Social Determinants of Health Recommendation Framework

Focus Area	Action Steps
Identification	• Ensure that staff prioritize equity, are conscious of the sensitive nature of the topic, and that screening remains helpful to support whole-person health independent of ability to meet that need • Develop communication tools to discuss SDOH screening and intervention with patients. Do not use jargon like "social determinants." Explain how their life situation may affect their health and well-being. Be clear that screening for social needs does not necessarily mean that the health system will be able to meet that need. Solicit informed consent prior to screening. • Employ "empathic inquiry" when conducting SDOH screening in-person. • Screen all persons/persons with X for unmet social determinant of health needs using the SIREN and KP Systematic Review of Social Risk Screening Tools to adopt an existing SDOH screener or adapt existing questions for local needs. • Identify how patient demographics, your location, and/or other assessments done in your region may inform the social needs of your patients • Tailor questions to community needs identified as high priority
Tracking and Measurement	• Develop a registry of patient SDOH data • Collect and store SDOH data to facilitate referrals and build the case for the return on investment of social determinants work. • Utilize ICD-10 z-codes for social risk. Follow the Gravity Project for future interoperable coded data sets for social risk. • Integrate screening questions and referral workflows into the EHR
Follow-Up	• Stratify by social need using a two-tiered system (i.e. high/low risk) • For low-risk needs: In the absence of a resource list that is clinic-specific, region-specific, or a partnership with an existing organization (e.g., Unite Us), use 211 which is available across Washington state • For high-risk needs: If available, follow-up occurs that day or within X days by a community health worker, social worker, or patient navigator who can provide care coordination, case management, or warm handoffs to known services. • Integrate workflow into the EHR, through auto-populated referral lists, or flagging patients with identified social risk for follow-up • Participate/invest in a community information exchange or social service resource locator to facilitate cross-sector communication and closed loop referrals • Build relationships with local community-based organizations and understand their capacity and eligibility requirements. • Co-locating social and healthcare services is the best practice for ensuring closed loop referrals and integrated health/social service delivery.

Incentives and Investments	• FFS models can provide reimbursements for SDOH activities like screening and EHR-data collection to incentivize implementation. • Value Based Payments models can use “pay for success” or provide risk-adjusted capitation payments which free up funds for social determinant interventions. • Federal programs like the Health Homes model can provide a framework for reimbursing care coordination as a social determinant intervention • Purchasers can include SDOH reporting requirements in their contracts • Consider directly investing more health care dollars in social service capacity. • Consider other investments including emerging CIE or SSRL technology or specific SDOH pilot projects or learning collaboratives.