Promising Practices In Social Needs Screenings and Referrals

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Agenda

1. Motivation To Address Structural Drivers
2. Defining Population Needs
3. Workflows
4. Assessments
5. Staffing
6. Referral Management
7. Tech Platforms
8. Data Collection and Billing

Four Main Aspects of Assessment Intervention Design

- Whom to assess
- What to assess
- What questions to ask
- How to implement the assessment → When and Where

Motivation To Address Structural Drivers of Health

Motivation To Address Structural Drivers of Health

Economic Stability

- Employment
- Income
- Expenses
- Debt
- Medical bills
- Support

Neighborhood and Physical Environment

- Housing
- Transportation
- Safety
- Parks
- Playgrounds
- Walkability

Education

- Literacy
- Language
- Early childhood education
- Vocational training
- Higher education

Food

- Hunger
- Access to healthy options

Community and Social Context

- Social integration
- Support systems
- Community engagement
- Discrimination

Health Care System

- Health coverage
- Provider availability
- Provider bias
- Provider cultural and linguistic competency
- Quality of care

Health Outcomes

Mortality | **Morbidity** | **Life Expectancy** | **Health Care Expenditures** | **Health Status** | **Functional Limitations**

Source: Kaiser Family Foundation

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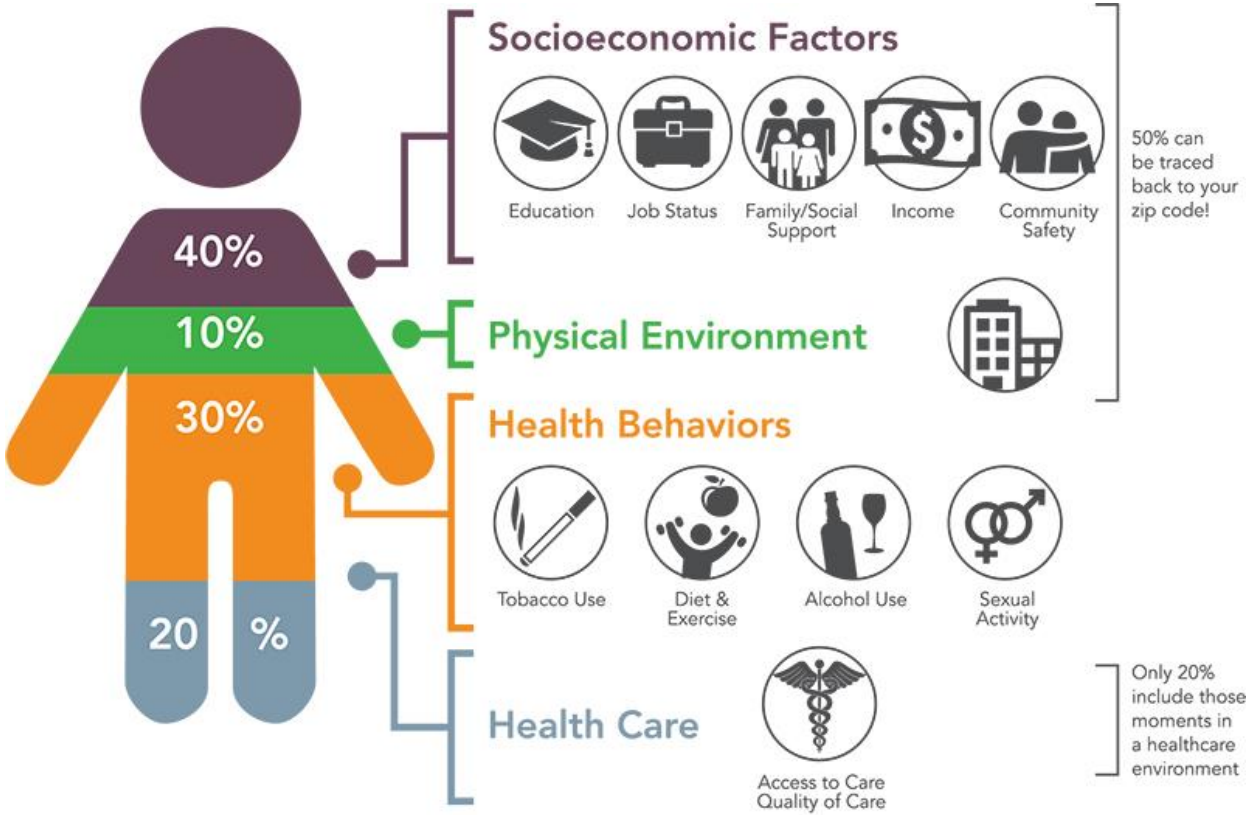
Health care has a small influence relative to the other factors that contribute to premature death in the U.S.

Shortfalls in medical care impact just 10% of early deaths; factors influenced by or interacting with the SDOH, such as social circumstances, environmental exposures, genetic predisposition and behavioral patterns, impact 90% of early deaths.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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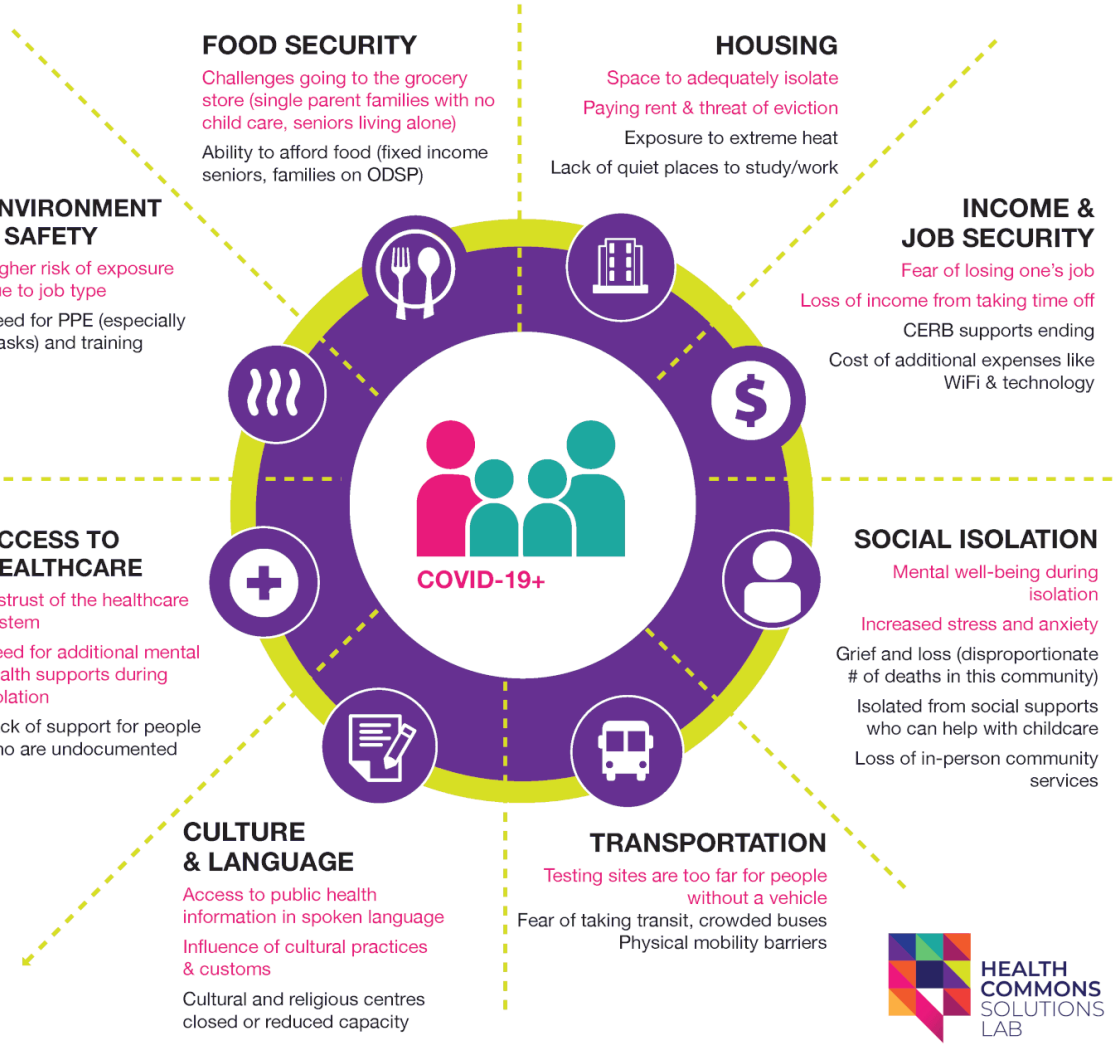
COVID-19 & SOCIAL DETERMINANTS OF HEALTH

Not everyone has been affected equally by the pandemic. The social determinants of health affect not only who gets sick (pink) but everyone in the community during this unprecedented time.

The pandemic is exacerbating the impact of these inequities, particularly for communities who are already under-resourced and experiencing barriers.



HEALTH COMMONS SOLUTIONS LAB

Care Seeker Archetypes

The Self-Reliant & Prideful

"I don't need no kudos for taking care of myself. Nobody's gonna take care of me but me."

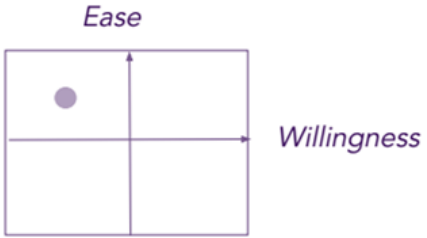
Current Behavior

+ Reluctant to use services or admit need, other than those that relate to being a provider
+ Proud to share information with others on useful resources they know about

Demographics

+ Male
+ Typically in his 20's or a senior
+ Father or grandfather

Service Engagement



Aspiration

Be a capable provider and offer value to others

Barriers

Unwilling to admit needing help; social stigma and expectations attached to accessing services

Priorities

1. Transportation
2. Education
3. Employment
4. Technology
5. Food

Access

+ Remote access
+ Places that are not out of the way, such as employment offices or LinkNYC
+ Dislike personified messaging and guidance

The Hard-to-Reach

"LGBTQ youth don't want them to experience more trauma or discrimination. So sometimes they actually end up not following through with medical care."

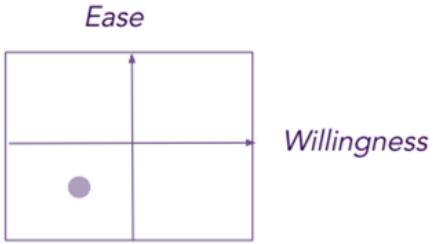
Current Behavior

+ Isolated and difficult to bring in to seek services
+ Skeptical about whether they will have a positive experience and outcome using services

Demographics

+ Comprised of 2 main groups: LGBTQ youth in 20's, isolated seniors in 60's+
+ Typically male, but often female

Service Engagement



Aspiration

Find accessible, inclusive resources that meet their needs

Barriers

Poor accessibility due to lack of relevant services in the area, reduced mobility, or inclusiveness of services

Priorities

1. Dental & vision
2. Exercise & physical fitness
3. Employment
4. Mental health
5. Food & nutrition

Access

+ Varying levels of digital literacy depending on age
+ Most reachable through remote access
+ Value word of mouth because they know the service will be accessible and inclusive for them

The Support Seeker

"I wanted to find somewhere I could access two resources because I have a lot of different appointments. I want to kill two birds with one stone."

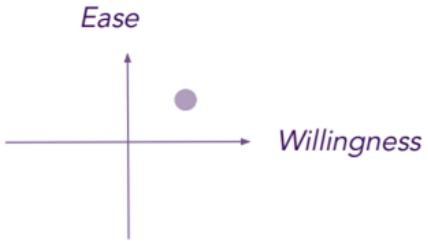
Current Behavior

+ Accesses multiple services already and proactive about seeking what they need
+ Eager to access additional services that help improve quality of life
+ Desires improved streamlining in navigating their multiple services

Demographics

+ A senior or someone with a disability
+ Typically female, but often male
+ Often unemployed

Service Engagement



Aspiration

Find additional resources to ease management of multiple and complex needs, improve quality of life

Barriers

No specific barriers, but may need to streamline use of multiple services

Priorities

1. Food & nutrition
2. Housing
3. Mental health
4. Dental & vision
5. Medical & healthcare

Access

+ Can be reached at other services used
+ Lowest overall comfort with technology
+ Prefers an ATM-style, familiar-looking kiosk
+ Prefers to have (direct) guidance

The Community Champion

"I'm a people person, so I try to find out what's going on in our community that can help benefit us and how we can be heard."

Current Behavior

+ Mainly consider services in light of others' needs and use, and have fewer needs of their own
+ Highly involved in community organizations and interact frequently with neighbors
+ View health holistically

Demographics

+ Female
+ Could be from 20s through 50s, but not likely younger or older
+ Likely to be employed

Service Engagement

Aspiration

Ensure access to high-quality resources for all members of their community

Barriers

Lack of available resources, issues with accessibility or inclusiveness of resources (for others)

Priorities

1. Housing
2. Food & nutrition
3. Employment
4. Exercise & physical fitness
5. Childcare & parenting

Access

Public spaces and services, such as schools, libraries, and centers as kiosk access points

The Caretaker

"I go to a a methadone program over here. But other than that I don't use any services to stay healthy, because I'm too busy taking care of my kids."

Current Behavior

+ Would like to access services particularly on behalf of family members
+ Overwhelmed by everything they must do
+ De-prioritize resources that could promote their own well-being in favor of putting out fires for others

Demographics

+ Female
+ Has children and is often a single parent
+ Mid-30's to early 40's

Service Engagement

Aspiration

Address basic needs for themselves and family members

Barriers

Given wide range of urgent needs, lacks the time and energy to find and access all services needed

Priorities

1. Mental health
2. Education
3. Medical & healthcare
4. Housing
5. Food & nutrition

Access

+ Has lower comfort with technology and frequently needs assistance from family members
+ Likely to learn about or use a resource finder while accessing other services

Who will be assessed?

Population Identification Strategy	Limitations	Examples
Universal Assessment Organizations can assess an entire patient or member population for unmet social needs with a universal screening tool, administered at the point of care.	Individuals facing barriers to care, often caused by SDOH factors, may not have regular encounters with healthcare and would be missed in assessment.	The American Academy of Pediatrics recommends universal SDOH screening for of all pediatric patients to help connect families with local resources.
Hot Spotting Organizations can identify a community, defined by zip code or local zoning, to assess for unmet social needs. Community-level population health metrics from Census and clinical data, can identify “hot spots”—communities with high levels of social risk or poor health outcomes.	Organizations may invest in community level interventions without knowing if their own patients or members will benefit.	Summer meals for children were offered during ED visits to connect families with the U.S. Department of Agriculture’s Summer Food Service Program (SFSP).

Who will be assessed?

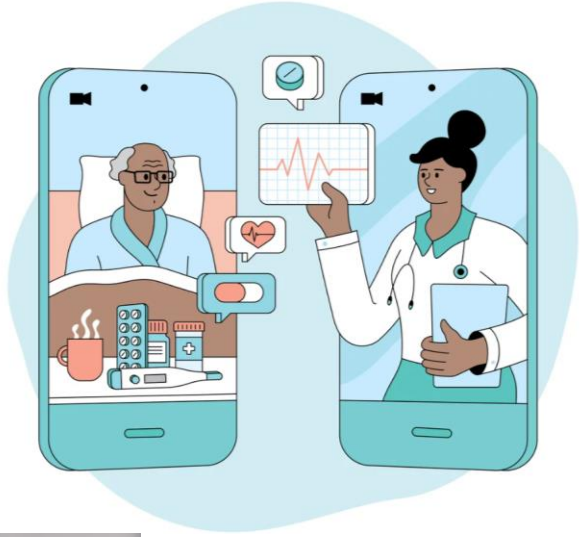
Population Identification Strategy	Limitations	Examples
Predictive Modeling and Machine Learning Organizations can use predictive modeling and machine learning to analyze cost, utilization and other data to identify candidates for screening. May first administer a low-resource intensive, high-sensitivity social needs screening to identify potential cases, then follow up with high-risk cases to confirm social needs using a more resource-intensive, high-specificity assessment.	The highest-performing models often provide fewer interpretable results. Because these approaches are designed to work at the population level, it may not be clear which factors are flagging specific individuals as high risk.	Kaiser Permanente of Colorado used electronic health record (EHR) and utilization data to predict need in a Medicare population.

Who will be assessed?

Population Identification Strategy	Limitations	Examples
Group-Based Risk Identification Organizations may use retrospective analysis of claims and patient record data to identify a population for SDOH assessment based on membership in a group known to have social needs. For example, selection criteria might include case management program enrollment, insurance type, area of residence, or other characteristics associated with high social needs (e.g. veteran status; English as a second language; live alone).	People outside of selected groups may have social risks and not all members of selected groups may be at risk.	Type 2 diabetics are often a focus of SDOH screening due to the impact of food insecurity on disease progression.

Workflow Considerations

Screening Method



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Frequency of Administration

- Each question or data element may have unique timing or collection frequency.

- Considerations:
  - What proportion of your patient population already attends recurring visits?
  - How often does a patient's status change for the question?
  - How often would the answer need to be collected for it to be considered accurate, and when would it be considered out of date?
  - Information about topics with immediate effects (e.g., safe home environment) may need to be asked more often than other questions (e.g., education level) that will change less often or with fewer immediate, potentially harmful results.

Ease of Access Via Personnel And Tech Hardware

Familiarity

Familiarity and intuitiveness attracted people to their preferred station.

Accessibility

Easy and comfortable to get to the kiosk and to see and navigate information on the screen.

Privacy

Protection from other visitors being able to see the participant's screen. Physical separation of kiosk from waiting area.

Ease of Approach

Ability to easily walk up to the kiosk and initiate use, without needing staff members.

Semi-Public Lobby Location

High-traffic, easily accessible location reduces barriers to approach, balanced with privacy.

Tools for Next Steps

Printer, pen and paper, and phone available at kiosk to take or request more information.

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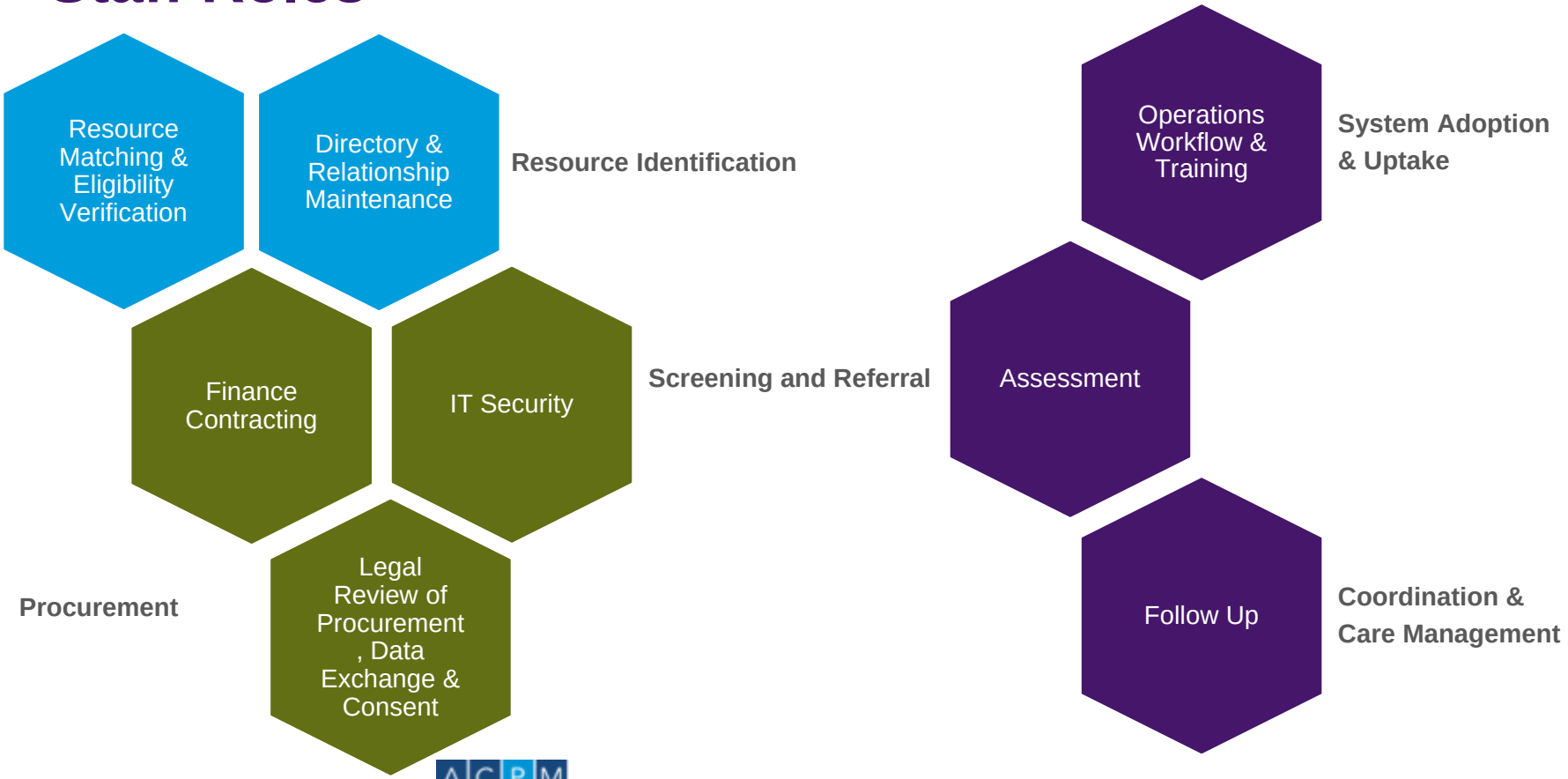
Staff Roles



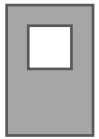
1

I need help finding health resources.

What should happen next?

2

What tools can lend support?



Which personnel can lend support?

Are additional supports available?

3

What if the client's needs are complex?

How should our approach change?

4

I need help with…_____ _____and _____ _____and_____ _____ _____

What type of follow up is needed?

Short Term

Long Term

Complex

5

At present, does your practice have the resources needed to respond to client's short-term needs?

Yes – Fillable/Not Needed	No – Missing/Needed

6

At present, does your practice have the resources to respond to client's long-term/complex needs?

Yes – Fillable/Not Needed	No – Missing/Needed

7

Who should help?

Public Health Departments

Internal Departments

Other Clinical Partners

CBO/FBO Partners

Preventive Medicine Programs

Other

Individual Administration (In-Person)

Recruitment
(1 month prior at 2 hrs per week)
1. Clinician referral.
2. Phone outreach.
3. Canvassing.
4. Host outreach event.

NOTES
**Dark shaded boxes indicate optional recommendations to enhance program delivery.*

** Partners may decide to add a **Session 0** for administrative purposes.*

All partners will complete screening activities prior to DSMP **Session 3.*

** Pre/Post Activities below may be individual community member consultations (30 min)* or group activities such as a fitness class *(1 hour).*

Enrollment (15 min)

Eligibility Screen
(10 min)
1. Provide DSMP program overview.
2. Screen community member for program eligibility (DM & 18yrs +).

If Eligible
1. Identify an open workshop cycle (start date & time).
2. Add community member to waitlist.

If Ineligible
1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).

Less Than 30 Days
If a DSMP workshop has open slots & is starting in 30 days or less, proceed to intake.

30 Days+
If no DSMP workshops are starting within 30 days+ of program eligibility screen:

1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).

Intake (OneCity Intervention) (1hr)
**All partners will complete screening activities prior to DSMP session 3.*

Consent
(5 min)
1. Provide overview of releases.
2. Obtain signatures for:
- NowPow information storage/referral
- IRB evaluation participation.

**Demonstration project participation is optional.*

**Community member refusal to participate in the demonstration project should not limit their ability to receive services.*

Screen & Refer to SDOH Resources
(15 min)
1. Administer SDOH screening tool.
2. Use SDOH screening tool to generate a custom eRx resource list for community member via NowPow.
3. Provide eRx resource list to community member (print, text, email).

**Community members who decline to have their personal information stored in NowPow should still be offered a printed eRx resource list.*

Registration
(20 min)
1. Administer intake questionnaire. 2. Provide class schedule.

Insurance Enrollment
(20 min)
Connect with insurance navigator.
**Recommended if community member reports uninsured status.*

Data Entry (+10 min if done separately)
If intake registration & SDOH screening are not entered into NowPow in real-time, it is recommended data entry occur weekly on a consistent schedule (via NowPow client upload).

DSMP Delivery (15 hrs)

Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity
Session 0 (2.5 hrs) 1. Introductions. 2. Self-management resource center (SMRC) intake administration. 3. Program overview.	**Session 1 (Program Start)** (2.5 hrs) 1. Education: Overview & Monitoring. 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting.	**Session 2** (2.5 hrs) 1.Education: Hypo/Hyperglycemia & Introduction to Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting.	**Session 3** (2.5 hrs) 1. Education: Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 4** (2.5 hrs) 1. Education: Medication & Complications of Diabetes 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 5** (2.5 hrs) 1. Education: Everyday Tips for Staying Healthy 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 6 (Program Completion)** (2.5 hrs) 1. Education: Grocery Store/Supermarket Tour 2. Take attendance & submit report to (SMRC). 3. Completion recognition ceremony 4. Discuss 6 month follow-up plan. 5. Distribute workshop participant satisfaction survey.
Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity

Follow-Up
(Month 6)
1. Administer repeated measures evaluation tool.
2. Offer to provide community member with a referral(s) to local resources.

Reporting
(Week 9)
1. Compile participant attendance records.
2. Submit workshop attendance records to DOHMH.

Individual Administration (By-Phone)

*Optional recommendations to enhance program delivery.

Recruitment
(1 month prior at 2 hrs per week)
1. Clinician referral.
2. Phone outreach.
3. Canvassing.
4. Host outreach event.

Eligibility Screen
(10 min)
1. Provide DSMP program overview.
2. Screen community member for program eligibility (DM & 18yrs +).

Enrollment (20 min)

If Eligible
1. Identify an open workshop cycle (start date & time).
2. Add community member to waitlist.

Less Than 30 Days
If a DSMP workshop has open slots & is starting in 30 days or less, proceed to intake.

Registration Part 1
(10 min)
1. Administer part 1 of intake questionnaire.
2. Provide class schedule.

If Ineligible
1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).

30 Days+
If no DSMP workshops are starting within 30 days+ of program eligibility screen:
1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).

Optional recommendation.

Intake (45 min)

Registration Part 2
(10 min)
1. Administer part 2 of intake questionnaire.
2. Provide class schedule.

Screen & Refer to SDOH Resources
(15 min)
1. Administer SDOH screening tool.
2. Use SDOH screening tool to generate a custom eRx resource list for community member via NowPow.
3. Provide eRx resource list to community member (print, text, email).

**Community members who decline to have their personal information stored in NowPow should still be offered a printed eRx resource list.*
**If data entry is not done at the time the phone intake, the SDOH eRx should be sent to the community member via text or email as soon as possible. Also consider providing a paper copy to community member in-person during session 1.*

Insurance Enrollment
(20 min)
Connect with insurance navigator.

**Recommended if community member reports uninsured status.*

Data Entry (+10 min if done separately)
If intake registration & SDOH screening are not entered into NowPow in real-time, it is recommended data entry occur weekly on a consistent schedule (via NowPow client upload).

Consent
(5 min)
1. Provide overview of releases.
2. Obtain signatures.
- NowPow consent to share information.
- IRB informed consent.
- HIPAA.
- Photo release.

**Demonstration project participation is optional.*
**Community member refusal to participate in the demonstration project should not limit their ability to receive services.*

DSMP Delivery (15 hrs)

Individual Community Member Consultation(s) (30 min each as needed)

Session 1 (Program Start)	Session 2	Session 3	Session 4	Session 5	Session 6 (Program Completion)
(2.5 hrs)	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity
1. Education: Overview & Monitoring. 2. Take attendance & input in QTAC Compass portal. 3.Distribute assignments & goal setting.	(2.5 hrs) 1.Education: Hypo/Hyperglycemia & Introduction to Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting.	(2.5 hrs) 1. Education: Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	(2.5 hrs) 1. Education: Medication & Complications of Diabetes 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	(2.5 hrs) 1. Education: Everyday Tips for Staying Healthy 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	(2.5 hrs) 1. Education: Grocery Store/Supermarket Tour 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting 4. Discuss 6 month follow-up plan. 5. Distribute workshop participant satisfaction survey.
Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity

Reporting
(Week 9)
1. Compile participant attendance records.
2. Submit workshop attendance records to DOHMH.

Follow-Up
(Month 6)
1. Administer repeated measures evaluation tool.
2. Offer to provide community member with a referral(s) to local resources.

Group Co-Facilitated Administration (In-Person)

**Optional recommendations to enhance program delivery.*

Recruitment
(1 month prior at 2 hrs per week)
1. Clinician referral.
2. Phone outreach.
3. Canvassing.
4. Host outreach event.

Eligibility Screen
(10 min)
1. Provide DSMP program overview.
2. Screen community member for program eligibility (DM & 18yrs +).

If Eligible
1. Identify an open workshop cycle (start date & time).
2. Add community member to waitlist.

If Ineligible
1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).

rollment (15 min)

Less Than 30 Days
If a DSMP workshop has open slots & is starting in 30 days or less, proceed to intake.

30 Days+
If no DSMP workshops are starting within 30 days+ of program eligibility screen:
1. Offer to provide community member with a referral(s) to local resources.
2. Offer to administer SDOH screening tool (as an aid to facilitate the referral process & connect the community member to best fit resources).
**Optional recommendation.*

Consent
(5 min)
1. Provide overview of releases.
2. Obtain signatures.
- NowPow consent to share information.
- IRB informed consent.
- HIPAA.
- Photo release.

**Demonstration project participation is optional.*
**Community member refusal to participate in the demonstration project should not limit their ability to receive services.*

Session 0 (Intake) (2.5 hrs)

Registration
(20 min)
1. Administer intake questionnaire.
2. Provide class schedule.

Screen & Refer to SDOH Resources
(15 min)
1. Administer SDOH screening tool.
2. Use SDOH screening tool to generate a custom eRx resource list for community member via NowPow.
3. Provide eRx resource list to community member (print, text, email).

**Community members who decline to have their personal information stored in NowPow should still be offered a printed eRx resource list.*
**SDOH eRx(s) should be sent to the community members via text or email as soon as possible. Following session 0. Also consider providing a paper copy to each community member in-person during session 1.*

Insurance Enrollment
(20 min)
Connect with insurance navigator.
**Recommended if community member reports uninsured status.*

Data Entry (4hrs if done separately)
If intake registration & SDOH screening are not entered into NowPow in real-time, it is recommended data entry occur weekly on a consistent schedule (via NowPow client upload).

DSMP Delivery (15 hrs)
Individual Community Member Consultation(s) (30 min each as needed)

Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity	Pre-Activity
Session 1 (Program Start) (2.5 hrs) 1. Education: Overview & Monitoring. 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting.	**Session 2** (2.5 hrs) 1.Education: Hypo/Hyperglycemia & Introduction to Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting.	**Session 3** (2.5 hrs) 1. Education: Nutrition 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 4** (2.5 hrs) 1. Education: Medication & Complications of Diabetes 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 5** (2.5 hrs) 1. Education: Everyday Tips for Staying Healthy 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting	**Session 6 (Program Completion)** (2.5 hrs) 1. Education: Grocery Store/Supermarket Tour 2. Take attendance & submit report to (SMRC). 3.Distribute assignments & goal setting 4. Discuss 6 month follow-up plan. 5. Distribute workshop participant
Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity	Post-Activity

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(Week 9)
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Follow-Up
(Month 6)
1. Administer repeated measures evaluation tool.
2. Offer to provide community member with a referral(s) to local resources.

Referral Prioritization

Provide comprehensive list of all resources needed based on assessment

Ask patient to prioritize actions and set goals accordingly. Be mindful that your primary concerns may not align with your patients' priorities.

We talked about many parts of your life. I am going to read the list we made together. Tell me which items you most want my help with today.

Make a follow-up plan for goals set and initiating action on outstanding referral connection needs

Steps Forward EdHub Training Module

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

Link to Module
https://edhub.ama-assn.org/steps-forward/module/2702762

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Assessment Structure & Efficacy

What Will Be Assessed?

- **Strengths-based assessment**
  - Focuses on measuring a patient's positive or protective factors that help them take actions toward improved health (e.g., relationships, methods for dealing with stress, ability to access resources). more often used in behavioral health.

- **Needs-based**
  - Needs-based assessment gauges individuals' immediate unmet needs based on their preferences and priorities.
  - To focus more practically on connecting individuals to services that may improve their health.

- **Risk-based assessment**
  - Risk-based assessment captures individual characteristics associated with poor health outcomes. Poverty, minoritized race, ethnicity, sexual orientation or gender identity and primary language other than English are all examples of characteristics associated with higher risk for poor health.

Need Identification And Volume

Safety net institutions tend to identify

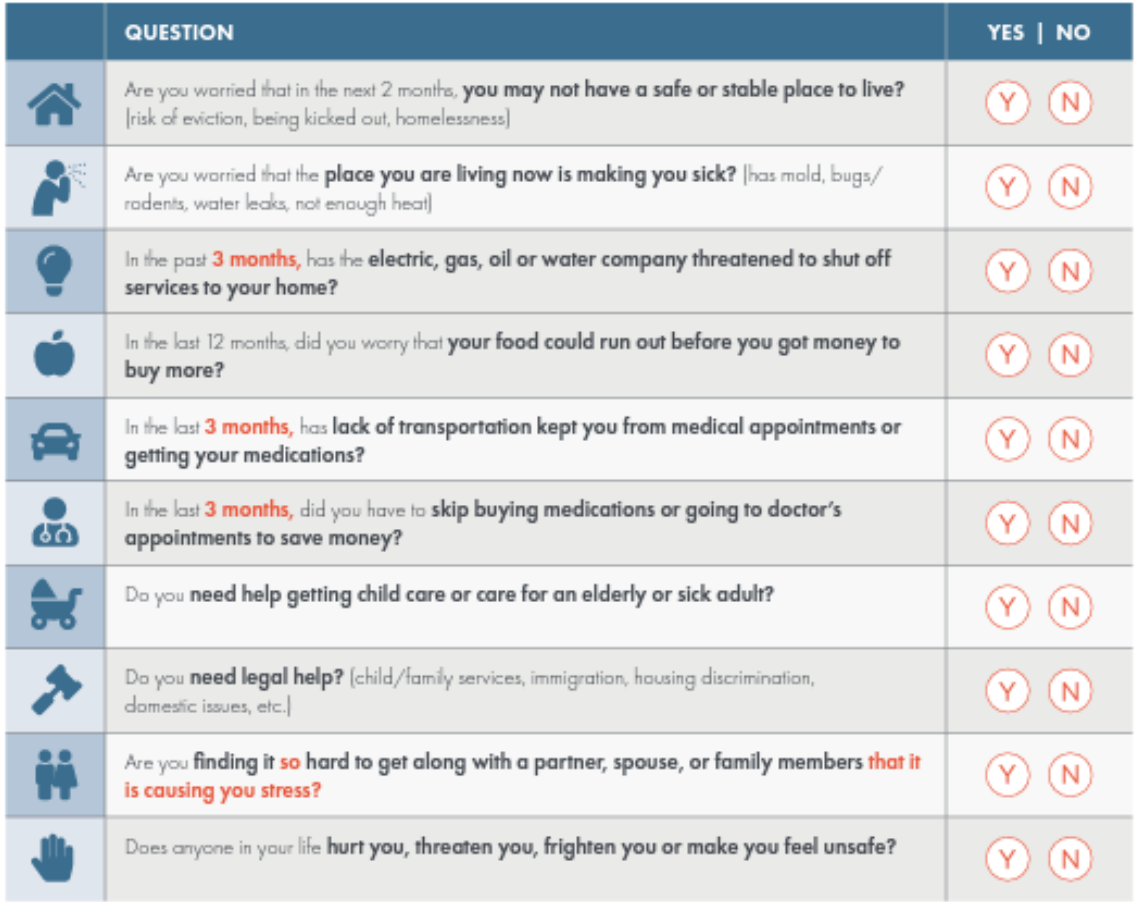
- higher patient volume of needs
- more complex needs
- greater comorbidity of needs

because of the populations they serve

What Questions Will Be Asked?

- The USPSTF has not made recommendations on SDOH assessment for transportation, food insecurity, safety, housing, financial situation, education and social connections
- Organizations often use existing SDOH screener questionnaires based on their areas of interest, their service capabilities or on the perceived needs of their population
    - If housing insecurity is a major issue in the population served, a question about recent experience with homelessness might be appropriate; if housing insecurity is less prevalent, a question about the risk of potential homelessness might be more relevant.
    - If specific resources (subsidized housing, homeless shelters, rent assistance, homelessness prevention programs) are not available, asking if those resources would be helpful does not help the individual in need, although such questions may be useful in making a case for programmatic funding.
- The tools are likely to change over time. In the context of the COVID-19 pandemic, new attention has focused on screening for broadband access, digital literacy, and experiences of racism and discrimination.

Example created by the Montefiore Health System in New York State



	QUESTION	YES | NO
	Are you worried that in the next 2 months, **you may not have a safe or stable place to live?** (risk of eviction, being kicked out, homelessness)	Y N
	Are you worried that the **place you are living now is making you sick?** (has mold, bugs/ rodents, water leaks, not enough heat)	Y N
	In the past **3 months,** has the **electric, gas, oil or water company threatened to shut off services to your home?**	Y N
	In the last 12 months, did you worry that **your food could run out before you got money to buy more?**	Y N
	In the last **3 months,** has **lack of transportation kept you from medical appointments or getting your medications?**	Y N
	In the last **3 months,** did you have to **skip buying medications or going to doctor's appointments to save money?**	Y N
	Do you **need help getting child care or care for an elderly or sick adult?**	Y N
	Do you **need legal help?** (child/family services, immigration, housing discrimination, domestic issues, etc.)	Y N
	Are you **finding it so hard to get along with a partner, spouse, or family members that it is causing you stress?**	Y N
	Does anyone in your life **hurt you, threaten you, frighten you or make you feel unsafe?**	Y N

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Screening Tool Comparison Domains

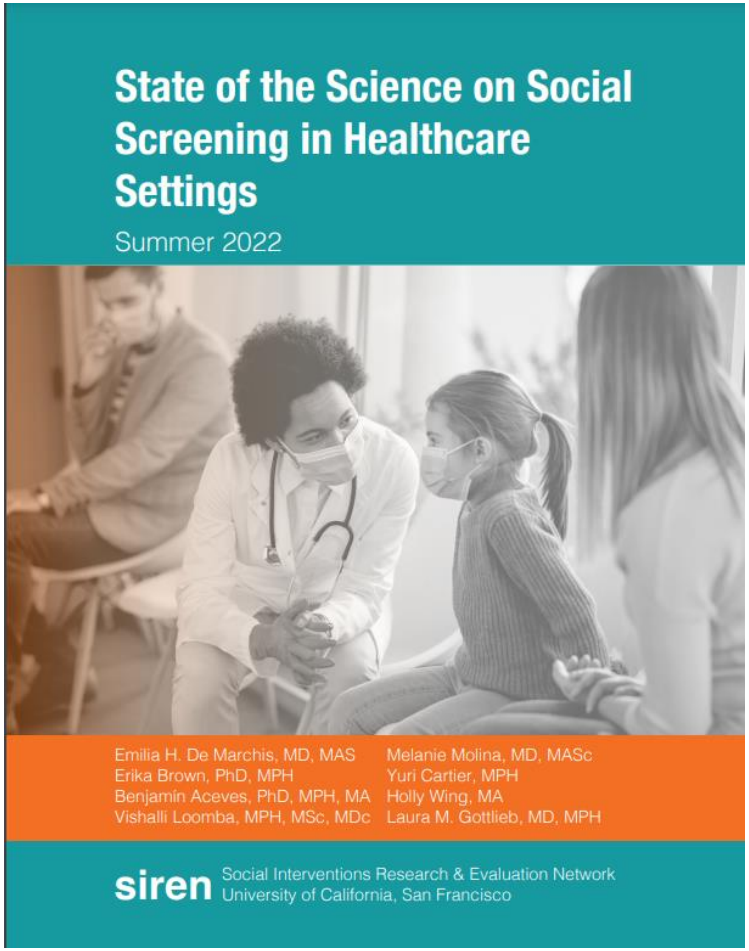
- Number of social needs questions
- Number of non-social needs questions
- Patient or clinic population
- Reading Level
- Reported Completion Time
- Additional Languages
- Scoring
- Cost

Adults

https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Pediatrics

https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison/peds



- The dual goals of this report are to synthesize and disseminate recent research and surface key knowledge gaps that should be addressed to meaningfully inform efforts to implement and scale screening practices in the US healthcare system.

- https://sirenetwork.ucsf.edu/sites/default/files/2022-06/final%20SCREEN%20State-of-Science-Report%5B55%5D.pdf

Which Screening Tools Work Best?

- Very limited testing of the psychometric and pragmatic validity of different social screening tools has been done to date and no two reported studies have followed the exact same methods thus far

- No study has explicitly explored psychometric and pragmatic validity differences by language

- Results of studies exploring differences in screening acceptability by race, ethnicity, and gender have varied

- Ease of use
- Patient engagement approach
- Allocating sufficient time
- Identifying a private location
- Creating a safe environment
- Feasibility of workflow in mobile settings and community environments
- Enhancing linguistic and cultural congruence to reduce communication issues (CHWs)

Address Concerns Through Appropriate Staffing

- Insufficient time and workflow disruption
- Provider discomfort with screening
- Patient discomfort/negative impacts on provider-patient relationship
- This included concerns that topics raised may cause patients to feel shame or stigma and damage patient-provider relationships
- Insufficient knowledge or resources to adequately address identified needs

- Continue and expand use of Community Health Worker staffing models in as direct hires and through community partnerships.
- Provide training but also acknowledge the benefit of integrating staff with varied lived experiences, and those specially trained in interpersonal engagement, outreach, crisis management, and social service navigation skills from other care sectors.

Referrals Management

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A Variety of Referral Platforms Have Emerged

- While there are many different approaches, these tools rely on the same core principle - empowering care professionals, or, in some cases, patients themselves, to connect needs to relevant, well-matched community resources.

- The most sophisticated market tools support directory maintenance, bi-directional referral tracking, cross provider communication within the platform, reporting, network analysis and electronic health record integration.

Availability of Platforms Varies By Geographic Region

UNITE US

Capable

one degree

Healthify

Health Leads

NOW POW

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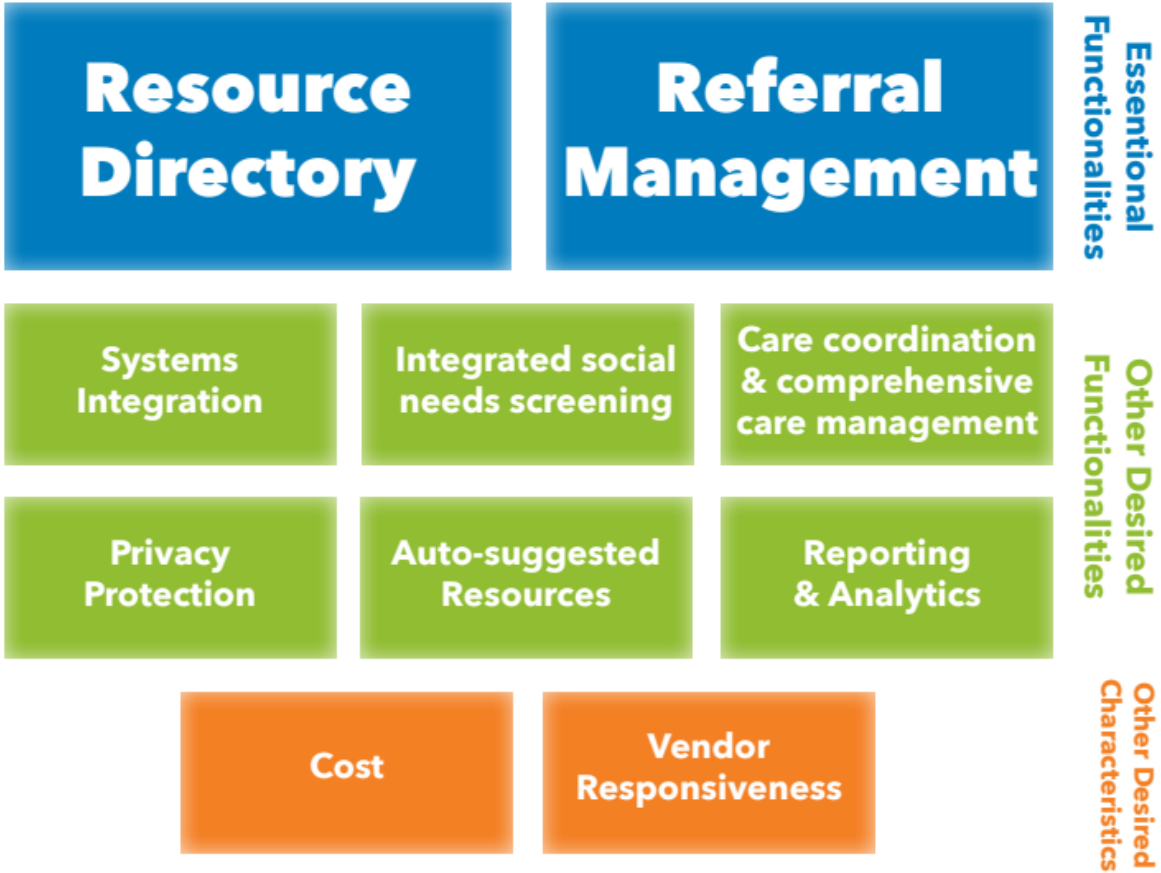
Directory maintenance is the most critical paid service offered through these types of platforms (ask about data sources, frequency and growth priorities.

None of the tech systems available will serve as a replacement for critical staff.

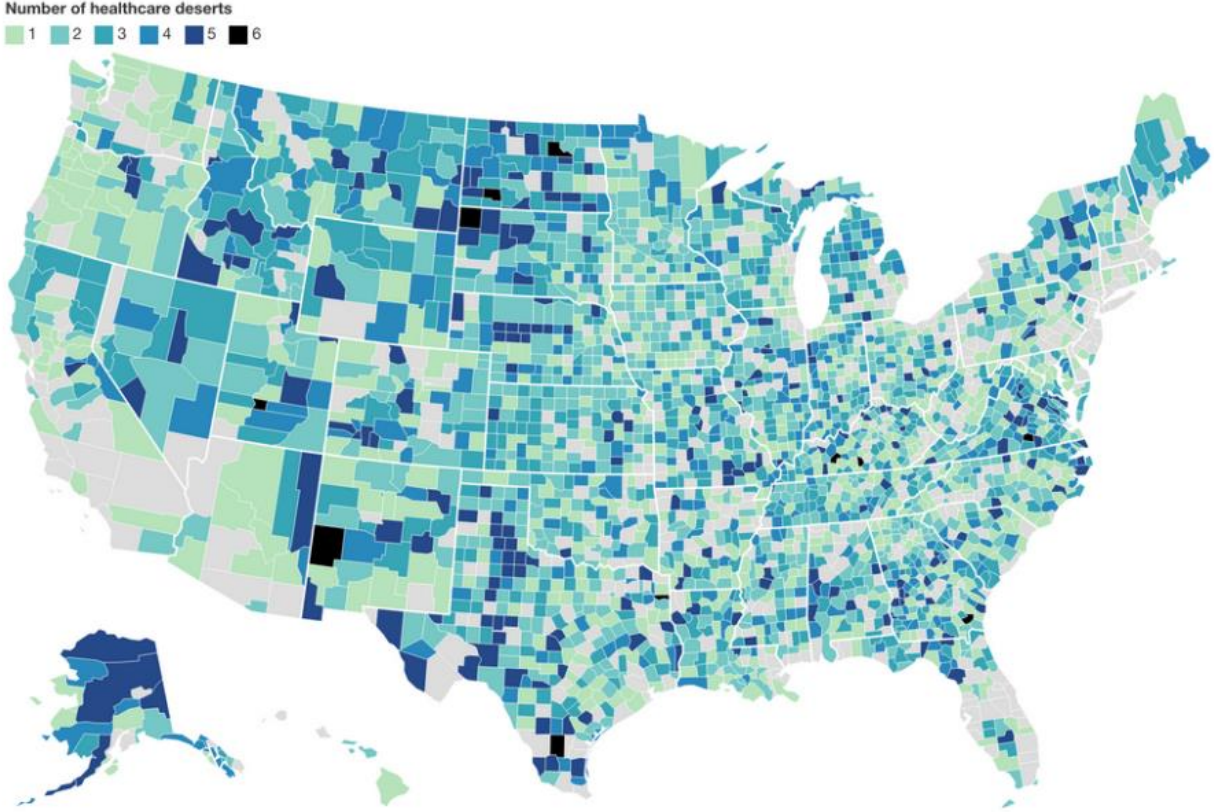
Tech companies should be leveraged for workflow guidance on how their platform can best meet your practice needs – not patient engagement or resource provision decisions.



The number of people potentially impacted by healthcare deserts is substantial: We estimate roughly 121 million people currently live in a healthcare-desert county, accounting for over 37% of the U.S. population.

Healthcare Deserts, County by County

Counties where most people lack adequate access to pharmacies, primary care providers, hospitals, hospital beds, trauma centers, and/or low-cost health centers.



Note: Pharmacy, hospital, trauma center, and low-cost health center deserts could not be calculated for the following counties due to missing data: Oglala Lakota, South Dakota; Shannon, South Dakota; Wade Hampton, Alaska; Kusilvak Census Area, Alaska; and Bedford, Virginia.

Source: GoodRx

GoodRx

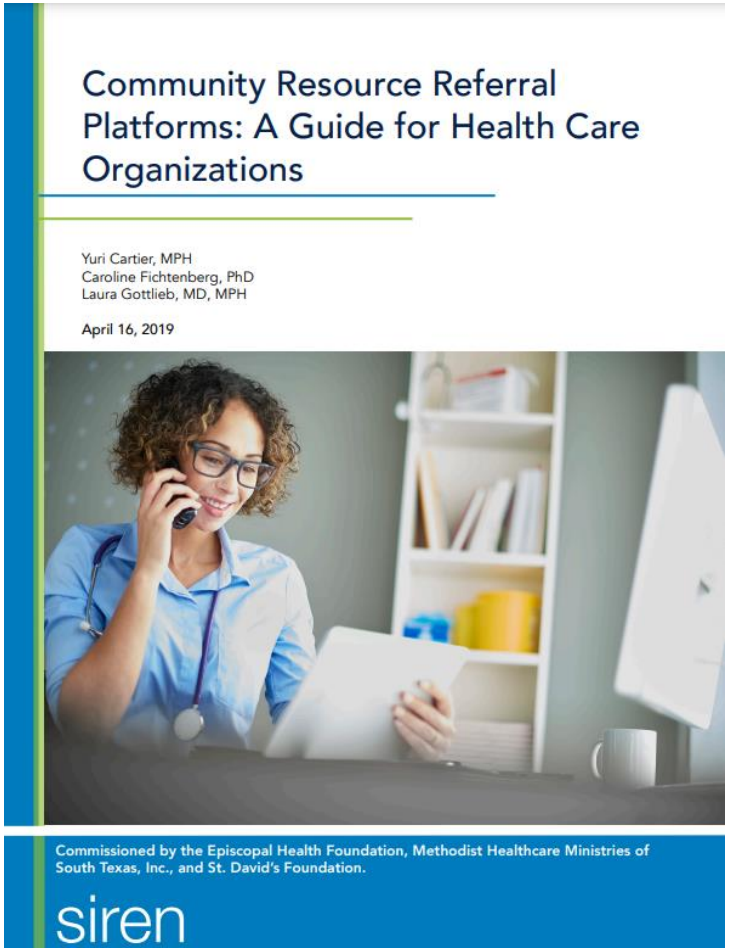
Partial Snapshot

Zip code/ZCAT 10460

According to ACS, the average ZCAT population during the period 2014 - 2018 was 59,505.

Residents of this area were 30% African American, 70% Hispanics. Of the people for whom poverty status was determined, 37% had income below the poverty level. Of the civilian, non-institutionalized population, 9% did not have medical insurance cover.

Services	Services in Zip Code	Average # of users served	Services in Spanish	Services with affordable fee structure
Dental, Vision, and Hearing	6		4	4
Dental care	3	19,835	2	2
Eye care	1	59,505	0	0
Health Care	52		33	44
Primary care	8	7,438	5	6
Health screening	13	4,577	6	13
Urgent health care	0	59,505	0	0
Health Care Supplies	12		4	1
Pharmacy services	9	6,612	2	0
Breast pumps	0	830	0	0
Mental Health	6		6	6
Individual counseling	3	12,359	3	3
Youth counseling	1	6,661	1	1
Immigrant Support	0		0	0
Immigration advocacy and legal services	0	10,610	0	0
English as a second language (ESL) classes	0	14,047	0	0
Child Care and Parenting	14		8	12
After-school program	5	2,733	3	5
Camp or summer program	3	4,556	1	1
Parenting skills classes	1	13,667	1	1



- This guide was developed to help safety net health care organizations understand the landscape of community resource referral platforms and learn from the experience of early platform adopters.

- https://sirenetwork.ucsf.edu/sites/default/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf

Data Collection & Billing

Standardize Data Source & Tools For Impactful Use

- **Patient-level health care data:**
  - **Patient-generated:** Patients report on SDOH, social risk factors or social needs to inform medical or social care decisions. Information may be gathered through formal assessment or individuals may incidentally disclose a social need (e.g., transportation issues that caused a missed appointment). Such data may be documented in the EHR, in case management or in other systems.
  - **EHR and claims data:** Health plans collect and integrate EHR and claims data from hospitals, clinical practices and other health care organizations to create a comprehensive view of an individual's health care across settings.

- **Neighborhood-level data:** Organizations use zip code as a proxy to understand patients' likely SDOH and social risks based on their neighborhoods.

- **Person-level non-health care data:** Organizations are using data about patients from large non-healthcare data sources (e.g., housing, financial, criminal) to make inferences about social risks and social needs.

Improve Billing Consistency Through Adoption of Standard Z Codes

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] cms.gov/medicare/icd-10/2021-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Improve Billing Consistency Through Adoption of Standard Z Codes

USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] cms.gov/medicare/icd-10/2021-icd-10-cm
[4] cdc.gov/nchs/icd/icd10cm.htm

Revision Date: February 2021

go.cms.gov/omh

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