

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 (i.e. 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:
 - Social Isolation
 - Stress
 - Financial Insecurity
 - Unemployment
 - Education
 - Broadband
 - Utility Needs
 - Racism
 - Neighborhood Safety
 - Intimate Partner Violence
- Solicit informed consent prior to screening.
- There is 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.) and trained in empathic inquiry for verbal screening.
 - If screening is self-reported, there is either an SDOH paper or electronic screener that is easy for patients to access and integrated into similar workflows to other screeners (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 need 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. CCDA or FHIR). New standard coded data sets are being developed by the Gravity Project.
- Patients are stratified by social risk into two categories: those with high-risk needs and those with low-risk needs.
 - 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 followed-up with 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 or community information exchange 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.
 - Empathic inquiry for social determinants conversations
- 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 complex 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.
 - Ex. Include medication storage plans for people who are experiencing homelessness or follow-up visit plans for those without adequate transportation.

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, and justice.
- Provide navigation and case management services for patients who are deemed high-risk for 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:
 - Fee-for-service might look like reimbursement for every social risk screening a practice completes or reimbursement for tracking 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.
 - Do NOT develop cost-sharing or gain-sharing reimbursements for sites based on the institution’s ability to meet social need.
- Consider investments in technologies that would improve closed loop referrals (Community Information Exchanges and Social Service Resource Locators) 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 (e.g., Centers of Excellence, Accountable Care Organizations)
- Include educational material about the relationship between health and social services in your benefits packages.

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 work with community-based hubs for care coordination.
 - 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, community-based hubs for care coordination and information exchange, and social service capacity.
- Follow the "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 adopted state-wide