Social Determinants of Health Practice Module

May 2021

Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension

Quality Insights

This publication was supported by the Cooperative Agreement Number NU58DP006516 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Publication number DEDPH-HD-052021

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Purpose of Module

The Quality Insights 2021 Social Determinants of Health (SDOH) Practice Module provides a framework for identifying social needs in the clinical setting and how the healthcare team can work together to reduce SDOH in Delaware communities. Designed to supplement the previously released 2020 SDOH Practice Module, this update includes new statistics and expanded content for:

- Assessing and screening social needs, including utilization of the PRAPARE Toolkit
- Implementing a standardized, closed-loop workflow that addresses SDOH and
- Getting started with connecting patients to local assistance resources

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. Please note that referenced guidelines and recommendations are to be used along with physician/clinician judgment and based on individual patients' unique needs and circumstances.

Background

In a 2020 national survey by The Physicians Foundation, 73% of respondents indicated that social determinants of health, such as access to healthy food and safe housing, will drive demand of healthcare services in 2021.

The 2020 Delaware State Health Improvement Plan (Delaware SHIP) confirms: "Racial and ethnic minorities and low-income communities have higher rates of these (heart disease, diabetes, asthma) chronic diseases. As chronic diseases are often associated with poor living and working conditions, the risk of poor outcomes associated with COVID-19 is elevated among some of our most vulnerable communities."

A few examples of disparities from the Delaware SHIP and The 2019 Impact of Diabetes in Delaware report include:

- African Americans make up 23% of Delaware's population and 44% of the positive COVID cases of which race is known.
- A higher percentage of racial minority groups in Delaware live in areas disproportionately impacted by environmental hazards, unhealthy land use, psychosocial stressors, and historical traumas, all of which drive health disparities.

- Household income is significantly associated with diabetes prevalence. In 2017, Delaware adults with the lowest household income (less than $15,000 annually) were significantly more likely to report having diabetes.
- Forty-four percent of Delaware adults making $15,000 or less per year report having HTN compared to 29.4% of those earning $75,000 or more per year (DPH, 2018).

While the COVID-19 pandemic has increasingly brought SDOH, health disparities and health inequities into focus, we know these challenges and opportunities long predated this current and ongoing crisis. This practice module aims to equip health professionals with the practical tools needed to identify and address social needs as part of their regular workflow and provide all Delawareans with equal opportunity to make choices that lead to good health.

Take the Next Step: Discover what is currently known about COVID-19 disparities by race and ethnicity in the U.S. Department of Health and Human Services March 2021 issue brief, *Health Disparities by Race and Ethnicity during the COVID-19 Pandemic*.

Population Focus: Delawareans & Chronic Disease

Chronic diseases such as heart disease, cancer and diabetes are the leading causes of death and disability in the U.S. and in Delaware. This section focuses on specific disease processes that are actively addressed through the *Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease and Stroke* program, which is funded through a Centers for Disease Control and Prevention (CDC) grant.

Delaware Division of Public Health (DPH) has contracted Quality Insights to provide technical support and assistance to more than 100+ participating Delaware healthcare practices statewide.

Cardiovascular Disease

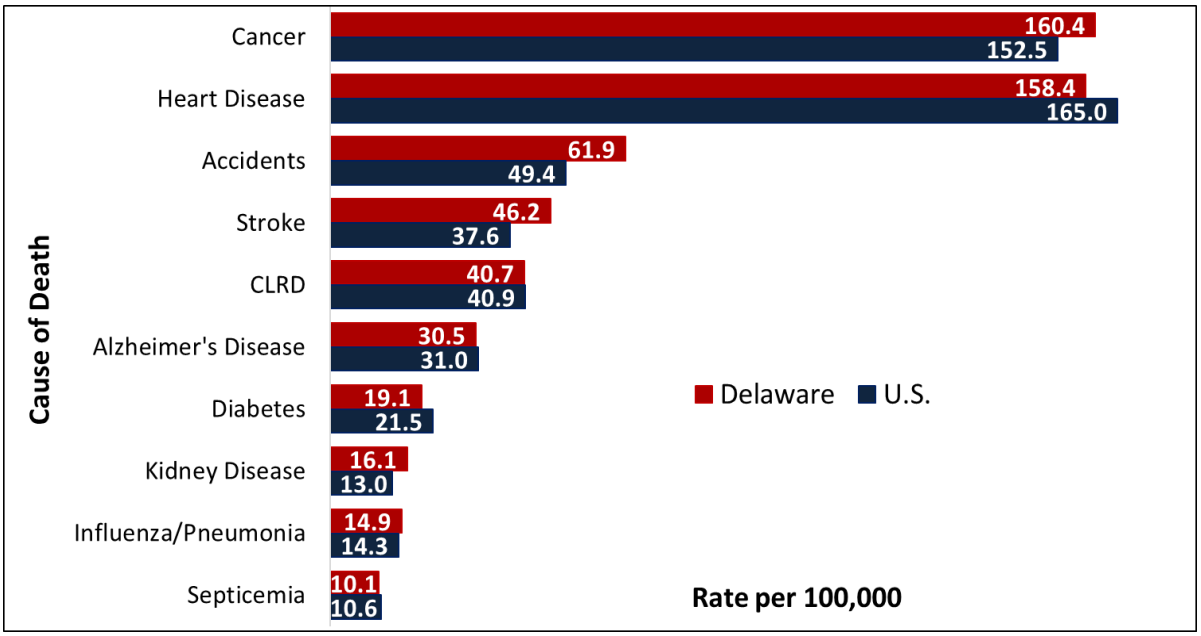
According to the 2019 Chronic Disease in Delaware: Facts and Figures report, **at least 5,989 Delawareans died from chronic disease in 2017, with cardiovascular diseases and cancer accounting for 51% of all deaths statewide**. An aging population, advances in medical care, and growing rates of health-damaging behaviors (such as obesity and reduced physical activity) make it likely that the number of Delawareans living with, and dying from, chronic diseases will increase in the future.

A 2020 *American Journal of Managed Care* article revealed food, housing and financial insecurity as the top three SDOH in a data review of more than 400,000 U.S. adults.

Read more about how these specific SDOH increase the risk of having heart disease.

Improvements in death rates from cardiovascular diseases, a complex group of diseases which includes heart diseases, vascular diseases, and cerebrovascular diseases (stroke), are also noteworthy. From 2001-2005 to 2013-2017, death rates decreased 32% for heart diseases, 14% for cerebrovascular diseases, 33% for high blood pressure and hypertensive renal disease, and 50% for aortic dissection. Despite these decreases, African American Delawareans continue to have higher death rates from these cardiovascular diseases compared to Caucasians.

Figure 1: Age-Adjusted Death Rates for Leading Causes of Death: Delaware vs. U.S., 2017



Note: CLRD: Chronic Lower Respiratory Diseases. Spirce: Centers for Disease Control and Prevention, Stats of the State of Delaware, Delaware Leading Causes of Death, 2017.

Take the Next Step: COVID-19 underscores the need for continued chronic disease prevention and management, as those with chronic conditions are especially vulnerable to severe illness from the virus. Download Quality Insights Care Team Interventions to Implement American Heart Association CVD Primary Prevention Guidelines to access several practical steps your care team can take to help reduce cardiovascular disease and health disparities in your community.

Blood Pressure

According to *The Surgeon General's Call to Action to Control Hypertension (Call to Action)*, released October 2020, certain groups of people have disproportionately high rates of hypertension and its related health consequences. Prevalence is higher among older adults and is also notably higher among certain racial and ethnic groups, especially non-Hispanic blacks. Although several modifiable and non-

modifiable factors are regularly recognized as contributing to hypertension, a "third arm of risk", identified as SDOH, should be prioritized.

SDOH have been associated with hypertension risk among non-Hispanic blacks and other minority groups. Psychosocial and socioeconomic stressors—such as low socioeconomic status, depression, job stress, financial stress, segregated neighborhoods, and neighborhood poverty level—also contribute to the risk of hypertension.

According to Delaware Health and Social Services:

- In 2019, 36.4% (about 281,000 people) of Delaware residents age 18 and older reported they had been told by a health care professional that they have high blood pressure, also known as hypertension.
- In 2019, African-American adults (42.1%) had a slightly (but not significantly) higher prevalence of reported hypertension than non-Hispanic white adults (38.8 percent).
- Hypertension prevalence increases with age. Prevalence of hypertension among Delaware adults by age:
  - **15.9%** of 18-44 year-olds
  - **38.7%** of 45-54 year-olds
  - **49.8%** of adults age 55-64, and
  - **61.2%** of age 65 or older
- As education and income increases, the prevalence of hypertension decreases. Among Delaware adults with a high school diploma or GED, 35.4 percent report being diagnosed with hypertension, compared with 30.5 percent of those with a college degree.
- 44.4 percent of adults in the lowest income category say they have high blood pressure, compared with 33.7 percent of adults with incomes higher than $50,000 a year.

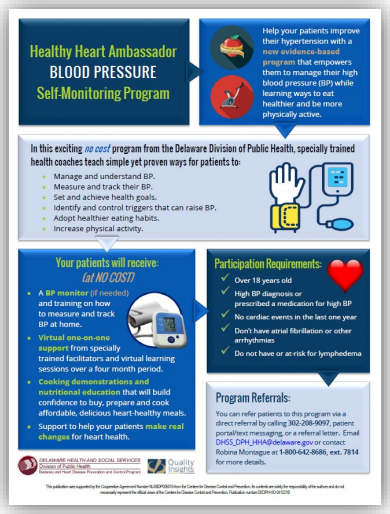
Take the Next Step: Given the toll that hypertension plays in our state and nation, as well as the impact COVID-19 has had on the decreased frequency of in-person check-ups, there is a compelling role for increased support for the use of self-management of blood pressure, or home monitoring.

Quality Insights, in partnership with the Delaware Division of Public Health, can supply medical practices with up to FIVE automated home blood pressure monitors that can be loaned to patients. This is a great program for patients who do not currently own or can't afford to purchase a BP monitor, are newly diagnosed with hypertension, or are experiencing a change in BP medication.

If your practice is interested in participating in the program, email Robina Montague or call **1.877.987.4687**, **ext. 7814**.

New Program: Introducing the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM)

Help your patients improve their hypertension with a new, evidence-based program that empowers them to manage their high blood pressure while learning ways to eat healthier and be more physically active.



In this exciting CDC-recommended program from the Delaware Division of Public Health, in partnership with the University of Delaware and Quality Insights, specially trained health coaches teach simple yet proven ways for patients to better manage and understand their blood pressure, increase physical activity, adopt healthier eating habits, and more.

Learn More: Quality Insights invites you to explore more information about this new opportunity by reviewing the links below and the attached flyer (Appendix A, Appendix B, and Appendix C):

- **For Providers**: Learn about the HHA BPSM program, participant requirements and program referral details.
- **For Patients and Delaware State Employees**: Explains program features, requirements and includes contact information for participation.

Diabetes

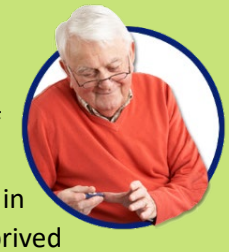
SDOH are increasingly being recognized for their relationship to the soaring incidence of Type 2 diabetes in the U.S., as well as opportunities for the healthcare community to counter it. Many current Type 2 diabetes interventions focus on biologic and behavioral factors, such as symptoms, diet and physical activity. However, it is equally important to address the influence of physical and social environments,

which may include low income, employment insecurity, low educational attainment, and poor living conditions, on health outcomes.

A 2013 *Permanente Journal* article reports Type 2 diabetes can be particularly problematic among less advantaged patients for several reasons:

1) The personal financial burden of increased health care costs can further intensify the effects of poverty, particularly because it consumes a greater portion of income (as compared with those who have greater financial resources).
2) A disadvantaged individual may not have sufficient access to the resources necessary to manage the condition, such as adequate housing, nutritious food, and healthcare services.
3) Diabetes can decrease an individual's productivity at work or limit educational attainment, particularly if left unmanaged, which can lead to further employment-related problems. These conditions exacerbate the cycle of inequality, as they lead to further poverty, material deprivation, and social exclusion if disadvantaged individuals are left to fend for themselves.

Life-course exposure



The length of time one spends living in resource-deprived environments—defined by poverty, lack of quality education, or lack of health care—significantly impacts disparities in diabetes risk, diagnosis, and outcomes.
Source: ADA, *Social Determinants of Health and Diabetes: A Scientific Review*, 2021

A 2021 Talking Points: Connection Between Diabetes and COVID-19 Complications document from the National Association of Chronic Disease Directors (NACDD) reports:

- 12.8% of Delaware adults are diagnosed with diabetes according to data from the 2019 Behavioral Risk Factor Surveillance System (BRFSS).
    - An additional 11.8% of adults are diagnosed with prediabetes.
    - Approximately 34.4% of Delaware adults are obese, putting them at increased risk for prediabetes and type 2 diabetes.
    - The American Diabetes Association (ADA) estimates that 37.7% of Delaware adults have prediabetes, most of which is undiagnosed.

Delaware Prevalence of COVID-19, Diabetes, and Overweight/Obese Individuals

County	Adult Diabetes Prevalence, 2019	Adult Obesity Prevalence, 2019	COVID-19 Cases per 10,000	COVID-19 Deaths per 10,000	COVID-19 Case-Fatality Rate*
State Average	12.8%	34.4%	858	14	1.6%
Kent	13.2%	42.0%	765	15	2.0%
New Castle	11.8%	31.5%	849	11	1.3%
Sussex	14.7%	31.5%	943	17	1.9%

Source: DE Health and Human Services 2019 Behavioral Risk Factor Surveillance System Delaware Division of Public Health, Coronavirus Response
Notes: *COVID-19 deaths as a percent of COVID-19 cases. COVID-19 data is as of February 18, 2021.

The Association of Diabetes Care & Education Specialists (ADCES) recommend the following strategies for understanding socioeconomic factors and promoting improved outcomes for diabetes patients:

1) Provide extra resources that help patients face difficult situations, including mental health services and other social services (food pantries, etc.)
2) If you serve multi-lingual populations, then provide language-appropriate information.
3) Use motivational interviewing techniques to address barriers and individualize care.
4) Identify their feelings or attitudes toward the problem and help them plan solutions that might work.
5) Offer other resources, such as healthy cooking classes, support groups, smoking cessation programs, and the National Diabetes Prevention Program.

Take the Next Steps: Shared medical appointments (SMAs) for patients with diabetes is an evidence-based intervention that aims to improve patient health by combining clinical care, health education and peer support. Receiving care together can shift the traditional patient-provider power dynamic and create relationships of care between patients, potentially interrupting the reproduction of inequalities in health care.

Learn more about the benefits of shared appointments for patients living with diabetes:

- CDC: DSMES Provided in Shared Medical Appointments: Learn about the structure, benefits and potential outcomes associated with offering SMAs
- Shared Medical Appointments Tip Sheet: This resource provides an overview of shared medical appointments and their benefits, staff requirements, information about frequency and duration, privacy tips, and billing information.
- Systematic Review on Shared Medical Appointments: This review of 17 studies compares SMA interventions with usual care, noting improvements in A1C and systolic blood pressure for SMA interventions.
- Group Visit Starter Kit: This resource from the Group Health Cooperative is designed for health care teams who want to begin offering group visits for people with diabetes.
- Reimbursement for Shared Medical Appointments Incorporating Diabetes Self-Management Education/Training or Diabetes Medical Nutrition: This article offers an overview of Medicare and private insurance reimbursement for SMAs.

Screening for Social Needs

As providers are increasingly held accountable for reaching population health goals, they need tools and strategies to identify 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.

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

PRAPARE Assessment Tool

The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the social determinants at both the patient and population levels. 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 reductions. A few additional benefits include:

EHR Integration:

Data from the assessment can be directly uploaded into many electronic health records (EHRs) as structured data. EHR templates and video demos are available for eClinicalWorks, Cerner, Epic, athenahealth®, athenaPractice™ (formerly GE Centricity), Greenway Intergy, and NextGen (Athena users must contact their customer success managers to implement PRAPARE in their EHR.).
For those who use an EHR where a PRAPARE template doesn't currently exist, there is an available paper form (available in 26 languages) and 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: 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.

American Academy of Family Physicians (AAFP) Social Needs Screening Tool

The AAFP offers the Social Needs Screening tool through the EveryONE Project™, which can be self-administered or administered by clinical or nonclinical staff. It screens for five core health-related social needs, which include housing, food, transportation, utilities, and personal safety, using validated screening questions, as well as the additional needs of employment, education, child care, and financial strain. The EveryONE Project™ Toolkit offers a variety of helpful strategies for use in the clinical setting to improve patients' health and address SDOH.

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

The CMS ten-question Health-Related Social Needs Screening Tool is meant to be self-administered. The tool can help providers find out patients' needs in five core domains that community services can help with, including housing instability, food insecurity, transportation problems, utility needs, and interpersonal safety.

Take the Next Step: Locate expanded information about SDOH screening and the tools referenced in this section by reading the 2018 *Family Practice Management* article titled, "A Practical Approach to Screening for Social Determinants of Health".

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

Robust data related to patients' social needs is critical to clinic and hospital efforts to improve the health of their patients and communities. Employing a standardized approach to screening for, documenting and coding social needs enables sites to:

- Track the social needs that impact their patients, allowing for personalized care that addresses patients medical and social needs
- Aggregate data across patients to determine how to focus a social determinants strategy; and
- Identify population health trends and guide community partnerships

One tool available to capture data on the social needs of a patient population is the ICD-10-CM codes included in categories Z55-Z65 ("Z codes"), which identify non-medical factors that may influence a patient's health status. Existing Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water or occupational exposure to risk factors like dust, radiation or toxic agents.

Utilizing Z codes allows clinics and hospitals to better track patient needs and identify solutions to improve the health of their communities. Clinical leaders can prioritize the importance of documenting and coding patients' social needs and allow coders extra time to integrate coding for social determinants into their processes.

Take the Next Step: Download these coding resources for 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
- American Hospital Association: ICD-10-CM Coding for Social Determinants of Health
- CMS: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes Infographic
- 2021 CMS ICD-10-CM Official Guidelines for Coding and Reporting
- e-Health Initiative Explains 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

Collecting data on SDOH using PRAPARE can be accomplished in a variety of ways. There is no absolute "right way"—only what works best in your setting. The Five Rights Framework is one option to determine the best data collection and response workflow for your own 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?
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?

SOCIAL DETERMINANTS OF HEALTH

Team Members/Roles	Actions
Administrative staff	• Support integration of SDOH tools into EHR • Train staff about SDOH • Track data for evaluation • Communicate outcomes to team
Front office	• Disseminate paper or electronic materials to patients via portal or mail • Provide assessment materials at check-in • Collect race, ethnicity, and language at check-in registration • Ensure data entered into EHR; alert clinical staff as needed • Maintain resource lists and provide to patients
MAs and/or nurses	• Verbally interview patients and enter responses into EHR • Discuss patient needs and assess for readiness to address • Discuss community resources and schedule per practice workflow • Enter Z codes into patient record (social needs codes Z55-Z65 can be entered by any clinician involved in patient's care) • Follow up on referrals
Provider	• Select assessment tool; determine workflow • Verbally interview patients and enter responses into EHR • Refer patients to other team members for supplemental counseling, using warm handoff where possible

Take the Next Step: Nine unique, standardized SDOH screening workflow options are available to review in the PRAPARE Implementation and Action Toolkit. Click here to find a SDOH workflow that compliments 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. The following options are provided as a means to help you locate available resources in your region:

- Unite Delaware: Partners in the network are connected through a shared technology platform, Unite Us, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. Unite Delaware is sponsored by ChristianaCare.
- Findhelp.org (Aunt Bertha): Visit this website to learn more about how patients can find food assistance, help paying bills, and other free or reduced cost programs in their region.
- 211 Helpline Center (United Way): From help with a utilities bill, to housing assistance, after-school programs for kids, and more, patients can dial 211 or text their zip code to 898-211 to talk with a resource specialist for free.
- 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 in need and facilitate long-term solutions to the problems of hunger and poverty through community education and advocacy.
- Delaware Healthy Neighborhoods: This is initiative is an innovative approach to addressing population health challenges. Healthy Neighborhoods is focused on creating sustainable interventions by convening local stakeholders to improve health in their communities.
- My Healthy Community: Provides community-level statistics and data that can be used to understand and explore health and related factors that influence health.
- Delaware State Service Centers
- Delaware Division of Services for Aging and Adults with Physical Disabilities
- Delaware Division of Public Health, Bureau of Health Equity: The mission is to promote and advocate for policy, programs, services, and initiatives which will eliminate the impact of the social determinants of health to ensure all Delawareans can achieve their optimal health with a special focus on the underserved populations of Delaware.
    - Delaware Health Equity Strategic Map
    - Delaware Health Equity Guide for Public Health Practitioners and Partners
- HelpIsHereDE - Behavioral health and substance use resources
- NNLM Consumer Health Information in Many Languages Resources

Measuring Outcomes: Documentation and Process Evaluation

Once you have implemented SDOH screening and developed the appropriate interventions, it is important to track those interventions to better understand the value of existing interventions to address patient risks. Research demonstrates that enabling services (non-clinical support services and interventions that support the delivery of basic health services and facilitate access to comprehensive care and community services) lead to positive impacts on outcomes, costs, access, and patient satisfaction.

By documenting both SDOH screening **AND** enabling services, your organization can:

- Determine which interventions are most effective at addressing particular risks for particular populations which can inform clinical operations as well as resource allocation to lead to improved patient care.
- Better quantify the extent to which your organization already provides enabling services in terms of staff involved, services provided and time spent providing those services.
- Evaluate the complexity of your patients and how your organization is working to address the barriers patients are facing.

Take the Next Step: Download and review the Quality Insights companion SDOH Workflow Modification Guide (see Appendix A) for access to a summary of action steps you can take to screen for SDOH and document services.

Success Stories: Reducing Disparities in Delaware

Unite Delaware

Unite Delaware is a statewide coordinated network that connects health and social service organizations through a shared technology platform, Unite Us, to send and receive trackable referrals. The network aims to address SDOH and create more equitable communities. Unite Delaware consists of over 80 participating community based organizations, offering 190 programs across the state to address needs such as housing, food, clothing and household goods, individual and family support services, health and wellness needs, employment and income support. Since the launch

of Unite Delaware in 2019, there have been over 1,100 referrals sent, of those turned into a case, 62% have successfully addressed the client's needs.

The benefits of joining the Unite Delaware platform include:

- Refer and connect your clients to local services they need
- Improve your clients' health and well-being through strengthened collaboration with partners offering a wide array of services.
- Improve organizational capacity through accurate referrals and access to a wealth of data on local service delivery.
- Track the outcomes of all referrals and services delivered for your clients.
- Identify gaps in services to proactively address barriers to care and increase health equity in your community.

Learn more about the Unite Delaware network by visiting it's website and reading this September 2020 article featured in the *Delaware Journal of Public Health*.

CareForceMD

CareForceMD is a telemedicine-based platform that connects patients with clinicians at CareForceMD clinics in Delaware and Pennsylvania, and also via smartphone, tablets, laptops, or computers from the patient's home or anywhere an internet connection is available, 24 hours a day.

As a technology-driven company, templated SDOH screening is included in the forms area of it's patient app, and also as part of intake when a patient is onsite at a kiosk (either electronically or by a Medical Assistant). CareForceMD utilizes ICD-10 Z-codes for SDOH and refers to community-based organizations (CBOs).

Learn more about CareForceMD by visiting their website and finding a location near you.

Westside Family Healthcare

As the COVID-19 pandemic creates rising challenges faced by the healthcare community and individuals across the state of Delaware, Westside Family Healthcare is taking steps to address the increasing problem of food insecurity for Wilmington residents. Through funding from Highmark Blue Cross Blue Shield Delaware's BluePrints for the Community: Social Determinants of Health grant, Westside's Feeding Families pilot program aims to expand access to fresh foods, provide routine nutrition counseling, and educate patients to better manage chronic disease. Through this program, families who

identify as food insecure receive fresh food delivered to their homes, and participate in monthly nutrition counseling sessions with a Westside dietitian who tailors the program to each patient with customized education and tools that encourage behavior change.

Westside Family Healthcare utilizes food access data provided from an abridged version the PRAPARE tool along with other geographic and diagnosis criteria, all pulled from the EMR, to determine patient eligibility. Leann Marcinek, External Affairs Manager at Westside Family Healthcare, shares the primary goal of this program is to improve food access and overall health outcomes. Learn more about Feeding Families from the Westside media release, by downloading the program flyer, or by contacting Leann.

One Health Delaware

Delaware Humane Association's (DHA) One Health Delaware is a free, once monthly clinic that provides both veterinary and human healthcare to an underserved community in Wilmington, Delaware.

The goal of One Health Delaware is to utilize the human-animal bond to help bring preventive healthcare to families no matter their income, ethnicity, or immigration status. An additional benefit is to provide clinical experience to health professional students while modeling compassionate care without racial bias and enhancing One Health thinking across professions in a time of great global need.

One Health Delaware is led by DHA, but is run with the volunteer help of veterinarians and technicians who join student volunteers from University of Pennsylvania School of Veterinary Medicine, University of Delaware, and Wilmington University Nurse Practitioner Program. The clinic runs in the community room of the Henrietta Johnson Medical Center, which is a Federally Qualified Health Center (FQHC) in the Southbridge section of Wilmington, Delaware. The team provides services for both the pets and people, side by side. The pets receive wellness exams, vaccinations, and health screenings. The families attending the clinic can access a variety of health and social services including blood pressure screenings, flu vaccines, or help enrolling for health insurance. All services are provided free of charge. They also have opportunities to schedule future health appointments, enroll in SNAP benefits, or sign up for healthy eating classes. Nurses and nursing students provide wellness information and opportunities to discuss any concerns. Spanish interpretation is provided by University of Delaware undergraduate students.

This inclusive healthcare model shows promise to provide access to services in both rural and urban areas for people and pets and could become an impactful way to reach populations that have been previously underserved. Pilot data collection during the first year of the clinic showed a profound

interest in families coming back to Henrietta Johnson Medical Center for both veterinary and human healthcare. Read more about One Health Delaware in the January 2021 edition of the *Delaware Journal of Public Health* and The Association for Animal Welfare Advancement blog.

Guidance for Overcoming Barriers

Although many in primary care agree about the importance of screening patients for social needs and referring to supportive community resources, legitimate concerns exist about the feasibility of doing so. The following resources explore these issues and offer mitigation strategies.

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, measurement suggestions and/or key takeaways for consideration for your business case are provided throughout each of the steps.

Click here to learn how to build a successful business case aimed at getting your SDOH initiative off the ground.

Advancing Health Equity

American Academy of Family Physicians (AAFP) EveryONE Project™

With the intent to help providers take action and confront health disparities head on, the AAFP created the EveryONE Project™. This initiative offers education and resources to help providers advocate for health equity, promote workforce diversity and collaborate with other disciplines and organizations to reduce harmful disparities.

Click here to access the EveryONE Project™ Toolkit website and the supplemental Social Determinants of Health in Primary Care: A Team-based Approach for Advancing Health Equity Implementation Guide, which provides sample patient visit flowchart and SDOH implementation plan, tips for connecting patients with community-based resources, and guidance for developing a practice culture that values health equity.

Screening Solutions

The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned

If addressing patients' social needs sounds overwhelming, the results of this pilot project might surprise you. Published in *Family Practice Management* in 2019, this SDOH screening project was conducted at AF Williams Family Medicine Center, an academic clinical setting made up of 45 family medicine faculty and residents associated with the University of Colorado School of Medicine. AF Williams has more than 18,000 patients empaneled and conducts almost 40,000 visits annually with nine physicians or other providers per clinic session**. In the authors' pilot study, 58 percent of clinicians began the project thinking they were too busy for social determinants of health (SDOH) screening, but only 21 percent felt that way by the end of the project.**

Click here to read the full report, which includes seven key lessons learned and a clinic readiness assessment template.

Housing

As a SDOH, the impact housing has on health and well-being extends beyond whether someone has a home or not.

Explore the Intersection of rural housing quality and health in this 2021 *Rural Health Information Hub* article.

Strategies for Using PRAPARE and Other Tools to Address Homelessness: Quick Guide and Recommendations

The Corporation for Safe Housing (CSH) and the National Healthcare for the Homeless Council (NHCHC) organized a learning collaborative to understand: 1) how social determinants data are being collected, 2) how the data collected inform individual care planning, 3) how health center staff use data to build partnerships and programs, and 4) how health center staff use the information collected to support fundraising and efforts at the local, state, and federal levels. Through a series of listening sessions conducted with six Primary Care Associations (PCAs) and one focus group session, key challenges and strategies were identified that provide state and local health center perspectives. Click here to review the challenges providers experienced with PRAPARE and key strategies and innovations offered to address these barriers.

Kaiser Permanente COVID-19 Social Health Playbook

This document, designed for clinical care teams, offers guidance and tools for screening patients for social needs, connecting them to help, and following up to ensure their needs are met. The playbook includes illustrative examples, action steps and starter resource lists for housing instability, food insecurity, social isolation, financial strain, and intimate partner violence, as well as additional guidance for assisting older adults, those with behavioral health needs, and victims of intimate partner violence.

Click here to review guidance on caring for patients with social needs within a COVID-19 context.

Workflow Modifications: Action Steps to Address Social Determinants of Health (SDOH) Assessment

Providers and practices who are actively engaged in the Delaware Division of Public Health's Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke program have the benefit of **scheduling a no-cost workflow assessment (WFA)** with a local Quality Insights Practice Transformation Specialists (PTS). WFAs are completed annually and designed to initiate a future state of processes that will move the needle on clinical quality improvement activities.

The following list of workflow modification options can be used in combination with Quality Insights 2021 SDOH Practice Module to help address SDOH and reduce health disparities in your clinical setting. **We encourage you to partner with your Quality Insights PTS to discuss scheduling a WFA and implementing at least ONE of the recommendations listed below.** If you are not currently working with a PTS and would like assistance, please email Robina Montague or call 1.800.642.8686, Ext. 7814.

Electronic Health Record (EHR) Actions

	Assess your EHR's capability of running reports based on clinical quality measures. Determine ability to collect and report patient race, ethnicity and preferred language data.
	Explore your EHR's ability to integrate with the PRAPARE SDOH assessment tool. Review available PRAPARE EHR templates and demo videos.
	Review Quality Insights' Quick Guide to Social Determinants of Health ICD-10 Codes as a starting point to utilize ICD-10 Z codes to link SDOH and diagnoses/problem lists.

	Develop and implement structured data fields to track referrals to community resources and ensure feedback is received. If your practice is participating in the CMS Quality Payment Program (QPP), consider monitoring this Clinical Quality Measure (for EHR or Registry collection and submission only).

Protocol & Workflow Actions

	Determine implementation plan for SDOH assessment, including staff roles and training, team communication, data collection and analysis, and referral to community resources.
	Utilizing Chapter 5 of the PRAPARE Implementation and Action Toolkit, build workflows to connect patients with resources and follow up.
	Develop external partnerships and refer patients to social resources. Start with state-based resources linked in the practice module.
	Initiate a process for addressing SDOH at both patient and population levels.

Practice & Clinical Solutions

	Use the electronic PRAPARE tool or implement a paper form to identify your patients' social needs, such as housing status and stability, neighborhood safety, income, educational attainment, transportation needs, and employment. Consider assessing social and emotional health measures such as social support and stress as well as Substance Use Disorder.
	Review Chapter 9 of the PRAPARE Implementation and Action Toolkit to learn more about how you can act on your SDOH data and think through possible services and interventions you can provide or build based on the needs in your patient population.
	Review common challenges related to collecting SDOH data and suggestions for resolution. Read about SDOH data collection and utilization challenges as well as strategies for innovation in the primary care setting here.

Patient Education Actions

	Plan and implement communications with your patients to help them understand why they are being asked about social determinants of health and ways in which they can benefit from the assessment.
	Survey patients to follow up and get feedback about their experiences with referrals.

Please contact your Quality Insights Practice Transformation Specialist for NO-COST implementation assistance for any of these workflow modifications.