Social Determinants of Health Recommendation Framework

Focus Area	Action Steps
Planning	• Embed equity principles into organizational mission, vision and values. • 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) ○ Clarify that screening for social needs does not necessarily mean that the health system 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	• 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.
	    ○ 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. Employ "empathic inquiry" if using a verbal screener.

Tracking and Measurement	• Integrate screening questions and referral workflows into the EHR • Develop a registry of patient SDOH data and consider using SDOH to stratify other health registries to identify disparities ○ Consider data privacy, patient perceived stigma, and information autonomy when developing the SDOH registry. • 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. • SDOH data should be linked to HIT vocabulary codes, both content codes (Existing ICD-10 z-codes) and exchanged using nationally accepted HIT standards

	(CCDA or FHIR). Follow the Gravity Project for future interoperable coded data sets for social risk.
Follow-Up	• Stratify patient social need using at least 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 communication and closed loop referrals • Build relationships with local community-based organizations and understand 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 • Screening for SDOH should not be tied to intervention for auditing purposes • Invest in CIEs/SSRLs that use Human Services Data Specifications for standardized community resources and that are inclusive of referral management across key stakeholders • Invest in funding for SDOH pilot projects or learning collaboratives at clinical sites across Washington state and include evaluation and follow-up. • Consider directly investing more health care dollars in social service capacity.