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MICHIGAN PHYSICIAN SURVEY

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Michigan Physicians' knowledge of where to refer patients for social needs has increased, but opportunities for growth remain

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Executive Summary

The social and economic conditions of the communities in which people are "born, live, learn, work, play, worship, and age" influence their health.[i] These social determinants[1] are a root cause of the health disparities that we observe in our communities by race, ethnicity, immigration status, income, and other social factors. They are also a root cause of the social needs that individuals experience on a day-to-day basis, such as food and housing insecurity.[ii]

One strategy that has been adopted to improve individuals' health and well-being has been to address their social needs. Physicians commonly do this by screening patients for social needs and then connecting them to community-based organizations for needed social services. Increasingly, physicians are offered incentives to encourage them to screen and refer patients for social needs. However, it is important to note that community-based organizations are rarely compensated by the medical community for their contributions to patient health.

In Michigan, there has been considerable momentum in this area in recent years. With support from the U.S. Centers for Medicare and Medicaid Services (CMS), Michigan launched a State Innovation Model (SIM) Initiative in 2016, which incentivized health care providers to screen patients for social needs; funded regional health, mental health, and social service collaborations; and laid the groundwork for greater collaboration between health care and social care providers.[iii]

In 2021, Michigan received funding from the U.S. Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention to launch the Promotion of Health Equity Initiative, which builds upon the state's earlier work by supporting the development and implementation of a health information exchange (HIE) infrastructure that would allow the scale up of regional collaboratives by facilitating greater information sharing and collaboration between health and social care providers across the state.[iv]

The COVID-19 pandemic has also served as a catalyst in the movement to address social determinants of health in general, as well as individual social needs that put individuals at risk

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[1] More and more people are using the term, "social influencers of health," as an alternative to "social determinants of health." Using "influencer" highlights the fact that the social conditions in which individuals are born, live, learn, work, play, worship, and age are highly predictive of, but not absolute determinants of, our health. While the authors agree with this view, they have chosen to continue to use the term "determinants," for now. The term "influencer" is simply not as well known to the general public.

CHRT is an independent 501(c)(3) impact organization with a mission to advance evidence-based care delivery, improve population health and expand access to care.

of worse health outcomes. While the pandemic has exacerbated existing social needs, it has also increased awareness about the connection between social needs and health. As a result, organizations at the federal, state, and community-level have devoted additional resources to address unmet social needs.[v]

Most recently, as part of its 2022-2024 Social Determinants of Health Strategy, Michigan's Department of Health and Human Services (MDHHS) outlined its continued commitment to pursuing health equity.[vi] A key component of MDHHS's strategy to achieve health equity is to build the capacity and infrastructure for health care and social care organizations to communicate and collaborate to address patients' social needs.

In this brief, the Center for Health and Research Transformation (CHRT) at the University of Michigan discusses how physicians' knowledge of where to refer patients for social needs has changed since the start of the COVID-19 pandemic. In addition, CHRT quantifies gaps between physicians' routine screening and referral ability for the social needs that are identified. To do so, CHRT presents findings from surveys conducted of licensed Michigan physicians in the summer of 2018 and spring of 2021.[2]

Based on these findings, this brief discusses areas of progress and opportunities for growth when it comes to identifying and addressing patients' social needs and, in turn, promoting health equity across Michigan.

Key Findings

- Physicians and their care teams routinely screen patients for their ability to afford treatment (61 percent), domestic violence (59 percent), and social isolation (54 percent). Physicians are less likely to report that they screen patients for health literacy (43 percent), employment status (39 percent), and traumatic life experiences (36 percent)—all of which can adversely impact health.
- Physicians' knowledge of where to refer patients for social support when needs are identified increased from 2018 to 2020. This growth was largest when it came to knowledge of where to refer patients for food (+20 percentage points) and housing (+22 percentage points).
- Physicians employed by Federally Qualified Health Centers (FQHCs) and health centers that serve a similar function in the community are significantly more likely to screen patients for social needs than physicians in other practice arrangements. Independent practice physicians are significantly less likely to screen.

[2] The 2021 Michigan Physician Survey was fielded online to licensed physicians in Michigan from April 7, 2021 to May 11, 2021. 2,188 physicians responded to the survey (8% response rate). To adjust for non-response, the final sample was weighted by the region in which the physician practices, as well as years in practice. The 2018 Michigan Physician Survey was fielded in the summer of 2018 and included a sample of 588 primary care physicians. To ensure that the samples are comparable, analyses comparing referral knowledge in 2018 and 2021 are restricted to only primary care physicians. All other analyses include the full sample of licensed physicians (both primary care and specialty physicians) from the 2021 survey.

- Significant and troubling gaps exist between the percentage of physicians who routinely screen patients for social needs and the percentage of physicians who know where to refer patients for social supports to meet those needs.

Routine Screening for Social Needs

Data from the 2021 Michigan Physician Survey show that the social needs that physicians were most likely to routinely screen for include:

- the patient's ability to afford their treatment or care (61%),
- domestic or relationship violence (59%), and
- social isolation or loneliness (54%).

Physicians were least likely to report that their patients were routinely screened for other needs that have also been proven to have a large impact on health,[vii] including:

- lack of health literacy (43%),
- unemployment or underemployment (39%), and
- traumatic life experiences (36%). (See Figure 1).

Primary care physicians were more likely than specialists to report that their patients were routinely screened for social needs.

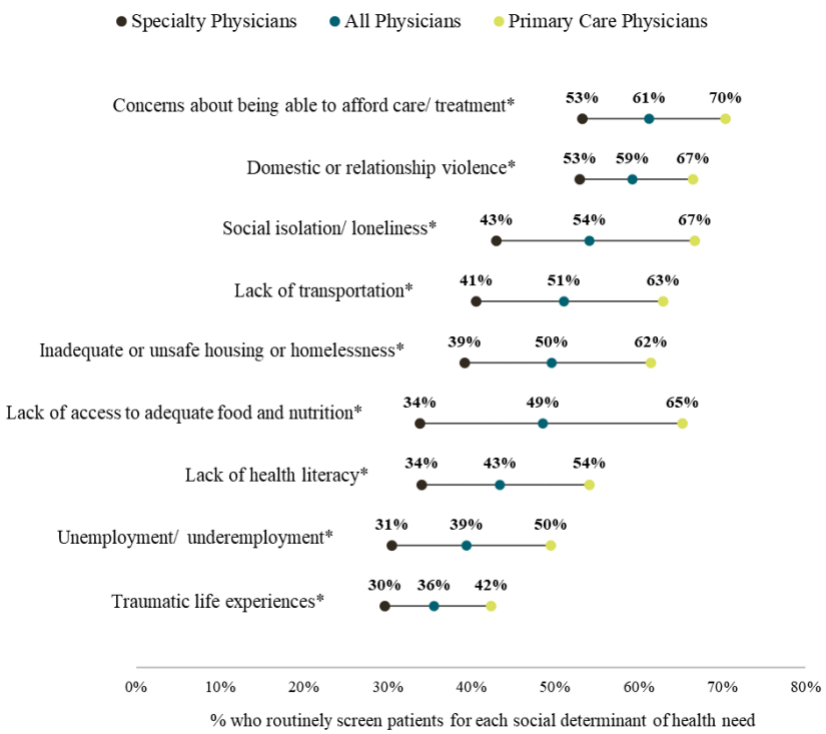
For all of the social needs measured, primary care physicians were significantly more likely than specialists to report that they routinely screened patients. This gap was largest when it came to screening for access to adequate food and nutrition; only 34 percent of specialists screened their patients for this social need, compared to 65 percent of primary care physicians (a difference of 31 percentage points).

Specialists also lagged notably behind primary care physicians when it came to screening patients for social isolation and loneliness; 43 percent of specialists reported that they or a member of their care team routinely screened for social isolation and loneliness, compared to 67 percent of primary care physicians (a gap of 24 percentage points) (See Figure 1).

Even among primary care physicians, however, there was variability in screening rates depending on the patient population. For example, pediatricians were more likely to routinely screen for traumatic life experiences (50%), and geriatricians were more likely to routinely screen for social isolation and loneliness (88%).

Figure 1

Primary care physicians are more likely to screen patients for social needs



Data Source: 2021 Physicians Survey
* Significant at $p<0.05$

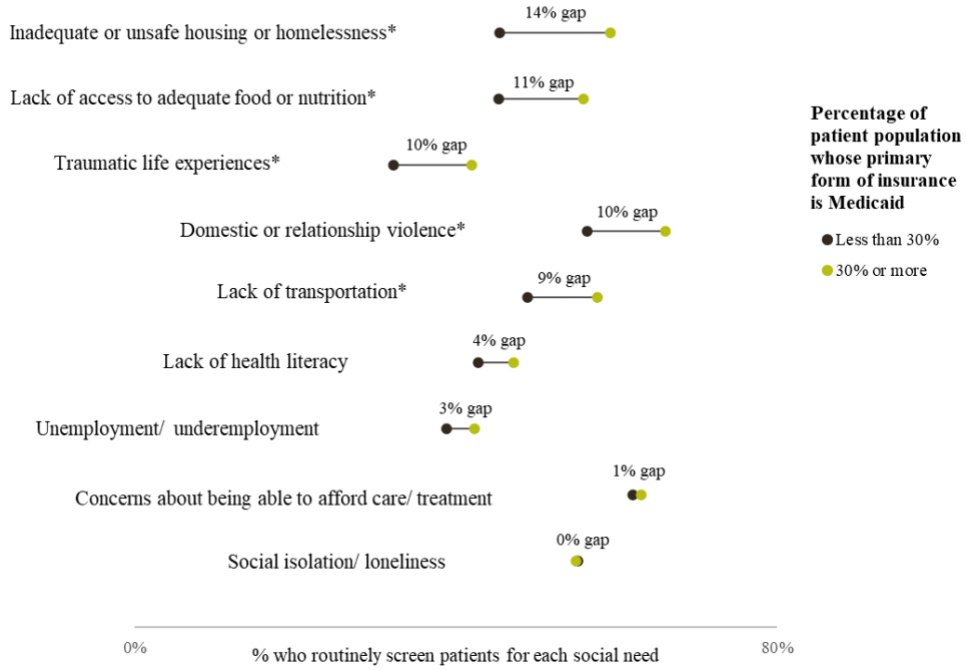
Physicians who serve a larger share of Medicaid patients are more likely to screen for social needs

Physicians who reported that 30 percent or more of their patients had Medicaid as their primary form of insurance were significantly more likely than physicians who served a smaller Medicaid population to report that they routinely screened their patients for needs related to:

- food (difference of 11 percentage points),
- housing (difference of 14 percentage points),
- transportation (difference of 9 percentage points),
- domestic or relationship violence (difference of 10 percentage points), and
- traumatic life experiences (difference of 10 percentage points) (See Figure 2).

Figure 2

Physicians who serve a larger share of Medicaid patients are more likely to screen for social needs.



Data Source: 2021 Physicians Survey
* Significant at $p<0.05$

Physicians employed by FQHCs are more likely to screen patients for social needs.
Physicians employed by a Federally Qualified Health Center (FQHC) or a health center serving a similar purpose in the community were significantly more likely than physicians in other practice arrangements to screen for each of the social needs.

Rates of routine screening for physicians in an independent practice lagged behind average rates of routine screening for physicians in other practice arrangements, including physicians employed by a hospital.

These findings are consistent with patterns observed at the national level.[viii]

Gaps in routine screening by practice arrangement were largest when it came to housing, food, and transportation needs (See Figure 3).

Notably, while 88 percent of physicians employed by an FQHC or FQHC look-alike screened for housing needs, only 56 percent of hospital-employed physicians and 35 percent of independent practice physicians screened for housing needs.

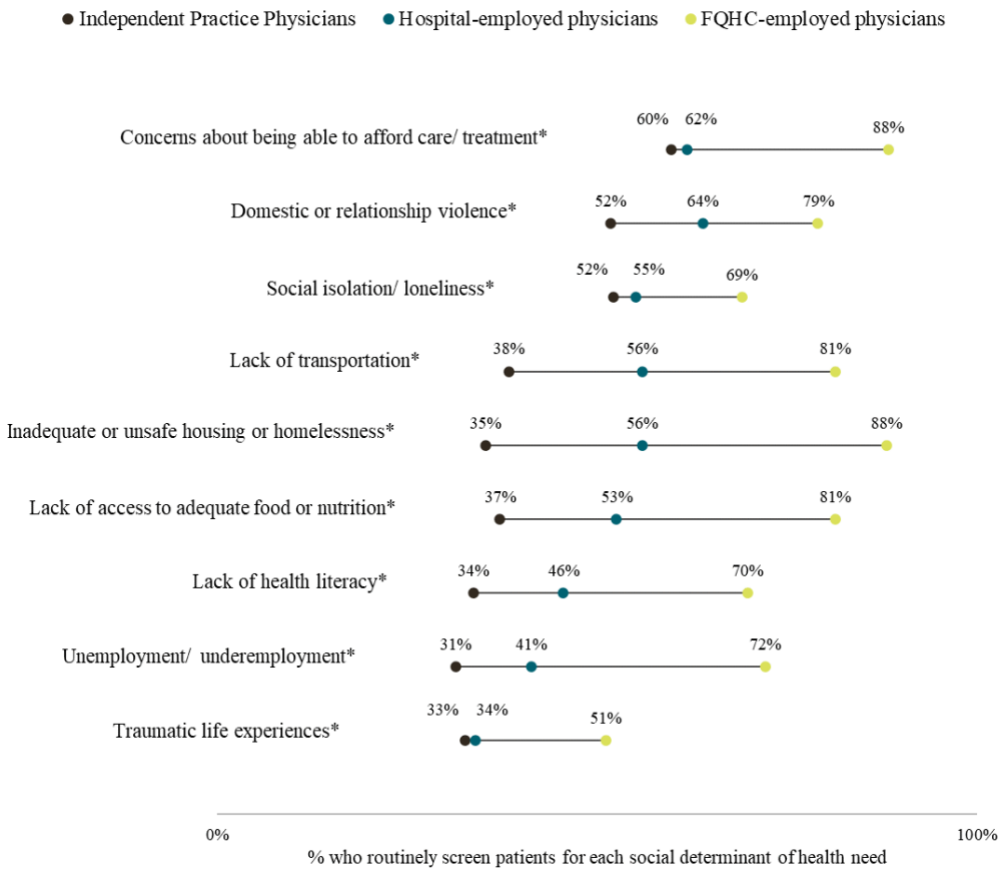
The gap in screening was smallest—though still significant—for social isolation and loneliness; 69 percent of FQHC-employed physicians, 55 percent of hospital-employed physicians, and 52 percent of independent practice physicians reported screening for this social need.

Lower rates of screening among independent practice physicians may reflect that these practices often have fewer resources to implement routine screenings than larger health systems, including less financial and technical support.

This variability in screening rates by practice arrangement may also be because physicians employed by FQHCs and hospitals, including those in this sample, tend to serve a larger Medicaid population than physicians in independent practices.[ix,x]

Figure 3

FQHC-employed physicians are more likely to routinely screen patients for social needs



Data Source: 2021 Physicians Survey
*Significant difference by practice arrangement at $p<0.05$

Referral Knowledge for Social Needs

Although the percentage of physicians who routinely screened patients for social needs varied considerably by practice arrangement, patient population, and whether the physician was a primary care physician or a specialist, there was notably less variability in knowledge of where to refer patients for social needs.

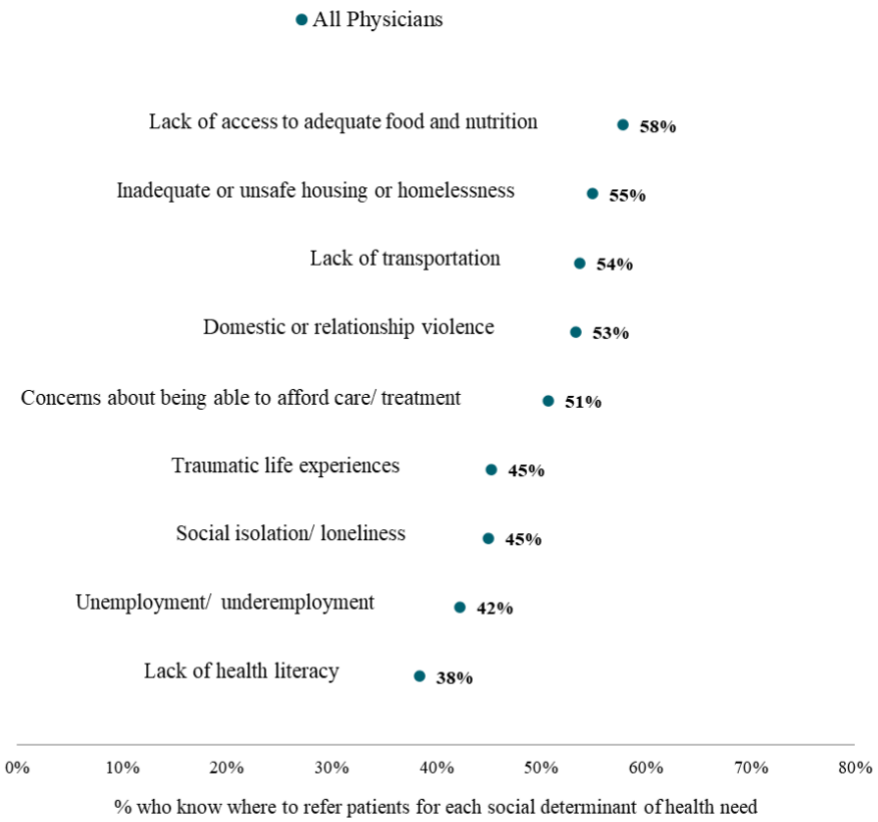
In 2021, physicians were most likely to report that they or a member of their care team knew where to refer patients with needs related to food (58 percent) and housing (55 percent).

Physicians were least likely to know where to refer their patients for lack of health literacy (38 percent) and unemployment or underemployment (42 percent).

Given the overall lack of significant variability in physicians' reported referral knowledge by specialty, practice arrangement, and patient population, only the percentages of all physicians who knew where to refer for each social need are presented in Figure 4.

Figure 4

Physicians are less likely to know where to refer patients for traumatic experiences, social isolation, unemployment, and lack of health literacy



Data Source: 2021 Physicians Survey

Although overall there was little variability in referral knowledge by practice arrangement, patient population, and physician specialty, instances in which there was significant variability[3] in knowledge of where to refer patients for social needs include:

By Practice Arrangement

- Knowledge of where to refer patients for social isolation and loneliness varied significantly by practice arrangement; while 49 percent of hospital-employed physicians and 42% of independent practice physicians reported that they knew where to refer patients for social isolation and loneliness, only 26 percent of physicians employed by an FQHC reported that they knew where to refer patients for this social need.
- Independent practice physicians were somewhat less likely than physicians in other practice arrangements to know where to refer patients who had concerns about being able to afford care (by 6 percentage points) or who had transportation needs (by 5 percentage points).

By Specialty

- Primary care physicians were somewhat more likely than specialists to know where to refer patients for traumatic life experiences (a gap of 6 percentage points).

By Patient Population

- Physicians who cared for a larger share of Medicaid patients, were more likely than others to know where to refer patients for transportation needs (by 5 percentage points).

Knowledge of where to refer for social needs has increased

Using data from a 2018 survey of primary care physicians, CHRT was able to examine how primary care physicians' knowledge of where to refer patients for social needs has changed since the COVID-19 pandemic.

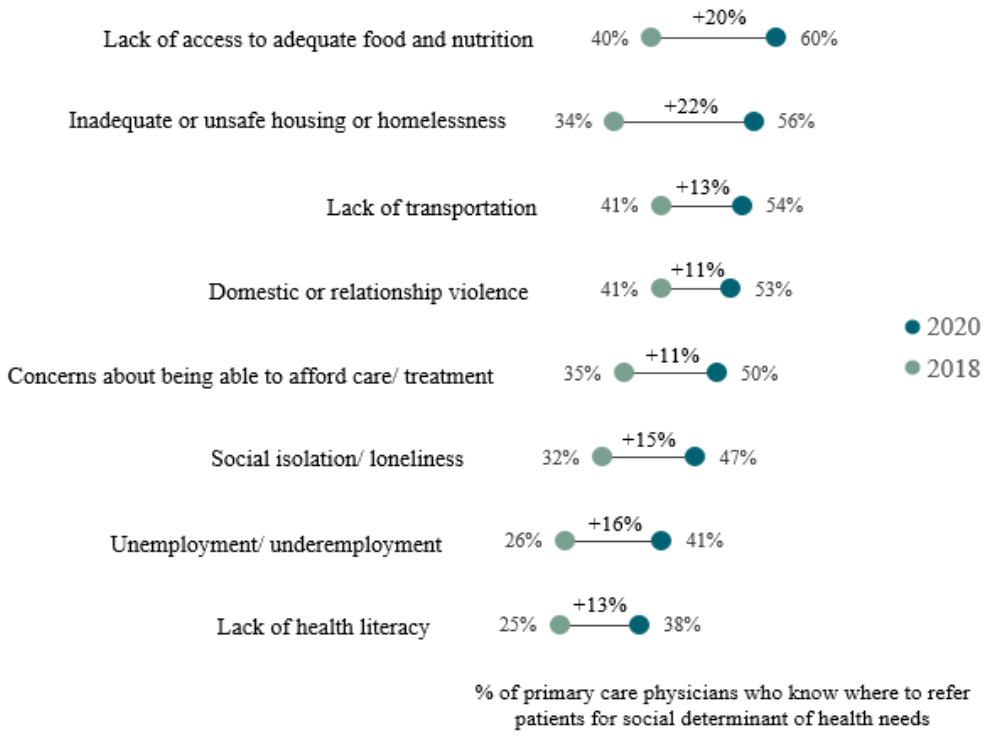
From 2018 to 2021, the percentage of primary care physicians who reported that they or a member of their care team knew where to refer patients for social needs increased. (See Figure 5).

This growth was greatest when it came to knowledge of where to refer patients for needs related to food and housing. Knowledge of where to refer patients for housing increased by 22 percentage points, and knowledge of where to refer patients for access to adequate food and nutrition increased by 20 percentage points.

[3] Significant difference ($p<0.05$)

Figure 5

The percentage of primary care physicians who know where to refer patients for social needs increased from 2018 to 2020.*



Data Source: 2018 and 2021 Physicians Surveys

*All changes over time statistically significant ($p<0.05$)

Note: The 2021 Michigan Physician Survey was fielded online to licensed physicians in Michigan from April 7, 2021 to May 11, 2021. The 2018 Michigan Physician Survey was fielded by mail to licensed primary care physicians in the summer of 2018. To make the samples comparable, analyses comparing referral knowledge in 2018 and 2021 are restricted to only primary care physicians. For both years, physicians were provided with a list of "non-medical issues that some patients experience" and asked to "Please indicate if you or a member of your care team know where you would refer your patients to get assistance in addressing those needs." Change in referral knowledge for traumatic life experiences is not presented because physicians were not asked about their referral knowledge for this social need in 2018.

Identifying gaps between screening and referral knowledge for social needs

More physicians routinely screened for domestic or relationship violence, patients' ability to afford treatment, social isolation and loneliness, and lack of health literacy than knew where to refer patients for these social needs.

This gap was largest when it came to patients' concerns about being able to afford the care or treatment they were prescribed.

While 61% of physicians reported that they routinely screened patients for concerns about the affordability of care, only 51% reported that they knew where to refer patients for this social need (an approximately 11 percentage point difference). (See Figure 6).

Routine screening for social isolation/loneliness also was more prevalent than knowledge of where to refer patients for this social need. While 54% of physicians routinely screened patients for this social need, only 45% of physicians knew where to refer for this social need (a gap of 9 percentage points).

There are a couple of factors that may contribute to this lag in referral knowledge.

There may not be adequate community resources in place to support patients with these social needs, which would necessitate investments in community safety net resources. In addition, physicians may not be aware of the resources that exist in their communities. Both of these factors should be considered when developing strategies to close these gaps.

More physicians knew where to refer patients for lack of access to food/nutrition, inadequate/ unsafe housing or homelessness, lack of transportation, traumatic life experiences, and unemployment/ underemployment than routinely screened for these social needs.

This gap was most pronounced when it came to needs related to traumatic life experiences and lack of access to adequate food and nutrition.

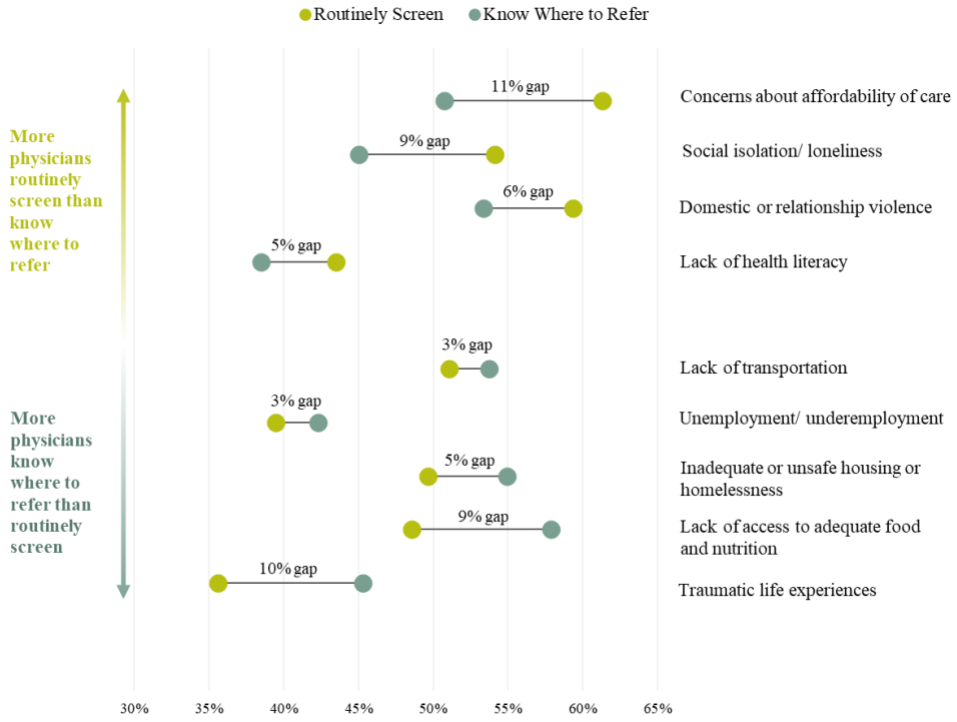
Routine screening lagged 10 percentage points behind knowledge of where to refer when it came to traumatic life experiences, and 9 percentage points behind when it came to lack of access to adequate food and nutrition. (See Figure 6).

Physicians may not routinely screen their patients for these social needs, despite knowing where to refer patients, for a number of reasons, including:

- the lack of a standard screening protocol at their organization,
- inadequate resources (i.e., time, staff, finances, technological support),
- limited understanding of the value of identifying patients' social needs, or
- the belief that screening for social needs falls outside the scope of their responsibilities.[xi]

Figure 6

Routine screening and referral knowledge for social needs are not closely coupled.



Data Source: 2021 Physicians Survey

Next Steps for Michigan

Signs of Progress

Primary care physicians' reported knowledge of where to refer patients for social needs increased from 2018 to 2021. This increase may reflect state efforts that were set in motion prior to the pandemic, such as Michigan's State Innovation Model initiative, which incentivized health care providers to screen patients for social needs and laid the groundwork for greater collaboration between health care and social care providers. This increase may also reflect a growing awareness about and investment in social determinants of health prompted by the economic and social ramifications of the COVID-19 pandemic.

Growth in referral knowledge was greatest when it came to needs related to food and housing. State efforts to both build the capacity to serve those experiencing food and housing insecurity and to develop cross-sector collaborations in Michigan, such as Michigan's Campaign to End Homelessness, [xii,xiii] may help explain why knowledge of where to refer patients for these social needs experienced the greatest growth from 2018 to 2021. Even with this growth in referral knowledge, however, in 2020 approximately 40 percent of physicians reported that their care team did not know where to refer patients for each of these social needs.

As part of its 2022-2024 Social Determinants of Health Strategy, MDHHS announced that both housing and food insecurity will be central foci of Michigan's strategy to address social determinants of health.[xiv] Building regional capacity to address food and housing security and increasing physicians' awareness of community resources will continue to be important steps toward achieving health equity moving forward.

Opportunities for Growth

Increase Screening Capacity

For some social needs (i.e. lack of access to food/nutrition, inadequate/unsafe housing or homelessness, lack of transportation, traumatic life experiences, and unemployment/underemployment) rates of routine screening lagged behind knowledge of where to refer patients. On one hand, it is encouraging that physicians report that they and their care team are aware of resources and services in their community to address these social needs. However, if there is not a systematic process for identifying patients with these social needs, then physicians may miss important opportunities to connect patients to social services. The development and adoption of standardized screening tools may help facilitate greater, more routine use of social need screenings. In developing these screening tools, it is crucial to get input both from physicians who will be using the tool and from community-based organizations who will be relied upon to connect patients with needed social services.

Specialists were notably less likely to screen patients for social needs than primary care physicians. If specialists are able to access information on patients' social needs from screenings conducted by primary care physicians, then ideally they can develop an informed and appropriate care plan for their patients without having to ask redundant questions and potentially re-traumatize patients by asking them to repeatedly disclose sensitive information. However, this model breaks down when there is no or a limited exchange of information between primary care and specialist physicians.

Moving forward, it is important to establish processes or mechanisms through which specialists can be made aware of their patients' social needs. One strategy is to offer specialists support and incentives to routinely screen patients for social needs. Another, perhaps more efficient, strategy is to improve mechanisms for sharing social needs data between primary and specialty care physicians. As Michigan continues to develop and improve its health information exchange (HIE) infrastructure,[xv] it is important that specialists are seen as key participants in the data exchange.

Physicians who were part of an independent practice were also less likely to report that they screened for a number of social needs, including food, housing, and transportation needs. Independent practice physicians may face more barriers to systematically implementing a social need screening tool than larger health systems, such as limited staffing, financial resources, and technological support. This suggests that independent practice physicians may require additional support to implement routine screenings.

Increase Referral Capacity

Physicians were more likely to screen than to know where to refer patients for some social needs, including concerns about the affordability of care, social isolation/loneliness, domestic or relationship violence, and health literacy. There has been some debate over the value of screening for social needs in the absence of a related social care intervention, such as referring patients to a community agency or resource.[xvi]

On one hand, screening for social needs without the ability to connect patients to related resources could result in feelings of frustration, distrust, and disillusionment among patients, which could be a deterrent for seeking needed health care. Screenings without referrals may also create a sense of disillusionment and burnout among physicians and other healthcare providers, who know that their patients are at risk of harm but do not have the mechanisms or capacity to promptly connect them to services. [xvii,xviii]

On the other hand, screening itself can lead to more patient-centered care and can be helpful context to physicians as they develop care plans with patients. In addition, data gleaned from these screenings can be paired with clinical, claims, and public health data to better identify gaps and areas for intervention at the community level.

A key aspect of increasing referral capacity is supporting the community-based organizations (CBOs) that are on the receiving end of physicians' referrals. Most initiatives that aim to address needs rely heavily on the services, expertise, and established networks of these CBOs. Despite the central role that they play in these initiatives, there are limited mechanisms in place to compensate CBOs for this work as they have not traditionally been part of payer networks. This places an unfair burden on these CBOs and limits their capacity to connect patients with needed social care.

A key step toward incorporating CBOs into these payment models is establishing the technological infrastructure to facilitate data collection and exchange between healthcare delivery and community-based partners. Establishing this infrastructure, however, poses its own administrative, legal, and technological challenges – especially for CBOs, which are often small nonprofits.[xix, xx] More administrative, legal, and technological support should be directed to CBOs to facilitate these efforts.

Social isolation and loneliness stands out as one of the social needs that was most commonly screened for, but also as a social need for which physicians were among the least likely to know where to refer patients. Although the COVID-19 pandemic has helped bring attention to how hazardous social isolation and loneliness can be for one's mental and physical health, it has also disrupted health system and community efforts to address this social need.[xxi] As COVID-19 continues to circulate within our communities, there is a need to build the capacity to address this social need within the context of this "new normal."

Recent resources outline strategies for addressing social isolation, including reports by Michigan's State Advisory Council on Aging and the Robert Wood Johnson Foundation. Some of the strategies discussed are developing inclusive public spaces (including virtual spaces) that give individuals the opportunity to connect, learning from and working with local leaders and organizations that have experience addressing social isolation in their communities, and identifying and addressing social needs that are barriers to social inclusion, such as inadequate access to transportation and internet.

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