**Questions from New SIREN Social Care Conceptual Model Webinar**

1. Is it possible to post a link for the upcoming webinars shown a minute ago?
   - https://sirenetwork.ucsf.edu/news-events/events
2. "These results are really interesting, in particular because they seem to contradict one of the primary drivers associated with the original model— that of technology interventions that seek to automate processes by which people are routed from healthcare to social services.
3. To what extent can technology imperatives complement efforts to build relational capacities that are context-sensitive— and to what extent might a tech focus actually be at odds with the key ingredients of equitable process?"
4. You are exactly right. You are starting us down the correct path, away from the false exactitude of the biomedical model (finding the single cause).
5. Do you have more detail on want is implied by "connect"? I think there is a difference between printing a list and giving a warm handoff  Such a great question - I once did a deep dive into this very question and found that most studies don't define it as precisely as you describe.  I think a good working measure should be "did the patient feel they got resources to address their social need" - which is tough to measure of course.  But I love your question.
6. Do you have more detail on want is implied by "connect"? I think there is a difference between printing a list and giving a warm handoff
   - I attempted to make a taxonomy of how social needs resource connections are defined years ago: https://pubmed.ncbi.nlm.nih.gov/35078672/ This could likely use an update, but may be helpful.
7. Wow...this model fits what we do at Senior PharmAssist - been doing for 30 yrs...Helping older adults with limited incomes pay for and manage their medications, TAILORED community referral. and Medicare insurance counseling! it is linking social and medical care - using ... CARE/navigation. My question is - do you know how much it matters WHO delivers/addresses the social needs? In-person/telehealth from insurer, provider office, CBO already in relationship or what? Terrific work!
8. Our work in Colorado strongly confirms your hypothesis that investing in people developing longitudinal relationships of trust is central, and almost the opposite of the transactional screening and referral with an IT platform which is the dominant answer today.
9. Did you look at how" Patient Activation" or "Distress" measures impact positive outcomes? Or look at the qualities of the "navigator" in positive connection on the part of the client.  I see a lot of work on "social connection" "distress" and other barriers such that patients/clients may even feel that they don’t deserve to get better or trust the providers.
10. So glad to hear about the over focus on referral management platforms instead of including more focus on personalized pathway platforms that can connect to all parties both social and healthcare parties connected.  What is your knowledge of personalized pathway platforms?

11. I am totally loving this. I have been reflecting deeply of late about how healing in community looks and sounds - especially in the context of systemic racism and health equity.
12. I think part of the issue is that the "social care" system is not all that caring often, and just referring people into it may be the opposite of supportive/effective, as people run up against obstacles, bureaucracy, and scarcity.
13. Also, where is the patient feedback? This feels very one-directional, but patient voice is important for evaluating the effectiveness
14. What is the research on the differential impact on the people we serve? All the focus is on what WE do. There are no successful businesses that treat their customers as a single, undifferentiated group. Why are we not studying the differentiation in the people we are seeking to help? There are huge differences in age, background, situations, gender, experience, etc. Some people will respond superbly to straightforward navigation. Some really need what we call an “companion” to walk through life with them for a while. Lots in between. One more reason to drive for much larger “n’s”, and treat this for what it is, a complex adaptive system with a multiplicity of vectors.
15. Are there successful models for clinician "training" to tailor the care plan? When suggesting this as a "treatment" for social risks/needs, I have received push-back that either (1) clinicians already do this (when there is limited evidence that they do) or (2) this could result in substandard care or not following clinical guidelines.
16. One of the things that I worry about is that the model reduces the emphasis on connecting people to resources to reduce their social risks. In the United States we spend less on social needs and more on healthcare than any other high-income country. Consider the Netherlands where the spending numbers are flipped, for example. The work to integrate health and human services is tough work, for good reason. It means not just changing practice but changing funding models and shifting funding to address social needs in a meaningful way.
17. It makes a lot of sense that navigators or CHWs can provide multi-layered supports. However, like complex care management programs, staff and longitudinal support are expensive. If we move toward more navigation, how will it be funded? and will it increase the (somewhat counterproductive) pressure to prove ROI?
18. one question is whether health improvement and dec health care utilization is the right/only final outcome - even in the health care setting. maybe the intermediator boxes are excellent ends into themselves. Should we be happy w improvements (ie. worth the intervention) in those areas even if we. don’t see changes in health care utilization? On the flip side, do we need ROI $$ so that we can get insurers to cover these interventions Agreed! Decreased acute care / overall health care utilization feels like a high standard to hold interventions to, especially in pediatrics. Can we make the case that those intermediate outcomes should matter to payers? Increased OP utilization seems like one potential intermediate outcome to emphasize.
19. We still need to control for the "navigation to nowhere" problem. Camden's early RCT was stymied in areas of housing and other inputs that the system could not provide. Granted that the Adverse Childhood Experiences (ACES) screening suggest that people appreciate being asked even if they don’t want to engage in an intervention. Any results

on social screening and the ACES screening in California? (Ever use "ACEs" or " resiliency" scores on outcomes with SDOH?

20. 1Not a question, but I think Realist Evaluation (Pawson and Tilley as well as many others) might provide lots of ideas along with specific tools for identifying and testing mechanisms as well as dealing systematically with context.
21. This data supports the work we are doing at our physicians organization. We recognized that physicians' offices handing a patient a list of resources wasn't enough to close the loop for patients with unmet social needs. We have partnered with a CHW organization that our practices can refer patients screening positive for unmet social needs to for resource support. The CHW organization reports back to the physicians' office on the outcome of the referral.
    -What is your organization and who do you partner with? Interested in this model.
22. This data supports the work we are doing at our physicians organization. We recognized that physicians' offices handing a patient a list of resources wasn't enough to close the loop for patients with unmet social needs. We have partnered with a CHW organization that our practices can refer patients screening positive for unmet social needs to for resource support. The CHW organization reports back to the physicians' office on the outcome of the referral. in this regard, we are building CHWs into our health system with EHR access and full bidirectional communication to the providers and to the other community resources - initially developed with UPenn IMPACT help, but now self supporting in our Integrated health system. We are hoping to do a multi-level evaluation to understand the differential impact of the CHW being integrated into the health system AND the community. (we are at Maine Medical Center, Portland Maine)
23. Great to hear that we might be able to address anxiety among health care staff about the (lack of) closed loop referrals. But how can we still keep the momentum around that (i.e. isn't there still a need to figure this out?) while encouraging health care to invest in screening for SDOH even if they haven't figured out the closed loop referral solution?
24. In a recent meeting with one of the board of directors of my professional college, they told my colleagues and I that a focus on SDOH in healthcare was "misplaced" and that we shouldn't discuss social factors, since we lack interventions to address them. We clearly do not believe that (since we are here in this call and work daily to address social and systemic needs), but how would you respond to this comment?
    -housing options that are affordable and accessible are very limited. (many year waiting lists often) food delivery can be very limited - as well as help for addressing interpersonal violence - of course effective transportation is often not an option to be able to refer to
25. what happens if you flip the model to be a model of a patient's (then aggregated) own journey and needs through the systems they encounter as opposed to a model like this model that uses an institutional or provider / worker perspective model? It might bear different insights
26. "Mechanism: may vary for the same intervention across trials/settings - and account for failure to replicate successful studies.
27. ‘Matrix causation’ is am analytic approach that’s worth thinking about."

28. The types of social needs can range a great deal - is there any evidence for different mechanisms of improving social risk depending on what specific needs people have? Or the chronicity of the need?
    *-Great question. I think it would be very different for those who are experiencing housing and food insecurity versus education and social isolation.*
29. The types of social needs can range a great deal - is there any evidence for different mechanisms of improving social risk depending on what specific needs people have? Or the chronicity of the need?
    *-Thanks so much for those thoughts! Interesting about sorting the underlying reasons for chronicity, and also the research finding about interventions for greater number of needs showing greater impact.*
30. The types of social needs can range a great deal - is there any evidence for different mechanisms of improving social risk depending on what specific needs people have? Or the chronicity of the need? Agreed, Michelle: there's an immediacy to needs like housing and food insecurity, but education and social isolation are no less critical for seeing long-term positive outcomes.
31. How do we implement this model outside of the research setting, especially in the inpatient setting, where resources are so stretched? Perhaps we need to test screening by different resources (peer navigators, for example)?
32. I like a proactive research approach versus a reactive research model to social needs navigation.
33. do you do any formal testing for whether your mechanism model is credible-plausible-trustworthy to the community of interest (those making decisions based on the model)
34. Can you share that study/report?
    *-You can find AHC evaluations (stay tuned for the upcoming release of the next report later this spring) on the CMMI website. There is also a guide to implementing HRSN screening and many case studies/white papers that may be of interest to this group. https://www.cms.gov/priorities/innovation/innovation-models/ahcm*
35. Related to David's question about differentiation on how people respond differently, having a personalized pathway platform in place allows customized intervention pathways to be developed based on an individual's unique circumstances that can provide a database of how different interventions work for different people
36. i do think the point that we tend to treat all social risks as the same in these models is probably erroneous - just as some are harder to fix than others (i.e. housing), different social risks. probably have stronger impacts on health healthcare utilization
37. I think that AI with avatars that have a real-life appearance will probably be a key component to making referral platforms more palatable and productive. As creepy as that may sound…
    *-Yikes. That sounds like dangerously magical thinking; i know that executives have a lot of incentive to believe this, but we have a LOT of empirical reason to believe otherwise. All due respect but I would recommend engaging with strong negative prejudice against any claims about the value of AI as appropriate interfaces for people in need.*
38. Re: platforms. Is there any evidence that a platform like Pathways Health Hub which uses a community health worker navigator achieves the personal touch needed for success vs

the other closed loop platforms that just load up the list of needs and sends them to a CBO? We are documenting evidence that a personalized pathways platform being used in TN is achieving the needed personalized touch that is not found in referral management systems only

39. any feedback about race concordance with navigation assistance? and to agree with what Caroline just said - the relationships (and ease of communication) b/w the social care orgs is really important - and with the medical care team... and mostly - with the patient/client/participant.
40. The other concern with IT platforms for referrals/access is that may worsen equity as people without access to technology - rural, elderly, unhoused will be further disadvantaged. Another reason to evaluate the effect on health equity of any of our interventions :)
    *-these access to tech inequity hurdles are not fixed - and the growing ubiquity of handheld tech across groups (even many of the homeless) seems to diminish. Maybe part of the interventions will be in helping them access the tech to help them more broadly*
41. This is great! A few comments: Particularly for the healthcare setting, I believe it is imperative to define the patient population esp. for ROI/value/$$ for the service. The SDOH screening questionnaire doesn't necessarily ask "point-in-time" unmet needs i.e., it asks in the past 12 months. There is a lot of discussion around asking the "right" question(s). Lastly, I think the person navigating/working with the patient matters. We are discussing a patient population that is vulnerable (whether historically or currently) & perhaps not interfacing with the healthcare system "appropriately" (I bet much of their reasons is not solely based on their SDOH) So, what type of person (characteristics/attributes) is this navigator that figured out how to connect emotionally with this patient and assist them in closing their needs or improving their health? Thanks!
42. Is the problem with referral platforms more the issue with the closed loop rate not really representing the person with needs connection to resources?
43. Has there been much research about social needs screening & support in languages other than English and Spanish? From the limited research I've done in this area, it seems like a major area where inequities may be worsened (in person and especially w/ higher-tech approaches).
44. IP nursing vs CHW/Navigators screening and providing referrals
45. can you speak a little in depth of the OSH model?
    *-Happy to connect you with the folks at OSH and Rush.. Email me at laura.gottlieb@ucsf.edu.*
46. translator tools should be utilized to diminish these issues. Mass2-1-1/United Way uses HelpSteps with a google translator tool that makes it available in 100+ languages Google translate just is not the same as language concordant humans!
47. translator tools should be utilized to diminish these issues. Mass2-1-1/United Way uses HelpSteps with a google translator tool that makes it available in 100+ languages Same comment above pertains here — about the inappropriateness of AI tools in this context.

48. RE: best person to do the navigation/screening. Also not aware of research, but the AHC participants did a lot of QI around this, and anecdotally there were differences across sites even for the same populations/settings
49. Whether you call them a CHW, navigator, social worker, or companion, a critical distinction is the responsibility (long-term relationship building versus one-off transactional referrals), and caseload (are there few enough clients to allow the building of relationships?). Any studies of these distinctions?
50. Do you have thoughts / can think of other studies related to trust as a possible component within the emotional support pathway? And then, have you looked at any studies related to the potential harms in the patient/provider relationship when referral services are not adequately provided?
51. I also think that it's important to understand the different cultures in different cities and how that influences the impact of screening and connections. Therefore a RCT in a city on the West Coast findings may not apply to a city in the Northeast.
52. Tina we just started into a 2 year grant project with MDHHS to do similar work. We are using the grant funding to build a bidirectional pathway between our practices and our CHW organization into the EMR. The barrier being that we support independent physicians and are working with multiple EHRs to build this into. :)
53. and sometimes providing assistance is the ethical right thing even if it doesn't have the outcomes we'd like. Highly recommend reading "Rough Sleepers" by Tracy Kidder about the Boston Healthcare for the Homeless program
54. And ACH had differences in the third level about what "connection to services" meant. Not necessarily a closed-loop referral or even a direct referral.
55. Do know the impact of bad/inappropriate/broken referrals (call X for food; and X is closed, etc.) - and how that impacts "hearing/listening to" the next referral...esp. since so hard to sometimes ask for and accept a referral.
56. but was also hear - "if it matters we really should measure it" - if only to document NEED; but those who hear might then have the responsibility to work upstream or help the local CBOs, etc...
57. Yes still important to ask. Part of shared decision making
    *-Agreed, also patients get more out of working with CHWs than connection to resources alone i.e., knowledge, empowerment, relationship*
58. "Regarding this question about whether it's appropriate to screen for social needs that can't be addressed because there aren't sufficient resources to address them:
59. To what extent might this tension be aggravated by the conflation of the concept of "SDOH" — which is about systemic, structural, cultural issues 'upstream' — with downstream matters of personal situations and organizational workflow?
60. How can we clarify as a field that "SDOH" relates to things like public policy NOT service delivery"
61. Thank you, Laura. I love the script and setting expectations up front. Does the script/suggestions for if/how this info is placed in the EMR?
62. I have been hearing this question/objection for years. I have never heard as good an answer as Laura's. She nailed it. Thank you.

63. screening around firearm availability in the household is similar - even if you can't provide the gun safe, you can still help provide guidance about safer storage. even if we can't fix the housing problem, we can help understand their needs and think with our patients about ways that may help. Always great to have the biggest best interventions available but the notion of not letting perfection be the enemy of good is important (but we can't blow off what our patients have trusted to us - needs to be acknowledged.)
64. "someone was trying to care" was the subtitle of our qualitative study years ago
65. Can you put the link to the paper you mentioned that frames screening more as a shared decision making tool?
    - https://sirenetwork.ucsf.edu/tools-resources/resources/time-now-fostering-relationship-centered-discussions-about-patients