

In This Issue: Confronting Constraints on Individual Behavior & Outcomes

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This issue of *Annals* addresses some of the structural and attitudinal boundaries that constrain individual behavior and health outcomes. It is easy to blame individuals for poor choices and to stigmatize groups for bad behavior. Articles in this issue take a more sophisticated and nuanced view to examine the environments, relationships, beliefs, knowledge, and communication approaches that can either restrict or provide new opportunities for health and health-promoting action.

Arthur Kaufman and Leif Solberg address the boundaries of medical practice in a set of Point/Counterpoint pieces that ask the question: "Should primary care practice take on social determinants of health now?"^{1,2} Jennifer DeVoe adds a Perspective on integrating the social determinants into health care.³ Their answers are timely in light of recent recommendations by the Institute of Medicine for capturing social and behavioral domains and measures in electronic health records.^{4,5}

Ferrer and colleagues use sophisticated analytic methods to examine how the choices people make depend on the options they have. In a sample of 746 adults visiting 8 large primary care practices in Texas, they find that people's realistic opportunities for healthy diet and activity affect their intentions, behaviors, and outcomes.⁶

Mercer et al compare patients' expectations, their general practitioners' behaviors in the consultation, and health outcomes in high and low deprivation communities. They find interesting associations with general practitioners' empathy,⁷ and interpret their findings in light of the inverse care law, which states that "the availability of good medical care tends to vary inversely with the need for it in the population served."⁸

Another novel intervention uses group visits in a geriatrics clinic to help patients consider together their personal values, and to understand how to engage in advanced care planning discussions. After two 90-minute sessions, patients report increases in detailed advance care planning discussions with their doctors.⁹

The use of an electronic consultation service that fosters communication between primary care clinicians in a community health center and specialty clinicians is tested in a clinical trial by Olayiwola et al.¹⁰ They find that a system for secure, asynchronous consultation results in much faster cardiology consultation compared to traditional referral, and lower rates of cardiac-related emergency department visits. Most electronic consultations do not end up requiring an in-person visit to a cardiologist.

An in-depth study by Cabral and colleagues examines the constraints of clinicians' and patients' beliefs and communications around antibiotic use for respiratory tract infections. They discover an apparently mutually reinforcing cycle of expectation and discussion that confirms patients' expectations that antibiotics are needed to treat more severe illness.¹¹

A mixed methods study by Greene et al uses aggregated quantitative patient activation data on a large sample of patients to compare the approaches of physicians with high vs low levels of improvement in their patients' level of activation. The exemplar physicians are more likely to use 5 strategies to support patient behavior change: emphasizing patient ownership, partnering with patients, identifying small steps, frequent follow-up visits to cheer success and/or problem solve, and showing caring and concern for patients.¹²

The potential constraints of a don't ask/don't tell approach are identified by Metheney and colleagues in an Internet study of men who have sex with men. They find that patients' disclosure of sexual identity to their clinicians is associated with higher rates of routine HIV testing and hepatitis A and B vaccinations.¹³

A systematic review by Khanassov et al goes beyond the constraints of an individually focused approach to care to identify the effects of care management in meeting the needs of patients with dementia and their caregivers.¹⁴

Rollow proposes a model for achieving value in primary care by focusing on 5 domains that are important to patients.¹⁵

We welcome your reflections at <http://www.AnnFamMed.org>.

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Peer reviewers are key to advancing scholarship and contributing to the quality of a research journal. We are grateful to the many individuals who volunteer their time and expertise in this important endeavor. Please see https://www.annfammed.org/sites/default/files/additional_assets/PDF%20Documents/PDF/reviewers15.pdf for the names of the *Annals'* 2014-2015 peer reviewers.

The *Annals* is also enriched by those who contribute e-letters. In 2015 we posted more than 150 e-letters reflecting on a wide range of published articles. Our sincere thanks to those who participated in this stimulating dialogue. To read e-letters, click on the eLetters tab on the right-hand side of any article.

CORRECTION

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The degree of MD was erroneously added to Jayme L. Mendelsohn, MPH in the author listing for: Casalino LP, Chen MA, Staub C, et al. Large independent primary care medical groups. *Ann Fam Med*. 2016;14(1):16-25. A new PDF will be uploaded and the online version will therefore differ from the print version of the article.

Theory vs Practice: Should Primary Care Practice Take on Social Determinants of Health Now? Yes.

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Of all ethnic groups in New Mexico, Native Americans have some of the best screening and treatment for diabetes, yet have by far the worst outcomes from that disease—kidney failure, amputations, blindness. High-quality care cannot adequately compensate for decades of low income, low educational achievement, poor nutrition, poor housing, and social marginalization—all social determinants of health (SDH). With appropriate transformation, primary care practices are well-suited to address SDH.

Physicians recognize the importance of SDH in their practices. Of 1,000 physicians surveyed, 4 out of 5 found SDH as important as medical needs, but lacked confidence in addressing these social needs, and believed their patients' health suffered when the needs were not addressed.¹ But how is this recognition to be addressed in practice?

The national environment, especially due to the Patient Protection and Affordable Care Act (ACA), provided support for this major effort. For example, the patient-centered medical home (PCMH) is being reconceived on a broader scale as a community-centered health home,² featuring a more community-focused, social-ecologic model of health and disease including different community stakeholders and sectors which influence health. And health extension, found in Section 5405 of the ACA, was fashioned upon the decentralized cooperative extension service model found in the agricultural sector, linking health science

center resources with community health priorities, including SDH.^{3,4}

What are the objections to incorporating SDH into medical care in general and into primary care in particular? First, some are concerned that physicians are "not paid to do this." Yet incentives have emerged in recent years to invest upstream. These incentives were triggered by the accountable care organizations, bundled payments, capitation, and, more recently, penalties to hospitals from Medicare for 30-day readmissions—all pressures for health systems to invest in prevention.

Another objection is that SDH are not in a physician's scope of service. Asking SDH questions takes too much time. And if a social need is uncovered, what can be done about it? Because primary care seems barraged with ever more requirements, paperwork, dynamic documentation, and adapting to ICD-10 coding, this is hardly the time, some warn, to burden primary care clinicians with yet more requirements.

Expanding the role of primary care physicians, however, toward addressing evidence-based prevention screening and interventions is feasible if the health team is expanded. Garg and colleagues from Johns Hopkins screened for SDH within the patient-centered medical home during the pediatric well-child visit while collocating community-based resources.⁵ Perhaps the most significant addition to the team are community health workers who spend more time addressing the SDH than do other team members. And today, evidence supports a measurable health benefit from primary care teams addressing social determinants. For example, medical assistants at all University of New Mexico's primary care clinics ask all patients SDH questions. This followed a preliminary pilot in which 3,048 patients, almost all seen at 3 university and 1 local federally qualified health center, were asked 11 questions related to income, education, food, housing, transportation, utilities, safety, and substance abuse over a 90-day period. Forty-six percent screened positive for at least 1 area of social need and 63% of those

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had multiple needs.⁶ As a consequence, 2 to 3 clinic-based community health workers were then hired for each of the 7 primary care clinics to address such needs. Primary care physicians laud this development's impact of unburdening them of having to address complex social needs presented by their patients.

Payers have also incented primary care clinicians to address SDH. Community health workers working with 448 high-risk, high-cost primary care Medicaid-managed care enrollees over a 6-month period demonstrated a significant increase in use of primary care services with a significant drop in emergency room visits, hospitalizations, and drug use.⁷ The managed care organizations estimated a return on investment of 4 to 1.

The Accreditation Council for Graduate Medical Education is now requiring all residency programs to address health disparities through quality-improvement activities. In New Mexico, family medicine residents work in community clinics staffed by local community health workers.⁸ There, residents' education is enhanced by inter-professional teamwork, cultural proficiency, effective communication, provision of cost-conscious care, and advocating both for individual and community.

In conclusion, primary care has not only the evidence to justify investments in addressing SDH, but also a growing, supportive health care climate which provides funding strategies to address those needs by broadening the clinical care team.

To read or post commentaries in response to this article, see it online at <http://www.annfammed.org/content/14/2/100>.

Key words: social determinants of health; primary healthcare; community health workers

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Theory vs Practice: Should Primary Care Practice Take on Social Determinants of Health Now? No.

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Recently, the recognition that medical care may contribute less to overall health than other aspects of people's lives do has led policy makers, academics, and even some physicians to argue that clinicians should make screening and action on the social determinants of health their responsibility. Although such an expectation is understandable, the additional requirements (that will fall largely on primary care) are likely to have serious unintended consequences and be unlikely to produce the hoped-for benefits.

First, anyone proposing any new responsibilities for primary care clinicians must be unaware of the degree to which most of them already feel overworked, stressed, and discouraged. There is little joy in Mudville. Shanafelt et al's national survey of 7,300 physicians in 2012 reported that 46% of them had at least 1 symptom of burnout, 38% screened positive for depression, and 37% felt that their work schedule didn't leave enough time for personal or family life.¹ Those in family or general internal medicine were at the wrong end of each of these spectrums among all medical specialties. Our recent unpublished survey from the 2013 COMPASS project of 700 primary care physicians in 18 widely diverse medical groups in 8 states found 30% reported feeling burned out; 12 months later this number had risen to 37%. Will an additional large responsibility help this unsustainable situation?

Much of this workload and stress comes from all of the expectations that have especially been added for primary care physicians since I began doing patient

care 43 years ago. Over the years, society seems to have decided that diagnosing and treating the problems that patients brought to our door was not adequate. Clinicians and care systems must now also screen and act upon assorted preventive services, fully control chronic conditions (not just relieve symptoms), provide the mental health care that an insufficient number of mental health professionals cannot, help patients modify a wide range of health behaviors, coordinate with a variety of community agencies, provide much more complete documentation, complete a bewildering number of forms, and proactively reach out to all of the people who had ever been seen in the practice in order to practice population medicine. In order to facilitate these tasks, clinicians have also been required to use electronic medical records and lead multidisciplinary teams that, while offering some clear advantages, also take a great deal of time. Many clinicians feel these added responsibilities are inefficient and not why they went into medicine. Finally, many of those social determinants (broken and dysfunctional families, substance abuse, homelessness, etc) have become much more frequent and problematic, often requiring greater time and adding stress to providing even traditional medical services.

Simultaneously, we are in the midst of a great national effort to transform primary care in order to achieve much-needed improvements in quality, costs, and patient experience. Making all the changes in clinic workflows, communications, and roles to be consistent with the patient-centered medical home requires considerable time and flexibility from clinicians. Although the evidence for these benefits is still not strong, the changes seem desirable enough to ask all the members of care systems to work on adapting them to their practices and patients. We know change is very slow, requiring many years under the best circumstances. It seems unlikely that care clinics can simultaneously address both these changes and social determinants, so upon which should they train their focus?

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Finally, there is no evidence that clinicians and care systems can either add this to their plates or have much impact on the social determinants of their patients. They certainly have no expertise or resources for this work, work that even the social service agencies created for this purpose find to be difficult, frustrating, and of limited success. Published literature on the topic is mostly theoretical or commentary, with the very few studies in small and atypical practice settings.²⁻¹⁰ The article by DeVoe and colleagues in this issue of *Annals* recommends a very reasonable approach of collecting community and patient data before taking individual patient and panel actions and then adding automated supports.¹¹ Before we ask practices to take on these tasks, however, we need much more evidence that it is both feasible and effective. We also need to know that taking on this added responsibility won't divert care systems from the important task of transforming the way we accomplish existing responsibilities and won't cause clinic personnel even greater stress.

As far back in history as we can track, healers of all kinds have focused on providing people with answers to what caused their problems, predicting what was likely to happen next, and relieving distress. Modern medicine has added the ability to actually change the course of many medical problems, but we need to improve our performance in all of those tasks. Do we or our patients really want to risk losing that focus and opportunity for the sake of yet another new responsibility, one that we have no reason to believe we can succeed at and one that may lead clinicians to no longer respond adequately to the medical needs of their patients?

To read or post commentaries in response to this article, see it online at <http://www.annfammed.org/content/14/2/102>.

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