Leveraging Robust Social Determinant Datasets to Understand Population Needs

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Overview

- 2-1-1 San Diego/CIE engages with over 125,000 individuals and families every year with diverse needs.

- These interactions generate robust, longitudinal client records.

- This presentation will highlight two examples of using data to drive action:
  1. Data insights from housing assessment, including initial findings on housing pathways
  2. Looking at whole-person needs through social determinant hardship indicators
2-1-1 San Diego

- Information and Referral
- Benefits and Navigation Services
- Resource Database

Food
Benefits and Enrollment
Veterans
Courage to Call
Health
Health Navigation
Housing
Housing Navigation
Person Centered Model

14 Social Determinant of Health and Wellness Domains

- Housing
- Employment
- Personal Care
- Education
- Transportation
- Utilities & Technology
- Disaster and Safety
- Legal
- Social Connection
- Activities of Daily Living
- Financial Wellness
- Nutrition
- Health Management
- Primary Care
- Education
Community Information Exchange (CIE)

An ecosystem comprised of multidisciplinary network partners that use a shared language, resource database, and integrated technology platform to deliver enhanced community planning.
Community Information Exchange Partners

[Logos of various organizations]
## CIE Impact

<table>
<thead>
<tr>
<th>Impact</th>
<th>Outcomes</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Health Indicators</td>
<td>Social Network Collaboration</td>
<td>Look-ups</td>
</tr>
<tr>
<td>Advance Quality of Life</td>
<td>Change from domain specific work to whole person care</td>
<td>Sharing Data</td>
</tr>
<tr>
<td>Address inequities (Race, Gender, Cycle of Poverty)</td>
<td>Change in intervention and interaction with people helping people</td>
<td>Client Consents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Referrals</td>
</tr>
</tbody>
</table>
Social Determinant Assessments

Measures risk across 14 social determinant of health domains

Assess vulnerability using evidence-based tools designed to understand whole-person needs

Plots risk on a Crisis to Thriving scale and can measure change over time
Assessment Framework

- **WHAT IS THE CLIENT’S OVERALL SITUATION?**
  - **CRISIS**
  - **CRITICAL**
  - **VULNERABLE**
  - **STABLE**
  - **SAFE**
  - **THRIVING**

- **HOW SOON DOES THE CLIENT NEED HELP?**
- **DOES CLIENT KNOW ABOUT RESOURCES IN THE COMMUNITY AND ARE THEY UTILIZING THEM?**
- **ARE THERE CLIENT LIMITATIONS OR BARRIERS PREVENTING CLIENT ACCESS?**
  - **WHAT SOCIAL SUPPORTS EXIST FOR CLIENT?**
Robust Datasets

68,784
Initial Assessments Completed

16%
Clients with Co-Occurring Needs

300+
Total Variables in 14 Assessments

Number of Initial Assessments - 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>16,786</td>
</tr>
<tr>
<td>Utility</td>
<td>16,582</td>
</tr>
<tr>
<td>Nutrition</td>
<td>15,245</td>
</tr>
<tr>
<td>Income &amp; Benefits</td>
<td>4,264</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4,013</td>
</tr>
<tr>
<td>Health Management</td>
<td>3,648</td>
</tr>
<tr>
<td>Criminal Justice/Legal</td>
<td>2,717</td>
</tr>
<tr>
<td>Education</td>
<td>1,503</td>
</tr>
<tr>
<td>Transportation</td>
<td>1,439</td>
</tr>
<tr>
<td>Social/Community Connection</td>
<td>855</td>
</tr>
<tr>
<td>Employment</td>
<td>519</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>437</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Household Goods</td>
<td>404</td>
</tr>
<tr>
<td>Safety &amp; Disaster</td>
<td>372</td>
</tr>
</tbody>
</table>

66% of assessments are captured in basic need domains (housing, utilities, nutrition)
2-1-1 San Diego recently launched the first policy brief around Housing Instability
Assessments Provide Housing Insights

About half (48%) of clients were in an unstable living situation, with about one-third needing help more immediately and a little over a third needing need within the month.

**Housing Situation**

- Unsheltered: 20%
- Sheltered: 24%
- Institutional Housing: 2%
- Unstable Housing: 3%
- Stable Housing: 43%
- Unknown Housing: 8%

**Immediacy of Housing Needs among Clients Experiencing Housing Instability**

- Immediately / Tonight: 14%
- Within a few months: 18%
- This week: 15%
- Within 1 month: 38%
- More than 3 Months: 14%

**Top 5 Barriers to Accessing Housing**

1. Rental costs
2. Move-in costs
3. Eviction
4. Violence or safety concerns
5. Credit or prior tenant history
Data Provides Better Picture of Need

There are higher numbers of people experiencing housing instability in areas in Central San Diego, with areas in North County experiencing similar rates of housing instability.

Population Summary

- 72% female
- 52% with children
- 42% Hispanic
- 24% White
- 20% African American
- 31% unemployed
- 17% working full-time
- 14% working part-time
- 90% with health insurance
Better Understanding of Pathways

Data shared through 2-1-1 San Diego and the Community Information Exchange provide insight into housing situations at first and second interaction.

The majority of clients who were homeless remained homeless, and those who were housed remained housed.

- 79% of clients remained homeless
- 73% of clients remained housed
Identify Populations for Targeted Interventions

Identifying populations of individuals who move from housed to homeless provide opportunities to understand barriers or factors that led to homelessness.

23% of housed clients became homeless by their second interaction.
Remaining Housed or Becoming Homeless

An initial dive into the population of individuals who were initially housed showed demographic differences between clients who remained housed and those who became homeless.

- African Americans comprise 5% of San Diego County, yet make up 27% of the housed to homeless population.

- Individuals in the housed to homeless group are more likely to be unemployed and have lower education levels.

Note: Housed includes clients in institutional and unstably housed, homeless includes sheltered, unsheltered, and unspecified homeless.
Remaining Housed or Becoming Homeless

Referral data also signal positive outcomes for prevention programs.

Intervention Differences

<table>
<thead>
<tr>
<th></th>
<th>No Prevention or Payment Assistance Referrals</th>
<th>Received Prevention or Payment Assistance Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining Housed</td>
<td>69%</td>
<td>79%</td>
</tr>
<tr>
<td>Becoming Homeless</td>
<td>31%</td>
<td>21%</td>
</tr>
</tbody>
</table>

- Individuals that received a referral to a housing prevention program or payment assistance program were more likely to remain housed than those who did not receive a referral to these types of programs.

- Further analysis is needed to explore the difference in outcomes for individuals who receive the service, versus those who are referred.

Note: Housed includes clients in institutional and unstably housed, homeless includes sheltered, unsheltered, and unspecified homeless.
Policy Implications

1. Identify Upstream Indicators to Prioritize and Differentiate Prevention Assistance: Need to better understand the situations that people face in the months leading up to homelessness and identify the most appropriate interventions and intervention access points. For example, emphasize programs that engage individuals with lower levels of education or limited job experience.

2. Employment is a Critical Factor: Individuals experiencing housing instability, including those in the housed to homeless group show higher rates of unemployment, and lower rates of full and part-time employment. Policymakers need to ensure households are connected to reliable workforce development resources and build on existing partnerships.

3. Persons of Color are Disproportionately Represented: African Americans only represent about 5% of the population in San Diego County, whereas they represent 27% of individuals moving from housed to homeless. Strategies aimed at addressing these issues must have an equity lens and framework.
Social Determinant Hardships
Social Determinant Hardships

Hardship indicators were initially chosen from a qualitative analysis on what led to the most recent housing crisis as a way to identify areas of the city most at risk for housing insecurity or homelessness.

SDOH Assessments → Variable Selection → Standardized Risk Levels → Hardship Indicators

- Recode responses to classify risk into three buckets:
  - High
  - Medium
  - Low

- Food insecurity
- Utility payments
- Housing insecurity
- Medical debt
- Unemployment
- Criminal justice
Localized Trends

SDOH Hardship Indicators were mapped by zip code to identify which areas experience which types of hardships.
Intersection of Health Concerns and Social Needs

SDoH Hardship Indicators rates were compared by health concerns to begin identifying the intersection of health and social.

Most Common Health Conditions by Top Social Determinant Indicators

<table>
<thead>
<tr>
<th></th>
<th>Cancer</th>
<th>Cardiovascular Disease</th>
<th>Diabetes</th>
<th>Anxiety and Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Financial</td>
<td>11%</td>
<td>4%</td>
<td>5%</td>
<td>27%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Utility Payments</td>
<td>23%</td>
<td>27%</td>
<td>27%</td>
<td>7%</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>26%</td>
<td>30%</td>
<td>34%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Reach out to 211 for data and research partnerships!

Thank you!

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