COMMUNITY HEALTH CARE ASSOCIATION of New York State
chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

SOCIAL DETERMINANTS OF HEALTH

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Introductions

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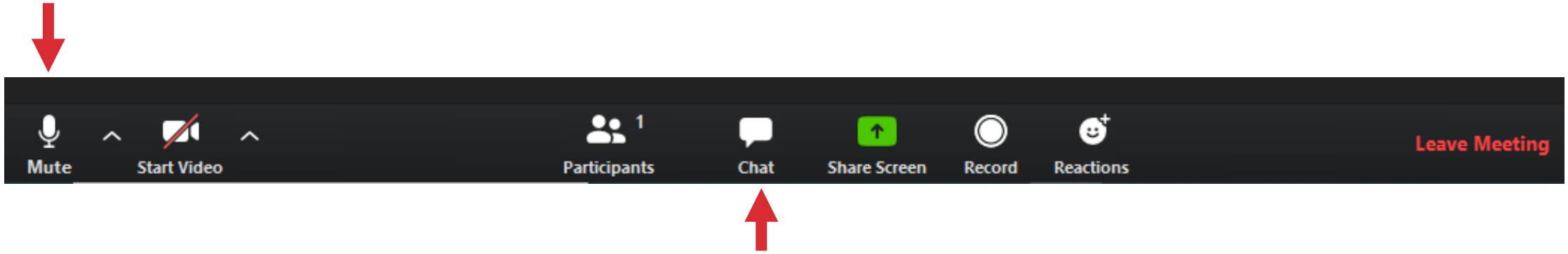
New CHCANYS' Social Determinants of Health Webpage

Housekeeping

- Phones have been muted to prevent background noise
- Use the chat box to type questions during the webinar
- This webinar is being recorded and will soon be available to all participants
- Tell us how we did in the evaluation, at the end of each session, and a follow-up evaluation will be sent 3 months from today

Zoom Meeting Controls

1. Manage your audio:
    - Dial ***6** to mute your phone, if your phone does not have a "Mute" button. Dial ***6** again to unmute.
    - Tap the "Mute" button on your phone or computer. Tap the "Mute" button again to unmute when you want to speak.



2. Use the chat box throughout the webinar

COMMUNITY HEALTH CARE ASSOCIATION of New York State

Part I: Social Determinants of Health Standardized Assessment Tools Overview

March 19, 2021

Agenda

I. Welcome

II. Social Determinants of Health - Terminology Review

III. Overview of 5 Social Risk Screening Tools

IV. Questions & Answers

V. Closing Remarks

Learning Objectives

To provide a comprehensive review of the most popular social needs screening tools among NY Community Health Centers

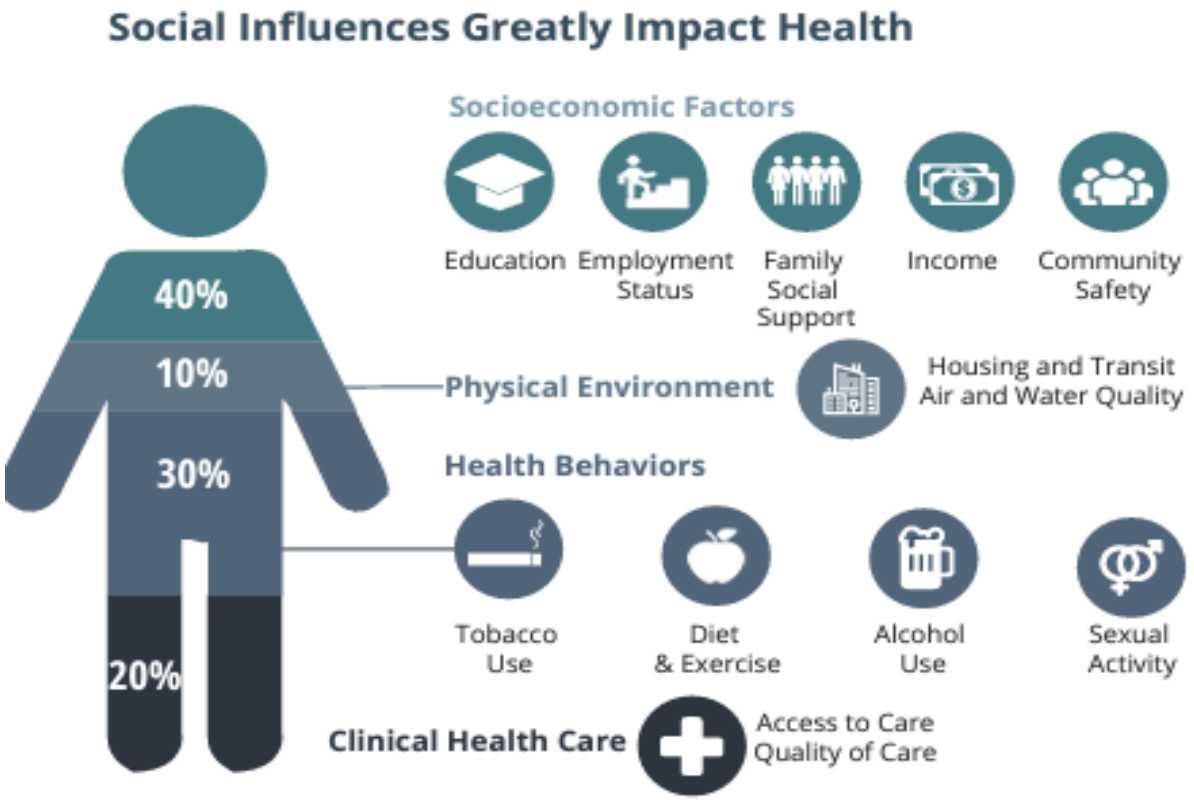
To discuss the benefits of integrating social and clinical care and standardized documentation

To share implementation resources, and action steps to begin or expand Social Determinants of Health work


The Path to Achieving Health Equity
What social and economic factors must be addressed on the continued path to achieving Health Equity?
Discrimination/Minority Stressors
Housing
Food Security and access to healthy foods
HEALTH is affected by
Educational Opportunities
Stable Income & Job Security
Quality Affordable Healthcare
Environmental Quality
Neighborhood Conditions
Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.
The Health Equity Institute
http://healthequity.sfsu.edu
1600 Holloway Avenue, HSS 359
San Francisco, CA 94132
P: 415-405-2540
HEALTH EQUITY INSTITUTE for Research, Practice & Policy
San Francisco State University
Find us on:

"Improving population health requires partnership and breaking down silos among health care, public health and social services."

Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health, January 2019.



Hood, CM, Gennuso, KP, Swain, GR, & Catlin, BB. (2015). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine.*

Terminology Overview

Training Resource

What are Social Needs?

Social needs are individual needs. Social needs are the patient's role in identifying and prioritizing social interventions.

Examples:

- food/water/utilities
- shelter/stable housing
- safety
- employment/job
- transportation, etc.
- access to care/medications
- access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)

What are Social Risk Factors?

Social risk factors are defined as the adverse social conditions associated with poor health. These make up the underlying factors in the arena of Social Determinants Of Health (SDOH).

SDOH: Economic Stability

- Employment
- Food Insecurity
- Housing Instability
- Poverty

SDOH: Education Access and Quality

- Early Childhood Education and Development
- Enrollment in Higher Education
- High School Graduation
- Language and Literacy

SDOH: Health Care and Quality

- Access to Health Care
- Access to Primary Care
- Health Literacy

SDOH: Social and Community Context

- Civic Participation
- Discrimination
- Incarceration
- Social Cohesion
- Social Integration

SDOH: Neighborhood and Built Environment

- Access to Foods that Support Healthy Eating Patterns
- Crime and Violence
- Environmental Conditions
- Quality of Housing

Source: A Social Determinants of Health Lexicon for Health Care Systems, June 2019.

Social Determinants of Health Domains

- *Economic Stability* refers to any measure of a person's finances and the ability or inability of an individual or family to afford basic life necessities.
- *Education* refers to the degree to which an individual has completed various levels of schooling or formal education. This could include public, private, or technical school or an extracurricular course or apprenticeship.
- *Health Care Access* refers to health and wellbeing of individuals and whether they have access to quality clinical care.
- *Social & Community Context* refers to the immediate social setting in which people live or in which something happens or develops. It includes the culture that an individual was educated or lives in, and the institutions with whom they interact.
- *Neighborhood & Physical Environment* refers to the land, air, water, plants, animals, buildings, other infrastructure, and all-natural resources that provide our basic needs and opportunities for social and economic development.

Overview of 5 Standardized Social Risk Screening Tools

Sources:

1. Social Needs Screening Tool Comparison Table | SIREN
2. Systematic Review of Social Risk Screening Tools | Kaiser Permanente

Poll Question #1

What tool, if any, are you currently using at your health centers?

Please select all that apply

- Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)
- Health Leads
- Accountable Health Communities Health-Related Social Needs (AHC-HRSN)
- WeCare
- Montefiore Social Determinants of Health Screen
- My organization is not screening at this time
- Other

1. PRAPARE Tool

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.

www.nachc.org/prapare

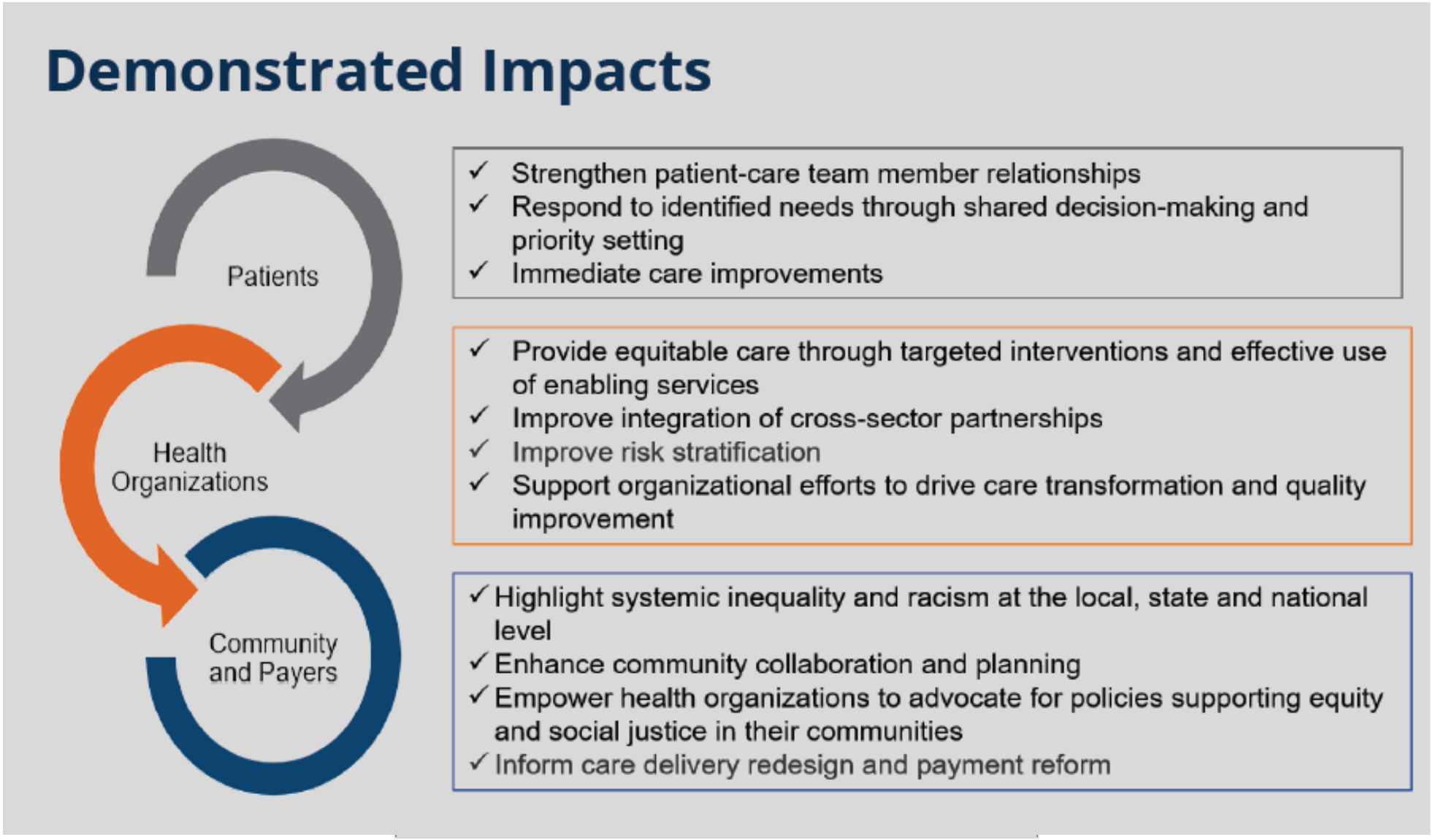
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE Overview

It is a 13-36-item questionnaire that addresses needs across 5 SDOH domains: economic stability, education, social & community context, health and clinical care, and neighborhood & physical environment.

- Year Created: 2016
- Reading Level: 8th grade
- Reported Completion Time: 11 minutes
- Patient or Clinic Population: **Community Health Centers/FQHCs**
- Languages: **English plus 25 other languages** (PDF)
- Electronic Health Record Availability: **Yes & Comprehensive Reporting**
- **Reporting Capabilities**: most EMRs, eBO PRAPARE for eCW users, Cognos, Azara DRVS (CPCI) & more
- Website & Implementation Toolkit: https://www.nachc.org/research-and-data/prapare/toolkit/

"What is PRAPARE?" Infographic



2. Health Leads Tool

It is a 7-item questionnaire assessing needs across 4 SDOH domains: economic stability, education, social & community context, and neighborhood & physical environment.

- Year Created: 2016
- Reading Level: 6th grade
- Reported Completion Time: Not Reported
- Patient or Clinic Population: Primary Care
- Languages: English & Spanish
- Electronic Health Record Availability: Yes
- Reporting Capabilities: w/ EMRs, Azara DRVS (CPCI)
- Website & Implementation Toolkit: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Health Leads Overview

SOCIAL NEED DOMAINS	EXAMPLES
Food Insecurity	Limited or uncertain access to adequate food
Housing Instability	Homelessness, unsafe or unhealthy housing conditions, inability to pay mortgage/ rent, frequent housing disruptions, eviction
Utility Needs	Difficulty paying utility bills, shut off notices, access to phone
Financial Resource Strain[2]	Inability to afford essential needs, financial literacy, medication under-use due to cost, benefits denial
Transportation Challenges	Difficulty accessing or affording transportation (medical or public)
Exposure To Violence[3]	Intimate partner violence, elder abuse, community violence
Socio-Demographic Information	Race and ethnicity, educational attainment, family income level, languages spoken

[2] Questions about financial resource strain often produce a high false positive rate; review these questions carefully

[3] These categories will likely require a more highly skilled workforce than other types of social needs

3. Accountable Health Communities Health-Related Social Needs (AHC-HRSN)

It is a 10-item screening tool, with 16 supplemental questions, to identify patient needs that can be addressed through community services in 3-5 SDOH domains: economic stability, education, social & community context, health and clinical care, and neighborhood & physical environment.

- Year Created: 2017
- Reading Level: 8th grade
- Reported Completion Time: Not Reported
- Patient or Clinic Population: Primary Care/Medicare & Medicaid
- Languages: English
- Electronic Health Record Availability: Yes
- Reporting Capabilities: w/ EMRs, Azara DRVS (CPCI)
- Website & Implementation Toolkit: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

AHC-HRSN Overview

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

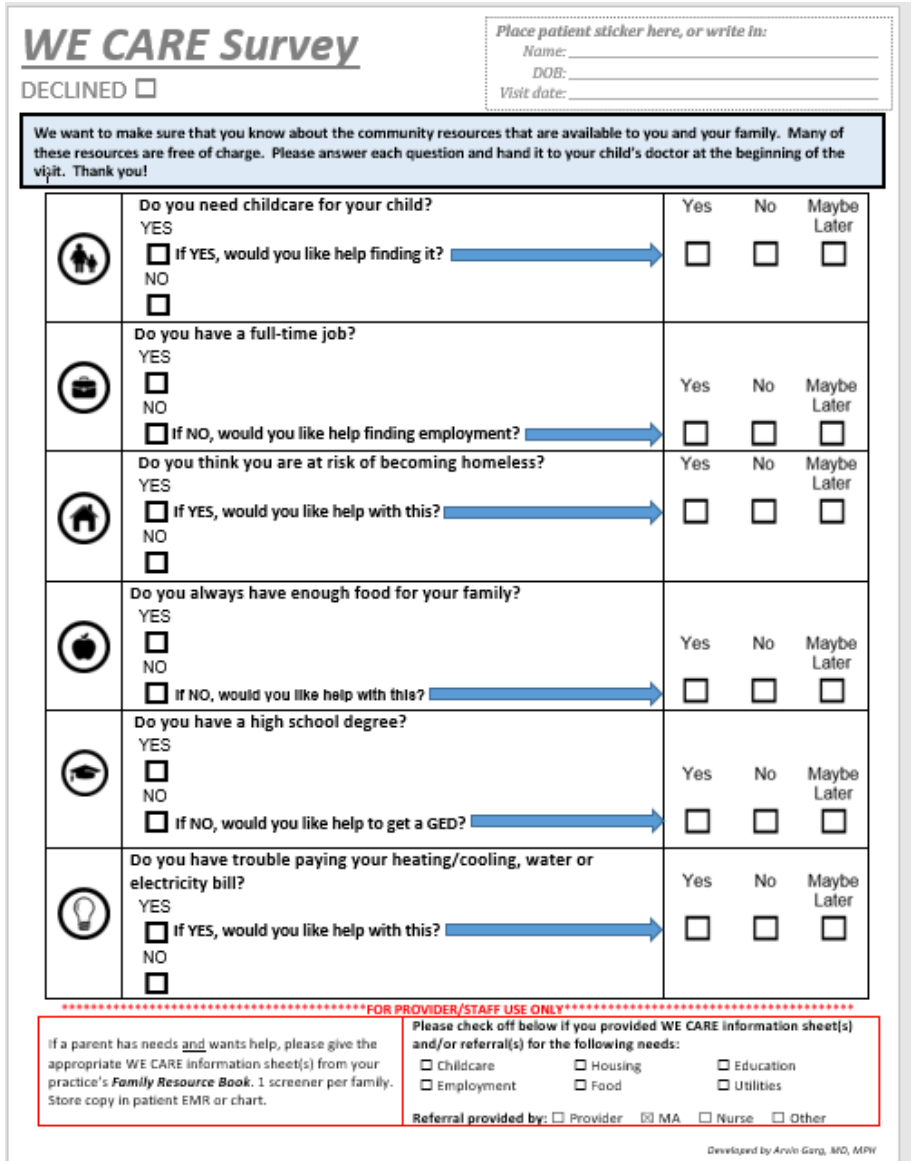
Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

4. WeCare Tool

Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE) is a clinic-based screening and referral system developed for pediatric settings. The 12-question WE CARE screening tool assesses needs, including parental educational attainment, employment, child-care, risk of homelessness, food security, and household heat and electricity.

- Year Created: 2007
- Reading Level: 9th grade
- Reported Completion Time: 5 minutes
- Patient or Clinic Population: Pediatrics & Primary Care
- Languages: English
- Electronic Health Record Availability: Not Reported
- Reporting Capabilities: Not Reported
- Website & Implementation Toolkit: https://sirenetwork.ucsf.edu/tools-resources/mmi/we-care

WE CARE Overview



WE CARE Survey

DECLINED ☐

Place patient sticker here, or write in:
Name: _____
DOB: _____
Visit date: _____

We want to make sure that you know about the community resources that are available to you and your family. Many of these resources are free of charge. Please answer each question and hand it to your child's doctor at the beginning of the visit. Thank you!

		Yes	No	Maybe Later
	Do you need childcare for your child? YES ☐ If YES, would you like help finding it? → NO ☐	☐	☐	☐
	Do you have a full-time job? YES ☐ NO ☐ If NO, would you like help finding employment? →	☐	☐	☐
	Do you think you are at risk of becoming homeless? YES ☐ If YES, would you like help with this? → NO ☐	☐	☐	☐
	Do you always have enough food for your family? YES ☐ NO ☐ If NO, would you like help with this? →	☐	☐	☐
	Do you have a high school degree? YES ☐ NO ☐ If NO, would you like help to get a GED? →	☐	☐	☐
	Do you have trouble paying your heating/cooling, water or electricity bill? YES ☐ If YES, would you like help with this? → NO ☐	☐	☐	☐

**********FOR PROVIDER/STAFF USE ONLY**********

If a parent has needs and wants help, please give the appropriate WE CARE information sheet(s) from your practice's ***Family Resource Book***. 1 screener per family. Store copy in patient EMR or chart.

Please check off below if you provided WE CARE information sheet(s) and/or referral(s) for the following needs:

☐ Childcare ☐ Housing ☐ Education
☐ Employment ☐ Food ☐ Utilities

Referral provided by: ☐ Provider ☒ MA ☐ Nurse ☐ Other

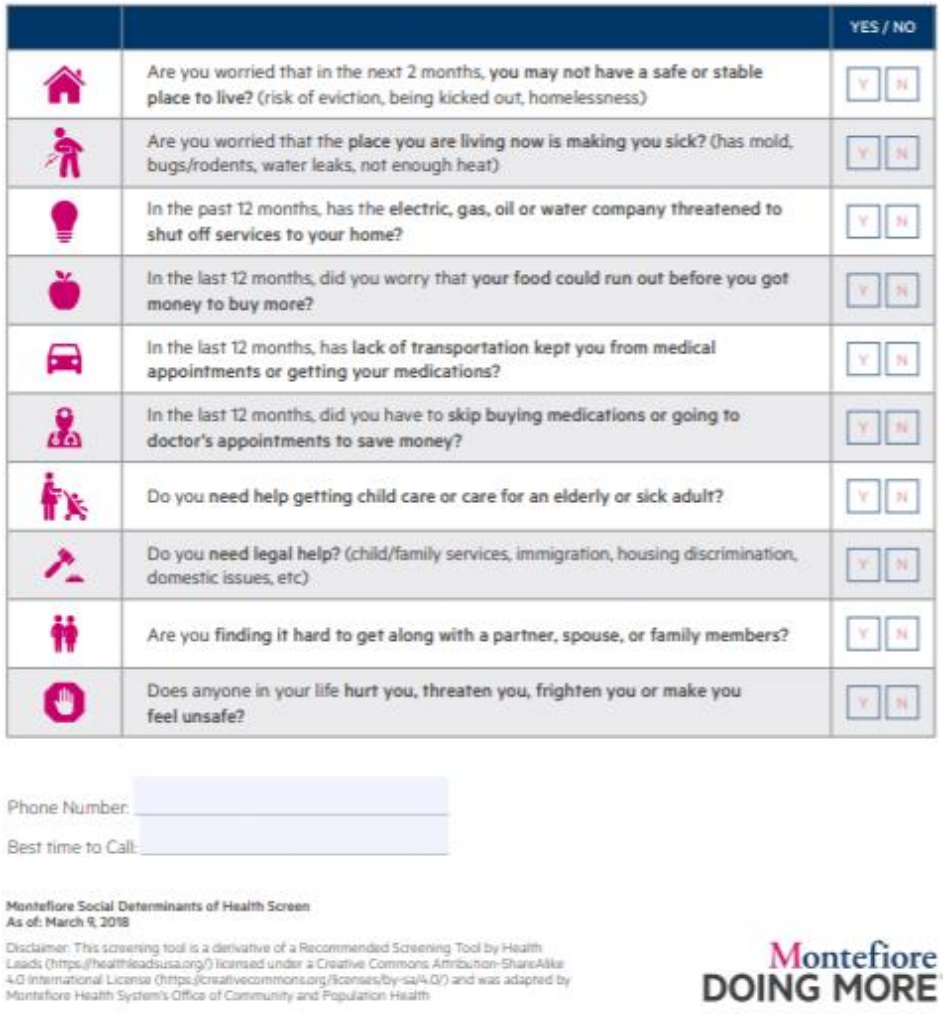
Developed by Arvin Garg, MD, MPH

5. Montefiore Social Determinants of Health Screen Tool

It is a 7-item questionnaire assessing needs across 5 SDOH domains: economic stability, education, social & community context, health and clinical care, and neighborhood & physical environment.

- Year Created: 2018
- Reading Level: 6th grade
- Reported Completion Time: Not Reported
- Patient or Clinic Population: Adults
- Languages: English & Spanish
- Electronic Health Record Availability: Yes
- Reporting Capabilities: w/ EMRs, Azara DRVS (CPCI)
- Website & Implementation Toolkit: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/docs/montefiore_sna.pdf

Montefiore SDOH Screen Tool Overview



		YES / NO
	Are you worried that in the next 2 months, **you may not have a safe or stable place to live?** (risk of eviction, being kicked out, homelessness)	Y N
	Are you worried that the **place you are living now is making you sick?** (has mold, bugs/rodents, water leaks, not enough heat)	Y N
	In the past 12 months, has the **electric, gas, oil or water company threatened to shut off services to your home?**	Y N
	In the last 12 months, did you worry that **your food could run out before you got money to buy more?**	Y N
	In the last 12 months, has **lack of transportation kept you from medical appointments or getting your medications?**	Y N
	In the last 12 months, did you have to **skip buying medications or going to doctor's appointments to save money?**	Y N
	Do you **need help getting child care or care for an elderly or sick adult?**	Y N
	Do you **need legal help?** (child/family services, immigration, housing discrimination, domestic issues, etc)	Y N
	Are you **finding it hard to get along with a partner, spouse, or family members?**	Y N
	Does anyone in your life **hurt you, threaten you, frighten you or make you feel unsafe?**	Y N

Phone Number: _____

Best time to Call: _____

Montefiore Social Determinants of Health Screen
As of: March 9, 2018

Disclaimer: This screening tool is a derivative of a Recommended Screening Tool by Health Leads (https://healthleadsusa.org/) licensed under a Creative Commons Attribution-ShareAlike 4.0 International License (https://creativecommons.org/licenses/by-sa/4.0/) and was adapted by Montefiore Health System's Office of Community and Population Health

Montefiore
DOING MORE

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Q
A

Poll Question #2

What additional information and resources does your health center need to more effectively use the PRAPARE/other SDOH tool?

Please select all that apply

- Training or resources on effective processes for data collection
- Resources to help patients address identified needs
- Assistance with reporting, using, and/or acting on the data
- EMR Vendor support (e.g., EMR, ICD-10 Z coding)
- Technology to support data capture (e.g., iPads, patient kiosks)
- Training or resources on getting support/buy-in from organizational leadership, governing board, patients, and/or clinical staff
- Other

PRAPARE & ICD-10 Z Codes Crosswalk Tool

https://bit.ly/3tAvKOr

Community Health Care Association of New York State
Social Determinants of Health (SDOH) - Technical Assistance (TA)

This tool is a crosswalk between the PRAPARE tool and its corresponding ICD-10 Z codes in the electronic medical record system (EMR). In addition to social risk factor data, it is important to code for social complexities using ICD-10 Z codes and dummy CPT codes to track, monitor, and close the loop on the services provided to patients with identified social needs. CPT codes, or procedural codes, describe what kind of "procedure" a patient has received while ICD codes, or diagnostic codes, describe any diseases, illnesses, or conditions a patient may have. PRAPARE/SDOH data & Social Intervention documentation is needed to demonstrate value to payers/stewards and seek adequate financing to ensure interventions are sustainable while creating an integrated, value-driven delivery system to reduce total cost of care.
PRAPARE Assessment Tool available at https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

PRAPARE Questions – SDOH Domains/Constructs	PRAPARE Responses – Social Risk Factors	ICD-10 Z Codes	Z Code Description	Social Intervention (SI)/Referral for identified social need (dummy CPT codes optional):
Current Housing Situation	I have no housing	**Z59.0**	Homelessness	SI-HS Housing Support Services
Worried About Losing Housing	Yes	**Z59.9**	Problem related to housing and economic circumstances, unspecified	SI-FC Financial Counseling/Eligibility Assistance
Education	Less than high school	**Z55.0**	Illiteracy and low-level literacy	SI-ED Education Support Services
Employment	Unemployed but seeking work	**Z56.0**	Unemployment, unspecified	SI-EM Employment Supportive Services
Other Needs/Financial Needs	Food, Clothing, Phone, Utilities, Childcare, Medicine or any health care, Other	**Z59.4** **Z59.6** **Z59.5** **Z63.6** **Z59.8**	Lack of adequate food and safe drinking water Low income Extreme poverty Dependent relative needing care at home Other problems related to housing/economic circumstances	SI-FD Food Supportive Services SI-CL Clothing Supportive Services Si-PH Phone Supportive Services SI-UT Utilities Supportive Services SI-CC Child Care Supportive Services SI-MH Medicine or Health Care Supportive Services SI-OM Other Materials Supportive Services
Transportation	Yes, Medical & Yes, Non-Medical	**Z75.3** **Z75.4**	Unavailability and inaccessibility of health-care facilities Unavailability and inaccessibility of other helping agencies	Si-MT Medical Transportation Services SI-NMT Non-Medical Transportation Services
Social Support	1-2 times per week and less than once	**Z60.8**	Other problems related to social environment	SI-SI Social Integration Supportive Services
Stress	Quite a bit and very much	**Z73.3**	Stress, not elsewhere classified	SI-ST Mental Health Supportive Services
Incarceration	Yes	**Z65.2**	Problems related to release from prison	SI-IN Incarceration Supportive Services
Safety	No	N/A	If the patient's response is a NO, that is a flag.	SI-ST Safety Supportive Services
Domestic Violence	Yes	**Z63.0**	Problems in relationship with spouse or partner	SI-DV Domestic Violence Support Services
Refugee Status	Yes	**Z65.3**	Problems related to other legal circumstances	SI-RF Refugee Supportive Services
Country of Origin	Other than USA	N/A	PRAPARE smart form in eClinicalWorks	PRAPARE eBO report for "free text" answers

Key Factors for Success

Understand the WHY

- Health Equity lens

Standardized SDOH Screening

- Have patient-centered screening principles for all screenings such as empathy, respect, trust, autonomy – tool agnostic

Team-based Care Approach

- Deploy a social need screening and intervention workflow and co-design the workflow with leadership and care team members

Document and Monitor Performance

- Screening tool & ICD-10 Z codes in the EMR

Social Intervention & Close the Loop

- Have a process for positive screens/social interventions

Develop a Data Strategy

- Analyze and develop a robust SDOH data strategy

Act

- Use SDOH data to drive transformation and community partnerships

https://www.youtube.com/watch?v=ZPVwgnp3dAc

Announcement

PRAPARE Smart Form Subsidy for eClinicalWorks Users:

CHCANYS has a limited-time opportunity expiring in *June 2021* to support health centers' systematic collection and response to patients' social needs by subsidizing the PRAPARE smart form in eClinicalWorks for a limited number of health centers.

If your health center is interested, please contact Gabriela Gonzalez at **ggonzalez@chcanys.org**.

Webinar Evaluation- Part I

Link: https://bit.ly/3erZZmh

Closing Remarks

LUNCH &LEARN series

- April 16: Part II - Leading with Empathy: Organizational Strategies for Effective Leadership and Patient Care
  - Presenters: Ariel Singer, the lead designer of Empathic Inquiry & Laurie Francis, Executive Director at Partnership Health Center
- May 21: Part III - Promising Practices to Address SDOH for Patients with Chronic Diseases
  - Presenter: Laurie Levasseur MSN/MHA, Practice Administrator at Hometown Health Centers

SCAN ME

Link: https://bit.ly/2OKEMJn

Social Determinants of Health Resources

- CHCANYS' Social Determinants of Health Webpage
- NACHC Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
- HITEQ Resource | Federal Activities and Approaches to Advance Social Determinants of Health Data Use and Interoperability in Support of Community Health Centers
- San Francisco State University| Health Equity Institute Resources
- Research on Integrating Social & Medical Care | SIREN https://sirenetwork.ucsf.edu/
- Kaiser Permanente Washington Health Research Institute
- The Gravity Project | A consensus-driven standards on Social Determinants of Health https://confluence.hl7.org/display/GRAV/The+Gravity+Project
- Centers for Medicare & Medicaid Services | State Health Official (SHO) letter: Opportunities in Medicaid and CHIP to Address Social Determinants of Health


рахмат
danke
謝謝
ngiyabonga
spas
teşekkür ederim
Баярлалаа
mersi
kia ora
barka
welalin
tack
mahalo
tapadh leat
спасибо
faafetai lava
vinaka
blagodaram
dank je
misaotra
matondo
paldies
grazzi
спасибі
kiitos
dankie
nanni
nandri
dhanyavad
thank you
gracias
хвала
asante
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