The Bree Collaborative at the Foundation for Health Care Quality, works to increase health care quality, outcomes, affordability, and equity.

Social Determinants of Health and Health Equity – A Community Standard

The social determinants of health (SDoH), conditions in which we live, work, and play, contribute ~40% to our overall health and length of life. A person's experience of racism is embedded within social determinants, and both racism and social needs (e.g., experiencing homelessness) are highly stigmatized. While social needs and racism both have a large impact on health, both are largely unrecognized and unacknowledged in a clinical visit.

While we currently lack a single screening tool to recommend above others and also have limited and variable social referral infrastructure and care team capacity at a delivery site level; we believe universal patient screening using a validated tool (when available) with results tracked with FHIR-defined resources (via the Gravity project) is urgently needed in the wake of the SARS-COV-2 pandemic and economic downturn. We propose a state-wide community standard, outlined below, to identify, track, and follow-up on our population's social needs and reduce harm from implicit racial bias within clinical delivery systems. When done universally, this process will help destigmatize both social needs and facilitate necessary conversations about race at an interpersonal level through naming and normalizing, connecting people with resources to meet immediate need, and informing regional infrastructure development with interoperable data.

Plan

- Embed diversity, equity, and inclusion into organizational principles
- Level-setting/buy-in
- Annual implicit bias training for all staff and board members
- Collaborate with patients and staff on pilot planning and workflow

Identify

- Universal FHIR-defined screening with validated tool(s) for:
  - Race
  - Housing security
  - Food security
  - Transportation need
  - Other high priority domain(s)

Track and Measure

- Integrate SDoH into existing disease or diagnosis registry or develop new registry
- Use FHIR-defined resources and bill using z-codes
- Stratify population by social need(s) into ≥2 tiers
- Stratify process, patient-reported outcomes, and health outcomes by race categories

Follow-Up

- Resource lists for low-risk patients Case management for higher-risk patients
- Closed loop referrals
- Plan-Do-Study-Act where disparity is identified

Incentivize and Invest

- Reimbursement mechanisms supporting above pathway aligned with value-based payment
- Interoperable community information exchanges, learning collaboratives, and social care integration
- Organizing body to align state-wide stakeholders

Next Steps

Further investment is needed to convene, coordinate, and lead efforts to address SDOH and reduce racial inequities. We propose the following three-step process:

Ongoing Coalition

- Aggregate emerging best practices from national and local organizations
- Synthesize national best practices to be meaningful to our region
- Disseminate findings to stakeholders

Data Registry

- Collect standard SDOH and race data
- Analyze and benchmark data to inform broad learning community and to demonstrate value
- Target gaps for quality improvement

Systems Transformation

- Facilitate public-private partnerships
- Develop resources and support for local SDOH pilot projects
- Partner with community-based organizations to expand capacity