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INSIDE

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Attention to Mental Health Improves Case Management for Patients with Diabetes

Depression twice as likely in this population

By Melinda Young

New research revealed the health of people with diabetes and other chronic illnesses improves when healthcare providers integrate medical and mental services, including better glycemic control.[1,2]

Diabetes affects about one in 10 Americans. People with diabetes are twice as likely to experience depressive symptoms as those without diabetes. One in four people with diabetes experience symptoms of depression, and about 11% meet criteria for diagnosis of a major depressive disorder.[3]

> "WITH THE RECENT DIABETES GUIDELINES, WE'RE TALKING MORE SERIOUSLY ABOUT INCORPORATING PSYCHOSOCIAL CARE FOR PEOPLE WITH DIABETES."

Investigators found patients with diabetes saw better physical health outcomes when they received integrated diabetes and depression care.[1]

"This is a study where we were interested in trying to understand whether better integration of diabetes and depression care was associated with better glycemic control," says **Neda Laiteerapong**, MD, MS, associate professor of medicine and associate director of the Center for Chronic Disease Research and Policy at the University of Chicago.

Laiteerapong and colleagues focused on a patient population at federally

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qualified health centers (FQHCs). They sent surveys to behavioral health directors, FQHC leaders, and primary care providers who worked with FQHCs. The surveys focused on defining features of behavioral health and primary care integration among patients with diabetes.[1] FQHCs provide healthcare to underserved populations, and some include integrative behavioral health services, Laiteerapong says.

The study began in 2016, the same year the American Diabetes Association (ADA) published a position statement encouraging the integration of psychosocial care and medical care for all people with diabetes.[1]

Other research supports integrated mental and medical health services. For instance, a study from the Veterans Health Administration (VA) revealed complementary and integrative health approaches can result in better patient health and satisfaction. The integrated services also were provided without difficulty at many VA sites. The integration included nonpharmacological options to address patients' pain, anxiety, depression, and well-being.[4]

The authors of another study focused on the Mental and Behavioral Health Capacity Project, collecting data on the integration of mental health into undersourced primary health clinics in four states affected by natural disasters. Investigators found long-term outcomes of better informed and connected communities and greater capacity and sustainability for quality healthcare.[5]

A three-state study of Midwesterners with diabetes and depression revealed significant improvements in glycemic management and symptoms of depression among people who received a 12-week exercise intervention or a 12-week intervention that combined exercise with cognitive behavioral therapy (CBT).[6]

"That demonstrated to us there are multiple ways to improve depression," says **Mary de Groot**, PhD, associate professor of medicine and acting director of the diabetes translational research center at Indiana University School of Medicine. She also is immediate past president for healthcare and education for the ADA.

For example, researchers found adults with type 2 diabetes benefited at three months postintervention assessment from exercise and/or therapy. Researchers found significant improvements in patients' major depressive disorder (MDD) with three interventions: exercise,

EXECUTIVE SUMMARY

People with diabetes are twice as likely to experience symptoms of depression as people without the disease. New research revealed integrated treatment is effective when it improves medical and mental healthcare of patients with diabetes.

- Investigators found complementary and integrative health approaches can result in better patient health and satisfaction.
- Another study revealed people with type 2 diabetes benefit from exercise and/or cognitive behavioral therapy.
- Patients achieve better glycemic control when their medical and mental health are integrated.

CBT, and a combination of exercise and CBT. Also, the combined exercise and CBT resulted in blood glucose (HbA1c) level improvements at three months postintervention.[7]

The researchers examined the cost-effectiveness of the exercise and CBT interventions, finding a savings of $313 per patient, representing a good value when compared with usual care. The interventions took place for three months in community settings and involved providers from healthcare systems and practice settings.[7]

"When we looked at the long-term effect and long-term outcomes, measured at 12 months postintervention, we observed that people in the exercise group not only had short-term improvement, but their improvement in HbA1c persisted even a year after the formal intervention was complete," de Groot says. "What's interesting is that not everyone maintained their same level of exercise a year later, but having this period of exercise — even for as little as three months — seemed to have a lasting improvement in A1c for up to a year later."

Those findings had implications for cost-effectiveness as well. "If you can get people access to exercise and help them do it in a way that's safe for them medically and physically, we can achieve significant health savings to health systems," de Groot says. "Whether exercise was combined with CBT or on its own, they showed improvements that were pretty similar. This was consistent with what we would expect."

The ADA's position statement on psychosocial care for people with diabetes, which de Groot co-authored, states psychosocial care should be integrated with collaborative, patient-centered medical care. It also asks that providers consider an assessment of symptoms of diabetes distress, depression, anxiety, and other mental health issues at the initial visit and at periodic intervals.[8]

"With the recent diabetes guidelines, we're talking more seriously about incorporating psychosocial care for people with diabetes," Laiteerapong says.

People with diabetes are two to three times more likely to be diagnosed with depression than people without diabetes, and at least half live with undiagnosed and untreated depression, according to the Centers for Disease Control and Prevention.[9]

Anxiety also is more prevalent among people with diabetes. Overwhelming feelings of worry, frustration, and discouragement can lead to diabetes distress, which can affect up to half of people with diabetes within any 18-month period.[9]

The first step to solving this problem is to improve depression screening and diagnosis. "Think about it as a process. You can't treat, support, or do anything if you don't know what to deal with, so it's really important to do a good assessment," says **Mark Peyrot**, PhD, professor emeritus of sociology at Loyola University Maryland.

Providers need to ask about patients' experiences and feelings during initial and subsequent visits. If a case manager or another provider asks if the patient with diabetes feels sad most days, and the patient says yes, then the patient needs further assessment for depression, Peyrot says. *(See story on assessing and helping patients with diabetes and depression in this issue.)*

In the FQHC study, researchers examined if better behavioral health integration could improve diabetes control. They surveyed people at FQHCs, asking about their behavioral health integration, the types of behavioral health services they provided, and whether they worked collaboratively with primary care clinics.[1] "We asked how things were going and what was the status of integration of depression and diabetes care," Laiteerapong says. "We linked survey data results to health center-level diabetes control."

The researchers found the FQHCs that used better or more integration of diabetes and depression care saw fewer patients with uncontrolled diabetes, Laiteerapong says.

"We also found that onsite diabetes health self-management education was associated with fewer patients with uncontrolled diabetes," she adds. "That's a finding you'd expect; you hope that having education was associated with better diabetes control."

But the success of integrated diabetes and depression care is an important finding. "There's something about not having just behavioral healthcare, but having behavioral healthcare and diabetes integrated, which is associated with better control of diabetes," Laiteerapong says.

The study revealed 65% of health centers used both diabetes and behavioral health patient tracking systems, and 43% had one person managing both tracking systems.[1]

"Someone might think it's uncommon to have someone manage both mental health and diabetes care, but at these federally qualified health centers, which generally are under-resourced, 43% had the same person," Laiteerapong says.

Other services associated with better glycemic control included a tracking system for clinical diabetes, clinical decision support tools, and self-management education. More than 80% of the FQHCs used a diabetes screening protocol and a

patient tracking system. Tracking systems included registries and case managers following up with patients.[1]

Integrated services may include one case manager helping patients with both their medical issues and their mental health issues. "Case managers can reach out to people who have uncontrolled diabetes and who haven't come into the clinic for a while to make sure they are using their new medicine," Laiteerapong explains. "This is an example of higher-level case management."

The researchers found primary care providers were satisfied with diabetes care resources and interventions. They agreed their diabetes screening protocol was accurate, efficient, and followed consistently. Behavioral health services at the FQHCs included counseling, same-day appointments as primary care appointments, depression screening, warm handoffs during clinic visits, and anxiety screening.[1]

The study results reinforce the concept that physical and mental healthcare should not be segregated to different facilities. "To have good physical health, you need good mental health," Laiteerapong says. "These problems are intertwined."

It creates an unnecessary barrier when healthcare organizations outsource their mental health care to other providers. It can prevent the health system from achieving better quality care for patients.

The other takeaway is that employing case managers in the role of assisting patients with their chronic illnesses and mental health issues is helpful for value-based care. "The old-fashioned lesson and concept is that physical and mental healthcare should not be segregated to different healthcare providers," Laiteerapong adds. ■

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Take the First Step to Screen and Identify Patients with Diabetes and Depression

By Melinda Young

Case managers should expect a large segment of patients with diabetes also to present with depression, and possibly distress or anxiety related to diabetes. These mental health issues are common among people with the chronic illness, according to government statistics.[1]

The key is to open the door for people to share information about their struggles and feelings, says **Mark Peyrot**, PhD, professor emeritus of sociology at Loyola University Maryland.

Screening is not a treatment for depression, but it is vital to identifying people who are at risk of depression, says **Mary de Groot**, PhD, associate professor of medicine and acting director of the diabetes translational research center at Indiana University School of Medicine.

"The next preferred step is to connect people with resources so they can make choices," she says. "People need to be screened annually for depression. They should be screened at any time there is a change in medical status, or a change that might include the onset of diabetes complications, or when there's a major life stressor that puts people at risk for clinical depression."

Case managers can play a major role in connecting patients with community resources and support, depending on what patients want, de Groot says.

There is no one method for assessing whether a patient is experiencing psychological difficulties, but case managers can ask simple questions. "Ask more open-ended questions that allow them to tell their story of what it's been like living with diabetes," Peyrot says.

Examples include:

• Are you experiencing any problems with your diabetes?

• Is there anything you would like to talk about regarding your diabetes?

• Is there anything else that concerns you about your diabetes?

"If you ask a general question, you might get an answer of, 'I had hypoglycemia,' or 'My blood sugar went really high, and I can't get it down,'" Peyrot says. "Or, someone might say, 'I am getting frustrated with my diabetes.'"

When patients share their feelings, problems with sleep or anxiety, or other issues that indicate a mental health component, the case manager can ask follow-up questions and identify a possible problem to be assessed by the patient's primary care provider, diabetes specialist, and/or a mental health professional.

"Cast your net more broadly to include things that no one has diagnosed and that maybe no one else has asked about," Peyrot says. "A person who is struggling with diabetes may feel helpless because they think nothing works, and they don't see this as a mental illness. They just think diabetes is horrible to live with."

That could indicate subclinical depression, where the person experiences feelings that have not met the technical criteria for a depression diagnosis, Peyrot explains.

If general questions do not elicit much information, case managers could ask questions that focus on patients' emotional reaction to diabetes, such as:

• Do you feel overwhelmed with managing your diabetes?

• How do you feel about how your management regimen?

• What kind of support do you receive? Is it adequate?

If the patient appears to harbor some emotional distress, the case manager could inform the provider and suggest the patient might need treatment or more support. "Everyone in the chain of treatment and referral has a role to play," Peyrot adds.

For example, patients' case management and diabetes teams could view this as not just the ABCs of diabetes care (A stands for A1c, B stands for blood pressure, and C is for cholesterol), but as the ABCDs, with

EXECUTIVE SUMMARY

Case managers should screen patients with diabetes for depression, as the condition is prevalent and often undiagnosed.

• Case managers could ask patients open-ended questions about any problems with diabetes.

• If patients are experiencing problems with sleep or other issues, case managers can follow up with more questions to pinpoint whether these issues could be related to depression.

• Every facility should implement protocols for depression screening.

D standing for depression. "You have to assess for depression, just like the other three," Peyrot says.

The big issue after asking patients about their emotional health is to know what to say when they acknowledge depressive feelings or suicidal ideation. The solution is for institutions to create protocols for handling mental health issues among their patients with chronic illnesses.

"We need to address it, and we need to have protocols in place for screening for depression," de Groot explains. "Case managers can get to know those protocols so when they're screening for depression, they'll feel comfortable and supported. When they're doing that, they're doing a great service for their patients."

When suggesting mental healthcare to patients, case managers and providers could think in terms of making a sale. They will see greater success in achieving buy-in with patients if they try a persuasive approach, Peyrot says. In sales, that usually means making the sales pitch with a closing line asking the person if they could put them down for the purchase.

The closing line for patients with diabetes could be to say, "Would you like some support or help with this? Would you like to do something about this to make the situation better?" he suggests.

It is a burden when providers expect the patient to volunteer his or her interest in counseling or some other solution. "Give them an opportunity to say, 'Yes, that's an issue for me,' and 'I could use some help dealing with it,' and so on," Peyrot says. ■

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Study Results Highlight Formerly Homeless Veterans' Need for Case Management

By Melinda Young

Housing is an important health factor among low-income and homeless people in the community, including veterans. New research revealed that clinicians should view veterans' housing status and their behavioral health factors, including loneliness and substance use disorder.[1]

Social workers and case managers should keep veterans' housing and substance use struggles in mind.

Investigators interviewed veterans in project-based housing and found substance use and social isolation were common themes, says **Max Winer**, LICSW, MPH, primary care social worker at Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA.

"One of the really nice things about the study was with qualitative work, you get a rich sense of what's actually going on," Winer says. "We had the actual perspective and words from participants."

For example, many veterans talked about their struggle with substance use disorders. "One of the focuses of the study was socialization and social engagement," Winer says. "Project-based housing is a congregate type of living; it's more communal living."

The apartments are independent, with their own bedrooms, kitchens, and bathrooms. But people share communal spaces, and Veterans Affairs (VA) staff are on site, along with social workers. "There's more support built into project-based housing," Winer says.

Substance Use Is a Struggle

Even with support, the veterans struggled with substance use issues. "They felt unsafe or frustrated because they were trying to maintain their own sobriety, but with certain triggers, it was difficult," Winer explains. "Triggers could be someone knocking at their door or someone using substances around them."

Social isolation also caused frustration. To avoid substance use triggers, residents sometimes missed out on social activities and interactions.

"It's challenging for someone to engage socially if there is substance use going on and they're trying to maintain their sobriety," Winer says.

Maintaining sobriety was easier for veterans who had access to detox services, post-detox programs, and aftercare. "The proximity of [project-based housing] to a hospital was a positive association for veterans being able to get support for their substance use," Winer says.

Transportation was a major issue for those who lived farther from hospitals and medical support. "Transportation was really tough for

most of the veterans we interviewed," Winer says. "Resources were limited, and that was a major barrier for those folks."

Isolation Is an Issue

Isolation was tied to both behavioral health and physical health issues. "In my mind, they are all tied together," Winer says. "Substance use relates to physical health, and the mental health of a person can impact their interest and ability to engage socially."

Because of their past and present struggles with substance use, many of the veterans found it difficult to feel like they belonged to a community that would be positive for their health. "It felt like socialization was centered around either their using substances or trying not to use substances," he adds.

But the interviews suggested veterans wanted to be social and maintain friendships and support networks. "Most people want support and people they can call friends," Winer says. "Many of those veterans did not have strong friendships or a lot of family, but it was clear they were interested in being social."

Researchers also found project-based communities offer programs and activities that can help tenants, but their engagement could be low. "That was something we talked a lot about on the research team," Winer says. "It has to do with anxiety of veterans in social settings."

Anxiety can run high among people who have been homeless. Almost all of them were chronically homeless before entering this program. "Suddenly, they're housed and there are a lot of people in that situation," he says. "It can be very scary for folks who've been homeless for a long time."

The veterans often would not take advantage of those opportunities, even if they were interested. "Homelessness is a traumatic experience," Winer says.

Trauma Can Create Barriers

People who have survived traumatic experiences find it difficult to engage in social activities and build friendships. "It's about thinking of the context of each individual person's experience, tragedy, and how they're housed," Winer explains. "When working with veterans, do so however they're comfortable and think about what can help them relearn."

From a case management perspective, working with a population that has experienced homelessness and substance use disorders requires a multifaceted approach to helping them with their needs, whether for medical care, social-behavioral care, or to overcome social determinants of health obstacles.

"A lot of it is meeting [people] where they are," Winer says. "There has to be some buy-in and some empowerment from the client to seek progress."

Case managers should listen to what their patients/clients want from their recovery. Their attitude should be nonjudgmental and open to helping the person meet his or her own goals for the next step. "Relying on multidisciplinary professionals is important, too," Winer notes.

People may need mental health specialists, substance use professionals, and others on their team. "This is so the case manager is not carrying everything, and there are a lot of different voices and support for the client," Winer explains. ■

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Address Social Determinants of Health with Multidisciplinary Team, Community Partnerships

By Dorothy Brooks

Every day, frontline clinicians see patients presenting with medical problems exacerbated by unstable housing, lack of healthy food, substance use issues, or lack of money. Further, many such patients return repeatedly to the ED because these underlying social concerns continue to deleteriously affect their health.

This is a frustrating cycle for emergency providers who often lack the time and resources to delve into a patient's complex needs. In fact, it is not uncommon for clinicians to suffer from moral distress over their inability to act on underlying social conditions that keep driving patients back to the ED.

What is the solution? A multidisciplinary group at Zuckerberg San Francisco General Hospital (SFGH) has created an ED Social Medicine (EDSM) team to deliver better outcomes for patients who present to the ED and to lift some burden off the shoulders of providers.

In operation since 2017, investigators are finding the EDSM team approach is delivering dividends on multiple fronts. They also believe they have created a roadmap to follow for other facilities struggling with similar concerns.

Assess Needs

The creation of the EDSM team grew out of a push to address challenges related to patient flow across the organization, explains **Hemal Kanzaria**, MD, EDSM team co-developer and medical director of the department of care coordination at SFGH.

"We were actually encouraged by our executive team to think about and study how often patients are hospitalized for primarily complex social needs, and then to understand and develop some solutions around that [patient population]," he recalls.

Initial funding for this effort came from the San Francisco Health Plan, the main Medicaid managed care payor in the region. Developers studied how they could create better care capable of addressing medical and social needs. Concurrently, they wanted to provide an alternative to hospitalization for patients who present with lower medical acuity but higher social complexity. "You want to preserve those really precious hospital beds for patients who [require the kind of medical interventions] that can only be provided in the hospital," Kanzaria says.

As a safety net hospital, SFGH sees many patients with medical and nonmedical needs, yet ED providers had been focused primarily on immediate medical concerns. However, Kanzaria says medical and nonmedical needs often are inextricably linked. "Those underlying social, environmental, and economic needs are really foundational to a person's health. If my job is to improve [a patient's] health overall, I need to be skilled at meeting both their medical and social needs," he says. "This program allows us to get closer to ... the foundational needs of those patients who are presenting here."

There were times when Kanzaria believed he should admit a patient and hope that sometime during the stay a solution would emerge to address the lack of housing, food insecurity, or financial distress. Alternatively, clinicians would just discharge the patient to an unsupported environment.

The EDSM team is designed to offer emergency providers a third alternative: Do right by the patient — and with tools at their disposal to achieve that goal.

Jenna Bilinski, RN, MBA, director of health operations, social medicine, and the Kaizen promotion office at SFGH, says the EDSM team is fortunate to work in an organization that is mission-driven and supports doing what is right for patients. "When you work in a safety net organization and your point of entry for folks is the ED, then you should be putting the services they need the most at the point of entry," she says. "That is really what our focus has been ... and it has turned out to be beneficial for both the organization and for the people we are serving."

Emphasize Collaboration

The EDSM has grown to include a patient navigator, multiple physicians, a pharmacist, social workers, care coordination nurses, and transitional care staff. The team also has nurtured multiple links with community resources such as substance use treatment providers, housing assistance groups, behavioral health providers, and organizations that can assist people dealing with food insecurity or domestic violence.

Jack Chase, MD, FAAFP, FHIM, co-developer of the EDSM team, recalls the recent case of a woman in her 70s who struggled to walk, lived with chronic hearing loss, and had fallen in her home where she lives alone. "She called 911 and was brought to the ED for evaluation and had a laceration on her forehead," says Chase, associate professor of family community medicine at the University of California, San Francisco. "The ED team that received her overnight [told] the day team that they felt very concerned about the patient's safety."

Chase, who was the consulting physician on the EDSM team that morning, learned about the case as he and other team members were rounding with the day shift clinicians in the ED. The attending physician was worried about the prospect of sending the patient home.

"[The attending] was seeing this person in front of her who she felt was very unsupported in the community, high risk, had just fallen, and had a significant head injury that required stitches," Chase recalls. "How were we going to make sure that it was safe for her to go home?"

After reviewing the case with the attending physician, Chase and other EDSM members visited the patient to hear her concerns and what she wanted from the ED encounter. "The patient was very clear. She was desperate to go home. She really did not want to be hospitalized and she did not want to go into long-term care. She was actually very satisfied with her home environment," Chase explains.

However, considering the patient's wishes did not alleviate the attending's concerns, there was a conversation among the attending, the patient's primary care provider (PCP), and the EDSM team. "We understood a little bit more about her longstanding values and healthcare-related needs," Chase observes. "She didn't have a hearing aid, and she had no help at home. We facilitated a referral for a home health team to go and visit her. We actually purchased — with dedicated funding — a hearing aid for the patient so she could ... better communicate with the PCP and her new home nurse."

In addition, the EDSM team ensured the patient received food delivery, and coordinated with the PCP to follow up after discharge. All these steps reassured the attending the patient would receive appropriate care. "It's a nice example of coordination of care throughout the system involving multiple disciplines," Chase shares. "We were meeting different kinds of needs, and [our efforts] also aligned with what the patient's values were."

Nurture Relationships

Besides regular rounding, there are multiple other ways the team can be brought into a case. For instance, an emergency provider can call the patient care coordinator or the consulting physician who is on service with the EDSM team that day. Nurse managers in the ED also will email the EDSM team about a patient.

"Increasingly, over the course of our team's existence, as word has gotten out about our team, people actually reach out to us about clients who are not even in the ED at the current time," Kanzaria observes. "We get referrals from protective service social workers who are caring for clients they are worried about. In a previous iteration, they would have just brought the patient to the ED and said they were concerned about the patient's safety, [indicating he or she] just needs to be hospitalized."

Now, there often is some prework whereby the social workers contact the EDSM team. They work together while the patient is in the community to either beef up services there or try some other alternatives before the patient comes to the ED.

Such steps are the result of increasingly robust relationships the EDSM team has formed with community organizations. "Adult protective services has started reaching out to us about clients who they are worried about," Chase reports. "We have had some really moving examples of people who were being abused or physically threatened in their home environment."

In such cases, the EDSM team often will partner with a community-based social services organization to create a plan that provides for needed services and a safe environment. "We know that we always have a backup safety net in that the patient can always be transported to the ED at any point, and we will help to facilitate their care within the building if need be," Chase says.

However, in many instances, such collaborative planning can put these individuals in a safe environment and ensure their medical needs are met without an ED trip.

Prioritize Mental Health

Patients who present to the ED with significant social needs often live with behavioral health issues, too. Kanzaria notes most patients the EDSM team works with present with some combination of substance use disorder, mental illness, homelessness, and low-level medical acuity.

While addressing such needs in an expeditious manner can be difficult, SFGH offers a psychiatric emergency service that operates next

to the medical ED 24/7. "We work closely with [the staff there], and we collaborate on a number of patients because people will present to both places," Kanzaria explains.

For example, there was a young woman with a history of severe trauma involving both physical and sexual abuse. She suffered from symptoms of PTSD, experienced instances of panic and severe agitation, and also was battling a comorbid substance use disorder. "All of those symptoms and behaviors had resulted in her being denied service at various community-based settings," Chase explains. "This rendered her with basically not a lot of options. She would just end up coming to the ED or psychological emergency services over and over again in really severe crisis."

The EDSM team decided to convene a meeting with representatives from various community organizations, the inpatient psychiatry consult team, psychiatric emergency physicians, and representatives from some residential treatment centers. Meeting participants agreed the next time the patient presented to the ED, clinicians would try to provide her with medications to reduce her psychosis while also presenting options for further treatment.

They understood the patient might be so ill she would have to be involuntarily observed for psychiatric treatment for a period until she was stabilized enough to voluntarily engage in treatment. Ultimately, the plan proved successful.

"The next time this patient showed up, she was hospitalized and provided with acute mental health treatment for crisis. She started on medication, and she started on groups," Chase notes. "There were some ups and downs ... and there were some episodes of agitation that she had, but they were manageable."

At the end of acute treatment, the patient transitioned to a treatment program where she stabilized. "Our role there was to try to bring people together, and to lower the barriers to doing the right thing for the patient," Chase adds.

Test Ideas, Interventions

On a typical day, the EDSM team will work with three or four patients who present to the ED. While the number of patients who could benefit from engaging with the EDSM team far exceeds the group's current capacity, data show the multidisciplinary approach to addressing patient needs is making a difference.

"We have served well over 4,500 patients, and we have multiple different initiatives," Kanzaria explains.

For instance, one initiative that provides medications free to patients who cannot access them has helped more than 2,000 people. Another initiative has helped more than 230 vulnerable clients obtain stable housing. "We have helped to avert 600 to 700 admissions or readmissions ... mostly by offering support and providing a safe alternative to hospital care," Kanzaria adds.

Further, in a study Chase, Kanzaria, and Bilinski published about the EDSM team, they reported 60-day ED use following an EDSM consultation decreased by 5.8% from October 2017 to March 2020.[1]

While the EDSM team continues to expand, Kanzaria's advice to leaders thinking about following a similar path is to understand the local landscape.

"Look at what your patient and community needs are, and use data to make transparent what these needs are — whether [they include] financial insecurity, food insecurity, access to affordable housing, or healthy food," he offers.

Then, it is a matter of devising potential solutions to apply to the identified needs, and testing to see if they are effective. When successful, use the results to obtain support. "We were able to garner interest from our hospital leadership and our city leadership to expand on our initial ideas. We have been fortunate to have some success," Kanzaria explains.

With any investment of resources, there will be concerns. At SFGH, ED leaders wanted to know how EDSM team consultations would affect operational metrics such as length of stay.

"We were able to understand those concerns, and then overcome them with data," Kanzaria says. "We were also able to engage with [the hospital's] executive team and align what we were trying to do with what their needs were."

Enhance Understanding

Kanzaria urges clinicians to advance their understanding of the underlying social, environmental, and economic factors that drive health.

"If you are taking care of a patient with an infection, cancer, or congestive heart failure who also is experiencing homelessness, unless you are someone who recognizes the impact of homelessness on that person's health, there is a missed opportunity to advocate and to help your patient to improve their health," he observes.

Even in hospitals without the kind of resources available to SFGH, an emergency clinician might partner

with a social worker or pharmacist to address an identified social need in a patient or the community. The idea is to make the effort multidisciplinary.

"You also want to look beyond your hospital. You can't do this in a silo," Kanzaria says. "Healthcare systems have to partner with ... community organizations and community members outside of the medical care system to advance the community's health." ■

REFERENCE

1. Chase J, Bilinski J, Kanzaria H. Caring for emergency department patients with complex medical, behavioral health and social needs. *JAMA* 2020;324:2550-2551.

Start Small, Employ Relevant Personnel to Manage Complex Social Problems

By Dorothy Brooks

How does one design a model to manage social determinants of health that will be effective? It is all about problem-solving.

"Our hospital uses Lean. We follow plan-do-study-act [PDSA]," explains **Jenna Bilinski**, RN, MBA, director of health operations, social medicine, and the Kaizen promotion office at Zuckerberg San Francisco General Hospital (SFGH).

However, Bilinski notes every hospital relies on a problem-solving method for performance improvement. "The approach of using small tests of change and understanding what the problems really are before addressing some sort of solution can be replicated at any organization and in any department," Bilinski says.

The key is putting the right people on the intervention. For example, when Bilinski and two other clinicians at SFGH created the ED Social Medicine (EDSM) concept, they started with a vision, but recognized they were not the best people to devise every intervention involved with this work.

"If there is an intervention related to pharmacy, our pharmacist comes up with that intervention," Bilinski explains.

Likewise, social workers develop solutions relevant to their arena. "Allowing the folks who do the work to be part of that problem-solving process is really beneficial for the whole team."

To achieve success, start small. "It is a basic tenet of the PDSA problem-solving concept," Bilinski says.

This was a tenet Bilinski and colleagues followed rigorously when developing interventions for the EDSM team.

"We would start with one shift of workers trying [an intervention] with the patients, or we would try it with one chief complaint and not every patient who walked through the door," she says. "This allowed us to learn from what we were testing, and then to scale up as we were adjusting and improving our intervention along the way." ■

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CE QUESTIONS

1. **One in four people with diabetes also show symptoms of:**

   a. hepatitis.
   b. chronic obstructive pulmonary disease.
   c. diabetes distress.
   d. depression.

2. **Which is a type of question case managers should ask patients with diabetes to screen for depression, according to Mark Peyrot, PhD?**

   a. Open-ended questions related to their life with diabetes
   b. Yes-no questions
   c. General questions about the person's life and work
   d. Specific questions regarding the patient's thoughts about suicide and self-harm

3. **A new study revealed people with diabetes and depression could achieve better glycemic control if they received medical care integrated with:**

   a. alternative therapies.
   b. physical therapy.
   c. mental healthcare.
   d. holistic healthcare.

4. **Which social determinants of health issues are common among formerly homeless veterans living in project-based housing, according to researcher Max Winer, LICSW, MPH?**

   a. Serious mental illness and housing insecurity
   b. Food insecurity and lack of access to healthcare
   c. Substance use disorder, loneliness, and isolation
   d. Depressive symptoms and lack of support

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.