Using Risk Assessments to Segment Persons and Drive Intervention Strategy

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Who We Are

2-1-1 San Diego

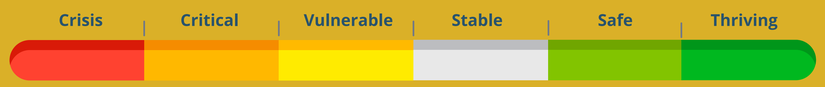
- Free, 24/7 service, 3-digit dialing code.
- Access to community, health, social and disaster services.
- Tailored programs take the client beyond just a referral.

Community Information Exchange

- Ecosystem of multi-disciplinary partner network.
- Uses a shared language and integrated technology platform.
- Community care planning, bi-directional referrals, and longitudinal client records.

Risk Rating Scale

- Measures vulnerability across 14 Social Determinant of Health and Wellness domains
- Evidence-based assessment tools designed to understand whole-person needs
- Plots risk on a Crisis to Thriving Scale



Assesses vulnerability within three major constructs

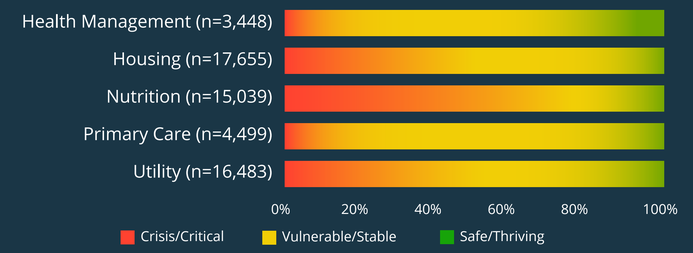
- **Immediacy**
- **Knowledge and Utilization**
- **Barriers and Support**

Phase I — Risk Level and Social Determinant Domain Segmentation

Objective

Utilize risk score to better understand the severity and complexity of the social determinant of health need.

Most Common Assessments by Risk Level



Data Highlights

- 2-1-1 San Diego collected 69,542 assessments between August 1, 2017 and July 31, 2018.
- Among the top 3 domains with completed assessments, 16% of clients were in a Crisis or Critical risk level for Housing, 30% for Utility, and 45% for Nutrition.

Intervention Strategy

- Utilize risk level to better identify appropriate resources for the individual, for example, if in crisis, find homeless shelter resources
- Based on risk, assign dosage, such as more or less intensive case management services.

Next Steps

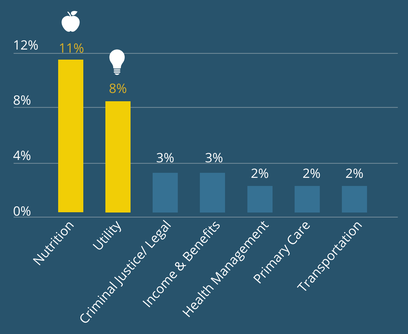
- Identify most common needs among risk and domain stratification.
- Develop risk profile, including demographics, who are the clients in Crisis/ Critical?

Phase II — Co-Occurring Social Determinant Needs

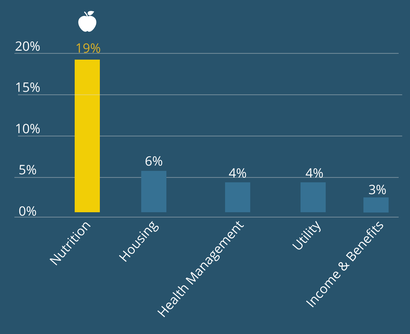
Objective

Understand trends and correlations among co-occurring social determinant needs, or the presence of two or more social needs.

Co-Occurring Housing Need with Other Domain



Co-Occurring Primary Care Need with Other Domain



Data Highlights

- 15% of clients have a need in more than one domain.
- **Housing and Nutrition** are most commonly paired needs.
- 46% of all clients showed indicators of food insecurity. For those in crisis for housing, 69% showed indicators for food insecurity.

Intervention Strategy

- Healthcare may change recommendations or care based on knowledge of multiple social needs.
- Social service providers could identify programs or resources that can address multiple needs or domains.

Next Steps

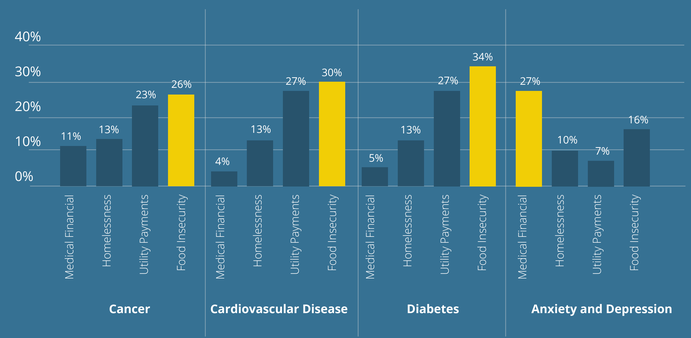
- Identify patterns that will allow for upstream interventions.
- Understand which domain correlations are the strongest predictors of future social needs, as well as identify combinations of social needs that are the strongest protective factors.

Phase III — Intersection of Health Conditions and Social Needs

Objective

Identify common social determinant needs among those with health conditions.

Most Common Health Conditions by Top Social Determinant Indicators



Data Highlights

- Food insecurity indicators were highest for clients with diabetes (34% of clients indicated some form of food insecurity, compared to those with anxiety or depression where only 16% experienced food insecurity).
- Medical financial indicators were highest for those with anxiety or depression (27% of clients experienced some form of medical financial hardships, compared to 11% with cancer).

Intervention Strategy

- Understanding which social needs present the most risk to populations with specific health conditions provides early indicators to proactively tailor intervention.

Next Steps

- Utilize SDoH data for hotspotting, identify populations of individuals with the highest health and social needs to create specific, targeted intervention strategies for this population.