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Social determinants of health and structrual racism:
A conversation with 3M experts

As part of our commitment to raising awareness and deepening knowledge about social determinants of health (SDoH), 3M Health Care recently hosted an internal event to discuss the link between structural racism and SDoH with employees. Victor Miranda, M.D., director of clinical operations and compliance at 3M Health Care, interviewed 3M HIS experts who shared their insights.

Victor: To reduce the longstanding disparities that exist in healthcare, we need to address SDoH. How do SDoH play an important role in healthcare?

Gordon: I think about when I had patients with diabetes visit my practice. They had varying capacity to manage their condition. Some people had terrific resources, easy access to care, could afford all the medications I prescribed and advocated for themselves. That capacity varied by individual and what the individual had access to.

When I think about SDoH, I'm thinking about the non-medical factors that help a person achieve wellness and good health. There's what a person can do and what I can help them do, but there's also what their families and lived experiences do. If they don't have a job or access to insurance or money for medication, this gets in the way of me being able to deliver the best outcomes.

Victor: Explain the relationship between structural racism and SDOH

Melissa: I like to start off with the goal in mind, so I think about health equity – which is where we really want to be. It means everyone has equal opportunity to live a long and healthy life.

Structural racism has created the conditions in the U.S. which resulted in African Americans and other non-white groups being at a disadvantage for those social factors that contribute to living a long and healthy life. There are three ways I see this playing out. It's in the community where we live, delivery of healthcare itself, and the direct effects of structural racism on health.

Let's start at the neighborhoods where we live.

In the 1930s, the Federal Housing Authority used redlining, or color-coded maps, to designate whether it was "safe" to issue mortgages in metropolitan areas. Any area where African-Americans lived were coded red. These maps were used until the 1970s to deny mortgages to African Americans. Redlining set up the current U.S. system of residential segregation, which fuels health disparities by limiting, for example, stores that offer healthy food and produce. Having fewer places to exercise and play, as well as food deserts, can impact chronic conditions like diabetes. Education and school funding are often based on local taxes. Historically redlined neighborhoods have less funding, which impacts health literacy.

Then, there's structural racism in healthcare. Doctors or hospitals may deny or not take insurance, and this disproportionally happens with Medicaid and Medicare, which is predominant the sole insurance among communities of color.

It's also well-documented that people of color have fewer referrals for pain and life-saving treatments, compared to their white counterparts. This is perpetuated by lack of cultural competency.

Then there are the direct effects of structural racism on health. If an individual must scramble for resources or experience micro aggressions or macro aggressions, like over-policing, this leads to stress and premature aging with impacts on the health of the individual.

Victor: How does data on SDoH help us focus our efforts to improve community health?

Katie: To remove a barrier, I need to know that barrier exists in the first place. I can't solve it if I don't know about it. For the healthcare system, we need to ask: What are we doing to institutionalize the process of knowing? I remember working with a client and the data collected about an individual varied from calls with the social worker to calls with the care coordinator. What started out as "I'm okay" changed to "I can't get to the doctor and I'm having trouble with rent." We need to be aware of survey bias and measuring your capacity to overcome a barrier versus acknowledging a barrier exists in the first place. In our quest for health equity, are we asking people to overcome those barriers or are we interested in knowing if the barrier is there? Once we have that data, we can put a program in place. Putting in transportation and translation services, for example, can help more people comply with care.

Victor: What role do clinicians play in addressing SDoH?

Gordon: It starts with curiosity beyond clinical findings – and adopting processes and infrastructure to address these factors. We empower clinicians with tools and resources. If I

Meet the experts

Katie Christensen
As a product manager for 3M Health Information Systems, Katie is responsible for value-based products and programs across payers (e.g. health insurance) and providers (e.g. hospital systems). She is a healthcare subject matter expert with over 25 years of experience managing changes in healthcare operations, including affordable care organizations, revenue cycle management and more.

Melissa Clarke, MD
As a physician consultant of clinical transformation for 3M Health Information Systems, Dr. Clarke collaborates with 3M customers and their clinical leadership to transform their operations and obtain rapid, quantifiable, sustainable results. She focuses extensively on patient engagement and quality outcomes to change how healthcare as we know it gets delivered.

Gordon Moore, MD

As a senior medical director of clinical strategy and value-based care for 3M Health Information Systems, Dr. Moore looks for ways to bridge policy, payment, quality, data, technology and workflows. He is passionate about helping clinicians deliver consistent, quality care.

work with people who have needs beyond what I prescribe, we need to think about connecting them to community-based organizations to address housing and food and income insecurity. Clinicians can have tools to help patients get resources and advocate to get the best possible outcomes.

Victor: Can you share some examples of how community-based organizations and public and private sectors can partner to do something that plays a big role in addressing SDoH?

Melissa: It's important to involve CBOs in SDoH because they help extend the reach of the healthcare organization. As much as healthcare providers want to help, they don't have the wide scope to help beyond the healthcare system. CBOs help effectively engage consumers in their own healthcare. Trust is huge and relationships between providers and people of color have been fractured over time. CBOs can help bridge the gap. One example is the Fruit and Veggie Rx program, which is available in my region through an organization called DC Greens.

It's for individuals who have a chronic disease, like diabetes, and are also food insecure. Their doctor writes a prescription for fresh produce and they can redeem this like a coupon at their local grocery store.

Victor: Where does 3M fit into this?

Katie: 3M Health Information Systems uses data analytics to identify clinical and social risk and provide actionable insight. We can accurately understand a populations' clinical risk group (CRG). This is important because if any specific population currently has or is at risk for, let's say a chronic condition, that knowledge can help predict outcomes. Patients with chronic conditions disproportionately explain total healthcare spend and ER visits. Evidence in the data shows that patients with chronic conditions also exhibit social risk and risk for disease progression. We really want to focus on these at-risk populations. Lower rates of doctor and pharmacy visits result in higher rates of ER visits. If we can identify how ER trips could have been avoided, we can help payers and providers be proactive.

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