A NEW APPROACH TO SDOH SCREENING & FOLLOW-UP

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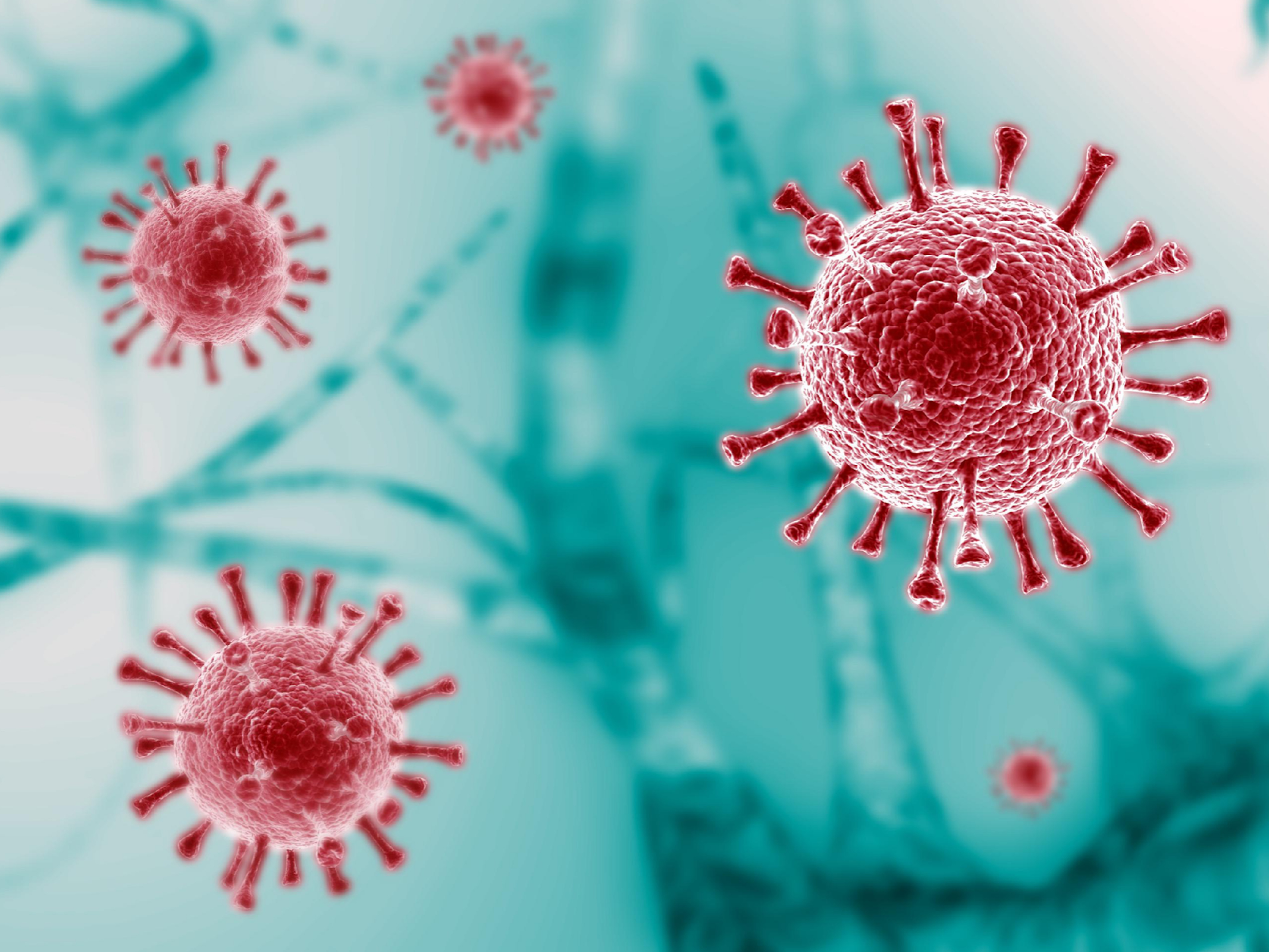
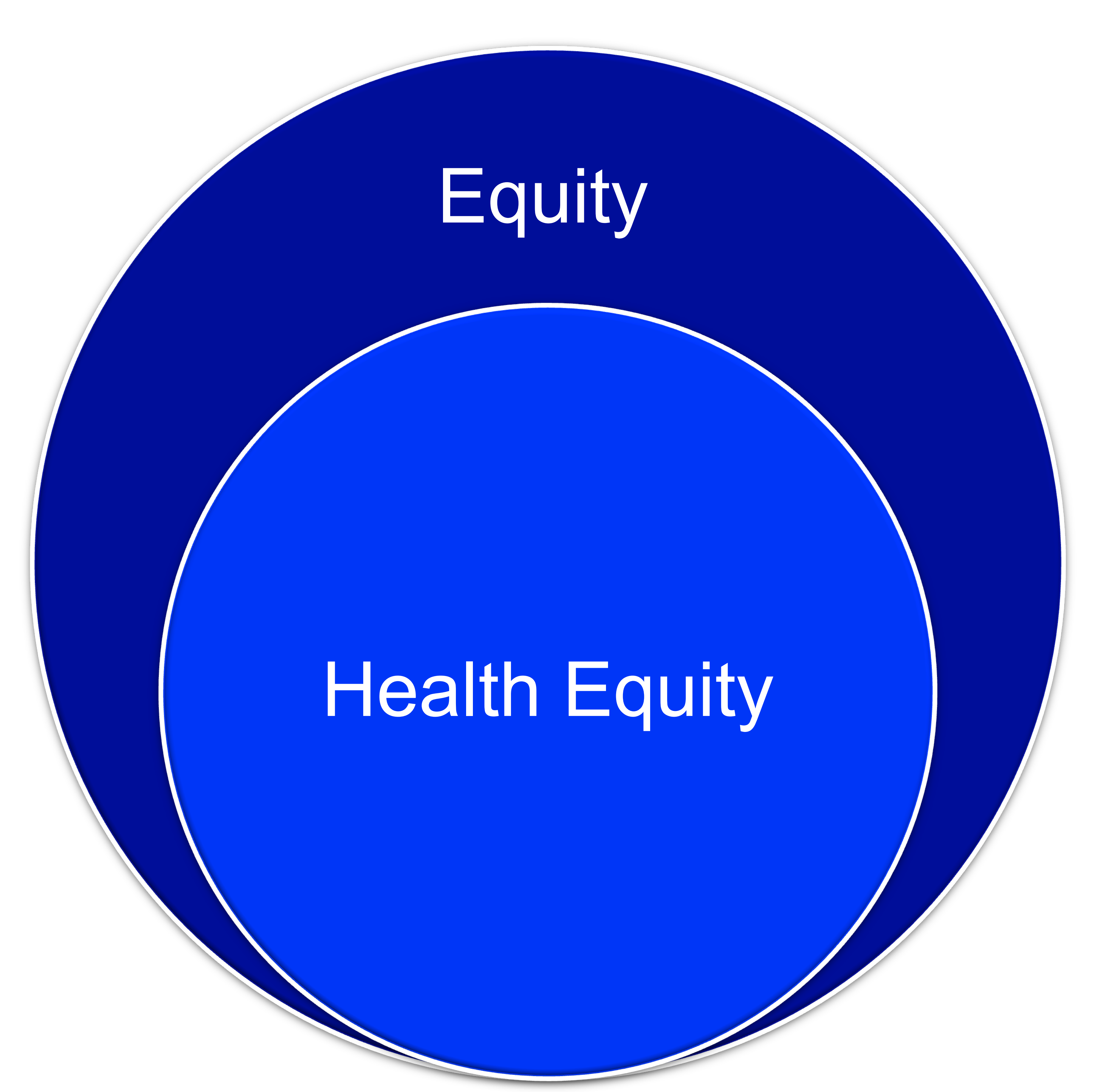
May 16, 2024



HEALTH EQUITY

Health equity means that everyone has a fair and just opportunity to be as healthy as possible



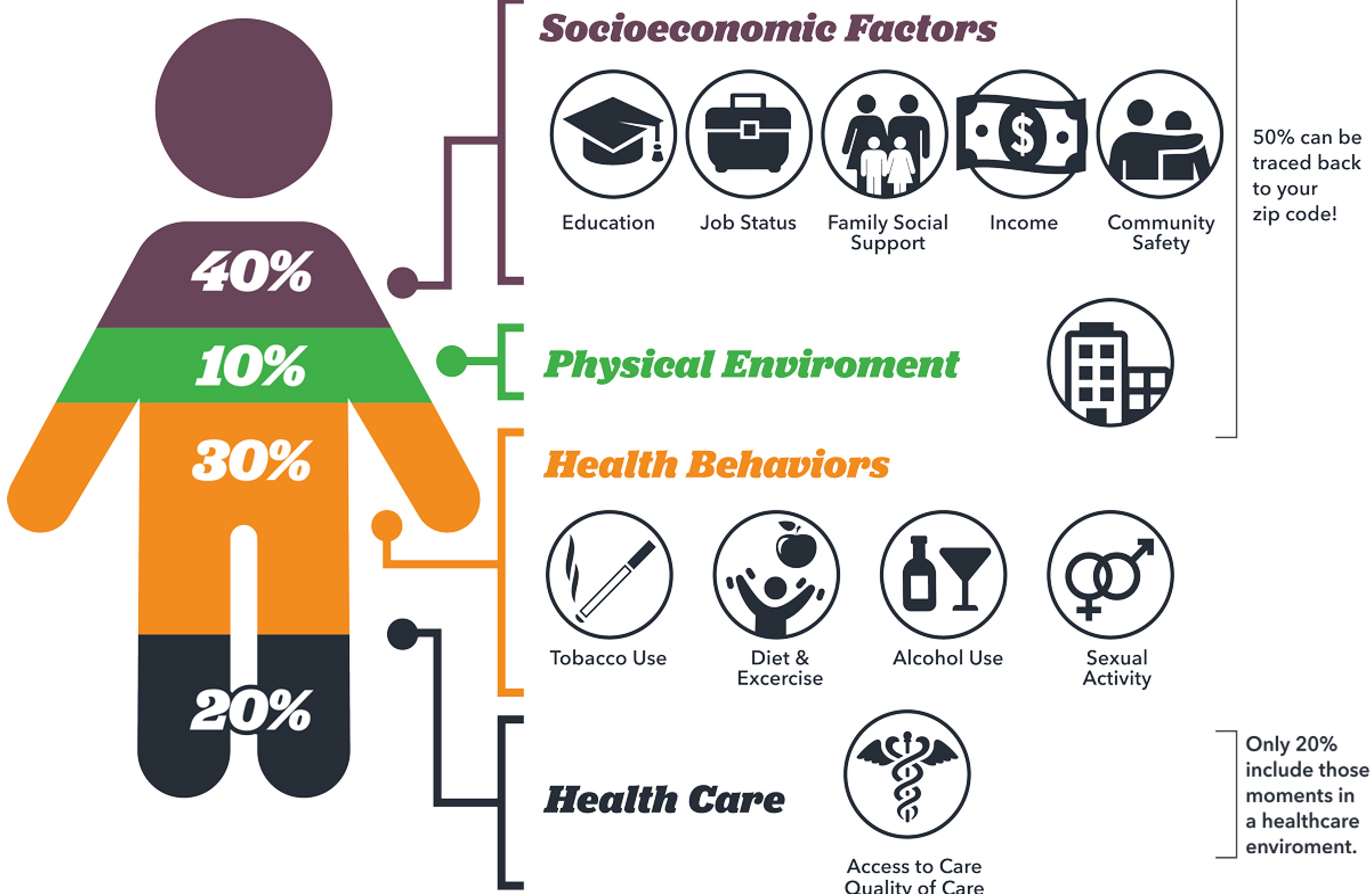
This requires **removing obstacles to health** such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare

- Robert Wood Johnson Foundation

Social Drivers of Health

The circumstances in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.

\- World Health Organization



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Structural Racism: The Root Cause of the Social Determinants of Health

September 22, 2020 · The Petrie-Flom Center Staff · Blog Symposia, Criminal Law, Doctor-Patient Relationship, Featured, Health Law Policy, History, Medical Quality, Patient Care, Public Health, Race, Social Determinants of Health, Understanding the Role of Race in Health

Taking an Anti–Health Inequity Approach to Counter the Unfair Burden of Poor Health

Sandro Galea, MD, DrPH, and Roger Vaughan, DrPH, MS

unevenly borne, as groups with fewer assets shoulder much of the burden of depression and anxiety nationally.[7] Akre et al. (https://bit.ly/3ePy67c) in this issue of *AJPH* add to this literature by showing that the rates of depression, anxiety, and alcohol use were higher among LGBTQ+ (lesbian, gay, bisexual, transgender, queer and other spectrums of sexuality and gender) people than among cisgender straight/heterosexual

UMass Memorial Health

REGULATIONS & REQUIREMENTS

The Joint Commission

CMS

EOHHS/MassHealth

Hospital Equity Incentive Program

MassHealth ACO Contractual Obligations and Equity Incentive Program

- Begin reporting of SDOH **Screening Rate** and **Positivity Rate** in CY 2024, performance-based by 2026.
- Screen for **4 domains using validated screening questions**
  - Housing Instability
  - Food Insecurity
  - Transportation Needs
  - Utility Difficulties
- **Follow-up on identified needs** by linking to community resources

UMMH VALUES

Deliver in a culturally-sensitive and patient-centered way

- Build trust with patients
- Mitigate experiences of double loss (e.g., not providing assistance if a patient asked for help)
- Minimize racial, ethnic and language inequities with screening, referral, and enrollment outcomes

Minimize Impact on caregiver/staff workload

- Automate when possible
- Streamline to remove duplicate work
- Identify new supports for navigation

Design screening questions thoughtfully

- Differentiating **'Risks'** (required by regulations and used for Z-codes) from **'Needs'** (basis for follow-up and intervention)
- Focus on screening for needs with actual/ tangible referrals and solutions

Developed by system-wide, multidisciplinary working group

ASKING ABOUT SDOH

Asking patients questions about their daily lives may feel uncomfortable but *if we don't ask, we won't know*

When patients give us their trust and share this information, we can use it to:

- Create a care plan that meets the patient's needs
- Connect patients to resources within the health system or community
- Improve overall health outcomes

EXPERIENCING DOUBLE LOSS

Double loss: Disclosing sensitive information without getting help frustrates parents

- Parents framed the disclosure of a social need as one loss
- Not getting help as a second loss

Parents did not want to just "talk it out" with pediatricians but wanted help instead

www.publicagenda. org/pages/its-about-trust-low-income- parents-perspectives-on-how-pediatricians-can-screen-for-social- determinants-of-health

WE CARE

Well Childcare Visits

Evaluation

Community Resources

Advocacy

Referral

Education

WE CARE intervention increased the referral **(70% vs 8%)** of adverse social determinants of health and receipt of resources **(39% vs 24%)** at low-income children's WCC visits

Source: Garg A et al. *Pediatrics*. 2007.. **Funded by**: The Commonwealth Fund

REAL WORLD CONDITIONS

- **29% of visits had WE CARE screener** documented
- **43% WE CARE families received resource referral** at a well-child visit in first 3 years of child's life
- **41% of parents** who asked for help on the WE CARE screener **did not get a referral (double loss)**
- **Asian and Vietnamese speaking parents** had higher odds for double loss (**64-67%**)
- Parents experienced double loss had **significantly lower WCV and immunization adherence**

Garg A et al. *Pediatrics.* 2023.

A NEW APPROACH

Launched in Primary Care April 16th, Inpatient launch June 25th

- **Updated screening tool** with new questions addressing social risks and needs
- More opportunities for patients to complete SDOH screening **prior to visits**
  - myChart and Get Well
- New ways to **help find and provide resources**
  - Updates to CommunityHELP to simplify search for community resources
  - Virtual resource navigation through partnership with Get Well
  - Improved resource guides for eight domains across UMMH service area
- **Improved visualization of SDOH results and data**
  - SDOH screening results visible across all care settings
  - Ability to document and view follow-up actions taken on patient needs

SCREENING TOOL

- Redesigned “two part” SDOH screening tool
  - Combination of Accountable Health Communities (CMS) and modified WE CARE screening tools
  - Appears as one questionnaire to patients
- Consistent experience for patients across care settings and screening methods
- Paper version of screening tool available in UMMH’s top seven languages

PART ONE:SOCIAL RISKS

- Questions come from standardized, validated screening tools
- Meets new regulatory requirements around SDOH screening
- Inform the use of diagnostic ICD-10 z-codes

PART TWO:SOCIAL NEEDS

- Assess patients’ desire for resources or assistance
- Drive follow-up efforts from the care team and vendor partner
- May not match patients’ responses to social risk questions

SDOH QUESTIONNAIRE

We would like to ask some questions about your life. We ask these questions because we may be able to help with any concerns you share with us. We ask every patient these questions. Your healthcare team may share your answers with other staff who may be able to help. Your answers are part of your medical record and are kept confidential.

Living Situation

1. What is your living situation today?
   - ○ I have a steady place to live
   - ○ I have a place to live today, but I am worried about losing it in the future.
   - ○ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ○ Prefer not to answer

2. Think about the place you live. Do you have problems with any of the following? (Choose all that apply)
   - ○ Pests such as bugs, ants, or mice
   - ○ Mold
   - ○ Lead paint or pipes
   - ○ No clean drinking water
   - ○ Lack of heat
   - ○ Oven or stove not working
   - ○ Smoke detectors missing or not working
   - ○ Water leaks
   - ○ None of the above
   - ○ Prefer not to answer

Utilities

3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - ○ Yes
   - ○ No
   - ○ Already shut off
   - ○ Prefer not to answer

Food

Some people have made the following statements about their food situation. Rate whether each statement is often true, sometimes true, or never true.

4. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ○ Often true
   - ○ Sometimes true
   - ○ Never true
   - ○ Prefer not to answer

5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ○ Often true
   - ○ Sometimes true
   - ○ Never true
   - ○ Prefer not to answer

6. Are you receiving SNAP and/or WIC? (check all that apply)
   - ○ Yes, SNAP
   - ○ Yes, WIC
   - ○ No
   - ○ Prefer not to answer

Transportation

7. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
   - ○ Yes
   - ○ No
   - ○ Prefer not to answer

WE CARE: CONNECTING YOU TO COMMUNITY RESOURCES

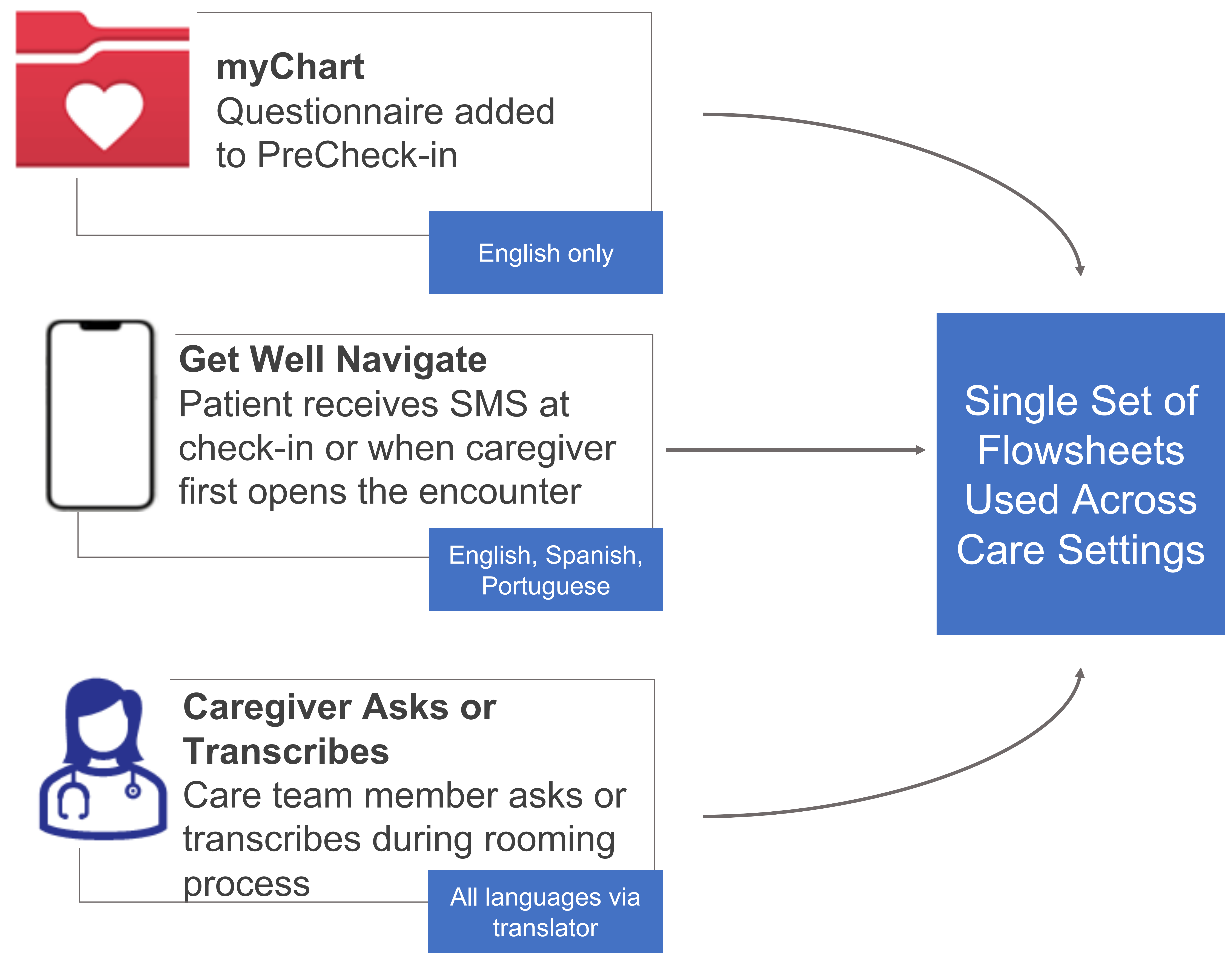
Please answer the questions below. If you say "yes," we will reach out to you with information about community resources by text, telephone, or in-person.

If you do NOT want to answer these questions today, please decline here: **DECLINE** ☐

Question		
Would you like help finding food resources? (Examples: SNAP, WIC, food pantries)	☐ YES	☐ NO
Would you like help finding housing resources? (Examples: housing programs, shelters, tenant rights)	☐ YES	☐ NO
Would you like help paying for utilities through community organizations or state programs?	☐ YES	☐ NO
Would you like help getting to medical visits? (Examples: regional transit programs, shuttle or ride services)	☐ YES	☐ NO
Would you like help finding support for medication costs?	☐ YES	☐ NO
Would you like help finding employment or adult education programs? (Example: job search center, English as Second Language (ESL) class, GED program)	☐ YES	☐ NO
Would you like help finding support for personal care? (Examples: bathing, dressing, walking, etc)	☐ YES	☐ NO
Would you like help finding childcare? (Examples: daycare, after school programs)	☐ YES	☐ NO

Can we share your name and contact information with community partners who may be able to help with your needs? ☐ Yes ☐ No

MULTIPLE METHODS FOR SCREENING



VISUAL MANAGEMENT

View recent screening data in Storyboard and Longitudinal Plan of Care

History

General
Medical
Surgical
Family

Social Determinants
Vaping
Substance & Sexual ...
Socioeconomic
Social Documentation
Military History
SDOH

Specialty
Birth
Obstetrics

Social Drivers of Health

Social Drivers of Health — Expand All Collapse All

Housing
Apr 1, 2024: High Risk

Transportation Needs
Apr 1, 2024: Unmet Transportation Needs

Utilities
Apr 1, 2024: Patient Declined

Food Insecurity
Apr 1, 2024: Patient Declined

SDOH Risks

Flowsheet Row	Follow-Up from 4/1/2024 in UMass Memorial Medical Center- University Campus Primary Care Clinic with Stephen B Erban, MD
SDOH Risks	
What is your living situation today?	I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY.	Prefer not to answer
Food Insecurity	
Within the past 12 months, you worried that your food would run out before you got the money to buy more.	Patient declined

New tab for SDOH data in History

FOLLOW-UP SUPPORTS

Printed Resource Sheets

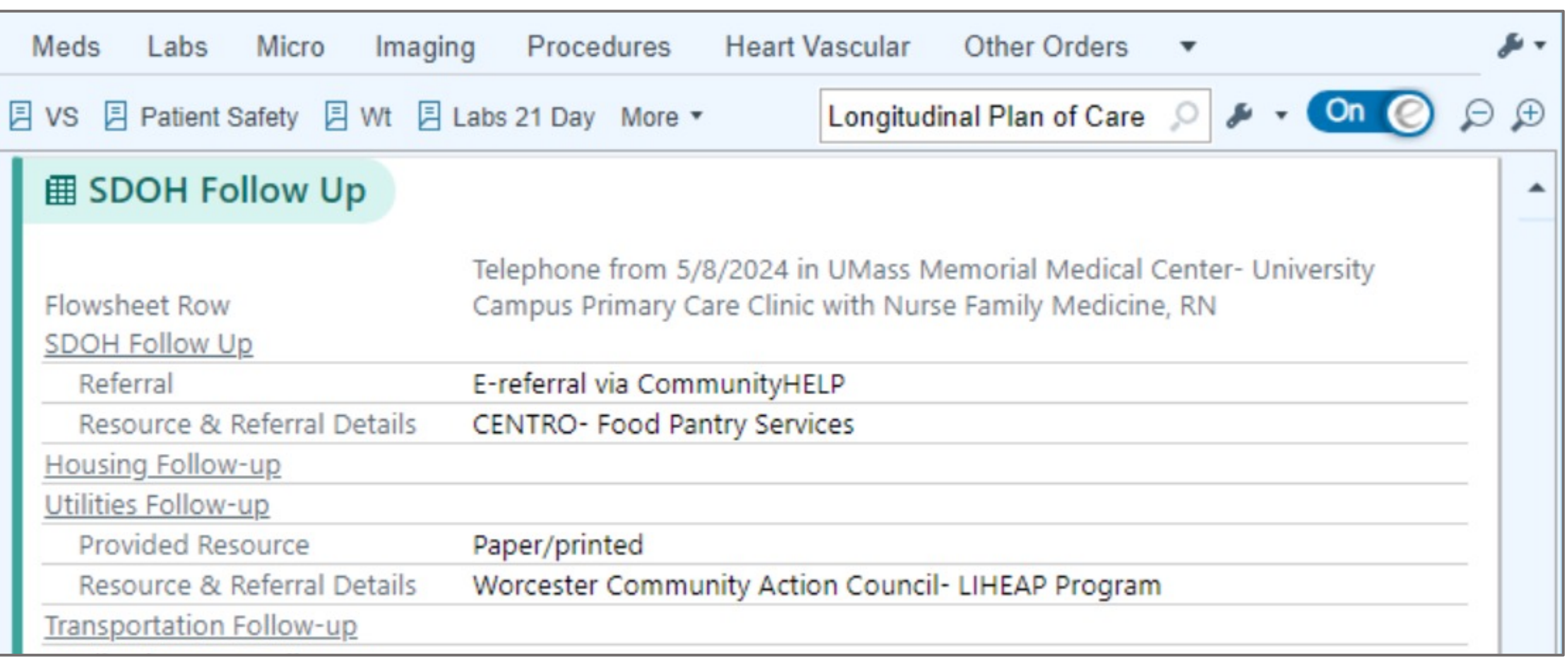
AVS General Info on CommunityHELP and community resources for identified needs

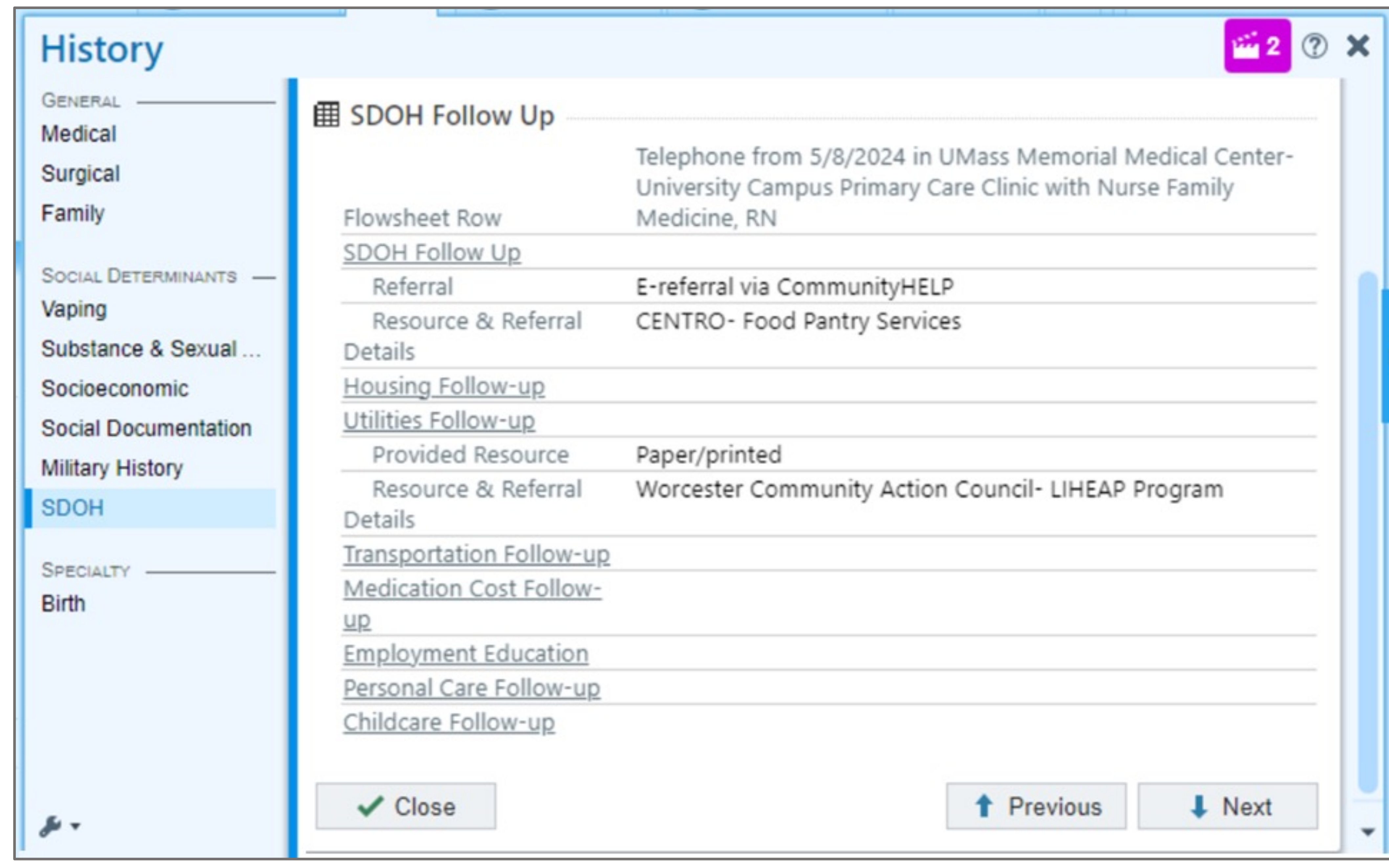
Get Well Navigate

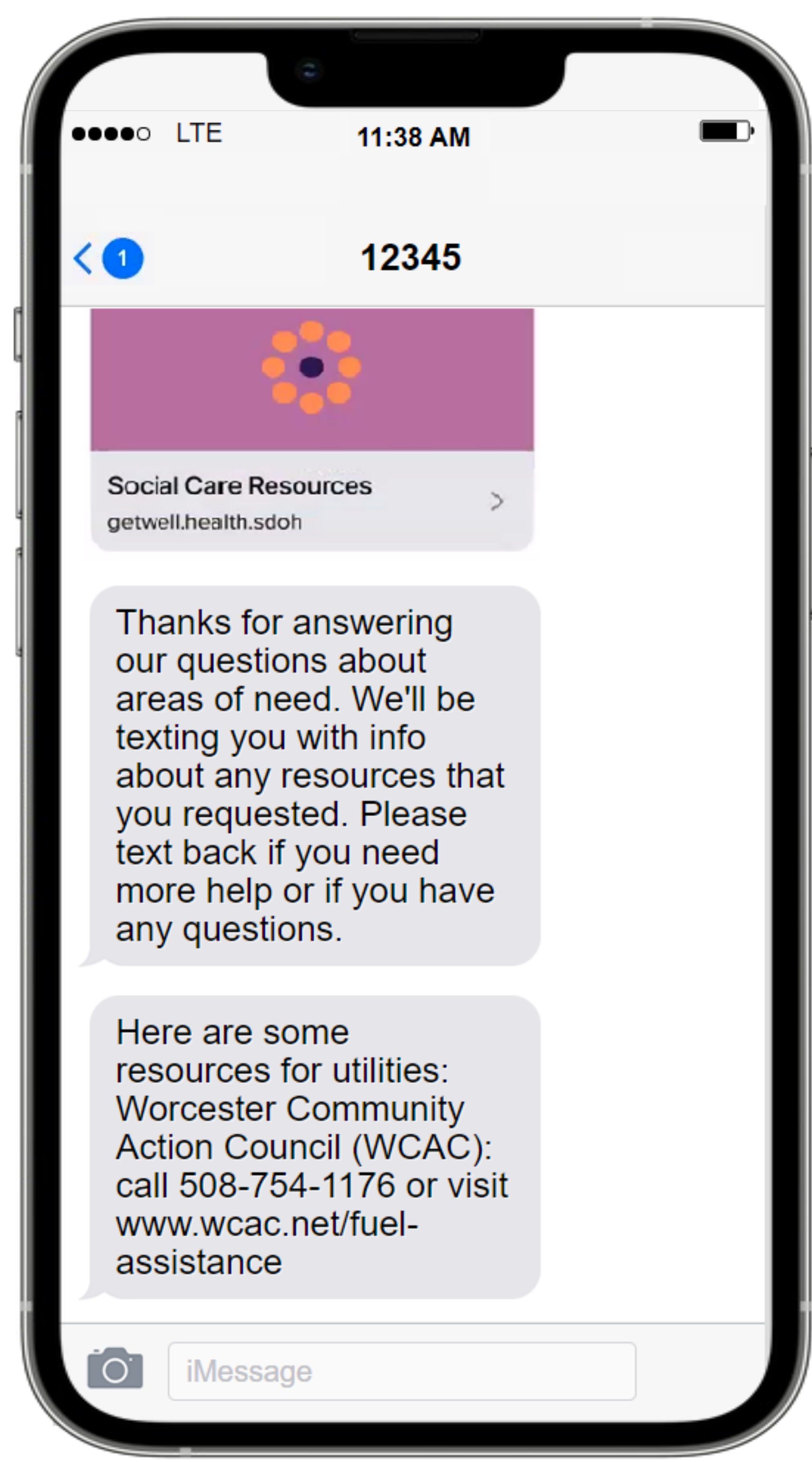
Caregiver launches and searches CommunityHELP

CHW or Social Work--where available

FOLLOWING UP ON NEEDS







Any information regarding outreach or resources provided by Get Well will flow into this flowsheet and be visible to care team

COMMUNITYHELP

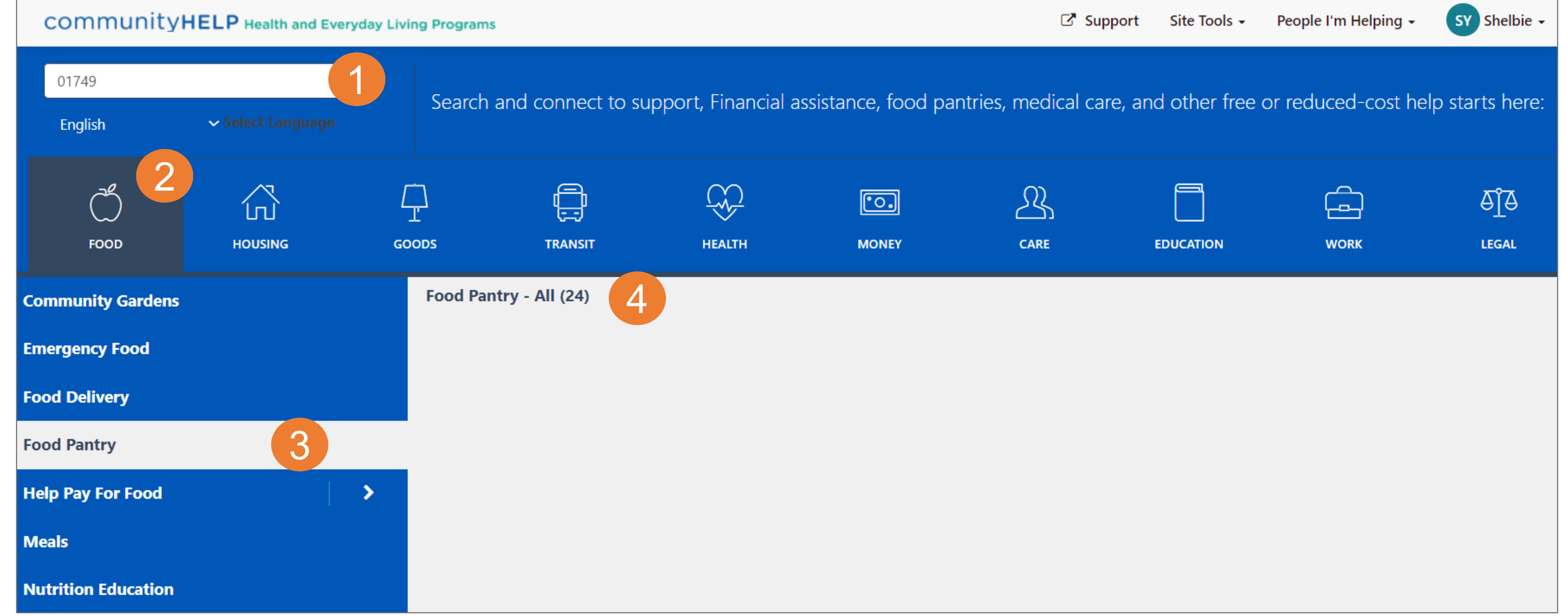
Find under Clinical Resources > Other Resources in your Epic toolbar

Search for resources in all domains by ZIP code

New icons for all eight "needs" domains (including emergency housing)

View resources in all domains by region (preferred programs)

NAVIGATING COMMUNITYHELP



NAVIGATING COMMUNITYHELP

hudson, ma (01749) / food / **food pantry (24)**

Sort by RELEVANCE **CLOSEST**

Personal Filters | Program Filters | Income Eligibility

Map | Satellite

Acton, Concord, Lancaster, Hudson, Sudbury, Marlborough, Northborough, Westborough, Framingham, Ashland, Hopkinton, Wellesley

Google | Map Data | Terms | Report a map error

Notice out-of-date information or see a program you work for? Click **Suggest** to share an update or claim your program listing to get access to free tools and data.

Food Pantry

by **Hudson Community Food Pantry**

Recommended Program

Hudson Community Food Pantry distributes food to those who have difficulty purchasing enough food to avoid hunger. This program provides:- FoodDocuments Required:- Proof of enrollment in a program...

Main Services: food pantry

Serving: adults 18+, benefit recipients, low-income

Next Steps:

Email hcfp28@gmail.com to get more info.

1.38 miles (serves your local area)

28 Houghton St, Hudson, MA 01749

Closed Today See open hours

MORE INFO | SAVE | SHARE | NOTES | SUGGEST | CONTACT ON THEIR SITE

Marlborough Community Cupboard

by **United Way of Tri-County**

Reviewed on: 05/09/2024

Featured Program

Our Marlborough Community provides support to individuals and families who find themselves experiencing economic and personal challenges by providing food assistance and programs that promote...

Main Services: food pantry

Serving: anyone in need, all ages, individuals, families, low-income

Next Steps:

Contact or go to the nearest location.

2.97 miles (serves your local area)

255 Main Street, Marlborough, MA

SHARING RESOURCES

Select “More Info” to print

Share via email or SMS

Select from 100+ languages

Confirm patient consent before sharing

MORE INFO

SAVE

SHARE

NOTES

SUGGEST

SEE NEXT STEPS

Tell someone about this program!

SEND AN EMAIL

SEND A TEXT

SHARE ON FACEBOOK

Your Name*

Shelbie Y.

To*

patient.name@email.com

Email of the person you're sending this to.

Message

Here's the information for the food pantry we talked about today- they are open every Saturday from 9am-11am and some Tuesday evenings.

Let them know your thoughts on this program.

Email Language

English

Confirm Consent*

☑ I have consent from this person to send them this program information.

SEND

We'll email them your message with a link to this program listing.

METRICS TO DATE

As of May 13th

- 23,840 patients screened
- 19.3% patients identified at least one area of risk
  - 6.5% with food insecurity
  - 5.5% with housing insecurity
  - 4.5% with transportation needs
  - 2.9% with utility difficulties
- 8.1% patients identified at least one area of need

Screening Method Breakdown

- myChart- 49.8%
- In Practice- 37.9%
- Get Well- 12.3%

UMASS MEMORIAL HEALTH

Community Healthlink | Harrington | HealthAlliance-Clinton Hospital | Marlborough Hospital
UMass Memorial Medical Center | UMass Memorial Medical Group | UMass Memorial Accountable Care Organization