

Social Determinants of Health Recommendation Framework

Focus Area	Action Steps
Planning	<ul style="list-style-type: none"> • Embed equity principles into organizational mission, vision, values and programming. • Educate staff about health equity, health disparities, the legacy of history on a person’s health, the determinants of health including from social factors, the sensitive nature of the topic, and that screening remains helpful to support whole-person health independent of ability to meet that need. • Adopt existing or develop communication tools to discuss social determinants of health screening and intervention with patients (e.g., do not use jargon, explain how life situation impacts health) <ul style="list-style-type: none"> ○ Clarify that screening for social needs does not necessarily mean that the provider, health, or site will be able to meet that need. • Identify how patient demographics, your location, and/or other assessments done in your region may inform the social needs of your patients. • Prioritize a subset of your population (e.g., pediatrics, diabetes management) prior to rolling out universal screening • Identify roles and responsibilities for staff in the SDoH workflow including how to keep the person’s provider and care team informed of social risk.
Identification	<ul style="list-style-type: none"> • Solicit informed consent prior to screening. • Screen for social determinants of health using a tool adopted from the SIREN and KP Systematic Review of Social Risk Screening Tools, prioritizing at least four domains: housing security, food security, transportation need, and one other high priority/common need identified by the community. <ul style="list-style-type: none"> ○ Screening can be integrated in both inpatient and outpatient settings to inform care plans, discharge planning, and follow-up care. ○ Follow-up screening should occur every time a person interacts with the health system, with a minimum of annual screening updates. • Integrate SDoH questions into pre-screen workflows (e.g. depression, alcohol use) if using written forms. Train staff on handling sensitive conversations (e.g. trauma-informed discussions, motivational interviewing, or “empathic inquiry”) if using a verbal screener.
Tracking and Measurement	<ul style="list-style-type: none"> • Develop and implement best practices for data privacy, patient perceived stigma, and information autonomy when collecting, using and interacting with SDOH data. • Define the site’s attributable population • Integrate screening questions and referral workflows into the EHR • Develop a queryable registry of attributable patient SDOH data and consider using SDOH to stratify other health registries to identify disparities.

	<ul style="list-style-type: none"> • Collect and store local SDOH data with reporting capabilities to facilitate referrals and build the case for the return on investment of social determinants work. • Link SDOH data to HIT vocabulary codes, both content codes (e.g. existing ICD-10 z-codes) and exchanged using nationally accepted HIT standards (CCDA or FHIR). • Commit to sharing information with all authorized community partners • Follow the <u>Gravity Project</u> for future interoperable coded data sets for social risk.
Follow-Up	<ul style="list-style-type: none"> • Develop a site-specific workflow for stratifying patient social need using at least a two-tiered system (i.e. high/low risk) which includes social risk, other physical and behavioral health needs, utilization rates, and urgency of concern. • For patients with relatively lower risks or barriers: Provide a resource list that is clinic-specific, region-specific, or developed in partnership with an existing community information exchange (CIE) or social service resource locator (SSRL). In absence of such a list, refer patients to 211 which is available across Washington state. • For patients with relatively high risks or barriers: If available, documentation of identified need and notification of relevant team members occurs that same day or within 7 days of positive screen by a community health worker, social worker, or patient navigator who can provide care coordination, case management, or warm handoffs to known services. • Integrate intervention workflows into the EHR, through auto-populated referral lists or flagging patients with identified social risk for follow-up. • Participate/invest in a CIE or SSRL that follows Human Services Data Specifications standards and is inclusive of referral management across key stakeholders to facilitate communication and closed loop referrals • Build relationships with local community-based organizations and understand capacity and eligibility requirements. • In the absence of a closed-loop referral system, follow-up with patients who were referred to social services occurs at least annually. • Co-locating social and healthcare services is the best practice for ensuring closed loop referrals and integrated health/social service delivery.
Incentives and Investments	<ul style="list-style-type: none"> • Incent screening for and collecting data on SDOH along the continuum from fee-for-service (FFS) to value-based reimbursement models, aligning with community movement toward VBP <ul style="list-style-type: none"> ○ Reimburse directly for SDOH activities like screening and EHR-data collection ○ Use “pay for success” or provide risk-adjusted capitation and quality payments to free up funds for SDOH interventions. ○ Federal programs like the Health Homes model can provide a framework for reimbursing care coordination as a social determinant intervention

	<ul style="list-style-type: none">○ Include SDOH reporting requirements in contracts but do NOT include cost- or gain-sharing reimbursements for sites based on ability to meet social need.● Invest in CIEs/SSRLs that use Human Services Data Specifications standards and that are inclusive of referral management across key stakeholders● Invest in SDOH pilot projects or learning collaboratives across Washington state that include evaluation and reporting on lessons learned.● Consider investing more healthcare dollars in social service capacity. These investments can include public health investment in health infrastructure, upstream prevention, and integrated care.● Provide funding for an organizing body that can align state-wide healthcare stakeholders, disseminate best practices and standards as they develop, and drive collaboration for social determinants work.
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Stakeholder Checklists

Delivery Organizations

- The organization has a plan for a pilot social determinants of health screening and intervention process beginning with a specific sub-set of the patient population (e.g. diabetes management, in-patient surgical care), with an eventual plan to scale-up to the entire patient population.
- Have a social determinants of health screening tool (whether developed internally or adopted from a national screener) that includes questions to identify social risk in at least four domains—housing, food, and transportation, and a high-priority need identified by the community. Other possible SDOH domains include (but are not limited to):
 - Social Isolation
 - Financial Insecurity
 - Education
 - Broadband
 - Utility Needs
 - Racism
- Solicit informed consent prior to screening.
- Have a standard workflow for SDOH screening based on local staff and technical capacity.
 - If screening is conducted by staff, there is an identified staff member/team responsible for screening (medical assistant, administrative assistant, etc.) who receives trauma-informed training for verbal screening.
 - If screening is self-reported, there is either a paper or electronic screener that is easy for patients to access and integrated into similar workflows for other screening tools (PSQ-9, alcohol use, etc).
- The EHR system captures SDOH information in a way that is visible to providers to help inform care planning and those with high-risk needs are flagged for care coordination and resource referral activities.
- Social risk information is linked to HIT vocabulary codes, both content codes (i.e. existing ICD-10 z-codes) and exchanged using nationally accepted HIT standards (i.e. CCD or FHIR). New standard coded data sets are being developed by the Gravity Project.
- Patients with unmet social needs are stratified into at least two categories: (i.e. high-risk needs and low-risk needs) based on number of unmet social needs, other physical/behavioral health needs, and urgency of need.
 - Those with low-risk needs are provided either a clinic-specific or region-specific resource list or referred to 2-1-1 which is available across Washington state.
 - Those with high-risk needs are given one-on-one assistance by a community health worker, social worker, or patient navigator who can provide care coordination and warm hand-offs to services.
- Prioritize outreach to populations with historical or demonstrated social risk
 - Use patient-identified Race, Ethnicity, and Language (REaL) demographic data and demonstrated historic need to help prioritize high-risk patients.
- There is a designated staff member/team tasked with developing strong partnerships with community-based organizations.

- These staff/team members can go out in the community to understand local social service capacity and eligibility requirements.
- These staff/team members can work with a social service resource locator (SSRL) or community information exchange (CIE) to streamline closed-loop referrals and cross-sector communication.
- Consider co-locating some social services, such as food banks or housing case management, to integrate services.
- Providers are trained or receive access to training on:
 - The effects of social determinants on health outcomes and the importance of care coordination/care planning.
 - Trauma-informed training for social determinants conversations
 - Communication between interdisciplinary team members.
- Patient educational and communication material is available to inform patients about the relationship between their health care and other needs, avoiding jargon (like “social determinants of health”) and clarify that even though social need information is important for care planning, the delivery system may not be able to solve all their identified social needs.

These recommendations not intended to be used in lieu of medical advice.

Patients and Family Members

- Understand the relationship between social needs and healthcare needs.
- Talk to your doctor or care team if you have non-medical concerns that make it difficult to access quality medical care, adhere to your care plan, or negatively impact your health.
- Consider reaching out to your health plan to ask about care coordination services if you have multiple health and social care needs.

Providers

- Understand the importance of social risk screening independent of your ability to provide resources for that identified social need.
- Understand your practice’s social risk screening tool and where you access data about your patient population’s social risk.
- Work with your practice’s interdisciplinary team for social risk screening, including staff responsible for administering screening and staff responsible for referrals to services (if any).
- Acknowledge a person’s individual social risk during a visit with the patient and develop an individual care plan to take these factors into account.
 - E.g. medication storage plans for people who are experiencing homelessness or follow-up visit plans for those without adequate transportation.

Healthcare Based Case Managers and Care Coordinators

- Follow professional standards (such as Case Management Society of America or Commission for Case Management Certification) which include principles such as cultural competency, cultural and linguistic sensitivity, advocacy, anti-racism, and justice.

- ❑ Provide navigation and case management services for patients who are deemed high-risk for unmet social needs including referrals, motivational interviewing, and care planning.
- ❑ Develop policies to provide necessary accommodations for patients with mobility, hearing, cognitive, and other impairments, as well as patients with varying linguistic and cultural needs.
- ❑ When possible, develop ties with local community-based organizations and try to keep up with eligibility requirements, capacity, and referral processes for social service agencies.

Health Plans

- ❑ Collect data on social determinants of health screening participation, including demographics such as patient race and ethnicity.
- ❑ Develop reimbursement mechanisms that encourage social determinants interventions and align with the community movement toward value-based payments:
 - Fee-for-service might look like reimbursement for every social risk screening a practice completes or reimbursement for tracking HIT content codes (e.g. z-codes)
 - Value-based payments like “pay for success” or risk-adjusted capitation models can encourage social determinants interventions as a cost-effective approach to addressing complex care needs.
 - Existing reimbursement models like the Health Homes federal program could provide a framework for reimbursing care coordination activities.
 - While you may include SDOH reporting requirements in contracts, do NOT develop cost-sharing or gain-sharing reimbursements based on the ability to meet social need.
- ❑ Consider investments in technologies that would improve closed loop referrals (CIEs or SSRLs) or in social service capacity at your hospitals. Co-located health and social services are the most efficient way to encourage cross-referrals.

Employers/Benefits

- ❑ Incorporate social determinant of health screening and intervention targets into value-based contracts.
- ❑ Review your benefits plan and vendors with social determinants in mind.
- ❑ Include educational material about the relationship between health and social services in your benefits packages.

Community Information Exchange Vendors

- ❑ Follow Human Services Data Specification standards to support the open and interoperable exchange of community resource directory data.
- ❑ Ensure interoperability inclusive of all referral sources and destinations.
- ❑ Update the resource directory information at least annually.

Washington State Health Care Authority

- ❑ Require Medicaid Managed Care Plans to report on percentage of eligible adults screened for social determinants of health and by race and ethnicity.

- ❑ Require Medicaid Managed Care Plans to offer care coordination aligned with NCQA accreditation.
- ❑ Encourage Value Base Payment reimbursement models to encourage providers to address social determinants of health
- ❑ Do NOT develop cost-sharing or gain-sharing reimbursements for sites based on the institution's ability to meet social need.

Washington State Department of Health

- ❑ Continue to develop regional community information exchange hubs for care coordination as an interoperable resource for health and social service partners.
 - ❑ Develop a sustainable plan for these regional hubs to continue beyond the state's Medicaid Transformation project.
- ❑ Develop training and resources for a community-based workforce that can screen for social risk and connect patients to resources.

Washington State Legislature

- ❑ Mandate health plan reporting on available race and ethnicity data for all quality performance metrics.
- ❑ Increase funding for provider social determinant of health projects, interoperable community information exchanges for care coordination, public health infrastructure, and social service capacity.
- ❑ Follow the federal "Improving Social Determinants of Health Act" ([H.R. 6561/S. 4440](#)) this legislative cycle as an example of possible social determinant legislation that could be adapted for Washington state.