Improving health outcomes through social determinants of health

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Social determinants of health (SDOH) have been defined by WHO as "the non-medical factors that influence health outcomes."[1] Conditions in which people are born, work, and live have important influence on their health status and health inequities at the population level. This *Pharmacy Today* article will review SDOH and their impact on health outcomes as well as provide pharmacists and technicians with tools and resources to address SDOH as part of their practice.

Defining SDOH

The 5 domains of SDOH defined by CDC include education, neighborhood environment (including housing and food security), social context, economic stability, and health care.[2]

The health care domain is defined as the connection between people's access to and understanding of health services and their own health (Figure 1).[2]

Studies suggest that SDOH contribute to between 30–55% of health outcomes.[1] Factors that impact a patient's ability to engage in healthy behaviors and access health care lead to poorer disease state control and health outcomes. WHO identified 3 actionable steps to reduce inequalities in health[1]:

- Improve daily living conditions.
- Address the inequitable distribution of power, money, and resources.
- Expand the knowledge base, develop a workforce that is trained in the SDOH, and raise public awareness about the SDOH.

This article will focus on the third step and how the pharmacy workforce can become more aware and equipped to address SDOH, specifically within the health care domain.

A recent review found many pharmacists already express that they identify SDOH factors naturally, but the increased focus on SDOH increased understanding of overall health impact, highlighting the need for more tangible training.[3] In recent years, research has been done to evaluate the problem, and resources have been created to help screen for and help patients with barriers related to SDOH.[4] Pharmacists, student pharmacists, and pharmacy technicians are uniquely positioned to play an important role in addressing SDOH.[5] As one of the most accessible, integral, and innovative members of the health care community, pharmacy personnel encounter opportunities to address SDOH barriers and improve patient outcomes.[5,6]

Impact on health outcomes

Two major factors of SDOH within health care are

- Access to needed components of health care.
- Understanding of disease state management with consideration to individual patient circumstances.

Access has many facets such as primary care access, laboratory testing compliance, insurance coverage, and medication possession. Other SDOH that feed into health care access include transportation resources, location of services, and affordability. Pharmacy teams can create plans to address some of these, as outlined in the toolkit below, but the foremost need to address is medication possession as without consistent access to medications, health outcomes will not improve despite many efforts to improve other aspects of SDOH (Figures 2 and 3).

As pharmacy teams prioritize medication access, the goal is not simply to measure medication adherence, but rather track chronic

Learning objectives

At the conclusion of this knowledge-based activity, pharmacists and pharmacy technicians will be able to:

- Define social determinants of health (SDOH) and related terminology.
- Discuss selected SDOH and their impact on health outcomes.
- Identify available tools and resources for pharmacists and pharmacy technicians to address barriers in care related to SDOH.
- Describe selected innovative practice examples which address SDOH.

Preassessment questions

Before participating in this activity, test your knowledge by answering the following questions. These questions will also be part of the CPE assessment.

1. Which of the following is not a domain of social determinants of health?

a. Neighborhood and built environment
b. Economic stability
c. Disease state control
d. Education access and quality

2. Social determinants of health contribute _____% to health outcomes.

a. 30–55%
b. 1–5%
c. 75–90%
d. 10–15%

3. Which of the following is the most important component for pharmacy teams to prioritize within social determinants of health?

a. Laboratory compliance
b. Medication access
c. Housing
d. Equitable employment

disease clinical health outcomes markers such as A1C, blood pressure, weight, COPD assessment test score, PHQ-9, lipid panel, etc. According to an article in *AMA Journal of Ethics*, "chronic diseases like diabetes, hypertension, dyslipidemia, and obesity[a]ffect 60% of Americans, account[ing] for 37% of office-based physician visits, and continue to be on the rise."[6]

The average medical expenditures incurred by individuals diagnosed with diabetes is $16,752 per year, with this chronic disease state accounting for 1 in 4 health care dollars spent in the U.S.[7] Uninsured patients with diabetes have 60% fewer physician office visits but have 168% more emergency department visits than people who have insurance, highlighting how vital access is especially in underserved care.[7]

Pharmacy teams can utilize CDC data mapping to determine regionally disproportionate disease states that uniquely affect their population and initiate SDOH programs customized accordingly.[8]

Helping patients understand disease state management and health literacy in general is the second component within health care SDOH, but emphasis on it is unfortunately fading in proportion to transaction-based pharmacy services. As businesses focus on medication adherence as a means of increasing their bottom line, they create services like automated filling, metrics targeted to adherence data only, mail-order delivery, etc. In theory, these would help patients improve their disease states, but it has removed the need for patients' ownership and involvement in their health. Pharmacy teams are thus not incentivized to reduce overuse of as-needed prescriptions or de-escalation of therapy when clinical targets are achieved. Face-to-face counseling has been reduced to the point at which many patients just take whatever pills they are given with no understanding of what the medication is doing to their body, what prescriptions help symptoms and which ones are preventive, and what lifestyle changes they could be incorporating. If/when insurance companies recognize the positive effects of a value-based pharmacy team, focus could shift away from fee-for-service models and toward clinical metrics like other health care professions.[9]

The American Medical Association has also identified the importance of a clinically focused pharmacist in relation to health outcomes stating,

Figure 1. SDOH domains

Figure 2. The problem

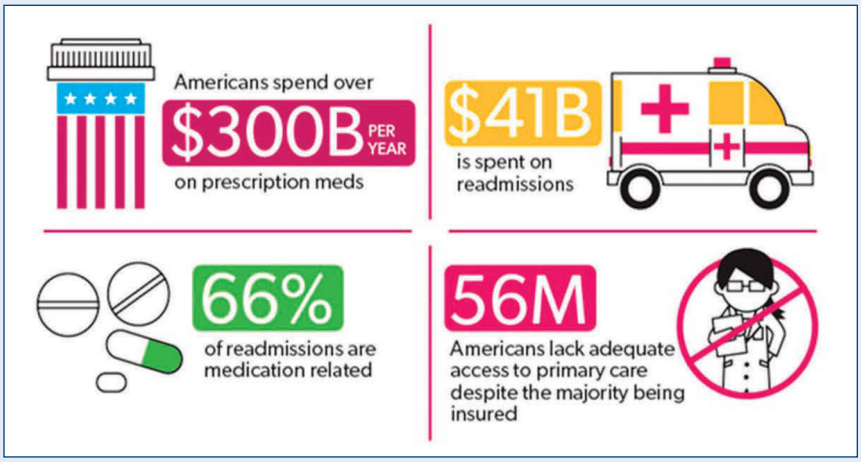


Figure 3. The solution

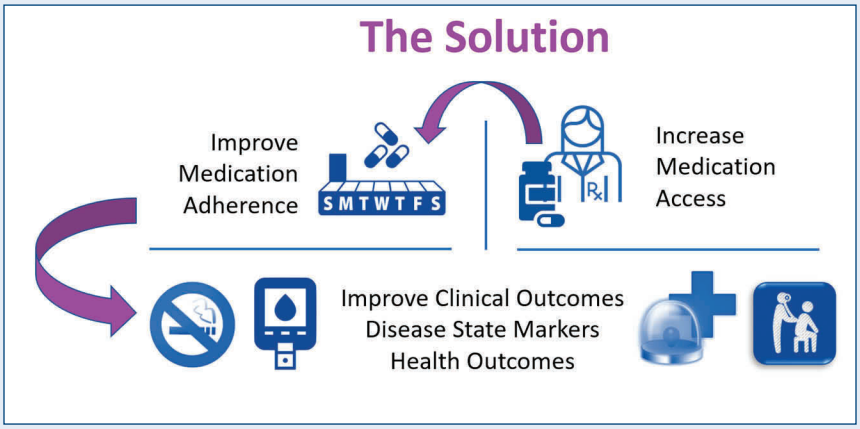
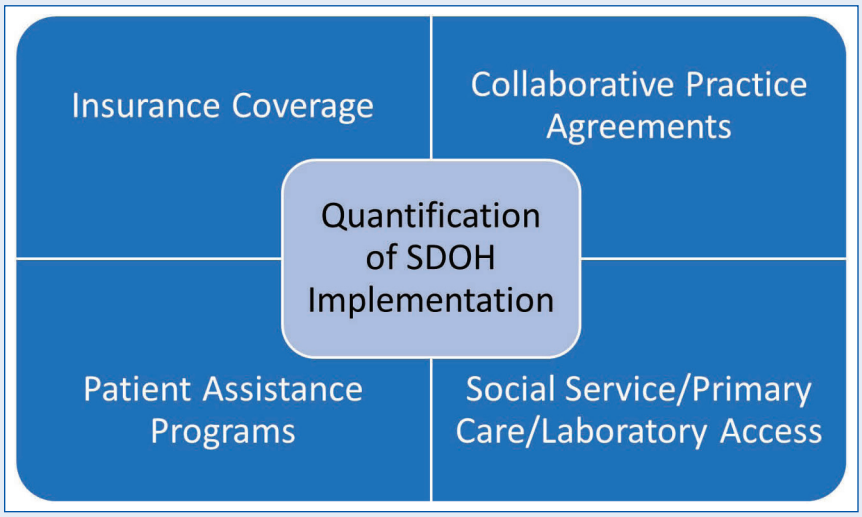


Figure 4. Toolkit of actionable steps



"pharmacists' involvement in clinical preventive services, chronic disease state management, and transitions of care is vital to the elimination of health disparities."[6]

Toolkit

Moving from an understanding of a problem into actionable steps is key. The following toolkit is not exhaustive, but a sample of tangible resources pharmacy teams can implement and customize to make the most meaningful impact on their specific patients. The last phase is quantifying that impact for the purposes of direct funding through insurance billing or indirect funding through grants.

Proving the worth of these initiatives is necessary for a sustainable focus on SDOH (Figure 4).

Improve medication access through insurance coverage

While the Affordable Care Act expanded access to health insurance starting in 2010, millions remain uninsured.[10]

Government assistance (e.g., Medicaid/Medicare) should be prioritized when assessing potential plans available to your patients.

Knowing if patients are eligible for government programs is the first step. Criteria are based on the Federal Poverty Level (FPL) and individual state requirements. For example, any Ohio resident who earns ≤ 138% of the FPL is eligible for Medicaid, which has $0 or low copays. In 2022, Medicare Extra Help has criteria of an FPL of ≤ 155%, age 65 years, and monetary savings of < $15,000, but provides 90-day supplies of medications for $3.95 generic or $9.85 brand-name medications, eliminates the "donut hole" gap of coverage, and pays for part B premiums, thereby saving patients up to $170.10 per month.

Many Americans are eligible for the immense benefits that come with these programs without even knowing it, indicating a large opportunity for pharmacy team members to improve health care access.

Pharmacy team members should be trained to calculate an estimated FPL by using an online calculator and asking questions about household size and income. If patients are eligible for services, pharmacy personnel should provide an application with directions for submitting it.

Next, trained team members should access the state's Medicaid portal to check eligibility. More detrimental than patients being eligible for government assistance programs and not applying are those

Table 1. Drug interchanges and cost savings

Disease state	Interchange			Cost savings
	From	To	Using	
Diabetes	Lantus, Levemir, Toujeo, Tresiba, etc.	Humulin NPH	1-to-1 dosing, split into twice-daily regimen, adjust as needed based on fasting blood glucose	$270/vial (Lantus = $300/vial, Humulin NPH = $30/vial)
	Humalog, Novolog, etc.	Humulin R	1-to-1 dosing, adjust as needed based on postprandial blood glucose, can use in insulin pump	$240/vial (Humalog = $270/vial, Humulin R = $30/vial)
Anticoagulants	Eliquis	Xarelto	Janssen savings card	$519/vial (Eliquis = $529/30-day supply, Xarelto copay card = $10/30-day supply)
Congestive heart failure	Entresto	Valsartan	26 mg valsartan in Entresto — 40 mg of valsartan	$520/month (Entresto = $544/30-day supply, valsartan = $24/30-day supply)
Asthma	Symbicort for rescue	Albuterol for rescue	1-to-1 as-needed dosing	$270/month (Symbicort = $300/30-day supply, albuterol = $30/30-day supply)
COPD	Advair	Fluticasone/ salmeterol	1-to-1 dosing	$360/month (Advair = $470/30-day supply, fluticasone/salmeterol = $110/30-day supply)

Advair–GSK; Eliquis–Bristol-Myers Squibb Co.; Entresto–Novartis; Humalog–Eli Lilly; Humulin–Eli Lilly; Lantus –Sanofi-Aventis; Levemir–Novo Nordisk; Novolog–Novo Nordisk; Symbicort–AstraZeneca; Toujeo–Sanofi-Aventis; Tresiba–Novo Nordisk; Valsartan–Sigma-Aldrich; Xarelto–Janssen Pharmaceuticals, Inc.
Source: Adapted from Drugs.com price guide.

that already have full Medicaid/Medicare Extra Help access but never utilize it because they didn't receive their card in the mail or were unaware of what that card indicated. This happens frequently when a different entity such as a hospital or health care system has applied for the patient as part of a health care visit, meaning patients may be less engaged to learn about their roles in receiving state/federal benefits. Being able to quickly assess benefit status access allows pharmacies to submit to insurance at the point of sale as the billing number is immediately retrievable. The state-specific portal may require the patient's social security number and date of birth to assess their status and obtain the billing ID number.

Providing training, creating a flow chart, and producing state-specific handouts for the pharmacy team will immediately impact your patient's health care access and SDOH.

CPAs

As the profession of pharmacy develops, collaborative practice agreements (CPAs) will continue to expand, allowing pharmacists to have a more immediate impact on clinical outcomes and SDOH.[11]

The Pharmacy Quality Alliance published a resource guide outlining 20 real-world SDOH services that are currently available to help improve quality of life and safe medication use, with several focused on CPAs.[12]

The *AMA Journal of Ethics* summarized, "although pharmacists, physicians, and other clinicians could address health disparities separately, it is through a collaborative effort that the health care system will become more efficient in addressing health disparities."[6]

Pharmacy teams should initiate CPAs focused on improving medication access before addressing clinical interventions.[13] Some medical teams still hesitate to add or remove medications or change dosages, but feel much more confident regarding refill approvals and/or preapproved therapeutic interchanges.

Understanding your specific populations' most common insurance coverage gaps will help pharmacy teams create an interchange table (Table 1), which can be reviewed with practitioners in your area for approvals. Especially in patient populations with limited transportation or changing schedules, reducing gaps in therapy from delayed refill approvals directly reduces hospitalizations and worsening disease state control.[11] Therapeutic interchanges are vital in cost reduction when considering formulary coverage for specific plans as well as available copay cards or generic alternatives.

PAPs

Pharmaceutical manufacturers often offer costly prescription medications for free or reduced prices through patient assistance programs (PAPs). Medications can be shipped directly to patients or to a pickup station like a provider's office or pharmacy.

However, these programs have specific document requirements (e.g., proof of income, proof of spenddown, Medicaid denial letters, etc.) and time-consuming application processes. Refills must be requested through the program dispensing pharmacy, and each year a new application is required. Providers and patients must sign each application, meaning pharmacy teams can either initiate approval with both parties before submitting the application on behalf of the patient or pharmacy teams could simply give the blank applications to the patient to bring directly to their provider's office. (This decision depends on the willingness of providers to complete the application and the initiative of the patient to submit it themselves.)

This brings up an additional barrier: unfamiliarity with PAPs from the perspective of a provider and/or patient. One study found 35% of patients reported that uncertainty about applying to patient assistance programs impeded their utilization, and 56% of referring pharmacy personnel reported the same barrier.[14]

Increased awareness of and training in these applications with a designated pharmacy team member will improve patient care through medication access, but programs should be tactical. Identifying critical patients and minimum necessary medications will help pharmacy teams spend time only on high-impact cases that have no other alternative. Communicating to providers before faxing over an application to be signed will also improve approvals and timeliness.

Having an on-site provider and designated pharmacy team member significantly improves ease and success of implementing a PAP program, as the UC Health and Cass Lake Indian Health Service programs observed in one study.[12] The UC Health PAP program is one of the most robust in the country, employing 14 medication access specialists and 2 coordinators, 86% of whom are certified pharmacy technicians.[15] Their team partners with UC Health providers to complete and submit PAP applications, order monthly refills, and track re-enrollments to ensure no loss of coverage.[15] In the 2020 fiscal year, their PAP program helped over 130,000 patients access medications, leading to a financial impact of $36.7 million.[15] In summary, PAPs can be an innovative initiative to address medication access and SDOH.

Improving and increasing care

Many other SDOH outside health care can be addressed through a pharmacy team that is confident in their referral sources. Creating or finding a region-specific handout organized by categorical need (e.g., food, housing, transportation) can be an instrumental in helping your patients.

Pharmacy team members should be familiar with the sources listed and what phrases patients could use to signal need. Alternatively, websites can be utilized for more real-time information. Nova Scripts Compass is one example that is organized by ZIP code and includes all domains of SDOH.

Primary care referrals should be at the forefront of pharmacy team members' minds, as the overutilization of emergency room and urgent care visits can lead to astronomical health care costs and worsening health care outcomes.[16] Knowing the location of local low-cost medical homes is critical. This may include federally qualified health centers, health departments, and nonprofit free clinics, among others. Handouts on this subject should include patient-specific qualifying information like insurance status, residency limitations, and income requirements so pharmacy team members can feel confident in their specific referrals.

In addition to primary care needs, laboratory monitoring is critical for effective disease state management. Point-of-care testing (POCT) alleviates barriers by providing convenient and cost-effective alternatives to traditional lab draws. Increased appointments to obtain laboratory measurements pose financial and transportation hardships, especially in an underserved population.

Accessible pharmacy teams can work collaboratively with providers to obtain more frequent measurements of disease state control, leading to more timely medication changes.

Specifically regarding diabetes, one study demonstrated point-of-care A1C tests were an effective and economical tool.[17] POCT may reduce health care costs while improving patient's laboratory compliance due to less invasive procedures, increased accessibility, and increased convenience.

Pharmacy teams can start with a focus on their most prevalent chronic

Table 2. Estimated cost avoidance by level

Level number	Type of savings	Estimated savings amount
Level 1	Reduced drug cost	$139
Level 2	Prevented routine physician office visit	$298
Level 3	Prevented urgent care visit	$878
Level 4	Prevented ED visit	$1,010
Level 5	Prevented inpatient hospital admission	$15,140

Accreditation information

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Learning level: 2
ACPE Universal Activity Number: 0202-0000-22-175-H04-P/T
CPE credit: 1 hour (0.1 CEU)
Fee: There is no fee associated with this activity for APhA. There is a $25 fee for nonmembers. APhA is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmacy education (CPE). The ACPE Universal Activity Number assigned to this activity by the accredited provider is 0202-0000-22-175-H04-P/T.

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disease states and later expand. Available POCT include A1C and blood glucose tests, lipid panels, comprehensive metabolic panels, INR coagulation time assessment, thyroid screening, urinalysis, streptococcus tests, pregnancy tests, and more.

Quantifying SDOH implementation

My personal pharmacy practice experience has been in the charitable pharmacy sector for the entirety of my career.

My workplace, St. Vincent de Paul Charitable Pharmacy (SVDPCP) in Cincinnati, prioritizes positive health outcomes for any program we implement, including SDOH initiatives. SVDPCP provides a last-resort safety net option for uninsured and underinsured individuals by providing no-cost prescription medications. The pharmacy has filled over 700,000 prescriptions (valued at > $90 million) since opening in 2006.

In addition to medications, the pharmacy provides other clinical services such as a free in-house primary care provider, medication therapy management, comprehensive medication reviews, health screenings (e.g., for hypertension and diabetes), and immunizations. SDOH services include insurance screening and navigation, homelessness prevention services, food insecurity screenings and pantry referrals, and more (Figure 5).

To sustain this model of care, estimated cost-avoidance calculations are tabulated from data below for each intervention (Table 2), generating over $5 million per year due to reduced hospitalizations and doctors' visits.[18]

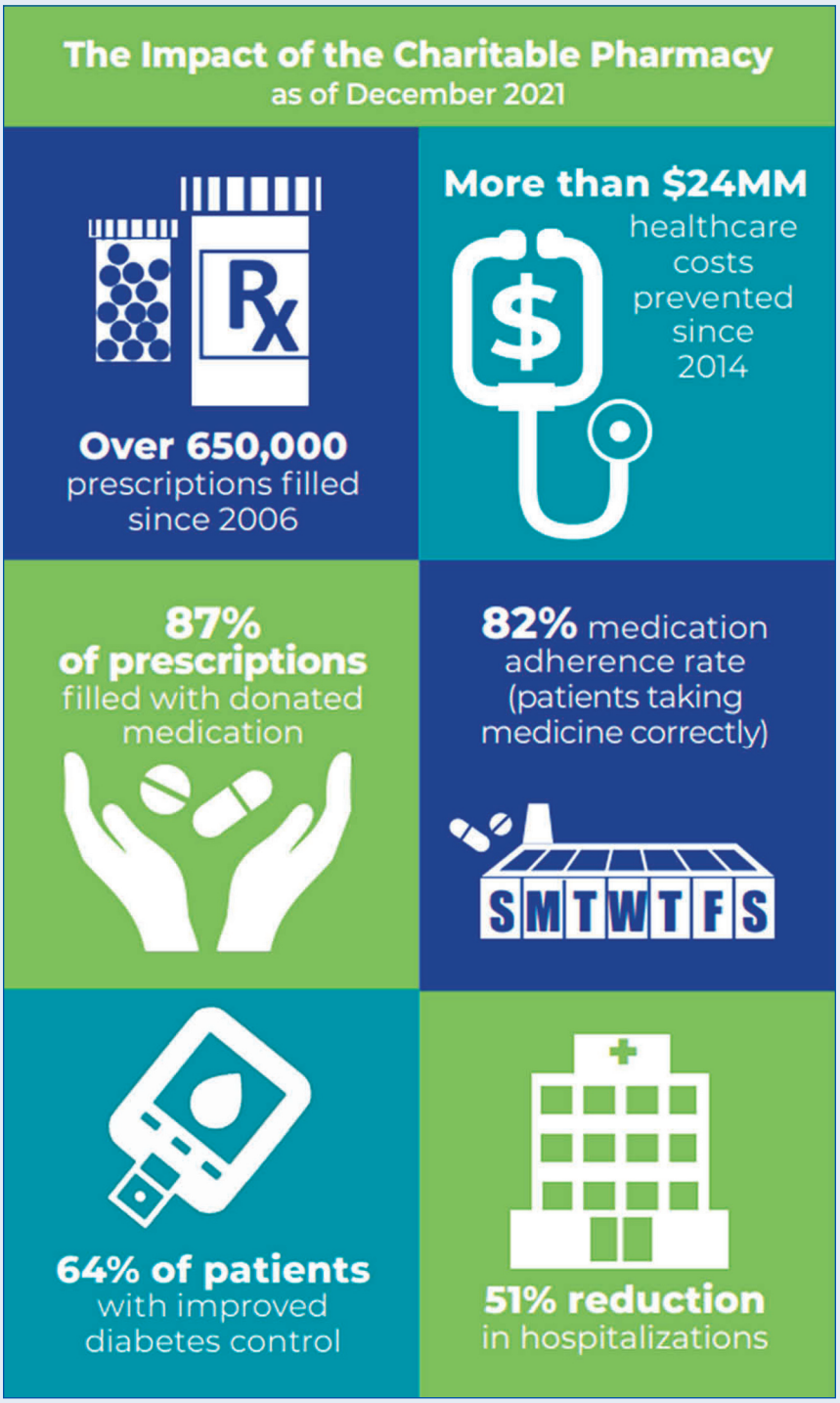
Linking SDOH interventions to health care dollars avoided is important to increase the capacity of pharmacy teams to implement the actionable items outlined in this article.

For example, SVDPCP calculates a level 2 intervention for each A1C we complete, as the patient avoided the cost of a routine health care provider visit just to obtain an A1C measurement.

With that reading, we were able to use our CPA to increase metformin and more quickly manage diabetes control. When we increased the metformin, we calculated a level 3 intervention, justifying that the patients' uncontrolled diabetes complications may have required more expensive urgent care had the pharmacists not provided this additional level of care.

As the pharmacy team prioritizes certain aspects of SDOH, a plan to assess, refer, and quantify the impact of each service provided should be predetermined and standardized among team members for higher quality data collection.

Figure 5. St. Vincent de Paul Charitable Pharmacy Outcomes



Conclusion

SDOH impact health outcomes. Pharmacy teams are uniquely positioned to identify and address multiple facets of SDOH, and should prioritize practical, customized training that targets patient-specific issues within your service area. Teams must be prepared to first focus on medication access barriers and create systems to quantify applied efforts. When pharmacy teams are motivated to improve the lives of their patients, SDOH barriers will naturally surface as opportunities to make a positive impact.

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CPE assessment

This assessment must be taken online; please see "CPE information" in the sidebar below for further instructions. The online system will present these questions in random order to help reinforce the learning opportunity. There is only one correct answer to each question.

1. **Which of the following is not a domain of social determinants of health?**
   a. Neighborhood and built environment
   b. Economic stability
   c. Disease state control
   d. Education access and quality

2. **Social determinants of health contribute _____% to health outcomes.**
   a. 30–55%
   b. 1–5%
   c. 75–90%
   d. 10–15%

3. **Which of the following is the most important component for pharmacy teams to prioritize within social determinants of health?**
   a. Laboratory compliance
   b. Medication access
   c. Housing
   d. Equitable employment

4. **What plan should be the pharmacy team's first choice when reviewing insurance coverage?**
   a. Medicaid
   b. Marketplace
   c. Private
   d. None/Uninsured

5. **To improve medication access, collaborative practice agreements should first focus on**
   a. Dose adjustments
   b. Medication removal
   c. Medication addition
   d. Therapeutic interchanges

6. **Barriers to implementing patient assistance program initiatives include all of the following except:**
   a. Complicated applications
   b. Medication cost
   c. Unfamiliarity with approval process
   d. Annual re-enrollment signatures for both patients and providers

7. **Point-of-care testing may improve health outcomes by:**
   a. Generating more accurate results compared to traditional labs
   b. Offering more tests available compared to traditional labs
   c. Being automatically uploaded to the electronic medical record
   d. Improving laboratory testing compliance

8. **Quantifying social determinants of health programs is important for all of the following except:**
   a. Improving sustainability
   b. Reducing effort
   c. Generating revenue
   d. Increasing quality of data collection

9. **Pharmacy team members can use a(n) _____ calculator to determine Medicaid eligibility.**
   a. ASCVD
   b. CHADS-VASC
   c. FPL
   d. GOLD

10. **Examples of innovative practice models use _____ as one way to quantify social determinants of health initiatives.**
    a. FPL
    b. Wait times
    c. Estimated cost avoidance
    d. Number of prescriptions sold

CPE information

To obtain 1 hour of CPE credit for this activity, complete the CPE exam and submit it online at www.pharmacist.com/education. A Statement of Credit will be awarded for a passing grade of 70% or better. You have two opportunities to successfully complete the CPE exam. Pharmacists and technicians who successfully complete this activity before November 1, 2025, can receive credit. Your Statement of Credit will be available online immediately upon successful completion of the CPE exam.

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