**Social Need Interventions Subcommittee**
Social Need Interventions
September 20th, 2022

Evidence for Social Needs Interventions
- PCORI: Social Needs Interventions to Improve Health Outcomes – Evidence Map and Visualization
- SIREN: Evidence and Resource Library – Especially Report on CHCs in Texas, Provider Impacts Study, and Payment Mechanisms Report

Key Components of Social Need Interventions:
- Social Need to Address
  - Multiple Health-Related Social Needs – especially housing security, food security, and transportation
- Intervention Setting/Intervention Administrator
  - Health Delivery Site – Inpatient vs. Outpatient (ex. FQHCs providing nurse navigators/social workers)
  - Health Plan (ex. MCOs care coordinators)
  - Public Health (DOH Care Connect)
  - Employers
- Staff Involved in Providing Intervention
  - Healthcare Provider
  - Social Worker
  - Care Coordinator
  - Administrator
- Technology Used in Providing Intervention
  - Community Information Exchange
  - Electronic Health Records
  - Other Closed Loop Referral
- Outcomes of Interest
  - Health Outcomes
  - Social Need Meet
  - Return on Investment (internality v. externality?)

- Payment Mechanism
  - Fee for service (provided to staff involved in intervention)
  - Grant funding (short-term)
  - Sustainable long-term funding

Interventions/Models:

| Intervention | Intervention Setting | Staff Involved | Technology Involved | Payment Mechanism |
|---|---|---|---|---|
| BMC WE CARE Model | BMC Pediatrics (healthcare facility in Boston) | Administration, providers (option to involve social workers) | EHR Integration of screening tools and resource information sheets | Donations (The Kids Fund), hospital's general fund. |
| Camden Core Model | Healthcare Facilities in New Jersey | Nurses, social workers, community health workers | Health Information exchange | Non-profit. Mostly grant funded, some billing for case management services. |
| OHSU NICH Program | Oregon/Portland Pediatric Services | Mainly an "interventionist" (social-work type position) | Unclear | Contracts with insurance companies for 12 months of services, some donations. |
| Kaiser Permanente | Kaiser, a large primary-care focused HMO (Health delivery system on west coast) | Navigators, Care Coordinators | Electronic Health Record, CIE (KP WA has invested in Unite Us, rebranded as KP Thrive Local) | Part of KP's operating budget. |
| MCO Care Coordination (Molina Example) | Health plan, offered to plan enrollees | Case Managers | Unclear | Provided as part of MCO contracts/benefits |

<u>Broad Categories from Interviews:</u>

Resource Lists:
- The use of an organization-specific resource list to guide people with health-related social needs for self-referrals.
- This is generally the least expensive/time consuming option for following-up on health-related social needs, but it can be difficult to continuously verify program eligibility and contact information, and people are easily lost to follow-up.

Community Information Exchange:
- Platforms designed to facilitate closed loop referrals between healthcare and social services.
- Examples include Healthify, 2-1-1, UniteUs, etc.
- This workgroup is not planning on developing CIE recommendations as the HCA is working toward a state-wide CIE currently.

Care Coordinators:
- Use of dedicated FTE to connect people to resources. This may include a social worker, community health worker, nurse navigator, or other who is tasked with working one-on-one with the patient/client/employee with a health-related social need and finding a solution.
- Examples include Boston Medical Center, OHSU's NICHE Program, etc.
- Organizations with dedicated FTE to care coordination may also use a community information exchange or other tools.

<u>Next Steps:</u>
- Highlighting/Talking to Programs Within WA State
- Determine availability of resources by region in WA
- Identify pros/cons of intervention types and solutions
- Answer Key Questions about Interventions:
    - What kind of resource provision is most effective? (I.e. self-referral, care coordination, closed-loop referral)
    - What kind of care coordination is most effective? (i.e. in-person at health site, in-person in community, telehealth – audio, visual, or both)
    - What are the most effective sustainable funding mechanisms?
    - How do we ensure partnerships with community based organizations?