Measuring Social Needs and Outcomes

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Current Approaches to Measuring Social Needs

2018 Community Information Exchange Summit
Measuring Social Needs and Outcomes
April 16, 2018

Caroline Fichtenberg, PhD, Managing Director, Social Interventions Research and Evaluation Network, UCSF
What Goes Into Your Health?

- **Socioeconomic Factors**
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- **Physical Environment**

- **Health Behaviors**
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- **Health Care**
  - Access to Care
  - Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group
Use Cases for SDH data in clinical settings

- Patient Care
- Population Health Management
- Risk Adjustment
- Community Health Improvement
- Research
How to identify social needs in patients?
Social needs screening tools

**SOCIAL SCREENING**

Do you need...?
- Food
- Housing
- Help with benefits
- Legal services
- Utilities assistance

Do you want help today?
- Yes
- No

- PRAPARE
- Accountable Health Communities
- Health Leads Tool kit
- Upstream Risks Screening Tool
- IOM 2014 Recommended Social and Behavioral Domains and Measures for EHRs
- iHELP
- WE CARE
- SEEK
- WellRx
- And more...
Social needs screening tools characteristics

Tools differ in terms of:
• Domains
• Length
• Target users/patient populations
| siren | armed services | childcare/access | childcare/afford | civic engagement | clothing | disabilities | education | elder abuse | employment | ethnicity | financial strain | food insecurity | health care/medicine | housing insecurity/instability/homelessness | immigration | housing quality | incarceration | insurance | IPV | literacy | migrant status | neighborhood safety | refugee status | social support | stress | transportation | utilities | health behaviors/behavioral health |
|-------|----------------|------------------|------------------|-----------------|------------|-------------|-----------|------------|-----------|-----------|-----------------|----------------|----------------|--------------------------|----------------|----------------|--------------|-----------|-----|---------|-------------|-----------------|---------------|--------------|---------|-------------|----------|----------------|--------------|
|       | PRAPARE        | AHC-Tool         | IOM Domains      | We Care         | SEEK      | Health Leads | SWYC     | iHELP   | WellRx   | Health Begins |
| armed services |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| childcare/access |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| childcare/afford |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| civic engagement |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| clothing |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| disabilities |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| education |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| elder abuse |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| employment |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| ethnicity |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| financial strain |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| food insecurity |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| health care/medicine |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| housing insecurity/instability/homelessness |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| immigration |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| housing quality |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| incarceration |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| insurance |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| IPV |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| literacy |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| migrant status |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| neighborhood safety |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| refugee status |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| social support |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| stress |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| transportation |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| utilities |               |                  |                  |                |           |             |          |         |          |           |     |               |              |                 |                           |             |               |             |           |     |         |              |                 |              |             |         |           |          |
| health behaviors/behavioral health | | MH, PA, SU | AA, D, PA, TU | AA, D, SA, TU | AA, D, SA, TH | AA, D, SA, TH | AA, D, SA, TH |

AA: Alcohol Abuse, D: Depression, MH: Mental Health, PA: Physical Activity, SA: Substance Abuse, TH: Tobacco in the Home, TU: Tobacco Use
<table>
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<th>AHC-Tool</th>
<th>IOM Domains</th>
<th>We Care</th>
<th>SEEK</th>
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<td>AA, SA, DU</td>
<td>AA, SA, DU</td>
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PRAPARE – Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences

- Target users: Community Health Centers
- Launched in August 2016
- 21 questions:
  - Race/Ethnicity
  - Migrant and/or Seasonal Farm Work
  - Veteran Status
  - Language
  - Food
  - Housing Status
  - Housing Stability
  - Address/Neighborhood
  - Education
  - Employment
  - Insurance
  - Income
  - Material Security
  - Transportation
  - Social Integration and Support
  - Stress

- Templates for EHR integration (Epic, eCW, GE Centricity, and Next Gen)

- [https://www.nachc.org/research-and-data/prapare/](https://www.nachc.org/research-and-data/prapare/)
Accountable Health Communities Tool

• Target users: 32 Accountable Health Communities Model sites
• Published in May 2017
• 10 questions:
  • Food insecurity (Hunger Vital Sign)
  • Housing instability
  • Transportation needs
  • Utility needs
  • Interpersonal safety
• Adopted by the American Academy of Family Physicians (Jan 2018)
Health Leads Toolkit

• Target users: Any
• First published in July 2016, updated in 2018
• 10 questions:
  • Food insecurity
  • Housing instability
  • Medical transportation needs
  • Utility needs
  • Child care
  • Health literacy
  • Social isolation
  • Urgency of needs
  • Desire for assistance

• [https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/](https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/)
Accountable Health Communities Screening Tool
2017  |  A. Billoux, K. Verlander, S. Anthony, D. Alley

From the National Academies of Medicine: “With input from a panel of national experts and after review of existing screening instruments, CMS developed a 10-item screening tool to identify patient needs in 5 different domains that can be addressed through community services (housing instability, ...

IOM Recommended Social and Behavioral Domains and Measures for Electronic Health Records
2014  |  Committee on Recommended Social & Behavioral Domains & Measures for Electronic Health Records

Determinants of health—like physical activity levels and living conditions—have traditionally been the concern of public health and have not been linked closely to clinical practice. However, if standardized social and behavioral data can be incorporated into patient electronic health records (EHRs...
Open questions

• Lack of standardization / Lots of customization
• Atomization of needs
• Needs vs. desire for assistance
• Should screening be structured?
• Who should screen?
• How should patients be screened?
• What is a successful outcome?
### Outcome Measures in Existing Literature

<table>
<thead>
<tr>
<th>Process Outcomes</th>
<th>Social Needs Outcomes</th>
<th>Provider Outcomes</th>
<th>Physical and Mental Health Outcomes</th>
<th>Utilization / Cost Outcomes</th>
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</table>

Outcome Measures in Existing Literature

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2018 Community Information Exchange Summit:
Measuring Social Needs and Outcomes

April 16, 2018

Damon Francis, MD
Chief Medical Officer, Health Leads
Assistant Clinical Professor, UCSF School of Medicine
We envision a healthcare system that addresses all patients’ basic resource needs as a standard part of quality care.
Health Leads’ Solutions

Empowering healthcare organizations to integrate social needs into care delivery with learning, consulting and technology solutions:

**Design**
Create your social needs strategy through our interactive workshops or hands-on coaching

**Implement**
Integrate social needs into care delivery and improve over time with our Implementation Services

**Enable**
Manage patients and track success using our Reach social needs technology

© 2017 Health Leads Inc.
My background: HIV and homeless health care

https://www.crush510.org/

Use cases

Patient Care

Risk Adjustment

Population Health Management

Community Health Improvement

Research

Measuring to manage
Does a “Yes” mean someone has a “need”? 

“Are you worried that in the next 2 months, you may not have stable housing?”

Source: Social Needs Screening Toolkit, Health Leads, 2018
Assessment: The Essential Link Between Screening and Intervening

Two critical elements--

• What are your goals?
• What are you eligible for?
Measuring Goals in Assessment –
Consider measuring the process of goal setting


3 Questions

• How much effort was made to help you understand your health issues?
• How much effort was made to listen to the things that matter most to you about your health issues?
• How much effort was made to include what matters most to you in choosing what to do next?

Source: Barr, et al, Journal of Medical Internet Research, 2014
Measuring Eligibility in Assessment – More important than validity?

Example: 1 Level of Government (Federal), 3 Definitions of Homelessness

**Housing and Urban Development** -- “Persons living in emergency shelters and transitional housing projects must be counted as sheltered homeless persons. Homeless persons who are living in a place not designed or ordinarily used as a regular sleeping accommodation for humans must be counted as unsheltered homeless persons.” [PITC (24 CFR 578.7(c)(2)]

**United States Department of Education** -- Includes “children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason...[McKinney-Vento, Title VII, Subtitle B, Sec. 725(B)(i)]”, and the United States

**Health Resources and Services Administration** – Includes individuals who “are forced to stay with a series of friends and/or extended family members...” [HRSA Bureau of Primary Health Care Program Assistance Letter 99-12]

*Takeaway*: Each definition is further specified in an administrative measurement system that defines what help your client or patient can receive, **whether they fit a scientifically valid construct of homeless or not.**
### Measuring Outcomes – Resource connections

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<tr>
<th><strong>FAILURES</strong></th>
<th><strong>WAITLIST</strong></th>
<th><strong>EQUIPPED</strong></th>
<th><strong>SUCCESSFUL</strong></th>
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<tbody>
<tr>
<td>(a) Patient hit a roadblock and was unable to resolve his or her need</td>
<td>Patient placed on a waiting list for two months or longer</td>
<td>Need not yet met, but the patient is actively working on solving the need AND Feels equipped to proceed without further assistance</td>
<td>Patient confirms successful resolution of social need</td>
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<td>(b) Patient did not meet eligibility requirements (e.g., income too high)</td>
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<td>(c) No resources exist to meet patient’s need</td>
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**UNKNOWN**: Health system did not follow up with patient OR patient did not respond after multiple contact attempts

### Measuring Outcomes – Resource Connections reporting example

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<th>Need</th>
<th>Sub-Need</th>
<th># Closed</th>
<th>% Connected</th>
<th># Days Open</th>
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<td>16%</td>
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<td>GED and Adult Basic Education</td>
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<td>Job Placement Services (e.g. One)</td>
<td>101</td>
<td>14%</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Job Training (e.g. Medical Assistance)</td>
<td>30</td>
<td>0%</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Employment 101</td>
<td>30</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>
Measuring Outcomes –
Self-Sufficiency Matrix

Possible status descriptions for food

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmarks</td>
<td></td>
</tr>
<tr>
<td><strong>Thriving (9-10)</strong></td>
<td>Always has resources and knowledge to purchase and prepare nutritious food of choice. (10)</td>
</tr>
<tr>
<td></td>
<td>Usually has resources and knowledge to purchase and prepare nutritious food of choice. (9)</td>
</tr>
<tr>
<td><strong>Safe (7-8)</strong></td>
<td>Always has resources and knowledge to purchase and prepare nutritious food. (8)</td>
</tr>
<tr>
<td></td>
<td>Usually has resources and knowledge to purchase and prepare nutritious food. (7)</td>
</tr>
<tr>
<td><strong>Stable (5-6)</strong></td>
<td>Has sufficient knowledge and personal/community resources to purchase and prepare food. (6)</td>
</tr>
<tr>
<td></td>
<td>Has some knowledge and able to buy and prepare some types of food. Occasionally relies on food stamps and food banks. (5)</td>
</tr>
<tr>
<td><strong>Vulnerable (3-4)</strong></td>
<td>Has little knowledge of and unable to buy and/or prepare some types of food; relies on food stamps and food banks. (4)</td>
</tr>
<tr>
<td></td>
<td>Extremely limited knowledge of and unable to buy and/or prepare food; inadequate resources to obtain food. (3)</td>
</tr>
<tr>
<td><strong>In-Crisis (0-2)</strong></td>
<td>Lacks knowledge and/or resources to purchase and/or prepare food. (2)</td>
</tr>
<tr>
<td></td>
<td>No food and is not aware of food resources. (0)</td>
</tr>
</tbody>
</table>


Measuring Outcomes – Self-Sufficiency Matrix reporting example

Outcomes in Practice – *Health outcomes*

Outcomes in practice – *Utilization of healthcare and other services*

Source: Brenner, Addressing the Social Determinants of Health, 2017
What the numbers can miss...

**Resource info is not the only barrier**

*Patient:* “Yeah, honestly I do think it was beneficial because I knew I needed help, I didn’t know where to begin and the steps, and [the navigator] helped me in a way get to a point of creating steps and then having a little bit more of ‘oh hey, I’m going to make this plan for myself.’ ”

*Navigator:* “A 59-year-old man called 2-1-1 for food. As we began discussing some options, I realized the situation was far more complex than just a matter of finding him some groceries. The gentleman told me he was living in an unfurnished apartment, and dealing with spinal cord injuries that impaired his movement.”

**Relationships and trust matter most**

*Patient:* “I felt like it actually gave us less stress and less worry. So it kind of helped us a lot to just not worry about having to always look online for food banks and everything. It just gave us a little more of an easy access to what we needed.”

*Navigator:* “One of my patients was undocumented and worried that applying for certain services would jeopardize their status in this country. I was able to help ease their worries a bit, but they never would have applied if we hadn’t talked.”

Summary

• **Patient-reported measures are critical** to monitoring interventions “day-to-day,” even when “hard” endpoints such as mortality or healthcare utilization are the ultimate goals of the intervention.

• **High quality assessment is about conversations that match client goals and eligibility with interventions** – measures support that process, but don’t replace it.

• **Screening and referral data by themselves are inadequate** to meaningfully monitor an intervention or measure success.

• **Systematic data collection and reporting remain rare** for SDOH interventions, regardless of the outcome measures, but fortunately experimentation is widespread and accelerating.
The Risk Rating Scale
Screening vs. Assessment

**Healthcare Provider**

**Priority:** Providing Medical Care

**Secondary:** Screening for Specific Social Risks

**Tools:** Positive or Negative

**Example:**
- Within the past 12 months, we worried whether our food would run out before we got money to buy more.
- Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.

**Social Service Provider**

**Priority:** Address bio-psycho-social of individual and family

**Secondary:** Connection between health and social

**Tools:** Target population focused and tailored

**Example:**
- **What is your current health situation?**
  - Open ended (Physical, Mental/Behavioral, Substance Abuse, Dental)
- **Are you experiencing any barriers to managing your health condition?**
  - Transportation, Prescription Costs, Health Insurance Issues, knowledge health condition, procedure costs, timeline for care, medical equipment
- **What types of services are you hoping access to help you?**
  - Medical home, Sobriety Services, Inpatient, Medical Access, Financial Assistance Programs, Medical Home
Objective: Creation of universal assessment tool to understand complexity of social influences
  • Clinical screenings exist, but lack comprehensive guide to capture holistic view

Designed to:

1. **Understand client situation, nature and severity of the need**
   • Standardized categories across domains

2. **Establish baseline risk to objectively measure change over time**
   • Built framework for shared measures

3. **Provide a roadmap for care planning**
   • Utilize continuum to move clients towards thriving

4. **Align resources with client need and risk**
   • Resources are tagged through standardized classification system
## Methodology

<table>
<thead>
<tr>
<th>Identify Existing Models for SDoH</th>
<th>Researched existing SDoH tools: World Health Organization (WHO), HealthyPeople2020, Live Well San Diego, Center for Disease Control, Kaiser Family Foundation, Alliance for Information and Referral Taxonomy (AIRS)</th>
</tr>
</thead>
</table>
| Outline Impact on Community Level | Identified micro and macro factors that impact San Diego community  
• Individuals’ Demographics, Behavior & Choices, Access to, Environment, Policy  
• Laid foundation for 2-1-1 San Diego’s 14 domains of health and wellness |
| Measure Impact (Risk Rating Scale) | Developed model to assess client’s change over time (adapted from Jewish Family Service’s Self-Sufficiency Model)  
• Plots clients within six levels of vulnerability: Crisis, Critical, Vulnerable, Stable, Safe, and Thriving |
| Identify Shared Measures through Assessments & Domain Standards | Developed domain-specific assessments, driven by evidence based tools, existing social service intakes, and practical application  
• Risk is defined by Immediacy, Knowledge & Utilization, Barriers & Support  
• Analytics also include situational factors such as demographics, socioeconomic status, health conditions, and place (geography) |
| Weighted Assessment Rubric | Weighted constructs that aligns specific responses to risk level  
• Values and point allocation driven by literature  
• Objective risk determination via standardized scoring  
• Establishes baseline risk to calculate change over time |
| Feedback & Integration | Review & feedback session with agency subject matter experts across multiple domains  
• Integrated assessments with existing intakes, including shared measures, aligning values and eligibility criteria across agencies  
• External validity through partnership with University of San Diego Caster Center for Non-Profit and Philanthropic Research |
14 Social Determinants of Health

- Housing Stability
- Food & Nutrition
- Primary Care & Prevention
- Health Management
- Social & Community Connection
- Activities of Daily Living
- Legal & Criminal Justice
- Financial Wellness & Benefits
- Employment Development
- Transportation
- Personal Care & Household Goods
- Utility & Technology
- Safety & Disaster
- Education & Human Development
<table>
<thead>
<tr>
<th>Domains/ Social Need Domains</th>
<th>HealthyPeople2020 (CDC)</th>
<th>2-1-1 San Diego</th>
<th>Henry J. Kaiser Family Foundation</th>
<th>SIREN</th>
<th>Health Leads</th>
<th>PRAPARE</th>
<th>Self-Sufficiency Matrix</th>
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<tr>
<td>Housing</td>
<td></td>
<td>x</td>
<td></td>
<td>x Quality &amp; Stability</td>
<td>x (Housing Stability)</td>
<td>x (Status &amp; Stability)</td>
<td>x (Housing and Household Management)</td>
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<td>Primary Care</td>
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<td>X (Primary Care and Access)</td>
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<td>x (Health Behaviors)</td>
<td>x (Insurance)</td>
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<td>Health Condition Management</td>
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<td>x (Behavioral/Mental Health)</td>
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<td>x (Mental, Physical Health, Substance Abuse)</td>
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<td>Food &amp; Nutrition</td>
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<td>x</td>
<td>X (Hunger and Food Insecurity)</td>
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<td>x</td>
<td>x</td>
<td>x (Social Isolation &amp; Support)</td>
<td>x (Social Integration &amp; Support)</td>
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<td>x (Career Resiliency/Training, Employment Stability, English Second Language)</td>
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<td>x (Incarceration History)</td>
<td>x (Legal)</td>
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<td>x (Exposure to Violence)</td>
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<td>X (Childcare &amp; Education, Life Skills (human relations and setting goals), Parenting)</td>
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<td>Human Development &amp; Education</td>
<td>x (Education)</td>
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<td>x</td>
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<td>x (Education &amp; Childcare)</td>
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<td>Neighborhood &amp; Built Environment</td>
<td>X (Access Healthy Food, Housing Quality, Crime &amp; Violence, Environmental Conditions)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x (Housing, Transportation, Park Safety, Walkability)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Framework

WHAT IS THE CLIENT'S OVERALL SITUATION?

DOES A CLIENT KNOW ABOUT RESOURCES IN THE COMMUNITY AND ARE THEY UTILIZING THEM?

ARE THERE CLIENT LIMITATIONS OR BARRIERS PREVENTING CLIENT ACCESS?
WHAT SOCIAL SUPPORTS EXIST FOR CLIENT?

HOW SOON DOES THE CLIENT NEED HELP?
Long-term safe and adequate housing that meets all needs with access to multiple resources and ability to access supports for long-term housing sustainability.
FOOD & NUTRITION

Long-term and sustainable access to nutritious foods and support services to maintain access

Crisis

Food Insecure

Critical

Food Insecure Without Hunger

Vulnerable

Food & Nutrition

Food Security

In collaboration with:

2-1-1 San Diego
**Concern Over Food Supply**
How often are clients worried that food would run out?

- Often True: 74%
- Sometimes True: 25%
- Never True: 1%

**Decisions between Food and Other Needs**
Do clients choose to meet other needs before nutritional needs?

- Basic Needs
  - Crisis/Critical: 97%
  - Vulnerable/Stable: 70%
  - Safe/Thriving: 17%
- None
  - Crisis/Critical: 3%
  - Vulnerable/Stable: 30%
  - Safe/Thriving: 83%
Preliminary Findings in Change Over Time

What does decreased vulnerability mean for clients?

- Reduced the rate of clients often concerned with food supply from 45% to 33%.
- Increased access to resources by 49%.
  - Connected clients to SNAP applications, food banks and other emergency food options, WIC, and congregate meals.

6% of clients initially in a Safe or Thriving risk level decreased vulnerability

37% of clients initially in a Vulnerable or Stable risk level decreased vulnerability

71% of clients initially in a Crisis or Critical risk level decreased vulnerability

NUTRITION ASSESSMENT

Reduced the rate of clients often concerned with food supply from 45% to 33%.
Increased access to resources by 49%.
Connected clients to SNAP applications, food banks and other emergency food options, WIC, and congregate meals.
Lessons Learned

1. Bridging the gap between research-based assessment tools and practical applications requires input and validation from multiple sources.

2. Seek partnership opportunities with other organizations to replicate and expand Risk Rating Scales to other settings.

3. Building assessments requires an Agile process, recognizing the need for continuous improvement and enhancements based on learning.

4. Generate more rigorous research grants to develop stronger outcomes and contribute high-quality research to the field.