ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

COMPETENCY ORIENTATION GUIDE

Competency: Integrating Social Determinants of Health (SDOH) Into Health Care Delivery
Competency: The Committee on Integrating Social Determinants of Health (SDOH)

JULY 2020

BACKGROUND

The Accountable Care Learning Collaborative (ACLC) is a non-profit dedicated to accelerating the transition to accountable care by identifying the care delivery competencies needed for providers to succeed in risk-bearing payment models. The ACLC's Competency Orientation Guides (COGs) give an overview of a single competency and break it down into more digestible components. Each COG represents the distilled insights from the deliberations of a dedicated committee comprised primarily of leaders from provider organizations, but also industry partners, and ACLC staff. In this case, this COG was developed by the Committee on Integrating Social Determinants of Health (SDOH) (the "Committee") which convened between October 2019 and January 2020.

Competency Framework

Competency: Integrating SDOH into health care delivery.

1. Measuring & tracking SDOH impact on designated populations over time
2. Engaging in external health system and community-based partnerships
3. Scaling up programs and demonstrating return on investment (ROI)*
4. Adjusting internal workforce and resource needs*

*Aspects to be considered in future committees

COMPETENCY IMPORTANCE & CONTEXT

The significance of SDOH to an individual's overall health and well-being has gained attention over the last several years. In particular, as we move from fee-for-service (FFS) to value-based payment arrangements, health care providers are increasingly interested in implementing care delivery models that address SDOH to lower costs and improve health outcomes. However, health care providers must understand the social risk factors in their particular population and cannot rely on a 'one-size fits all' approach.

To make the concept more approachable and concrete for health system leaders, the Committee, through pre-session interviews and committee deliberations, developed a competency framework that includes four sub-competencies (enumerated top right). While the third and fourth competencies were deemed very important, and likely even pre-requisites, it was the Committee's preference to focus on tracking SDOH impact and engaging in partnerships (sub-competencies 1 &2).

IMPORTANT TERMS

The Committee asserts that definitions are especially important when talking about the health system's role in addressing SDOH. Because social care has not historically been included in the wheelhouse of a health care provider's responsibility, aligning on definitions is an important part of determining a provider's role in addressing a patient's SDOH. The Committee agreed to the Healthy People 2020 definition of SDOH: "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

SUB-COMPETENCIES & COMMON ELEMENTS

A: Measure and track SDOH impact on designated populations over time

Committee Insights:

- Standardized questions in screening tools are important as they help coordinate focus on identifying and addressing SDOH needs. In addition, questions should address SDOH domains (e.g., food, housing, transportation, etc.) where evidence links to health outcomes.
- As providers conduct SDOH screening, they should be aware of patient eligibility for services and the capacity of their organizations to act and respond appropriately to patients' SDOH needs. Providers need to be equipped to connect patients with tools and resources addressing SDOH needs when identified (rather than simply checking off a box as they ask SDOH screening questions).
- Providers should have cultural competency and cultural humility when interacting with patients, particularly concerning SDOH needs which are often personal and sensitive.
- It is critical to build a trusted relationship between the provider and the patient when collecting and sharing patient data – especially when it goes beyond data that patients are accustomed to sharing.
- It is important to document the services and actions that occur after a positive screening result. In particular, understanding what is happening in terms of employing a health system's own team can be used at a strategic/planning level to know what types of interventions to invest in and which ones are the most effective in addressing some of these issues.
- Organizational awareness regarding data limitations and availability, as well as the state of technological capabilities (specifically with regard to data and analytics), is paramount.

- The interplay between social needs and behavioral health is significant and partnerships between health and the social sector should include responsibility for providing adequate behavioral health services.

Challenges & Responses:

- **Challenge:** Providers run the risk of having a narrow view of patient population needs when they do not consider sources of data beyond what is obtained through social risk screening.
- **Response:** Provider organizations can utilize publicly available resources, Community Health Needs Assessments, and other resources to ensure a more complete understanding of their patient populations' needs.

Potential Qualitative Competency Indicators:

- SDOH tracking reports are generated automatically through existing EHR data collection and validated external sources.

B: Engage in SDOH-specific health system and community-based partnerships

Committee Insights:

- Each community will have a different fingerprint of community-based organizations (CBOs) and faith-based organizations available, and not every CBO or faith-based organization will have the same capabilities. Some vendors can be used to help provider organizations identify what is available.
- There is no shortcut to getting to know a community. Whether or not a provider organization partners with CBOs, it is beneficial to both the CBO and provider organization to get to know each other. Establishing these relationships will ultimately help form future partnerships.
- A provider organization demonstrating a long-term commitment to the partnership is important so that CBOs are confident that the partnership will be worthwhile and lasting.
- Larger CBOs that are better resourced and have experience dealing with a variety of problems are typically ideal organizations for providers to partner with, though not every community has one.
- In many communities where trust between the social service sector and the health care sector may be lacking, a trusted broker (a trusted broker could be a philanthropic organization or non-profit organization) who plays an intermediary role between providers, payers, and CBOs may be a good resource to bridge that relationship.
- Holding a private forum on various topics is one way to bring CBOs and provider organizations together to build relationships and trust (even holding period meetings with CBOs can help build trust).
- It is helpful when CBOs feel like they are part of a shared effort and have a say in funding allocation and/or project implementation.

Challenges & Responses:

- **Challenge:** The health and social sectors view their roles and define success differently.
- **Response:** Ensure upfront and continual communication around goals and clearly delineate responsibilities of each partner organization.

Potential Qualitative Competency Indicators:

- Leadership has positive relationships with all CBOs in their market regardless of whether a partnership exists.
- Steering committees have CBO representation.

GENERAL RESOURCES FOR FURTHER EXPLORATION:

- The National Academies of Sciences, Engineering, and Medicine report on Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health (link).
- Health Affairs Blog on Defining Success In Resolving Health-Related Social Needs (link).
- The Commonwealth Fund's Return on Investment Calculator for Partnerships to Address the Social Determinants of Health (link).
- The American Hospital Association's guidance on ICD-10 Coding for Social Determinants of Health (link).

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