211 AND THE SOCIAL DETERMINANTS OF HEALTH

November 1, 2020
INTRODUCTION

Today, many health experts promote the importance of identifying patients' Social Determinants of Health (SDOH) and linking them to social services to effectively manage their health conditions and to improve health outcomes. 211 Centers play a key role in connecting people to services to address unmet needs as well as opportunities to partner across multiple sectors to address those needs. However, the level of understanding and participation in SDOH initiatives varies greatly across our system. Multiple 211 Centers have been actively engaged in SDOH work for nearly 20 years while others may be early in their implementation and understanding on how SDOH impacts a person’s overall well-being.

The intent of this document is to help standardize that understanding and implementation and examine the role 211 Centers can play in that work in addressing social needs from different sectors of society. Practitioners will learn simple, concrete things that can be done to standardize and integrate SDOH into their work and leaders will gain an understanding of how integrating SDOH is mission-centric, opens avenues of partnership, and creates community impact.

SOCIAL NEEDS AND SDOH

What are the social determinants of health, social risks, and social needs?

Over the past several decades, a large amount of research has documented that our environment and our living conditions influence our health more than the medical care we receive. Experts estimate that as much as 80% of the modifiable factors that determine an individual’s health are separate from health care (see figure below). Examples include:

- Availability of resources to meet daily needs (e.g., safe housing and availability of food markets);
- Access to educational, economic, and job opportunities, access to health care, socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it);
- Physical determinants such as natural environment and green space, housing, and community design;
- Physical barriers, especially for people with disabilities.

These factors shape the behaviors we engage in, including our eating and exercise habits, opportunities to access affordable healthy food, safe places to exercise, and our drug, alcohol
and tobacco use. Together those non-medical factors have more impact on our health than our health care. In turn, our health can impact our ability to lead a thriving life.

Figure 1 - Modifiable factors that affect our health.

These non-medical, non-biological, and non-behavioral factors are called the social determinants of health, defined by the World Health Organization as the conditions in which people are born, grow, live, work and age. SDOH are, in turn, shaped by the societal distribution of money, power and resources. Unequal distribution of these resources means that the SDOH affect people and communities in unequal and unfair ways, generating health inequities, which are unfair and avoidable differences in health status.

The following figure demonstrates the SDOH and how spheres of influence interact with those determinates which are represented by the yellow, green, and purple bands of this figure.
Figure 2 - People’s health and wellbeing are affected by different spheres of influence that interact with each other.

How do we understand the interplay of the different levels of influences on health? One parable, often used in public health, begins with a stream. People fall in and are carried down the stream of social and health risks, swept up in the currents of harmful policies, adverse environments, and everyday obstacles. By the time they are pulled from the stream and arrive in the emergency department, they may be drowning. In this analogy, medical professionals are jumping in to save those who are drowning. What could we do to prevent them from falling into the stream in the first place? When we look upstream, we can find opportunities to intervene at multiple levels to promote people’s health and wellbeing and foster environments in which they can live full, thriving lives.
The figure above distinguishes between community conditions (SDOH) and individuals’ social risks. As an example, the community condition may be a food desert, an area in which it is difficult to buy affordable or good-quality fresh food, manifesting as food insecurity. Likewise, the lack of local affordable housing policies to protect low-income tenants may be visible at the individual level as multiple evictions. The further upstream you go, the more you are trying to prevent people
from experiencing any harm in the first place. At the same time, you have the capacity to act in ways that affect more people.

Those working in this field are also starting to distinguish between social *risks*, of which there can be many operating simultaneously in a person’s life, and social *needs*, which take into account what the person prioritizes as the most pressing risk they face and where they are requesting assistance[1]. In either case, working with individuals on their social risks or social needs is relatively downstream work. The risk of focusing exclusively on social needs is addressing the *consequences* of adversity over and over without preventing people from experiencing adversity in the first place.

To most of us working in the 211 world, this is not news. 211 has been working both upstream and downstream of health care since its inception, providing crucial, timely information and referrals for social needs. However, the connection between the services provided by 211 and the health outcomes of patients, communities, and populations has yet to be broadly articulated.

**How is the Healthcare Sector responding?**

Within the healthcare system, patients who experience more social needs like food insecurity, housing instability and lack of quality, affordable childcare have worse outcomes. These outcomes include, but are not limited to, the following:

- Stress
- Sleep problems
- Mental health conditions
- Physical health conditions
- Poorer management of chronic diseases
- Missed and unfilled prescriptions
- Missed doctor’s appointments
- Fewer preventive behaviors
- More risk behaviors
- Cognitive decline
- Fewer healthy days
- Poorer self-rated health
- Higher health care cost
- Higher rates of death

In short, patients with unmet social needs tend to be sicker, visit the ER more frequently and cost more to treat. The novel coronavirus 2019 (COVID-19) pandemic has further impacted SDOH services and worsened health outcomes of vulnerable populations. How health services are funded has also had a significant influence on healthcare’s interest in addressing SDOH, even though research shows it has a larger impact on health than medical care alone, health spending is not well aligned with this knowledge. As highlighted in the figure below, 90% of our national
health expenditures are spent on medical care, which is estimated to account for only 6% of what makes us healthy.

![Figure 4 - The spending mismatch: Determinants vs. Expenditures^vii]

This is especially problematic given that there is evidence that increased social spending can pay health dividends. A 2016 study found that states with higher ratios of social service spending outperformed states that had a lower social-to-health spending ratio when it came to health outcomes related to obesity, asthma, mental health, cancer, myocardial infarction, and type 2 diabetes^viii.
At the same time as knowledge about SDOH has solidified, national health care payment reforms are transforming how hospitals and health systems are being paid for services. Value-based care initiatives in Medicare and Medicaid are moving payments from a fee-for-service model to a capitation-based model. This incentivizes systems to improve patients’ health and reduce avoidable health care utilization. In this new payment environment, healthcare organizations, especially those serving economically vulnerable populations that are affected most by unmet social needs, have realized that addressing the social needs can help them achieve their health improvement and cost-containment goals, while generating more revenue.

As a result, the healthcare sector is increasingly engaged in a range of efforts to understand and address the social needs of their patients and plan members. A recent report by the National Academies of Science, Engineering, and Medicine summarized five types of roles for health sector organizations in integrating social needs:

- **Awareness**
  - Identifying social risks and assets of defined patients and populations

- **Adjustment**
  - Altering clinical care to accommodate identified social barriers

- **Assistance**
  - Reducing social risk by connecting patients with needed resources

- **Alignment**
  - Understanding existing social care assets in the community, organizing them to facilitate synergies, and investing in and deploying them to positively affect health outcomes

- **Advocacy**
  - Partnering with social care organizations to promote policies that facilitate creation and redeployment of assets or resources to address health and social needs

**Figure 5 - Types of Roles**

Although healthcare organizations are actively experimenting with a wide range of solutions across these five domains, the most-used approaches to date have been awareness and assistance. In the language of 211, this approach is quite familiar: screening and referral. Within
the healthcare sector this approach is sometimes referred to as a “linkage intervention” because it seeks to connect patients to community organizations outside the health system that might be able to assist with needed services. In a 2018 national survey, over 90% of healthcare organizations serving low-income patients reported using this approach\textsuperscript{2}. As applied by healthcare organizations, linkage interventions have three main components:

- Screening
- Referral
- Support

Currently, there are no universally accepted or validated standards when it comes to administering healthcare-based screening for social risks or social needs. A variety of screening tools have been developed. Some of the most widely used include the following:

- Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE), developed specifically for use in community health centers
- The Accountable Health Communities Health-Related Social Needs Screening Tool, developed by the Centers for Medicare and Medicaid Services (CMS) as part of an intervention model
- The Health Leads Social Needs Screening tool\textsuperscript{3}.

To standardize the social needs data that are collected from patients nationally, several of these screening tools have been recommended for national use. All the tools assess needs in at least five core areas:

1. Housing
2. Food
3. Transportation
4. Utility assistance
5. Personal safety.

Some screening tools also assess needs related to childcare, education, employment, neighborhood safety and health care access. These domains are closely aligned with those assessed by 211s that administer social needs screening to callers. For example, 211 San Diego’s screening tool assesses housing, food/nutrition, primary care, health management, social and community connections, activities of daily living, criminal/legal, financial, transportation, personal/household, utility/technology, safety/disaster, and education.
Social needs screening in clinical health settings is implemented in many ways across the country by using:

- Different modalities (e.g., paper, tablet computer, verbally)
- Different staff (e.g., social workers, community health workers, nurses, medical assistants)
- During different points in a clinic encounter (e.g., waiting room, exam room, post-visit).

Research has shown that patients find social needs screening to be acceptable and don’t have strong preferences for screening being administered in a particular modality, setting, or point in the clinical encounter, though there is some indication that self-administered screening tools seem to yield higher disclosure of needs\textsuperscript{iii}. However, studies also find that patients desire and expect a caring, empathetic approach when screening for social needs\textsuperscript{iii}.

When the screening process identifies unmet social needs, referrals are made to internal programs, such as hospital-based fresh food pharmacies or medical-legal partnerships, where available. They can also be made to external local service agencies such as homeless shelters, food banks, utility payment assistance programs or vocational programs that may be able to provide the needed assistance. There are many models for executing referrals. Some healthcare organizations, especially those with social work staff or community resource desks, have compiled and maintain their own printed resource inventories and will either complete warm handoffs by phone or provide lists of resources for patients to contact on their own. Other organizations pay to access an online resource inventory that is compiled and maintained by commercial vendors who in many cases also offer the functionality to send electronic referrals to agencies through a resource platform\textsuperscript{iv}. Lastly, some rely on publicly available resource inventories such as 211 or Community Information Exchanges (more on these below).

In some instances, commonly involving patients who have complex, poorly managed or costly health conditions, the patient may also receive special support services to help access assistance addressing social needs. This often takes the form of a case manager, community health worker or social needs navigator, who works with, and on behalf of, the patient to secure needed assistance. This support can be provided in person or by phone. This practice also has parallels within some 211s, which provide “Level 3” or “Navigation services” to some callers, often as part of special contracts executed in collaboration with external partners, including some from the healthcare sector.
Apples to Apples: efforts to standardize coding for social needs:

There are long-standing efforts in the human service sector and more recently the healthcare sector to standardize the way social needs and social services are captured in their respective IT systems. The LA211/AIRS Taxonomy is the pre-eminent classification system for human services, having evolved over the past 20 years to encompass over 9000 fully defined terms to describe the variety of services provided. In the healthcare sector, efforts are also underway to standardize coding for social risks and social interventions in the medical coding vocabularies. One such effort is the Gravity Project, an open, national collaborative that seeks to identify coded data elements and associated value sets to represent social needs in four domains (food insecurity, housing instability, housing quality, and transportation) documented in electronic health records (EHRs) across four clinical activities: screening, diagnosis, planning, and interventions.

While the Gravity Project’s focus is on standards and value sets developed for LOINC, SNOMED and CPT, some of the medical coding vocabularies found in Electronic Health Record (EHR) systems, the long-term vision is for these standards to be mutually intelligible for other sectors who will use the data to provide referrals and services, including 211s. Likewise, for resource directory data, the Open Referral Initiative is developing common formats and open platforms for the sharing of community resource directory data — i.e., information about the health, human and social services that are available to people in need. The Association of Information and Referrals Systems (AIRS) has recommended the adoption of Open Referral’s Human Service Data Specification and API protocols as methods of establishing interoperability among 211 resource databases and associated technologies such as EHRs.

Where and how does 211 fit in?

From a healthcare perspective, 211 has at least three assets that are directly relevant to addressing social needs for health improvement.

1. **Resource databases that 211s have compiled and maintain.** To the extent that these are comprehensive and current, they may have value to health organizations, particularly those that do not have some equivalent to it already. Many healthcare organizations contract with commercial vendors for resource database services, some of which include resources scraped from 211 websites.
2. **211 data on social needs within a community.** By capturing every social need expressed by callers to 211 and visitors to 211 websites, 211 is effectively the nation’s leading surveillance system for social needs. 211s possess highly unique data that documents not only the level of demand for a wide range of social need services, but also how those needs are distributed geographically, how they change over time, and in many instances, who they affect most. Such data are invaluable for identifying gaps in service, community planning and integrating the “alignment” and “advocacy” roles the healthcare sector seeks to fulfill, as outlined earlier.

3. **211s navigation expertise.** An increasing number of 211s provide more intensive case management, or navigation, to help callers secure the assistance they need from community organizations. Such support is likely most valuable to highly vulnerable 211 callers who might lack the resources and connections to act on social needs referrals on their own. These case management or navigation services are not unlike those that many healthcare organizations currently contract for.

The value of these assets to healthcare organizations depends on a number of factors, including whether they have access to alternatives they perceive as comparable, whether 211 resources and data are easily accessible, and whether 211s are willing and able to establish formal partnerships and sharing agreements with healthcare organizations. In addition, while the assets of any individual 211 may hold some value to a healthcare organization that serves the same community, region or state, the value of 211 assets will be maximized when these databases are linked and aggregated across all 211s.

**Besides healthcare, what other sectors might partner with 211s?**

Web analytics from *211 Counts*, an online data dashboard service used by 211s in 33 states, confirms that healthcare organizations have been one of the sectors most interested in 211 data over the last five years. In the three year period from 2014 to 2017, use of 211 social needs data by healthcare organizations more than tripled, and now accounts for roughly one in six identifiable users of *211 Counts*. These include the sectors listed below:
Although the exact reasons for these healthcare organizations accessing 211 social needs data cannot be known with certainty, a series of in-depth interviews with 18 healthcare leaders conducted in 2018 provides some clues. In the interviews, four distinct “use cases” emerged for healthcare accessing 211 data:

1. Support their efforts to prepare a Community Health Needs Assessment (CHNA), a federal triennial requirement for all not-for-profit healthcare organizations
2. Help them evaluate the effectiveness of their efforts to address SDOH
3. Identify social service agencies in their communities with whom they might partner to address SDOH
4. Convey SDOH priorities to healthcare executives and board members.

But healthcare is not the only sector actively seeking 211 data, or even the most common user group. That distinction belongs to government agencies. Among all identifiable users of 211 social needs data, nearly one quarter represent local, state or federal government agencies involved in aging, children and families, corrections, disability, education, health, housing, income and revenue, insurance, justice, labor, law enforcement, libraries and information services, public health, security, social services, and others. Viewers also include the offices of many elected officials.

**How might government agencies use 211 data on social needs and SDOH?**

- Those responsible for planning, budgeting, and administering programs like SNAP or unemployment might use these data to help with modeling and projections or tracking demand.
- Agencies such as FEMA value the real-time data 211s provide on community needs in the lead up to and aftermath of natural disasters.
- Elected officials and their staff members may use 211 data to help understand the life experiences and needs of their constituents.

Many 211s already have a history of collaboration with state and local government agencies, and even some federal agencies, such as the Centers for Disease Control and Prevention (CDC) and FEMA for national disasters or pandemics like COVID-19. These can serve as models for new partnerships aimed at understanding and addressing SDOH in communities.

Another sector, accounting for nearly as much use of 211 Counts as healthcare, is education. Education sector users are split roughly evenly among institutes of higher education and providers of K-12 public education. The former group likely appreciates 211 social needs data for research and student learning purposes. The latter, which includes individual schools, school districts, and departments of education, stand to gain valuable information about the social needs of families within their geographic boundaries, which could in turn shape classroom, school and system-level responses and support to address social needs that might impede children’s learning if left unaddressed.

Opportunities for 211s to partner with both Higher Ed and K-12 systems is advancing beyond just social needs data. As healthcare is focused on SDOH, education is similarly focused on nonacademic student supports. Nonacademic student supports are activities and programs that are designed to encourage academic success but that do not deal directly with academic content\textsuperscript{xvi}. In 2015, a Wisconsin HOPE Lab study revealed that 52 percent of college students were food insecure, with 20 percent qualifying as hungry, and 52 percent were housing insecure, including 13 percent who were homeless\textsuperscript{ xvii}. The National Center for Education Statistics reported in 2014-2015 that 51.8 percent of K-12 students were eligible for Free and Reduced Lunch\textsuperscript{xviii}. Students’ learning and development is impacted by more than just the quality of the experiences they have in school. Their progress is also impacted by the experiences they have at home and in the community, the relationships or partnerships between individuals in these different settings, and the policies, cultural norms and values that govern interactions in these spaces\textsuperscript{ xix}.

Others accessing 211 data include organizations in the financial, retail, insurance and social service sectors. In short, there appears to be a wide range of potential partners for 211 collaborations related to, and beyond, social needs.
What should 211’s role be and why is it important?

A key aspect for health systems in addressing SDOH is referring patients who have been screened for SDOH or social needs to community resources. But how do health providers identify the right resource for the patient? How do health providers know which community-based organizations (CBO) are the most appropriate? Once a patient is referred, how do they track whether a successful referral was achieved? These are questions that healthcare organizations are trying to answer.

Those in the 211 system know, and can provide answers to these questions. Not everyone within the health system, or higher up within the human services sphere, may know about 211 – but the most vulnerable people in the communities where they live DO know about 211. They are calling 211s regularly about food, utility assistance, rent assistance, financial help, prescription assistance, and more. 211s provide a very specific role in addressing social needs, but not many people know about 211 or the role it plays. There are no national advertisements or public service announcements for 211; there is no Federal support for 211 or national health policy that directs citizens to use this free public service. Since 211 is still unknown in the healthcare sector, many health organizations have developed their own resource directories and closed loop referral systems, or have turned to one of the many commercial software startups. Vendors such as Aunt Bertha, Healthify, Unite Us, and Now Pow have evolved over the past few years to address this need.

With the growth of information and referral systems and services, many new software vendors have turned to the internet to collect information on local resources in a practice known as web scraping or purchase data from sources such as Google or Facebook. These practices are seen as a threat by many 211s, as the majority of 211s post their resources through freely accessible online resource directories. Without legal protections, or deep pockets to fight copyright infringements, 211s may feel vulnerable. To add to this vulnerability, a recent court ruling on the case of HiQ Labs v. LinkedIn, the 9th Circuit Court of Appeals held that it is not against the law to scrape information off of a public website, regardless of what the site’s ‘terms of service’ might stipulate.\textsuperscript{x}
Even with competition from commercial vendors, there are opportunities for 211s

A criticism of commercial resource directories is that of outdated or inaccurate information. 211 is guided by the standards established by the Alliance of Information and Referral Systems (AIRS), which ensures accurate resource data. There are no such standards for commercial vendors. To meet demands for more accurate data, vendors invest in data validation, but this comes with a financial cost to both the vendor and to the healthcare system, not to mention the time spent by CBOs responding to validation requests. In a more recent trend, vendors are partnering with 211s to exchange data due to the return on investment 211 can provide with updated, comprehensive, and high-quality resource data at a lesser cost.

As a service that addresses the SDOH, and interest from the healthcare system to partner around resource coordination, 211s have an opportunity to gain more recognition and to generate steady revenue to support their efforts. 211s in the national network, such as San Diego 211, Washington 211, Michigan 211, NC 211, 211 Oklahoma and 211info in Oregon have entered into contracts or data sharing agreements with vendors and health systems to exchange resource data. The results from these partnerships are varied and each has experienced successes and challenges. The following are examples of 211s who are engaging in SDOH partnerships that are generating additional partnerships and revenue:

211 San Diego is working with social service and health care providers to improve care coordination through an online platform:

*Connecting patients to needed social services can be challenging for health care providers, who are generally focused on clinical care. Additionally, they are often neither aware of the full range of community services nor have the capacity to refer and follow up with patients. Recognizing that social factors significantly impact health outcomes and spending, 211 San Diego developed the Community Information Exchange (CIE), a cloud-
based platform that enables participating providers to better understand a client’s interactions with health and community services.

The CIE includes a social risk assessment tool, provides alerts, and facilitates connections across multiple agencies and providers. The rich client information collected through the CIE is also used to monitor community trends and address local challenges. 211 San Diego is actively engaging community partners to participate in the CIE in the hopes of improving care coordination and health outcomes for at-risk patients throughout San Diego.

Washington 211 has collaborated with regional Accountable Communities of Health to exchange 211 resource data with the Pathways HUB and HealthBridge platform to insure patients’ social needs are addressed:

An Accountable Community of Health (ACH) is a regional coalition consisting of representatives from a variety of sectors, working together to improve population health. A few of the Accountable Community of Health regions in Washington State have adopted the “Pathways Hub” model. Pathway Hub enhances care coordination and facilitates the ability of health providers and community agencies to work collaboratively to deliver evidence-based interventions, with a focus on prevention and early treatment, leading to improved outcomes and reduced cost.

The Pathways HUB acts as a central clearing house that registers and tracks at-risk individuals, making sure their physical and behavioral health, and social needs are identified and addressed. Upon enrollment in the Hub, every client meets with a community health worker (CHW), who completes a comprehensive risk assessment. Each risk is translated into a “pathway,” including unmet needs for food, housing and other social services. Risks are addressed one at a time, with clients helping to determine priorities. Pathway referrals are made using 211 resource data and tracked through completion of an electronic record in a shared health information database.

Central Michigan 211, in collaboration with the Michigan Department of Health and Human Services/CMS State Innovation Model, Jackson County Health Network and the Michigan Institute for Clinical & Health Research, created the Jackson Care Hub. The Jackson Care Hub is similar to a community information exchange, but developed independently of, 211 San Diego.
The Jackson Care HUB is a screening system inside the Riverstar Care Coordination platform that screens patients/callers/community members on 10 SDOH domains. If an individual has a positive screen in a domain, they are offered either a Community Navigator through 211 or a direct electronic referral to a partnering agency. The agency or navigator receives the referral, follows up with the individual, and tracks their progress (agency and individual) in the HUB system.

COMMERCIAL USE OF RESOURCE DATA

Through the early work of 211s who adopted a SDOH partnership, common issues and lessons learned have been identified that impact the overall 211 network.

The most common issue is how to add a monetary value to 211 resource data. The struggle and challenge of putting a value on resource data has been around since 211 became a service, but recent demand for 211 resource data from health and other sectors has pushed the 211 system into finding quick solutions that either undervalue or overvalue 211 data.

To respond to this new consumer demand, it is imperative that 211s create a business model for the sale of resource data that uses universal standard pricing. Standard pricing is based on the real costs of procuring and managing 211 resource data. Ideally, the national network of 211s should consider establishing a pricing standard which will help eliminate any inconsistency or ambiguity between 211s and potential partners that are wanting to purchase 211 resource data across the country.

Some 211s have developed a data pricing standard that establishes a cost per record as well as a tiered fee structure based on whether the customer is a for-profit, government or nonprofit entity. When setting a standard price per record based on actual costs, 211s will need to consider other factors such as the method that will be used to exchange the data (APIs vs. CSV files), frequency (once a week, once a day, real time, etc.) and any additional time and effort that will be incurred by the 211. These additional costs can be factored into the pricing or negotiated separately.

Once pricing is established, 211s should evaluate the price the market is willing to support. If the cost of 211 data is too high, potential partners may look to cheaper, but lower quality, ways to procure data through scraping. By negotiating a fee that doesn’t overprice the end product for their partners, buyers will be more likely to purchase resource data from 211s and may become loyal customers over time because of data quality and value.
In addition to overpricing data, there is also a risk if a 211 underprices, or openly shares their resource data. This has been an area of extensive discussion among national 211 leaders who are concerned that providing 211 data at low, or no, cost creates a precedent of under valuing all 211s resource data. Others argue that openly sharing their resource data can strengthen 211s standing as a community leader in building social data infrastructures, across multiple sectors to create greater outcomes for community health efforts. Whether sharing data openly or charging a fee, 211s should clearly identify the risks, benefits and value created and document this through a data sharing agreement. In establishing an agreement, 211s should consider avoiding language that creates exclusivity. There is a great deal of need for 211 resource data and 211s should not limit their opportunities to create additional data sharing partnerships.

To avoid the risks as well as take advantage of the opportunities of data sharing, it is imperative that 211s establish a data governance structure. Data governance is defined as the overall management of the availability, usability, integrity, and security of data used in an enterprise. 211 and the organizations that partner, benefit from data governance because it ensures data is consistent and trustworthy. Although efforts are underway, there currently is no data governance structure at the National level that sets standards for the exchange or commercial use of 211 data, so 211s should consider developing standards that could align with other 211s.

This reality and other factors, has led to the development of the 211 National Data Platform by United Way Worldwide. The National 211 Data Platform has the potential to link all 211 resource data together to provide standardization in data structure and exchange at a national level. The implications for this level of standardization could provide opportunities for national level SDOH partnerships, increase the impact of 211 during national disasters, impact social policy and become a revenue stream for participating 211s.

Social needs data

As previously mentioned, another value that 211 provides is in the collection and dissemination of social needs data. 211 social needs data is unique to the 211 system and acts as a social barometer, providing a community picture of emerging needs and gaps in services. 211 needs data supports collaboration on community goals, informs government decision-making, helps in identifying where to invest resources, assists community partners to advocate for people in need, and measures community change.
Community needs data is of great value to healthcare as well as other social service agencies who are required to conduct community health assessments. Community health assessments, also known as a Community Health Needs Assessment (CHNA), gives organizations comprehensive information about the community’s current health status, needs, and issues. In turn, this information can inform the development of a community health improvement plan, justifying how and where resources should be allocated to best meet community needs.

The Affordable Care Act requires nonprofit hospitals to complete a CHNA process every three years. While CHNAs are a recent requirement, community health assessments (CHAs) have long been used as a tool by hospitals, public health departments, Head Start, Community Action Agencies and other social service organizations to identify key community health concerns. This creates additional opportunities for 211’s to partner and has led to the creation of 211 Counts. 211 Counts is a service offered by Health Communication Impact (HCI) which provides an interactive, online dashboard that maps the community problems and needs of live 211 callers, including aggregate caller demographics and US Census data. More recently, HCI has developed “Calls to Action”, custom printed 211 community need assessment reports, with participating 211s to create shared revenue opportunities.

NAVIGATION SUPPORT

Lastly, many 211s provide program enrollment and navigation services that focus on specific services, or areas of service. Examples of this include:
Other specialized services are funded through grants and contracts and may require follow up, client data collection and outcome reporting through closed looped referrals. Whether or not a 211 participates in these types of services, a precedent has been established within the 211 system that, with proper funding and capacity, 211 can be a full service partner with healthcare and provide value based services that lead to value based payments.

**Stages of Readiness**

Is your 211 ready to engage in SDOH partnerships? The following questions may help you determine your stage of readiness:

- Is there buy-in from agency leadership?
- Have the benefits and risks been identified?
- Is there a commitment to invest staff time and effort in community engagement and building partnerships?
- Do you know who the key stakeholders are in your community that are engaged in SDOH?
- Is there already interest in your data? Has your 211 been approached to share its resource database or needs data?
- Does the 211 have the technical capability to exchange its resource data with different databases?
- Does your 211 have an existing data sharing agreement?
- Has your 211 determined the cost of procuring and managing its resource data and set a price for sharing it?
- Is your 211 able to guarantee a higher level and frequency of data validation, if not are you prepared to invest more resources into data management?
- Besides data sharing, is your 211 is also considering engaging in care coordination?
- Does your 211 have the capability or capacity to provide specialized service navigation, enhanced community outreach or closed looped referrals?
- What would it cost to add these services and is there potential for community partners to fund this work?

If your 211 is considering engaging in SDOH work after answering these questions, assistance is available. A list of references, helpful articles and contact information for the authors are listed and the end of this document. Team 211 at United Way Worldwide, in partnership with the National 211 CEO Partnership and National 211 Steering Committee, have also created the 211
Toolkit. The 211 Toolkit is an online resource for United Way and Non-United Way 211s, where you will find a SDOH Toolkit with articles and links to resources. You can create an account by going to https://211toolkit.unitedway.org/user/login or contacting Sawyer Baker at United Way Worldwide sawyer.baker@uww.unitedway.org

CONCLUSION

Nationally, 211 services remain fragmented, with state and/or regional 211s operating autonomously. Many potential healthcare partners operate regionally, or nationally serving patient populations across multiple 211s. Having to work separately with each 211 to access resource data is inefficient and costly and likely puts 211s at a competitive disadvantage relative to other cheaper less complicated options. Supporting resource data aggregation at a national level, through efforts such as the National Data Platform, will make 211s much more valuable and attractive to national partners.

For 211 to be successful in local and national SDOH efforts, it needs to be at the table with the healthcare sector as an equal partner. 211 is the expert on the SDOH and social needs in local communities and can provide direction to the healthcare sector on how to effectively refer patients to social service organizations. 211 can also facilitate trust and partnerships between healthcare and community-based organizations, encouraging investment from healthcare in the existing community safety net instead of recreating safety nets. Making 211 data more accessible to the healthcare sector can be a first step towards realizing this greater role of 211.

211 has been engaged in SDOH work since its inception and continues to be a vital service in communities across the country. Because of our intimate knowledge of resources and our ability to provide a central point of access to social determinants of health referrals, 211 is uniquely positioned to be a key partner with healthcare to provide whole-person care. The opportunity for new partnerships, expanded services and financial support for 211 services is here now and it's time for 211s to be a leader in this work.

“IT'S THROUGH CURIOUSITY AND LOOKING AT OPPORTUNITIES IN NEW WAYS THAT WE'VE ALWAYS MAPPED OUR PATH.”

MICHAEL DELL
ACKNOWLEDGMENTS

The development of “211 and the Social Determinants of Health” whitepaper was through the leadership and efforts of the National 211 Steering Committee as part of its 2019 action plan to “Focus on information and education of the 211 Network and increase the output of tools to the 211 Network”. Development of this whitepaper was led by the SODH Taskforce and was not possible without the “extra special” contributions of SDOH Taskforce members and coauthors:

- **Tim Sullivan, National 211 Steering Committee**
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Special Thanks to Lee Murdock, RiverRock Consulting, for editing this document

INFORMATION AND RESOURCES

- 211 Counts. Available at: https://211counts.org/
• Indicators for Professional Information and Referral at www.airs.org/standards


• Health Affairs - Addressing Social Determinants: Scaling Up Partnerships with Community-Based Organization Networks. Access at: https://www.healthaffairs.org/do/10.1377/hblog20200221.672385/full/?fbclid=IwAR1vwLnYs9pClRssGqzclbQ-ICAU0-aNZ4nBvLtedy8_UVV90RNCOFzD4RY##.XlPkKXFMEVo.facebook

• Health Affairs - Assessing The Capacity Of Local Social Services Agencies To Respond To Referrals From Health Care Providers. Access at: https://www.healthaffairs.org/do/10.1377/hblog20200221.672385/full/?fbclid=IwAR1vwLnYs9pClRssGqzclbQ-ICAU0-aNZ4nBvLtedy8_UVV90RNCOFzD4RY##.XlPkKXFMEVo.facebook


• Patchwise Labs - Safety net innovation and the social determinants of health resource. Access at: https://www.patchwiselabs.com/
ENDNOTES


iv Source: Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog

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xi Cartier Y, Fichtenberg C, Gottlieb L. Screening tools comparison tables. Social Interventions Research and Evaluation Network


xv Kreuter M. Enhancing dissemination for health equity: a marketing and distribution perspective.

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