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Authors

Gottlieb, Laura M
Lindau, Stacy Tessler
Peek, Monica E

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Why add ‘Abolition’ to the National Academies of Sciences, Engineering and Medicine’s Social Care Framework?

Laura M. Gottlieb, MD, MPH,

Stacy Tessler Lindau, MD, MAPP,

Monica E. Peek, MD, MPH, MS

Abstract

Abundant evidence demonstrates that enduring, endemic racism plays an important role in determining patient health. This commentary reviews a patient case about disease self-management and subsequent health outcomes that are shaped by social and economic circumstances. We analyze the case using a framework for social care developed in 2019 by the National Academies of Sciences, Engineering and Medicine. We then propose that the NASEM framework be adapted by adding the category *Abolition*, which could make the other social care practices transformative for historically marginalized populations.

Case

Mr W is a 59-year-old man with type II diabetes mellitus. Mr W takes oral medication for diabetes and uses a glucometer when he has access to lancets and strips. Mr W has a primary care physician, Dr PCP, but clinic appointment attendance is rare since he does not have transportation. He eats mostly food he finds in trash cans or food that is given to him. When he is able to purchase meals, it is often fast-food. He is currently unsheltered, living in a tent encampment.

A few days after his last lancet fingerstick, Mr W’s index finger became swollen, red, and painful. He went to a nearby hospital emergency department (ED), where Dr ED drained a felon abscess and prescribed antibiotics. Mr. W’s lack of control over his diet and only occasional access to soap and water have contributed to his ill health, so Dr ED also prescribes food assistance from a social services agency and offers Mr W a box of alcohol wipes to use to clean his fingers before and after fingersticks. Dr ED suggests to Mr W that he take a shelter bed offered by an ED social worker, Mr P, but Mr W declines, stating that he prefers to return to his tent and his belongings.

To enroll in the food assistance program Dr ED prescribed, Mr W must attend a nutrition consultation, but he has no way to get there and no address to which food could be delivered. His phone is stolen, so Mr W misses a reminder call from Dr PCP’s office, can’t access his calendar, and misses his follow-up appointment. The box of alcohol wipes from Dr ED runs out and he stops checking his blood sugar.

Feeling ill again, Mr W goes to the ED. Dr ED sees him again and diagnoses him with hyperglycemia and a urinary tract infection. Dr ED prescribes antibiotics and also writes

prescriptions for Mr W to access clean water and a hygienic, private bathroom. Dr ED calls the city health department to demand water and bathroom access for residents of the encampment. Mr P lists Mr W for permanent housing placement. In the meantime, Mr W returns to his tent.

Commentary

A popular public health parable describes the dual urgency of pulling drowning children from a river and looking upstream to prevent more children from entering the water.¹ Over decades of telling, the story has taken many forms. A second version of the story casts poisoned fish in the role of the drowning children.² In health care settings, Mr. W's finger abscess is more commonplace than children drowning in a river or poisoned fish, but the moral of the story is similar. Consistent and convincing evidence shows that social and environmental deprivation—including insufficient or unsafe food, housing, water, and transportation—contribute to poor health.^{3–9} In the US, however, we are less attentive to addressing adverse social conditions than to immediate injuries.¹⁰

In this case, Mr. W's medical condition and social circumstances are inextricably linked; their synergies lead to his acute illnesses, diminish the effectiveness of his medical treatment, and impede his opportunity to flourish. In formulating a plan for treatment, Dr ED reasonably looked upstream. In addition to draining Mr. W's abscess and prescribing antibiotics, the physician made referrals to help him obtain nutritious food, safe housing, and clean water. Since emerging evidence suggests that in cases like Mr. W's, interventions to address social needs and disease self-management may yield health improvements and cost savings,^{11–16} it may be surprising that after multiple well-intentioned attempts by Dr ED to address social needs, neither Mr. W's circumstances nor health improved. Why?

In our analysis, we start by turning to a National Academies of Sciences, Engineering, and Medicine (NASEM) 2019 report on medical and social care integration, which was the first modern national effort in the US focused explicitly on articulating roles for health care stakeholders in response to the rapidly growing evidence that health is powerfully shaped by social circumstances. The 2019 NASEM report defined five broad “social care” categories, each of which describes different types of activities where health care systems might engage to influence patients' social determinants of health.¹⁷ The five included categories span patient-level, health care delivery-targeted interventions and also more community-directed initiatives; all are relevant to Mr. W's case. In this paper, we explore ways that the NASEM report's recommendations might be used to spur more intentional and coordinated actions by the health care system to improve outcomes for patients like Mr. W. We then consider how the NASEM social care categories also might be interrogated and re-envisioned to more deliberately dismantle the inequity of opportunity to achieve health and well-being that more fundamentally shapes Mr. W's story. This re-envisioning process leads us to suggest that the NASEM report's original categories be viewed through the frame of a sixth A: “*Abolition*,” which would make health care's social care activities more impactful and enduring.

NASEM Social Care Framework is Necessary but Insufficient

The NASEM framework begins by underscoring the relevance of efforts to understand patients' socioeconomic environments (Awareness), including patient and community-level social needs and assets, as a core element of integrated care approaches. It moves on to define two categories of patient care interventions that might stem from increased awareness about social conditions. These include activities to tailor the delivery of medical care based on identified social barriers (Adjustment) and to more directly intervene on social barriers (Assistance). Finally, alongside patient-level activities, the framework recommends work at the community and policy level. In these areas, health care systems might assume roles to better align their own efforts with community needs and priorities (Alignment) and to advocate for deeper social and structural investments (Advocacy). (See Table.) A robust social care program would involve complementary work at both patient- and community-levels. In Mr. W's case, the ED physician learns about Mr. W's housing instability (Awareness), provides cleaning supplies and referrals for food and housing (Assistance), and advocates for improved hygiene resources for the tent encampment (Advocacy).

In the NASEM report, a strong emphasis is placed on the systems of care that can ensure social care activities in each of these categories are not only feasible but impactful for both individuals and populations. Feasible and impactful systems of social care in this case, for instance, would eliminate reliance on the good-hearted Dr. ED and instead embed social care practices into Dr. ED's workflow to identify and intervene on the socioeconomic adversity faced by Mr. W and many other patients like him. Yet it is not clear from the case presentation that the health care system involved has committed to systematically engaging in high quality activities in any of the NASEM categories. Dedicated social care staff and staff training, clinical workflows, and health information technology tools embedded in those core workflows are needed to provide high quality social care and to ensure that data generated from individual patient care can be used in real time both to improve care and guide investments at the population level.¹⁸ For instance, is a standardized social risk/asset screening systematically conducted by or in a setting with well-trained, culturally competent staff who sensitively approach Mr. W's lived experience? Are data about socioeconomic risks documented and well-protected in electronic health records? What informatics tools and processes exist to generate and, as appropriate, track relevant referrals to community-based supports for social services and disease self-management needs? How are data from many patients like Mr. W aggregated and applied by the health care team to inform community-level alignment and advocacy?

Unfortunately, Mr. W's health outcomes might not improve even in a health care system investing in the high quality practices defined in the NASEM report. Though the framework provides a useful organizing tool to operationalize health care sector actions related to social adversity, these social care activities—whether focused on patient care or at the community level—are often implemented absent an awareness of the racialized systems and structures that have led to and perpetuate health inequities. Inattention to structural and systemic racism as fundamental causes of individuals' socioeconomic risks means that health care's social care practices will prove insufficient for improving health outcomes for marginalized patients. Though the case does not provide information about Mr. W's

racial or ethnic identity, in the US, Black, Indigenous, and other Persons of Color are disproportionately homeless.¹⁹ Black Americans, 12% of the US population, make up 39% of the US homeless population¹⁹ as a result of structural inequities in housing, education, employment, and policing and carceral systems that discriminate against Black people.²⁰ These same structures also limit opportunities for other socially marginalized groups.²¹

It is therefore not surprising that we must do more, do it differently, and do it better in order to improve health and health equity. Overcoming health inequity will demand more than adding social care practices to health care. It also will require addressing the inequities in other sectors and institutions (e.g. education, criminal justice, housing) that influence the physical health and well-being of Black and other marginalized populations.

Abolition as a 6th A for Social Care

In this particular case, we are specifically tasked with improving the design and delivery of social care practices in the health care sector to better meet the needs of Mr. W. To do so, we follow the lead of a recent *Lancet* article describing “Abolition Medicine.”²² The 13th amendment to the U.S. Constitution, which abolished slavery as we currently understand it, nonetheless allowed “slavery and involuntary servitude” to continue for those convicted of crimes. As a result, the abolition movement has predominantly focused on eradicating racialized policing, surveillance, and carceral systems.²³ The *Lancet* article authors advocate for similarly challenging racialized practices in medicine,²² which also have worked to diminish the health and well-being of Black people. We now extend their argument to propose Abolition as a 6th category through which we frame the other health care’s social care activities, appreciating that this framing simultaneously will influence outcomes more broadly for all racial/ethnic minorities and other socially marginalized populations. [See Figure 1.]

Applying an Abolition frame involves redefining the goals, methods, and activities of each of the five social care categories originally articulated by NASEM (Awareness, Assistance, Adjustment, Alignment, and Advocacy). This would mean explicitly designing and implementing care integration practices as anti-racist practices, or practices that help health care teams both to understand and reverse racial inequity and opportunity gaps for patients like Mr. W.

Awareness.

Abolition-influenced Awareness activities would be designed in collaboration with patients from marginalized backgrounds, whose input on framing, content, and implementation could improve patients’ experiences with social risk and asset screening.^{24,25} Health care teams would also protect against the potential harms of such screening—including the possibility that collected data could increase opportunities for police surveillance and discrimination, and exacerbate distrust—instead ensuring that data collection is paired with data use and distribution safeguards as well as meaningful interventions.^{26,27} Awareness also would not end at patient-directed socioeconomic risk and asset assessments; it would demand health care teams simultaneously increase their own awareness about racism, including current and historical institutional racism and anti-racist practices.^{28–31}

Adjustment.

Looking at Adjustment strategies through an Abolition frame would pro-actively involve patients in treatment planning (e.g., using shared decision-making) with the intent of using these discussions to improve both the experience of social care and associated outcomes for historically marginalized patients.^{32,33} In Mr. W's case, a shared decision-making discussion might explore the comparative advantages of his transition to a temporary shelter bed versus staying close to his worldly possessions and familiar community. Shared decision-making is a particularly powerful Abolition strategy because shared decision-making is fundamentally about giving patients agency, which can affect both the experience of health care and health outcomes. The practice has been used less frequently in care provided to racial/ethnic minorities and other socially marginalized patients than in care provided to White patients,³³ but if implemented both well and routinely, would support Abolition's goals of sharing power, increasing patient agency, and building clinician humility. Together these would counter institutional racism and help to decrease health inequities.

Assistance.

Abolition also would involve ensuring that Assistance activities are designed in ways that maximize patient dignity. For instance, health systems might develop ways in which people can simultaneously give (e.g. time, comfort) and receive (e.g. material needs). Three studies of CommunityRx, a community resource referral intervention, show that half the patients who received social care information shared it with others.^{25,34,35} A separate study of a self-serve, no barriers, hospital-based food pantry showed that patients who received food also contributed back (e.g. donating food, stocking shelves, or participating in advocacy).^{35,36,27} Providing these kinds of opportunities can simultaneously strengthen patients' self-respect and build community, both of which are foundational to Abolition.

Alignment and Advocacy.

As in the original NASEM framework, Abolition would require pairing patient-focused social care interventions with community-directed Alignment and Advocacy activities. But now these community-directed investments would more specifically focus on the systems and structures that perpetuate inequities, including racist policies and practices both within and external to the health care system. Consistent with the Abolition movement's original focus, health systems committing to social care would analyze and share data about the health effects of police violence and incarceration. They would use those data to advocate to overcome racialized policing and carceral policies that in turn perpetuate and exacerbate homelessness.³⁷ They would leverage the health care system's health care's role as an anchor institution to invest in neighborhood low-income housing³⁸ with special attention to eliminating racist programs and policies built into many housing assistance programs.^{29,30,31}

Conclusion

Returning to Mr. W, we again pose the question why Dr. ED's well-intentioned efforts did not clearly change the course of Mr. W's illness. One potential explanation may lie in the lack of institutional investment in a high-quality system that supports the integration of social and medical care for individuals and populations. But our collective failure for

patients in circumstances like Mr. W's also reflects the lessons from a modern version of our public health parable. In the modern retelling, the bank of the river is three dimensional: Black and other Persons of Color living in the US, people living in poverty, and others affected by structural and systemic racism are forced to stand closer to the edge of the river than other groups of people, thereby disproportionately increasing their initial risk of falling into the water. As a result of restricted access to pools, lakes, and rivers, marginalized groups also are less likely to have learned how to swim, which increases their risk of drowning.^{32,33} The updated parable underscores how social determinants of health are closely tied to social determinants of equity. In the case of Mr. W, that link forces us to critically evaluate health care initiatives to intervene on social adversity not only to ensure they are high quality, standardized, and systematically implemented, but also that they are designed in ways that both acknowledge and begin to close the deeply entrenched and inequitable threats to health levied on historically marginalized people.

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Biographies

Laura M. Gottlieb, MD, MPH is a professor in the Department of Family and Community Medicine at the University of California, San Francisco. Her research focuses on the effectiveness of health care-based strategies to intervene on social adversity. She is the founding director of the Social Interventions Research and Evaluation Network (SIREN) based at UCSF.

Stacy Tessler Lindau, MD, MAPP is a professor of Ob/Gyn and Medicine-Geriatrics and a practicing gynecologist at the University of Chicago. Her community-engaged research focuses on identifying and activating the strengths and assets of individuals and organizations to promote health and health equity.

Monica Peek, MD, MPH, MS is an associate professor of Medicine and the Director of Research (Associate Director) at the MacLean Center of Clinical Medical Ethics at the University of Chicago. Her research pursues health equity and social justice, with a focus on promoting equitable doctor/patient relationships among racial minorities, integrating the medical and social needs of patients, and addressing healthcare discrimination and structural racism that impact health outcomes (eg, diabetes, COVID-19).

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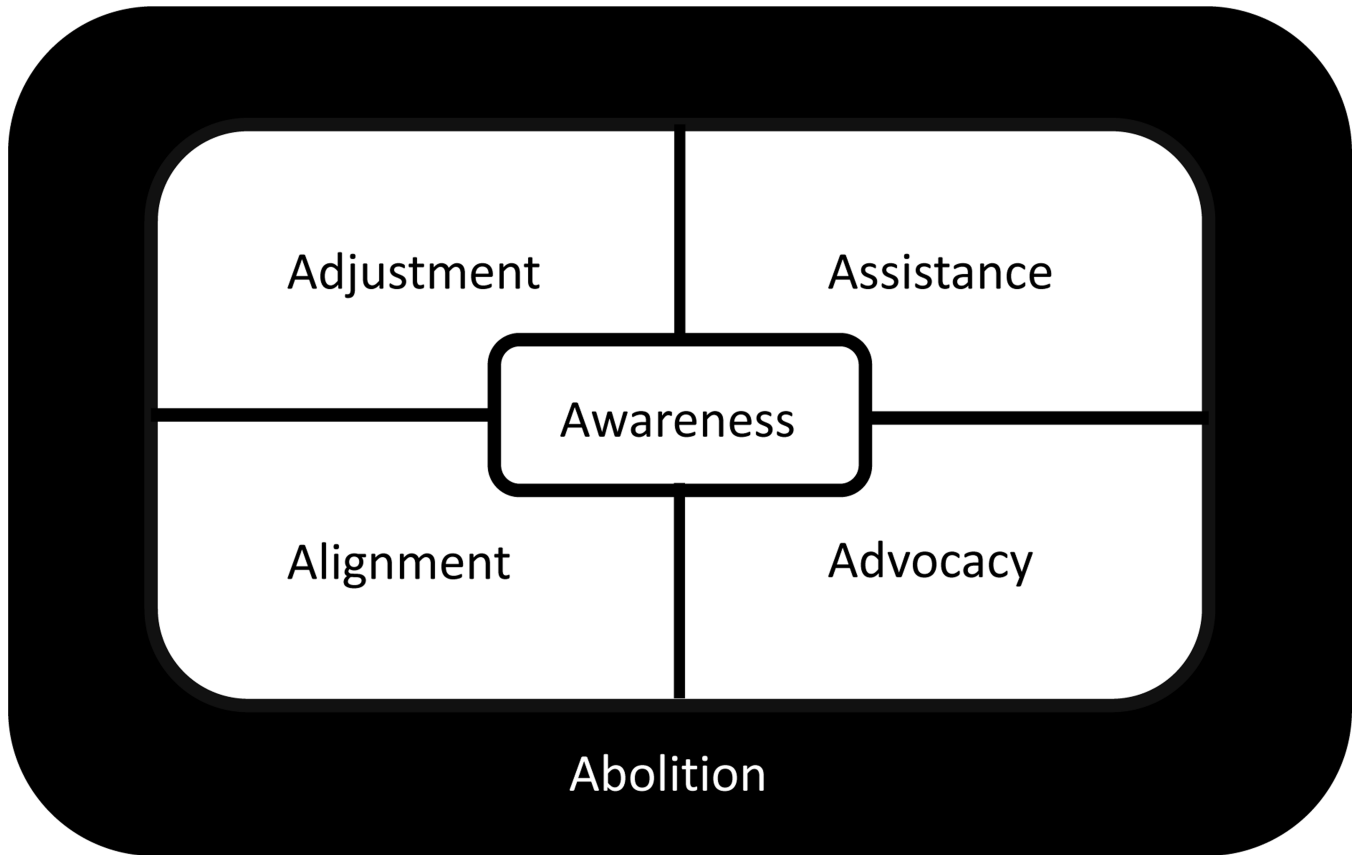


Figure 1. Modified NASEM Social Care Framework
(Adapted from NASEM Committee 2019 report.¹⁰)

Table.

NASEM Social Care '5A' Framework. (Adapted from NASEM Committee 2019 report.¹⁰)

Social Care Category	Definition
Awareness	Activities to identify the social risks and assets of defined patients and populations.
Adjustment	Activities that alter clinical care to accommodate identified social barriers.
Assistance	Activities that reduce social risk by connecting patients with social care resources.
Alignment	Activities undertaken by health care systems to understand existing social care assets in the community and then organize and invest in health care activities to facilitate synergies that positively affect health outcomes.
Advocacy	Activities in which health care organizations work with partner social care organizations to promote policies that facilitate the development and (re)deployment of assets or resources to address health and social needs.

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