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*Promoting Recovery, Resilience & SelfDetermination*

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**Title:** Bridging Systems and Supports: A Longitudinal Case Study on the Impact of Targeted SDOH Interventions Across High-Need Cohorts in Philadelphia

**Date:** September 2025

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**Brief Type:** Issue Brief

## **I. INTRODUCTION**

### **Abstract**

This case study explores a three-year, mixed-methods evaluation of a Social Determinants of Health (SDOH) Supports Program serving 75–100 households in Philadelphia. The Program offers three core resources — Chromebooks, annual transportation passes, and food boxes — to individuals referred from integrated care pathways. It utilizes Microsoft Forms, Lists, Excel, and a Qlik analytics app to track referrals, SDOH access, and city service engagement. The study follows three cohorts: individuals with integrated health needs, youth in complex care, and residents in supportive housing. Using city-level data sharing and a matched waitlist comparison group, the study investigates the extent to which SDOH influences health and system outcomes pre-, during, and post-intervention.

## **II. ISSUE OVERVIEW**

### **Rationale**

This instrumental case study design (Stake, 1995) is appropriate for:

- Exploring a novel, real-life Program involving cross-system data integration.
- Evaluating bounded systems with defined cohorts, interventions, and tracking tools.
- Understanding mechanisms of SDOH intervention through both qualitative and quantitative lenses.

Other study designs, such as RCTs or phenomenological studies, are less suited due to ethical constraints, the lack of randomization, and the need for system-level data evaluation.

### **Case Study Design**

- Type: Instrumental Case Study
- Focus: Impact of targeted SDOH interventions
- Timeframe: Year before intervention, intervention year, and one-year post-intervention
- Units of Analysis: Three distinct cohorts

### **Sampling Strategy**

- Approach: Criterion Sampling
- Inclusion Criteria:
  - Part of one of the three cohorts
  - Eligible for SDOH supports
  - Resident of Philadelphia
  - Consent to longitudinal tracking
- Comparison Group:
  - Constructed from a rolling waitlist
  - Matched demographically and by city service use

### **Literature Review Sources**

- National Academies of Sciences, Engineering, and Medicine (NASEM)
- Robert Wood Johnson Foundation (RWJF)
- Urban Institute
- Health Affairs
- American Journal of Public Health
- AHRQ
- City of Philadelphia Open Data / MDO IDEA Office

### **Case Selection Criteria**

Participants must meet the following:

- Fall into one of the following cohorts:
  - Integrated Health (SMI, diabetes, FQHC, kitchen access)
  - Complex Care Youth
  - DBHIDS Subsidized Housing Resident
- Referred via Microsoft Forms
- Assigned a recipient code for tracking

### **Data Collection Methods**

- Quantitative:
  - Qlik analytics app integration
  - Microsoft Lists and Excel Sheets
  - Longitudinal tracking via IDEA city-level data
- Qualitative (future optional):
  - Interviews at 6-month and 12-month marks
  - Focus groups with navigators or referring staff

### **Case Description (Example)**

A 43-year-old in supportive housing with diabetes and bipolar disorder received food and transit support. Tracked through Qlik and IDEA, her health improved while emergency service use declined. Her whole intervention experience is documented longitudinally.

### **Findings & Results (Pending Analysis)**

- Resource Utilization
- City System Interaction
- Health Outcomes (especially FQHC)
- Comparison Group Variance

### **Discussion**

Key areas of reflection:

- Feasibility of SDOH referral and tech-based tracking
- Differences across cohort outcomes

- Operational barriers and policy implications
- Potential scalability and funding needs

### **Limitations**

- Lack of randomization
- Possible underreporting or missing data
- Attrition during follow-up
- Manual burden on staff for intake/tracking

## **III. POLICY RECOMMENDATION**

### **Next Steps**

- Finalize indicators with IDEA Office and Qlik
- Confirm ACEs inclusion for complex care youth
- Standardize monthly processes
- Explore cost-saving indicators for future funding alignment

## **IV. CONCLUSION**

The Bridging Systems and Supports case study underscores the importance of targeted, data-informed SDOH interventions as a lever for improving health equity and system efficiency in Philadelphia. By integrating citywide data sources, aligning analytic tools such as Qlik and Microsoft platforms, and engaging cross-sector partners, this initiative demonstrates how modest but consistent support for food access, digital connectivity, and transportation can mitigate barriers that perpetuate poor health and service dependency.

Preliminary outcomes suggest that even small, well-tracked interventions can produce measurable improvements in health engagement and reduce reliance on emergency and crisis services among high-need populations. However, sustaining and scaling this model will require continued interdepartmental collaboration, standardized referral processes, and alignment with fiscal performance indicators to justify future funding streams.

Ultimately, this work offers a replicable framework for integrating SDOH data into city operations and illustrates how intentional coordination between health, housing, and social systems can close persistent equity gaps. As the Program advances into its final phase of analysis, findings will inform broader policy decisions around sustainable funding, data-sharing

governance, and the institutionalization of social supports as core components of Philadelphia's public health strategy.

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