MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

Social Drivers of Health Primary Care Clinician Resource Guide

MBHP MassHealth PCC Plan Support Services

Contents

1. Introduction to the Social Drivers of Health (SDoH) Resource Guide

Massachusetts Behavioral Health Partnership (MBHP) Primary Care Clinician (PCC) Plan Support Services created this resource guide to aid MassHealth PCC Plan practices in understanding the importance of screening and referring Members with Social Drivers of Health (SDoH) needs to improve health outcomes. The resources included are not meant to be exhaustive of all resources available regarding SDoH, but they are meant to be practical and useful.

If you have questions related to this resource guide, please contact MBHP PCC Plan Support Services.

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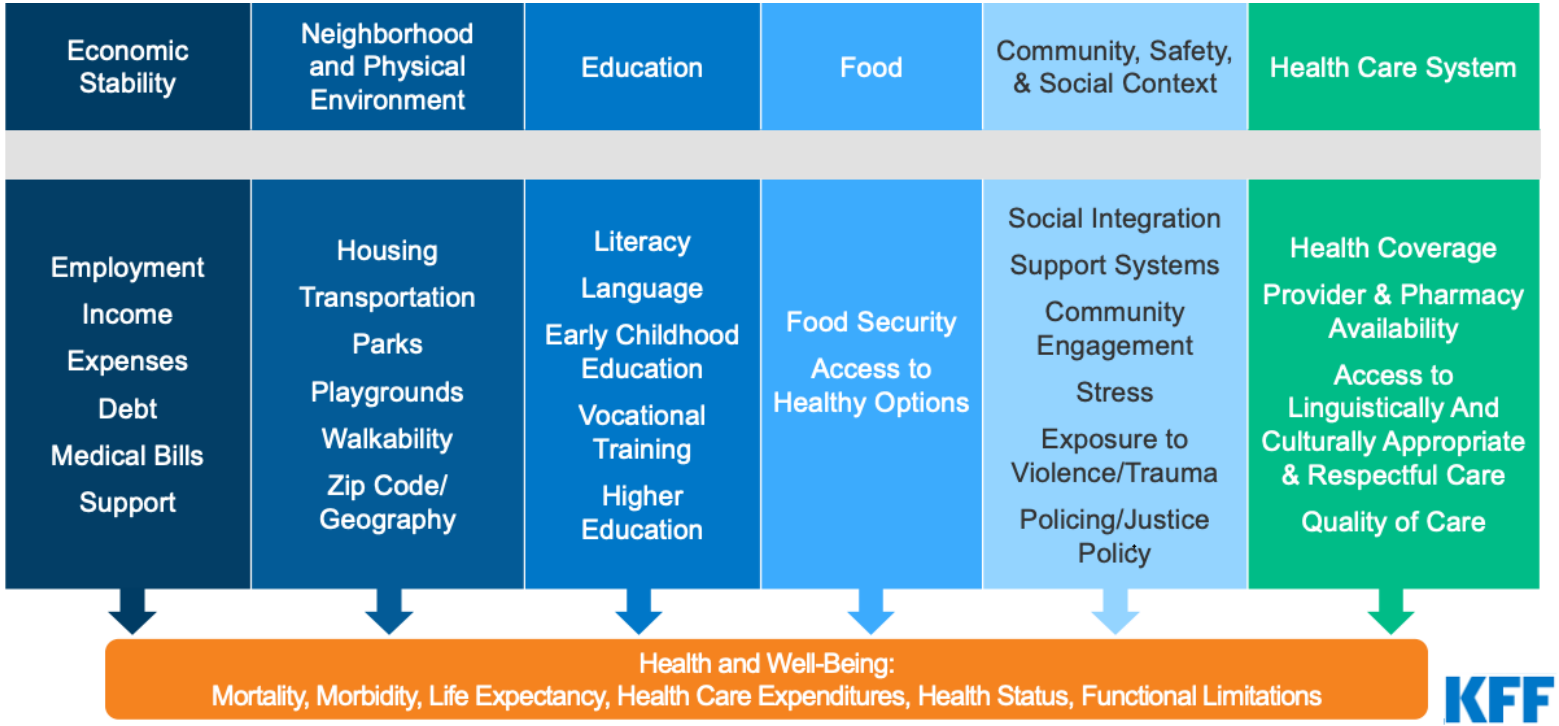
These materials are only intended for providers in the MassHealth PCC Plan.

2. Social Drivers of Health — Brief Topic Overview

Screening and Referral in the Primary Care Setting: Improving Health Outcomes by Addressing Members' Social Needs

What Are Social Determinants of Health?

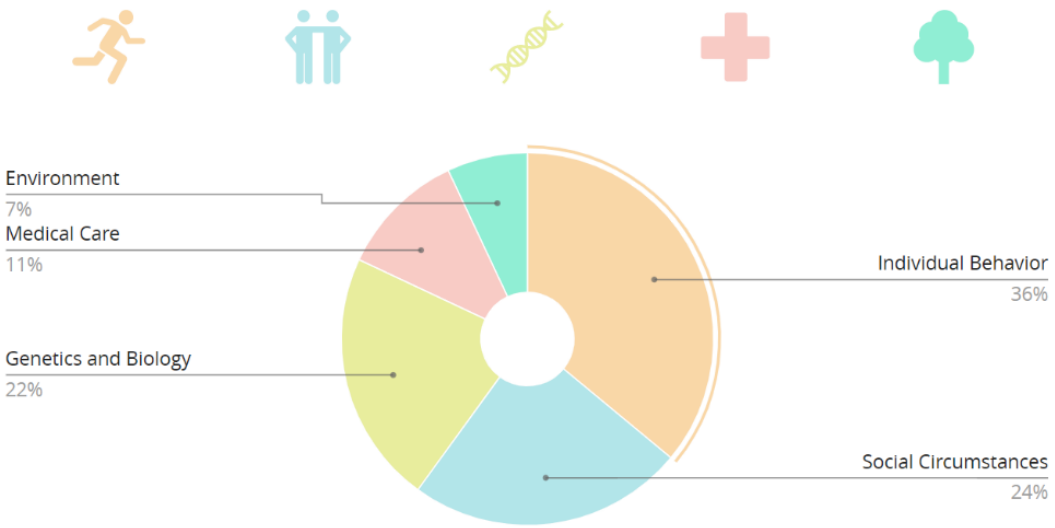
They are the non-medical factors that influence health outcomes. The World Health Organization defines SDoH as, "the conditions in which people are born, grow, live, work, and age, and the wider set of forces and systems shaping the conditions of daily life." [1] The National PRAPARE® Team has adopted the term "social drivers of health" instead of "social determinants of health" as this more accurately describes the ability for these factors to change through actions of government, communities, and individuals.[2]



**Infographic sourced from Kaiser Family Foundatin.org, accessed 6.23.2023*

2. Social Drivers of Health — Brief Topic Overview (continued)

Impact of Different Factors on Risk of Premature Death



Social Circumstances

Eighty-nine percent of health occurs outside of the clinical space, through our genetics, behavior, environment, and social circumstances. Social circumstances are factors that reflect the social environment that we have lived and developed in. Poor social circumstances such as discrimination, concentrated poverty, and low education level often result in poor health outcomes and a lower quality of life.[3]

Social Needs

Refers to an individual's perception of their own needs, based on the negative SDoH they face in their own lives.[1]

Should Primary Care Practices Screen for Social Needs?

- SDoH are widely recognized as having an important impact on health and mortality, and there is now strong evidence of the benefits of addressing people's unmet social needs.
- Screening for and attempting to address unmet needs within a primary care practice can improve patient health.
- Collecting information about social needs allows clinicians to tailor treatment plans to a patient's individual needs and priorities, resulting in plans that a patient may be more likely to follow. Satisfaction has been shown to improve for patients and providers. Provider burnout can be reduced. [1]

2. Social Drivers of Health — Brief Topic Overview (continued)

What Social Needs Information Should Be Collected?

- Practices can choose the approach that feels right for them. This could mean choosing a detailed screening tool or choosing one or two key social needs to screen.
- Consider your patient population when deciding on a screening tool or questions to ask patients.
- Include patients' spoken languages and literacy levels when selecting a tool. [1]

References

1. *Booker, G. J. (2021, May 12). IDENTIFYING AND ADDRESSING SOCIAL NEEDS IN PRIMARY CARE SETTINGS. Agency for Healthcare Research and Quality. Retrieved June 12, 2023, from https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf*
2. *Halpin, S. (2022, August 12). USING CLEAR TERMS TO ADVANCE HEALTH EQUITY-SOCIAL DRIVERS VS. SOCIAL . Prapare.org. Retrieved June 12, 2023, from https://prapare.org/using-clear-terms-to-advance-health-equity-social-drivers-vs-social-determinants/*
3. *Choi, E., & Sonin, J. (n.d.). DETERMINANTS OF HEALTH. Retrieved June 12, 2023, from https://www.goinvo.com/vision/determinants-of-health/*

3. Evidence Base Supporting SDoH Screening and Referral in Primary Care

Evidence Base for SDoH Screening and Referral in Primary Care		
Source	Title	Link
American Medical Association	AMA Steps Forward®	https://www.ama-assn.org/delivering-care/health-equity/importance-screening-social-determinants-health
The Commonwealth Fund	Guide to Evidence for Health-Related Social Need Interventions: 2022 Update	https://www.commonwealthfund.org/sites/default/files/2022-09/ROI_calculator_evidence_review_2022_update_Sept_2022.pdf
Children, 2019	The Hunger Vital Sign Identifies Household Food Insecurity among Children in Emergency Departments and Primary Care.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6827017/
Center for Disease Control and Prevention	Screening and Referral Care Delivery Services and Unmet Health-Related Social Needs: A Systematic Review	https://www.cdc.gov/pcd/issues/2021/20_0569.htm
JAMA Internal Medicine, 2023	Estimated costs of intervening in health-related social needs detected in primary care	https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2805020
Journal of Advanced Nursing, 2023	Barriers and facilitators to nurses addressing social needs and associated outcomes in the ambulatory setting in adult patients: Systematic review	https://onlinelibrary.wiley.com/doi/10.1111/jan.15670
American Journal of Preventive Medicine, 2023	Food insecurity is under-reported in surveys that ask about the past year.	https://www.sciencedirect.com/science/article/pii/S0749379723001629?via%3Dihub=

3. Evidence Base Supporting SDoH Screening and Referral in Primary Care (continued)

Evidence Base for SDoH Screening and Referral in Primary Care		
Source	Title	Link
Healthy People 2030	Social Determinants of Health Literature Summaries: Topics include economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, social and community context	https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries
Pediatric Clinics of North America, 2023	Addressing Social Determinants of health in practice: This review summarizes the current pediatric literature related to social determinants of health, including strengths and weaknesses of screening practices and intervention strategies, common concerns and potential unintended consequences, and opportunities for further research and provides evidence-informed practical strategies for clinicians.	https://sirenetwork.ucsf.edu/tools-resources/resources/addressing-social-determinants-health-practice
Primary Care: Clinics in Office Practice, 2023	Social Determinants of Health: An overview for the primary care provider	https://sirenetwork.ucsf.edu/tools-resources/resources/social-determinants-health-overview-primary-care-provider
Diabetes Care, 2023	Food insecurity and diabetes: Overview of intersections and potential dual solutions: The article describes the complex relationship that exists between food insecurity and diabetes and describes potential mechanisms that may underlie this association. The article describes how two distinct types of interventions, food-is-medicine and federal nutrition assistance programs, may help address both food insecurity and health.	https://sirenetwork.ucsf.edu/tools-resources/resources/food-insecurity-and-diabetes-overview-intersections-and-potential-dual
American Academy of Family Physicians, 2020	Integration of Primary Care and Public Health: Position Paper	https://www.aafp.org/about/policies/all/integration-primary-care.html

4. SDoH, Health Equity, and Implicit Bias

SDoH, Health Equity, and Implicit Bias		
Source	**Description & Highlights**	**Link**
Social Interventions Research & Evaluation Network (SIREN)	SIREN's mission is to improve health and health equity by advancing high-quality research on healthcare sector strategies to improve social conditions. SIREN projects are focused on: • Catalyzing high-quality research to fill evidence gaps through an innovation grants program and support for researchers in this field. • Collecting, summarizing, and disseminating research resources and findings to researchers and other industry stakeholders via an interactive website and evidence library, reports, and meetings and presentations. • Increasing capacity to evaluate SDoH interventions by providing evaluation, research, and analytics consultation services to safety-net and mission-aligned health systems.	https://sirenetwork.ucsf.edu/tools-resources/resources/differential-impacts-social-care-interventions-part-2
AMA ED Hub™ – online learning platform. Some courses are CME eligible for Members.	This panel discussion webinar, part of the AMA STEPS Forward® series, discusses how to effectively address SDoH in your practice. • Social Determinants of Health - CME course • The Importance of Screening for Social Determinants of Health - podcast • The Basics of Health Equity - CME course	https://www.ama-assn.org/about/events/ama-steps-forward-webinar-series-social-determinants-health https://www.ama-assn.org/delivering-care/health-equity/importance-screening-social-determinants-health https://edhub.ama-assn.org/ama-center-health-equity/interactive/18646635

4. SDoH, Health Equity, and Implicit Bias (continued)

SDoH, Health Equity, and Implicit Bias		
Source	**Description & Highlights**	**Link**
Critical Care Nurse Journal	This article illustrates that, despite the best intentions of healthcare professionals, all patients do not receive the same level of care. An abundant volume of research attests that many groups of patients receive a significantly lower quality of care—that is, substandard care—attributable in part to biases held by healthcare providers. • Implicit bias refers to positive or negative attitudes or stereotypes, activated automatically and involuntarily, that influence our understanding, decisions, and behavior without our awareness or voluntary control. Despite these attitudes operating outside the provider's conscious awareness, they can compromise patient care. • Patients with any of the following attributes have cause for concern regarding whether they will receive the current standard of care for their health problems: female gender, advanced age, non-white race, low socioeconomic status, non–English speaking, non-heterosexual, disabled, obese, mental illness, AIDS, and drug addiction. • Two recent systematic reviews have confirmed reports that healthcare professionals exhibit implicit bias at levels comparable to those in the general population. • Implicit bias is manifested in 4 key areas: patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes. • A meta-analysis examining 494 implicit bias studies found that although implicit bias can be changed, the effects are often weak; that procedures that changed implicit bias altered explicit bias considerably less; and that no evidence was found that changes in implicit bias mediate changes in behavior. These findings underscore the importance of monitoring care actually delivered to patients as the litmus test of quality care before any conclusions related to efforts to reduce bias are offered.	https://aacnjournals.org/ccnonline/article/38/4/12/3698/Implicit-Bias-in-Patient-Care-An-Endemic-Blight-on
My Diverse Patients	*My Diverse Patients* is a unique collaboration between Elevance Health and Training Systems Design, LLC with a common goal of expanding the way we think about healthcare to ensure more people have the opportunity to make the choices that lead to healthy, longer lives, regardless of their diverse backgrounds. • Provides CME learning experiences and short videos on topics such as Caring for Children with ADHD, Improving Care for LBGTQIA+ patients, Medication Adherence, Promoting Birth Equity, Breast Cancer Screening for African American Women	https://www.mydiversepatients.com/index.html

4. SDoH, Health Equity, and Implicit Bias (continued)

SDoH, Health Equity, and Implicit Bias		
Source	**Description & Highlights**	**Link**
Kirwan Institute at Ohio State University	The Kirwan Institute has created this website to help practitioners consider the concept of implicit bias and explore its operation in your field. Beginning first with the topic of healthcare, the materials focus on two specific areas: clinical education and patient care. The guidance offered creates an opportunity for healthcare professionals operating in these areas to consider their own biases and the circumstances in which they may unknowingly rely on their implicit biases. • Research-based strategies which can help to mitigate implicit bias include: Using the Implicit Association Test, https://implicit.harvard.edu/implicit/, fostering reflections on bias, fostering and increasing motivation toward egalitarian goals, perspective taking and empathy building, mindfulness, and building new associations (counter-stereotypes, inter-group contact, fostering "teamness" among doctors and patients).	https://u.osu.edu/breakingbias/

5. SDoH Screening Tools

SDoH Screening Tools		
Source	Tool	Link
National Association of Community Health Centers/Oregon Primary Care Association	Protocol for responding to and assessing patients' assets, risks, and experiences (PRAPARE) Available in 25 languages, detailed screening tool	https://prapare.org/
American Academy of Pediatrics	Bright Futures Toolkit	Bright Futures Toolkits
American Academy of Family Physicians	The EveryOne Project Social Needs Screening Tool SDoH Short form- 11 questions SDoH Long form – 15 questions	https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html
Health Leads	Social Needs Screening Toolkit	The Health Leads Screening Toolkit — Health Leads (healthleadsusa.org)
Boston Medical Center	Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE) 6 questions	https://www.bmc.org/pediatrics-primary-care/we-care/confirmation-we-care-surveys
Center for Medicare and Medicaid Services (CMS)	The Accountable Health Communities (ACH) Health-Related Social Needs (HRSN) Screening Tool: 10 core domain questions to assess five core domains including housing instability, food insecurity, transportation problems, utility help needs, interpersonal safety; 16 supplemental questions to assess eight supplemental domains that include financial strain, employment, family and community support, education, physical activity, substance use, mental health, disabilities.	https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

5. SDoH Screening Tools (continued)

SDoH Screening Tools		
Source	Tool	Link
Children's HealthWatch	Hunger Vital Sign™ a validated 2-question food insecurity screening tool based on the U.S. Household Food Security Survey Module to identify households at risk of food insecurity.	https://childrenshealthwatch.org/public-policy/hunger-vital-sign/#top
American Medical Association	AMA STEPS Forward™ toolkit "Social Determinants of Health: Improve Health Outcomes beyond the Clinic Walls"	https://edhub.ama-assn.org/steps-forward/module/2702762

6. Implementation Resources

Implementation Resources		
Source	**Content**	**Link**
Health Leads Social Needs Screening Toolkit	This toolkit is based on 25+ years of experience in the field and well-researched, clinically-validated guidelines — all in a single how-to guide. Key Highlights/Best Practices: Simple, Effective Questions • Come from validated tools or measures • Written at a 5th grade reading level • Separately assess the prevalence of the need and the patient's interest in receiving help with the need identified. • Questions should be designed to open a conversation with your patients, while reducing the likelihood of misidentifying patients (balance of broad and specific questions). Easy for Patients to Complete • Visually appealing, concise • Similar response options (e.g., all Yes/No, Likert scale, etc.) for each question • Sequence questions, starting with the relatively passive content to more sensitive content. Integrated into Clinical Workflow • Identify workforce responsible for administering the screens (e.g., registration, Community Health Workers, medical assistants) • Clarify workflow for distributing screens, capturing screening data, and connecting patients to resources if they want assistance.	Download the toolkit here: https://healthleadsusa.org/communications-center/resources/the-health-leads-screening-toolkit/
American Academy of Pediatrics and the Food Research & Action Center	Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity (Jan. 2021) Key Highlights/Best Practices: • Food insecurity is a sensitive subject. Parents and caregivers may be embarrassed, ashamed, uncomfortable, or even afraid to admit that they struggle to meet the food needs of their families. Some may even worry that discussing food insecurity puts the family at risk of a child-neglect report. • Hunger may be lurking where you might least expect it. A family may have private insurance but still have difficulty putting food on the table. • Food insecurity can coexist with obesity. • Stigma associated with assistance programs and emergency food has been identified as a barrier to participation - reassure families in a supportive, empathetic, culturally effective, and nonjudgmental way. • Toolkit information about Federal Nutrition Programs, including SNAP, WIC, Child Care Meals, School Breakfast and Lunch, Afterschool Meals, Summer Nutrition Programs	https://frac.org/aaptoolkit 2-minute webinar: https://www.youtube.com/watch?v=RMZ88E559EE

6. Implementation Resources (continued)

Implementation Resources		
Source	**Content**	**Link**
AMA STEPS Forward® SDoH Toolkit	In addition to influencing health outcomes, social determinants impact a practice's clinical outcomes data, financial sustainability, resource allocation decisions, and the overall health of communities and the healthcare system. As the nation moves toward value-based care, expanding our healthcare focus to include SDoH is increasingly necessary to achieve improved outcomes. Learning Objectives: 1. Define social determinants of health, social needs, and their impact on individual health 2. Identify methods to understand the unique health needs of your community and ways to engage community members to improve overall health 3. Formulate a plan to help your practice begin addressing social determinants of health 4. Explain the different tools available to screen patients, including how and when and to use these tools, and connecting patients to appropriate resources Key Highlights/Best Practices: • Assessing Readiness – understand your own internal biases. Consider having your team take the Project Implicit® tests that identify potential biases related to attributes such as gender, skin tone, and religion. Project Implicit: https://implicit.harvard.edu/implicit/takeatest.html • Link patients to a list of resources, but to have a bigger impact, consider a more active role in arranging a resource alongside each patient and follow up to ensure they successfully accessed it. • Understand and Engage your Community - Community Health Needs Assessment (CHNA): The CHNA report is posted on each hospital's website and includes information about the population the hospital serves, identifies disparities, and prioritizes health issues of concern. If you are in a community practice with patients seeking care across multiple hospitals, we recommend sampling a few CHNA reports to further define your patient population's needs. The assessment can be easily accessed online by typing your organization's name (nearby hospital) and "Community Health Needs Assessment" into a search engine.	https://edhub.ama-assn.org/steps-forward/module/2702762

6. Implementation Resources (continued)

Implementation Resources		
Source	Content	Link
BMC Health Services Research - Social needs screening and referral in pediatric primary care clinics: a multiple case study	Pediatric primary care practices are well-positioned to amplify the effects of social needs screening and referral programs because all members of the household have the potential to benefit from connection to needed social services; however, more research is needed to determine effective implementation strategies. Key Highlights/Best Practices: Integration into Clinic Workflows - • Medical assistants are responsible for providing the screening tools to the family. • Creating bound packets of all required screenings for each age group was helpful for staff and boosted screening rates. • Pre-visit planning the day before the appointment to flag which patients should receive a social needs screen when they arrive. • Sites started by developing their own screening tool using previously validated tools as a starting point. After a pilot period, the sites modified their tool to include the most commonly identified needs of their population as well as the needs for which community resources were available for referral. • Low literacy inhibited caregivers	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08692-x
AAFP-The EveryONE Project: Social Determinants of Health - Guide to Social Needs Screening	These tools can be used by family physicians and their practice teams to screen their patients for social determinants of health, identify community-based resources to help them, and work with patients to develop an action plan that encompasses social needs to help them overcome health risks and improve outcomes. Key Highlights/Best Practices: • Team-based care, team members and roles and responsibilities • SDoH Patient Action Plan - a quick form to guide a discussion with your patients about their social determinants of health and document a plan to address them - translated into Spanish, Chinese, French, Korean, Tagalog, Vietnamese • Broaden your view and explore factors that drive health in your county. County Health Rankings & Roadmaps www.countyhealthrankings.org provides a snapshot of a community's health.	https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html

6. Implementation Resources (continued)

Implementation Resources		
Source	Content	Link
Kaiser Permanente Center for Health Research and OCHIN - Guide to Implementing Social Risk Screening and Referral-making	Pragmatic guide which uses a five-step roadmap for implementing or improving social risk screening and related activities at your clinic. It provides tools and materials to support each step and a list of useful resources. Key Highlights/Best Practices: There are no national standards for the focus and frequency of social risk screening. Therefore, your social risk screening goals will be driven by what makes sense for your clinic, and how you want to use the social risk data you collect. This guide provides: • Things to consider when deciding which patients to screen • A decision tool to help your practice decide on an approach • Ways to incorporate your EHR into the workflow • Tips on developing a workflow • Examples of social risk rollout plans • FAQ for orienting staff to screening and referrals, including a slide deck that you can adapt for your practice. • Kick-off package, including staff engagement tools such as videos on social risk, empathic inquiry, and patient-facing videos on social risks • Resources to support implementing social risk data collection	Guide to Implementing Social Risk Screening and Referral-making | SIREN (ucsf.edu) Empathic inquiry video: https://www.youtube.com/watch?v=9rfmfsMMeEU
EvidenceNOW, an Agency for Healthcare Research and Quality Initiative (AHRQ): Identifying and Addressing Social Needs in Primary Care Settings	This tool is designed for practices that are thinking about beginning to screen patients for social needs. For these practices, the tool will help you: • Find resources and information to get started • Consider what implementation approaches might work best in your practice • Understand how you can use collected information to address patients' social needs, tailor care to their circumstances, and maximize reimbursement. Key Highlights/Best Practices: • Identify trusted organizations in your community where you can refer patients for identified social needs. • Make sure patients want assistance before making any referrals • Consider using a Warm Handoff Intervention when possible - when a practice makes a referral while the patient is present. The patient gets to hear what is being discussed and is engaged in the process, allowing them to clarify or correct information as needed. Be sure to only share information that the patient has given you permission to share. • Provide a tailored resource list. • Follow up with patients after referring them to a community resource to make sure they received the assistance they needed. If patients report negative experiences, identify alternative agencies for future referrals.	identifying and addressing social needs in primary care settings (ahrq.gov)

6. Implementation Resources (continued)

Implementation Resources		
Source	**Content**	**Link**
PRAPARE®- Implementation and Action Toolkit	The PRAPARE® Implementation and Action Toolkit is designed to provide interested users with the resources, best practices, and lessons learned to guide implementation, data collection, and responses to social needs. This Toolkit is based on the experiences, best practices, and lessons learned of early adopting and pioneering health centers. Each chapter focuses on major steps that are needed to implement a new data collection initiative on socioeconomic needs and circumstances. **Key Highlights/Best Practices:** • The PRAPARE® Readiness Assessment Tool can be used to help identify your organization's readiness to implement PRAPARE® related to the culture of the organization, leadership and management, technology, workflow, and process improvement. • PRAPARE® Data Findings: uncontrolled diabetics experience a greater number of SDoH needs than controlled diabetics; there is a positive correlation between the number of SDoH needs a patient faces and having hypertension; patients' being able to afford medicine affects the likelihood of having diabetes control; stress levels affect the likelihood of having hypertension control. • The PRAPARE Youtube Channel has a variety of recordings available to review that highlight PRAPARE® functionalities and data findings, user stories, promising practices, and lessons learned. • Supports focus on patient strengths and resilience during SDoH screening • EHR PRAPARE® Implementation: when building out PRAPARE® onto the EHR platform, most of the time, the responses will be automatically mapped to ICD-10 Z codes which allows staff to easily add ICD-10 Z codes to the problem or diagnosis list. • Sample workflow diagrams and workflow best practices and lessons learned • Includes intervention ideas to respond to social needs at the clinical level, the non-clinical level, and at the community level for each specific social driver. Each social driver has a list of existing ICD-10 Z codes that closely match with the social risk identified by the screening tool.	https://prapare.org/wp-content/uploads/2022/09/Full-Toolkit_June-2022_Final.pdf

7. Referral Sources to Address Social Needs

Referral Sources to Address Social Needs		
Source	**Resource**	**Link**
Findhelp.com (formerly known as Aunt Bertha)	A free resource, a search engine specializing in locating local resources and services to meet social needs. Built in Google translate with enhanced native Spanish translation. • Staff can create an account to save and share lists of favorite programs, contacts, refer programs directly, and keep notes about programs and people you are helping. • Patients can use the tool without logging in. • EHR integration is available but is not free. In 2018 it was integrated with Epic, Cerner, Athenahealth, Altruista Health, and VirtualHealth.	https://www.findhelp.org/?ref=ab_redirect Findhelp training center: https://organizations.findhelp.com/training/ Attend a webinar, view quick tutorial videos on YouTube
MBHP Integrated Care Management Program	Integrated Care Management Program (ICMP) - an enhanced care management program offered to Primary Care Clinician (PCC) Plan Members with complex medical, mental health, and/or substance use disorders. • Clinical staff provide integrated medical and behavioral health care management which can include direct, face-to-face care management visits with Members. • Members engaged in the care management program have access to assistance with SDoH needs as a part of their integrated care plan.	https://www.masspartnership.com/pcc/ICMP.aspx ICMP Online Referral Form
AAFP The EveryONE Project	Neighborhood Navigator - Use this interactive tool at the point of care to connect patients with supportive resources in their neighborhoods. It lists more than 40,000 social services by zip code. • Food • Housing • Transportation • Employment aid • Legal aid • Financial	https://www.aafp.org/content/brand/aafp/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html

7. Referral Sources to Address Social Needs (continued)

Referral Sources to Address Social Needs		
Source	**Resource**	**Link**
Mass 211 Essential Community Services Program	By simply dialing "211," callers are routed to referral specialists who can match them to available resources and oftentimes will make a direct referral to an organization that can provide assistance. Mass 211 responds immediately during times of crisis, to field calls regarding the crisis and to direct callers to services most appropriate for their needs.	Call 2-1-1 or 877-211-6277 https://www.helpsteps.com/#/
Behavioral Health Help Line (BHHL)	The Massachusetts Behavioral Health Help Line (BHHL) is here to connect you directly to clinical help, when and where you need it. Even if you are not sure what kind of help or treatment you may need, we can help guide you. • It is free, confidential, and no health insurance is required. • Real-time interpretation in 200+ languages • 24/7, 365 days/year	Call/Text 833-773-2445 or Chat here: https://www.masshelpline.com/#
Community Behavioral Health Centers	Community Behavioral Health Centers (CBHCs) are one-stop shops for a wide range of mental health and substance use services and treatment. The statewide network of CBHCs includes 26 centers across Massachusetts that offer immediate, confidential care for mental health and substance use needs. • Mobile Crisis Intervention (MCI) - 24/7 in-person crisis support for anyone in Massachusetts experiencing a mental health or substance use crisis. • Community Crisis Stabilization (CSS) for adults and kids in need of short-term, overnight crisis care, less restrictive to inpatient hospitalization. Covered by MassHealth and come commercial insurers. • Routine Outpatient Services - comprehensive outpatient mental health and substance use for MassHealth Members also covered by some commercial insurers.	https://www.mass.gov/community-behavioral-health-centers

7. Referral Sources to Address Social Needs (continued)

Referral Sources to Address Social Needs		
Source	Resource	Link
Social Interventions Research & Evaluation Network (SIREN Network)	Community Resource Referral Platforms: A Guide for Health Care Organizations (April 2019) Explores the landscape of community resource referral platforms and the experiences of early adopters. Provides a primer on the current features and functionalities of these technologies and distills lessons learned and recommendation on how to implement a community resource platform. Associated webinar available as well as the guide.	Community-Resource-Referral-Platforms-Guide.pdf (ucsf.edu)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