

Bowling Alone, Healing Together: The Role of Social Capital in Delivery Reform

Sachin H. Jain, MD, MBA; Riya Goyal, BA; Susannah Fox, BA;
and William H. Shrank, MD, MS, HS

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In 2001, the political scientist Robert Putnam described the causes and effects of declining social connectedness in his book *Bowling Alone*.¹ Among Putnam's conclusions: Americans are both happier and healthier when they have strong relationships with one another. Not surprisingly, the literature offers several pillars of support for Putnam's thesis that social connectedness is associated with improved clinical outcomes.

As delivery reform unfolds and payers and delivery systems begin to experiment more broadly with new organizational forms such as accountable care organizations and patient-centered medical homes, "social capital"—the term Putnam and other social scientists use to quantify levels of social connectedness—will be a powerful concept to incorporate into their design and evaluation. The concept of social capital has been defined variably in the literature. For the purposes of its application to healthcare delivery, "social capital" refers to the collective value of bonds formed between and among individuals within social networks. These networks create a setting of trust and support in which people learn to reciprocate and perform actions that are mutually beneficial to others.²

Putnam defines 2 types of social capital: bridging and bonding capital. Bridging capital is the social connectedness that results when members of unlike groups engage with one another. Bridging across occupational lines, racial and ethnic groups, and socioeconomic classes often produces an exchange of information, ideas, norms, and values that cannot be achieved if individuals restrict social contact to others like themselves.

Bonding capital, conversely, is the social connectedness that uniquely follows when individuals from within a particular group relate closely to one another. The experience and background shared by group members draws them close and promotes rewarding interaction. Examples of bonding capital might be the feelings experienced by individuals who share a common racial identity, profession, or interest.

Through the lens of this distinction, the models of care delivery that pervade medical practice are oriented more around maximizing bridging capital between pa-

tients and providers—physicians, nurses, and allied professionals—than toward generating bonding social capital among patients and their families.

Bonding social capital is an overlooked tool to improve the quality and reduce the cost of care for patients with chronic disease. The use of bonding social capital reflects the belief that levels of interpersonal trust and reciprocity norms can enhance cooperation around common medical conditions; patients who participate within a network of other patients with the same illness may be more likely to follow care recommendations and encourage others to follow if they trust the people within their network and receive support gratification from the members for their efforts.

With significant payment and medical education reform simultaneously under way, an important opportunity exists to enhance the importance of both types of social capital in care delivery and physician training models.

Physicians and the organizations in which they work may want to actively consider how they connect willing patients with one another—as supporters, teachers, and advocates for one another. Patient-centered medical homes may include patients and family members as integral members of care teams. The medical practice could become both a center for individualized care and a source for disease group management.

Diabetes management, for example, has been shown to benefit from efforts to promote social capital development among patients. Patients who participate in group visit programs over extended periods have been shown to have better glycemic control and compliance with evidence-based guidelines.³ Patients are more engaged and satisfied with their care and more likely to achieve better outcomes for themselves when involved in helping others achieve their goals. Group visit programs have been successfully implemented in many clinical settings, but have historically struggled to gain traction because third party payers have failed to reimburse them.

Enhancing social capital between patients and family members may also improve care. By focusing on the practical issues of supporting healthier lifestyles, family members and close social contacts have been shown to substantially increase the rates of healthy behaviors.⁴

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Take-Away Points

- There is a link between high levels of social capital and good health.
- Care delivery models have historically ignored opportunities to enhance social capital between providers and patients and among patients themselves.
- As resources to manage care diminish, medical practices and payers should increasingly consider how medical practices and hospitals can leverage social capital as a means of improving the quality and efficiency of healthcare.

Physician practices can systematically enhance social capital by more regularly and systematically enrolling family members in the oversight of treatment and in promoting emotional support from family members. Such approaches cost little, and may encourage meaningful behavior change and improved health outcomes.

Online communication tools may be an important facilitator in promoting social capital.⁵ Online communities focused on specific conditions have been shown to offer rich, supportive environments where patients and their caregivers share personal stories, provide emotional support, and offer advice about up-to-date clinical care. In new care delivery models that integrate online communications into their work flow, clinicians may engage patients with common conditions within their practice to help manage one another's conditions. Moreover, they may use linkages to other practices and clinicians to seek help for patients with more rare conditions. In these ways, the clinical practice might expand its walls to be available to help patients find support at any time of the day.

The ImproveCareNow network of pediatric gastroenterologists and patients demonstrates how online collaboration can build social capital by *encouraging social connectedness* to improve health outcomes. Sponsored by the American Society for Pediatric Gastroenterology, Hepatology, and Nutrition and the American Board of Pediatrics, ImproveCareNow has reported improvements in care processes such as appropriate medication dosing, as well as in clinical outcomes⁶; by sharing data and ideas, the network has improved the remission rate among children and adolescents with ulcerative colitis and Crohn's disease from 49% to 67%.⁶

Unquestionably, efforts must be made to better understand how best to harness social capital to encourage better self-management of chronic conditions. Clinicians may want to look first to successful models of patient-led groups which are thriving in in-person and online communities alike. They may also aim to explore how they can plug into ongoing efforts within their communities to support them in becoming even more effective.

Ultimately, the power of social capital has largely gone unharnessed as a means of improving health outcomes and lower costs of care that could be easily incorporated into medical

home settings, accountable care organizations, and other new models of payment and delivery. As an example, the mean annual cost of living with Crohn's disease or ulcerative colitis is \$8000 and \$5000, respectively.⁷ By leveraging social capital, the ImproveCareNow network reduced remission rates and care utilization rates of patients with both diseases. Although upfront costs to implement programs similar to the ImproveCareNow network may initially exceed savings, if strategies to generate social capital are maintained, they may lead to significant savings in total costs of care borne by payment provider organizations, payers, and patients.

Efforts to promote social capital will not appeal to all patients or clinicians, however. Some patients may be wary of sharing information about health problems with strangers. Some clinicians and patients may be more comfortable at delivering and receiving care in one-on-one patient encounters. For others, participation in online forums may be too time intensive and impersonal.

Attempts to utilize social capital could have potentially adverse effects on patients, where patients may share and adopt negative behaviors in addition to positive ones. Inclusion of family members and close social contacts in the oversight of treatment could also have negative health consequences for the caretakers.^{8,9} Regardless, patients and clinicians who are ready to participate in efforts to promote social capital should be encouraged to do so, whether by means of reimbursement, practice design, or models of medical training. Cost-effectiveness analysis could be used to compare building social capital with alternative approaches to improve patient care or to evaluate different ways of implementation in practice.

As the burden of chronic disease grows and our resources to manage healthcare problems diminish, healthcare providers, health systems, and commercial and government payers would be wise to consider the role of creating greater social capital as a means of improving the quality and efficiency of healthcare. Perhaps a variety of metaphorical "patient bowling leagues" will have their place in the healthcare delivery system of the future.

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Author Affiliations: From Department of Medicine (SHJ), Division of Pharmacoepidemiology (WHS), Brigham and Women's Hospital, Boston, MA; Harvard University (RG), Harvard College, Boston, MA; Pew Internet Project (SF), Washington, DC.

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Address correspondence to: Sachin H. Jain, MD, MBA, Department of Medicine, Brigham and Women's Hospital, 75 Francis St, Boston, MA 02115. E-mail: shjain@gmail.com.

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