UNDERSTANDING SOCIAL DETERMINANTS OF HEALTH (SDoH) ISSUES AND ADDRESSING DISPARITIES IN HEALTH CARE

Presented by [Name]
[Date]

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Meeting agenda

1. Health disparities
2. Social determinants of health (SDoH)
3. Suggestions for identification of patient needs
4. Merck educational materials

What are health disparities?

Health disparities refer to differences in health outcomes that are closely linked with social, economic, and/or environmental disadvantage[1,2]

Health disparities affect groups of people who have systematically experienced greater obstacles to health on the basis of factors such as[1]:

- Race or ethnicity
- Religion
- Socioeconomic class
- Age
- Sexual identity and orientation
- Mental health
- Disability status
- Geographic location

Reducing these disparities is important for improving health outcomes.[3]

References: 1. Disparities. Healthy People 2020. Accessed June 21, 2024. https://wayback.archive-it.org/5774/20220414003754/https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities **2.** HHS action plan to reduce racial and ethnic health disparities: a nation free of disparities in health and health care. US Department of Health and Human Services, Office of Minority Health. April 8, 2011. Accessed August 8, 2024. https://cg-b88759ce-d31b-439a-9898-092a58f9927c.s3.us-gov-west-1.amazonaws.com/s3fs-public/documents/HHS_Plan_complete.pdf **3.** Health disparities in HIV, viral hepatitis, STDs & tuberculosis: social determinants of health. Centers for Disease Control and Prevention. Last reviewed February 7, 2024. Accessed June 3, 2024. https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/social-determinants-of-health.html

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What are some examples of health disparities in cancer?

Health disparities are driven by social determinants of health (SDoH).[1] Patients who have obstacles to proper health care are affected by health disparities[2]

Some examples of health disparities:

Black/African-American men are **twice as likely to die** of prostate cancer as non-Hispanic White men[3]

People who live in medically underserved areas have **higher incidence rates of certain cancers** and subsequently **higher cancer mortality rates** than those who live in other areas[4]

Hispanic women are **40% more likely to be diagnosed with cervical cancer**, and 30% more likely to die of cervical cancer as non-Hispanic White women[5]

References: 1. Health disparities in HIV, viral hepatitis, STDs & tuberculosis: social determinants of health. Centers for Disease Control and Prevention. Last reviewed February 7, 2024. Accessed June 3, 2024. https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/social-determinants-of-health.html **2.** Social determinants of health. US Department of Health and Human Services. Accessed August 18, 2023. https://health.gov/ healthypeople/priority-areas/social-determinants-health **3.** Cancer and African Americans. US Department of Health and Human Services. Accessed June 21, 2024. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16 **4.** AACR cancer disparities progress report 2024. American Association for Cancer Research. May 2024. Accessed June 13, 2024. https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2024/05/AACR_CDPR__2024.pdf **5.** Cancer and Hispanic Americans. US Department of Health and Human Services. Accessed June 21, 2024. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=61#

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How do health disparities affect health outcomes in oncology?

Examples of health disparities:

The 5- and 10-year survival rates for invasive breast cancer are around 10% lower for Black/African-American women than for non-Hispanic White women[1]

Hispanic men and women are twice as likely to be diagnosed and die of stomach cancer as non-Hispanic White men and women[2]

The incidence rates of colorectal, lung, and cervical cancers are higher in rural Appalachia than in urban areas in the region[3]

People with more education are less likely to die before the age of 65 from colorectal cancer than those with less education, regardless of race or ethnicity[3]

Older women who are of a racial or ethnic minority, have a lower sociodemographic status, or lack health insurance, have worse breast cancer health outcomes than younger women of the same demographic[4]

References: 1. Cancer Facts & Figures 2023. American Cancer Society; 2023. Publication No. 500823. **2.** Cancer and Hispanic Americans. US Department of Health and Human Services. Accessed June 21, 2024. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=61# **3.** Cancer disparities. National Cancer Institute. Accessed June 21, 2024. https://www.cancer.gov/about-cancer/understanding/disparities **4.** San Miguel Y, et al. Age-related differences in breast cancer mortality according to race/ethnicity, insurance, and socioeconomic status. *BMC Cancer*. 2020;20(1):228.

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What are examples of SDoH?

They include the conditions in which people are born, grow, live, work, and age[1]

- Quality housing
- Access to healthy foods
- Secure employment
- Child care[2]
- Safe neighborhoods and easy access to transportation
- Community involvement
- Educational opportunities
- Access to health care services

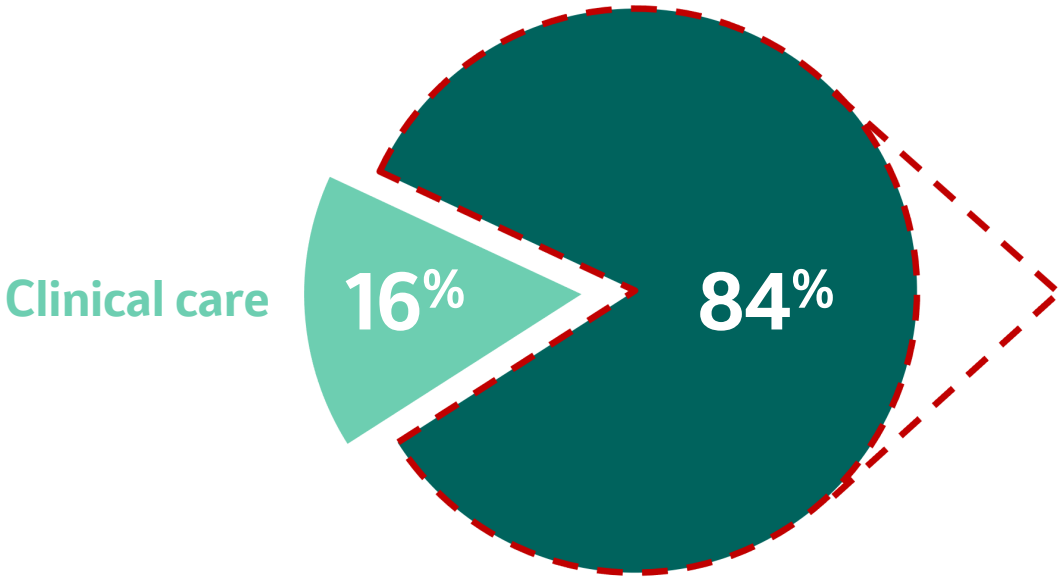
The health impact of SDoH reaches across many aspects of life.[1]

References: 1. Social determinants of health. US Department of Health and Human Services. Accessed August 18, 2023. https://health.gov/healthypeople/priority-areas/social-determinants-health
2. Kennedy LB. Child care and early education is a social determinant of health—for children and adults. Harvard Medical School Center for Primary Care. October 23, 2020. Accessed June 21, 2024. http://info.primarycare.hms.harvard.edu/review/child-care-early-education

SDoH can contribute to overall health outcomes[1]

Clinical care contributes only 16% to overall health outcomes, while nonclinical factors account for the remaining 84% (health behaviors 34%, social and economic forces 47%, physical environment 3%)

Factors in overall health outcomes



Nonclinical factors

- **47%** Social and economic
- **34%** Health behaviors
- **3%** Physical environment

SDoH can manifest at any point along the patient's continuum of care[2]

References: 1. Rodriguez L, et al. A medical school's community engagement approach to improve population health. *J Community Health.* 2021;46(2):420-427. **2.** AACR cancer disparities progress report 2024. American Association for Cancer Research. May 2024. Accessed June 25, 2024. https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2024/05/AACR_CDPR__2024.pdf

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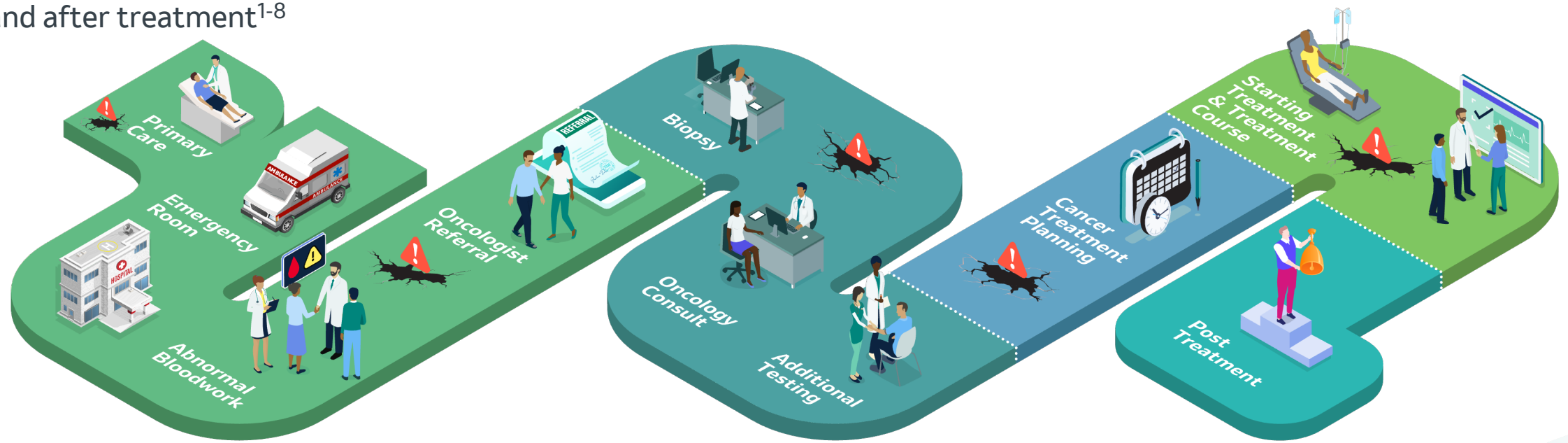
Potential challenges to care for underserved patients

Throughout the patient's cancer journey, inequities and social determinants may present obstacles before, during, and after treatment[1-8]



Delays Between Diagnosis and Treatment[1]

Lack of Guideline-Concordant Care[1,4]

Challenges to Adherence[1,7]

References: 1. AACR cancer disparities progress report 2024. American Association for Cancer Research. May 2024. Accessed June 25, 2024. https://cancerprogressreport.aacr.org/wpcontent/uploads/sites/2/2024/05/AACR_CDPR__2024.pdf **2.** How often should you visit your primary care physician? Weirton Medical. February 24, 2021. Accessed June 25, 2024. https://www.weirtonmedical.com/blog/how-often should-you-visit-your-primary-care-physician/ **3.** Levin M. CBC blood test. MedlinePlus. Updated October 16, 2022. Accessed June 18, 2024. https://medlineplus.gov/ency/article/003642.htm **4.** Choosing a cancer doctor. American Cancer Society. Accessed June 25, 2024. https://www.cancer.org/cancer/managing-cancer/finding-care/where-to-find-cancer-care/choosing-a-cancer-doctor.html **5.** What do doctors look for in biopsy and cytology samples? American Cancer Society. Accessed June 25, 2024. https://www.cancer.org/cancer/diagnosis-staging/tests/biopsy-and-cytology-tests/testing-biopsy-and-cytology samples-for-cancer/what-doctors-look-for.html **6.** Waiting for your biopsy or cytology test results. American Cancer Society. Accessed June 25, 2024. https://www.cancer.org/cancer/diagnosis-staging/tests/biopsy-and-cytology-tests/waiting-for-your-biopsy-or-cytology-test-results.html **7.** How treatment is planned and scheduled. American Cancer Society. Accessed June 25, 2024. https://www.cancer.org/cancer/ managing-cancer/making-treatment-decisions/planning-scheduling-treatment.html **8.** When treatment should start. American Cancer Society. Accessed June 25, 2024. https://www.cancer.org/cancer/managing-cancer/making-treatment-decisions/when-treatment-should-start.html

Hypothetical patient journey negatively influenced by SDoH

- Lives in low-income housing in a rural area
- 20 miles from closest medical center
- Limited public transportation
- Unreliable support system
- Hourly job paying minimum wage
- English as second language/limited health literacy
- 2 children under 8 years with limited child-care options

OCTOBER 9 — Symptoms appear

NOVEMBER 1 — Visit to urgent care

NO PAID TIME OFF FROM WORK

NOVEMBER 29 — Tests to inform diagnosis

NO PUBLIC TRANSPORT

NO CHILD CARE

JANUARY 4 — Visit to oncologist

MISUNDERSTANDING OF NEXT STEPS FOR TESTING

JANUARY 26 — Tests to confirm diagnosis

FEBRUARY 7 — Follow-up with oncologist, cancer diagnosis confirmed

POOR UNDERSTANDING OF OPTIONS

MARCH 3 — Tests to determine treatment

ACCESS AND PAYMENT ISSUES STEMMING FROM MINIMAL HEALTH BENEFITS

APRIL 17 — Treatment infusion

See why our patient misses her first infusion appointment

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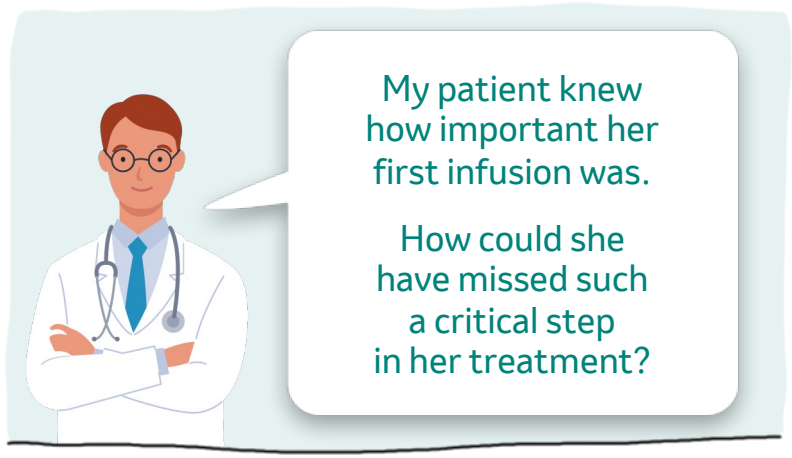
Hypothetical patient journey negatively influenced by SDoH (*continued*)



6 am
Get a friend to help take children to childcare

8 am – 2 pm
Job #1 – waitress

2:15 pm
Wait for a family member for a ride to infusion center for 3:00 appointment

2:30 pm
Ride doesn't show up – need to quickly arrange for friend to pick up

3 pm
Friend arrives, but car gets a flat tire on way to infusion center

5 pm
Patient is 2 hours late for appointment

5:15 pm
Infusion center is closed and patient is unable to receive her infusion.

The appointment needs to be rescheduled.

- Limited public transportation
- Unreliable support system
- Hourly job paying minimum wage
- 2 children under 8 years with limited child-care options

Single mom with newly diagnosed cancer, underinsured, 2 children, 2 jobs, reliant on friends and family for child care and transportation.

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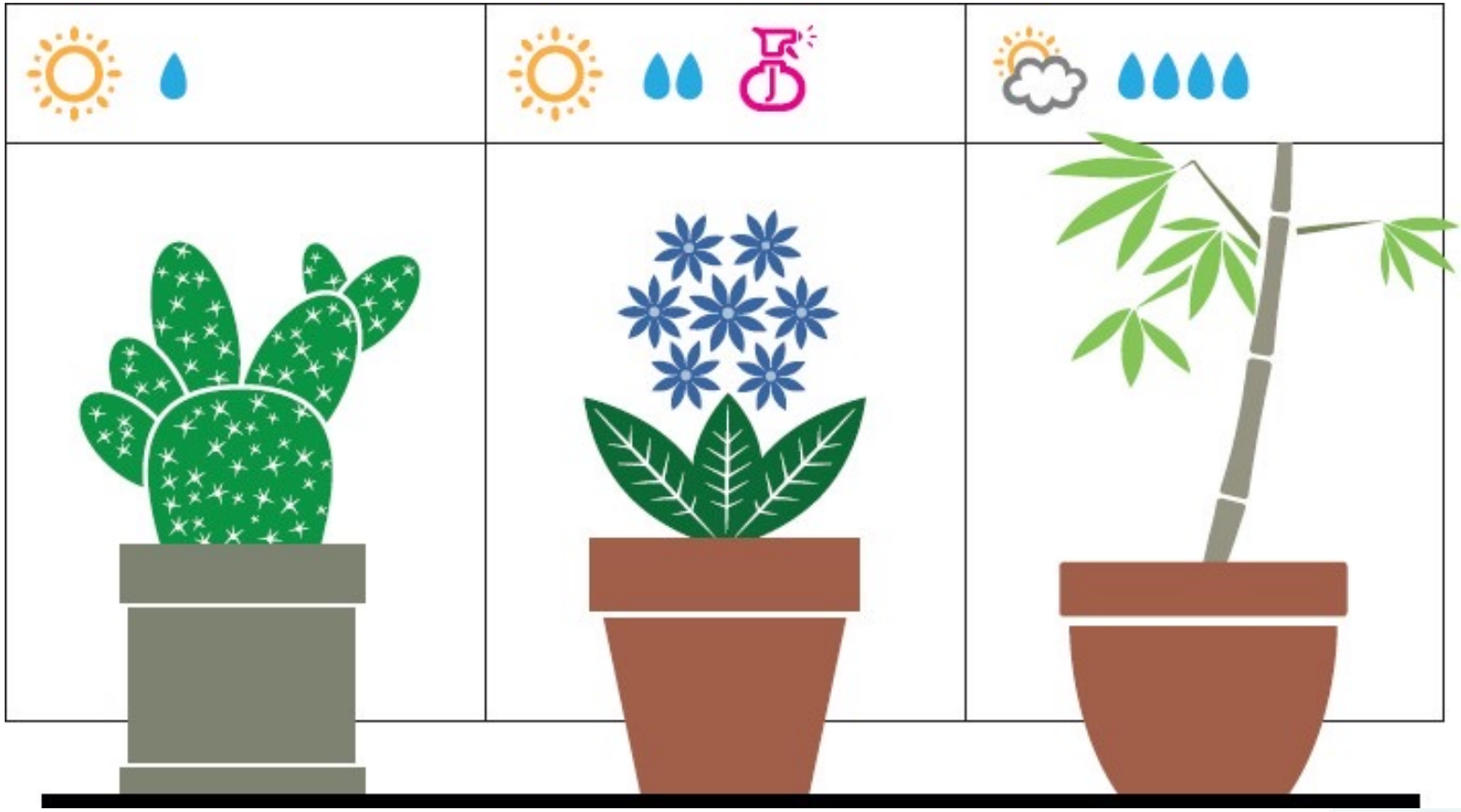
We don’t all require the same level of support[1]



Reference: 1. Tucker-Seeley R, et al. Social determinants of health and cancer care: an ASCO policy statement. *JCO Oncol Pract.* 2024;20(5):621-630.

Suggestions for identification of patient needs

Asking patients about their SDoH[1]

Identifying resources in patients' communities that can help address disparities[1,2]

Connecting patients with resources to help address disparities[1,2]

Other considerations include:

Documenting SDoH in electronic health records[3]

Understanding bias and the importance of cultural competency for providers[1]

References: 1. Addressing social determinants of health in primary care: team-based approach for advancing health equity. American Academy of Family Physicians. 2018. Accessed December 21, 2022. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf **2.** Alcaraz KI, et al. Understanding and addressing social determinants to advance cancer health equity in the United States: a blueprint for practice, research, and policy. *CA Cancer J Clin*. 2020;70(1):31-46. **3.** Chen M, et al. Social determinants of health in electronic health records and their impact on analysis and risk prediction: a systematic review. *J Am Med Inform Assoc*. 2020;27(11):1764-1773.

Recommendations for identifying individual SDoH

The Working Group convened by the National Comprehensive Cancer Network® (NCCN®) recommends screening for health-related social needs (HRSN) to help further reduce disparities in access to guideline-adherent cancer care[1]

Patient screenings for HRSN should be:

- **A routine** part of clinical care (annually & care transitions)
- **Discussion-based** interactions that support a comprehensive care conversation (not a "check the box" exercise)

Recommendations for practices include:

- **Investing** in technology
- **Allocating** dedicated staff for screenings
- **Establishing** a plan to address unmet needs (referral systems, sources, and partnerships for needed services)
- **Providing** training and education (why HRSN screenings are important and how to do them well)

Reference: 1. Measuring and addressing health-related social needs in cancer: working group recommendations. National Comprehensive Cancer Network. Accessed April 11, 2024. https://www.nccn.org/docs/default-source/oncology-policy-program/HRSN-WG-Recommendations.pdf

HRSN screenings: NCCN patient and provider considerations[1]

There are certain patient sensitivities that are important for HCPs to keep in mind with HRSN screenings

Considerations for **patients**:	Considerations for **providers**:
 Patients can often face **question fatigue** when answering questions repetitively	HCPs should incorporate **open-ended questions:** Example: "What has changed since I last saw you that might impact your ability to continue your treatment?"
 Changes in **lifestyle factors** can impact a patient's ability to continue treatment (employment, insurance coverage, caregiver support, or living situation)	**Conduct routine HRSN screening** to support treatment planning and inform needed adjustments
 Given the sensitive nature of some of the information asked, patients **may not feel comfortable** sharing certain information	HCPs should **ask permission** to ask **HRSN questions**, acknowledge the potential sensitivity of some information, and respect a patient's decision on what to share

HRSN=health-related social needs.

Reference: 1. Measuring and addressing health-related social needs in cancer: working group recommendations. National Comprehensive Cancer Network. Accessed April 11, 2024. https://www.nccn.org/docs/default-source/oncology-policy-program/HRSN-WG-Recommendations.pdf

Putting conversation into practice[1]

In addition to prioritizing certain areas for initial HRSN assessment, the Working Group convened by NCCN recommends additional personalized, patient-centered questions

4 core assessments include:

1. Access to transportation
2. Access to food
3. Financial security
4. Housing security

Recommended secondary topics of conversation to further understand patient's needs:

- Social/caregiver support
- Utility assistance
- Work support (employer accommodations, paid sick leave)
- Neighborhood and community safety
- Health insurance
- Health literacy and health insurance literacy
- Digital connectivity

HRSN=health-related social needs.

Reference: 1. Measuring and addressing health-related social needs in cancer: working group recommendations. National Comprehensive Cancer Network. Accessed April 11, 2024. https://www.nccn.org/docs/default-source/oncology-policy-program/HRSN-WG-Recommendations.pdf

Appropriate ICD-10-CM Z and HCPCS codes may be used to identify SDoH needs of the patient[1,2]

Recently introduced by the Centers for Medicare & Medicaid Services, these codes may be used by providers, social workers, case managers, nurses, and others to help identify SDoH factors that may impact a patient's health outcomes[1-3]

When this information is identified and documented, it can help improve quality, care coordination, and experience of care for the patient that can include[1,2]:

- Informing follow-up appointments and discharge planning
- Generating referrals for needed social services
- Tracking referrals between providers and social service organizations

HCPCS=Healthcare Common Procedure Coding System; ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

References: 1. Using SDoH Z codes. Centers for Medicare & Medicaid Services. June 2023. Accessed July 17, 2023. https://www.cms.gov/files/document/zcodes-infographic.pdf **2.** Care management services and proposed social determinants of health codes: a comparison. American Society of Clinical Oncology. Accessed May 10, 2024. https://society.asco.org/sites/new-www.asco.org/files/content-files/practice-patients/documents/Care-Management-SDOH-CHI-PIN-Comparison.pdf **3.** HHS action plan to reduce racial and ethnic health disparities: a nation free of disparities in health and health care. US Department of Health and Human Services, Office of Minority Health. April 8, 2011. Accessed August 8, 2024. https://cg-b88759ce-d31b-439a-9898-092a58f9927c.s3.us-gov-west-1.amazonaws.com/s3fs-public/documents/HHS_Plan_complete.pdf

Merck educational materials regarding SDoH and health disparities

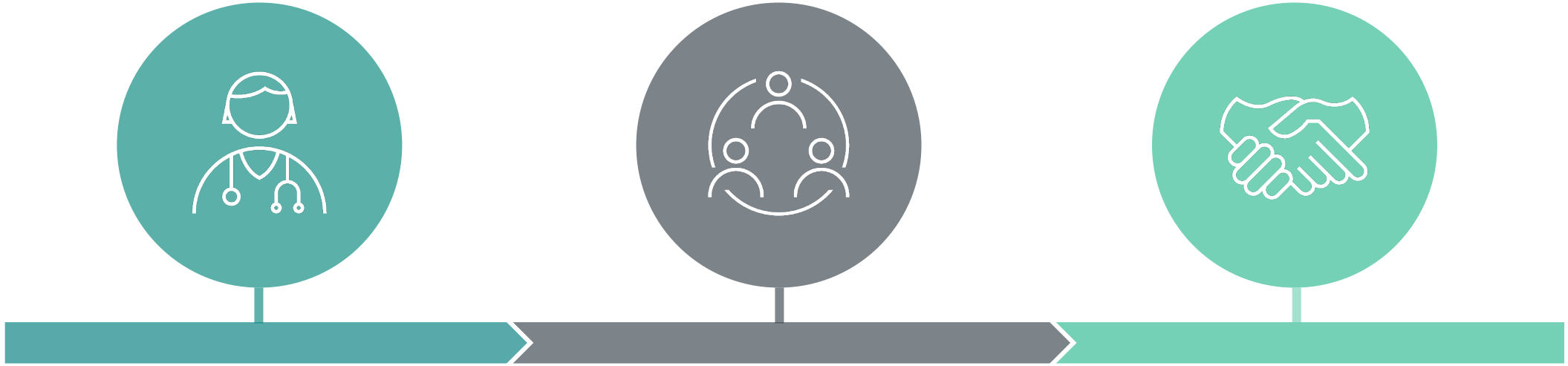
Medication adherence resources	**Health care professionals** Resources to help HCPs support and facilitate more productive conversation with patients, gauge the likelihood of patients adhering to their newly prescribed medication, and gather feedback from patients **Consumers** Resources to help patients keep track of their medications and important prescription information, and to share information with their HCPs to enable informed conversations
Relationship-centered communication resources	**Health care professionals** Informational and guiding resources to help foster shared decision-making between patients and HCPs to help improve communication, encourage collaboration, and empower patients to make positive behavioral changes **Consumers** Resources to educate patients on shared decision-making and identification of potential issues for consideration with support from their health care team before transitioning from the hospital
Patient activation/ caregiver engagement resources	**Health care professionals** Available resources that explore health literacy challenges, create awareness, promote action for change, and help bridge communication gaps through patient activities and provider strategies **Consumers** Resources for both patients and caregivers to help address: • Informational needs for newly diagnosed patients and those beginning treatment • Daily caregiving, such as managing and administering medications, healthy eating, and being active

Merck educational materials regarding SDoH and health disparities

Health literacy	**Health care professionals** Resources designed to help HCPs understand health literacy and how to communicate with patients to help them understand their disease, course of treatment, and medication regimen
Health care disparities	**Health care professionals** Resources intended to help HCPs identify, address, and reduce disparities in health equity needs by initiating and navigating discussions with patients who may face challenges and barriers to care
Transitions and coordination of care	**Consumers** Resources to help prepare for the patient's transition across settings of care, and guidance on how to capture important information and action items related to each oncology appointment
Prevention and wellness	**Consumers** Food, communication, and confidence—resources focused on lifestyle, food, and mindset to help address the unique needs of patients, including making healthy food choices
Screening	**Health care professionals** Resources that reinforce the clinical importance of screening

What are some next steps for your organization to consider?

It is critical to identify SDoH and to make resources available to patients to help diminish health disparities



Health care organization (HCO) identifies common SDoH in its patient population

HCO connects patients with community-based organizations to address specific SDoH

Potential to improve equitable access to care for all patients