Social Determinants of Health Quality Guide

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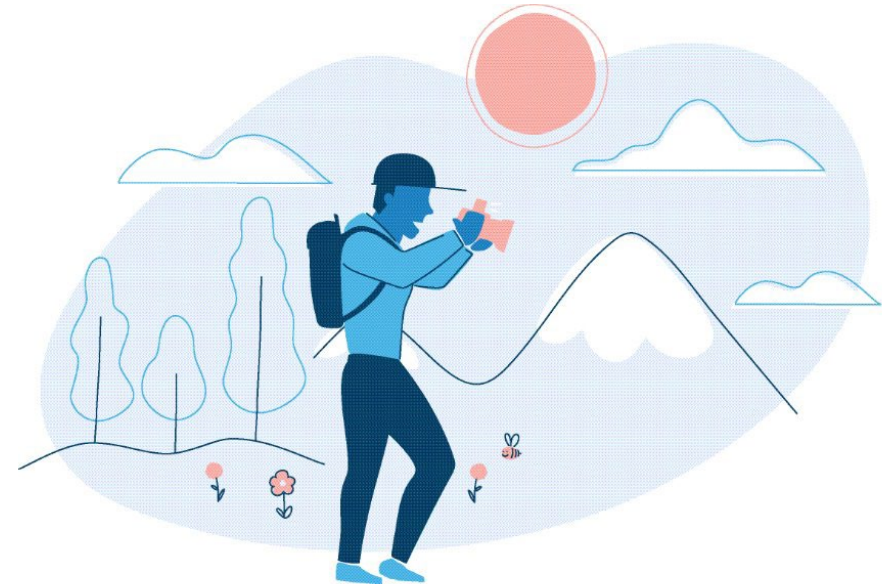

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Introduction to SDOH

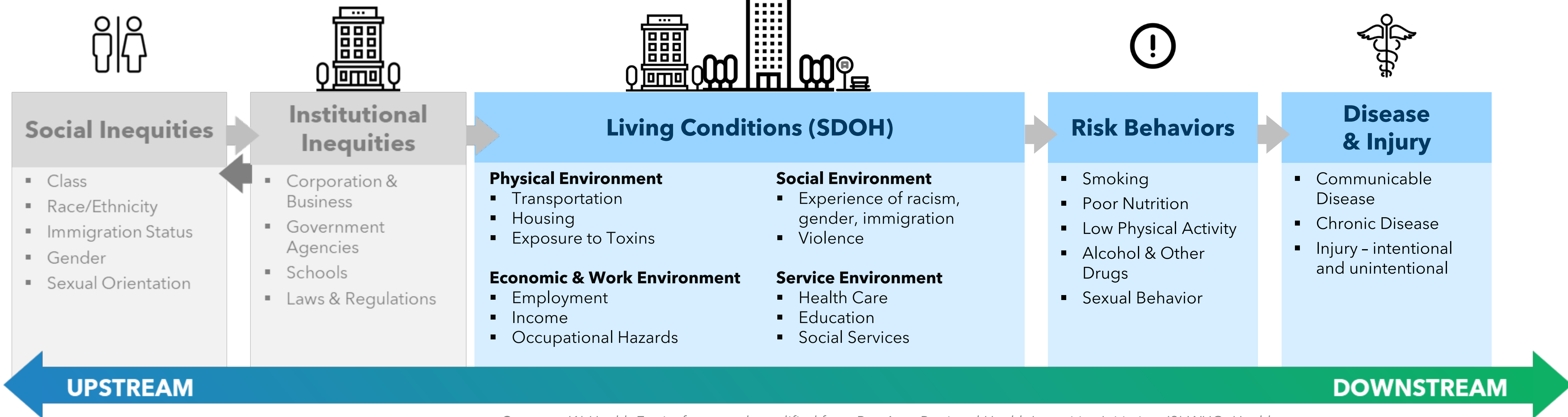
Social Factors are Part of a Larger Health Equity Framework[1]

Population Health[2] is determined by many factors, spanning from biological to societal. Improving population health requires a comprehensive, multisectoral approach to health and healthcare improvement.

Health Equity[3] is the state in which every individual has a fair and just opportunity to achieve their health potential.

SDOH[4] are the environmental conditions where people are born, grow, live, learn, work, play, worship, and age affecting their quality-of-life and health care outcomes.

Health-Related Social Need (HRSN)[5] is an individual's unmet, adverse social conditions that contribute to poor health and are a result of underlying SDOH.



Sources: (1) Health Equity framework modified from Bay Area Regional Health Inequities Initiative; (2) WHO, Health systems strengthening glossary, 2013; (3) Braverman P, what is health equity and how does a life-course approach take us further toward it? Maternal and Child Health Journal; (4) Healthy People 2020, US HHS; (5) KFF summary of CMS guidance, 2023

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SDOH Can Impact up to 80% of Someone's Health

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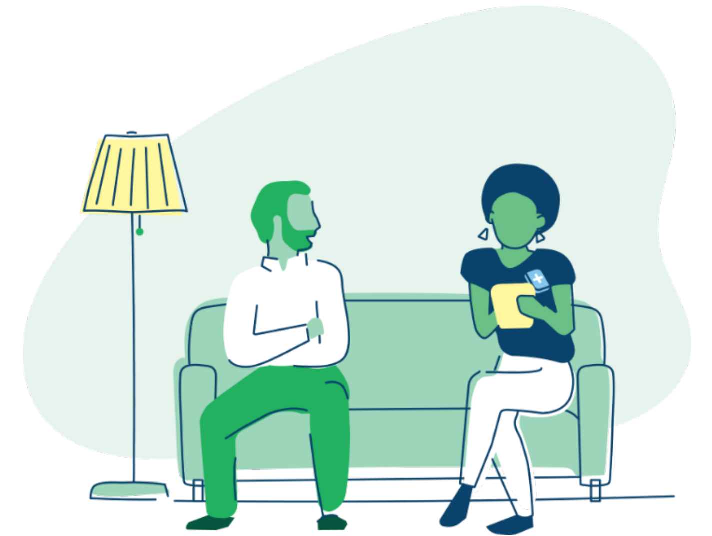
SDOH Impacts Health Outcomes

People with food insecurity have a **56% probability** of developing a chronic disease[1]

Nearly 40% of patients skip appointments due to financial concerns[2]

Individuals experiencing housing insecurity used the ED **3x as often**[3]



Sources (1) Seligman, H. K., Laraia, B. A., & Kushel, M. B. (2010). Food insecurity is associated with chronic disease among low-income NHANES participants. The Journal of Nutrition, 140(2), 304–310. (2) Cerullo, M. (2023, January 18). Nearly 40% of Americans skipped medical care in 2022 because of cost concerns, poll finds. CBS News. https://www.cbsnews.com/news/medical-care-costs-americans-skipped-gallup/
(3) Franco, A., Meldrum, J., & Ngaruiya, C. (2021). Identifying homeless population needs in the Emergency Department using Community-Based Participatory Research. BMC Health Services Research, 21(1). https://doi.org/10.1186/s12913-021-06426-z

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Amelia's Story

An Example of How SDOH Impacts Health

Issue

Amelia was a **new mom**, along with older children at home. Amelia had to take **unpaid medical leave** due to health complications after her delivery. She was concerned about providing basic needs for her family and later problems occurred related to immigration.

Actions

A Highmark social worker **provided resources** for Amelia to apply for **medical, food, energy and rent assistance**. Assistance was also provided regarding the immigration issue her family was facing. The social worker consistently called and emailed Amelia to follow and provide support, information, and assistance.

Results

Amelia **successfully applied** for **all** the assistance programs which led to help with rent, utilities, and food assistance through SNAP. She successfully made contact with the Christian immigration advocacy agency in Pittsburgh to receive the assistance she needed to resolve her concerns.

Stable housing and food helped Amelia recover from surgical complications, avoiding emergency visits.

Age : 46
Location: Pennsylvania
Domain: Financial Assistance

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Regulators are Requiring Social Screening with Patients

Regulators recognize the impact that social needs have on a person's health and are requiring providers and payers to take action as part of whole person health.

- Social risk **screening**
- **Intervention**
- Closed loop referrals
- Future Medicare Advantage **Stars** measure

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SDOH Assessment Screening Tools

Evidence-Based Tools Guide Us to Better Outcomes

They provide us with:

- Consistent and interpretable results
- Ability to report on patient outcomes
- Systematic approach to enhance decision-making

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Screening Tools

There are many assessment instruments to explore and use

Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)	Highmark Health SDOH Assessment
Health Leads Screening Tool	Comprehensive Universal Behavior Screen (CUBS)	Hunger Vital Signs (HVS)	Safe Environment for Every Kid
U.S. Household Food Security Survey	We Care Survey	Children's Health Watch Housing Stability Vital Signs	WellRx Questionnaire

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Highmark's Universal SDOH Assessment

SOCIAL CONNECTIONS

- ❑ How often do you feel isolated from others? (UCLA Loneliness Screening)

TRANSPORTATION NEEDS

- ❑ Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (PRAPARE)

FINANCIAL RESOURCE STRAIN

- ❑ Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you? (OECD)

HEALTH LITERACY

- ❑ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist? (SILS)
- ❑ I know how to find helpful health resources on the Internet. (eHealth Literacy Scale)

FOOD INSECURITY

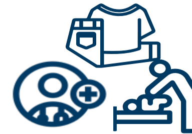
- ❑ "Within the past 12 months we worried whether our food would run out before we got the money to buy more." (Children's Health Watch Hunger Vital Signs)
- ❑ "Within the past 12 months the food we bought just didn't last and we didn't have money to get more." (Children's Health Watch Hunger Vital Signs)

SAFETY

- ❑ Do you feel physically and emotionally safe where you currently live? (PRAPARE)

HOUSING STABILITY

- ❑ Are you worried about losing your housing? (PRAPARE)
- ❑ In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? (AHC)



ACCESS & AFFORDABILITY

- ❑ In the past year, have you been unable to get childcare when it was really needed? (PRAPARE)
- ❑ In the past year, have you been unable to get clothing when it was really needed? (PRAPARE)
- ❑ In the past year, have you been unable to get medicine or any health care when it was really needed? (PRAPARE)
- ❑ Do you have access to any of the following devices? (ACORN)

EMPLOYMENT

- ❑ What is your current work situation? (PRAPARE)

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Who can screen patients for social needs?

Leveraging Team-based Care, anyone can screen patients. Screeners can include but are not limited to the following:

- Providers
- Nurses
- Medical Assistants
- Front-desk Staff
- Registration Staff
- Patient Navigators
- Social Workers
- Behavioral Health Clinicians
- Community Health Workers
- Case Managers

Individuals who conduct screenings should be trained on how to ask the questions in an empathetic and thoughtful manner that is culturally sensitive to each patient

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How to Talk SDOH with Patients

Example language:

- "We ask everyone"
- "Your provider is interested in how things are going in your life"
- "Dr. Smith is/ we are/ I am concerned about your overall health."
- "We ask these questions for all of our patients because we care about how you're doing in all areas."
- "We have resources available that can be helpful when we know someone is in need."
- "These areas impact health and we want to be sure we are making appropriate recommendations for the whole picture."

Helpful Tips:

- Make it a standard part of your day-to-day operations
- Show concerns for patient's overall health and wellness
- Avoid showing judgement & show empathy

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How and When can data be collected?

How

- In person with a member of the practice
- During the registration process (including electronically)
- Individual self-reporting
- Through a health risk assessment
- Patient Portal

When

- At a minimum **annually**
  - Annual wellness exam
  - New Patient visit
- Upon admission to an in-patient stay
- Recommended to **reassess** patients following changes in physical, social, or behavioral health status and at subsequent encounters

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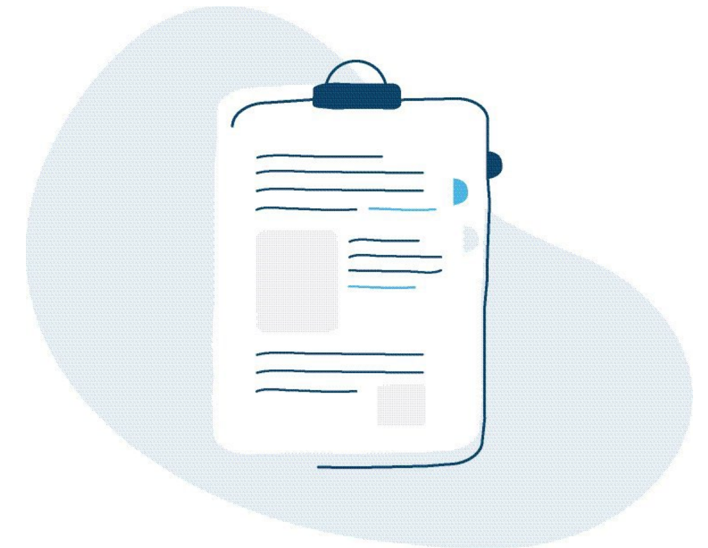
Integration & Workflow

Streamlining SDOH Implementation

- **Start Small:** Begin with a manageable scope. Select key questions relevant to your practice and gradually expand.
- **Patient Preparation:** Promote SDOH screening beforehand. Explain the purpose and format through various channels.
- **Supporting Staff:** Provide introductory SDOH training. Develop workflow aids (cheat sheets, resource guides) and foster knowledge sharing.
- **Develop a Workplan:** Create a living document outlining program goals, tasks, timelines, roles, and a monitoring/evaluation plan.



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Decision Point for Screening & Interviewing Workflows

To ease the burden on busy providers, adopt a team-based approach for comprehensive social determinants of health (SDOH) screening.

What	When	Who	Where	How
• What tools are being used? • What domains need addressed?	• When does someone get screened? • When does someone need re-screened? • Changes in social health such as lost job or insecure housing • When is someone referred to services?	• Who will screen? • Who will intervene?	• Where does screening take place? • Where are people referred?	• How will data be captured? (EHR, Paper?) • How is someone alerted to do a screening or that one has been completed?

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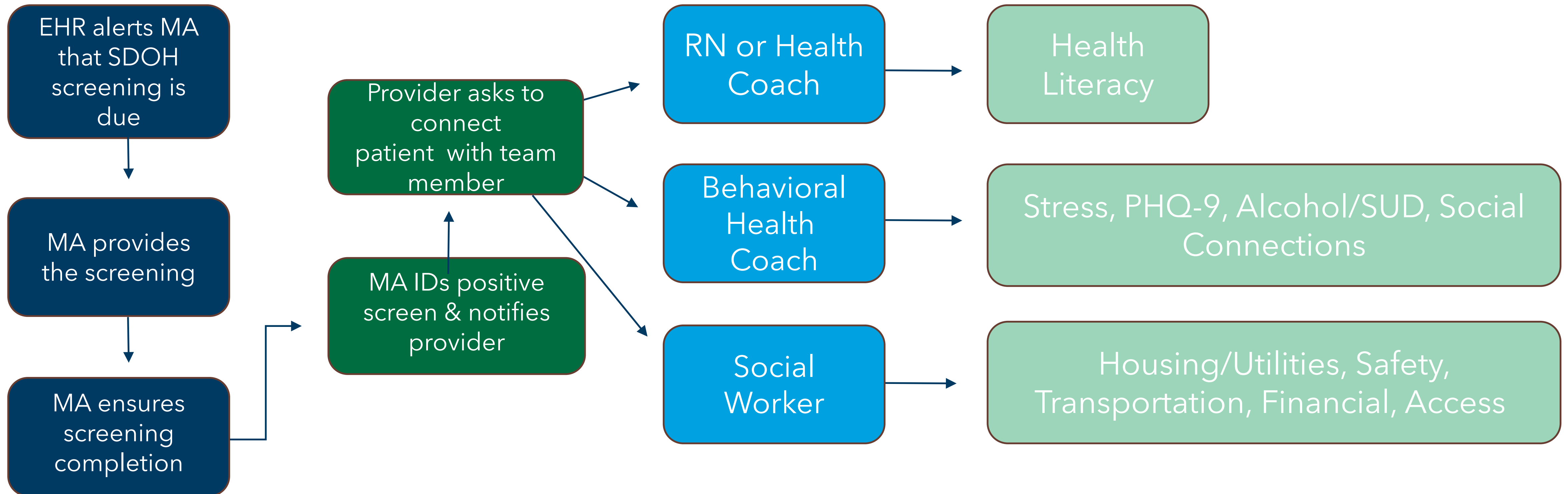
Example Workflow for Positive Screenings



Any team member may refer to services using the **[Community Support Platform]()**.

*This is just one example of a workflow, and each organization will vary based on existing roles.

HIGHMARK BCBS HIGHMARK BS
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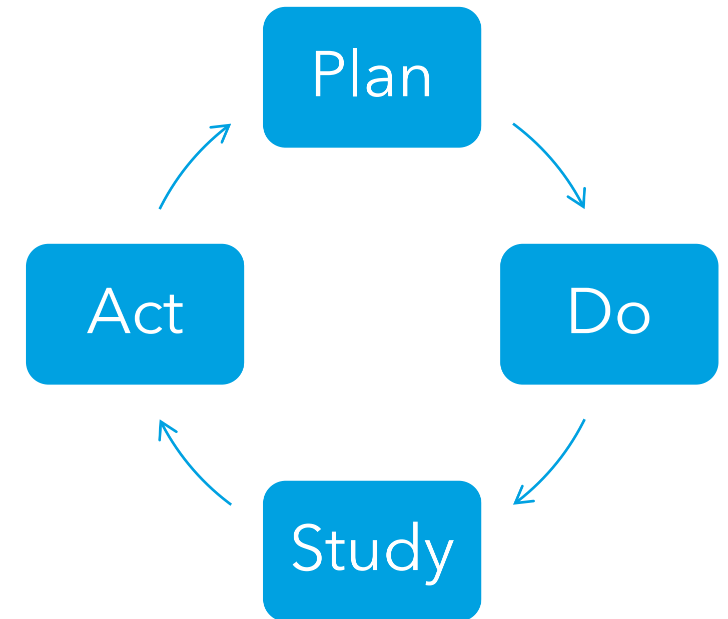
Monitoring and Evaluation

Measuring Success

The Importance of Monitoring & Evaluation

Monitoring & Evaluation improve outcomes, create a greater impact, and enable informed decision-making

- Offers transparency and accountability
- Allows for early problem detection
- Makes room for learning from mistakes



Monitoring & Evaluation

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Coding

Document SDOH Response Regardless of Need

Documentation should be Captured in the Record and in Codes

- In the patients Electronic Health Record
- Leverage coding for reporting
  - Z-codes
  - LOINC Question Codes & Answer Codes
  - SNOMED
- NCQA HEDIS and CMS are requiring LOINC codes for assessments and SNOMED codes for interventions
- Some government contracts *require* Z-codes

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Standardized SDOH Coding

Assessing

Z-codes

- Z codes ranging from Z55 – Z65 are the ICD-10-CM diagnosis codes used to documents SDOH data (e.g., housing, food insecurity, transportation, etc.)
- Follow the ICD 10 CM coding guidelines (https://www.cms.gov/)
- 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.
- https://www.cms.gov

LOINC (Logical Observation Identifiers Names and Codes)

- LOINC is a code system (i.e., set of identifiers, names, and codes) for clinical and laboratory observations, health care **screening/survey instruments**, and document type identifiers
- LOINC Codes for both Questions and Answers must be used
- https://loinc.org

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Standardized SDOH Coding (Cont.)

Intervention

SNOMED codes (Systemized Nomenclature of Medicine)

- SNOMED codes can be used to track and measure SDOH interventions.
- www.snomed.org

Intervention Type	Example
Assistance	Assistance with application to Homelessness Prevention program
Coordination	Coordination of care plan
Counseling	Counseling for readiness to implement food insecurity care plan
Education	Education about area agency on aging program
Evaluation	Evaluation of eligibility for a fuel voucher program
Referral	Referral to area agency on aging or community program
Provision	Provision on home-delivered meals

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Coding Examples: Housing

Z-code

Statement: Problems related to housing and economic circumstance

Code: Z59

LOINC

Question: Are you worried about losing your housing?

Question Code: 93033-9

Answers:

Yes - Code: LA33-6

No - Code: LA32-8

I choose not to answer - Code: LA30122-8

SNOMED

Name: Housing Instability Procedures

Definition: Coordination of resources to address housing instability (procedure)

Code: 1162347009

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Resources for Social Needs

Pathways to Social Support

- **Internal Practice Supports**
  - E.g. – Care Navigator, Behavioral Health Coach, Social Work
- **Community Support Platform**
- **Insurance Plan Benefits**
  - E.g. – Social Work, Supplemental Benefits

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Community Support Platform

The Community Support Platform, **powered by FindHelp**, is a tool designed to **connect individuals to nationwide programs offering free or reduced cost services located within their community, with a zip code search**. This free, online database allows for anonymous searching for programs that help meet basic personal and social needs, such as food or transportation.

Go to the Highmark Community Support Platform.

*AHN team members can access at ahnstaff.findhelp.com

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Benefits of Using the Platform

- Share and identify valuable and **trusted agencies** that can meet social needs
- **Search for and send referrals** directly to community-based organizations (CBOs) and programs
- View your **referral history**
- **Search referral history** for a specific patient/member– check or update

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Community Support Platform (FindHelp)

HIGHMARK Community Support
Support | Site Tools | My Program Tools | People I'm Helping | OC Olivia

ZIP or keyword or program name
Select Language English

FOOD | HOUSING | GOODS | TRANSIT | HEALTH | MONEY | CARE | EDUCATION | WORK | LEGAL

pittsburgh, pa (15222) / food / food pantry < 1 - 25 of 62 >
Sort by RELEVANCE CLOSEST

Personal Filters | Program Filters | Income Eligibility

Food Pantry
by Community Human Services (CHS)
Reviewed on: 02/15/2024
High Performing Social Care Network

Community Human Services (CHS) food pantry serves children, adults or senior citizens with limited or no income, who simply have fallen on hard times or recently unemployed and need assistance to...

Main Services: food pantry
Serving: anyone in need, all ages

Next Steps:
Contact or go to the nearest location or call 412-246-1686.
1.96 miles (serves your local area)
370 Lawn Street, Pittsburgh, PA 15213
Closed Now : See open hours

MORE INFO | SAVE | SHARE | NOTES | SUGGEST | REFER

Notice out-of-date information or see a program you work for? Click Suggest to share an update or claim your program listing

Translation available in >100 languages

Thousands of programs across the country to support social needs.

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Understanding the Program Card in the Community Support Platform

Drive-Up Food Distribution Events
by Greater Pittsburgh Community Food Bank

COVID-19 Response Program

We are committed now more than ever to serving those in need of food assistance during the COVID-19 crisis. We've implemented our new drive-up emergency food distribution model. Updates on our...

Main Services: emergency food , food pantry

Serving: anyone in need , all ages , covid19

Next Steps:

Go to the program's website or call 412-460-3663 ext. 655.

Serves your local area

Open Now : 8:00am - 4:30pm

MORE INFO

SAVE

SHARE

NOTES

SUGGEST

SEE NEXT STEPS

The ✓ indicates that the organization has reviewed their information for accuracy and has "claimed" their program on the platform

Clicking on this "More Info" button displays additional information about the program

Clicking on this "See Next Steps" button displays the next steps to connect with the program. There are also other options that may appear in this box which will be shared on the next slide

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Clinical and Wellness Programs for Highmark Members

Reference Guide of Referral Options for Highmark Providers

How to Access the Reference Guide:

- Log into **Availity**
- Click on **Payer Spaces**
- Click on **Provider Resource Center**
- Click on **Education/ Manuals**
- Click on **Reference Guide of Highmark Member Programs**

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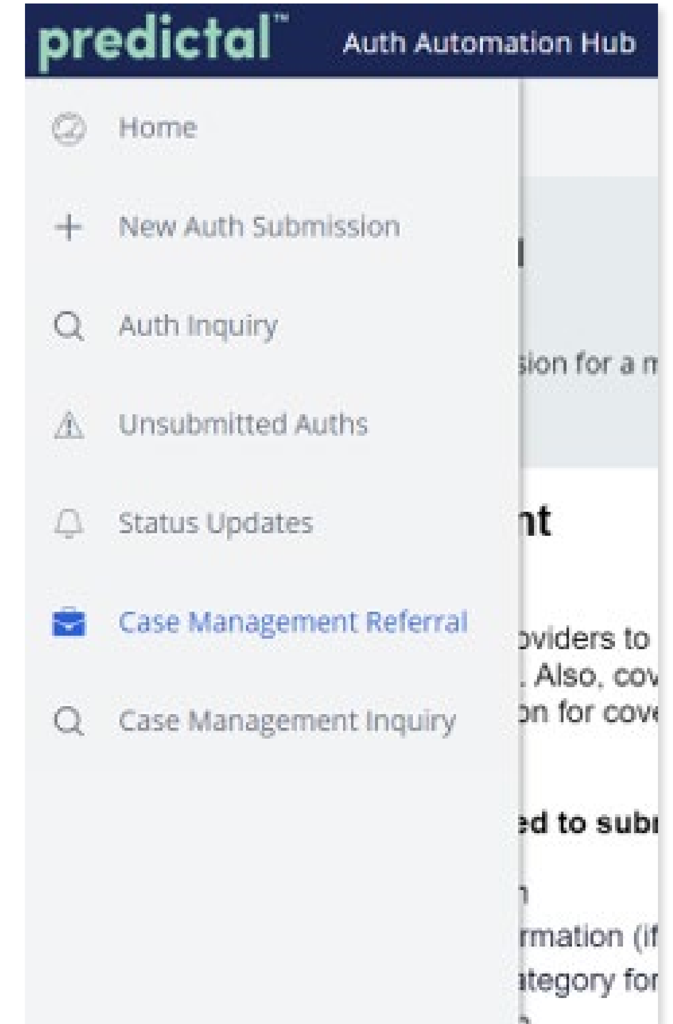
Case Management Referral Process

Getting Started:

- Log into **Availity**
- Click on **Payer Spaces**
- Select the **Predictal Tab**
- Click on **"+"** on left side of the screen
- Select **Case Management Referral**
- Follow the prompts to submit a Case Management referral



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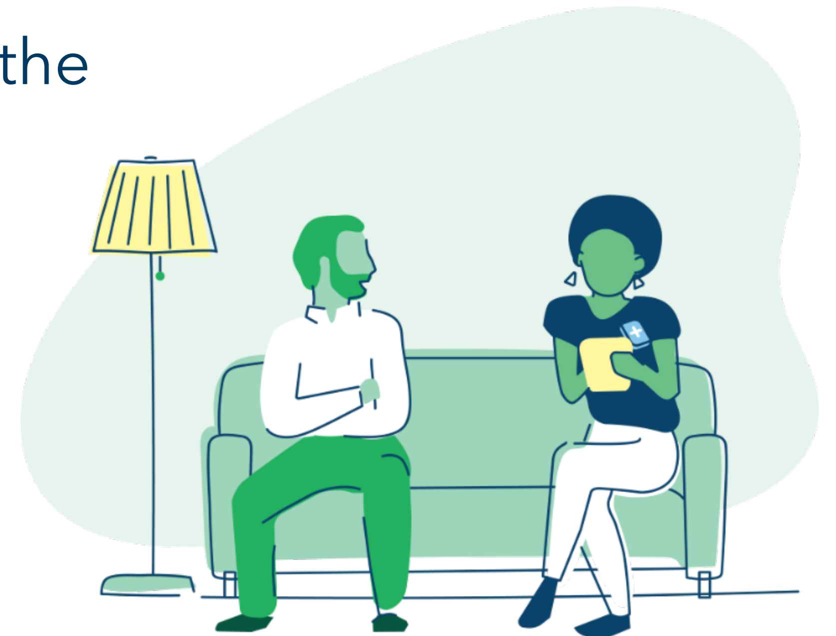
Highmark Social Work Supports

- Social workers will receive the referral through the case management platform and reach out over the phone to further evaluate the need and connect members with appropriate resources

- Social workers will promptly attempt to contact the member within a two-day timeframe



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Creating an Effective Referral

Referral Details should Include:

- Name
- Referral source
- Reason for outreach (SDOH Need)
- Phone Number
- Best time to reach
- Primary diagnosis

Example:
Primary Diagnosis: COPD Exacerbation

Reason for Outreach Request: Mbr needing help obtaining food delivery and information on how to obtain medical alert that is not costly.

Preferred Day and Time to Reach: Best Time To Call after 11am

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Additional Resources

Additional Resources

- Healthy People 2030
- Becoming a SDOH Champion
- ACS Screening for Social Determinants of Health
  Health System Assessment Tool
- PRAPARE Implementation and Action Toolkit
- Z Code Infographics & Z Code Process Graphic

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