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An Evolving Roadmap to Address Social Determinants of Health

January 16, 2019 | **Damon Francis, M.D.**

Today, health care providers and system leaders understand that the health of our patients is driven in large part by the conditions in which they are born, grow, live, work, and age — what we call the social determinants of health. A growing body of research shows that integrating social services into health care delivery **can improve health and reduce spending**.

But so much remains unknown. How do we determine what social services patients might need? How can we leverage care teams to improve patients' social circumstances? How can we address the social determinants of health without adding to an administrative and measurement burden that is already **unacceptably high for health providers**?

To help us learn from what has already been done and to guide us toward answers for these critical questions, a group of health system leaders from across the country came together in 2015 to examine how health care organizations address social determinants of health as a standard part of quality care. This workgroup developed a framework to guide and support fellow health care and community leaders working to establish or expand effective social determinants of health initiatives.

That framework, called the ***Essential Needs Roadmap***, serves as a gateway to a curated library of tools, best practices, implementation guidance, and other dynamic content. Both the roadmap and a broader *Resource Library* are organized into six "drivers" that are key to successful social needs strategies in clinical settings:

1. **Patient Identification and Screening:** Which patient population will you target and how will you assess their social needs?
2. **Navigation and Resource Connections:** For which specific social needs will you offer support? What level and type of support?
3. **Social Health Team and Workflow:** Who will provide resource support for patients? How will this integrate with broader clinical processes?
4. **Data and Evaluation:** How will you know how much to invest in social supports in the long run? How will you know how to maximize the impact of this investment?
5. **Community Partnerships:** What community-based organizations are critical to the health of your members? How will you partner with them to continually improve access to resources?
6. **Leadership and Change Management:** Have you identified a social needs champion with the ability to allocate resources? Do you have the necessary buy-in from key stakeholders?

As the leaders who developed the *Roadmap* anticipated, the tool has already begun to evolve.

For example, thanks to lessons from the **Collaborative to Advance Social Health Integration** — a group of 22 primary care teams with successful pilot initiatives that address social determinants of health using the *Roadmap* — we have made additions and improvements. We have found **clinical microsystems**, or small groups of professionals who work together on a regular basis to provide care to discrete populations of patients, are key to spreading a given innovation from one care team to another. The

collaboration also has helped us identify and share new tools, such as **Empathic Inquiry**, a screening approach, and the **Partnership Assessment Tool for Health** for those working on developing community partnerships.

In his poem entitled *Caminante no hay camino* (Wayfarer, there is no path), the Spanish poet Antonio Machado wrote "Se hace camino al andar," which translates roughly as "We make the road by walking." Widespread inequity in access to essential resources in the United States underlies epidemics of opiate use, chronic disease, and mental illness. Health providers and their partners must carve many paths for addressing patients' social needs into health care. Using tools like the *Essential Needs Roadmap* to share our collective experience, we can help each other chart progress and accelerate the journey to becoming a healthier nation.

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