Levels of HRSN & SDH Integration Framework

A practical framework to help healthcare and social service partners address health-related social needs and social determinants of health

April 2019

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A standard framework for levels of integration of health-related social needs and social determinants of health

Background

In recent years, as moves to value-based payments and place-based community health improvement have accelerated, efforts to coordinate and integrate healthcare and social service approaches to health-related social needs (HRSNs) and social determinants of health (SDH) have increased. Despite the spread of these efforts, few updated taxonomies currently exist to describe the levels of HRSN and SDH integration.

- As a concept and term, "SDH" is widely and inconsistently used by healthcare stakeholders to reference everything - from clinic-based screening of HRSNs, analytic projects that assess "social risk" data, and partnerships with social service providers to improve "population health" to participation in data sharing collaboratives and collective impact approaches that address community-wide SDH and engagement of hospitals as "anchor institutions" for community and economic development.

- While the empiric evidence base is still growing, the integration of HRSNs and SDH in healthcare is widely believed to be essential to the pursuit of improving health and health equity among defined populations, if not entire communities. Increasingly, stakeholders are exploring how integration of HRSNs and partnerships to improve SDH can advance the healthcare "quadruple aim" - improve the experience of healthcare, improve population health outcomes, lower total and per-capita costs of care, and increase joy and resilience among professionals. Meanwhile, social service providers are weighing the costs and benefits of healthcare partnerships in relation to their own mission and bottom line.

The Levels of HRSN & SDH Integration Framework

The *Levels of HRSN & SDH Integration Framework* ("Framework") outlined here draws on HealthBegins' direct experience in the field and the evolving traditional and gray literature. Most notably, it adapts a taxonomy developed in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions to describe levels of behavioral health integration in primary care.[1] The Framework is part of the *Upstream Communications Toolkit*, which also includes a *Glossary of Upstream Terms* and a *Discussion Guide*.

The goal of this Framework is to provide healthcare, social service, and public health stakeholders with clarity, increase the precision of their communication, and accelerate practice and system redesign related to HRSN and SDH integration. We recommend reviewing the *Glossary of Upstream Terms* to better understand the terms used in this Framework. The *Discussion Guide* can help partners apply these terms in the context of their settings, priorities, and concerns. Excerpts from the *Glossary of Upstream Terms* can be found below.

This practical six level framework begins with coordination and moves through increasing levels of collaboration and integration. Even if outcomes improve as levels of integration increase, it is not practical to believe that every healthcare and social service partner will be able to implement increasing levels of integration due to external pressures, organizational capacity, financing, and/or differing values.

By implication, the numbering of levels suggests that the higher the level of integration, the more potential for positive impact on health for defined populations and, more broadly, whole communities. This belief has not been empirically tested. With further research and experience, the benefits of different levels of collaboration and integration can be more firmly stated and can identify which models and aspects of coordination, collaboration, and integration contribute most directly to health outcomes.

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[1] Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

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Glossary of terms (Excerpts from the *Glossary of Upstream Terms*)

community health

A multi-sector, multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health, quality of life and SDH of all persons who live, work, or are otherwise active in defined communities
Source: https://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/creating-clarity-distinguishing-between-community-and-population-health

population health

The health outcome of a group of individuals including the distribution of such outcomes within a group.
- Often used by healthcare stakeholders in association with the Triple Aim of improving the quality of care, improving the health of populations and reducing the per capita cost of healthcare.
- *Population health management* manages health needs, including *HRSNs*, to improve health status, utilization, and cost indicators for *defined populations*
Source: https://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/creating-clarity-distinguishing-between-community-and-population-health

public health 3.0

In addition to maintaining essential governmental public health functions, this model emphasizes collaborative engagement and actions that directly affect SDH, health inequities, and structural determinants (social determinants of health inequity).
- Acts to confront institutionalized racism, sexism, and other systems of oppression that create inequitable conditions leading to poor health
Source: https://www.cdc.gov/pcd/issues/2017/17_0017.htm &
https://www.naccho.org/uploads/downloadable-resources/NACCHO-PH-3.0-Issue-Brief-2016.pdf

social determinants of health (SDH)

Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age.
- The systems that offer health and social services to a community are themselves a SDH.
- As intermediary determinants, SDH shape individual material and psychosocial circumstances as well as biologic and behavioral factors.
- Commonly refers to defined communities or regions, typically defined by geography.
Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

social needs   *see also: **health-related social needs (HRSNs), basic human needs***

Individual material resources and psychosocial circumstances required for long-term physical and mental health & wellbeing.
- Material circumstances describe physical living and working conditions and include factors such as housing, food, water, air, sanitation.
- Psychosocial circumstances include stressors such as negative life events, stressful living circumstances, and (lack of) social support.
- Commonly refers to specific individuals or defined populations, typically defined by attribution.
Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

structural determinants   *see also: **social determinants of health inequities***

The climate, the socioeconomic-political context (e.g. societal norms and macroeconomic, social & health policies) and the structural mechanisms that shape social hierarchy and gradients (e.g. power, class, racism, sexism, exclusion).
- Commonly refers to cities, states, nations, or the world, typically defined by political jurisdictions, cultural boundaries, or economic relationships.
Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

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Coordination of Healthcare and Social Services

- Level 1 — *Minimal Coordination*

  Healthcare and social service providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient/client.

- Level 2 — *Basic Coordination at a Distance*

  Healthcare and social service providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. Healthcare and social services, respectively, are most often viewed as resources to satisfy HRSNs.

Collaboration of Healthcare and Social Services

- Level 3 — *Basic Collaboration of Practices*

  Healthcare and social service providers collaborate more regularly. Providers still use separate systems, but communication becomes more regular, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between healthcare and social service sites is most often through a referral process that has a higher likelihood of success because sites have well-established processes. Staff at each site may feel like they are part of a larger team, but the team and how it operates are not clearly defined.

- Level 4 — *Close Collaboration with Some System Integration*

  There is closer collaboration among healthcare and social service providers, and there is the beginning of integration in care through some shared systems. Often, complex patients/clients with multiple medical conditions and HRSNs drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients/clients, they have a better basic understanding of each other's roles.

Integration of Healthcare and Social Services

- Level 5 — Basic Integration of Practices and Systems

  There are high levels of collaboration and integration, with frequent personal communication between healthcare and social service providers. Leaders and providers actively seek system solutions as they recognize barriers to integration for a broader range of patients. While some system issues may not be readily resolved, providers at each site understand the different each other's roles and cultures and have started to change their practice and structure of services to better address HRSNs for defined patient populations and impact SDH for broader communities.

- Level 6 — *Full Integration in a Transformed Practice and Network*

  The highest level of integration involves the greatest amount of practice and system-level change. Integration between providers has allowed organizational cultures to blur and blend to support practice and/or system-level change. Providers and patients view healthcare and social services as a seamless network serving and accountable to defined populations and geographic communities. Solutions are regularly developed and tested to satisfy HRSNs for patients/clients and to address identified system and policy barriers to SDH.

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COORDINATION		COLLABORATION		INTEGRATION	
Level 1 *Minimal Coordination of Services*	**Level 2** *Coordination at a Distance*	**Level 3** *Basic Collaboration of Practices*	**Level 4** *Close Collaboration with Some System Integration*	**Level 5** *Basic Integration of Practices and Systems*	**Level 6** *Full Integration in a Transformed Practice and Network*
Goals & Vision					
➤ Scope: Narrow, time-limited effort to address a goal of one partner - often the the healthcare system - by identifying **HRSNs** for some patients/clients and referring them to social services. Focus varies.	➤ Scope: Narrow, focused, time-limited effort to address different healthcare and social service goals by screening and referring for HRSNs for a defined patient population.	➤ Scope: Focused, time-limited effort to address a shared goal for healthcare and social service providers by addressing HRSNs for defined patient populations.	➤ Scope: Focused effort to address shared goals over time, including improving effectiveness and efficiency of the collaborative, by addressing HRSNs for defined populations; commitment to grow collaboration over time. Shared interest to address **SDH** for communities.	➤ Scope: Long-term effort to address shared goals, pool resources, and hold each other accountable by improving HRSNs and SDH at the community, system, practice, & individual level for defined populations within a geographic community.	➤ Scope: Long-term commitment to redesign core structures, systems, and business relationships to achieve common goals by improving HRSNs and SDH at the policy, community, system, practice, & individual level for defined populations and communities.
➤ Targets of intervention are one or more patient populations with HRSNs. ➤ Success only measured in **population health**-related clinical utilization and health outcomes.	➤ Target of intervention are specific patient populations with HRSNs. ➤ Success measured primarily in **population health**-related clinical utilization and outcomes.	➤ Target of intervention includes organizations and specific patient populations with HRSNs. ➤ Success measured in clinical & social service outcomes and utilization. This includes but is not limited to **population health** outcomes defined by healthcare partner.	➤ Target of intervention includes organizations, families, and specific patient populations with HRSNs. ➤ Success measured in shared utilization, outcomes and organizational costs/revenue. May involve some non-clinical settings. Aligned with **population health** outcomes.	➤ Target of intervention includes defined communities, organizations; and all individuals and families with HRSNs. ➤ Success measures include **population health** & **community health** e.g. changes in health & social conditions & system-level costs. Interventions across clinical & non-clinical settings.	➤ Target of intervention includes policy-making bodies, defined communities, organizations, and all individuals/families with HRSNs. ➤ Success measures include **population health, community health & public health** domains. e.g. change in health outcomes, HRSNs, social & structural determinants.

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Healthcare and Social Service providers:					
➢ Have separate systems and facilities ➢ Communicate about cases only rarely and under compelling circumstances, driven by provider need ➢ Rarely meet in person, with limited understanding of each other's roles ➢ Rarely review care team and/or program level outcomes	➢ Have separate systems and facilities ➢ Communicate periodically about shared patients, driven by specific patient issues ➢ May meet as part of larger community; appreciate each other's roles as resources ➢ Occasionally review care team and/or program level outcomes; information sometimes used for separate quality improvement projects	➢ Have separate systems; may be near or co-located ➢ Communicate regularly about shared patients, by phone or email ➢ Collaborate, driven by need for each other's services and more reliable referral ➢ Meet occasionally, feel part of a larger, informal team ➢ Regularly examine care team and program level outcomes; information used for separate quality improvement projects	➢ Share some systems, like scheduling or referral platforms ➢ Communicate as needed, sometimes in person ➢ Collaborate, driven by need for consultation and coordinated plans for difficult patients ➢ Have regular face-to-face interactions about some patients ➢ Basic understanding of roles and culture ➢ Regularly examine care team, program and, occasionally, system level outcomes; identify shared challenges; information used for shared quality improvement campaigns to improve care and HRSNs. SDH barriers identified.	➢ Actively seek system solutions or develop workarounds together ➢ Communicate frequently, often in person ➢ Collaborate, driven by desire to be part of joint team ➢ Have regular team meetings to discuss overall patient/client care ➢ In-depth understanding of each other's roles and culture ➢ Regularly examine care team, program level, system outcomes and system barriers; information used for organization & cross-sector improvement efforts; system solutions to improve SDH discussed and tested	➢ Have resolved most system issues, functioning as a robust network ➢ Communicate consistently at the system, team and individual level ➢ Collaborate, driven by shared concept of team care ➢ Have formal & informal meetings to support medical and social care; Have roles and culture that blur or blend ➢ Regularly examine care team, program, system & policy level outcomes and barriers; information used for cross-sector improvement efforts; regularly test and advance system & policy solutions to improve SDH and **structural determinants**

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Screening, Referrals, and Care Plan					
- Screening and assessment done according to separate practice models; high variability of processes - HRSN screening instruments may not be validated - Separate treatment plans	- Screening based on separate practices; information may be shared through formal requests - HRSN screening instruments are largely validated - Separate treatment plans shared based on established relationship between specific providers - Separate responsibility for care; trainings	- May agree on specific screening criteria for more effective social service referral; largely use validated instruments - Separate service plans with some shared information that informs them - Assessment performed for some patients with HRSNs; including patient desire for help, immediacy of need, and barriers - Some shared knowledge of each other's practices, especially for high utilizers	- Agree on specific screening criteria using validated instruments, based on ability to respond to results - Collaborative treatment planning for specific patients - Assessment performed & documented for some patients with HRSNs; including patient desire for help, immediacy of need, and barriers - Some practices and training shared, focused on interest or specific population needs	- Consistent set of agreed upon screenings done across departments, which guide treatment interventions - Collaborative assessments & care plans for all shared patients - Practices shared across system or network with some joint monitoring of health and HRSNs for patients and community-wide SDH - Dimensions of HRSN tracked (including patient desire for help, immediacy of need, and barriers)	- Population-based screening for HRSNs is standard practice with results available to all and standard response protocols in place - Shared assessment approach and care/service plan for all patients - Practices are team-selected, trained, and implemented across departments as standard practice - Dimensions of HRSN, SDH, and structural determinants tracked; results easily available to all
- Practices use separate systems to collect and track HRSNs for some patients; - Social service providers cannot access/view healthcare data and vice versa; - Manual HRSN data entry into electronic health record and/or registry	- A separate software system collects and track HRSNs for some patients; - Social service providers have limited view; - Some data entry automated; Views of HRSN data limited	- Population-based registry used to track some patients with HRSNs; - Basic interfaces support some data entry/view; - Social service providers can view/edit registry; - Some HRSN & service data shared electronically	- Some systems shared; Population-based registry used to track all patients with HRSNs; - EHR interface works well; +/- HIE - Social service providers share data on service provided and issue resolution electronically - Some use of HRSN data for risk analytics	- Shared systems facilitate data sharing, monitoring and management of all shared patients/clients, including data on HRSNs, outcomes, and services. Some agreements for data use sharing, governance. +/- HIE - Risk models and predictive analytics utilize shared data.	- Robust systems for management of clinical and social data for all shared patients in defined communities. Well-developed agreements for data use sharing, governance, shared accountability - Data systems inform tracking of SDH data (e.g. CHNA)

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Patient/Client Experience					
➢ Patient/client medical and HRSNs are treated as separate issues ➢ Patient/client must negotiate separate practices and sites on their own with varying degree of success	➢ Patient/client health needs and HRSNs are treated separately, but records are shared, promoting better care team knowledge ➢ Patients/clients may be referred, but a variety of barriers prevent many patients from accessing social services	➢ Health and HRSNs are treated separately, but services may be at the same location ➢ Medical, social service, +/- mental health providers co-locate services to improve service experience for patient/clients, although referral systems are still underdeveloped	➢ Patient/client health needs and HRSNs are treated separately, but warm handoffs occur regularly between providers ➢ Patients/clients are referred with better followup, but still experience collaboration as separate services	➢ Medical needs and HRSNs are treated by a team for shared patients/clients (e.g. those who screen positive for HRSN) and separately for others ➢ Service is responsive to identified needs of patients/clients regardless of point of service (medical, mental health, and social service)	➢ Patient/client needs are treated for all patients by teams, who function effectively together in a network or integrated system ➢ Patients experience a seamless response to all medical, mental health, and social needs as they present. ➢ Patients engaged in efforts to address SDH
Team/Practice					
➢ No coordination or management of collaborative efforts ➢ Little care team buy-in to integration or even collaboration, up to individual providers to initiate HRSN screening and referral as time and practice limits allow	➢ Some practice leadership in supporting information sharing for HRSNs ➢ Some care team buy-into collaboration and value placed on having needed information on HRSN	➢ Subset of organization leaders supportive but intervention is viewed as a project or program ➢ Care team buy-in to making referrals work and appreciation of social service availability	➢ Organization leaders provide stewardship, support integration through mutual problem-solving of some system barriers ➢ More buy-in to concept of integration but not consistent across care teams, not all opportunities for integration or components;	➢ Organization leaders provide stewardship, support integration, if funding allows. Efforts placed in solving ➢ Nearly all care team members engaged in integrated approach. Buy-in may not include change in practice strategy for individual providers	➢ Organization leaders provide stewardship, strongly support integration with expected change in service delivery, and resources provided ➢ Integrated care embraced by all providers, active involvement in practice change and system redesign

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