SONNET
Social Needs Network for Evaluation & Translation

LEARNING HEALTH SYSTEM

OPTICC
Optimizing Implementation in Cancer Control

Social Determinants of Health, Social Risk & Social Needs

Cara Lewis, PhD | April 28, 2021

Kaiser Permanente Washington Health Research Institute

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Definitions: SDOH, Social Risks, Social Needs

- **Social Determinants of Health (SDOH)[1]:** "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[2]:** "Specific adverse social circumstances that are associated with poor health, like social isolation or housing instability."

- **Social Needs[3]:** 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.

[1] World Health Organization, Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Commission on Social Determinants of Health final report. Published 2008. https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=365271ACE2052888542881700EEDCA8B?sequence=1.

[2] Alderwick and Gottlieb https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/

[3] Based on Alderwick and Gottlieb.

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KP's Social Needs Network for Evaluation and Translation

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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.

Enterprise-wide goal

Deliver **superior quality** and drive **equitable health outcomes** for our members and improve conditions for health in our communities

1	Convene	Bring content and methods expertise to the most important questions facing KP and the field regarding universal screening for social needs
2	Communicate	Act as a learning and action network to support KP's research priorities, learn across regions, and accelerate adoption of best practices
3	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

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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

Enterprise-wide goal

Deliver **superior quality** and drive **equitable health outcomes** for our members and improve conditions for health in our communities

Social Health Practice

Identify

Connect

Support and Follow up

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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, sate, 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

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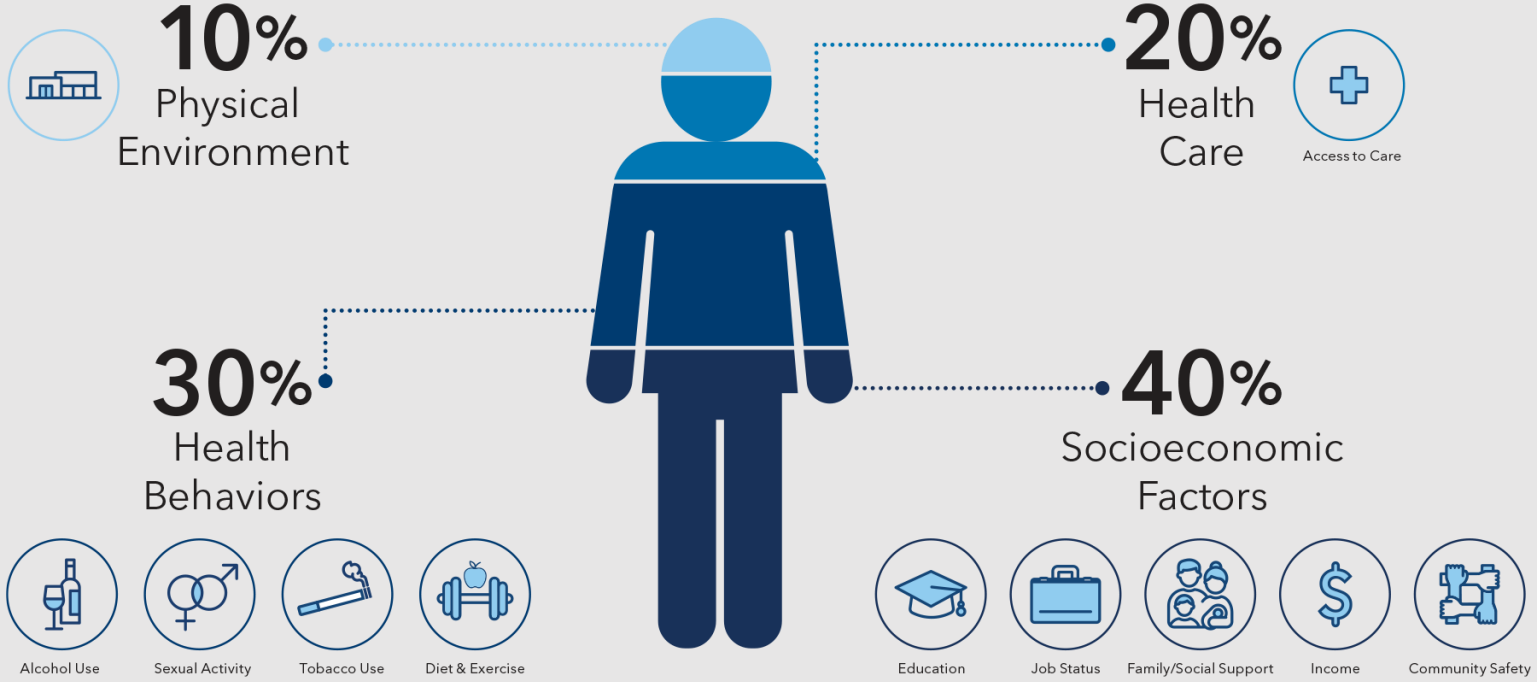
KP Washington's vision for Integrated Social Health: Universal social health screening

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***.

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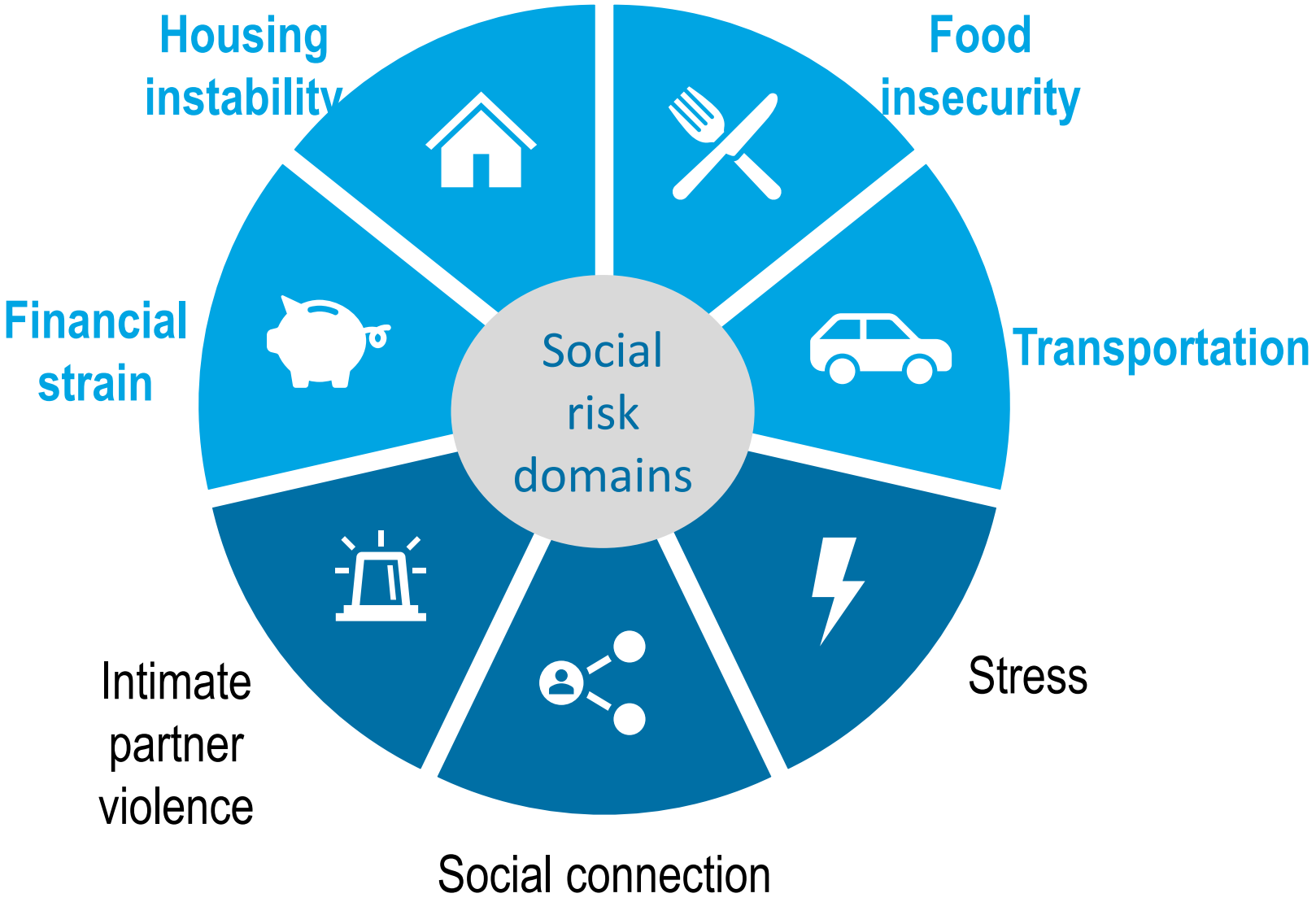
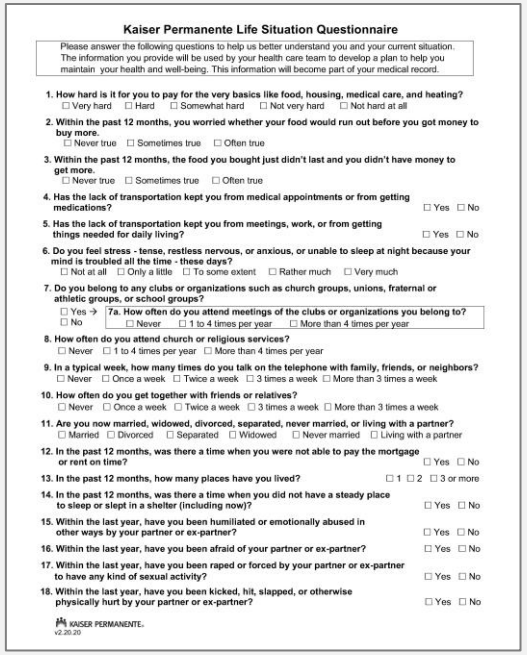
Screening for social risk – with a focus on 4 key domains



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**."



Kaiser Permanente Life Situation Questionnaire

Please answer the following questions to help us better understand you and your current situation. The information you provide will be used by your health care team to develop a plan to help you maintain your health and well-being. This information will become part of your medical record.

1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard ☐ Not hard at all
2. Within the past 12 months, you worried whether your food would run out before you got money to buy more.
☐ Never true ☐ Sometimes true ☐ Often true
3. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
☐ Never true ☐ Sometimes true ☐ Often true
4. Has the lack of transportation kept you from medical appointments or from getting medications? ☐ Yes ☐ No
5. Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living? ☐ Yes ☐ No
6. Do you feel stress - tense, restless nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?
☐ Not at all ☐ Only a little ☐ To some extent ☐ Rather much ☐ Very much
7. Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
☐ Yes → 7a. How often do you attend meetings of the clubs or organizations you belong to?
☐ No ☐ Never ☐ 1 to 4 times per year ☐ More than 4 times per year
8. How often do you attend church or religious services?
☐ Never ☐ 1 to 4 times per year ☐ More than 4 times per year
9. In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?
☐ Never ☐ Once a week ☐ Twice a week ☐ 3 times a week ☐ More than 3 times a week
10. How often do you get together with friends or relatives?
☐ Never ☐ Once a week ☐ Twice a week ☐ 3 times a week ☐ More than 3 times a week
11. Are you now married, widowed, divorced, separated, never married, or living with a partner?
☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married ☐ Living with a partner
12. In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time? ☐ Yes ☐ No
13. In the past 12 months, how many places have you lived? ☐ 1 ☐ 2 ☐ 3 or more
14. In the past 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? ☐ Yes ☐ No
15. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? ☐ Yes ☐ No
16. Within the last year, have you been afraid of your partner or ex-partner? ☐ Yes ☐ No
17. Within the last year, have you been raped or forced by your partner or ex-partner to have any kind of sexual activity? ☐ Yes ☐ No
18. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? ☐ Yes ☐ No

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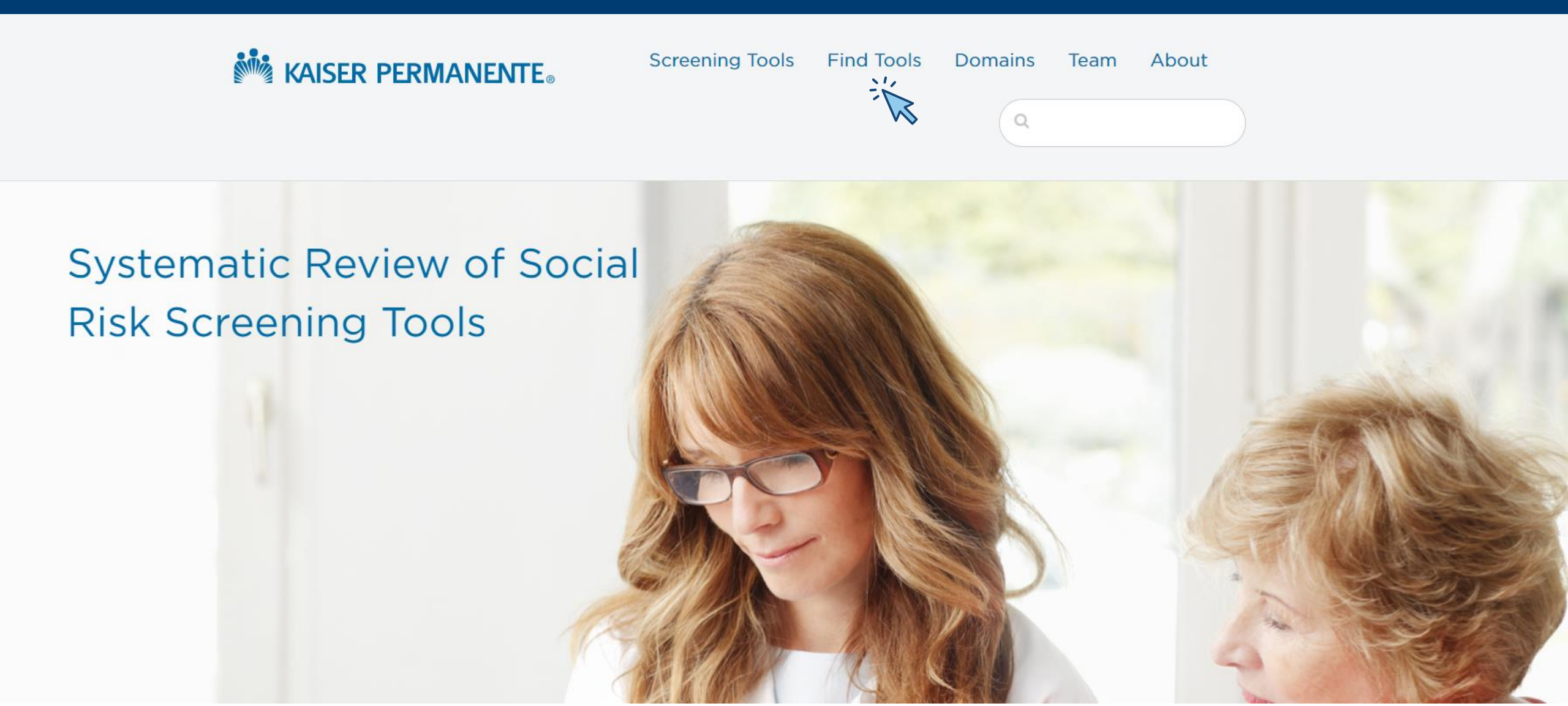

https://sdh-tools-review.kpwashingtonresearch.org/

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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.

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We're working with members, care teams, and KPWA's LHS Program to co-design and implement universal screening

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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

	May	June	July	Aug	Sept	Oct	Nov	Dec	2022
Prework									
Member design launch and ongoing work	*~mid-May* →								
Care team design sessions		*90 minutes ~June 1-11*							
LIT launch and ongoing work				*90-minute kickoff meeting Weekly meetings for 4-6 months* →					
									Scale systemwide

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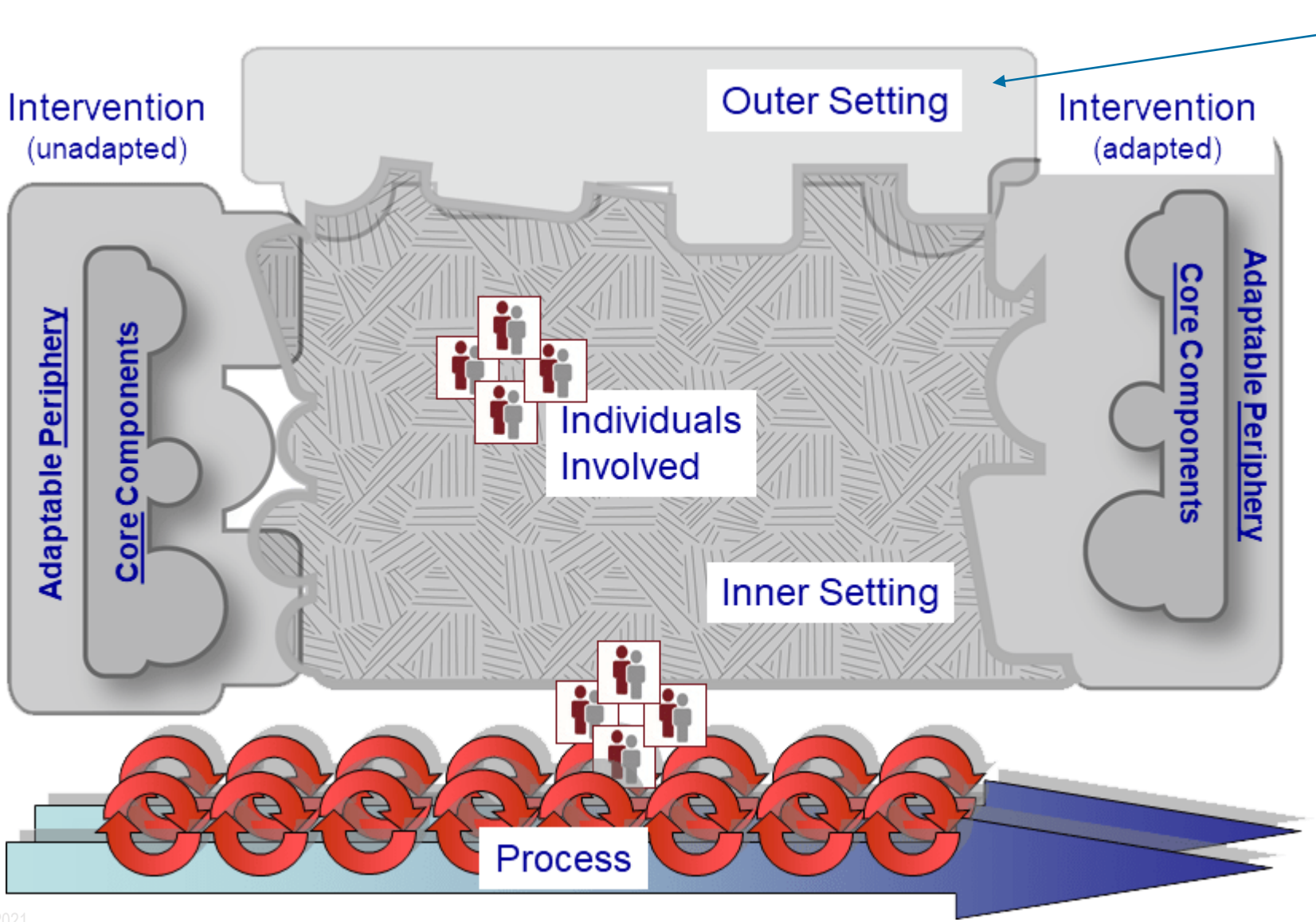
The Forgotten Domain of Implementation Science: The Outer Setting (aka Social Determinants of Health)

Consolidated Framework for Implementation Research (CFIR)



The “forgotten domain”

CFIRguide.org

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Implementation Science Centers in Cancer Control (ISC3)

OPTICC: Optimizing Implementation in Cancer Control

ISC³

Funded by the National Cancer Institute

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Grand challenge: Optimize evidence-based intervention implementation

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Achieving health equity with implementation science

Goal	Understand the influence of social determinants of health (SDoH) and social risk on implementation outcomes
Process	Create a common SDoH data ecosystem for all of ISC3
Domains	• Food Environment • Physical Environment • Economic Environment • Social Environment • Health Care Environment • Cancer Risk – Behavioral Screening Environment • Cancer Risk – Policy Environment
Measures and Methods	Attempt to standardize catchment area Utilize Existing Measures: • Community Vital Signs • Wang 6-Domain Measure

Questions, input, and discussion

Thank you!

Cara.C.Lewis@kp.org @CaraCLewis

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