

PRESIDENT'S COLUMN

IT'S THE ZIP CODE, ST*P#D

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It was during my time as health commissioner for New Orleans that I learned firsthand how smart the community is about what drives health and how we, as their public servants, should be prioritizing actions to improve health. (W)e intended to develop strategies to improve equitable access to quality care and close gaps in healthcare outcomes. But, an intensive community-wide effort to work with the community to understand challenges and opportunities in health improvement caused us to rethink the priorities and the work ahead.



Like the famous quote from Louisiana-native and campaign strategist James Carville during the 1992 Clinton campaign, “[It’s] the economy, stupid,” health care has lost its way in understanding the priorities of the people we serve.¹ Zip code is a bigger driver of health than genetic code or even medical care. This concept is sometimes difficult for those of us in health care to get our head around. We went into medicine to help people and learn a special set of skills to put us in a special relationship with our patients, their families, and often our shared community. But the reality is that the non-medical determinants of health (SDOH), where we live, learn, work, and play, have a great impact on our health. According to the widely accepted medical model of US HHS Healthy People 2020, these non-medical determinants impact 60% of health outcomes.²

If this notion doesn’t come naturally to us in our medical model, it certainly does to the average person. I have shared previously that my post-Hurricane Katrina experience brought this concept forward for me. The people seeking care at our makeshift street care stations were prioritizing issues about food access, transportation, housing, and employment over acute or chronic disease needs. They wanted to know when these non-medical drivers of health would be available in their zip code. They were also concerned that historical redlining approaches that prevented people of color from living in certain zip codes would be amplified by decision makers in the rebuilding of the New Orleans community, boxing them out of their homes, communities, and the place they knew as *home*.

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munity is about what drives health and how we, as their public servants, should be prioritizing actions to improve their health. I walked into my role as health commissioner in 2011 with a goal of improving the health of our city. The leading drivers of morbidity and mortality were cardiovascular disease, cancer, and infant mortality, and we intended to develop strategies to improve equitable access to quality care and close gaps in healthcare outcomes. But, an intensive community-wide effort to work with the community to understand challenges and opportunities in health improvement caused us to rethink the priorities and the work ahead.³ New Orleanians told us that their priorities were more aligned with the social determinants of health including areas such as community violence.

Unfortunately, sometimes the nation mistakenly presumes that the social determinants are a challenge only to low-income individuals, including those served by the Medicaid program or communities of color. The reality is that social needs can impact people from all walks of life at many points along the life span. This recognition is essential for building policy, payment, and public health systems to address health needs of all people and also eliminate disparities in health outcomes. It is also essential for general internists to understand that our patients may have social needs that do not seem obvious to us on the surface.

Survey data from McKinsey showed that of over 2,000 people covered by Medicare, Medicaid, or an ACA marketplace or individual plan, more than half of those surveyed indicated that they had at least one social need. The majority of respondents with multiple unmet social needs reported that they would be interested in help from their health insurer in addressing the need. The most common issue, in one third of respondents, was food

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insecurity, followed by community safety, housing, social support, and transportation. Eighty-five percent of respondents reported they would use a social program offered by their health insurer to address a social need.⁴

A survey of smaller size found similar results including that SDOH impacts are common, irrespective of payer category, indicating that we need policy and practice in health care that transcends a single population and can serve everyone. In this survey, consumers preferred discussing their SDOH issues with their doctors and providers rather than health plans, suggesting our patients are looking to us for solutions.⁵ This finding is a reminder that consumers are expecting us to be engaged in efforts to understand and address their social determinants.

The National Partnership for Women and Families (NPWF), a consumer advocacy organization, conducted focus groups to inform policymakers and the private sector, including the care system, about consumer perspectives on SDOH. What they learned is in keeping with what I have heard from my own patients and the community:

1. People want to be treated as a whole person, which means understanding the social determinants because they are the reality of the day-to-day texture and atmosphere of people's lives.
2. Consumers in these focus groups expressed strong concerns about motivations, opportunity for misuse, and unintended consequences of asking about and intervening in social needs.
3. They emphasized the importance of health care, public health and social services collaborating, in lieu of medicalizing social services or having health care entities providing those services.
4. And finally, they expressed a strong desire to partner in

development of policies and programs.

Based on these focus groups, the NPWF worked with others to lay out a consumer-focused framework for policymakers and the private sector to use when approaching work around the social determinants of health.⁶ The framework is grounded in the recognition that efforts to address the social determinants must have equity as an explicit goal. Second, they recommend working in multi-sectorial partnerships to share responsibility and accountability, including with consumers and communities. NPWF also recommended a person-centered approach that “reflect[s] the perspectives, preferences, and decision-making of individuals and communities most affected.”

“It’s the zip code” is a dramatic over-simplification of the challenge our patients and communities are facing related to social determinants of health, just as Carville’s words were an over-simplification of the challenges voters were facing in 1992. However, the complexity should not scare us off. Just the opposite. Academic general internists are experts at complexity of any sort and the challenges around understanding, impacting and mitigating against future social determinants driving inequity are just the sort of issue that our members should and are working on in the clinical, educational, research and policy environment.

This work has never been more important. We are in a race that is high stakes like that of a presidential election. To reverse the distressing decline in life expectancy, the rise in infant mortality, the scourge of multiple, burdensome chronic diseases worsening daily quality of life, and to find our way to improving the public’s health, we must work with partners to address all determinants. It will take more

than addressing medical and genetic determinants, but also the zip code drivers where our patients live, learn, work and play. Our patients understand that their health is impacted by more than medical care.

It is time for medicine to catch up with what consumers want.

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