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Complex Construction:

A Framework for Building Clinical-Community Partnerships to Address Social Determinants of Health

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Overview

A growing number of health care providers and community-based social services organizations in New York and across the country are forging partnerships to address non-medical needs. Known collectively as social determinants of health (SDH), factors such as housing, food security, and poverty reach beyond the medical and clinical setting and profoundly influence physical and mental health and well-being. Over the past year, with funding from the New York City Population Health Improvement Program (NYC-PHIP), United Hospital Fund (UHF) has developed an initial framework for primary care providers to establish social needs screening and referral programs in concert with human services partners.

The steps for a referral process may appear deceptively simple: screening at the primary care practice; referral to the appropriate community-based organization (CBO); provision of social services by the CBO; and closing the communication loop between the CBO and the practice. However, successfully executing these steps is extremely complex. This report provides guidance on issues such as choosing a screening tool, developing a realistic workflow, identifying appropriate CBO partners, and building relationships. We also explore how these referral processes work in the "real world."

Scale and Sustainability Challenges

Partnerships between the health care and social services sectors are still in their infancy—they are a new and complex function for all parties involved. Though these collaborations hold promise to improve the health and well-being of individuals and communities, four challenges relating to scale and sustainability deserve an ongoing focus from stakeholders and policymakers:

- **There is no single standardized/interoperable approach to information technology** that supports tracking social needs in the primary care practice, identifies the most appropriate CBO to respond to various social needs, creates an electronic referral between practices and CBOs, and closes the feedback loop to determine if needs were addressed.

- **Increased screening is likely to increase the demand for services provided by CBOs.** It is not clear that those organizations—particularly the smaller human service organizations with fixed funding—have the resources needed to increase service supply to meet growing demand.

- Beyond highly-targeted investments in specific services for high-cost, high-need patients, **value-based payment (VBP) methods are unlikely to generate the provider and payer investments needed to respond to the type and volume of social needs** that may be identified as partnerships proliferate.

- **The effectiveness of these new programs needs to be evaluated**—whether they work from the patients' perspective in recognizing and responding to their social needs, and whether they are effective at a population level in identifying and reducing social needs which underpin many of the historical and current disparities in care and outcomes.

Introduction

A growing body of literature documents the impact of social factors on health. People with adequate income, who live in the "right" zip codes, tend to have adequate housing, nutrition, education, and a range of social supports. They tend to live longer with a lower burden of chronic disease than those who are less socioeconomically advantaged. People without such resources, particularly the poor, face a series of social and economic adversities—like homelessness and housing problems, food insecurity, unemployment, intimate partner violence, toxic stress, involvement with the immigration and/or criminal justice systems—that can negatively affect their lives and health.[1,2,3] These social factors (commonly referred to by the health care community as "social determinants of health," or SDH), often have a larger impact on a person's (and/or a community's) health than the medical care they receive.[4,5]

Driven by efforts to improve outcomes, reduce costs, and improve health equity, health care providers, payers, and policymakers are focusing on the need to systematically identify and respond to these issues. Screening for the presence of social and economic needs is a critical first step in identifying people who require specific services and referring them to organizations that can help them.

Primary care practices are trusted sources in addressing the health needs of patients. They are uniquely positioned to screen for, and respond to, the social needs of their patients.[6] Often, that entails referring the patient to community-based organizations (CBOs) that can provide services to meet the unique needs of that patient. In a perfect world, CBOs would report back to the primary care practice on the outcome of referrals, so the practice could be sure that documented problems are being addressed. Such information could provide answers to the following questions: Did the patient make and keep an appointment? Did she or he receive services? Has the issue been resolved?

The report provides a framework for better integrating primary care and social services in urban communities. It is a complicated, multi-faceted, and essentially local undertaking in a complex environment, in which medical and social services have grown and developed separately and are funded in very different ways. For health care providers and CBOs interested in developing clinical-community partnerships to address social needs, this report can serve as an operational guide with tools and techniques that can be customized to local capacity and context. It explores four basic steps—screening, referral, getting patients needed services, and informing the practice of the outcomes of the referral ("closing the referral loop")—and notes key questions, issues, and considerations for each step. For policymakers and other stakeholders, this report is a primer in the operational complexity of making these partnerships work, concluding with policy considerations that could be addressed to better support effective clinical-community collaboration that could improve overall health and well-being.

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[1] Adler, N. E., Cutler, D. M., Jonathan, J. E., Galea, S., Glymour, M., Koh, H. K., & Satcher, D. (2016). Addressing social determinants of health and health disparities. *National Academy of Medicine*.

[2] Magnan, S. 2017. Social determinants of health 101 for health care: five plus five. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

[3] Daniel, H., Bornstein, S. S., & Kane, G. C. (2018). Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Annals of internal medicine*, 168(8), 577-578.

[4] Schroeder, S. A. (2007). We can do better—improving the health of the American people. *New England Journal of Medicine*, 357(12), 1221-1228.

[5] For a more in-depth discussion of this issue, see Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health, https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

[6] (Ibid 3) Daniel, H., Bornstein, S. S., & Kane, G. C. (2018). Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Annals of internal medicine*, 168(8), 577-578.

Methodology

In 2018, as part of its participation in the New York City Population Health Improvement Program (NYC-PHIP), United Hospital Fund undertook a multipronged strategy to develop a "Blueprint for Primary Care/Community Partnerships" that would assess how primary care practices and partnering community-based social service organizations could collaboratively respond to the social needs of their patients/clients. This report is a result of that work. It is informed by the experiences of two federally-qualified health centers (FQHCs), dozens of key informant interviews, a broad literature review, and UHF's experience fostering clinical-community partnerships in pediatric settings. The two FQHCs, with grant support from UHF, planned and tested processes to identify and respond to social needs in their patient populations. FQHCs were a natural choice for this project because they: 1) serve patients with complex medical and social problems, living in underserved communities; 2) have traditionally taken a more expansive view of their role, often going beyond the provision of primary care in serving their communities; and 3) generally have augmented staff (social workers, care managers, behavioral health staff, designated enrollers) who are familiar with the resources already in place.

Framing Tools

This report is built on the premise that primary care practices need to establish more formal personal and organizational relationships with selected CBO partners, so that they can jointly develop an effective process for screening, referral, and the provision of needed services. To do this effectively, they need to develop and document their goals for the partnership, agree on mutual expectations and commitments, and pursue a series of basic steps and activities.

Building a clinical-community partnership to address social needs in a patient population requires significant change management. The tools developed at the outset, starting with clearly defined goals, will be important for planning and ongoing project management, helping to ensure that the partnership remains focused on the change sought.

The logic model in Figure 1 describes general processes and outcomes associated with developing a clinical-community partnership to address social determinants of health needs in a community. In building a partnership, primary care practices and community-based organizations that provide social services can define and develop their own inputs, activities, outputs, and desired outcomes that recognize and leverage resources and community and organizational contexts to achieve specific partnership outcomes.

[7] In early 2018, UHF awarded grants to Community Health Network (CHN) and NYU-Lutheran Family Health Centers (FHC), to help support their efforts to design and test approaches to improving their SDH screening and referral processes.

Figure 1: Primary Care – Community Partnership Framework Logic Model

Inputs	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes
• SDH screen • Referral network investigation and development • Workflow modification at Primary Care Practice and CBO to receive and make referrals • Staff education on CBO services	• Referrals • Patient follow-up (self report at next patient encounter) • CBO/Primary Care Practice closed loop communications • Workflow and service mapping between Primary Care Practice and CBO • Referral evaluation (process and outcome measures)	• Patient/Client data sharing • Referral uptake and adherence • "Preferred provider" relationship development	• Develop Primary Care Practice staff knowledge of CBO services, increase appropriate referrals • Improved # of patients with needs met • Develop CBO network of peer organizations providing similar or related services to same population	• Improved health outcomes/Stabilized patients • Bi-directional data sharing • Bi-directional referrals • Service attribution for VBP Contracting

Organization of This Report

This report describes some of the major issues partners will face as they develop and implement processes in the health care setting to identify and address social needs influencing health. Section 1 tackles the operational issues inside the primary care practice for social needs screening and all steps preceding referral to a partner social services organization. Section 2 focuses on developing partnerships between the practice and CBOs to get individuals connected with resources that can help address social needs. In Section 3, real-world examples of how a patient/client will navigate this system highlight the importance of an effective feedback loop between the practice and CBO(s)—both for tracking success and for continuously improving the entire process. Each of these sections includes a series of operational considerations and concludes with a set of tools that can be customized by practices and CBOs embarking on the social needs, clinical-community partnership journey.

The final section of the report takes a step back from the operational complexities and considers a number of policy—and environmental—context challenges that policymakers and stakeholders must consider to support the long-term success of clinical-community partnerships that address the social determinants of health.

I. Screening for Social Needs in Primary Care

Background

Primary care practices are accustomed to screening for, diagnosing, and treating medical problems (e.g., hypertension, diabetes, tuberculosis, or HIV). Problems that are beyond the practices' capacity and require specialty care are generally referred to a network of trusted specialists for consultation and care. In most cases, practices have well-established methods for referring patients to specialists and for receiving consultation reports from those specialists. However, similar processes for handling social needs are an unfamiliar task for most clinicians, for several reasons:

- Practices are generally hesitant to ask patients about issues unless they feel they can help address them

- Patients put substantial trust in their primary care providers, and clinicians may worry that questions about social needs will be viewed as an intrusion into patients' private lives, creating discomfort or undermining the trusted relationship
- Screening for social needs adds yet another task to an already complex workflow, one which is not inherently familiar or comfortable for practices

Before pursuing a clinical-community partnership, a practice's leaders must ensure that staff members recognize the value of screening for and addressing patients' social issues in the primary care setting. The practice, and all individual staff members involved, must also be willing to tackle the difficult issues that have previously kept them from screening for social needs and developing referral processes like those in place for specialty medical care. The considerations and related tools that follow are designed to help practices handle these difficult issues and ease the burden of developing social needs referral partnerships.

Considerations

Designing and piloting a process to systematically screen patients for social needs is a new function for most primary care practices. It is a complicated process that requires considerable planning. Doing it well requires an understanding of patients' needs and cultures; the development of tools and methods for screening; education (and perhaps changes in responsibilities and job descriptions) of key staff; and, ultimately, changes in the practice workflow.

Why it matters: How the screening process is designed and implemented can affect patients' willingness to disclose the social issues they face and can also influence the reliability of screening results in identifying important social needs. There are several aspects to this process, discussed below.

A. Selecting a Screening Tool:

Which Social Problems to Screen for?

The literature contains an extensive roster of social factors that can affect a person's health. In designing a screening process, practices must strike a balance between comprehensiveness and usability. Primary care practices should develop screening questions that are related to social factors and problems that are likely prevalent in their patient population and the communities they serve, and/or those that have the greatest impact on physical and mental health.

Providers currently screening for social needs generally focus on between five and ten broad categories. Major categories on one oft-cited screener include:[8]

- Food/nutrition
- Housing (e.g., access and quality)
- Income
- Literacy
- Safety
- Transportation

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[8] Mount Sinai PPS Social Determinants of Health Screening Tool, at https://partner.mountsinai.org/web/mt-sinai-pps/news/SDH-Screening-Tool

What Screening Tool(s) to Use?

To screen for social needs, practices can choose from a growing inventory of tools. The tools vary considerably in length, detail, reading level, and cultural competence.[9] Longer tools probe a wider range of issues, and some include "if yes" options that are designed to elicit more detailed information about specific social needs. Other screens emphasize brevity and patient/user-friendliness, focusing on broad problem identification and leading to in-depth discussion and probing by designated staff, later in the visit.

Testing has shown many of these tools to be generally reliable in eliciting honest and useful information from patients about their issues. Practices should select a tool based on the time needed to complete the screen, existing capacity for second-level probing of issues identified as current problems (a "positive" screen), and reading levels and cultural issues specific to the patient population. For some practices, it may make more sense to select questions from different screens instead of adopting an existing screening tool in its entirety.

Market-Test the Screening Tool

Patients are accustomed to being asked uncomfortable questions by their clinicians about factors and behaviors that may affect their health and treatment, and they often trust that the information will be handled confidentially. Screening for social needs goes well beyond that, probing for issues that patients may not be comfortable discussing with providers and potentially raising more serious confidentiality concerns (e.g., "Why are you asking me this? It's none of your business."). Practices need to test the acceptability of a process focused on screening patients for non-medical factors and, based on that feedback, decide how best to approach screening for social needs.

The wording of questions can be critically important. Before finalizing a screening tool, practices should consult a sample of patients to ensure that the screen includes pertinent questions and that the questions are appropriately phrased (e.g., not threatening or offensive) and likely to elicit accurate responses.

These considerations should also address how the screening tool is introduced to patients and by whom. Are they presented on paper or a tablet? Will a staff member ask questions, or will patients self-assess? Other issues to consider include wording questions at the appropriate reading level (especially if a patient will self-assess), availability in languages prevalent in the patient population, and the general cultural competence of the screening tool. Failure to test and subsequently address any of these issues before full implementation risks both patient and staff pushback and inaccurate patient reporting of their actual social needs.

B. Designing the Workflow

Whom to Screen, and When?

Not all patients need to be screened at every visit. Universal screening is likely to prove unwieldy and inefficient and to generate substantial "negative" screens. The intent of a social needs screening process is to identify patients' needs for specific social supports and respond to those needs. Objective criteria can help practices decide how best to introduce a screening process to their patient panel and

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[9] Social Interventions Research and Evaluation Network (2018). *Social Need Screening Tools Comparison Table*. Available at https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/adult-nonspecific.

what population to focus on (e.g., high-risk patients, all new patients, all annual well-visits, etc.). If these criteria alone do not fully resolve whom to screen and how often, practices must also consider appropriate timing between screens to assess whether identified social needs have been resolved and if new needs have emerged.

How Should Screening Be Administered?

Deciding how, where, when, and by whom the screening is done is the most important aspect of designing the process. These decisions can influence whether patients will be forthcoming about the social issues they face, and ultimately, determine the reliability of the results.

There are many different ways to administer a screening tool: patients could complete a survey in the waiting area using a paper form or electronic screening tool on a tablet; designated staff members (e.g., community health workers, intake specialists) might administer the screen verbally in the waiting area (using paper or electronic data collection); nursing staff could administer the screen in the exam room; or specialized staff (e.g., social work, nursing, health education, or behavioral health professionals and health home care managers) could ask survey questions consistent with their core job responsibilities.

One health center participating in this project chose to integrate social needs screening interviews as part of its regular patient interactions, rather than administering the screening tool as a discrete activity. Front desk staff asked about insurance or transportation, while nurses, social workers, or behavioral health staff asked other role-appropriate questions when meeting with the patient either before or after the physician interaction. While more organic to the practice's existing workflow, this approach required the documentation of screening outcomes by different staff in a common problem list/worksheet.

Each of these approaches could affect workflow in a number of ways, including how patients in need of services are identified, who interacts with them, and how follow-up actions are handled.

Tracking and Expanding on Identified Social Needs

However a social needs screening is administered, the initial results (particularly social needs identified by the patient as current problems) must be collated and entered into a patient's record so that subsequent steps and outcomes can be tracked. If the practice has an electronic medical record (EMR) system capable of accepting and managing social needs information, positive screening results can be entered directly into it. If not, staff will need to enter that information into a designated registry or care management system so they can track screen results and flag identified social needs for further action and follow-up at future visits.

A social need identified during screening is a high-level indication of a patient's need for assistance, but it is often insufficient on its own to generate a referral to a CBO for a specific service.[10] Patients with an identified need in a given category often require further discussion with a designated clinician in the workflow, to more clearly define the problem(s) patients and families face and enable the practice to make a targeted referral. (See call-out box below for an example, using a positive screen for housing issues).

While physicians can hold more in-depth discussions during the patient visit, these conversations often take place with a designated staff member (e.g., a social worker) with specific expertise. In

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[10] Health care-related transportation needs and connection to benefits enrollment resources are possible exceptions to this general rule, especially in FQHCs where there are existing in-house capabilities or referral mechanisms to nearby resources.

such cases, after an initial discussion with the physician in which the social need is discussed, the patient receives a warm handoff[11] (including an explanation of what will happen next and a personal introduction) to the designated staff member who can more deeply explore the results of the screen with the patient. This individual can help further define the social service need so that the patient can be referred to a CBO that offers the specific service he or she requires.

That follow-up discussion also provides staff with an opportunity to assess the patient's readiness—is he or she willing at this time to pursue/accept a referral to an organization that could provide assistance? It also provides an opportunity to understand the patient's own sense of relative priority/urgency of the identified need. The goal is to give staff additional information to help prioritize issues that require specific rapid response (e.g., intimate partner violence) and/or those the patient feels are most pressing.

Clarifying the Need To Make the "Right" Referral

Most screening tools are designed for efficient administration, focusing on identifying social needs across a range of different factors at a fairly high-level. They can reveal social needs in categorical areas (e.g., housing) which require a next-step discussion by an experienced staff person to clarify the problem and generate a referral to the "right" CBO.

For example, the screen may ask whether the patient is facing issues with housing, which may encompass a wide variety of different issues:

- Homelessness
- Living in a shelter
- Unstable housing, "couch surfing"
- Overcrowding
- Difficulty paying the rent or utility bills
- Poor building maintenance, including vermin infestation, elevators not working, lack of heat or hot water
- Landlord trying to evict them, to bring in higher-rent payers
- Paying more than 50 percent of income on housing
- Safety concerns in the building

Each of these issues is quite specific and addressing it may require a referral to a different, specialized CBO. Patients often benefit from having a "warm handoff" to a staff person with the requisite expertise to whom they can explain their need. This person can help them understand and weigh their options; decide whether to accept a referral (it is ultimately the patient who makes the decision, and he or she may not be ready or may have different priorities); and help them make initial contact with a CBO, if appropriate.

C. Preparing to implement the new workflow

Staff Training

Because screening for social needs requires a new workflow, staff buy-in is critical to success. Practice leaders need to educate and sensitize staff to the importance of this work and elicit input on how best to accomplish it without unnecessary disruption to the practice's existing workflow. All staff should be educated on the general importance of SDH, the health benefits of addressing patients' social needs, and the operational logistics of the new workflow. Staff directly involved in the screening process must be trained to perform their own roles and on how to handle internal or external referrals for patients identifying one or more social needs (a "positive" screening result), and how to respond to questions that might arise when the survey is administered.

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[11] The Agency for Healthcare Research and Quality defines a *warm handoff* as an encounter that "is conducted in person, between two members of the health care team, in front of the patient (and family if present). It includes the patient as a team member so that he or she can hear what is being discussed about the clinical problem, current status, and plan of care." Agency for Healthcare Research and Quality. (2017). Implementation Quick Start Guide: The Warm Handoff. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-qsg-letter.pdf
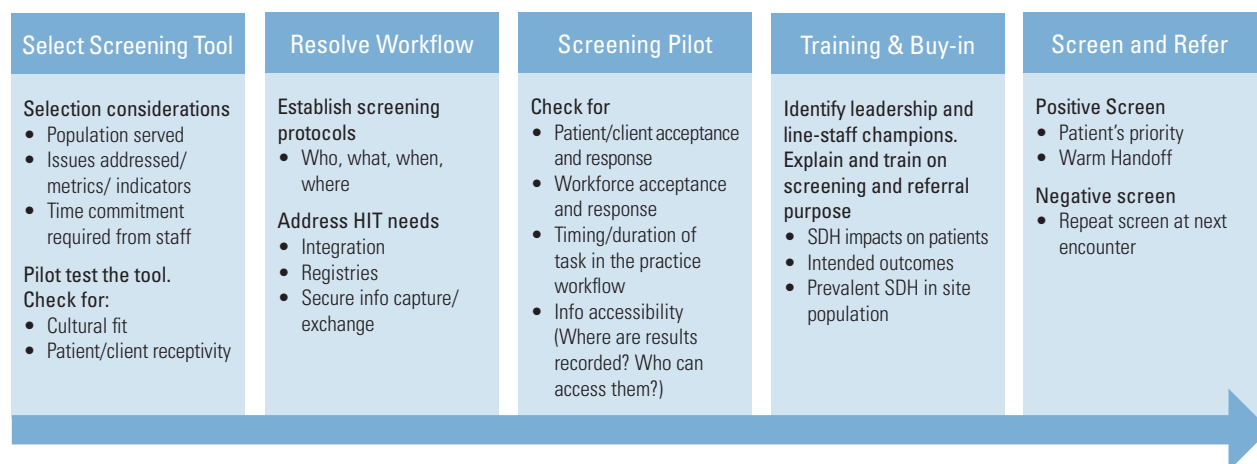
Implications for Information Systems

The new workflow should leverage existing information systems and/or include new tools that can support the screening process and subsequent actions. Practices need to have reliable systems to: 1) log, track, and report the results of social needs screening processes; 2) record referrals made to different CBOs; and 3) document the results of those referrals. Staff must be trained on how to document screening results, assign responsibility for responding to the initial documentation, and when and how to document follow-up actions. Ideally, the information systems will support efficient screening, referral, and follow-up, providing especially timely information to prompt future actions by staff and clinicians' future interactions with clients around identified social needs.

While not yet necessary for payment purposes, practices should consider building documentation of social need diagnostic codes into the billing system. This could be useful both in the current workflow and for future billing. Results of positive response to a given social need screen can be mapped to relevant "Z-codes" that exist in the ICD-10 coding system, but the crosswalk is not perfect, and there is no agreed upon standard for doing so. Eventually, this information may become important for broader population health management via improved risk stratification and potentially enhanced payment through risk adjustment based on social needs. In the interim, use of "Z-codes" or their analogs can help practices to better understand the SDH that are prevalent in the populations they serve and to correlate those SDH with other diagnoses and/or health care utilization.

Screening Process Map, Screening Tools, and Workflows

The two health centers participating in this project differed slightly in their approaches to screening tools and workflows, based on their pre-existing infrastructure and organizational relationships. Each addressed the considerations noted above in ways that "fit" their practice and the patient populations they serve. Their overall approaches to resolving those considerations were quite similar, however. The process continuum in Figure 2 generalizes those efforts into a more universally applicable approach. The health centers each went through steps of screening tool selection, internal workflow resolution, pilot testing the screening process, training staff and securing staff buy-in, and lastly, implementation of the screening and referral process. At each step, significant effort went into identifying and testing the screening tool with patients and clients to secure community buy-in. Then the practices had to develop clinical practice and documentation workflows to ensure that the information was collected, documented, and utilized thoughtfully during the course of care.

Figure 2: Primary Care SDH Screening Process Map

Select Screening Tool	Resolve Workflow	Screening Pilot	Training & Buy-in	Screen and Refer
Selection considerations • Population served • Issues addressed/ metrics/ indicators • Time commitment required from staff Pilot test the tool. Check for: • Cultural fit • Patient/client receptivity	Establish screening protocols • Who, what, when, where Address HIT needs • Integration • Registries • Secure info capture/ exchange	Check for • Patient/client acceptance and response • Workforce acceptance and response • Timing/duration of task in the practice workflow • Info accessibility (Where are results recorded? Who can access them?)	Identify leadership and line-staff champions. Explain and train on screening and referral purpose • SDH impacts on patients • Intended outcomes • Prevalent SDH in site population	Positive Screen • Patient's priority • Warm Handoff Negative screen • Repeat screen at next encounter

As noted, there are many different tools primary care providers can use to screen for social needs. Screening tools vary widely according to several factors: the types of social needs that are addressed; reading level; language availability; and the assessment of health behaviors, behavioral health factors, and health status.[12,13] Screening processes also vary widely from setting to setting, so a given primary care practice needs to tailor its own workflows to the existing workflow at the primary care site.

Figure 3 provides an example of a screening workflow as implemented by one of the FQHCs participating in this project. Practices considering screening for social needs need to consider where and how it fits in the litany of other screenings and the resulting designation of staff roles. The figure depicts what happens with different types of screens in this practice and who is responsible at each stage. For identified social needs, the social worker ideally receives a warm handoff from the nursing staff. If the social worker is not immediately available, he or she is tasked with following up with the patient promptly via a telephone call. In an emergency situation, when a subsequent phone call would not be adequate, multiple backup staff members are designated to step in for the social worker and receive the warm handoff from the nurse.

Figure 3: Sample FQHC Screening Workflow[14]

Nursing Warm Handoffs for Positive Screenings

	Social Determinants (Housing, Food, Legal, Literacy, Income)	Intimate Partner Violence	Mental Health Screenings (PHQ-2, PHQ-9, GAD-7, Edinburgh) Substance Use (AUDIT, DAST, CRAFFT)	Sexual Health (Sexual History, Positive HIV/STI/Hep C Test, Pregnancy Test)	Age-Based Medical Screening (MCHAT, Imm., Fall Risk, Mini Cog) Substance Use (Tobacco)
Clinical Staff Involvement	Social Worker (Warm Handoff to HHCM if patient is enrolled)	Social Worker	Social Worker	Health Educator	Provider Addresses
	TF to Social Worker	Health Educator	TF to Social Worker	Social Worker	
	On-site staff instead of TF if emergency	RN Manager	MH Emergency: BHT/PSYCH instead of TF Urgent Detox: BHT instead of TF	Provider	

(Leftmost column label: **Identified Need** for the header row, **Clinical Staff Involvement** for the body rows.)

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[12] A comprehensive overview of SDH screening and examples of various screening tools, with training guidance for residents and other members of the primary care workforce, is available from Greater New York Hospital Association at https://www.gnyha.org/tool/training-primary-care-residents-on-the-social-determinants-of-health/.

[13] UCSF's Social Innovation Research and Evaluation Network (SIREN) compiles screening tools, use cases, and links to evidence, if any, at http://sirenetwork.ucsf.edu/tools-resources/screening-tools.

[14] HHCM- health home care manager; TF- telephone follow-up; BHT- behavioral health therapist; PSYCH- psychiatrist; STI-sexually transmitted infection.

II. Developing Primary Care-CBO Partnerships for Effective Social Needs Referrals

Background

While primary care practices generally know their clinical specialty referral network quite well, they often know much less about CBOs that offer social services. There are myriad CBOs, ranging from large, citywide, well-developed, and multi-service organizations to small providers that focus on specific niche services in a specific community. Understanding that ecosystem and how to refer patients for specific services is a serious challenge for practices.

Similarly, while there are accepted standards for primary care to make a "good" referral to a medical specialist with an expectation of a timely and responsive consult note in return, there are no standards for making referrals to CBOs. Many CBOs have different organizational and service- or funding source-specific eligibility requirements, and their processes for accepting referrals and reporting back to referral sources tend to be more idiosyncratic. In addition, most CBOs lack the information systems required to provide patient/client-level reports and updates to their referral sources.

These two problems—the variety of and variability among CBOs, and their relative lack of infrastructure—substantially complicate the process of referring patients from a primary care site, getting needed social services, and "closing the referral loop." Existing and emerging information technology resources offer some tools for addressing these problems, but they are not a panacea. Promising social needs referral processes in the current market rely on formal and intensely personal referral relationships between primary care practices and CBOs. This section explores the process of forming partnerships and describes considerations for both practices and CBOs as they develop relationships.

Considerations

Primary care practices screening for social needs will identify a wide range of patient issues. Addressing those needs requires connections with CBO(s) providing the specific services that can meet their patients' identified needs. The following steps are designed to help practices and CBOs collectively develop partnerships that are mutually beneficial to the organizations and their patients/clients.

Identifying and Selecting CBO Partner(s)

The large number of CBOs can make it difficult for practices to know where to begin when developing clinical-community partnerships to address social needs. In addition to general community knowledge and input from patients on where they tend to go for support, practices can also use existing or emerging online and information system-based tools to locate potential partners. The Health Information Tool for Empowerment (HITE) was developed by the Greater New York Hospital Association in 2005 to provide hospital staff and clinicians with an organized online resource directory of social and community resources in and around New York City. Today, HITE offers information on more than 5,000 health and social services[15] organized in

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[15] Greater New York Hospital Association. (2019). *Health Information Tool for Empowerment (HITE)*. Retrieved from https://www.hitesite.org/

multiple categories and subcategories, searchable by service type and location/distance. Other emerging platforms that offer functionality beyond CBO "look-up" are discussed in more detail below.

Whether using an online or other social service identification resource, it is important for practices to develop criteria for selecting CBO partners. The following criteria represent one example based on UHF's experience supporting clinical-community partnerships, but they may need to be adjusted or prioritized to account for the unique practice and community context.

- Prior knowledge and positive working relationships
- Range of social services provided
- Capacity to accept and serve additional clients
- Alignment of social services provided with high-prevalence needs among the patient population
- Proximity to clinic and or patient residence
- Language and cultural alignment with patient population

Each of the health centers participating in this project chose to partner with large, multi-service organizations, with which they had prior experience. This enabled them to work with familiar CBOs in their respective communities that had the scale and capacity to address a range of different social needs. It is important to note that this is not the only, or necessarily the best, approach for partnerships in other communities, as the specific needs, resources, and partners may vary considerably.

Building Relationships into Partnerships

Effective relationships that address the social needs of patients require a commitment from leaders on both sides to establishing a true partnership and allocating the time and staff to develop and help manage that relationship. Clinical providers may not be aware of the range of services available from the CBO or its capacity constraints. Many CBOs may generally understand their clients' health needs but may not be familiar with the medical needs and treatments available for patients at the specific primary care site. To begin the process of becoming more familiar with each other's services and issues, the health centers and partner CBOs in this project started a series of informal interactions at the senior and staff levels, exploring the idea of a broader and more formal partnership and focused on making the referral-and-feedback system more effective and predictable. These interactions culminated in the development of memoranda of understanding between and among the partners that expressed the goals of the partnership, mutual expectations, and specific elements on which they would work together.

Developing Shared Goals, Mutual Expectations, and Accountability

The basic purpose of a PCP-CBO partnership is to regularize the referral process so that the social needs that harm the practice's patients' health and well-being can be addressed. This entails establishing standardized communication mechanisms, including tailored referral forms with expectations for the level and type of information to be submitted along with a referral.

Partnerships must be built upon shared expectations regarding service levels, accessibility, and feedback, with mutual accountability for reporting and follow-up. Regular team meetings and case conferences can promote ongoing communication and accountability, providing

opportunities to sync the rosters of active patients/clients, review the status of "open" cases, identify patients/clients for follow-up, and obtain and respond to feedback on what is, and is not, working in the partnership.

Resolving Difficult Issues Around Bi-Directional Data Exchange:

Establishing methods for information exchange is a fundamental issue in developing a clinical-community partnership to address social needs. Such an exchange must include referrals, notifications, alerts, and status reports on individuals referred for services. The partners need to agree on the communication format or mode for sending and receiving referrals, tracking services provided at the CBO, and reporting patient/client status back to the practice.

Most clinical providers use electronic medical records and embedded registries to record, query, and track patient-related information. CBOs generally have more rudimentary information systems; in such cases, the partners can use other ways to share information (e.g., exchanging client and status rosters in Excel and sending them by secure email or fax). Some CBOs may have the capacity to connect to practice medical records directly, but this is currently not common.

Practices and CBOs are increasingly using new platforms that have the potential to streamline the referral process, enabling providers to both "look up" available services by category and make referrals to CBOs using a single referral tool. If they have the proper access and capacity, CBOs can use the platform to generate status reports and close the referral loop. Such systems can also offer CBOs the ability to refer their own clients to other community-based services, adding to their value/utility.

While there is, as yet, no fully functional, system-wide referral platform in New York City, there are at least four competing platforms (NowPow, Healthify, UniteUs, and Aunt Bertha) which offer varying levels of search and referral capacity, each with its own client base, proprietary software, and capabilities. Adoption of these technologies is growing, but many of their potential capabilities (like the ability to send or accept a referral and/or to feed information back to referring providers) are still underdeveloped or underused. That said, the increasing adoption and use of such technologies has the potential to greatly simplify the exchange of information between clinical providers and CBOs.

Medical providers are particularly concerned about exchanging patient information and clinical data with non-clinical service providers, which may require formal inter-organizational data sharing agreements. Processes are currently under way to parse the issues involved and to develop standards and guidance for information exchange in clinical-community partnerships (e.g., a state-funded initiative sponsored by the Rochester Regional Health Information Organization), but until there is further guidance, this will remain an issue.

Specific Benefits to the CBO

Developing a stronger working relationship with primary care partners can give CBOs a deeper and more nuanced understanding of the services available in the health care provider's clinical sites and network and improve communications and the exchange of information. It can also yield some additional, CBO-specific benefits:

- Potential for increased referrals
- Increased awareness among CBO staff of the health care system's role in supporting client social well-being
- Opportunities to develop organizational capacity around data measurement, exchange, and reporting on both service processes and long-term outcomes
- Opportunities for increased efficiency through standardized processes across referrers
- Access to referral IT platforms that may broaden CBO referral networks and reach
- Opportunities to develop additional business acumen for responding to performance-based revenue opportunities, such as value-based payment contracts

Partnership Development Process Model

As noted, the health centers participating in this project chose to partner with two or more large, multi-service CBOs. In each case, the approach taken involved two phases, generalized in Figure 4, below. Health care providers and CBOs considering a partnership should consider each step in the partnership process model and ensure each step is addressed during the two phases of partnership development.

In phase 1 (see Figure 4), the health centers identified prevalent social needs in the community and population they serve and conducted an environmental scan to identify CBOs with which they might partner. In phase 2 (see Figure 5), practices worked with those CBOs to establish a process for managing the partnership and for communication and feedback loops regarding patients referred for services.

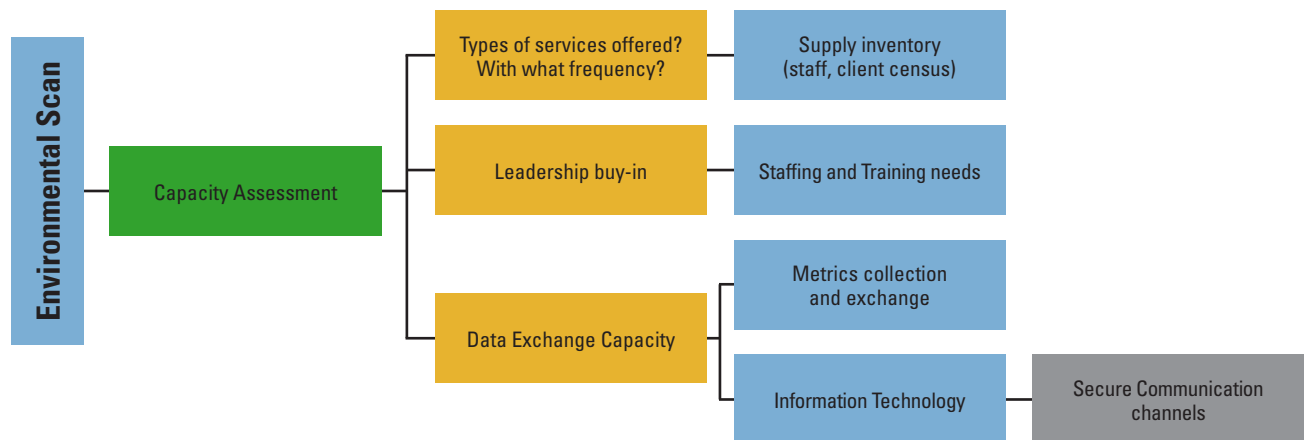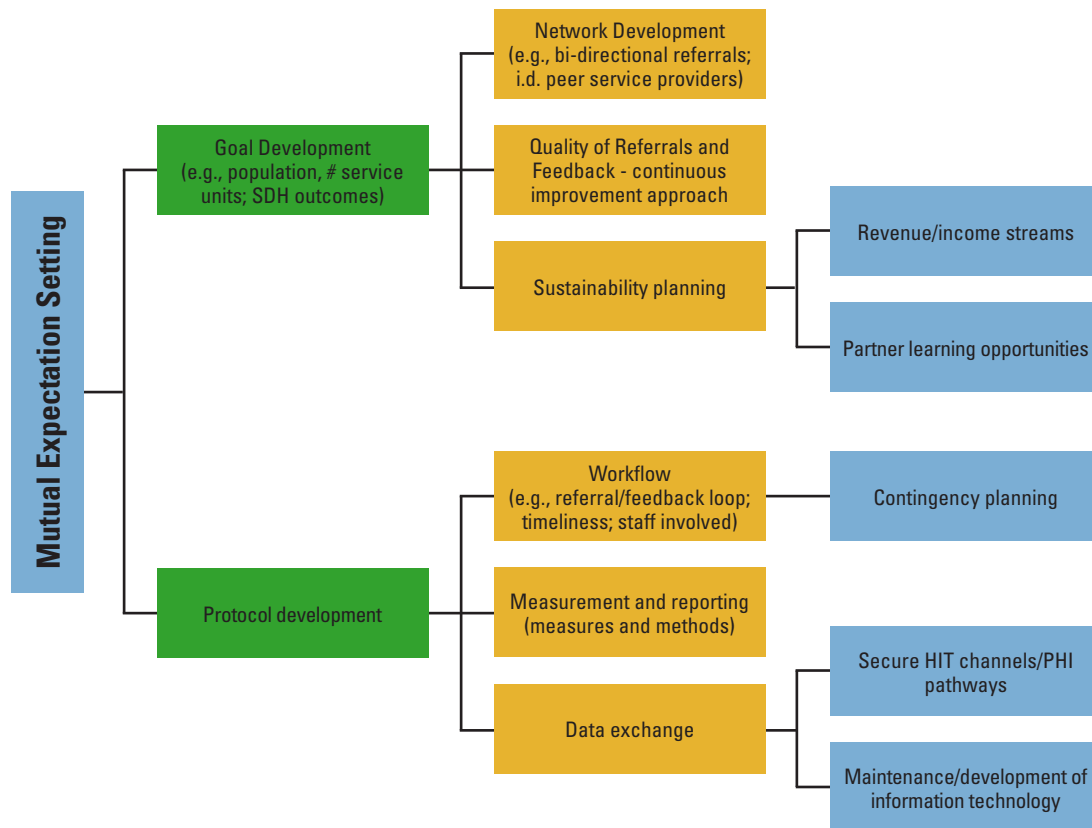### Figure 4 - Phase 1: Environmental Scan

Figure 5 – Phase 2: Mutual Expectation Setting

III. Referral Processes in the Real World

Formalizing referral-and-follow-up partnerships to address social needs is intended to create efficient and reliable pathways for consistently making referrals and delivering services to patients and clients. In an ideal example, this would mean that screening is effective; referrals, if needed, are appropriate and well-handled; the patient follows through with the referral; services are received; problems are addressed or fully resolved; and all partners know the resolution of the case.

To be effective in the real world, however, the process must also be able to respond to situations in which those ideal conditions are not present. In practice, the process must recognize the complicated lives underpinning the social needs discovered by a primary care practice and the potential CBO capacity constraints in meeting those needs.[16]

Meeting patients and participating organizations where they are requires a referral and feedback process that considers the following patient pathways where ideal processes may break down. Some examples include:

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[16] Gold, R., Bunce, A., Cowburn, S., Dambrun, K., Dearing, M., Middendorf, M., ... & Davis, J. (2018). Adoption of Social Determinants of Health EHR Tools by Community Health Centers. The Annals of Family Medicine, 16(5), 399-407.

- Patient refuses a referral
- Patient accepts a referral, but does not—for any of a number of reasons—connect to the CBO for services (this sometimes includes inability to follow-up due to bad contact information for the patient)
- Practice refers for the wrong service or to an inappropriate CBO
- The CBO is capacity-constrained and cannot provide the needed service in a timely fashion

Both the primary care practice and CBO partner need to be aware of the status of the patient at all points along any of the pathways noted above. Despite difficulties in bi-directional data exchange discussed previously, the referral and feedback loop must include the ability to flag and report each of these outcomes, so the CBO and/or practice can follow up as provided for in the workflow.

Whether the referral and feedback communications channels are electronic, phone, email, or fax, these flags should be documented in the practices' medical record or registry and communicated between the parties on a one-off basis or as a batch during regularly scheduled interactions. All partners should identify responsible point-persons whose contact information includes a telephone number and email, so they can be alerted of problems with their shared patients/clients.

Real World Examples

Patient Not Ready

The intent in improving primary care practices' social need screening and referral processes is to help their patients receive the social and support services they need. The fundamental principle in program design is that it should be patient-centered—patients should have the ability to agree or decline to participate in the screening process and/or to accept referral for services.

The literature on behavior change[17] suggests that a patient's stage of change—or readiness to act—can significantly influence whether he or she will pursue a given course of action. Understanding where a patient is in their progression—from pre-contemplation to contemplation, to preparation, and then action—is something that providers in the primary care setting must appreciate and respect. Not every patient is ready to act every time a referral for services is made. Often the best a practice can do is to let the patients know that help will be available when they are ready.

Missed Social Service Appointments

People are beset by a variety of stressors that can make their lives complicated and unpredictable. Making and keeping appointments with social and supportive service providers may be important to a patient when they are visiting a primary care practice, but once they leave the office, life can intervene. Sometimes they are unable to keep a scheduled appointment, or the appointment conflicts with another priority (e.g., work or needing to care for a sick child). In addition, some immigrant populations, depending on their status, may fear that accessing benefits or services may

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[17] The *Transtheoretical Model of Behavior Change* refers to Prochaska and DiClemente aggregate model of the behavior change continuum through six stages: precontemplation, contemplation, preparation, action, maintenance, and termination. More information on the model is available in Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. American journal of health promotion, 12(1), 38-48.

make it harder for them to secure permanent residency in the country.

Social service agencies are familiar with these issues and generally will accommodate "no-show" clients with another appointment. Primary care practices should also be alerted to missed appointments, so they can discuss it with the patient at the next visit and help facilitate rescheduling if needed. If a patient does not receive the needed service for which they were referred, the CBO should alert the practice; the practice can then follow up with the patient, reassess the options for service providers, and take appropriate action.

Wrong Referral / Inadequate Capacity to Provide Social Services

However well the screening process works, and however closely the referral matches the patient's identified need, there are likely to be instances when the community service provider turns out not to offer the type of services the patient actually needs and/or lacks the capacity to provide the needed services in a timely fashion.

Community social services agencies are not unfamiliar with either of these situations. In most cases, they will know alternative service providers and can help redirect the client to one that is able to accommodate the patient. In such situations, it is again important that the referring practice be made aware of the referral result, so that they (or the CBO) can reconnect with the patient and provide him or her with an alternative referral, if necessary.
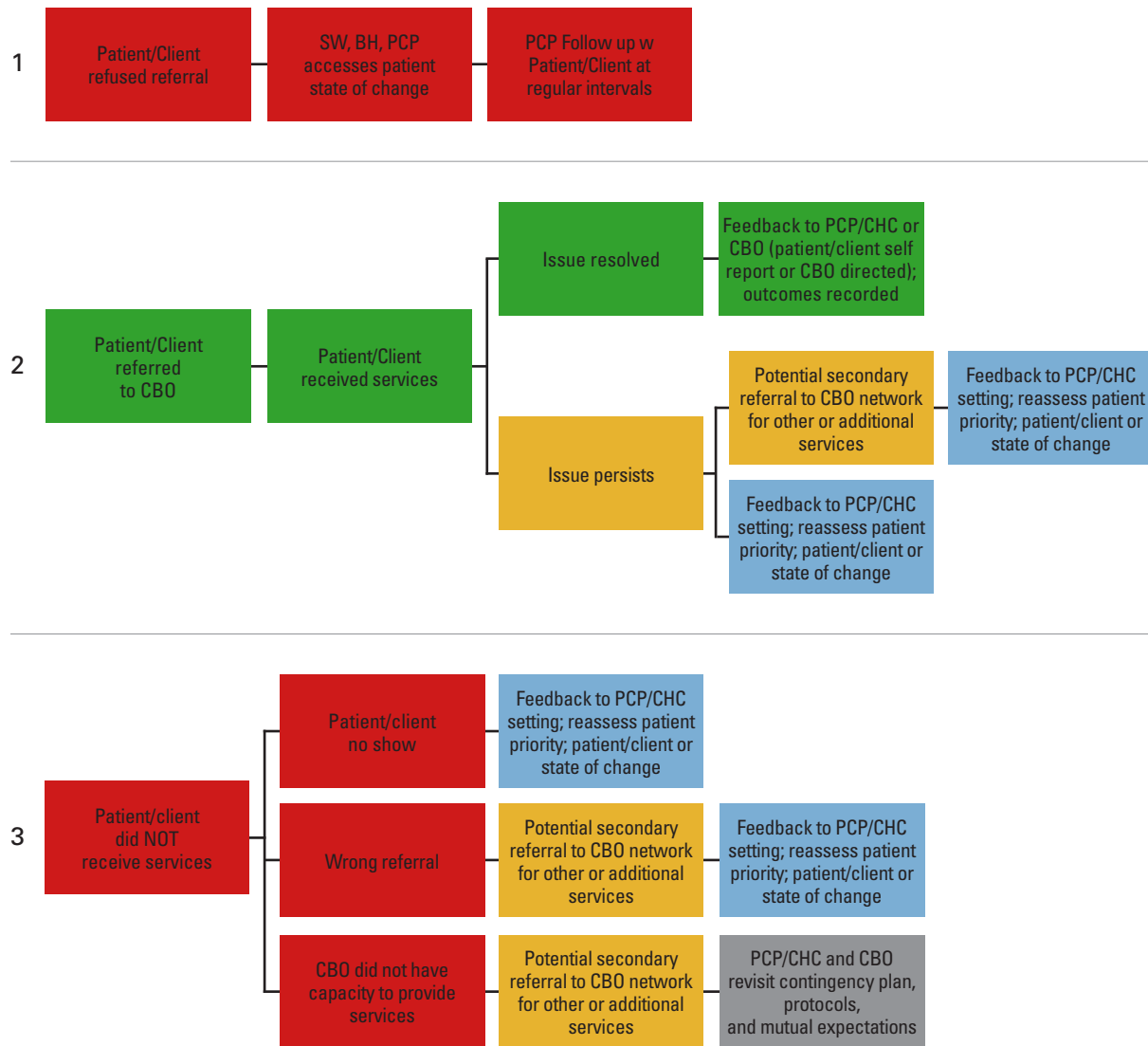
Frameworks and Processes

Participants in this project anticipated these potential breakdowns and developed referral processes that reflected the reality of serving people with complex social needs in the context of varying partner capacities.

Figure 6 depicts three common pathways of a referral and feedback loop continuum once a referral has been made. Each pathway depicts a potential complicating factor, introduced by either the health care setting, the patient, or the social service provider. The pathways also show the subsequent steps for addressing the issue in the referral and feedback loop workflow.

- Pathway 2 (center) shows an idealized referral feedback loop with the patient receiving the referral and pursuing services with the CBO; it also shows the potential workflows for the CBO and health care setting depending on whether the issue is resolved.

- Pathway 1 (top) shows a referral that has been stopped because the patient or client refused it; it also depicts the next steps of assessing the patient's preferences or capacity for action on the issue to be addressed and includes a note to follow up at the next encounter.

- Pathway 3 (bottom) shows a referral interrupted for a variety of possible reasons: patient inaction after the referral was made; a determination that the health care provider made an inappropriate referral; or the inability of the CBO provider to perform the service.

Figure 6: Referral and Feedback Loop – Process Map

1 | Patient/Client refused referral | SW, BH, PCP accesses patient state of change | PCP Follow up w Patient/Client at regular intervals

2 | Patient/Client referred to CBO | Patient/Client received services

Issue resolved → Feedback to PCP/CHC or CBO (patient/client self report or CBO directed); outcomes recorded

Issue persists → Potential secondary referral to CBO network for other or additional services → Feedback to PCP/CHC setting; reassess patient priority; patient/client or state of change

Issue persists → Feedback to PCP/CHC setting; reassess patient priority; patient/client or state of change

3 | Patient/client did NOT receive services

Patient/client no show → Feedback to PCP/CHC setting; reassess patient priority; patient/client or state of change

Wrong referral → Potential secondary referral to CBO network for other or additional services → Feedback to PCP/CHC setting; reassess patient priority; patient/client or state of change

CBO did not have capacity to provide services → Potential secondary referral to CBO network for other or additional services → PCP/CHC and CBO revisit contingency plan, protocols, and mutual expectations

IV. Policy Considerations for Social Needs Partnerships

Efforts by primary care practices and CBOs to establish partnerships focused on improving social needs screening and referral processes can help identify and address a range of factors that affect patient health. That work is not, however, taking place in a vacuum. A number of issues, largely beyond the control of practices and CBOs, can influence partnership success: the lack of a standardized, interoperable information platform to support the work; questions about the extent to which the social service sector can expand in response to a potentially sharp increase in demand; questions about whether and how emerging value-based payment methodologies can provide

resources to help support an expansion in needed social services; and the evaluation of partnership outcomes to foster payment discussions.

A. The Need for Common Language and Referral Technologies

Stakeholders interviewed throughout this project cited the need for information systems to assist health care providers with the following steps: screening for social needs, referring patients to the "right" CBOs for services, and communication between primary care practices and CBOs about the status of shared patients/clients from screening to referral through "closing the referral loop." Several technical, logistical, and adoption barriers stand in the way of information systems becoming the cure-all some are hoping for.

Screening Integration

There are many different social need screening tools. Some have the capacity to interact with EMRs, allowing primary care practices to see and query results, but many are stand-alone products, which require re-entry of the findings into an EMR, registry, or other care management/tracking system. Few of the screening systems include the capacity to translate identified needs into diagnoses like ICD-10 Z-Codes. These Z-codes are expected, at some point in the future, to enable payers to recognize and risk-adjust for the social burden of patients for whom providers are caring.

Identifying the "Right" CBOs

No database currently exists that is publicly available, generally accepted and adopted, comprehensive, updated, accurate, searchable, and that includes a full census of CBOs with descriptions of their specific offerings in an organized and logical typology. Databases that do exist are often proprietary, comparatively expensive, and may lack comprehensive descriptions of program eligibility requirements and up-to-date CBO contact information. None of the tools provide a sense of the CBO's current capacity to accept new referrals. This makes the process of identifying a CBO that can meet the needs of a specific patient difficult and time-consuming.

The Promise of Evolving Platforms

As noted, new information technology platforms are emerging to assist health care providers and CBO partners with many of the logistical steps in social needs screening, referral, and feedback. Some providers in New York City have used funding from the Medicaid Delivery System Reform Incentive Payment (DSRIP) program to acquire licenses for a platform. In some cases, providers have funded licenses for CBOs with which they are working, enabling them to receive referrals from that provider. In parallel, the Center for Health Equity at the New York City Department of Health and Mental Hygiene has funded licenses for a specific platform for a group of CBOs across the city. Generally, these licenses are packaged and priced as distinct modules, with tiered levels of service and capabilities: "look-up," sending and receiving referrals, and ongoing communication between clinical and community providers.

While there is potential value in the wider use of electronic referral platforms, substantial challenges to widespread adoption remain:

- Different tools operate on different platforms, to which both the "sending" and "receiving" organizations must subscribe. Once a provider selects a vendor, it can only use that tool to

communicate electronically with a CBO that uses the same tool. Referrals to CBOs without the appropriate tool (or license) will require different solutions.

- Perhaps more vexing, since CBOs generally receive referrals from a wide variety of providers (and from other CBOs) who may be using different tools with different capacities, they face the challenge of having to use two or more different referral systems.

- Until there is broad adoption of a specific tool as an "industry standard"—and/or interoperability standards (like HL-7 standards for clinical information exchange) for electronic referral platforms—providers and CBOs will likely need to continue to use partial solutions or create manual work-arounds to accomplish basic tasks.

B. Capacity limitations in CBOs

As providers become more effective in screening for social needs in primary care settings, the demand for social services for patients may increase substantially. This will place increased pressure on CBOs to provide more services and to invest in the capacity to work more effectively with their referral sources, likely using the electronic platforms noted above.

Ideally, increased demand would be met by an increase in the supply of CBO services. That may be a challenge for many CBOs, whose programs are largely funded in discrete annual allocations by city, state, and federal governments, and/or by a variety of grants, which often have program-specific eligibility requirements and limited opportunities for increased funding.

Another related issue is the number and diversity of CBOs across the city, their varying capacities for developing new ways of doing business, and new accountability requirements that may accompany partnering with health care providers.

There are thousands of CBOs in New York City, varying tremendously in size, scope, and infrastructure. Their sources of support and financial viability vary widely, as does their ability to expand services. Many of the smaller CBOs have limited staffing, resources, and information systems, relying on a small number of limited funding sources for their ongoing operations.

It is not clear how smaller CBOs, many of whom are well positioned to meet the needs of specific populations, will fare in this changing environment. To survive and thrive, these organizations may need to develop new capacities, like the ability to partner effectively with health care providers, participate in electronic referral systems, and demonstrate performance outcomes. For these smaller organizations, there may be pressure to consolidate and/or share key infrastructure elements (like information technologies, quality improvement, reporting, and contracting), which can enable them to do together what they may not be able to do alone.

C. Value Based Payment May Help, but It Won't Fix Everything

There is ample documentation that social determinants contribute to disparities in health and to increased health care utilization and costs. Existing literature often supposes—and small-scale demonstrations are beginning to show—that addressing at least some specific social needs for some populations will result in better health and lower utilization and costs. This potential for cost reduction is cited as a reason that providers and payers should invest in services that address social needs as part of emerging value-based payment (VBP) arrangements. Under the simplest

financial interest logic, it would seem to be in their best interest to do so because investments that respond to social needs will pay off in terms of reduced health care utilization and costs.

As part of the state's Medicaid DSRIP program, many Performing Provider Systems (PPSs—generally hospital-led coalitions of providers and CBOs) have invested in new health and social service staff who are focused on addressing social determinants.[18] They are arguably doing this in anticipation of VBP and its incentives for providers and payers to reduce preventable costs, which may be driven, in part, by non-medical needs. With the State's DSRIP program now in its final year, many stakeholders hope that the rapid expansion of VBP contracts will sustain those efforts. In addition to supporting existing PPS-developed infrastructure, VBP is cited as the vehicle for health care providers and payers to provide broader, sustained funding for community-based services that can improve health and reduce costs for Medicaid members with identified social needs.

Using VBP's projected savings as a source of investment in CBOs that are responding to social needs has great appeal, but there are some issues which may reduce its attractiveness to providers and payers.

Variable Proof of Impact

Evidence shows that targeted funding of social services for specific, high-cost, high-need populations can reduce preventable hospital or emergency department utilization. However, most investments have focused on addressing high-impact needs (like housing and food insecurity) in high-need populations.[19,20] Less evidence exists that investing in many other social services will by themselves reduce near-term utilization and cost.

Timeframe of Return on Investment

From the perspectives of equity and social justice, it makes inherent sense to address social needs like education, child care and parenting support, assistance in paying rent or utility bills, or assistance with legal issues. From a financial perspective, however, many of these interventions are investments with a longer-term return. Investing in such services is unlikely to result in measurable savings in health care costs during a given VBP contract.

Investing Ahead of Savings

Upfront investments are required to fund the expansion of services that address social needs and that may generate savings for a given population. Most VBP arrangements pay for health services using a variation of the existing fee-for-service methods, calculating and distributing savings by comparing actual costs against a benchmark. This model assumes that providers and payers are willing to invest ahead of the projected savings, which has implications for cash flow and involves financial risk.

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[18] For examples of DSRIP PPS projects focused on addressing social determinants of health, see Medicaid Matters NY's June 2018 DSRIP update, available at http://medicaidmattersny.org/cms/wp-content/uploads/2018/08/MMNY-DSRIP-updates-6-7-18-full-slide-deck.pdf

[19] McCarthy, D., Ryan, J., & Klein, S. (2015). Models of care for high-need, high-cost patients: an evidence synthesis. Issue Brief (Common Fund), 31, 1-19.

[20] Long, P., M. Abrams, A. Milstein, G. Anderson, K. Lewis Apton, M. Lund Dahlberg, and D. Whicher, Editors. 2017. Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health. Washington, DC: National Academy of Medicine. (p. 43-48) https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf

Misalignment of Investment and Return (Multiple Wrong Pockets Problems)

Payers are rightly concerned about retaining their members long enough to see financial benefits from these investments. When people change health plans, there is a significant potential that benefits flowing from an intervention funded by one payer will be captured by another.

Similarly, while investing health care dollars in social services may not generate measurable savings in health care costs, it could result in substantial benefits and potential savings to other sectors, like education and the criminal justice system. Given that the budgeting of costs and assignment of savings (or recognition of benefits) tends to be calculated in a sector-specific way, recognizing such cross-sectoral benefits is a challenge.

D. The Need for Evaluation

As health care providers develop and implement new processes to screen for social needs, effectively refer patients to partner organizations for services, and create feedback loops to track referral results, there is a pressing need to use data generated as part of that effort both to improve partnership performance and to assess the impact on people's health and lives.

Operational Feedback and Improvement

Developing a screening and referral process presents an opportunity for operational improvement using classic continuous quality improvement techniques (e.g., Plan, Do, Study, Act cycles). Tracking the rates of response to the screening tool (the number of screens administered and the specific social needs identified in each screen) can help guide future iterations of the tool and focus the practice on high-prevalence social needs as it develops and expands its CBO network.

Another area for ongoing evaluation and improvement is the content and applicability of the screening tool itself. For example, a tool designed to screen working-age adult patients for social needs may not be suited for screening other populations (e.g., children and adolescents, or the elderly). One of the health centers participating in this project found that pediatric providers felt the basic screening tool used by their practice was not well suited to identify their patients' needs.

Program Performance Improvement

The most important performance issue is whether patients who were screened and referred felt that the process helped them get the services they needed. Using focus groups and patient satisfaction surveys (both of which were piloted by the health centers involved in this project), practices can identify opportunities to tailor and improve the process. Qualitative feedback could include asking patients the following questions:

- How did you feel about the screening and referral process, and how it could be improved?
- Did the CBO address your identified social needs?

Impact of Social Needs Partnerships on Outcomes

Ultimately, practices need to assess whether an enhanced social needs screening process in primary care can effectively address issues affecting their patients' lives, health, and health care utilization. Implementing a formal screening process is important, but it is yet another new role being proposed

for already overburdened primary care practices, a role that will also require workflow changes and additional resources—so far without any additional compensation.

The value test of clinical-community partnerships in addressing social needs is twofold:

- Are patients/clients benefitting? Are the processes and partnerships effective in identifying and resolving problems related to social factors, thereby improving their quality of life?
- Do partners benefit? Are the health care providers, payers, and CBOs and their funders benefitting from these new processes and partnerships? Are they creating more effective and efficient ways of connecting patients who have specific social needs with services and, at least in some instances, by reducing health care utilization and costs?

Conclusion

Systematically screening for and responding to patients' social needs is increasingly recognized as an important new function for primary care practices, particularly those who care for underserved populations. Doing so more effectively and creating functional partnerships with social and supportive service CBOs can make a marked difference in patients' lives and health.

Designing and implementing effective processes to screen and refer patients, get them services they need, and "close the referral loop" are all new functions. They will require new processes and workflows both in the primary care setting and at partnering CBOs. It is a challenge, but providers across New York City and the state are broadly engaged in the effort to do just that.

Screening for social needs in the primary care setting makes sense from an equity and social justice perspective, as does partnering with CBOs to facilitate referrals for services; but it is, and will continue to be, a challenge. The lack of a common technology platform for connecting health care providers and CBOs, constrained resources for social services, and the absence of a compelling financial case regarding a return on investment are all factors likely to be rate-limiting. The potential of Medicaid and value-based payment systems to create a sustainability "solution" is raising hopes, but those hopes may not be completely fulfilled.