



SOCIAL DETERMINANTS OF HEALTH TOOLKIT

ADDRESSING
HEALTH EQUITY

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Commissioner

City of Philadelphia
 **DBHIDS**
DEPARTMENT of BEHAVIORAL HEALTH
and INTELLECTUAL *dis*ABILITY SERVICES



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Objectives

This toolkit serves as a guide to understanding the social determinants of health (SDOH), their impacts at the city, state, and national levels, and the Philadelphia Department of Behavioral Health and Intellectual disAbility Services' (DBHIDS) approach to improving behavioral health equity and population health overall.

Toolkit users will be able to:

1. Define and conceptualize various SDOH.
2. Understand facts and figures related to SDOH.
3. Identify at least three partnerships and projects that DBHIDS has undertaken to improve SDOH in Philadelphia.
4. Develop their own action plan for improving SDOH at an organizational level within their communities.
5. Use online resources to address SDOH in their communities.

INTRODUCTION

Key Terms and Concepts

Childcare

Services that offer safe, skilled, age-appropriate, accessible, and affordable supervision of children via daycare sites, babysitters, or other non-academic providers.

Community-Based Organization

A non-profit group that supports and serves the specific needs of their local community via volunteers, donations, and sponsorships.

Cost-Burden Refers to instances in which the monthly cost of rent or mortgage is more than 30 percent of household income.

Employment

The state of being employed, unemployed, or inactive. Employed individuals may be engaged in either full-time or part-time work; they may also be self- or under-employed. Under-employed individuals either do not have enough paid work or do not engage in work that allows them to use their full skill set. Unemployed individuals are looking for work but not yet working. Inactive individuals are not employed and are not looking for work.

Food Desert

A geographic area within a community, neighborhood, or city in which there is no access or extremely limited access to fresh and healthful

fruit, vegetables, and whole foods. These often exist in high-poverty areas.

Food Insecurity

Uncertain or limited access to food at a household-level, and lack of access to three healthful meals daily.

Place-Based Approach

Considers barriers and challenges that occur at the neighborhood level; focuses on change within a specific community.

TIP (Transitions, Integrations, Partnerships)

A unit at DBHIDS that focuses on housing opportunities for individuals with behavioral health needs.

Transportation

The infrastructure, systems, and automobiles that individuals use to travel from one location to another. This includes but is not limited to access to vehicles, cost to travel, and commute times.

Walkability

The measure of neighborhood or community's access to sidewalks and paths that can be safely used.

Part I

THE SOCIAL DETERMINANTS OF HEALTH



SOCIAL DETERMINANTS OF HEALTH

The U.S. Centers for Disease Control and Prevention defines social determinants of health as the “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes.”

ECONOMIC STABILITY	NEIGHBORHOOD AND PHYSICAL ENVIRONMENT	EDUCATION	FOOD	COMMUNITY AND SOCIAL CONTEXT	HEALTH CARE SYSTEM	CONDITIONS ↓ OUTCOMES
Employment	Housing	Literacy	Hunger	Social Integration	Health Converage	
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability	
Expenses	Parks	Early Childhood Education		Community Engagement	Provider liguistic and Cultural Competency	
Debt	Playgrounds	Vocational Training		Discrimination	Quality of Care	
Medical Support	Walkability	Higher Education				
HEALTH OUTCOMES Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations						
Source: Addressing Social Determinats of Health: Beyond the Clinic Walls, AMA STEPS Forward						

Factors noted above such as housing, employment, discrimination, and access to healthy food impact life expectancy, mortality rates, health status, and a variety of other qualitative and quantitative outcomes.

The United States Office of Disease Prevention and Health Promotion's Healthy People 2020 initiative has established five key areas of social determinants of health, utilizing a place-based approach:



Source: healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

According to their framework, various social determinants of health fall into each key area. Housing, employment, and food insecurity, for example, are associated with economic stability. Housing quality and access to healthful foods, however, correlate with neighborhood and built environment considerations.

The World Health Organization (WHO) goes on to note the SDOH "are mostly responsible for health inequities -the unfair and avoidable differences in health status seen within and between countries." When SDOH are addressed and improved, health inequity is reduced, and health justice is achieved. The WHO Commission on SDOH also posits that "the social conditions in which people are born, live, and work are the single most important determinants of good health or ill health, of a long and productive life, or a short and miserable one."

Although there are numerous SDOH categories, this toolkit will focus on:

- Housing Security
- Employment and Economic Security
- Food Insecurity
- Transportation
- Technology

Housing Security

Housing instability may include one or multiple challenges related to the maintenance of safe, stable, and affordable housing. Problems such as experiencing cost-burden for rent or mortgage payments, being frequently displaced, and residing in overcrowded dwellings are all examples of housing instability.

Employment & Economic Security

Employment and financial security transform systems so people are healthy, housed, prepared for work, connected to job opportunities, and more, while acknowledging the impact that racial inequities have had on employment and other systems. Obtaining and sustaining employment and financial security allows Philadelphians to improve their quality of life by providing access to employment-based healthcare benefits and the ability to afford housing in a community of their choice. Employment and financial security provide Philadelphians a sense of contribution to society conducive to mental and physical wellness.

Food Insecurity

If a household is unable to have enough food for each member to have a healthy, fulfilling life, then they are experiencing food insecurity. Hunger is often measured as a function of food insecurity. Some organizations define food insecurity as missing at least one meal per day. Conversely, the U.S. Department of Agriculture defines food security as "access by all people at all times to enough food for an active, healthy life."

Transportation

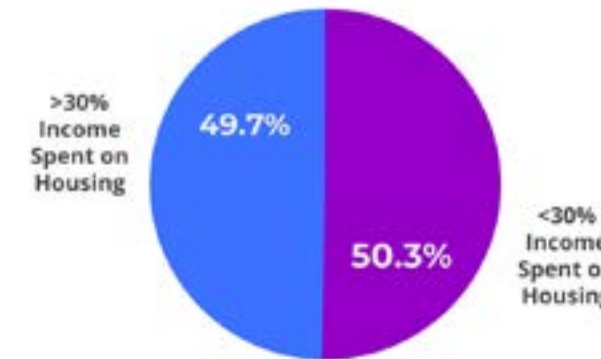
Access to reliable, affordable, safe, and efficient means of transportation impacts multiple health outcomes. Updated city infrastructure for public and private transportation as well as increased walk-ability to access various services and resources also plays a role. Lack of dependable transportation can result in missed physical and mental health appointments, decreased job opportunities, and unemployment.

Technology

Although technology is not traditionally considered a social determinant of health on its own, access to, affordable and efficiency technology has immense influence on other social determinants of health and health outcomes. Lack of a cellular phone reduces ability to access healthcare appointment scheduling, social supports, and local services and resources. Slow internet speeds impede a student's capacity to engage in online learning and academic research. Lack of a computer and internet impedes a job seekers chances of obtaining gainful employment.

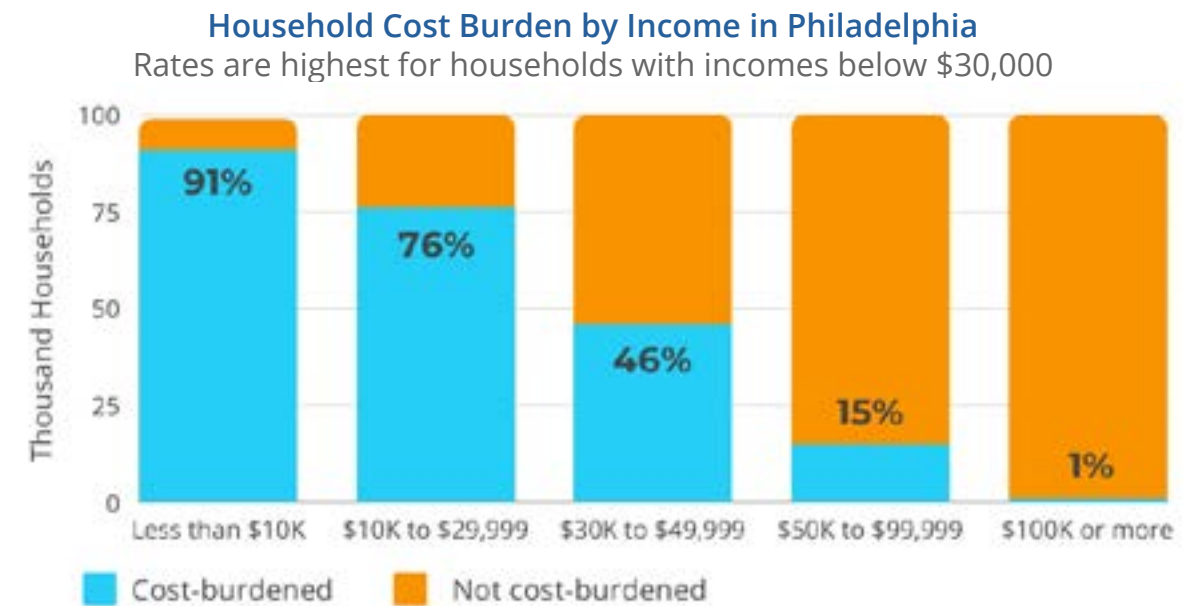
Housing Insecurity in Philadelphia: Facts & Figures

The COVID-19 pandemic exacerbated all social determinants of health domains, including housing. Data from previous years showed that nearly half of Philadelphians were cost-burdened before the pandemic, spending over 30 percent of monthly income on housing.



Source: 2018 American Community Survey 1-Year Estimates, U.S. Census Bureau

In 2018, housing cost-burden was worse for Philadelphia's poorest community members. Households with an income less than \$30,000 annually were six times as likely to be cost-burdened than a household in the \$50,000 to \$90,000 income bracket.

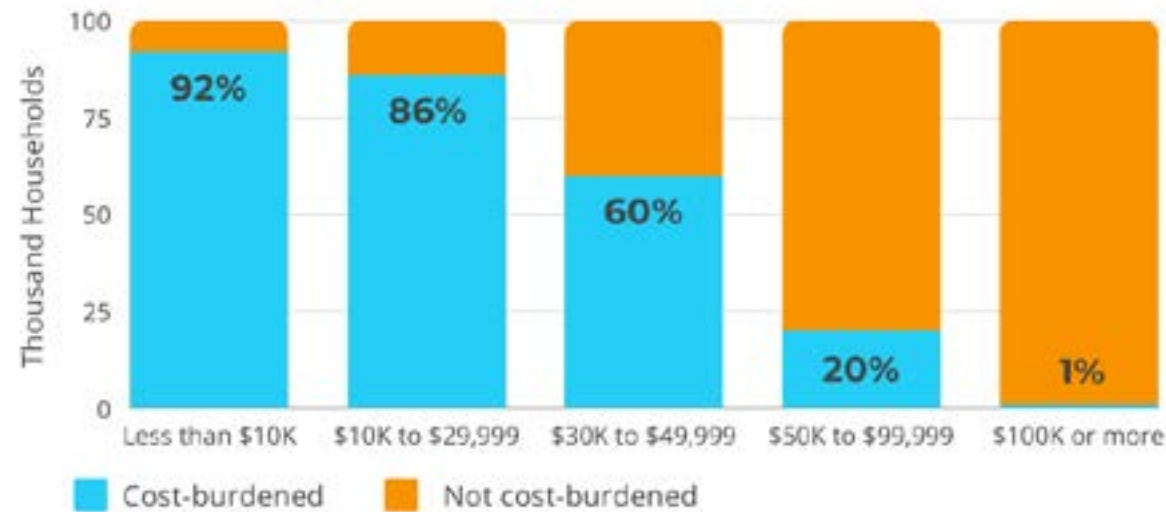


Source: Pew analysis of U.S. Census Bureau, American Community Survey, Public Use Micro data Sample (2018 one-year estimates)

Housing Insecurity in Philadelphia: Facts & Figures

For renters, these numbers were not improved. In fact, over half of renters in the \$30,000 to \$49,999 income bracket were cost-burdened.

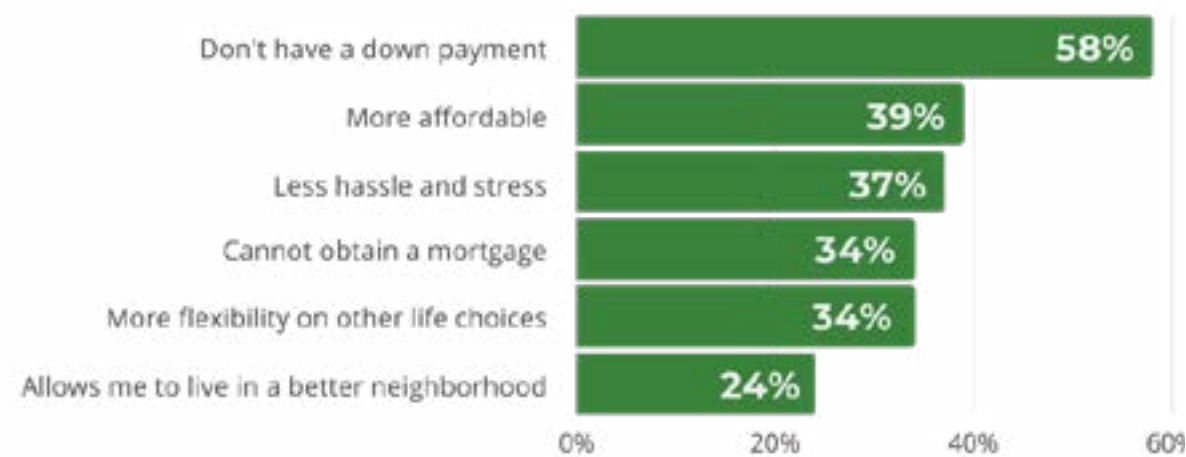
Household Cost Burden by Income for Renters in Philadelphia
Rates are highest for households with incomes below \$30,000



Source: Pew analysis of U.S. Census Bureau, American Community Survey, Public Use Micro data Sample (2018 one-year estimates)

Reasons Tenants Rent Instead of Own

Renters identify down payment as leading barrier to ownership



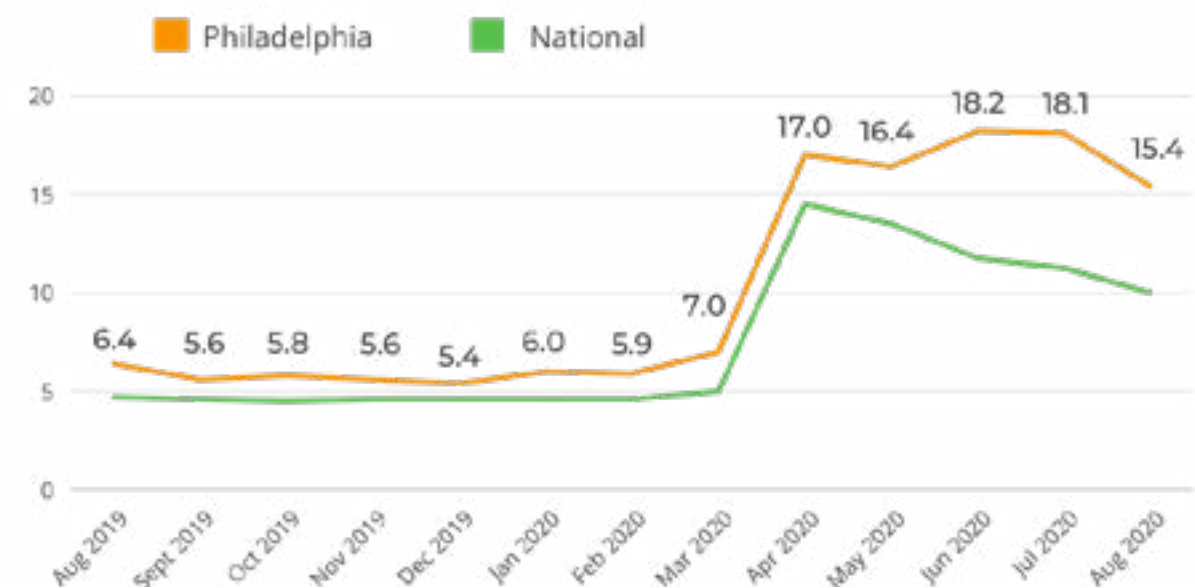
Source: The Pew Charitable Trusts, Philadelphia Residents Survey (2019) © 2020 The Pew Charitable Trusts

In 2019, Pew Charitable Trusts conducted a survey to learn more about why people rent instead of purchasing homes. Over half of respondents did not have money available for down payment on a house, while over one-third of individuals were unable to secure a mortgage in their name.

Employment in Philadelphia: Facts & Figures

Before COVID-19, the poverty rate in Philadelphia was approximately 25 percent. This became exacerbated by pandemic-related layoffs, reduced hours, and furloughs. By June 2020, the unemployment rate rose to 18.2 percent, up over 10 percentage points from February 2020's rate of 5.9 percent.

Employment Rates by Month
Aug. 2019 to Aug. 2020



Source: Custom Unemployment Data Series, U.S. Bureau of Labor Statistics

Employment in Philadelphia: Facts & Figures

In Philadelphia alone, 40 percent of working residents experienced negative job impacts due to COVID-19. Many experienced loss of wages, reduced hours, and layoffs, and households often experienced a lag between when unemployment claims were filed and fulfilled. This lag placed additional financial and emotional stress on individuals and families, serving as a detriment to their overall physical and behavioral health.

COVID-19 Employment Status Changes



Source: The Pew Philadelphia Poll, 2020

Food Insecurity in Philadelphia: Facts & Figures

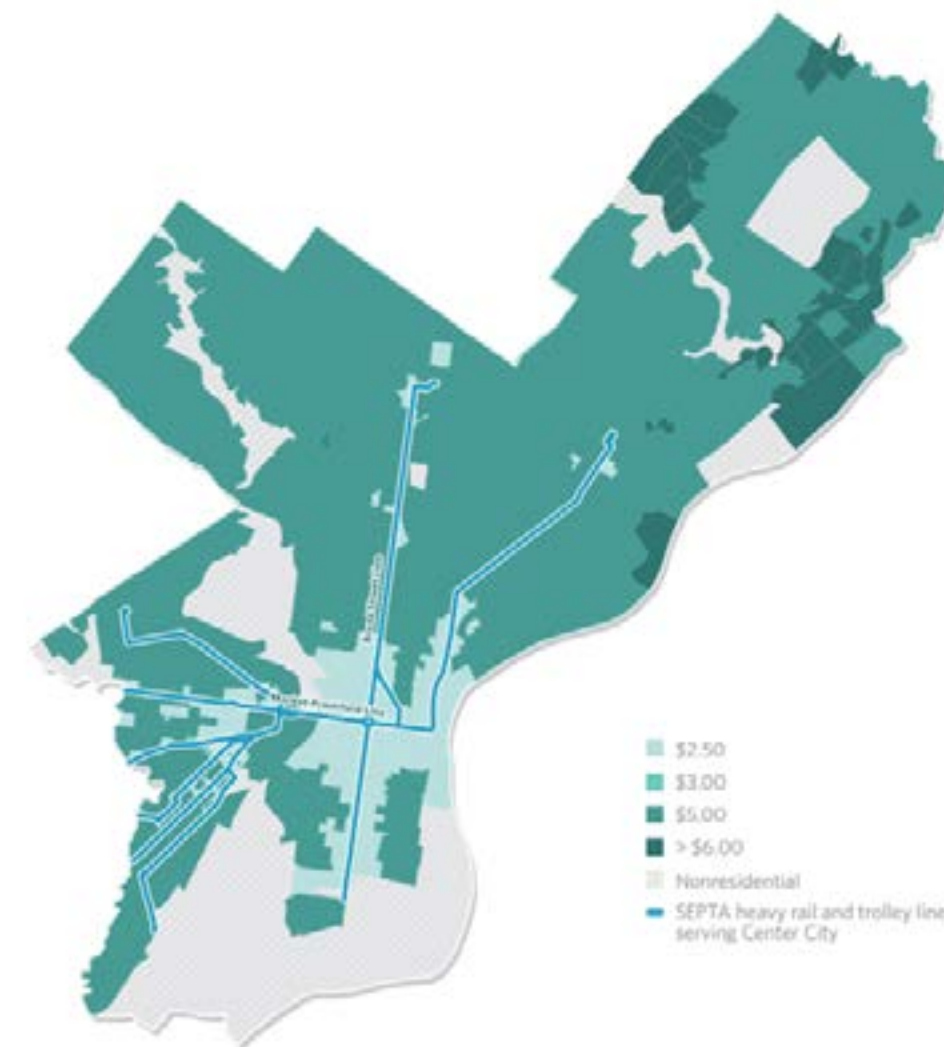
In 2018, 16 out of every 100 households in Philadelphia experienced food insecurity. At that time, it was estimated that at least 257,180 people in Philadelphia were food insecure. When comparing program eligibility for SNAP/EBT benefits with the actual number of food insecure Philadelphians, an annual food budget shortfall of over \$145 million existed. In other words, a number of individuals and families experienced food insecurity but did not meet nutrition program requirements.

As the COVID-19 pandemic unfolded, the projected food insecurity rate in Philadelphia overall for 2020 was 21.2 percent, while for children, the number was even more staggering at 30.6 percent. Local food cupboards became overburdened due to this increase. The People's Emergency Center cupboard in West Philadelphia went from distributing meals to 14,500 families in 2019 to 80,000 in 2020.

Transportation in Philadelphia: Facts & Figures

For most Philadelphians who use public transportation, the median cash fare is \$5 per work commute, or approximately \$10 per workday. If we assume a 5-day workweek and use US Census Bureau's estimate of median annual household income in Philadelphia of approximately \$46,000, then more than 5 percent of a household's annual income would be spent on use of public transportation for work commutes alone.

Median Cash Fare to Residents' Workplaces in Philadelphia



Note: Fares are symbolized by a common set of colors on all fare maps; not all fare classes are present on all maps.

Source: Pew analysis, based on SEPTA fares accessed Aug. 31, 2018, and U.S. Census Bureau LEHD Origin-Destination Employment Statistics 2015, accessed March 27, 2018
 © 2019 The Pew Charitable Trusts

Technology Access in Philadelphia

As of 2018, 16 percent of households in Philadelphia lacked Internet access. Less than 50 percent of households in Philadelphia's lowest income and most under-resourced neighborhoods had access to high-speed Internet service. Although the pandemic has afforded more households the opportunity for less expensive Internet access, speed and equipment access remain barriers for success

Veterans

Social Determinants of Health for veterans are the same as the general population but with the caveat of military experience or military way of life. Most veterans are conditioned to be service providers rather than service recipients. The completion of the "mission" is primary, focused and foremost, thus leaving themselves and their personal needs as a secondary. Many times, veterans are in "survival and completion" mode and may be oblivious to standard needs for their physical and mental well-being.

Veterans are at risk for several dynamics of SDOH. Among those risks are unemployment and homelessness coupled with food insufficiency. An economic news release from February 2021 states that approximately 497,000 veterans were unemployed in the Philadelphia area including 70,000 female veterans. This is a 5.4 percent unemployment rate compared to a 3.7 percent pre-pandemic rate in February 2020. (5) Additionally, the federal Office of Housing and Development (HUD) listed 39,471 veterans as homeless as of January 2020 (pre-pandemic) in Philadelphia, with most experiencing food/nutritional insufficiency. (6)

All DBHIDS units are aligned to support veterans with their unique needs and SDOH. They are especially supportive through the Behavioral Health and Justice Division and The Office of Veteran Affairs Liaison components. The needs of this specialized population should not go unserved.

LGBTQIA+ Community

Housing Security

LGBTQIA+ people face barriers in housing related to the way our systems and society respond to non-normative gender or sexuality. Our collective unwillingness to incorporate LGBTQIA+ people into how people are housed leads predictably to vulnerability, discrimination, housing instability, and homelessness.

LGBTQIA+ people experience rejection from family of origin at higher rates than their non-community peers and are more represented in the foster care system. This also impacts older community members, as LGBTQIA+ elders are more likely to live alone and may not receive support from their family of origin. (4)

Housing services and institutions are often organized in terms of a binary gender (man, woman), and segregated by sex assigned at birth. As a result, these services exclude and harm people who are not cis-gender. (4)

Housing services or institutions that are based around the hetero-normative nuclear family model often exclude LGBTQIA+ families, including chosen family.

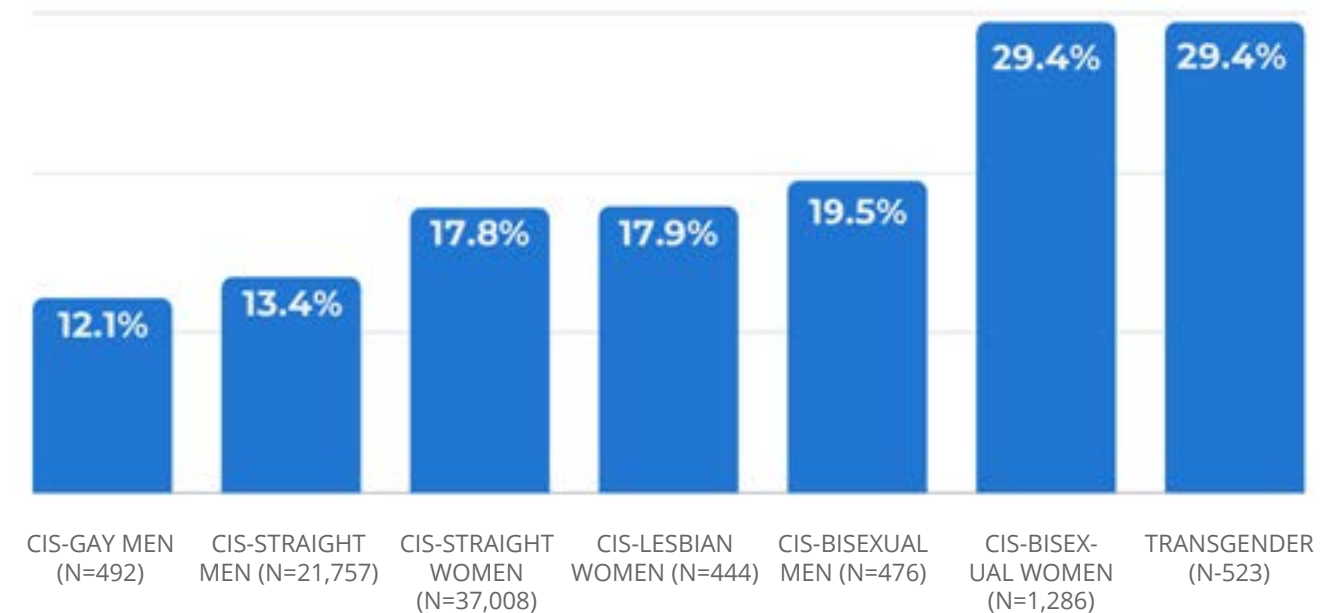
LGBTQIA+ people face discrimination when finding private housing in both renting and homeownership. (4)

Employment & Economic Security

There is a real calculation of safety and financial security LGBTQIA+ people must take into account when deciding to disclose their gender identity or sexual orientation to members of their workplace. Despite federal and state employment discrimination protections, LGBTQIA+ people still face discrimination and harassment regularly in their places of work based regarding their gender identity, sexual orientation, or both.

Overall, LGBTQIA+ people are more likely to be living below the federal poverty line. Poverty rates are also distributed unequally within the LGBTQIA+ Community based on intersections of sexual orientation and gender identity. (1)

Poverty Rates by Sexual Orientation and Gender Identity



Source: UCAL School of Law The Williams Institute

Food Insecurity

LGBTQIA+ people are impacted by food insecurity similarly to other communities who experience poverty at high rates. (2)

A recent needs assessment survey of LGBTQIA+ Pennsylvanians demonstrated that food insecurity impacts this community specifically. (3)



For 1 in 5 respondents, the food they bought didn't last and they did not have money to get more.

LGBTQIA+ Community

Transportation

LGBTQIA+ people are affected by poverty and face the challenges associated with accessing reliable transportation.

LGBTQIA+ people also face the threat of violence for simply being in public. This applies to public amenities such as transportation.

Technology

LGBTQ+ people are affected by poverty and have similar challenges as other communities in reliably accessing technology.

Racism

The impacts of intentionally and historically racist and inequitable housing, education, healthcare, and employment systems and structures are evident in today's assessment of the social determinants of health. Housing cost-burden, for example, disproportionately affects Blacks and Black Hispanics due to historical practices such as redlining and mortgage refusals. Nearly 50% of Blacks in Philadelphia are cost-burdened, regardless of household income. Black Philadelphians experience higher rates of poverty and unemployment due to structural racism, which caused failing and under-resourced education and workforce development systems in neighborhoods and communities where people of color reside. The ability to self-actualize, as noted in Maslow's hierarchy of needs below, is compromised when one's daily life is filled with attempting to meet and maintain basic physiological and safety needs that overlap with SDOH.



Source: carrothealth.com/importance-of-sdoh

Part II

DBHIDS' APPROACH TO SOCIAL DETERMINANTS OF HEALTH AND IMPROVING HEALTH EQUITY





P.A.C.E., TEC, and Social Determinants of Health

P.A.C.E. (Prioritizing to Address our Changing Environment) is a strategy to unite DBHIDS efforts, sharpen our focus, and move us forward. A clear path forward will help DBHIDS set priorities for delivering services and programs in a manner that aligns with our values and our population health approach. Our comprehensive strategic plan centers around five priority areas:

- Our population health approach begins with [Prevention and Early Intervention](#). Our aim with this priority area is to keep health challenges from arising while addressing challenges before they worsen.
- [Treatment & Services](#), play a central role at DBHIDS. This priority area focuses on creating services that engender trust, increase hope for positive outcomes, and encourage individuals to seek and use our services.
- The [Health Economics](#) priority area seeks to improve the value of services provided by improving health and quality of life outcomes.
- With the [Infrastructure & Intelligence](#) priority area, DBHIDS seeks to create a data-informed culture that continually learns and improves services based on that data.
- The [Innovation](#) priority area seeks to design imaginative ways to achieve results.

Prevention and Early Intervention	Treatment and Services	Health Economics	Infrastructure and Intelligence	Innovation
Further develop services around community needs	Increase access to service	Improve processes and practices to enhance cost effectiveness	Increase the use of business analytics and information flow to inform service delivery and improve outcomes	Innovate to improve programs, processes, and efficiency
Increase the number of community engagement activities by 20%	Increase community access to assessment and treatment by 10% through community-based and mobile entry points	Increase number of initiatives by 20% with improved outcomes	Increase the number of new request for dashboards by 10%	Increase the number of programs that have transitioned to sustainability by 25%



P.A.C.E. looks at all projects and initiatives through the lenses of Quality Improvement, Social Determinants of Health (SDOH), and Addressing Trauma, Achieving Equity, and Engaging Community (TEC).

DBHIDS continually improves quality by measuring our progress on each project and initiative and working to address and consider SDOH.

The TEC lens pushes work with the goals of being trauma-informed and trauma-mitigating, reducing behavioral health disparities and promoting racial equity amongst Black, Indigenous, and People of Color (BIPOC), and shifting services to be increasingly community-based.

Assessment & Planning

DBHIDS uses several approaches to assess and plan for members SDOH needs. Member and provider surveys, and evidence-based tools are helpful with gathering information about SDOH needs to help map our work.

Baseline SDOH Needs Surveys

A variety of informal and formal tools have helped assess the social determinants of health landscape for Philadelphians engaged by DBHIDS. A baseline SDOH survey was created and distributed to several teams across the department to gain a better understanding of member needs by domain.

SDOH Assessment Tools

Numerous assessment tools exist to measure SDOH at an individual level, including the Arizona Self-Sufficiency Matrix, Vermont Self-Sufficiency Outcomes Matrix, and LifeWorks Self-Sufficiency Matrix (LSSM). The LSSM includes:

- Housing
- Employment
- Income
- Food
- Healthcare Coverage
- Education
- Adult Education
- Language/Literacy
- Mobility
- Disabilities & Physical Health
- Mental Health
- Substance Abuse
- Legal
- Safety
- Credit
- Life Skills
- Community Involvement
- Network Support
- Family Relations: Family of Origin

See the LSSM User Manual at bit.ly/LiWorksManual

Tools to Measure Outputs and Outcomes

Our SDOH workgroup is reviewing several tools to help track metrics and outcomes related

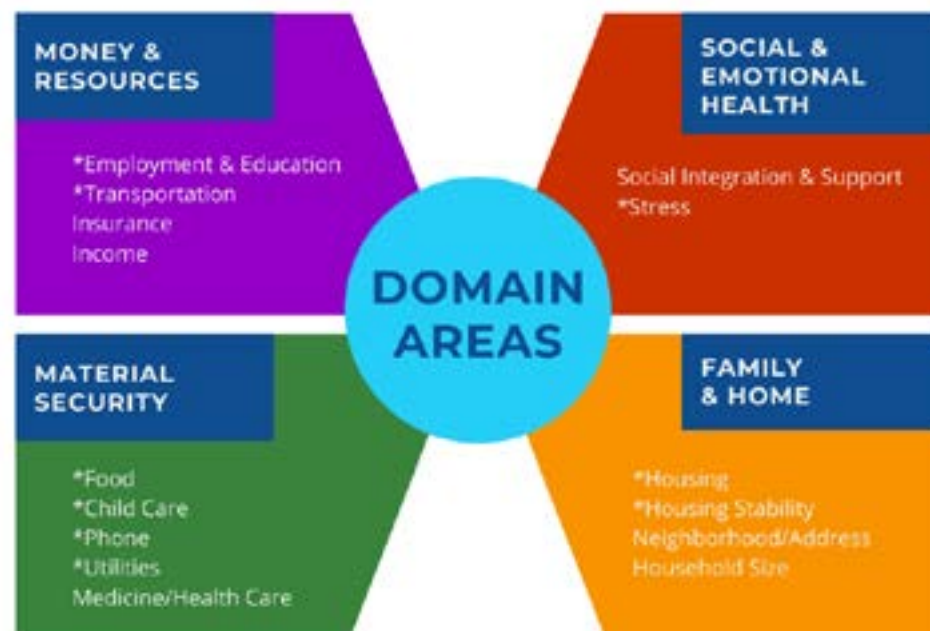
to SDOH projects. Below is a brief overview of the SDOH screening tools and SDOH categories that we intend further vet and utilize and track.

Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)

As stated on the National Association of Community Health Centers’ (NACHC) website: “The Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health.” Four domain areas are covered by the tool, which are further parsed into SDOH areas as needed; asterisked SDOH have been identified as focus areas by our workgroup; others are considered as part of our framework for planning. See bit.ly/2019prapare for a full copy of the PRAPARE toolkit.

Health-Related Social Needs Screening Tool (HRSN)

The Centers for Medicare and Medicaid’s (CMS) Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool (HRSN) was developed “to inform patients’



treatment plans and make referrals to community services.”¹ Thirteen domains are addressed throughout the 26-question tool which offers a standardized approach to screening for and measuring SDOH needs.



Healthy People 2030

The U.S. Department of Health and Human Services’ Office of Disease Prevention and Health Promotion’s (ODPHP) Healthy People 2030 initiative is a continuation of previous Healthy People projects in which “data-driven national objectives to improve health and well-being over the next decade”² have been developed.

Using 355 core objectives, providers across the United States will be able to measure the overall population health of Americans. A number of these core objectives focus on SDOH, and some have been highlighted for our workgroup, noted on the next page.

¹ The Accountable Health Communities Health-Related Social Needs Screening Tool, innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf, accessed on 4/26/2021.

² Healthy People 2030 website landing page, health.gov/healthypeople



Internal Partnerships & Projects

DBHIDS SDOH Workgroup

The DBHIDS Social Determinants of Health Workgroup is comprised of management and team members across all seven DBHIDS divisions. Together, we collaborate, strategize, and operationalize our approach to population health and address the social determinants of health for our members across Philadelphia.

Sharing of respective areas of expertise in areas such as housing, food insecurity, peer culture, and immigrant and refugee affairs, the workgroup meets monthly to review and set new goals with an innovative approach to increased access to services and treatment.

Several days before each meeting, an agenda is shared for review by workgroup members. Each meeting begins with assessing the previous month's action items to enhance accountability and efficiency.

We then review one domain from our logic model, such as employment or transportation, and leaders from our divisions share their input about opportunities for improvement that they see in each respective area. Minutes are taken and retained to ensure that follow-up items, such as additional discussion related to certain needs or potential initiatives, are addressed. Other related updates, such as tools used to measure success, related journal articles about SDOH needs, and other learning community items are also shared for discussion. Please contact our team at DBHIDS.SDOH@phila.gov for additional information and a sample SDOH Workgroup meeting agenda.

Social Determinants of Health Tracker

In addition to the DBHIDS SDOH Workgroup, the SDOH Tracker is used to plan, monitor, and communicate information about all SDOH-related initiatives and projects across DBHIDS. The tracker helps capture information about what we are doing to address the SDOH. The following categories are noted in an Excel spreadsheet, and project leads vary across our department:

- Project Activity/Title
- Activity Category (Project, Plan, Tool, Funding)
- Project Lead(s)
- Description of Activity/Project
- Populations Engaged (e.g., children, adults, pregnant women)

SDOH Factors Noted

1. Housing insecurity
2. Financial insecurity
3. Employment
4. Food insecurity
5. Transportation
6. Utilities
7. Clothing
8. Childcare access/afford-ability
 - Goals
 - Objectives
 - Measures
 - Timelines
 - Date/Status

Please contact the team at DBHIDS.SDOH@phila.gov for more information and a sample tracker entry.

Grant Funding Tracker

To ensure that appropriate funding streams are explored in a timely fashion, we created a spreadsheet to monitor grant proposal request opportunities from local and national foundations. It is monitored monthly and includes a calendar of upcoming deadlines.

Please contact Audrey Davis at DBHIDS.SDOH@phila.gov for more information and a sample tracker entry.

SDOH Logic Model

In contrast with the SDOH Tracker, the SDOH Logic Model was developed to assist our workgroup with discussion and conceptualization of how the work we are doing attains short-and long-term outputs and outcomes. During each monthly workgroup meeting, we review a focus area to enhance communication about what we are seeing across the system, brainstorm how to address opportunities that arise, and note whether related metrics are being addresses. The Logic Model categories are as follows:

SDOH Focus Areas

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Housing 2. Food Insecurity 3. Employment 4. Transportation 5. Technology 6. Childcare | <ol style="list-style-type: none"> 7. Trauma <ul style="list-style-type: none"> • Objectives • Resources • Activities • Outputs • Short-term Outcomes • Long-term Outcomes • Metrics |
|---|---|

Included also are the supporting activities in whichw we are engaged as a workgroup that help support our work. This section's categories are:

1. Supporting Activities
2. Objectives
3. Resources
4. Activities
5. Outputs
6. Short-term Outcomes
7. Long-term Outcomes

Please contact Audrey Davis at DBHIDS.SDOH@phila.gov for more information and a logic model entry.

Internal Partnerships & Projects

Housing & Residential Services Unit

The DBHIDS Housing and Residential Services unit has made great strides with creative and innovative ways to support individuals with behavioral health challenges through a variety of housing opportunities. The individuals that the unit serves come from the 1,400 program beds that are part of the TIP/Residential unit, Safe Havens, Journey of Hope sites, and the Recovery Housing Initiative.

- Safe Haven Opportunities: For those individuals who have behavioral health challenges and are chronically homeless.
- Recovery Housing: 27 houses for men, women, mothers and children, LGBTQIA, Spanish-speaking men and women, and co-ed living options are offered.
- Transitions, Integrations, and Partnerships (TIP) Mental Health Housing: 131 programs for individuals with serious mental illness (SMI), forensic background, homelessness history, and/or long-term hospitalization.
- Supportive Independent Living: Support individuals in the community with rental support and supportive services.

Resource and Referral Platform Subcommittee

Resource and referral platform tools are cloud-based sites that serve as an integral cross-departmental and provider community resource network. Physical and behavioral health system providers across Philadelphia can screen individuals for SDOH needs and link them to appropriate services and resources to reduce health inequities and disparities. A subcommittee has been formed to address potential implementation of such a platform at our front-facing doors.

Food Plan

As each SDOH domain is addressed at DBHIDS, we develop a related short-and long-term strategy to mitigate related health disparities and inequities that exist in the physical and behavioral health spheres. For food insecurity, for example, we developed a food plan using a data-and place-based approach to eliminating food insecurity for our members. The DBHIDS Food Plan was created to document all the steps taken to develop this approach, as well as the funding, objectives, and outcomes involved.

SDOH Behavioral Health Training

In fall 2021, DBHIDS finalized an internal training module for employees. This project involved the creation of a virtual deck to define and explore the social determinants of health and how they are linked to behavioral health. Numerous resources for addressing SDOH in behavioral health settings was also included.

SDOH for New DBHIDS Employees

Former Deputy Commissioner Roland Lamb helped furnish a virtual “crash course” in SDOHs for new DBHIDS employees so all team members could have a solid understanding of basic SDOH concepts and how they relate to our ongoing work.

External Partnerships & Projects

Employment: DBHIDS Universal Workforce Referral

Launched in November 2020, the referral and related resource guide allow members being served by local recovery houses, residential sites, homeless shelters, and forensic service providers to be referred for employment needs. After referral, members are matched with the employment and workforce development opportunities that are the best fit for their experience and interests. Where additional job training and readiness are needed, our external partners also work diligently to provide resume-building and feedback, interview preparation, and vocational skills assessments. These efforts help members focus on recovery and wellness and build confidence in their abilities at engaging in meaningful work.



Food Insecurity: SNAP Grocery and Meal Delivery Programs

In January 2021, DBHIDS shared information about SNAP's Online

8. Purchasing Program with all external community-based case management and residential services providers. Members who are SNAP-eligible may use sites such as Amazon to order discounted groceries with their SNAP/EBT cards and receive free grocery delivery when a reasonable minimum spend is reached (\$25 grocery total results in waived delivery fee). Neighborhoods and communities that were traditionally not served by other grocery delivery services are now able to have healthy, inexpensive groceries delivered through the program. Members can better focus on their behavioral health needs as food security needs are met and addressed.

As of March 2021, DBHIDS was in the process of forming two distinct partnerships with local food justice organizations [Philabundance](#) and [Food Connect](#).

Consultant Partnership

In addition to internal meetings and work to address SDOHs, DBHIDS initiated a partnership with Strategy Arts, a local certified B Corporation consultant firm, to identify SDOH best practices across the country and gain knowledge about actionable steps we can take as an organization to remain innovative and helpful in service to our members.

Work with Strategy Arts involved two phases: interviews with subject matters experts and leaders across the nation in the employment, food insecurity, and transportation sectors and developing a best practice scan and language to use for grant funding. The graphic on the next page, developed by Strategy Arts, encapsulates that phase-wise approach and working session schedule initially agreed upon by both parties (working sessions were eventually increased in frequency to twice monthly and reduced in duration to 45 minutes from 1.5 hours, to enhance communication and momentum).



SDOH Foundation Proposal

In anticipation of potential partnerships with local grant-making foundations to support our SDOH work, we created a proposal deck to educate foundation board members on opportunities to improve SDOH for DBHIDS members. This presentation gives a thorough

background of SDOH needs, local statistics, and how grant monies can be used to sustain long-term improvements in the physical and behavioral health spheres in Philadelphia.

Action Planning

Organizations or teams interested in developing a strategic and operationalized approach to addressing the social determinants of health in their communities may refer to the following flow chart and worksheet to get started.



Action Planning Worksheet

- List partners with SDOH work at your organization

Internal	External

- Distribute a Baseline SDOH Needs Survey, to be completed by staff who engage with members at “front doors” (e.g., case management teams, recovery houses, etc.). Click for a sample survey surveymonkey.com/r/GNYZTZ9.
- Contact internal partners identified in Step 1 to form internal workgroup. Review SDOH Survey results at first meeting and set workgroup objectives and develop logic model accordingly.
- Contact external partners identified in Step 1 to discuss their SDOH needs, projects, and potential pilots. Develop a plan for each SDOH domain that addressed funding needs, target population(s) served, duration/frequency of the pilot, and anticipated outcomes.

- Explore various options for funding, such as reinvestment dollars, federal and philanthropic grants, and organizational budgets.
- Use Baseline Survey year-over-year, along with metrics from an agreed upon tool (e.g., Healthy People 2030), to track progress and adopt pilots into long-term programs.

Resources

Housing

- [National Housing Resource Center](#)
- [HUD Rental Assistance Information](#)
- [National Low Income Housing Coalition](#)

Employment

- [Career Information, Training, and Jobs](#)
- [American Job Center](#)

Food Insecurity

- [Food Assistance Programs](#)
- [Feeding America – Food Bank Locator](#)

Transportation

- [National Transit Database](#)

Technology

- [Emergency Broadband Benefit Program](#)

Works Cited

- Badgett, M. V., Choi, S. K., & Wilson, B. D. (2019). LGBT poverty in the United States: a study of differences between sexual orientation and gender identity groups.
- Brown, T. N, Romero, A. P, & Gates, G. J. (2016). Food Insecurity and SNAP Participation in the LGBT Community. UCLA: The Williams Institute. Retrieved from escholarship.org/uc/item/6f84z0m9
- Research & Evaluation Group at Public Health Management Corporation and Bradbury-Sullivan LGBT Community Center. (2020). 2020 Pennsylvania LGBTQ Health Needs Assessment.
- Romero, A. P, Goldberg, S. K, & Vasquez, L. A. (2020). LGBT People and Housing Affordability, Discrimination, and Homelessness. UCLA: The Williams Institute. Retrieved from escholarship.org/uc/item/3cb5b8zj
- U.S. Bureau of Labor Statistics “Economic News Release.” bls.gov/news.release/vet.nr0.htm, March 18, 2021, Employment Situation of Veterans.
- U.S. Bureau of Labor Statistics “Economic News Release.” bls.gov/news.release/empsit.t05.htm, March 20, 2021, Table A-5 Employment status of the civilian population 18 years and over by veteran status, period of service, and sex, not seasonally adjusted.



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