ADDRESSING
SOCIAL DETERMINANTS OF HEALTH
IN A HEALTH CARE SETTING

JULY 2017

INTRODUCTION

The structural conditions in which Coloradans live, work, learn, and play have a larger impact on their ability to live a healthy life than the health care system does. To achieve health equity, we must ensure these conditions, known as social determinants of health (SDOH), don't determine a person's health outcomes or their access to timely, quality, affordable health care.

Throughout Colorado, new approaches are being tested to identify and address SDOH in health care settings. These interventions include screening and referral tools, population data, risk stratification, and workforce interventions—to name a few.

To better understand the varied approaches to integrating SDOH interventions into health care settings, we completed ten key informant interviews with project leaders. This report includes summaries of each studied intervention, classifications by their structures, and high-level recommendations for successful integrations.

LANDSCAPE OF **SDOH INTERVENTIONS** IN COLORADO

Three categories of interventions emerged from the interviews, but many interventions do not fit cleanly into one distinct category. It is also important to note that **this is not an exhaustive list of SDOH interventions in Colorado**.

PROVIDER-BASED

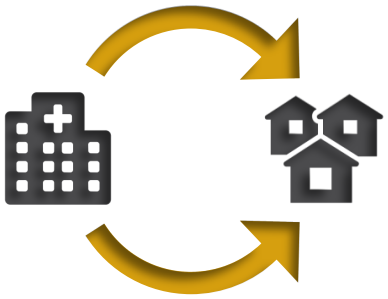
These originate from within a hospital or clinic. They generally use a screening process to identify SDOH affecting a patient's health, and then make referrals to appropriate community resources or case management services. One strength is their access to patients for screening purposes.

SYSTEMS-INTEGRATED

These promote collaboration between hospitals/clinics and communities. They can lead to improved screening, service alignment, referrals, and data collection and usage, which can improve health outcomes and reduce cost. One strength is their ability to collaborate at a high-level across systems.

COMMUNITY-BASED

These originate from organizations that work closely with community members. They generally work with a specific community, identifying health concerns and making connections to resources. One strength is their understanding of the population they serve and the SDOH barriers facing them.



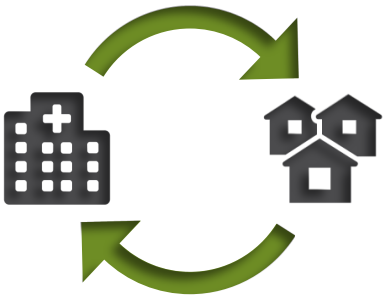
PROVIDER-BASED INTERVENTIONS

21st Century Health at Denver Health uses a segmentation/risk stratification technique to assign patients to four tiers according to the complexity and severity of their health needs. Then, patient navigators help patients manage their health, and clinical social workers connect them with community resources.

BUILD Health Challenge at Colorado Children's Hospital engages families during the first 1,000 days of a child's life to identify and address SDOH, understand the policies causing these inequities, and develop an action plan for data sharing with primary care practices.

Kaiser Permanente Colorado and Hunger Free Colorado partnered to address food insecurity. Kaiser Permanente providers screen patients for food insecurity. If patients screen positive, they are contacted by Hunger Free Colorado, who helps connect them to resources.

Whole Health, LLC supports repeat emergency room utilizers. Community Health Workers work with patients to modify behaviors and coordinate services with hospitals and mental health centers, reducing unnecessary visits and hospitalizations.



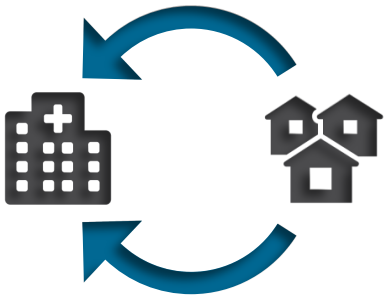
SYSTEMS-INTEGRATED INTERVENTIONS

Colorado Governor's Office Homeless of Initiatives manages policies and programs that end and prevent homelessness. Current interventions include the Pathways Home Supportive Housing Toolkit, identifying long-term services funding, piloting housing for parolees, and running a joint initiative to increase permanent supportive housing.

Colorado SOURCE will be a statewide database of up-to-date community resources. Once the project is complete, it will allow physicians to assess patients' needs, create profiles for them, and connect them with a set of appropriate resources.

Denver Regional Council of Governments (DRCOG) was awarded $4.5 million to implement the Accountable Health Communities Model. This grant will test service delivery approaches that link beneficiaries with community services.

Rocky Mountain Health Plans was also awarded $4.5 million to implement the Accountable Health Communities Model. This grant will test if addressing social needs through referral and community navigation can reduce costs and utilization, and improve quality and delivery.



COMMUNITY-BASED INTERVENTIONS

CREA Results is a grassroots organization that harnesses the talents of community members in eliminating health disparities and environmental poverty through local action. Promotores de Salud, or Community Health Workers, talk with and organize community members, emphasizing accountability. Promotores also refer people to available resources and help them navigate the local health care system. CREA Results is particularly focused on Latino immigrants.

Native American Cancer Research Corporation (NACR) and Native American Cancer Interventions (NACI) work within Colorado's Native American communities to reduce cancer incidence and mortality. They utilize patient navigators to provide cancer screenings in the community and technical assistance to others who work with Native Americans. One of the strengths of NACR/NACI patient navigators is that they work with both communities and medical providers.

STRATEGIES FOR SUCCESSFUL INTEGRATIONS

In addition to information about the categories of SDOH interventions, key informant interviews also revealed several strategies that could improve the integration of SDOH interventions into health care settings. These strategies cut across the categories of SDOH interventions and were highlighted in multiple interviews.

1. **ELIMINATE POWER DIFFERENCES BETWEEN ORGANIZATIONS**

   There is a large divide between medical providers and community organizations; they operate within different cultures and environments. Differences in funding, resources, education, and staff salaries are apparent. Organizations must value the work of their partners and honestly acknowledge their own strengths and limitations.

2. **INCREASE FUNDING FOR SDOH INTERVENTIONS**

   There is a general lack of funds to support SDOH interventions. Many SDOH rely on grant funding, which is not always sustainable and makes scaling interventions a challenge. A substantial financial commitment is essential.

3. **REORGANIZE WORKFLOW TO INCORPORATE SDOH INTERVENTIONS**

   SDOH intervention work should not be casually added to an employee's existing responsibilities, but should be part of comprehensive workflow strategy. Staff should also receive appropriate training to implement SDOH interventions.

4. **IMPROVE DATA COLLECTION AND EVALUATION**

   There is a lack of data to evaluate the impact of SDOH interventions on population health. There are also no common definitions of success. Current data is often not available in real-time, limiting its usefulness in connecting patients with the most appropriate community resources. Organizations should improve data collection and evaluation methods.

CONCLUSION

These interventions have shown that, through collaboration, it is possible to mitigate the structural barriers Coloradans face to achieving their best health. Although most projects are new enough to not have robust evaluation results, Kaiser Permanente and Hunger Free Colorado have been able to demonstrate that they've increased the percentage of referred patients receiving resources from 5% to 78% through continual refinement of their intervention. As SDOH interventions become more common and established, it will be critical to evaluate their impact and make adjustments as needed. This redefinition of "health care" to include addressing the social determinants of health provides our greatest new opportunity to transform the health and lives of Colorado's patients, and we look forward to seeing more of the results.