighted the compelling need to acknowledge and correct existing systemic inequities in health care services delivery and outcomes. Consequently, *The American Journal of Managed Care (AJMC)* is soliciting the submission of research and commentary manuscripts aimed at better informing our readership of the breadth and extent of existing disparities and evaluations of potential solutions implemented to reduce them. As such, this month's issue of *AJMC* includes an evaluation of a collaborative model between managed care and affordable housing and a narrative of how a new federal rule will provide higher Medicare payments for homeless patients, which may encourage hospitals to identify homeless patients and help them with their needs.^{1,2} Forthcoming *AJMC* articles address a broad range of social determinants of health (SDOH) including health care literacy and charity care for uninsured patients.

Growing recognition of the importance of SDOH as a contributor to health status has prompted the routine incorporation of questions regarding unmet social needs into clinical workflows.³ Although such SDOH checklists are well intentioned and may facilitate more equitable clinical care delivery, their use should not be deemed a solution to this worsening problem. They should instead be regarded as one tool of many helpful in addressing an extremely broad set of issues, some of which may not be included in the list. Unmet social needs coexist with other factors, including health literacy limitations, medical mistrust,⁴ clinician implicit bias,⁵ and systemic racism,⁶ all of which contribute to health inequities. Identifying and addressing unmet social needs to the exclusion of attention to other contributors—most significantly in the absence of a trusting relationship—is unlikely to yield the desired outcome. Thus, in order to meaningfully address systematic inequities, an expansive, patient-centered approach with an emphasis on trust building is warranted.

Give Clinicians Incentives to Enhance Engagement

Despite growing awareness of health inequities, progress in identifying, measuring, and reducing them has been slow. Clinicians

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remain largely focused on clinical care delivery, with a payment structure organized around financial incentives often tied to the use of measurable process measures such as evidence-based management guidelines. For many, collection and documentation of SDOH data has become an incremental clinical responsibility—reinforced by the CMS Framework for Health Equity⁷ and the National Committee for Quality Assurance health equity initiatives.⁸ Although these are well intended, concerns have arisen that another administrative requirement for an already overburdened workforce that is increasingly prone to burnout may not achieve the goals of trust building and better patient health outcomes.⁹

At a foundational level, achieving health equity necessitates an enhanced focus on what matters to patients. Michellene Davis, JD, president and CEO of National Medical Fellowships, said in an interview that health equity “only moves as quickly as the speed of trust.”¹⁰ When clinicians and patients are able to better align interests and build trust, that sense of connectedness is associated with improved care adherence and more favorable patient-centered outcomes.¹¹ Calls for greater attention to trust-building behaviors by physicians have long acknowledged trust as a foundational component for health equity efforts to advance.¹²

Understandable Communication Builds Trust

From the patient's perspective, reducing medical mistrust among individuals experiencing health inequities may be the last—and

potentially most important—hurdle for the health care system to address, and that is likely to change only when patients witness trustworthy behaviors across all members of the health care team. As Lisa Fitzpatrick, MD, MPH, MPA, a noted epidemiologist and professorial lecturer at George Washington University's Milken Institute School of Public Health and founder and CEO of Grapevine Health, recalled a patient stating, "If I don't understand you, I don't trust you."⁴ Addressing attendees at a recent trust and health literacy workshop, Fitzpatrick said, "The language of health literacy is often communicated as a patient deficit, as if to say a patient's health is failing because they do not understand something. But speaking in plain language is *our* responsibility, and addressing health literacy is *our* work to do, for we are responsible for ensuring that people understand what we say—and that builds trust."⁴

Checklist Use Can Simultaneously Help With and Distract From Progress on SDOH

Clinician checklists have become an integral part of the process of care delivery. In his 2011 book, *The Checklist Manifesto: How to Get Things Right*, Atul Gawande, MD, MPH, highlighted the value of the checklist as a simple tool to help overcome the volume and complexity of medical knowledge that limits clinician ability to consistently, correctly, and safely deliver health care services.¹³ In relation to health equity, checklists to identify SDOH have been broadly recommended.¹⁴ Although these are designed to facilitate more equitable clinical care delivery, current lists are frequently more clinician centered than patient centered, largely due to the use of standardized checklists that limit patient input to responses only to the items included on the list. And although checklist use may lead to identification of patient-specific unmet social needs in certain circumstances, notable variability in checklist content and detail³ may limit collection of information that may be of higher priority to the patient—such as nonclinical concerns and priorities that limit patients' ability to effectively engage in their own care. For example, although the preponderance of SDOH checklists include transportation concerns, food insecurity, and housing instability, inclusion of other issues such as caregiving demands and rent/utility payment is more variable. By failing to include specific issues or concerns that are central to the health of individual patients, especially those with multiple unmet social needs, a checklist approach may not help with the prioritization of the most beneficial interventions.

Worse yet, the use of checklists may perpetuate a perception of "clinician dominance" and further affirm the subordinate role of the patient. Such an unintended outcome—which is unlikely to build trust—may contribute to finding that only a minority of patients are willing to accept support for unmet social needs.¹⁵ Thus, the context in which SDOH questions are asked—rather than the questions themselves—may impact the rate of successful referrals to community resources. Transitioning to a more patient-centered approach to the information-gathering process may help empower patients to be more active participants in their care.

Patient Consequences of the Clinically Focused Care Delivery Model

In the current clinically focused model and for individuals with appreciable unmet social needs, clinicians may feel frustrated by their inability to impact what may appear as a seeming lack of patient interest or commitment to health improvement. However, as previously noted, other patient factors, including personal priorities aside from health, trust issues, or literacy concerns, may also negatively affect the outcomes of patient-clinician interactions. Without the foundation of a trusted or connected¹¹ relationship, desired clinician outcomes may not be realized. Examples of this are prevalent in the clinical literature, including the following:

- Greater prevalence of chronic conditions among low-wage workers and individuals in minority subpopulations,¹⁶ increasing the complexity of care for individuals who already have more challenges to treatment adherence
- No change in emergency department visits or hospitalizations among Black individuals with diabetes following implementation of an intervention to reduce emergency department visits¹⁷
- No change in medication use among seniors when co-pay is eliminated¹⁸

Conversely, incorporating a thoughtful approach to addressing the foundational components of trust, cultural alignment, and a whole-person approach to care can yield a favorable impact. Representative examples include the following:

- The US Department of Veterans Affairs' Whole Health care management approach has shown benefits in reducing opioid use and enhancing patient engagement.¹⁹
- Racial concordance between primary care clinicians and patients can improve outcomes for Black patients.²⁰
- Addressing implicit bias and structural racism in health care can improve health outcomes.⁶

Focus on What Matters

With the 2018 deployment of its Whole Health initiative, the Department of Veterans Affairs shifted clinician focus on patients from "What's the matter with you?" to "What matters to you?"—effectively transitioning from a clinician-centered perspective to focus on patient priorities, with an open-ended, patient-centered approach to team-based care delivery.²¹ An alternative way to approach the issue may be by asking the question, "What stands between you and taking better care of your health?" Clinicians who do so may be more likely to elicit a more meaningful and perhaps more actionable response from patients, who may appreciate the opportunity to volunteer their concerns.

Relationship-Based, Patient-Centered Medical Care

The value of the patient-centered medical home includes a holistic approach to patient care that recognizes what's important to

each individual and builds care around each patient's priorities. Organizations that focus primarily on clinical care delivery for low-income individuals or minorities may overlook the barriers to care adherence—including personal priorities, medical mistrust, and implicit bias—for the sake of adhering to a strict patient visit schedule. For many health care entities, the clinical care focus has been effectively reinforced by development of a standardized and growing set of clinically oriented health equity outcomes measures to quantify progress toward equitable treatment.⁸ Although beneficial, these serve to maintain a focus on achieving clinical outcomes and may detract from the trust building necessary to overcome inequities in patient care.

Vanjani et al have suggested alternative terminology, noting that contextualization allows for acknowledgment of real-world patient challenges to managing their health, along with development of an individualized care plan that incorporates management of unmet social needs.¹⁵ As the authors describe, this approach broadens the practitioner's role to encompass a whole-person perspective, expanding beyond clinical issues. This approach is similar to the Veterans Affairs Whole Health care model, as previously described.¹⁹

Contextualizing care in a truly patient-centered model effectively incorporates use of human-centered design principles to innovate health care delivery and merits serious consideration for broader adoption.²² The field of human-centered design incorporates an understanding of human needs, with development of approaches to meet those needs. The resulting design is a practical, relevant, and systems-based approach. In their 2016 *BMJ* commentary, Erwin and Krishnan state, “The key is to shift our focus from helping people to fit our care delivery system, to one where we design our care delivery system to fit people where they live, work, learn, play, and receive [health care].”²³

Key Stakeholders Need Aligned Incentives

When thoughtfully implemented as part of a systems-based approach, a human-centered design for addressing SDOH has the potential to build patient trust and facilitate the desired patient health and well-being outcomes.²⁴ Ideally, such an approach would also favorably impact clinicians, which is important in the current environment of high rates of burnout and retirement (and critical for program success). Benishek et al describe using a human-centered approach to care delivery that may help simultaneously enhance patient outcomes while also easing clinician stressors—and facilitate, rather than impede, patient clinical improvement.²⁵

The requirement of completing an SDOH checklist is likely to be viewed by some clinicians as an *additional* administrative burden. Simply put, it's not that SDOH aren't important, but rather that we need a better way to ask about them and refine the information-gathering process so that it is viewed as beneficial—instead of burdensome—for both patients and clinicians. Substituting administrative tasks by replacing less impactful administrative tasks (eg, prior authorization policies) with SDOH assessments—coupled with adequate reimbursement for the completion of this activity

(similar to the new payment codes for care navigation for patients with cancer)—could encourage their use.

When considered in the broader context of patient engagement, opportunities exist to enhance the patient-centeredness of approaches aimed to reduce health care disparities and optimize clinical outcomes.²⁶ As standardized health equity measures are routinely incorporated into Medicare and health plan reporting, clinicians can expect increasing accountability for addressing the social needs of their patients. To increase the likelihood that these programs meet their ambitious aims to enhance equity, they must better prioritize patients' individual needs and concerns and be implemented in a manner that improves—not lowers—clinician satisfaction. ■

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