Social Determinants of Health, Social Risk & Social Needs

Cara Lewis, PhD │ April 28, 2021
Definitions: SDOH, Social Risks, Social Needs

- **Social Determinants of Health (SDOH)**: “The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.”

- **Social Risk Factors**: “Specific adverse social circumstances that are associated with poor health, like social isolation or housing instability.”

- **Social Needs**: Incorporate an individual’s preference, priority, or readiness to seek support or assistance on a social factor (like food, housing). An individual may not be fully aware of their current social needs that may be more apparent to those around them. Also, an individual may have current needs but may choose not to receive help. Administering a questionnaire can uncover needs and risks that might not be immediately evident but are essential to address when patients are discharged from hospitals or seen in outpatient settings and returned to their homes. Additional screening actions for homelessness, food insecurity, social isolation, and financial strain are listed separately.

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3. Based on Alderwick and Gottlieb.
KP’s Social Needs Network for Evaluation and Translation

SONNET aims to **optimize** the health of KP members by cultivating a national network of applied researchers and evaluators that **leverage** scientific capabilities to **inform** social health policy and practice.

**Convene**
- Bring content and methods expertise to the most important questions facing KP and the field regarding universal screening for social needs

**Communicate**
- Act as a learning and action network to support KP’s research priorities, learn across regions, and accelerate adoption of best practices

**Consult**
- Provide consultation to KP National SHP and regionally on best practices, implementation, measurement, and evaluation

SONNET was established in 2017 and is supported by Kaiser Permanente’s National Community Health Program
Addressing social health is 1 of 5 key areas in Kaiser Permanente’s enterprise strategy

 Execution plan

- Identify, predict, and incorporate social factors that impact health and contribute to inequities into member care paths
- Incorporate social factors into quality performance reporting
- Develop and implement evidence-based strategies to address social factors

 Social Health Practice

Identify  Connect  Support and Follow up

Enterprise-wide goal

Deliver superior quality and drive equitable health outcomes for our members and improve conditions for health in our communities
Connecting to resources via Thrive Local

Resource Directory

Online platform allows user to search and filter for community resources

• Includes information about a broad range of local, state, and federal programs that address basic social and economic needs
• Enables users to search for organizations based on service type, zip code, and other criteria
• Allows users to share resources with members via text, email, or print-out
• Member consent is not needed

Community Networks

Community Based Organizations (CBOs) join the platform to accept and make social referrals

• CBOs that have onboarded to use the platform are listed as “In Network” and agree to accept social referrals
• When a social need is identified, users with referral access can place a referral through Thrive Local to in-network CBOs
• CBOs that receive referrals will reach out to members directly and provide support
• Member consent is required to share their information with CBOs through Thrive Local
KP Washington’s vision for Integrated Social Health: Universal social health screening

Whole-person care elevates social health on par with physical and mental health. The goal is to make screening our patients for access to things like food, transportation, and housing as common as taking their vitals.

1. A new clinical standard to **reliably and equitably** identify members and personalize care for better outcomes.

2. Population Health that recognizes social health factors in risk-stratification and reaches out to those at risk for barriers to care.

3. Insight into our community needs and resources and informs how to make meaningful contributions to our community.
Screening for social risk – with a focus on 4 key domains

Housing instability

Food insecurity

Financial strain

Transportation

Social risk domains

Stress

Intimate partner violence

Social connection

Member questionnaire

“If you have non-medical needs (like food, housing, transportation, etc.) that are making it difficult to maintain your health and well-being, we’re here to help. This information will become part of your medical record and can be updated at any time.”
Systematic Review of Social Risk Screening Tools

https://sdh-tools-review.kpwashingtonresearch.org/
Find Screening Tools

Use the filters below to select domains and constructs to find screening tools that meet any of the selected criteria.

**Economic Stability**
- Select all

- Employment
- Income
- Expenses
- Debt
- Medical Bills
- Economic Support

**Education**
- Select all

- Early Childhood Education and Development
- High School Graduation
- Higher Education
- Language
- Literacy and Health Literacy
- Vocational Training

**Food**
- Select all

- Hunger/Food (In)security
- Access to Healthy Options

**Health and Clinical Care**
- Select all

- Access to Health Care
- Health Coverage
- Provider Availability
- Linguistic and Cultural Competency within Healthcare Systems
- Quality of Care

**Neighborhood and Physical Environment**
- Select all

- Safety, Crime and Violence
- Environmental Conditions
- Quality of Housing
- Transportation
- Parks
- Playgrounds
- Walkability

**Social and Community Context**
- Select all

- Discrimination
- Incarceration
- Social Integration
- Social Support Systems
- Community Engagement
- Immigration / Refugee Status

[Find Tools]
What whole-person care will look like for KP Washington members

Universal social health screening will enable KP Washington to provide:

**Social risk informed care**
Adjusts how traditional healthcare is provided in response to patients’ social circumstances. (Some may call this “social context informed care” or “adjusted care.”)

Screening reveals that it’s hard for Abe to find reliable transportation. So his doctor talks with him about meeting by video or phone instead of in person.

**Social needs targeted care**
Directly addresses patients’ social needs by providing referrals or immediate assistance.

Screening reveals that Carla and her young daughter are facing food insecurity. So her doctor refers her to the Community Resource Specialist, who connects Carla with available resources.
We’re working with members, care teams, and KPWA’s LHS Program to co-design and implement universal screening

Members and care teams are the true experts in designing care that is practical, sustainable, and patient-centered.

1. Design sessions with member panel
2. Design sessions with care teams at Burien and Rainier Medical Centers
3. Pilot universal screening with local implementation teams (LITs) at Riverfront and Olympia Medical Centers

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The Forgotten Domain of Implementation Science: The Outer Setting (aka Social Determinants of Health)
Consolidated Framework for Implementation Research (CFIR)

The “forgotten domain”

Intervention (unadapted)

Outer Setting

Intervention (adapted)

Adaptable Periphery

Core Components

Individuals Involved

Inner Setting

Process

CFIRguide.org
Implementation Science Centers in Cancer Control (ISC3)

OPTICC: Optimizing Implementation in Cancer Control

Funded by the National Cancer Institute
Grand challenge: Optimize evidence-based intervention implementation
### Achieving health equity with implementation science

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<th>Understand the influence of social determinants of health (SDoH) and social risk on implementation outcomes</th>
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<td>Create a common SDoH data ecosystem for all of ISC3</td>
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<td><strong>Domains</strong></td>
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<td><strong>Measures and Methods</strong></td>
<td>Attempt to standardize catchment area Utilize Existing Measures: • Community Vital Signs • Wang 6-Domain Measure</td>
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Questions, input, and discussion

Thank you!

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