SOCIAL DETERMINANTS OF HEALTH: OVERCOMING THE GREATEST BARRIERS TO PATIENT CARE

Health care leaders and front-line clinicians have long understood the connection between essential needs—such as food, housing, and transportation—and the health of their patients. Leading studies indicate **social and environmental factors** account for nearly **70 percent of all health outcomes.**[1]

Improving population health requires organizations to adopt comprehensive health equity solutions that address healthcare holistically—including social determinants of health.[2] To tackle these complex social needs directly, many healthcare systems build or source community resource directories for their patients.[3] While information is a critical part of the solution, it is not the whole equation. Information about available resources is only valuable if the information is comprehensive, up-to-date, and if patients know how to navigate through the structural barriers in their way.

Health Leads, United Way, and 2-1-1 have come together to share social needs challenges, barriers, and keys to success. For over 20 years our organizations have developed tools and programs that help connect patients with the essential community resources they need to be healthy.

In this whitepaper, we will discuss:

Challenges

Why it is hard for patients to access community resources to address their essential social and health needs.

Barriers

Patient stories about what it is like to search for resources.

Keys to Success

How to connect patients to essential community resources.

---

1 Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness. 2015. Data from Network for Excellence in Health Innovation (NEHI) 2013. http://www.tbf.org/impact/initiatives/~/media/TBFOrg/Files/Reports/HPHE_ReportCard_2011.pdf

2 López, N., & V.L. Gadsden. 2016. Health Inequities, Social Determinants, and Intersectionality. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2016/12/Health-Inequities-Social-Determinants-and-Intersectionality.pdf

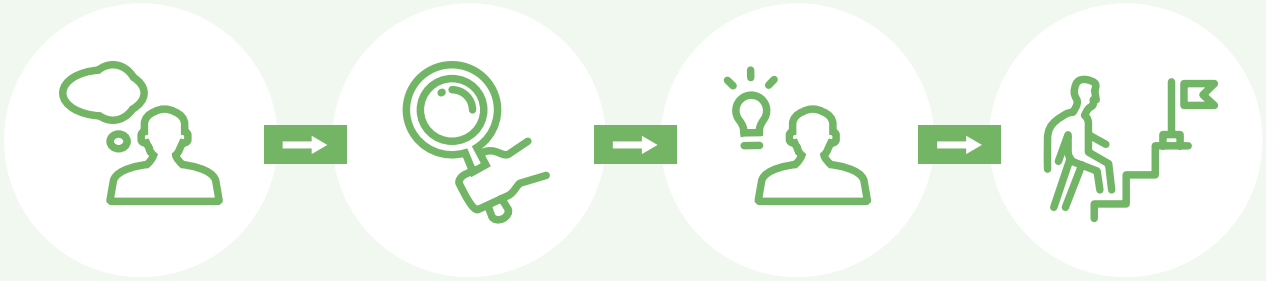
3 Hotstetter, M., & Klein, S. (2017, June 22). In Focus: Creating Pathways and Partnerships to Address Patients' Social Needs. Retrieved November 06, 2017, from http://www.commonwealthfund.org/publications/newsletters/transforming-care/2017/june/in-focus

Challenge: Why it is hard for patients to access community resources

Despite many recent efforts to provide resource information online and simplify public benefits applications, many patients do not receive the critical social resources they need to be healthy. In the United States, 51 million individuals are eligible for the Supplemental Nutrition Assistance Program (SNAP or food stamps) benefits. However, almost 8 million do not utilize these important benefits.[4] Underutilization of social resources has a clear impact on health. According to a recent report, **food insecure patients are 50 percent more likely to be diabetic and 60 percent more likely to experience heart failure.**[5]

Access to community resources is not as simple as a search on a Yelp-like website. Patients face numerous barriers to obtain community resources, including how to navigate complex benefit application requirements, cultural or language differences, and concerns about divulging sensitive information such as immigration status.

Challenges to Access Community Resources



Know What Exists

Find Viable Resources

Understand How to Apply

Overcome Barriers to Access

[4] Rosenbaum, D., & Keith-Jennings, B. (2017, October 10). SNAP Caseload and Spending Declines Accelerated in 2016. Retrieved November 06, 2017, from http://www.cbpp.org/research/food-assistance/snap-caseload-and-spending-declines-accelerated-in-2016

[5] Sullivan, T. (2017, October 12). Social determinants of health and the $1.7 trillion opportunity to slash spending. Retrieved November 06, 2017, from http://www.healthcareitnews.com/news/social-determinants-health-and-17-trillion-opportunity-slash-spending

Barrier #1: Know What Exists

The first challenge is to empower patients to seek information and then enable them to find available community resources near their home or work. Common barriers include:

- Patients do not know what resources exist or that there is someone to help them find the most relevant resources.
- If there are too many resource options, patients may not know where to begin, how to navigate the system, or the best resource to choose.
- In some situations, it is possible no resources will exist to meet the patient's needs.
- Patients may waste time and resources on inaccurate or outdated resource information.
- Patients may have exhausted all available benefit options, but still need further assistance.

> A 62-year-old disabled school bus driver finally found 2-1-1 after spending two days without heat in her uninsulated trailer home, where temperatures had dropped to -24°F. She had run out of propane heat, out of cash to fill the tank, and out of state assistance because she'd spent too much already on soaring fuel costs.
>
> **Case Manager, 2-1-1 in Michigan**

> It's important to have access to a place where you can get healthy food. But in this area, there's nothing nearby where people can buy fresh produce.
>
> **Patient, Health Leads in Texas**

Barrier #2: Find Viable Resources

Once a patient identifies nearby resources in their community, the next challenge is to identify which resources are viable for them to access. Common barriers include:

- The patient may not meet the eligibility rules of the resource or believe they aren't eligible.
- The patient may not have reliable transportation or the means to afford transportation to the resource.
- The resource may have limited hours of operation and require individuals to take time off work or find childcare, which may not be possible or financially feasible.
- The resource may cost too much or not provide sufficient assistance for their need.
- Some community resources may be slow to respond or have limited capacity to help.

> A recent client was living primarily in her car, having lost her housing after her husband's death. Because of the benefits she received from Social Security as the surviving spouse, she did not qualify for many low-income housing programs. She has been on two different housing wait lists for more than four months with 30 people ahead of her.
>
> **Patient Specialist, 2-1-1 in California**

> I had to wait three months for LIHEAP to get back to me to get [help paying my utility bill], but the good thing is that they did provide me with the financial assistance in the end.
>
> **Patient, Health Leads in California**

Barrier #3: Understand How to Apply

Some resources are available to anyone who visits or requests them, while other services have complex application or enrollment processes:

- Patients may not understand how to complete applications or navigate the process, especially for government or health insurance resources.
- Some may require multiple trips or steps, which may discourage patients from completing the process and getting the resources they need to be healthy.
- Patients may not have the necessary documents to complete an application. For example, to acquire a birth certificate without internet access or a printer may be a challenge.
- Low literacy or limited English proficiency may make it difficult for patients to complete an application process or understand the requirements.

> A homeless client couldn't get her children enrolled in Medicaid. When she lost her home, she also lost her birth certificate, which she needed for her application, and she didn't have the $20 to get a new one.
>
> **Case Manager, Health Leads in Massachusetts**

> A refugee family needed urgent legal services and they were eligible for support from Legal Aid. The local office didn't have a translator, so family is currently stalled due to the language barrier.
>
> **Advocate, Health Leads in Maryland**

Barrier #4: Overcome Barriers to Access

Patients may also have personal factors that affect their ability to access social needs resources. Patients may not be able or willing to:

- Ask for help due to a perceived stigma with the social services or government benefits.
- Travel through unsafe or unfamiliar areas to access a resource.
- Divulge sensitive personal information, such immigration status, domestic violence history, or sexual orientation.
- Access community resources due to physical disabilities or mental health issues.

> One of my patients was undocumented and worried that applying for certain services would jeopardize their status in this country. I was able to help ease their worries a bit, but they never would have applied if we hadn't talked.
>
> **Advocate, Health Leads in Massachusetts**

> A 59-year-old man called 2-1-1 for food. As we began discussing some options, I realized the situation was far more complex than just a matter of finding him some groceries. The gentleman told me he was living in an unfurnished apartment, and dealing with spinal cord injuries that impaired his movement.
>
> **Community Resource Specialist, 2-1-1in Ohio**

Keys to Success: How to Connect Patients with Community Resources

For many patients, there are real, systemic barriers to access essential social services and resources. What can your healthcare organization and clinicians do to help patients get the resources they need to be healthy?

1 Ask every patient about their social needs.

Many of our healthcare partners find this work requires them to engage with their patients in new ways and ask questions about social needs, such as food security, housing options, and employment.

Patients' needs may surprise you: initial assumptions about which patients have social needs are often incorrect. Moreover, patients many not share every personal challenge in their first meeting with your staff. It is critical to educate your organization and staff about common barriers, train your team for cultural competence, meet with community experts, and act based on what you learn through these patient and community interactions.

2 Don't go it alone.

In most communities, there are social needs organizations and human services professionals that can help clinicians navigate patients' unique needs. Organizations such as Health Leads and United Way map the best community services available and identify how to connect patients to those services.

Whether through a local nonprofit, Veterans Affairs healthcare facility, or a local 2-1-1, your community probably has resources to help patients access social services. Ask patients what resources they already use and leverage what exists in your community before you build and implement a new solution.

3 Track the results of your referrals.

Like medical interventions, the only way to know if a social needs intervention works is to find out what happened after each referral. Create a clear definition of success that is specific to each type of need[6] so you can determine if the patient receives food, obtains housing, or has their heat turned back on. Confirm your technology can track if the patient's needs are successfully met and which specific resource was useful. If there is a gap in available resources, track this information as well.

Tracking the outcome of a referral is one part of a bigger picture—remember to ask for qualitative feedback from patients. Patients may have sought a given resource, but found the service organization was not easy to access or did not treat them with respect. This information will help you narrow down what resources are available, as well as which are most helpful for patients in your community and enable you to share useful feedback with community partners.

---

[6] Perla, R., Stiefel, M., Francis, D., & Shah, N. (2017, January 26). Defining Success In Resolving Health-Related Social Needs. Retrieved November 06, 2017, from http://www.healthaffairs.org/do/10.1377/hblog20170126.058458/full/

4 Analyze patients' feedback to identify top resources and monitor barriers.

If you analyze referral data and trends, you may gain valuable insights that can help your patients. In an internal resource analysis, Health Leads found **four percent of our community resources produced more than half of successful connections.**[7] For a long time, Health Leads' focus had been to map as many community resources as possible. However, this data highlights the need to focus more closely on building relationships with our top community partners.

The United States underinvests in social services, which many studies link to the higher cost of care and poorer health outcomes verses other developed countries.[8] This lack of investment has left many local communities without the full set of resources they need to be healthy. As you analyze your own community data, patterns will emerge about which social needs are easier or harder to resolve, what barriers occur most frequently, and how to focus on the most successful resources available. Your organization may also notice patterns about patients that have multiple, simultaneous resource needs. Local 2-1-1 networks refer multiple resources for the same client nearly 40 percent of time.

5 Don't assume a website will solve every patient's needs.

With many decades of experience working with patients and clients who need additional resources, both the 2-1-1 network and Health Leads realize that different patients need different types of services. Some patients want a quick referral, while others prefer comprehensive guidance and follow-up support.

A recent analysis of Health Leads' patient data found that a one-time referral, without any follow-up consultation, was successful for 10 to 15 percent of patients. This does not negate the value of a web-based search service. However, a single referral or self-service web search function may only connect a small fraction of your patients with essential resources. It is important to ensure your patients have access to effective, comprehensive, up-to-date information, as well as explore what assistance your patients may need beyond the initial referral.

6 Embrace your role as community advocate.

As you get to know your patients' social needs and track referral results, your organization will begin to understand community resource strengths and gaps. Many 2-1-1 providers publish annual reports of community needs and assets, which your organization can use to set state and local policy and advocate for changes that fill resource gaps. For example, the United Way of Connecticut found patients lost their homes due to a local ordinance that issued foreclosures due to late water bill payments. Data from Connecticut 2-1-1 drove a local policymaker to make changes that keep patients in their homes.

As a healthcare provider, your organization may be able to provide valuable resources. Some health systems that identify a lack of accessible food resources offer on-site food pantries, distribute free lunches, and provide cooking classes to patients.[9] You can help promote health equity by investing in local resources that your community needs the most.[10]

---

[7] Health Leads, *Internal Resource Audit Analysis*, 2017.
[8] Adler, N.E., D.M. Cutler, J.E. Jonathan, S. Galea, M. Glymour, H.K. Koh, and D. Satcher. (2016, September 19). Addressing Social Determinants of Health and Health Disparities. Discussion Paper, Vital Directions for Health and Health Care Series. National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2016/09/addressingsocial-determinants-of-health-and-health-disparities.pdf
[9] Aisha, S. (2017, April 27). How Hospitals Are Addressing Food Insecurity. Retrieved November 06, 2017, from http://www.hhnmag.com/articles/8240-how-hospitals-are-addressing-food-insecurity
[10] National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, & Committee on Community-Based Solutions to Promote Health Equity in the United States. (2017, January 11). Communities in Action: Pathways to Health Equity (J. N. Weinstein, A. Geller, Y. Negussie, & A. Baciu, Eds.). Retrieved November 06, 2017, from https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity

Conclusion

It is truly a groundbreaking moment for essential health needs initiatives. New, exciting efforts to address social determinants of health are underway across the country, such as the Center for Medicaid and Medicare (CMS)'s Accountable Health Communities model, payers and insurers' reimbursement rates that include social needs, and original programs lead by innovative health systems.

Healthcare organizations, however, should avoid the conclusion that a community resource directory alone will solve every patient's need. Patients may face several barriers to access resources: knowledge of what resources are available, complex benefit applications, cultural or language differences, and concerns about divulging sensitive information such as immigration status. You can be confident there are organizations and people in your community that can help patients access the resources they need to be healthy—but you must also get to know patients and track their outcomes to fully support their journeys to better health.

Summary Recommendations

- **Get to know the common barriers your patients face to access resources.**
- **Track the outcome of each referral to understand if your intervention is working.**
- **Identify gaps in your community resource landscape and find ways to fill them.**
- **Don't go at it alone—reach out to community organizations for help, guidance, and support!**

Acknowledgements

Health Leads, United Way, and 2-1-1 would like to thank the many partners and advisors for their support and contribution to this whitepaper. Our lead contributors include: Zach Goldstein, Rachel Krausman, Marisa Howard-Karp, Russ Paulsen, Sheena Nahm, Andrea LeBeouf, Meghan Barp, Tanya Barrett, and the Health Leads Patient Advisory Council. We also thank our many advisors: Damon Francis, Jennifer Valenzuela, Jessica Nordstrom, and Jason Stephany.

Contact Us

Contact us to today to learn more about our organizations, solutions, and services: Health Leads, United Way, and 211. We also welcome your feedback, ideas, and suggestions—please email us today at **info@healthleadsusa.org** or **211@uww.unitedway.org**

Health Leads

United Way

United Way • AIRS 2-1-1™ Get Connected. Get Answers.