FOUNDATION FOR
Health Care Quality

Improving health outcomes through collaboration, data, and finding common ground

Social Need Interventions

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Background

Only about 20% of health outcomes are determined by clinical care. The other 80% are influenced by health behaviors, the physical environment, and social and economic factors.[i] Some of the social determinants, or social influencers, include housing, food security, and transportation needs. In 2019, the National Academies of Science released a report on integrating social care into the delivery of healthcare to better address upstream factors that influence patient health outcomes.[ii] Many healthcare organizations now recommend assessing patients for social need as a routine part of care, including the AAFP's EveryOne Project, the NACHC's PRAPARE Toolkit, and Kaiser Permanente's Social Risk Playbook.[iii,iv,v]

Spurred by accumulated evidence on the impacts of social need, many healthcare organizations are experimenting with interventions to address social need.[vi] Interventions range from self-referral resource lists to complex partnerships and investments. Effective interventions require effort and investment,[vii] although gaps in research remain, especially around comparative analysis and avoiding unintended consequences.[viii]

The Foundation's Social Need and Health Equity Steering Committee convened a Social Needs Interventions workgroup to specifically review strategies for connecting people to resources once a social need has been identified. The workgroup examined existing interventions and decided to focus on addressing social need along the socioecological model. Intervention focus areas are listed in **Table 1.**

Table 1: Interventions Focus Areas

Focus Area	Goals
Individual Interventions	• Develop interventions to target individual social need. • Integrate social need information into clinical care plans, develop care coordination programs, and build referral pathways.
Organizational Interventions	• Address organization readiness to intervene on social need. • Develop cross-sector partnerships and advocacy efforts to address social drivers of health. • Determine how organizations will fund or reimburse social need interventions and how to meaningfully measure interventions.
Structural Interventions	• Consider policies that impact social need. • Develop sustainable funding for social need interventions.

Recommendations

Individual Interventions

Care Planning

- Tailor the care plan to address social needs. For example, offer to provide patients a small amount of medication at a time rather than all at once if the patient is experiencing housing instability or lacks a safe space to store their own medication.

Self-Referral

- When feasible, provide people with options for connecting to community resources to meet those needs. Try to offer multiple community resource lists in multiple modes and formats, including in-person conversations, phone lines, text printouts, or web resources.
- Maintain an organization-specific or region-specific resource list for self-referrals. When possible, provide culturally appropriate resources.
    - If feasible, assign a staff member to maintain an updated resource list for self-referrals.
    - Provide at least one face-to-face education session when providing a self-referral resource list.
- In absence of a specific resource list, refer patients to 2-1-1, which is available for free across Washington state.
- If organization participates in a Community Information Exchange offer clear information about how patients or clients can access and use the resource locator to identify community resources to meet their need.

Care Coordination

- Hire and train staff to perform care coordination activities. Support care coordination staff (see NCQA/Penn Medicine Guidelines for community health workers)
- Follow professional standards for care coordination as applicable to the setting and funding (such as Case Management Society of America, the Commission for Case Management Certification, National Care Coordination Standards for Children and Youth).
- Ensure care coordinators are trained in cultural humility, implicit bias, and trauma-informed interviewing.
- Leverage cultural navigators, cultural liaisons, and peer navigators to help connect with patients.
- Connect people who are high-risk for unmet social need to navigation and case management services. These services should include facilitating referrals, conducting motivational interviewing, and care planning.
    - Follow-up with people with unmet social needs at least twice-yearly. Ensure all care coordination services and follow-up are conducted on an opt-in, voluntary basis.
- Align care coordination activities across audiences (e.g. communicate care coordination activities between clinics and plans). Engage with the patient's self-identified support systems and assign one of the patient's care coordinators as the main point of contact.

- Clinics integrate intervention workflows into the EHR using auto-populated referral lists or flagging patients with identified social risk for follow-up. Ensure care coordination/care management and clinical notes are accessible via the same platform.
- If possible, ensure care coordinators are able to use the organization's community information exchange to make referrals on behalf of the patient.

Organizational Interventions

Internal:

Protecting Staff

- Prioritize social needs at the leadership level and promote staff champions and buy-in.
- Recognize and understand the social needs of staff and the potential for secondhand trauma and provide resources for staff who experience secondhand trauma. Provide ongoing training and evaluation of staff well-being and offer support for identified needs.
- Ensure social need interventions or services (such as community information exchanges or social need referral resources) are available to staff as well as patients.
- Provide a living wage to all staff members.

Leadership and Development

- Ensure all care provided is inequity-responsive, trauma-informed, contextually tailored, and culturally humble.
- Train staff on the history of the organization, past relationships with local community, and implicit bias.
- Educate staff on existing resources within the system/organization.
- Bring accountability and transparency for social need interventions (bring impact data to board, including community health measures).
- Offer leadership and development and education opportunities to all staff members

Workflow/Service Structure

- Reduce barriers to access and increase quality of care for hard-to-reach patient groups. This could include offering extended hours, virtual care options, demonstrating a culturally welcome environment, and creating opportunities to provide services outside clinic walls (see partnerships section).
- Invest in increased capacity for leadership, workforce and technology.
- Implement workflow changes when possible – embed patient social support navigators into the primary care team, develop mechanisms for "social prescribing."
- Implement care coordination and/or peer-navigator models.

Investing in Community Information Exchange (CIE)

- If possible, participate in a region-wide community information exchange for closed-loop referrals. Follow the Washington State Health Care Authority for more up-to-date information about a state-wide Community Information Exchange.
- When choosing a community information exchange, ensure the vendor or service includes relevant resources for the local community before investing.
- If participating or investing in a CIE, ensure the CIE follows Human Services Data Specifications standards and is inclusive of referral management across key audiences. When possible, choose a CIE that is capable of closed-loop referrals.
- Review the ONC SDOH Information Exchange Toolkit for more information about the foundational elements of SDOH information exchange.
- Partner with other organizations for future collaboration on community information exchanges to improve alignment and capacity.

Financial Models

- Leverage reimbursement models along the spectrum from fee for service to population-based payment, focusing on alternative payment models that support social need integration.
    - Fee-for-service models can include reimbursement for SDOH screening and provision of follow-up resources.
    - Employ a stepped approach when transitioning to alternative payment models to allow flexibility for smaller clinics to run demonstration projects and prepare to collect data on costs, quality and outcomes.
    - Ensure payment models cover all patients and includes risk-adjustment for complex patients.
- Evaluate social need interventions program for efficacy and cost.
    - Define and measure services and metrics to hold plans, providers, and delivery systems accountable for improvement related to social care integration.

Metrics/Evaluation

- Review the National Alliance to Impact the Social Determinants of Health's shared principles for measuring social determinants of health interventions brief information about aligning measurement strategies across stakeholders.
- For organizations tracking internal social need interventions, consider using the "Social Needs Funnel" framework for tracking social need interventions. This framework involves four key measures:
    - Social Need Identified
    - Resource Identified
    - Referral Status (closed-loop referral)
    - Health Outcome

- At a minimum, track the percentage of members who received a corresponding intervention within a month of screening positive for unmet social need. Follow NCQA and/or Joint Commission standards on measuring social need interventions for your setting. (NCQA, Joint Commission)
- Develop nontraditional key performance indicators related to social need interventions. Four considerations for social need intervention metrics include:
    - Choose validated indicators,
    - Ensure feasible implementation and measurement,
    - Ensure longitudinal data can be compared across key audiences, and
    - Include patient-reported outcome measures.

External Partnerships

Healthcare-Community Partnerships

- Initiate partnerships with community-based organizations that involve those with lived experience in the planning process for social need interventions.
    - Cultivate existing common capacity.
    - Learn from community organizations that are already addressing social need and determine how to support them to create synergy.
    - Aid patients in navigating cultural or language barriers, provide material to make community referrals easier (maps to food banks, applying for orca cards, etc.).
    - Expand information sharing using data-sharing agreements, feedback loops, and integrated data systems.
- Develop clinic-community relationships to create healthier environments. Examples include partnering with schools or community centers to introduce violence prevention programs or introducing farmer's markets to combat food deserts.
    - Connect with public agencies (Washington DSHS, HCA, DOH) and community-based organizations that may help facilitate community partnerships.
    - Review the "One Stop Shop for Healthcare and Community Partnership" resources from Health Begins.
- Continue to develop best practices for healthcare-community partnerships.

Community Hubs

- Replicate CBO networks as hubs to curate and manage networks of community service providers with hubs at local, state, and multi-state levels.
- Develop a multi-stakeholder, standards-based approach to financing and implementing CBO network hubs.

Community Investment

- Develop partnerships that share savings with community-based organizations, such as the Unite Us payment platform for investment in social care.
- Develop funding models that reimburse both healthcare and community organizations for their work to address social need and upstream drivers of health outcomes.

Structural Interventions

Intervention Components

- Create systems-level partnerships and interventions to address upstream drivers of health outcomes. Key components of structural interventions include:
    - Authentic engagement –transparent access to resources and an equitable balance of power.
    - Disease-Agnostic - address upstream health disparities through prevention and early intervention that focus on risk factors rather than a single disease.
    - Consider unintended consequences – consider discordance between interventions and local community culture or norms to ensure uptake. Ensure rigorous, long-term evaluations.

Alignment

- Work toward alignment on social care integration into health care delivery in Washington state.
    - Continue the state-wide community information exchange project from the WA HCA.
    - Align care coordination activities across healthcare and community-based organizations, building off the WA Department of Health's Care Coordination hubs.
- Align healthcare services with community sites for improved access. Consider embedding health services at additional community sites through co-located services or mobile clinics.

Funding

- Develop alternative payment models to provide sustainable funding for social need interventions at healthcare organizations. The AAFP offers five principles for clinical APMs.
- Leverage the Health Care Authority's Medicaid 1115 waiver and Primary Care Transformation Model to move toward population-based payment to address health-related social needs.
    - Other Medicaid strategies include: expanding in-lieu of services, reimbursing community health workers, and developing new programs for social services, such as the Foundational Community Supports program.
- Target federal funding to address upstream health-related social needs. The ASPE Office of Health Policy provides a few examples of evidence-based strategies for addressing health-related social need.
    - Consider directing healthcare funds for community benefit improvement services to increase community-based organization capacity.

Policies

- Support collaborative research on social need interventions and provide funding for cross-sector interventions.
- Consider health service access during planning and development projects. Consider embedding health services at community sites.
- Advocate for federal policies that create conditions that improve health, especially by addressing education, economic stability, health care access, environmental harm, neighborhood safety, and other forms of systemic disadvantages. The Center for American Progress offers several recommendations for congressional investments in social need.
- The WHO recommends advancing policies across four main themes (early child development, fair employment and decent work, social protection, and living environments) to have the greatest impact on health related social needs and health inequities.
- Increasing awareness of existing policies at the state and community level to increase opportunities for impact.

Stakeholder Roles and Responsibilities

Each stakeholder plays several roles in the health and social care ecosystem. This list (adapted from the Robert Wood Johnson Foundation Raising the Bar Report) provides several suggested actions for specific stakeholders to take depending on their role. The actions suggested are not in chronological order. Stakeholders are invited to develop an action plan to achieve the objectives relevant to their organization.

Leaders: C-suite executives, directors, and managers in charge of setting priorities and allocating resources.

Goal: Develop internal and external plans to incorporate social care into the delivery of healthcare services.

- 1.1: Invest in social care integration including the workforce and technology to assess for patient social need.
- 1.2: Create and sustain workflows for addressing patient social need.
- 1.3: Develop partnerships with other healthcare stakeholders and community organizations to better meet patient social need.
- 1.4: Develop innovative funding strategies and invest in programs that address upstream social drivers of health.

Health Care Providers: Physicians, other clinicians, and other providers responsible for treating and managing patients.

Goal: Provide whole-person care that considers patient social needs.

- 2.1: Screen patients for social need and communicate information with the care team.
- 2.2: Use social need information to inform care and treatment plans.
- 2.3: Connect patients with social need support services, including care coordinators, patient navigators, and referrals to community organizations. Track closed-loop referrals.

Employers: Any organizations that support and manage staff, human resource departments.

Goal: Offer social need support services and benefits in addition to health benefits.

- 3.1: Develop social need benefits for employees.
- 3.2: Evaluate healthcare purchasing strategies for social care integration.
- 3.3: Partner with community organizations and advocate for policies that address upstream social drivers of health outcomes.

Partners: Organizations that facilitate relationships across multiple sectors to achieve equity

Goal: Collaborate with community organizations and residents to address upstream drivers of health outcomes.

- 4.1: Engage with organizations and community residents, prioritizing those most affected by inequities
- 4.2: Build trusting relationships with individuals and organizations in the community
- 4.3: Respect and build on the expertise and power of individuals and organizations in the community.

Advocates: People and organizations who advocate for greater change.

Goal: Advocate for improved policies and greater investment to address social drivers and social need

- 5.1: Actively push for and adopt payment reforms, especially reforms that align investments with the mission of improving health and well-being
- 5.2: Use healthcare's voice to shape public understanding about the importance of health equity and dismantling racism and all forms of discrimination
- 5.3: Use power and influence to advocate for health equity in the development and implementation of public policies
- 5.4: Use investment and procurement power to contribute to the health and resilience of communities.

Purchasers: Organizations in charge of purchasing benefits for their employees, staff, or other clients.

Goal: Develop plans and reimbursement strategies to incorporate social care into the delivery of healthcare services.

- 6.1: Invest in social care integration strategies for members
- 6.2: Support social care integration at healthcare organizations through reimbursement strategies, education, and implementation activities.

Insurer: Organizations that manage health plans for enrollees.

Goal: Leverage contracts and develop new initiatives to address enrollees social needs.

- 7.1: Leverage coverage, reimbursement, and eligibility policies to address enrollee social need.
- 7.2: Develop education, awareness, and support programs to aid clinics and providers in meeting enrollee social need.
- 7.3: Develop internal interventions and services to address enrollee social need.

Regulators and Policy: Organizations and people in charge of developing policy that governs healthcare organizations and regulating/enforcing these policies.

Goal: Review public policies to incentivize upstream interventions that impact health outcomes, support organizations in achieving these goals.

- 8.1: Develop population-level metrics to track intervention progress.
- 8.2: Aid organizations in social care integration into health care delivery.
- 8.3: Leverage public policies to address individual social needs and upstream drivers of health outcomes.

- 8.4: Direct sustainable funding to organizations that address social need and upstream drivers.

Population Health: Organizations that collect population-level data and focus on multi-sector partnerships to advance health.

Goal: Track population health outcomes for evaluation and improvement.

- 9.1: Track population-level metrics about social need interventions and outcomes.
- 9.2: Facilitate partnerships between healthcare and social care organizations.

Tools and Resources

- CMS: Care Coordination Toolkit
- PCORI: Evidence Map for Social Need Interventions to Improve Health Outcomes
- KP: Social Health Playbook
- Washington Health Care Authority: Community Information Exchange Resources
- Camden Coalition: Community Information Exchange Toolkit
- One Stop Shop for Healthcare and Community Partnership
- Commonwealth Fund: Guide to Evidence for Social Need Interventions

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