# Social Determinants of Health Practice Module

## May 2022

*Live Healthy: Prevention and Management of Hypertension, Diabetes and Stroke Project*

Quality Insights

Funding provided by the Pennsylvania Department of Health through the Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke federal grant from the Centers for Disease Control and Prevention. Publication number PADOH-HD-051022B

# Table of Contents

## Purpose of Module

The Quality Insights 2022 Social Determinants of Health (SDOH) Practice Module provides a framework for identifying social needs in the clinical setting and how the health care team can work together to reduce SDOH in Pennsylvania communities. The module includes information related to:

- 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. 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 percent of respondents indicated that SDOH, such as access to healthy food and safe housing, will drive future demand of health care services.

The 2020 Pennsylvania Health Assessment confirms: "Health disparities persist throughout Pennsylvania and the nation, and COVID-19 has underscored and magnified this reality. Residents across the state die prematurely and live with a poor quality of life due to social, economic, service environment, and physical environment factors, which are the social determinants of health." A few examples of disparities from the report include:

- Black Pennsylvanians had higher rates of death due to heart diseases, cancers, cerebrovascular diseases, diabetes, infectious and parasitic diseases, homicide, kidney diseases, and septicemia.
- In 2019, 13,199 people experienced homelessness on any given day (10.3 of every 10,000 people). About 52 percent of these individuals were black.
- About 7 percent of Pennsylvanians reported having difficulty understanding information from health professionals. Challenges with health literacy were more common among Hispanic people (16 percent), people with household incomes below $15,000 (18 percent), and those with less than a high school education (21 percent).
- The COVID-19 pandemic has exacerbated unemployment, as it jumped from 5 percent in January to 13 percent in June 2020.

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 Pennsylvanians 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: Pennsylvanians & Chronic Disease

Chronic diseases are a major public health challenge throughout Pennsylvania. 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. Pennsylvania Department of Health (DOH) has contracted Quality Insights to provide technical support and assistance to more than 200 providers at 80+ participating health care practices statewide.

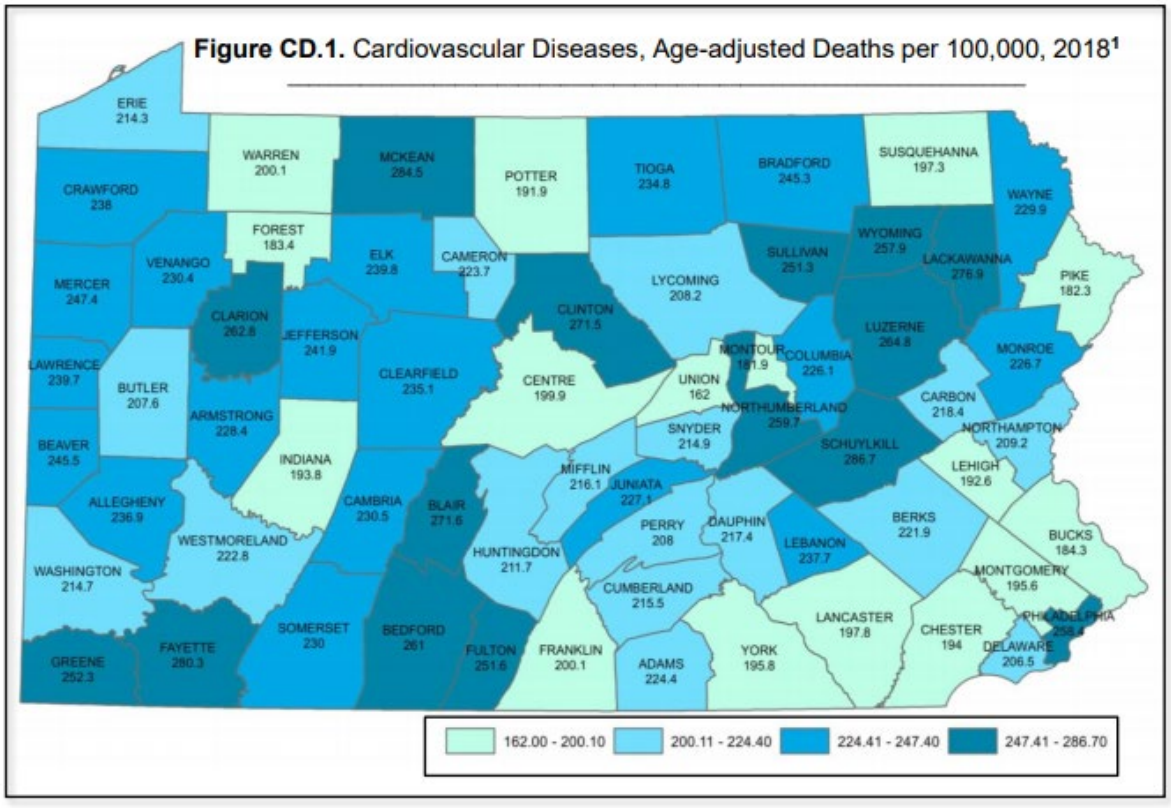
A 2020 *American Journal of Managed Care* article revealed food, housing and financial insecurity as the top three SDOH in a data review of more than 400,000 US adults. Read more about how these specific SDOH increase the risk of having heart disease.

### Cardiovascular Disease

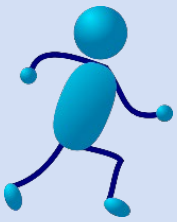
**In 2018, the most common cause of death in Pennsylvania was cardiovascular disease** and 47 percent of residents lived with one or more chronic diseases (i.e. cancer, cardiovascular disease, diabetes, arthritis). Tobacco use, excessive alcohol use, physical inactivity, and poor nutrition are major risk behaviors for these chronic conditions.

Other important societal and environmental aspects that vary throughout the state and seriously affect the health of Pennsylvanians include:

- Racial disparities
- Poverty
- Illiteracy
- Various types of stigma
- Unavailability/unaffordability of fresh food
- Lack of access to safe places for play and exercise



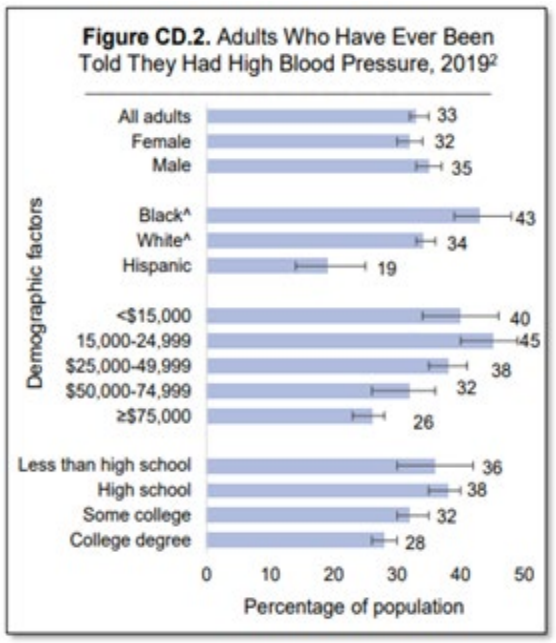

Source: The State of Our Health: A Statewide Health Assessment of Pennsylvania, 2020



**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.




Source: [The State of Our Health: A Statewide Health Assessment of Pennsylvania, 2020]

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.

**For Pennsylvanians:**

- In 2018, 26 percent of adult Pennsylvanians had one or more disabilities. People with disabilities are more likely to also have other risk factors such as obesity, smoking, inactivity, and high blood pressure.
- In 2019, 33 percent of adults had ever been told they had high blood pressure.
- Among those with high blood pressure, 81 percent were taking medication for it.

**Take the Next Step:** Given the toll 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 PA Department of 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 cannot 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 Ashley Biscardi or call **1.800.642.8686, ext. 137**.

## 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 health care 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.

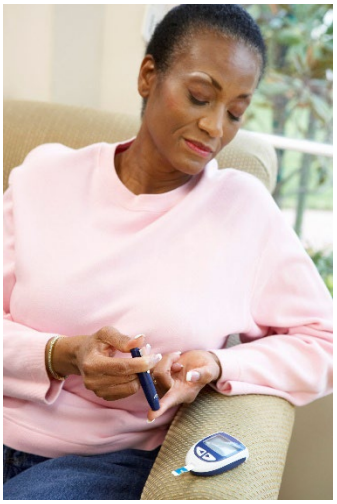
A 2013 *Permanente Journal* article reports type 2 diabetes can be particularly problematic among less advantaged patients for several reasons:

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 health care 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**

based on 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



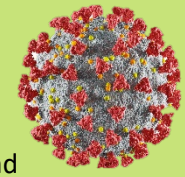
According to the American Diabetes Association (ADA) and the 2020 Pennsylvania Health Assessment:

- Diagnosed diabetes costs an estimated $12.9 billion in Pennsylvania each year.
- Approximately 11.3 percent of the adult population have diagnosed diabetes.
- Every year, an estimated 67,000 people in Pennsylvania are diagnosed with diabetes.
- People age 65 and older and people with lower household income levels were more likely to have diabetes. Sixteen percent of black non-Hispanic adults, 11 percent of non-Hispanic white adults, and 6 percent of Hispanic adults had ever been told they have diabetes.

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, 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.

### The Connection between Diabetes & COVID-19



Learn more about the connection between diabetes and COVID-19 complications in Pennsylvania by reviewing this 2021 Talking Points document from the National Association of Chronic Disease Directors (NACDD).

**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 living with diabetes.

## 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:

**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 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 30 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 Z codes, including coding categories, frequently asked questions, and addressing common barriers:

- Quality Insights: 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
- 2022 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?<br>• Part of registration<br>• Part of other health assessments or initiatives | What information and resources do you have to respond to social determinants data?<br>• Update your community resource guide and referral list with accurate information<br>• Track referrals, interventions and time spent |
| **Right Format: HOW** | How are we collecting this information and in what manner are we collecting it?<br>• Self-Assessment?<br>• In-person with staff? | How will intervention and community resource information be stored for use and presented to patients?<br>• Searchable database of resources (in-house or via partner)?<br>• Printed resource for patients to take with them?<br>• 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?<br>• Providers and other clinical staff?<br>• Non-Clinical staff? | Who will respond to social determinants data?<br>• By a dedicated staff person?<br>• By any staff person who administers PRAPARE with the patients?<br>• By the provider? |
| **Right Channel: WHERE** | Where are we collecting this information? Where do we need to share and display this information?<br>• In waiting room? In private office?<br>• Share during team huddles? Provide care team dashboards? | Where will referrals and/or resource provisions take place?<br>• In private office?<br>• In the exam room? |
| **Right Time: WHEN** | When is the right time to collect this information so as to not disrupt clinic workflow?<br>• Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.)<br>• During visit?<br>• After visit with provider? | When will referrals take place?<br>• Immediately after need is identified?<br>• After the patient see the provider?<br>• At the end of the visit? |


# SOCIAL DETERMINANTS OF HEALTH

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

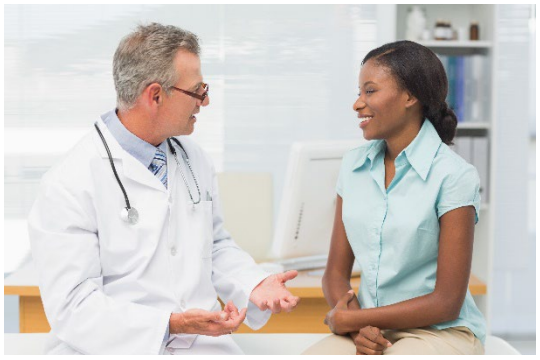
# Locating Resources & Referral Partners

## 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 Pennsylvania: Partners in this network are connected through the Unite Us shared technology platform, which enables them to send and receive electronic referrals, address people's social needs and improve health across communities.
- Findhelp.org (Aunt Bertha): Visit this website to find local food assistance, help paying bills, and other free or reduced cost programs.
- 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 Program Education (PA SNAP-Ed): Find local and statewide partners providing a variety of nutrition education programming, including:
    - Feeding Pennsylvania: Health Pantry Initiative Nutrition and Cooking Classes
    - Feeding Pennsylvania: Find Your Food Bank
    - PennState Extension: Nutrition Links: Offers free nutrition education programs to participants eligible for public assistance to develop the knowledge and skills necessary to achieve a healthful diet on a limited budget.
    - PA Nutrition Education Network: Works to ensure that effective, evidence-based, appropriate nutrition resources primarily for low income populations are available across the state. They offer a variety of statewide nutrition classes, food assistance resources and an interactive, patient-facing webpage called Be Healthy PA.
- Expanded Food and Nutrition Education Program (EFNEP): Delivers research-based education in the home, the classroom and in communities to help Pennsylvanians make better nutrition and health decisions.
    - PennState Extension: Offers a variety of nutrition workshops, online courses, videos, and guides designed to help patients live a healthy lifestyle.
- Pennsylvania Department of Transportation: Find information about transportation services available for seniors and persons with disabilities
- Pennsylvania Department of Human Services: Website offers several assistance services, including housing, employment and training programs and food assistance.
- Pennsylvania Department of Aging: Website offers several assistance services, including prescription assistance, help at home, and local programs.
- MedLine Plus: Health Information in Multiple Languages

## 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 the Quality Insights resource, Social Determinants of Health & Your Practice: Tools to Reduce Health Disparities, for access to a two-page summary of steps you can take to screen for SDOH and document services.

## Success Stories: Reducing Disparities in Pennsylvania

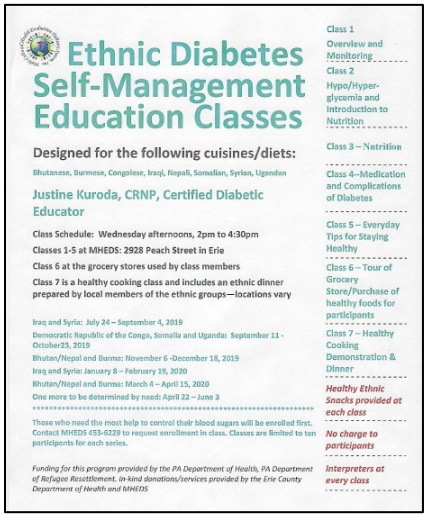
### Community Health and Dental Care: Pottstown, PA (Montgomery County)


As practices increasingly turn their attention to addressing social determinants of health, one PA practice has taken the initiative to help address food insecurity and encourage patients to make healthy food choices. On June 17, 2020, the Care Management Team of Community Health & Dental Care located in Pottstown rolled out a new **EatFresh Program** in cooperation with the Chester County Food Bank.

As part of the program, the team conducted a hypertension and diabetes management outreach to identify patients for enrollment. The EatFresh team then delivered boxes of fresh fruits, vegetables, and yogurt to the homes of the 14 patients (and their families) who participated. Another 13 patients picked up boxes at the local mall. In addition to food supplies, patients received education materials

related to healthy eating, recipes, and cooking safety. They were also given access to take part in live cooking classes using Zoom and related nutritional videos. Interactions with the patients were used as an opportunity to discuss overall well-being, self-management of chronic conditions, and if available, receive a blood pressure check.

The program was very well received; in fact, all patients who agreed to enroll participated in the program. As a result, the Food Bank has agreed to continue partnering with Community Health & Dental Care to expand the program and allow additional participants. This program is currently set to resume June 2021 with continued food delivery and pickups.




## Multi-Cultural Health Evaluation Delivery Systems (MHEDS): Erie, PA (Erie County)

MHEDS is nonprofit, primary care clinic committed to assisting patients in need in the Erie area. Many health care professionals donate time and expertise to MHEDS to deliver health education workshops and resources, and their staff represents many of the populations they serve, including Bosnian, Bhutanese, Burmese, Congolese, Eritrean, Iraqi, Kurdish, Mexican, Puerto-Rican, Russian, Ukrainian, Somalian, Sudanese, and Vietnamese patients.

Because MHEDS provides services to patients representing a wide array of ethnic backgrounds, providing culturally relevant lifestyle change programming can be a challenge. To help address this barrier, MHEDS developed and hosted a no-cost Diabetes Self-Management Education and Support (DSMES) program tailored to the needs of their patients.

Some of the adaptations they implemented included:

- Classes were scheduled with consideration of specific cultural background and cuisine/diet needs. Interpreters were available for every class.
- One class included a visit to grocery stores used by class members to make healthy food purchases.
- A healthy cooking class was hosted that provided an ethnic dinner prepared by local members.

Learn more about the mission and services of MHEDS by visiting their website.

**"The goal of any Blue Zones Project is to have a positive impact on a community's health and well-being to help people not just live longer, but also do so with a good quality of life."**

*-Jennifer Eberlein, Community Program Manager, Blue Zones Project® Corry*

## Blue Zones Project®: Corry, PA (Erie County)

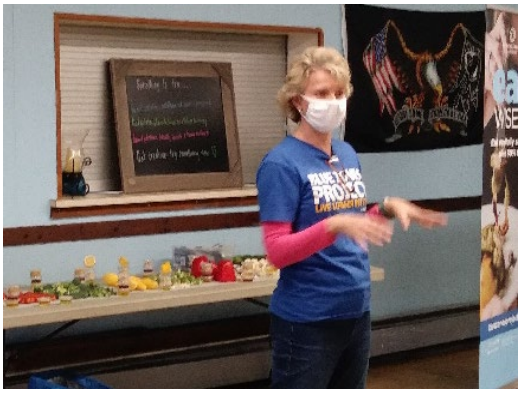
Blue Zones Project® is a national-level, community-focused initiative that provides a holistic and comprehensive solution addressing the key drivers of behaviors in all the places people live, work, learn, and play.

The rural, northwestern city of Corry became the 47th Blue Zones community in the world in June 2019. The $3.5 million cost of the project is funded primarily by UPMC, Highmark Health, and LECOM Health's Corry Memorial Hospital. It also has received $100,000 from the Erie County Gaming Authority and several smaller grants.

At the community level, the Blue Zones Project® is designed to help improve the well-being of residents by lowering rates of chronic diseases and helping people enjoy a higher quality of life.

In Corry, several initiatives are underway to help the community realize this goal and reduce SDOH, including:

1. Partnering together with the local school district, grocery stores, restaurants, and worksites to support student, employee and community well-being.
2. Providing a monthly newsletter for the Corry Area Food Pantry. The newsletter is included with the food that is provided to area residents.
3. Having a presence at the local Farmer's Market to provide well-being resources and information, promote Blue Zones Project® events, community outreach, and more.
4. Hosting community healthy cooking classes.
5. Inviting guest speakers, such as health coaches, to provide well-being presentations.
6. Offering virtual "Purpose Workshops" to help people identify their gifts and talents and to use those to volunteer in the community.
7. Organizing "Walking Moais" (Walking Groups) to meet regularly over a 10-week period.
8. Hosting virtual "Potluck Moais" (groups) to meet once per week for 10 weeks to provide well-being education, usually on a nutrition topic.
9. Facilitating relevant policy work (i.e. built environment/bike & walkability of a community, food and tobacco policy), including partnering with the current Rails to Trails Corry Committee to support & promote use of the trails.



Future community projects for Blue Zones Project® include partnering with the local Salvation Army and Adagio Health to offer nutrition education and cooking demos to Corry residents. Keep up with Blue Zones Project® activities in Corry by visiting their website, or contact Jennifer Eberlein, Community Program Manager, for more information.

## 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.

## Earn Complimentary CME or CNE Credit

Thank you for reviewing the Quality Insights 2022 Social Determinants of Health Practice Module.


If you would like to claim Continuing Medical Education (CME) or Continuing Nursing Education (CNE) credit, please click this link and complete a brief evaluation: Social Determinants of Health Practice Module Evaluation.

If you do not have a Pennsylvania Medical Society account, you will be prompted to create one. For questions related to the PAMED website or evaluation completion, please contact the PAMED Knowledge Center at 855-PAMED4U (855-726-3348) or **knowledgecenter@pamedsoc.org**.

**Accreditation Statement:**

*This enduring material activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Pennsylvania Medical Society and Quality Insights. The Pennsylvania Medical Society is accredited by the ACCME to provide continuing medical education for physicians.*

*The Pennsylvania Medical Society designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

*This course is approved for 1.0 hours of Continuing Education for Nursing. Quality Insights is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.*

**Conflict of Interest Disclosure:**

*The planners and the faculty for this live activity have no relevant financial relationships with ineligible companies to disclose.*

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

Providers and practices who are actively engaged in the PA Department of 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 2022 SDOH Practice Module to help address social determinants of health (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 Ashley Biscardi or call **1.800.642.8686, ext. 137**.

## 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

| | |
|---|---|
| | Partner with Quality Insights to mitigate barriers related to use of SDOH identification tools and ICD-10 codes. |
| | Review and implement 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. If already utilizing PRAPARE, document current workflow and utilization of information gathered in the tool. |
| | Evaluate and report use of SDOH ICD-10 codes. |
| | 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 SDOH 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.**