CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Social Determinants of Health (SDOH): Resources for Safety Net Organizations

Updated May 2019

1. How can we build a business case for this work? → **2. What info should we capture, and how?** → **3. How can we organize and track referrals?** → **4. How do we establish and maintain partnerships?**

KEY RESOURCE	KEY RESOURCE	KEY RESOURCE	KEY RESOURCE
★ ***The ROI for Addressing Social Needs in Health Care (#1)*** **(**October 2018) This webinar provides information about Contra Costa Health Services' efforts to measure return on investment for their social needs initiatives. – CIN (CHCF)	★ ***SDOH Screening Tools Comparison*** (2018) A thorough crosswalk of the most widely used social health screening tools. – SIREN UCSF	★ ***Community Resource Referral Platforms: A Guide*** Compares common tools and advises on how to choose and implement (spoiler: partner first, then choose). – SIREN UCSF	★ Tools for Supporting Social Service and Health Care Partnerships to Address Social Determinants of Health Practical resources and tools addressing common barriers and strengthen collaborative activities. – CHCS

See following pages for more resources on each of these program development steps.

1 How can we build a business case for this work?

- ★ ***The ROI for Addressing Social Needs in Health Care (#1)*** (California Healthcare Foundation (CHCF) California Improvement Network (CIN), October 2018) On this webinar, Contra Costa Health Services shared their efforts to measure return on investment for their social needs initiatives, as well as their progress, lessons learned, challenges, and insights.
- ***The ROI for Addressing Social Needs in Health Care (#2)*** (CHCF CIN, November 2018) Kaiser Permanente presented how they measure return on investment tackling social needs.
- ***The ROI for Addressing Social Needs in Health Care (#3)*** (CHCF CIN, December 2018) Partnership HealthPlan of California joined a conversation about establishing a formula and process for evaluating ROI for social needs that impact health.
- ***Beyond the Exam Room—Social needs that impact health*** (CHCF CIN, Summer 2018) CIN Connections report features actionable information to address social needs and case studies from three leading organizations, and tools and information to help leaders address social needs and implement cutting-edge initiatives in their own organizations.
- ***Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case*** (The Commonwealth Fund, March 2018) A guide from the KPMG Government Institute and the Commonwealth Fund for health plan and providers investing in services that address social needs that impact health.
- ***ROI Calculator for Partnerships to Address the Social Determinants of Health*** (The Commonwealth Fund) Online tool generating financing models based on variables for revenue increases and decreases, and costs of program components like staff salaries.
- ***Social Determinants of Health 101 for Health Care: Five Plus Five*** (National Academy of Medicine, October 2017) An orientation to addressing social needs that impact health, and five competencies needed for organizations working in this field.
- ***Medicaid Payment Strategies for Financing Upstream Prevention*** (Center for Healthcare Strategies (CHCS), February 2018) Executive summary highlights lessons and synthesizes takeaways for how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives.

Feedback on a tool? Missing something?
Please email kmody@caph.org for updates

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What info should we capture, and how?

- ★***SDOH Screening Tools Comparison*** (SIREN UCSF, 2018) UCSF's SIREN compiled information from several of the most widely used social health screening tools and compared the instruments for intended population or setting, domains/topics covered, and number of questions dedicated to each domain.
- ***Compendium of Medical Terminology Codes for Social Risk Factors*** (SIREN UCSF, 2018) Spreadsheet contains codes related to social risk factors extracted in a systematic search of four medical vocabularies (LOINC, SNOMED CT, ICD-10-CM, and CPT).
- ***IOM Recommended Social and Behavioral Domains and Measures for Electronic Health Records*** (Institute of Medicine, 2014) In Phase 1 of the report, the committee identified 17 domains that they considered to be good candidates for inclusion in EHRs. Phase 2 pinpoints 12 measures related to 11 of the initial domains and considers the implications of incorporating them into all EHRs.
- ***Standardizing Social Determinants of Health Assessments*** (*Health Affairs*, March 2019) Analysis describes how health care institutions can overcome challenges when seeking to implement SDOH including lack of standardized tools in the EHR, reliance on staff, non-systematic diagnostic codes for documentation.
- ***Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*** (CHCS, October 2017) Brief examines how organizations participating in Transforming Complex Care, a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs and reviews key implementation considerations.
- ***Using Data to Drive SDOH Priorities*** (Center for Care Innovations (CCI), November 2017) In this webinar, Cincinnati Children's Hospital shared their experience using data to identify and prioritize key SDOH to improve child health outcomes.
- ***Health Leads Social Needs Screening Toolkit*** (Health Leads, 2018) Toolkit provides screening best practices, questions library, and a sample recommended screening tool for some of the most common unmet social needs: food insecurity, housing instability, utility needs, financial resource strain, transportation, exposure to violence, and socio-demographic information.
- ***Becoming Trauma-Informed & Screening for ACES*** (CCI, October 2018) Montefiore Medical Center shared their trauma-informed care training and trauma screening implementation.
- Commonly-used tools
  - ***PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences)*** PRAPARE was developed by the National Association of Community Health Centers and partners to help health centers and other providers collect the data needed to better understand and act on their patients' SDOH.
  - ***The Accountable Health Communities Health-Related Social Needs Screening Tool*** Developed for use in the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) Model.

How can we organize and track referrals? Technology Platforms

- ★***Community Resource Referral Platforms: A Guide for Health Care Organizations*** (SIREN UCSF) Compares common tools and advises on how to choose and implement (spoiler: partner first, then choose).
- ***Community Resource Referral Platforms: Lessons from Early Adopters*** (SIREN UCSF, April 2019) Webinar provides overview of functionalities provided by nine platforms on the market in 2018 as well as key recommendations for selecting and implementing a platform based on interviews with 39 organizations that have used a platform.
- ***2018 Buyer's Guide: Social Innovation Technology for Health Care*** (Patchwise Labs, 2018) Buyer's guide examines policy and market trends in the emerging social needs technology industry and includes profiles of six leading companies (Aunt Bertha, Health Leads, Healthify, NowPow, One Degree, Unite Us).
- Commonly-used platforms and how they describe themselves
  - ***Aunt Bertha***: Helps users find food, health, housing, and employment programs based on zip code. Free to search. Paid subscriptions tailored to different org types allows for closed-loop referrals, reporting, other benefits.
  - ***One Degree***: Makes it easy to find community and nonprofit resources, get personalized recommendations, keep track of opportunities, and share them with others.
  - ***Healthify***: Helps health plans and providers address social needs through referrals and coordination with services such as housing, food, and low-cost behavioral health services. Home of the platform Purple Binder.
  - ***Health Leads***: Helps health systems create models for integrating patient social needs into care, using full spectrum of tools, education, and consulting.

How can we organize and track referrals? Internal workflows

- ***Trends in Serving Patients Inside and Outside the Provider Office*** *(*CHCF CIN, February 2016) This CIN meeting & resulting report highlights innovative ways organizations are providing care inside the provider office through the use of technologies and distributed care sites.
- ***Advice for Tackling the Social Determinants of Health in Your Clinic*** (CCI, September 2018) Seven health care organizations spent a year testing and clarifying the role that health care safety net organizations can play in addressing SDOH and shared the advice for tackling upstream challenges, whether just starting out or expanding this work in this workshop.
- ***Optimizing the Flow of Information and Work for Social Needs*** (CCI, December 2017) HealthBegins presented ideas and strategies for optimizing the flow of social needs information and work in a clinical setting, including how to map your current information and workflows and how to identify opportunities for work and information flow improvement.
- ***ROOTS Program Early Lessons Learned*** (CCI, July 2018) In this webinar, the CCI team shared a summary of early lessons learned gathered from teams through various program activities, including in-person sessions, team coaching calls and evaluation activities.

- ***Empathic Inquiry in Clinic Settings*** (CCI, May 2018) In this webinar, Elevation Health Partners presented how to use empathic inquiry within the medical clinic setting, a key staff dependency when effectively communicating and engaging patients who may have social needs.
- ***ROOTS Convening: Addressing Social Needs from the Perspective of Health Centers*** (CCI, October 2017) Program participants share SDOH initiatives and receive feedback from peers and faculty.

How do we establish and maintain partnerships?

- ***Partnership Assessment Tool for Health*** (CHCS, October 2017) Strategy tool to guide effective partnerships between health care organizations and community-based organizations, with case studies from partnerships serving low-income and vulnerable populations.
- ★***Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations*** (CHCS, 2018) Resource outlines common approaches to partnership and establishes a framework to describe integration between community-based and health care organizations.
- ***Advancing Health Care and Community-Based Organization Partnerships to Address Social Determinants*** (CHCS, August 2018) Webinar explores promising strategies for creating and sustaining health care and CBO partnerships that address SDOH. Presenters include: Project Access NOW, Hunger Free Colorado, and 2-1-1 San Diego's Community Information Exchange.
- ★***Value Proposition Tool: Articulating Value Within Community-Based and Health Care Organization Partnerships*** (CHCS, 2018) Tool to assist partners in articulating their value within an emerging or existing partnership through a series of reflection questions and considerations.
- ***Partnership Assessment Tool for Health*** (CHCS, 2018) Tool designed for CBOs and health care organizations in existing partnerships provides a template to: understand progress toward benchmarks characteristic of effective partnerships; identify areas for further development; and guide strategic conversations. The objective of the tool is to help partnering organizations work together more effectively to maximize the impact of the partnership.
- ★***Health Care and Community-Based Organization Partnership: What Does It Cost?*** (CHCS, 2018) Excel-based tool for partnerships to estimate their total cost over a three-year period to help align goals, prioritize decisions, communicate with stakeholders, and advocate for funding.
- ***Working as a System to Optimize Family Wellness*** (Moving Health Upstream, 2018) Guidebook for taking a learning-by-doing approach to address social needs. Describes the journey of eight multi-organization partnerships working to meet the medical and social needs of a defined population. Partnerships featured include The Boys and Girls Club, a middle school, and a health center.
- ***Making a Compact to Strategically Connect Transportation and Public Health Goals*** (CHCS, May 2018) Series of case studies details how diverse state-level, cross-sector collaborations can positively impact population health.
- ***Partnerships for Health: Lessons for Bridging Community-Based Organizations and Health Care Organizations*** (CHCS, January 2018) Report outlines characteristics of successful HCO-CBO partnerships and provides recommendations to guide the development of successful collaborations between health care and social service organizations.
- ***Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations*** (CHCS, October 2017) Fact sheet includes insights for partnerships between health

care and community-based organizations, particularly those serving low-income and/or vulnerable populations.

- ***Closing the Loop on Referrals*** (CCI, September 2018) In this webinar, HealthBegins discusses key components involved in closing the loop on community referrals.
- ***Innovation Spotlight: School-Clinic Collaboration*** (CCI, July 2018) Santa Cruz Community Health Centers, the Live Oak School District, Live Oak Cradle to Career, and Live Oak parents created the Community Care Team, which engages parents and school-clinic partners to identify, treat, and monitor high-risk, high-need students.
- ***Addressing Social Needs Through Community Partnerships*** (CHCF CIN, October 2016) Report highlights California safety net systems discussing efforts to address patients' social needs through partnerships with community-based organizations.
- ***Connecting those at risk to care: the quick start guide to developing community care coordination pathways*** (AHRQ 2016) Publication provides a detailed overview of the Pathways Community HUB Model, community care coordination approach focused on reducing modifiable risk factors for high-risk individuals and populations

SPECIFIC INTERVENTIONS

Social Determinants of Health Series: Food insecurity and the role of hospitals (Health Research & Educational Trust (HRET), 2017) Guide discusses link between food insecurity and health issues, including chronic illness and child development, and role of hospitals identifying food-insecure individuals and households to help address this determinant of health.

Social Determinants of Health Series: Housing and the role of hospitals (HRET, 2017) Includes five case studies about hospitals and health systems engaging in innovative programs to address different housing issues in their communities.

Social Determinants of Health Series: Transportation and the Role of Hospitals (HRET, 2017) Guide explains link between transportation and health and discusses the role of hospitals and health systems in addressing transportation issues, improving access and helping design and support better transportation options.

Screening and interventions for food insecurity in health care settings state strategies to increase an underutilized practice in California (California Food Policy Advocates, 2016) Informative guide for administrators, health care affiliates, and advocates at the city, county, and state level.

EXPERT ORGANIZATIONS

National Center for Complex Health and Social Needs: Combines complex care and social needs efforts into a national network of conferences and expertise. A program of the Camden Coalition, Robert Wood Johnson Foundation, and other partners.

California Accountable Communities for Health Initiative: Resources on the Accountable Communities for Health (ACH) model. Includes a searchable database organized into nine categories, including: consumer, community engagement and equity; data & data sharing; evaluation & impact; financing, sustainability and the Wellness Fund; and governance, leadership and partnerships.

Health Begins: Consulting and resources to equip providers to design upstream solutions that improve health at lower costs.

Health Outreach Partners: National nonprofit providing training, consultation, and information services to community-based organizations striving to improve the quality of life of hard-to-reach populations.

Root Cause Coalition: A national collaboration working on health inequity and cross-sector partnerships, member-based network, including policy and advocacy. Annual conference is in San Diego in 2019.

GENERAL RESOURCES

America's Essential Hospitals – Resource Library (registration required) Resource for hospitals on the journey to community-integrated health care and how safety net hospitals across the nation address social and economic factors that influence health.

Social Needs Roadmap (Health Leads USA) A library of resources to guide health care organizations in launching programs & partnerships that address patients' social needs

Opportunities for Medi-Cal to Support Community Health Initiatives (John Snow, Inc. and Center for Health Care Strategies, May 2018) White paper explores ways that Medi-Cal managed care plans and community health initiatives (e.g., the California Accountable Communities for Health Initiative) can align resources and partner more effectively to achieve common priorities such as improving health equity.

Promoting Better Health Beyond Health Care (CHCS, May 2018) This report, informed by more than 30 key informant interviews representing programs in 19 states and a small group convening, explores the many ways that states are collaborating across agencies to improve population health while accomplishing reciprocal goals in areas like transportation and education.