Social Determinants of Health Practice Module

October 2022

Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension

Quality Insights

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Purpose of Module

The Quality Insights Social Determinants of Health (SDOH) Practice Module provides a framework for identifying social needs in the clinical setting and ways in which the health care team can work together to reduce SDOH in Delaware communities. This module includes information related to:

- Leveraging data to address SDOH;
- Identifying social needs via screening tools, including utilization of the PRAPARE tool;
- Implementing standardized, closed-loop workflows;
- Connecting patients to local assistance resources, and;
- Addressing health literacy.

> **"Social Determinants of Health (SDOH)** are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."
>
> *Source:* *Healthy People 2030*

This module can be utilized by clinic leadership to determine next steps for workflow modification and alignment with resources available in your region. Note that referenced guidelines and recommendations are to be used along with physician/clinician judgment, with consideration given to a patient's unique needs and circumstances.

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
• Employment • Income • Expenses • Debt • Medical Bills • Support	• Housing • Transportation • Safety • Parks • Playgrounds • Walkability • Zip code/ geography	• Literacy • Language • Early childhood education • Vocational training • Higher education	• Hunger • Access to healthy options	• Social integration • Support systems • Community engagement • Discrimination • Stress	• Health coverage • Provider availability • Provider linguistic and cultural competency • Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Adapted from "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," by KFF, 2018.

Introduction: Integrating SDOH and Health Equity

Source: *CDC, Minority Health*

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health equity, as defined by the Centers for Disease Control and Prevention (CDC), "is the state in which everyone has a fair and just opportunity to attain their highest level of health." **Where there is health inequity, there are health disparities.** By addressing SDOH, preventable health disparities can be reduced, thus improving the health of all people and achieving greater health equity.

SDOH greatly impact health outcomes in a number of ways. They may create barriers to health care access as well as barriers to engagement in and adherence to medical care. According to *Health Disparities Report 2021*, poverty, lower educational attainment, and severe housing problems are strongly associated with poor health outcomes, such as chronic disease, premature mortality, and mental health challenges.

Health care organizations nationwide are increasingly looking to integrate SDOH and health equity into value-based strategies. Where should these organizations focus their efforts? "Payers and providers are considering patients with chronic conditions because they disproportionately consume a significant portion of the health care spend and system utilization" (Oyekan et al., 2022).

Recent Data on Health Disparities

Diabetes:

- Based on age-adjusted data for 2018 to 2019, among U.S. adults 18 years of age and older, American Indians and Alaska Natives, non-Hispanic Blacks, Hispanics, and non-Hispanic Asians are more likely to be diagnosed with diabetes than non-Hispanic Whites (14.5 percent, 12.1 percent, 11.8 percent, 9.5 percent, and 7.4 percent, respectively).
- For the same time period, prevalence of diagnosed diabetes was highest (13.4 percent) in adults with less than a high school education, followed by those with a high school education (9.2 percent), and those with more than a high school education (7.1 percent).

Cardiovascular Disease:

- Cardiovascular mortality rates have declined for both Black and White adults, but there is a higher mortality rate for Black men and women.

- After adjusting for socioeconomic status of a person's neighborhood, income, education, and access to health care, when compared to White adults, Black adults had a 16 percent higher risk of death.

Rural:

- From 1999 to 2019, death rates for both males and females were higher in rural areas than in urban areas, with the rate difference widening during that time as well. By 2019, death rates in rural areas were 21 percent higher than in urban areas for females and 19 percent higher for males.
- Of the 10 leading causes of death in 2019, all were higher in rural areas, with the largest differences occurring for heart disease, cancer, and chronic lower respiratory disease (CLRD).
- By 2019, death rates in rural areas were 21 percent higher than rates in urban areas for deaths from heart disease (189.1 per 100,000 compared with 156.3, respectively), 15 percent higher for cancer (164.1 compared with 142.8), 48 percent higher for CLRD (52.5 compared with 35.4).

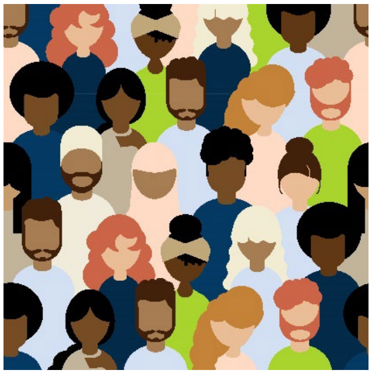
Consider the communities in which your organization provides services as well as the common diagnoses of those residents. For example, language barriers in health care, in addition to being a source of miscommunication, also reduce the satisfaction of both the patient and the provider (Shamsi et al., 2020). Choosing to ignore a language barrier, or any other SDOH, causes health care to be less effective. Through data collection, one can become more informed about their patient population's health trends, SDOH, and health outcomes, ultimately resulting in the delivery of more culturally competent care.

This module will explore the value of data gathering and provide resources to aid in the acquisition of data, so your organization can effectively evaluate the impact of SDOH in your patient population and devise mitigation solutions through dialogue and collaboration with community partners. Through this education, we hope to assist your organization in providing exceptional value-based care and making "the Quintuple Aim (better care; healthier people; smarter spending; care team well-being; and health equity) become a reality for all" (Oyekan et al., 2022).

Take the Next Step:

- The Health Equity Challenges and CMS Resources to Help Address Them infographic outlines various barriers to health equity and related challenges that populations often face and shares CMS resources that can help close the health equity gap.
- The Health Equity Guide for Public Health Practitioners and Partners, produced by the Delaware Division of Public Health, the University of Delaware's School of Public Policy & Administration, and other partners, is designed to help all sectors address causes of health inequities and adopt policies that promote health.
- Download Delaware Focus: Health Inequities and Race in the First State. This policy brief from the University of Delaware explores how SDOH are the most important drivers of health.
- Visit the Delaware Division of Public Health's Bureau of Health Equity for additional resources targeted at improving the health of Delawareans by eliminating differences in health outcomes due to SDOH.
- Learn more about health disparities by reviewing the *America's Health Rankings Health Disparities Report (2021).*

Collecting Race, Ethnicity, and Language Data



Addressing SDOH is a primary approach to achieving health equity, and progress toward eliminating health disparities requires widespread, consistent, and reliable population data.

The COVID-19 pandemic has further highlighted health disparities between different races and ethnicities. In order to address these disparities, practices can work to properly document a patient's race, ethnicity, and language data, thus allowing the practice to:

- Identify the need to develop diverse patient materials
- Provide more culturally appropriate care and education
- Recognize areas where care disparities exist
- Develop quality care initiatives to ensure equitable care

Take the Next Step:

- Is your practice experiencing barriers to collecting race, ethnicity, and language data? Contact your local Quality Insights Practice Transformation Specialist for no-cost technical assistance.
- Download Quality Insights' Health Equity Infographic to learn more about the importance of collecting race and ethnicity data.
- For in depth materials and resources related to systematically collecting race, ethnicity, and primary language data from patients, review the American Hospital Association Institute for Diversity and Health Equity's (AHA IFDHE) Disparities Toolkit.
- From CMS: Inventory of Resources for Standardized Demographic and Language Data Collection
- Target: BP™ CME Course: How to Collect Accurate and Complete Race/Ethnicity Data – A Step Toward Improving Health Equity
- Target: BP™ Infographic: Race & Ethnicity Data Collection Essentials

Screening for Social Needs

With the goals of both value-based care and Healthy People 2030, there is an increased emphasis on the need for effective tools and strategies to assist providers in "identify[ing] the upstream socioeconomic drivers of poor outcomes and higher costs. With this data, they can transform care with integrated services to meet the needs of their patients, address SDOH, and demonstrate the value they bring to patients, communities, and payers" (Health Center Partners of Southern California, 2019).

Several screening instruments are available to aid physicians in identifying SDOH in a primary care setting. The following options are provided for consideration:

Source: *Healthy People 2030*

PRAPARE Assessment Tool

The National Association of Community Health Centers' (NACHC) Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool is a national standardized tool designed for the purpose of aiding health care organizations and community based organizations in assessing SDOH, with the goal of improving health equity. "By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, as well as improved health and cost reduction" (NACHC et al., 2019).

A few additional benefits include:

Electronic Health Record (EHR) Integration:

Data from the assessment can be directly uploaded into many electronic health records (EHRs) as structured data. EHR templates and demo videos are available for eClinicalWorks, Cerner, Epic, athenahealth®, athenaPractice™ (formerly GE Centricity), Greenway Intergy, and NextGen. To access the free PRAPARE EHR templates, an End User License Agreement must be signed. (Athena users must contact their customer success managers to implement PRAPARE in their EHR).

For those who use an EHR where a PRAPARE template does not currently exist, alternative methods include a paper form (available in over 30 languages) and an Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed.

When integrated into the EHR, PRAPARE automatically links to relevant ICD-10 Z codes (where applicable) that can be added to the assessment, diagnostic, or problem list.

Implementation Tools for Practices:

PRAPARE Readiness Assessment Tool: Use this tool to help identify your organization's readiness to implement PRAPARE.

Implementation Strategy Work Plan: Outlines tasks, roles, responsibilities, and provides space to document progress.

Training: Free webinars and resources are accessible from the PRAPARE website and the PRAPARE YouTube Channel.

Take the Next Step:

- Guidance (2021) from the Centers for Medicare and Medicaid Services (CMS) provides information on the plan of Medicaid and State Children's Health Insurance Program (SCHIP) to shift reimbursement to a value-based model. With rising costs and declining health outcomes, SDOH must be addressed. The guidance letter discusses specific services and supports and can be viewed here.
- The best first step to get started with PRAPARE and/or evaluate your current use of this tool is to review the PRAPARE Implementation and Action Toolkit. If you need assistance or have questions, please contact your local Quality Insights Practice Transformation Specialist.
- Download Quality Insights' Social Determinants of Health and Your Practice: Tools to Reduce Health Disparities. This two-page resource includes helpful tips for utilizing the PRAPARE tool and addressing SDOH in your practice.

Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities' Health-Related Social Needs Screening Tool

The Centers for Medicare & Medicaid Services (CMS) Health-Related Social Needs Screening Tool is meant to be self-administered. The tool, consisting of 10 core and 16 supplemental questions, can help providers discover patients' unmet needs for which community services can help. The five core domains addressed in the initial 10 questions include housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. Supplemental questions, which may or may not be used in the standard screening process, cover eight additional domains including financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities.

Utilizing ICD-10-CM Codes ("Z Codes")

ICD-10-CM codes included in categories Z55-Z65 ("Z codes") identify non-medical factors that may influence a patient's health status.

Key Statistics from the 2021 CMS Office of Minority Health Data Highlight:

"Among the 33.1 million continuously enrolled Medicare FFS beneficiaries in 2019, 1.59 percent had claims with Z codes, as compared to 1.31 percent in 2016."

"The top five provider types representing the largest proportions of Z codes were family practice physicians (15 percent), internal medicine physicians (14 percent), nurse practitioners (14 percent), psychiatry physicians (13 percent), and licensed clinical social workers (12 percent)."

"Black and Hispanic beneficiaries accounted for 8.8 percent and 5.9 percent of the overall FFS population, respectively, but represented 24.8 percent and 9.2 percent, respectively, of those with a Z59.0 – Homelessness claim."

"Existing Z codes identify issues related to a patient's socioeconomic environment, including education and literacy, employment, housing, lack of adequate food or water or occupational exposure to risk factors like dust, radiation, or toxic agents" (American Hospital Association [AHA], 2018). When considering modifiable determinants, medical care is estimated to account for 10 to 20 percent of a person's health, while non-medical factors (SDOH) account for the remaining 80 to 90 percent (Magnan, 2017).

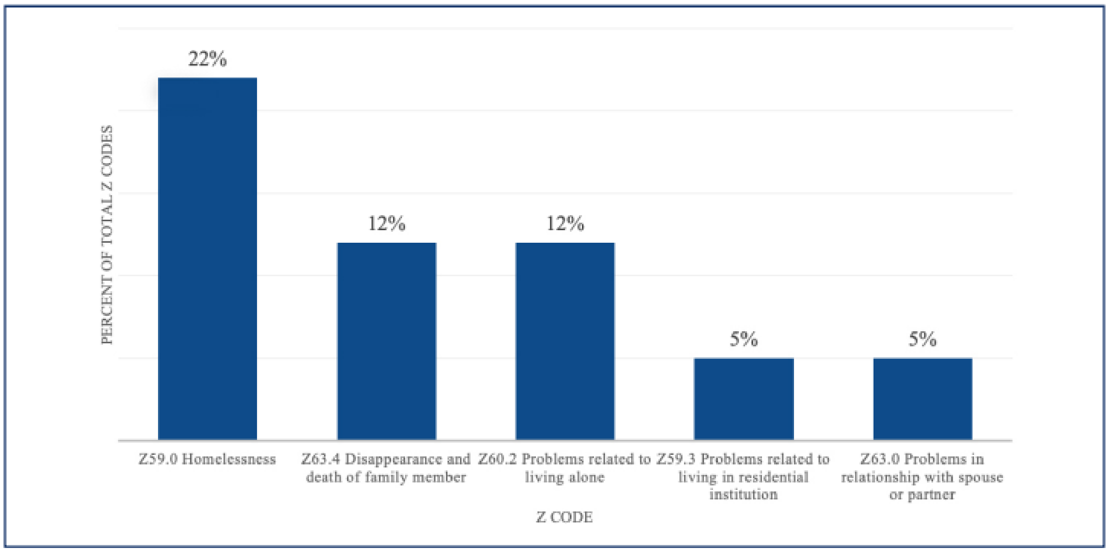
According to the AHA, as of 2018, "codes from categories Z55-Z65 can be assigned based on information documented by all clinicians involved in the care of the patient." One study showed that the rate of utilization for the SDOH Z codes increased from 255.62 to 292.79 per 100,000 once non-physician clinicians were able to report. With clinical constraints such as limited visit time placed on physicians, inadequate training on how to extract SDOH information from patients, and lack of knowledge regarding referral resources, Z codes continue to be grossly underutilized (Guo et al., 2020). While some clinicians may be documenting

SDOH in visit summaries or clinical notes, utilizing Z codes allows clinics and hospitals to more easily access data indicating the primary needs of their patients, thus simplifying the path toward the most impactful solutions for improving the health of their communities.

In 2021, the CMS Office of Minority Health published a Data Highlight reviewing SDOH Z Code utilizations among Medicare Fee-for-Service (FFS) Beneficiaries in 2019.

The **top five Z Codes** representing the largest shares of all Z Code claims in 2019 are highlighted below.

Top Five Z Codes Representing the Largest Shares of All Z Code Claims (N=1,262,563) in 2019



From "Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019," by CMS, 2021.

Take the Next Step: Explore more information about ICD-10 Z codes, including coding categories, frequently asked questions, and addressing common barriers:

- Quality Insights: Provider's Quick Guide to Social Determinants of Health ICD-10 Codes
- CMS: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes Infographic
- 2022 CMS ICD-10-CM Official Guidelines for Coding and Reporting
- E-Health Initiative Explains ICD-10-CM Coding for Social Determinants of Health

For additional guidance on non-physician clinician use of Z codes:

- CMS: ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 (see Section I. B.14.)
- Review Coding Guidance section of AHA's ICD-10-CM Coding for Social Determinants of Health.

Care Team Workflow

A successful, integrated workflow that prioritizes SDOH screening, coding, and referrals to community resources truly necessitates the coordination of the entire care team. **The following SDOH workflow model referenced in this section is summarized from Chapter 5 of the PRAPARE Implementation and Action Toolkit.**

The Five Rights Framework

When collecting and responding to SDOH data, use the most effective method for **your** setting. The Five Rights Framework is a guide meant to assist with determining the best data collection and response workflow for your setting.

Using the Five Rights Framework to Plan Workflow for PRAPARE Data Collection and Response

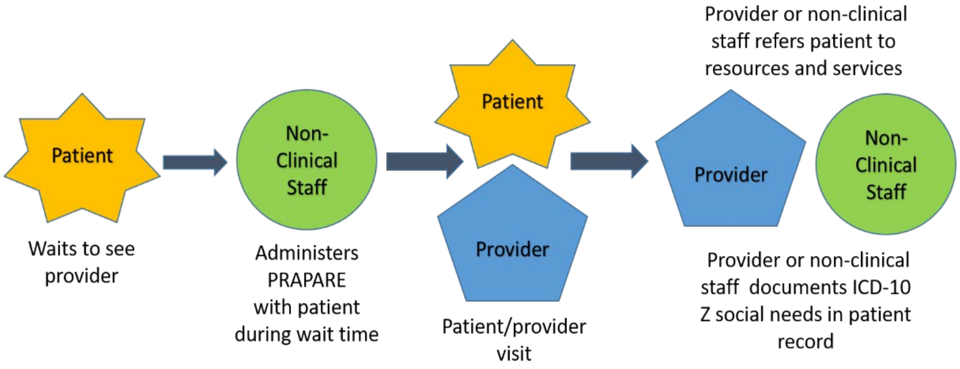
5 Rights	Workflow Considerations	Response Workflow Considerations
Right Information: WHAT	What information in PRAPARE do you already routinely collect? • Part of registration • Part of other health assessments or initiatives	What information and resources do you have to respond to social determinants data? • Update your community resource guide and referral list with accurate information • Track referrals, interventions and time spent
Right Format: HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment? • In-person with staff?	How will intervention and community resource information be stored for use and presented to patients? • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care? • Providers and other clinical staff? • Non-Clinical staff?	Who will respond to social determinants data? • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?

5 Rights	Workflow Considerations	Response Workflow Considerations
Right Channel: WHERE	Where are we collecting this information? Where do we need to share and display this information? • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?	Where will referrals and/or resource provisions take place? • In private office? • In the exam room?
Right Time: WHEN	When is the right time to collect this information so as to not disrupt clinic workflow? • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	When will referrals take place? • Immediately after need is identified? • After the patient see the provider? • At the end of the visit?

Adapted from [Chapter 5 of the PRAPARE Implementation and Action Toolkit](), NACHC.

PRAPARE Tool: Sample Workflows

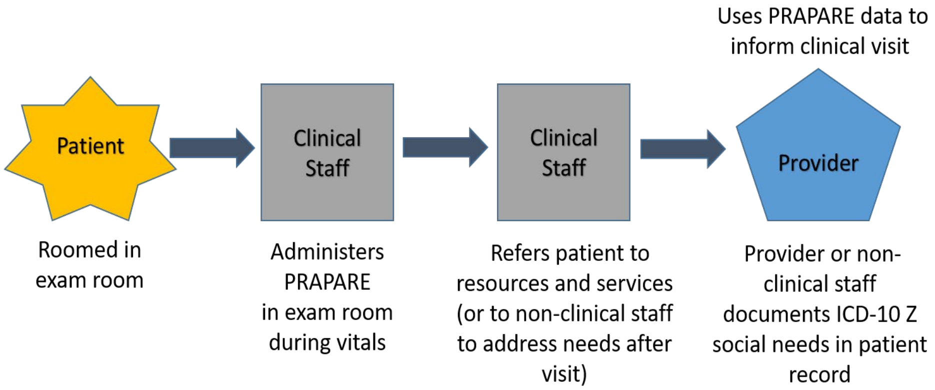
Option 1: Using Non-Clinical Staff Before the Clinical Visit



Option 1 Advantages:

- PRAPARE data informs clinical visit to ensure appropriate treatment plan developed.
- Uses “value-added” time when patient would otherwise be waiting.

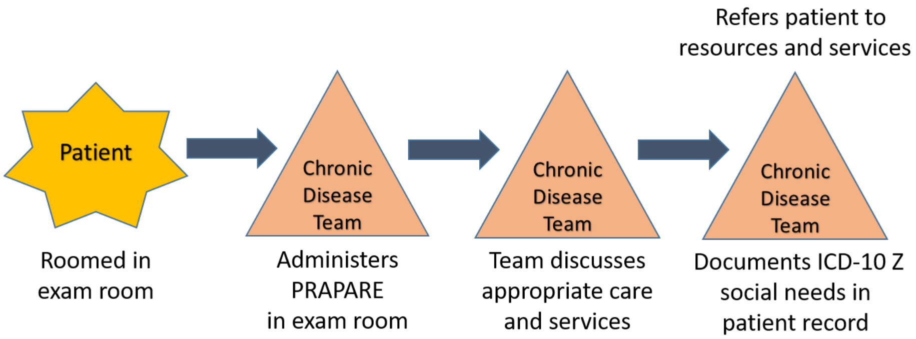
Option 2: Using Clinical Staff During Clinical Visit



Option 2 Advantages:

- Administering PRAPARE in exam room ensures privacy.
- Use PRAPARE data to inform clinical visit with provider to ensure appropriate treatment plan developed.

Option 3: Using Chronic Disease Management Team



Option 3 Advantages:

- Comprehensive team to assess and address patient's social determinant needs and use data for care planning.
- Eases burden on staff who conduct other screenings.

Take the Next Step: Share the sample workflows above with your care team by downloading Quality Insights' *PRAPARE Social Determinants of Health Screening: Sample Workflows*.

- Nine unique, standardized SDOH screening workflow options are available to review in the PRAPARE Implementation and Action Toolkit. Options include email assessment prior to an appointment as well as in-office self-assessments. Click here to find a SDOH workflow that complements your practice environment.

Locating Resources & Referral Partners

Getting Started: Where to Find Assistance in Times of Need

Once a patient's needs have been assessed, the next important step is identifying available community partners for coordinating appropriate referrals. Further, researchers suggest that staff inquire about assisting the patient immediately upon a positive SDOH screening, instead of waiting for office staff to reach out at a later date and creating additional workload surrounding repeated attempts to communicate (Chagin et al., 2021).

The CDC's guide, Community-Clinical Linkages: Implementing an Operational Structure with a Health Equity Lens, is designed to help practitioners in community, public health, and clinical sectors incorporate health equity into their organizations' operational structure. Utilizing the guide, a health care organization can develop structured, collaborative relationships that achieve the goals of both the practice and the community partner in positively impacting SDOH. Having such relationships also increases the likelihood that outcomes can be tracked by the practice.

The following options are provided as a means to help you locate available resources in your region or to aid in facilitating data-driven initiatives:

- Unite Delaware: Sponsored by ChristianaCare and Beebe Healthcare, Unite Delaware is a bidirectional system for practices and community-based organizations to bring resources to their patients. Joining is free of cost for many organizations. Through Unite Us, a shared technology platform, network partners can address social needs through the sending and receiving of electronic referrals.
- Findhelp.org (Aunt Bertha): Visit this website to learn more about how patients can find social care programs and services in their communities.
- Delaware 211: Offering aid in multiple languages, the Delaware 211 call center provides free support services to assist individuals in finding necessary resources related to utilities, housing, food, COVID, mental health, clothing, substance use, and much more. To reach out to a resource specialist, patients can call 211, live chat online, or text their zip code to 898-211. To view real-time data on 211 requests in Delaware, view this dashboard.
- Supplemental Nutrition Assistance Education Program (DE SNAP-Ed): The University of Delaware offers a variety of ongoing food, nutrition, and health programs as the implementing SNAP-Ed agency in Delaware. More information about the availability and format of class offerings can be found by visiting the website or by contacting your local county extension office.
- Food Bank of Delaware provides nutritious foods to Delawareans through various pantries. They also offer job training in food service and warehousing/logistics.

- Delaware Healthy Neighborhoods: This initiative is an innovative approach to addressing population health challenges. Healthy Neighborhoods is focused on creating sustainable interventions by engaging numerous local stakeholders in collaborative efforts to transform health care and improve outcomes.
- My Healthy Community provides community-level statistics and data on a number of topics including chronic disease, environment, health services utilization, healthy lifestyles, and infectious disease, in order to empower communities to educate on the connectivity between health and environment.
- Delaware State Service Centers: The website provides information regarding the location of service centers, volunteerism, community services, disaster preparedness, and family support services.
- Delaware Division of Services for Aging and Adults with Physical Disabilities
- HelpIsHereDE provides behavioral health and substance use resources.
- National Library of Medicine: Providing Multilingual and Multicultural Health Information Resource List
- Delaware HELP Initiative provides the following programs to underserved communities statewide: Lights-ON, Health-ON, Jobs-ON, Weatherization-ON, Heat-ON, and the Home Energy Counseling and Checkup Program.
- The Senior Roll Call Lifeline in New Castle County is a free service for senior or home-bound citizens living in the county. An automated service calls the participant, and if the call is not answered after three attempts, someone is sent to check on the participant.
- Delaware Health and Social Services, Community Partner Support Unit: Social workers will help with numerous needs such as referrals to partner organizations, applying for food benefits, housing resources, locating childcare, utility assistance, and locating employment or training. Social workers will be available at various Delaware libraries as posted on the webpage. Appointments can be made through the provided link.
- Literacy Delaware provides basic reading or English language classes to Delawareans 16 years of age and older.
- ContactLifeline provides a no-cost, 24/7 Crisis Helpline in addition to sexual assault counseling services. Those in need of a listening ear or additional support can call 1-800-262-9800.

Delaware Emergency Medical Diabetes Fund

The Delaware Emergency Medical Diabetes Fund provides, on an emergency need basis, an allowance for prediabetes or diabetes medications, services, or supplies to residents of Delaware. Payments are made to vendors, and client assistance is capped at a maximum of $500 per rolling year.

Eligibility Requirements*:

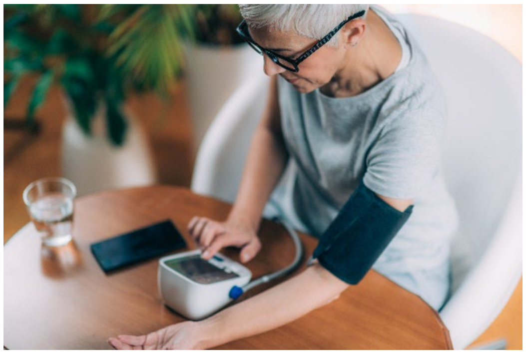
- Individual has diabetes (type 1, type 2, gestational, or other) or prediabetes.
- Medical need is present that could result in serious impairment of health, prolonged hospitalization, complications, or death.
- Individual is without resources immediately accessible to meet his/her health needs.
- Individual must not have other insurance that will provide the services requested.

**Requests are evaluated on a case-by-case basis, using established Delaware State Service Center financial screening and other criteria.* *More detailed program information may be accessed here.*

Learn more about eligibility and referral by downloading this flyer for providers and patients (Spanish language flyers are available on the Quality Insights website). This program is administered by the Delaware Division of State Service Centers. Referrals can be made by calling the Delaware Diabetes and Heart Disease Prevention and Control Program at **302-744-1020**.

The Healthy Heart Ambassador - Blood Pressure Self-Monitoring Program (HHA-BPSM)

Help your patients improve their hypertension with an evidence-based program that empowers them to manage their blood pressure (BP) while learning ways to eat healthier and be more physically active. This **NO-COST program** from the Delaware Division of Public Health (DPH) provides specially trained health coaches to teach simple yet proven ways for patients to better manage and understand their BP, increase physical activity, adopt healthier eating habits, and more.



Participants who enroll in the HHA-BPSM program receive:

- A BP monitor (if needed) and training on how to measure and track BP at home
- Personalized virtual consultations from trained facilitators
- Virtual cooking classes and nutrition education
- Support to help people with hypertension make real changes for heart health

Learn More

Quality Insights invites you to explore more information and refer patients to the HHA-BPSM program by reviewing the links below:

- For Providers: Learn about the HHA-BPSM program, participant requirements, and program referral details.
- For Patients Who Are Also Delaware State Employees: This flyer explains program features, participation requirements, and how to enroll.
- HHA-BPSM Program Provider Enrollment Fax Form: Practices can complete this form to refer patients by fax. A phone number, 302-208-9097, is also included on the form as an additional method for referral.
- HHA-BPSM Provider “Script Pad” Referral Flyer: This document can be given to patients to encourage them to learn more about the program and enroll.
- Healthy Delaware’s HHA-BPSM Program: This website provides information on each class in the program, lists entrance qualifications, and shares testimonials. Patients may also enroll online.

Get Involved: Become a HHA-BPSM Volunteer Program Facilitator

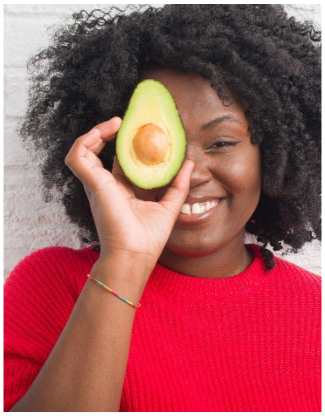
If you, or someone you know, has a desire to help people living with high blood pressure achieve better control through a supportive, evidence-based, holistic approach, Quality Insights and Delaware DPH is now offering a great opportunity to get involved. Download this HHA-BPSM Volunteer Program Facilitator flyer to learn more about the program and related qualifications. Clinical background is not required. **Apply to become a Volunteer Program Facilitator by calling (302) 208-9097.**

Free Blood Pressure Screening Locations by County

Delaware residents can have their blood pressure measured for free at a variety of locations across Delaware. By referring to Quality Insights’ county-specific flyers, interested parties can find numerous blood pressure screening locations to choose from, or alternatively, kits available for check out in their vicinity:

- New Castle
- Kent
- Sussex

Health Coaching Services



Through improved patient activation and engagement, health coaching has been shown to result in more positive health outcomes and lifestyle modifications. "'Patient activation' refers to a patient's knowledge, skill, confidence and motivation to manage his or her own health and care. 'Patient engagement' is a broader concept that combines patient activation with the behaviours individuals must master to benefit optimally from the health care services." (Lee, 2017)

Health coaches are proficient in "facilitating an evocative discussion to increase the client's self-awareness regarding [health] issues" and providing peer-like education to assist the client with positively addressing failures, building new strengths, continuing positive behaviors, and making long-term, sustainable changes (Jordan, 2021).

Quality Insights offers no-cost health coaching for patients living with prediabetes, diabetes, or hypertension. We can assist patients with addressing modifiable determinants such as medication adherence, lifestyle modifications, goal-setting, self-monitoring, shared decision-making, and SDOH. We will work with your practice to develop a health coaching workflow to best meet your practice and patient needs. Access Quality Insights' health coaching flyer for more information. Your practice can contact Ashley Biscardi or your current Practice Transformation Specialist to start this service.

Closing the Care Loop: Follow-Up Guidance

Knowing which community resources have proven to be useful can guide the organization's future referrals and interventions. Follow-up with patients who have known social needs to ensure that needs were met and to identify any new concerns.

Bidirectional systems, mentioned previously, can ease the burden associated with tracking of referral outcomes.

Kaiser Permanente's *Coronavirus Disease 2019 (COVID-19) Social Health Playbook* offers guidance on following up with patients post-referral to community-based services. See page 19.

Ways to Follow Up with Patients Post-Referral to Community-Based Service

Where available, use existing follow-up protocols.

If existing protocols are not available, identify individuals (e.g., navigators, care coordinators) to do follow-up outreach. If available, a risk score can be used to prioritize patients for follow-up outreach.

When determining timeframe for follow up, consider patient acuity, the nature of their social need(s), and the availability of resources.

- Suggested timeframes:
    - **Follow up within one week:** Patients at high risk for medical decompensation due to their social need and/or a high-risk transition.
    - **Follow up after one week or longer:**
        - Patients not currently experiencing acute medical symptoms. Follow up as clinically indicated or per existing program follow up protocol.
        - Example: Patient experiencing food insecurity but without any nutrition-related medical conditions and is self-sufficient or has caregiver support in following up on resource information.

Action Steps for Frontline Care Team

- Conduct outreach:
    - Ask if previously offered resources were used and/or helpful.
    - Ask if patient has new or additional needs. If possible, conduct a full screening (see "Screening for Social Needs" section of this module).
    - Connect to new/additional resources as needed (see "Locating Resources and Referral Partners" section of this module).
- Document status/outcome to follow up (i.e., needs met, connected to resources, any additional follow up needed).

Adapted from Coronavirus Disease 2019 (COVID-19) Social Health Playbook, by Kaiser Permanente, 2020, p. 19, Copyright 2020 by Kaiser Permanente.

Evidence-Based Support for Addressing SDOH

Business Case Strategy

LexisNexis® Risk Solutions: 3 Steps for Building an SDOH Business Case
This playbook is designed to "help your organization build a strong business case for implementing SDOH initiatives that will positively affect the health outcomes for your patient population and provide a methodology that can be used to scale into larger, more encompassing programs over time. Because measuring success throughout the process is vital to understand the effect of SDOH initiatives and

because different stakeholders look at different metrics, we've [LexisNexis® has] highlighted measurement suggestions and/or key takeaways for consideration for your business case are provided throughout each of the steps." (LexisNexis, 2022)

Download the white paper/playbook which provides a structure for building a successful SDOH business case.

Return on Investment (ROI) Calculator for Partnerships to Address SDOH

"This calculator is designed to help community-based organizations and their health system partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost (HNHC) patients" (The Commonwealth Fund, 2022). Access the calculator and several valuable resources for optimizing its use here.

Develop an Organizational Response to Health Disparities

According to CMS' guide, *Building an Organizational Response to Health Disparities*, "focused quality improvement efforts should be targeted to populations at risk for disparities." The guide not only highlights key actions for addressing disparities, but also provides links to additional resources on data collection, data analysis, culture of equity, quality improvement, and interventions.

Advance Health Equity

Leverage Data to Reduce Health Inequities

Gathering social care data at scale can meaningfully contribute to advancing health equity, and analyzing the relationship between health and social care data can lead to valuable insights about how to improve overall health. How can this realistically be achieved in the practice setting?

A 2022 Unite Us white paper, *Leveraging Data to Advance Health Equity*, outlines five principles of practice that are critical to reducing health inequity:

1. Ensure communities and individuals most impacted have power to make decisions.
2. Leverage the power of referral data to improve access to social care.
3. Measure and evaluate.
4. Remove barriers to data sharing.
5. Use data to drive action.

Explore each of these principles in detail by downloading the white paper on the Unite Us website.

Understand the Relationship between Health Equity and Primary Care

Healthy People 2030, recognizing the impact of primary care on a patient's overall health, includes the following objective: increase the proportion of people with a usual primary care provider. "Patients with a usual source of care are more likely to receive recommended preventive services such as flu shot, blood pressure screenings, and cancer screening" (Healthy People 2030). Additionally, they often develop a trusting and collaborative relationship with the clinician, creating a safe environment for patients to share personal information and increasing the likelihood the patient will accept assistance for social needs. Primary care "play[s] a vital role in ensuring population health and equity by providing whole-person care, advocating for polices to accelerate practice transformation, and partnering with sectors outside of clinical medicine like social programs" (Primary Care Collaborative (PCC), 2022). Explore specific actions that primary care stakeholders can undertake to advance health equity by reviewing this May 2022 report from the PCC, *Primary Care: A Key Lever to Advance Health Equity*.

Address SDOH in Rural Communities

The Rural Health Information Hub (RHIhub) is funded by the Federal Office of Rural Health Policy and supports rural health needs by providing tools for planning programs, developing services, learning the latest information, and connecting with interested parties. In 2020, they published a *Social Determinants of Health in Rural Communities Toolkit*, which serves as an evidence-based compilation of promising models and resources.

View the toolkit on the RHIhub website. Learn about SDOH in rural communities and models for addressing them by reviewing the topic guide, *Social Determinants of Health for Rural People*. Consult RHIhub's *Human Services to Support Rural Health* for specific rural services that affect health care.

Make Progress on Standardization of SDOH Data with the Gravity Project®

Launched by the Social Interventions Research and Evaluation Network (SIREN) with funding from the Robert Wood Johnson Foundation, the purpose of the **Gravity Project®** is "to create and maintain a consensus-building community to expand available SDOH core data for interoperability and accelerate standards-based information exchange by using HL7® [Health Level Seven International] FHIR® [Fast Healthcare Interoperability Resources]" (Businesswire, 2021). The project is a response to the need for "consensus driven SDOH data standards for health and social care interoperability and use among multi-stakeholders" (Gravity Project, n.d.).

The Gravity Project depends on the contribution of sponsors and volunteers who are eager to standardize SDOH data. Partners include organizations such as the American Medical Association and Unite Us. Participants are asked to join the project's HL7 Consensus Process at any time either as a **Committed Member** or **Other Interested Party.**

To join the project, **sign up here**.

Social Determinants of Health: Health Literacy Supplement

October 2022

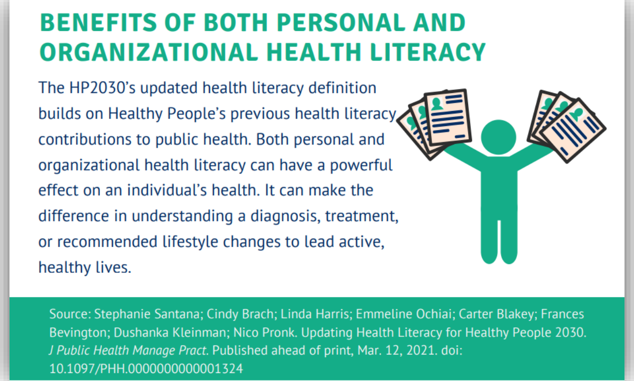
Background

Health literacy was formerly defined by the U.S. Department of Health and Human Service (HHS) as "the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions."

With HHS' updated version of Healthy People 2020, came a number of changes. The number of objectives was significantly reduced, 10-year targets were set for objectives related to social determinants of health (SDOH), and the definition of health literacy was updated. The 20 year-old definition was updated to emphasize the need for both personal health literacy and organizational health literacy.

Healthy People 2030 provides the following definitions:

- **"Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."
- **"Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."



BENEFITS OF BOTH PERSONAL AND ORGANIZATIONAL HEALTH LITERACY

The HP2030's updated health literacy definition builds on Healthy People's previous health literacy contributions to public health. Both personal and organizational health literacy can have a powerful effect on an individual's health. It can make the difference in understanding a diagnosis, treatment, or recommended lifestyle changes to lead active, healthy lives.

Source: Stephanie Santana; Cindy Brach; Linda Harris; Emmeline Ochiai; Carter Blakey; Frances Bevington; Dushanka Kleinman; Nico Pronk. Updating Health Literacy for Healthy People 2030. *J Public Health Manage Pract*. Published ahead of print, Mar. 12, 2021. doi: 10.1097/PHH.0000000000001324

From "Updating Health Literacy for Healthy People 2030," by *JPHMP Direct*, 2021.

The Network of the National Library of Medicine (NNLM) reports, "nearly 9 out of 10 adults struggle with health literacy." Health literacy is a national problem resulting in poorer health, an increased

burden upon the health care system, and an increase in morbidity and mortality. "It is the product of individuals' capacities *and* the demands the health information places on individuals to decode, interpret, and assimilate health messages" (Andrulis & Brach, 2007). Health literacy can be dynamic, changing in high stress situations (Edward, 2021).

Healthy People 2030 indicates that we lack a current national measure of personal health literacy, and failure to address personal health literacy increases health disparities. Organizational health literacy is a SDOH; even those with personal health literacy can be harmed by receiving care from a local organization with low health literacy. Improving health literacy results in better prevention of health problems, improved management of health issues, and reduced health care costs. The National Action Plan to Improve Health Literacy calls us to actively engage in the complex task of improving both personal and organizational health literacy (Healthy People 2030).

Factors affecting one's health literacy include:

- Communication methods and styles
- Physical or mental limitations
- General literacy
- Digital literacy
- Food literacy
- Numeracy skills
- SDOH

Health literacy affects one's ability to:

- Make informed health care decisions
- Interpret risks and benefits regarding care
- Lead a healthier lifestyle
- Get necessary and appropriate medical care
- Better understand their health issues, especially chronic diseases
- Access and understand medical records
- Participate in shared-decision making
- Take medication as prescribed
- Understand healthcare legislation and be an informed voter
- Complete follow-up care – visits, lab work, postoperative care, and related services

“Understanding health care literacy, cultural competency, and health disparities/inequalities is essential for providing empathetic care to patients and their family members” (Polster, 2018). Patient outcomes are adversely impacted by poor health literacy. Clear communication between patients and providers is essential.

A 2019 article featured in *Harvard Public Health Review* identifies three main components to effective communication in the health care setting:

1. Health literacy
2. Cultural competency
3. Language barriers

Ineffective communication occurs when there are deficits associated with any of these components. Two factors affecting health care literacy are the patient’s ability to comprehend and the complexity of the health system. Patients are expected to understand or navigate health care costs; reimbursement; insurance plan requirements; multifaceted treatment plans; the impact of comorbidities; medication tier plans; evidence-based information; self-management of one or more disease processes;, differences between emergency, urgent, and routine care; and how to make maintainable lifestyle changes. (Ratna, 2019)

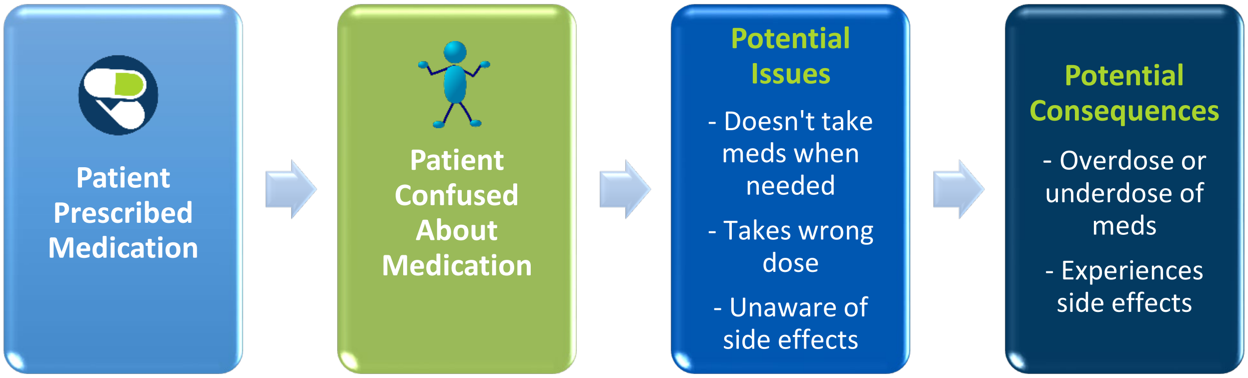
Interpreter services indirectly increase the cost and length of treatment visits. However, implementing online translation tools such as Google Translate and MediBabble may improve the quality of health care delivery, patient safety, and level of satisfaction for both patient and provider (Shamsi et al., 2020).

Scenario

As health care becomes more complex, low health literacy skills can lead to more severe consequences for patients. Let us assume we have an insured patient who has access to transportation and the financial means to pay for his meds. English is his first language. This patient already lacks a number of common barriers that can affect one’s health care. What could go wrong?

“Studies have shown that **40-80%** of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect” (AHRQ, 2020).

During an office visit, the patient was prescribed a medication to be used as needed. The teach-back discussion was not used, and he left the appointment without a clear understanding of the symptoms that would necessitate medication administration. He may unnecessarily take medication or fail to take it when it is indicated. If he received a number of medications, some of which require cutting to meet the dosing requirements, he may not possess the numeracy skills to accomplish this task. The result may be overdosing or underdosing of medication. He could have a reaction which he may not recognize due to failure to understand the side effect paperwork that accompanied his medication. If we add in a language barrier, lack of a support system, shift work that necessitates the patient use a 24-hour pharmacy 20 miles from his home, a short-term memory deficit, and failure to complete high school, it is easy to see that despite the patient's best efforts, he may not be able to appropriately follow provider instructions. As one can see, health literacy and social determinants of health can have a significant impact upon the patient's self-care.



Suggested resources:

- Health Literacy Patient Survey – Use this to assess patients' perceptions regarding the organization's explanations of health information.
- Always Use Teach-back! Training Toolkit – The toolkit focuses on learning and coaching teach-back while using plain language.
- Teach-back handout – 10 Elements of Competence for Using Teach-back Effectively
- Plain Language Materials & Resources – Use these tools compiled by the Centers for Disease Control and Prevention (CDC) to train/remind staff to use plain language when they communicate with the public.
- Microsoft Word Readability and Level Statistics – This website provides instructions for determining the reading level of a document.

Healthy People 2030's Health Literacy Objectives

"The level of health literacy of individuals or communities often mirrors disparities in society" (Lopez et al., 2022). Because of its impact on public health, attaining health literacy is both a foundational principle and an overarching goal of Healthy People 2030.

Six objectives were developed in relation to health literacy:

1	Increase the health literacy of the population – HC/HIT-R01	- This objective has research status which means, at this time, it lacks evidence-based interventions to address it, and reliable baseline data may not be available. A change in status will be reflected on the link provided.
2	Increase the proportion of adults whose health care provider checked their understanding – HC/HIT-01	- Of adults aged 18 years and older, 25.6 percent reported that a health care provider asked them to describe how they will follow instructions in 2019. - The target is 32.2 percent.
3	Decrease the proportion of adults who report poor communication with their health care provider – HC/HIT-02	- Of adults aged 18 years and older, nine percent reported poor provider communication in 2019. - The target is eight percent.
4	Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted – HC/HIT-03 shared-decision making tools added here	- Of adults aged 18 years and older, 57.2 percent reported that their health care providers always involved them in decisions about their health care as much as they wanted in 2020. - The target is 62.7 percent.
5	Increase the proportion of people who say their online medical record is easy to understand – HC/HIT-D10	- This objective has developmental status which means there are evidence-based interventions to address it, but no reliable baseline data at this time. A change in status will be reflected on the link provided.
6	Increase the proportion of adults with limited English proficiency who say their providers explain things clearly – HC/HIT-D11	- This objective has developmental status which means there are evidence-based interventions to address it, but no reliable baseline data at this time. A change in status will be reflected on the link provided.

Health Literacy Data

While health literacy has been deemed a high-priority public health issue, baseline data and evidence-based interventions are lacking. Data on adult literacy and numeracy skills is collected and reported by the U.S. Department of Education (ED). However, the only national data on health literacy skills was published in 2006 and referenced 2003 data, according to the CDC. In that study, researchers found that only 12 percent of U.S. adults had proficient health literacy, meaning 88 percent lack the skills to navigate the current health care system and aptly address their health care needs. Other more recent research has investigated the relationship between literacy and numeracy skills and educational attainment, employment, and health status. Through this data, it becomes clear there is an intertwining of social determinants or social drivers of health and health literacy. (CDC, 2022)

The Program for the International Assessment of Adult Competencies (PIACC), in a cyclical, large-scale study conducted by the National Center of Education Statistics, found that overall average scores in literacy, numeracy, or digital problem solving were not measurably different for U.S. adults between 2012/14 and 2017. While adults aged 16 to 74 were surveyed, the focus of the report was on the age range of 16 to 65. Educational attainment levels were categorized into three groups: less than high school, high school, and more than high school. Employment status was also categorized into three groups: employed, unemployed, and out of labor force.

Based on 2017 results, adults attaining higher education levels scored higher than those with lower education levels in both literacy and numeracy. The results held true at each level. With digital problem solving, the average score for adults with a high school education when compared to those with less than a high school education was not measurably different. There were no statistically significant changes in average scores for employed U.S. adults in literacy, numeracy, or digital problem solving between 2012/14 and 2017. Curiously, adults who were out of the labor force scored lower in digital problem solving in 2017, and unemployed adults showed an increase in both literacy and numeracy skills as compared to 2012/14, with an increase in the number performing at the highest level (3 or above) in numeracy.

Non-native born U.S. adults scored higher in literacy and problem solving in 2017 compared to 2012/14, showed no statistically significant changes in average scores during the same time. Regarding health status, the percentage of U.S. adults reporting “fair” or “poor” health increased from 15 to 17 percent. Accordingly, those reporting “excellent” or “very good” health decreased from 57 to 54 percent.

For literacy, numeracy, and digital problem solving, adults reporting higher levels of health scored higher than those with lower levels of health. These results echo those from the ED’s study, The Health Literacy of America’s Adults: Results from the 2003 National Assessment of Adult Literacy.

Health Literacy Universal Precautions

We have all come to know universal precautions as they apply to infection control, but there are now health literacy universal precautions. The U.S. Department of Health and Human Services (HHS) created the Health Literate Care Model which calls for health care providers to take a universal precautions approach and adopt actions that can result in increased patient engagement in health promotion, disease prevention, decision-making, and self-management. A universal precautions approach includes treating all patients as if they are at risk of not understanding health information, employing a range of strategies for clear communication, and confirming that patients understand what providers are saying.

Using a Health Literacy Universal Precautions Approach

✓ Structuring the delivery of care as if everyone may have limited health literacy
  - You cannot tell by looking
  - Higher literacy skills ≠ understanding
  - Anxiety can reduce ability to manage health information
  - Everyone benefits from clear communications

Adapted from "Health Literacy: Hidden Barriers and Practical Strategies Presentation" **(Slide 3), AHRQ, 2020.**

The Agency for Healthcare Research and Quality offers a Health Literacy Universal Precautions Toolkit for primary care practices. The second edition is an evidence-based comprehensive guide designed to help practices enhance support for patients of varying literacy levels. The Toolkit provides 21 tools addressing spoken communication, written communication, self-management and empowerment, and supportive systems.

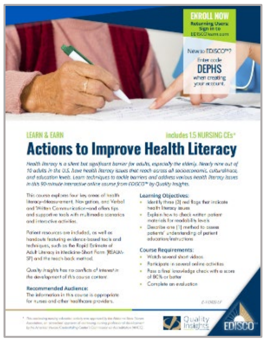
Training Courses

New skills must be learned in order to adapt and effectively meet the needs of the patients being served. The CDC offers Health Literacy Training designed for health professionals. The training consists of three courses:

1. Health Literacy for Public Health Professionals
2. Fundamentals of Communicating Health Risks
3. Effective Communication for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency and Cultural Differences

Four additional courses are undergoing updates but will be available on the same link in the future.

For those seeking no-cost non-CDC training courses, Health Literacy on Demand is a one hour, self-paced course designed for professionals and offered by the NNLM. Numerous health literacy training options of varying duration can be found here.



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Actions to Improve Health Literacy

Health literacy is a silent but significant barrier for adults, especially the elderly. Nearly nine out of 10 adults in the U.S. have health literacy issues that reach across all socioeconomic, cultural/race, and education levels. Learn techniques to tackle barriers and address various health literacy issues in this 90-minute interactive online course from EDISCO™ by Quality Insights.

This course explores four key areas of health literacy—Measurement, Navigation, and Verbal and Written Communication—and offers tips and supportive tools with multimedia scenarios and interactive activities.

Patient resources are included, as well as handouts featuring evidence-based tools and techniques, such as the Rapid Estimate of Adult Literacy in Medicine-Short Form (REALM-SF) and the teach-back method.

Quality Insights has no conflicts of interest in the development of this course content.

Recommended Audience:
The information in this course is appropriate for nurses and other healthcare providers.

Learning Objectives:
- Identify three (3) red flags that indicate health literacy issues
- Explain how to check written patient materials for readability levels
- Describe one (1) method to assess patients' understanding of patient education/instructions

Course Requirements:
- Watch several short videos
- Participate in several online activities
- Pass a final knowledge check with a score of 80% or better
- Complete an evaluation

Quality Insights e-Course: Actions to Improve Health Literacy

Quality Insights offers an e-course, free to Delaware health care professionals, that details evidence-based techniques that can be employed to tackle barriers and address various health literacy issues. Additional information about this e-course is available on the Quality Insights website.

Given its ever-increasing importance, consider adding health literacy training as a professional development goal for staff.

Health Literacy Action Plan

Becoming a health literate organization will take time, intention, planning, and continual reassessment. Align the organization's strategic plan as well as mission and vision statements with a goal to positively impact the health of patients by actively addressing health literacy.

Ten Attributes of Health Literate Health Care Organizations	
1	Has leadership that makes health literacy integral to its mission, structure, and operations.
2	Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3	Prepares the workforce to be health literate and monitors progress.
4	Includes populations served in the design, implementation, and evaluation of health information and services.
5	Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6	Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7	Provides easy access to health information and services and navigation assistance.
8	Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9	Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10	Communicates clearly what health plans cover and what individuals will have to pay for services.

Adapted from *Ten Attributes of Health Literate Health Care Organizations*, Institute of Medicine or of the National Research Council, 2012.

Assess how well the organization currently meets the needs of its patients, solicit feedback, and implement changes. Consider a deeper dive into issues the organization is already tracking, such as medication adherence and compliance with follow-up visits, which can be impacted by health literacy.

There are many tools and resources available to guide organizational change.

- Utilize "Making Health Literacy Real: The Beginnings of My Organization's Plan for Action" as a framework when endeavoring to improve health literacy as an organization. It may be helpful when operationalizing a strategic plan.
- HLE2 The Health Literacy Environment of Hospitals and Health Centers: An Updated Assessment Tool for Identifying Facilitating Factors and Barriers to Information, Care, and Services offers a revised tool for identifying and rating literacy related factors within an organization.
- Health Literacy Tool Shed will direct you to the right health literacy measurement tool to meet your needs.
- Health Education Materials Assessment Tool from the National Library of Medicine aids one in determining if patient-facing materials are "easy-to-read."
- The Health Literacy Environment Activity Packet is to be used by staff in an effort to evaluate the organization from a patient's point of view.
- The National Institutes of Health provides information and a number of resources on clear communication as it relates to health literacy, plain language, and cultural respect.

Organization Resources:

- For a guide on simplifying the user experience of a health website, consult Health Literacy Online.
- CDC Clear Communication Index serves as an aid for the development and assessment of communication products.
- CAHPS Health Literacy Item Sets can be used as a quality improvement tool. Available surveys aid in acquiring patient perspectives and measuring how successful health care professionals are at reducing health literacy demands on patients.
- Strategies to Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff helps educate pharmacy staff on the problem of low health literacy and how to improve communication with this population.
- The National Library of Medicine and its partners offer a Digital Health Literacy Curriculum for interested parties to use in their communities.

Patient Resources:

- "National Action Plan to Improve Health Literacy," Appendix B: What You Can Do To Improve Health Literacy provides suggestions for individuals, communities, and educators.
- MyHealthfinder offers plain language content, in English and Spanish, about health promotion and disease prevention.
- Evaluating Internet Health Information: A Tutorial provides a tutorial and checklist to help individuals assess the reliability of health information on the internet.
- The Over-the-Counter Medicine Label: Take a Look provides information to help patients decipher non-prescription medication labels.
- Navigating the Health Care System is a health literacy curriculum originally created for adolescents and young adults but recently updated to include an adult version.
- Patients can prepare for medical appointments by visiting Question Builder Online, choosing appointment type, selecting associated questions they would like to ask, and printing the resulting list.

Health Insurance Literacy

The University of Delaware Cooperative Extension offers an online health insurance literacy course, Health Insurance 4U, for consumers and small business owners.