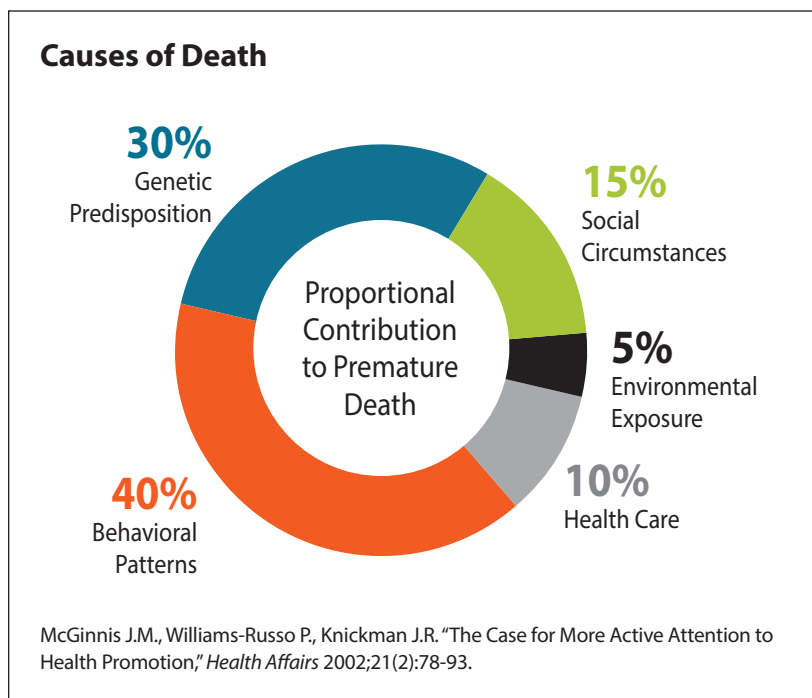


# CIN Partners Share:

## More Than Health Care to Improve Health: Addressing Social Needs Through Community Partnerships

**Main Takeaway:**  
Good health requires far more than good health care. Environmental, economic, social, and behavioral factors all play a role.

Decades of research have shown that good health requires far more than good health care. While access to high-quality clinical care is essential for good health, at a population level, medical care prevents only 10% of premature mortality.



Having far more impact are health behaviors, such as tobacco use; the physical environment, such as water quality; economic factors, such as education and employment status; and social support. Collectively, these nonmedical factors are termed the "social determinants of health" because they have been found to profoundly influence health outcomes and life expectancy.

Despite the importance of social determinants of health, the US health care delivery system has evolved to focus on clinical care, often ignoring major everyday social factors that profoundly impact people's health, such as violence, poverty, or lack of healthy

food. Recently, policymakers and health care stakeholders have called attention to this inconsistency and initiated new programs to address patients' social needs.

The partner organizations of the California Improvement Network (CIN) met in October 2016 to discuss efforts to address patients' social needs through partnerships with community-based organizations. CIN partners heard from the following organizations:

- San Diego's **La Maestra Community Health Centers** shared its approach for addressing food security.
- The **YWCA (Young Women's Christian Association) of San Gabriel Valley** and **ChapCare** (a Federally Qualified Health Center) discussed their partnership to support families experiencing violence.
- The **Oregon Primary Care Association (OPCA)** talked about how primary care practices can gather sensitive information from patients.

## Identifying Social Needs

### *How can health care organizations collect information about the social needs of their patients/members?*

Information on patients' social needs can come from patients themselves (housing status, education level, social supports) and from community-level data sources (water quality, census-tract median income). The gathered information is used to address community, family, and individual needs.

Emerging research and increased national attention on the impact of the social determinants of health have given rise to a number of new screening tools to help health care teams identify patients with risks or unmet needs or both. Most of these tools focus on the key domains identified by the Institute of Medicine (IOM) in a 2014 report (see Resources list on page 7 for a link): alcohol use, race and ethnicity, residential address (for census-tract median income), tobacco use and exposure, depression, education, financial resource strain, intimate partner violence (for women of reproductive age), physical activity, social connections and social isolation, and stress.

CIN partners looked at five of these tools:

1. PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool developed by the National Association of Community Health Centers
2. Kaiser Permanente's "Your Current Life Situation" questionnaire
3. A variation of Kaiser's questionnaire developed by two Northern California health centers: West County Health Centers and Petaluma Health Center
4. California School-Based Health Alliance's tool for use with school-age patients up to age 21
5. Patient-Centered Assessment Method tool

These tools include most of the IOM-recommended domains, and each adds additional measures. For example, the PRAPARE tool asks about immigration status, and the Kaiser Permanente tool includes an item about dental care.

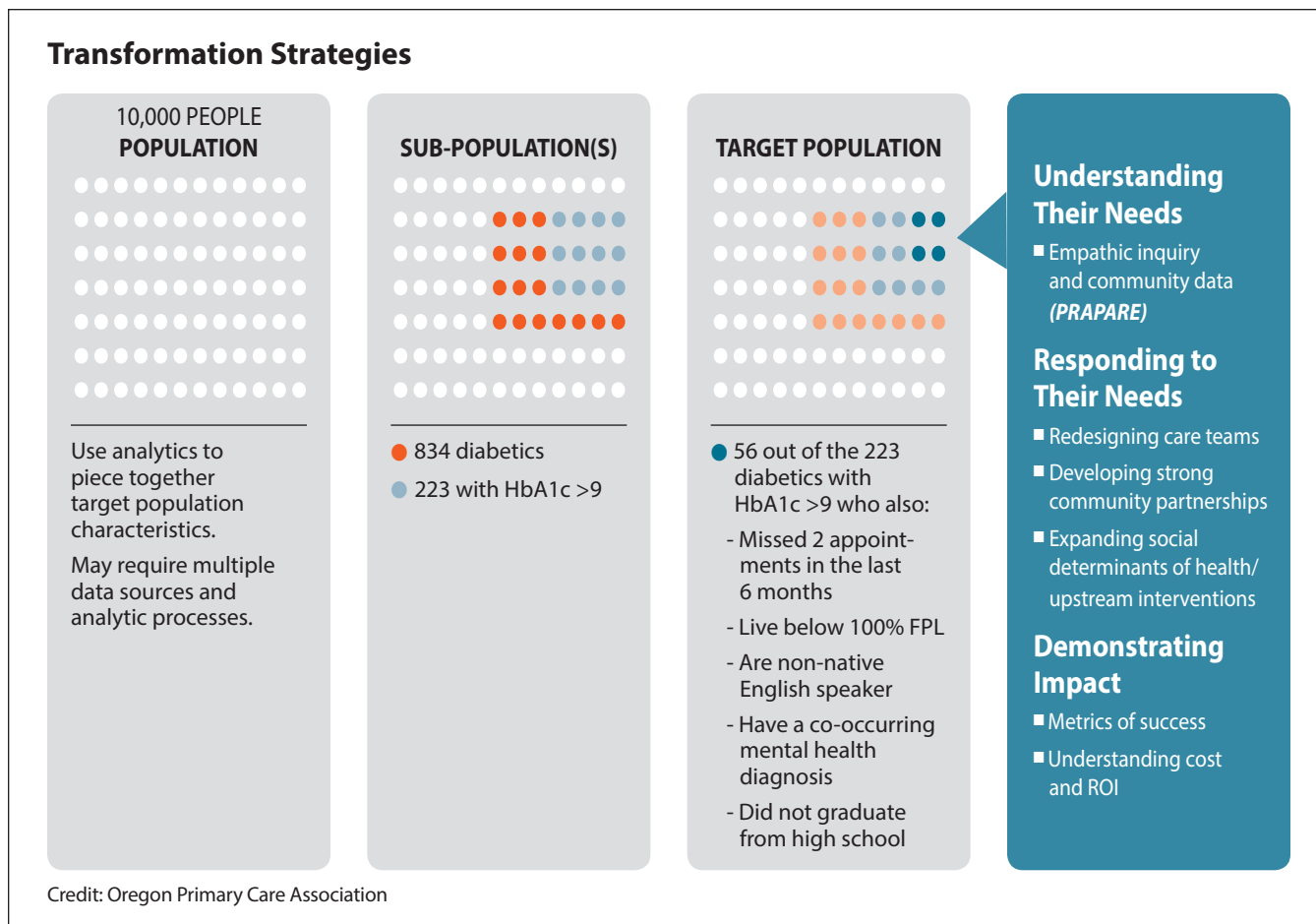
Laurie Francis, senior director of innovation at **OPCA**, led a discussion about barriers to good health and health equity, such as poverty and racism. At OPCA, providers are trained to interview for and listen carefully to the patient's priorities, and then address the identified social determinants of health in clinical care encounters and beyond. OPCA asked staff in 14 of its health centers to use the PRAPARE screening tool, practicing with just three questions and 10 patients, and going forward, using an approach they call "empathic inquiry," which draws from the principles of trauma-informed care and motivational interviewing to learn more about the patient's life. For example, providers ask permission before asking sensitive questions.

Using an empathic, patient-directed approach to collect information on social needs may require multiple discussions with a patient or require acceptance of an incomplete survey if a patient chooses not to discuss all of the sensitive issues included in the screening tool. While a patient-directed approach takes time, it has been shown to surface important needs in a respectful manner. When done well, the conversation itself is a therapeutic intervention, even before any additional care and services are provided as a result of the discussion.

What are examples of social needs that can impact the health of individuals, families, and communities?

- Income
- Housing
- Food
- Education and employment
- Social support
- Public safety
- Residential segregation
- Transportation options

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Francis shared a hypothetical example of a patient scenario where the PRAPARE tool is expected to be useful. A community health center patient with high blood pressure sees her primary care provider, who treats her with the usual medical approach: medications and advice on cutting back salt and making other lifestyle changes. A conversation about her life situation could bring into the picture the fact that the patient is extremely stressed because of her family’s current lack of housing and her inability to keep her children fed and supervised. This additional information would allow the health care team to connect the patient with housing resources and other social services to address her urgent needs, and also to acknowledge how stressors affect physical health concerns like blood pressure.

**What are the most pressing social needs facing CIN partner organizations’ patients and members?**

CIN partner organizations, particularly those in the safety net, said their patients’ highest-priority needs were affordable housing and access to healthy food.

**How are partners responding?**

To help increase their patients’ access to healthy food, partners are referring individuals to CalFresh, the federal Supplemental Nutrition Assistance Program, and following up to ensure that they have applied. Some partners can access CalFresh data to track the status of referrals and acceptance to the program. This type of follow-up is called a “closed-loop referral.”

To help patients with housing issues, CIN partners are working closely with housing agencies and providing them closed-loop referrals. In San Francisco, where residents face a particularly challenging housing shortage, many organizations, including CIN partner San Francisco Health Plan, are working to create an integrated referral platform for housing resources, which would prioritize applicants based on factors such as duration of homelessness, medical acuity, veteran status, and number of children.

In addition, partner organizations are working to better integrate addiction treatment, including outpatient treatment groups and referrals to residential treatment, into primary care. Most partners understand these needs as high priorities based on informal data collection and community-level information; no specific efforts to collect data about addiction services from their patient/member populations were conducted.

## Partnership in Action: Providing Access to Healthy Food

**La Maestra Community Health Centers** is a Federally Qualified Health Center in southern San Diego with four freestanding clinic locations, four school-based health centers, and a mobile clinic. Dental care is provided at seven of its sites. La Maestra (“the teacher”) was established as a social service and community education organization before adding medical care services in 1990. Its main clinic site in the City Heights area of San Diego is home to resettled refugees from more than 60 countries. This diverse patient population and the clinic’s proximity to the US-Mexico border have influenced the services provided and the care team composition at La Maestra.

Sonia Tucker, director of quality improvement at La Maestra, shared the clinic’s multifaceted approach to helping patients and families access healthy food, particularly for those with a medical condition with a nutritional element, such as hypertension or kidney disease. In setting up this program, La Maestra leaders discussed whether to develop nutrition-related services in-house or work with organizations in the community to deliver these services. La Maestra chose to do both. La Maestra partners with local food banks Feeding America and the San Diego Food Bank; each organization plays a specific role, as detailed below. In addition, La Maestra partners with Leah’s Pantry, a nonprofit organization that provides nutrition programs to underserved populations.

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La Maestra’s role:

- Diagnose and treat medical needs related to nutrition, such as diabetes and hypertension.
- Screen patients for food insecurity.
- Refer patients to CalFresh and monitor CalFresh data to close the referral loop when needed.
- Provide a food pantry program for patients (food is supplied by Feeding America and the San Diego Food Bank, and paid for by La Maestra).
- For patients with specific medical needs, package food from the food bank by medical condition; patients pick up packages of food specifically assembled for their needs (e.g., low-salt), and receive recipes for flavorful meals with minimal additions of problematic ingredients like sodium or fat.
- Offer nutrition classes that are culturally appropriate and age-specific.
- Teach cooking classes that feature healthy recipes to patients.

The food bank’s role:

- Provide food in bulk to La Maestra’s food pantry program.
- Refer clients to La Maestra for food resources tailored to medical needs, and for nutrition education for clients who are La Maestra patients.
- Share data on La Maestra patients’ use of food bank services.

## Partnership in Action: Addressing Family Violence

The **YWCA of San Gabriel Valley** is a nonprofit organization founded in 1935 located in the Los Angeles County city of Covina. The YWCA offers services and programs for older adults, teens, and victims of domestic violence. Its domestic violence services include counseling, a 24-hour hotline, and a domestic violence shelter.

**ChapCare** is a Federally Qualified Health Center that provides medical, dental, and behavioral health care in eight clinic locations in the San Gabriel Valley. ChapCare serves almost 15,000 patients per year and has opened a new clinic site in Los Angeles County in each of the past four years.

ChapCare CEO Margie Martinez and behavioral health director Karen Tinsley joined Ana Interiano, the YWCA of San Gabriel Valley's director of domestic violence and prevention services, to share the history, operations, and goals of their partnership.

In 2014, the YWCA of San Gabriel Valley approached ChapCare, a primary care organization, to partner with them to improve services for survivors of intimate partner violence and their families. The resultant bidirectional referral relationship is a model for how primary care organizations can enhance their capacity to address patients' social needs through collaboration. Technical assistance is supported by a grant from the Blue Shield of California Foundation. The partnership has improved the health and safety of ChapCare patients experiencing intimate partner violence.

*Working together has improved both organizations' knowledge and appreciation of the interconnections between health, safety, and wellness.*

There have also been some unexpected results: Some ChapCare staff members have sought help for their own experiences with family violence, and YWCA staff have been able to connect clients with unmet medical needs directly to a primary care medical home. Working together has improved both organizations' knowledge and appreciation of the interconnections between health, safety, and wellness.

ChapCare's role:

- Educate all health center staff on intimate partner violence signs, trauma-informed systems, and office safety protocols (in the event that abusers seek their victims or information about their victims at the clinic).
- Identify patients who need intimate partner violence counseling or emergency shelter services.
- Refer patients to YWCA counseling services and/or shelter services, and follow up to close the referral loop.
- Coordinate shared care for referred patients who engage with YWCA services.
- Serve as a resource on health care needs for YWCA staff, including providing health and nutrition-related trainings at the YWCA.

YWCA's role:

- Provide counseling and shelter services for intimate partner violence victims and survivors.
- Staff a 24-hour phone help line.
- Colocate staff at ChapCare site to support ChapCare staff and to take warm handoffs of patients requiring services for intimate partner violence.
- Educate ChapCare staff about the signs of intimate partner violence and how to assess patients' needs for services thoroughly and sensitively.
- Coordinate care and services for shared clients/patients.
- ChapCare and the YWCA participate together in a regional learning community to reduce interpersonal violence.

Their shared role in these efforts:

- Coordinate partnerships with over 30 local and regional law enforcement agencies, including multiple local police departments and the Los Angeles County Sheriff's Department.
- Train law enforcement officers on their role and best practices in working with victims of intimate partner violence.
- Advocate for more and better-coordinated services, and provide expert consultation to many agencies, including the Los Angeles County Department of Mental Health and its contracted provider organizations; health plans including LACare, HealthNet, and CareFirst; and other community-based organizations.

## Building Effective Partnerships

### *What does it take to build an effective partnership between a health care organization and a community-based organization?*

Presenters agreed that effective partnerships require clear roles and responsibilities, and frequent communication. To achieve this, the YWCA of San Gabriel Valley, ChapCare, and La Maestra Community Health Centers establish detailed memoranda of understanding to specify the goals of each partnership and the expectations of each partner organization. Organizations also invest a substantial amount of time in meetings and ongoing communication between partner staff members to review shared patients and clients, plan for the financial sustainability of their collaborative efforts, and reinforce coordination roles and workflows at the level of their frontline program staff.

### *What strategies can health care organizations use to gain commitment from community-based organizations?*

CIN partners emphasized the importance of understanding the organizational missions and business models of community organizations, particularly their revenue streams. Presenters also recommended understanding what drives community organizations to partner with medical organizations and establishing a sense of mutual urgency and mutual benefit. In many cases, data are a beneficial outcome of establishing a partnership. For example, the food bank, in its partnership with La Maestra, and the YWCA, in its partnership with ChapCare, each use patient data to demonstrate the impact of their work to funders.

### *How can health care organizations monitor and measure the impact of partnerships intended to address patients' social needs?*

CIN partners are developing metrics to understand the effectiveness of partnership activities, as well as systems to manage daily workflows for referrals and care coordination. One key challenge is how to exchange data on shared patients and clients. Presenters and partners reported two key strategies to overcome this challenge:

1. **Using EHRs:** ChapCare uses its electronic health record (EHR) to track data from universal screening for intimate partner violence. ChapCare adds "known violence" to a patient's main medical problem list in the EHR and tracks referrals to the YWCA in the EHR.

The PRAPARE survey for community health centers is available in an EHR template format for four commonly used EHR systems. Once incorporated into the EHR, data on social needs can be used to coordinate care at the patient level, and also for population-level needs assessment, much like the two levels of disease registry use for chronic conditions like diabetes.

2. **Purple Binder:** Several CIN partner organizations use Purple Binder, software that helps manage referrals to social service providers. Purple Binder also updates information on social service providers so health care organizations can stay abreast of what services are available for referral. (See Resources list on page 7 for a link.)

### ***What are the keys to sustaining community partnerships?***

CIN partners identified several keys to sustainability:

- Clear shared understanding of the goals of the partnership
- Ongoing executive-level commitment to the work of the partnership
- Investment of time in the ongoing operations of the partnership, including regular meetings and the use of tools like communications plans and documented care and service coordination pathways
- Continued investment in personal relationships among staff at partner organizations, which can be threatened by staff transitions and competing priorities
- Continual updates between partners about overall priorities and challenges for each organization as well as inter-partner support needed to maintain their respective roles in the partnership
- Collaborative effort to maintain funding for the partnership, through grants or other means

ChapCare CEO Margie Martinez highlighted the importance of ongoing staff training to maintain the work of the partnership: “Make sure your internal systems support your staff with access to the information needed to make referrals and clear collaborative services pathways.” In the case of support for intimate partner violence survivors, staff require education and training on trauma and trauma-informed systems of care. This type of training helps staff to serve patients well and to manage their own issues related to intimate partner violence. YWCA staff have received training on health care issues, which has helped them become more effective partners.

***“Make sure your internal systems support your staff with access to the information needed to make referrals and clear collaborative services pathways.”***

— ChapCare CEO Margie Martinez

## **Resources**

The Institute of Medicine’s “Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2”

<http://nationalacademies.org/hmd/Reports/2014/EHRdomains2.aspx>

The National Association of Community Health Center’s PRAPARE Implementation and Action Toolkit

<http://nachc.org/research-and-data/prapare/toolkit/>

Video: “Empathic Inquiry: A Patient-Centered Approach to Social Determinants of Health Interviewing” from the Oregon Primary Care Association

[www.youtube.com/watch?v=9rfmfsMMeEU](http://www.youtube.com/watch?v=9rfmfsMMeEU)

Domestic Violence Health Care Partnership

[www.futureswithoutviolence.org/health/dv-health-care-partnership-project/](http://www.futureswithoutviolence.org/health/dv-health-care-partnership-project/)

Purple Binder software platform to support social services referrals and coordination

[www.purplebinder.com/](http://www.purplebinder.com/)

