AHN Successful Implementation of SDOH Screening and Follow-Up

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AHN

Beginning…

Everybody always welcomes change, especially when they're comfortable. Right?

Usually not. When we began planning for implementing screening for social determinants of health, we knew we'd need to be:

- Strategic
- Patient
- Supportive

We weren't going to run to the finish line, but it was important to keep it in view.

Spoiler alert- the course is always changing in healthcare, and we've needed to be flexible and rethink the finish line.

Using PCMH Concepts as a Guide to SDOH Screening

1. AHN Primary Care introduced Redesign in Fall 2017 with a select group of practices, based on attribution, readiness and interest in partnering in a pilot program (PCMH). We used a shared learning format to educate practices on the PCMH model.

2. As a component of **Team-Based Care**, we added behavioral health and social work extended care team members to serve as a resource for newly implemented depression and SDOH screenings. Adding BHC appointments also increased **Patient-Centered Access and Continuity of Care**, as patients are able to schedule with a behavioral health professional right in the primary care office, avoiding long waits for new referrals.

3. We began working with Highmark Health in 2019 to:
   a) Roll out the AHN Community Support platform (aka FindHelp)
   b) Identify which evidence-based questions would be included in our screening.

4. Began documenting interventions to comply with CMS, aligning with nationwide **Population Health Management** standards.

5. Worked with Highmark and Patient Family Advisory Councils to identify strengths and opportunities in our processes. We then implemented improvements in our training materials from feedback PFAC provided.

6. **Measure performance** by tracking completion rates and follow-up using EHR fed reports.

7. Implemented changes as regulatory requirements were established.

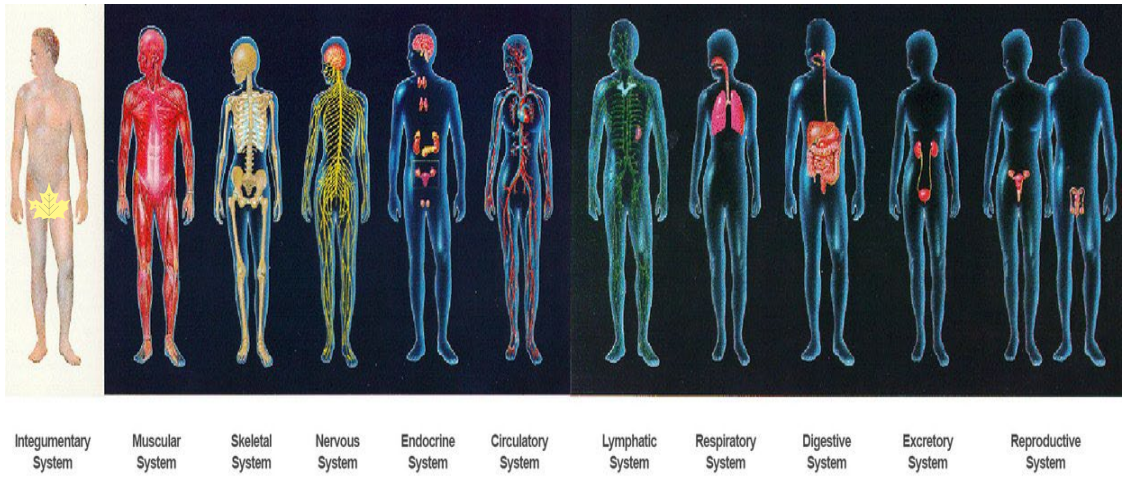
8. Trained staff in Motivational Interviewing to increase confidence and understanding of human behavior.

9. Worked with staff to identify vulnerabilities during **care transitions and coordinate care** with the appropriate teams to improve patient outcomes.

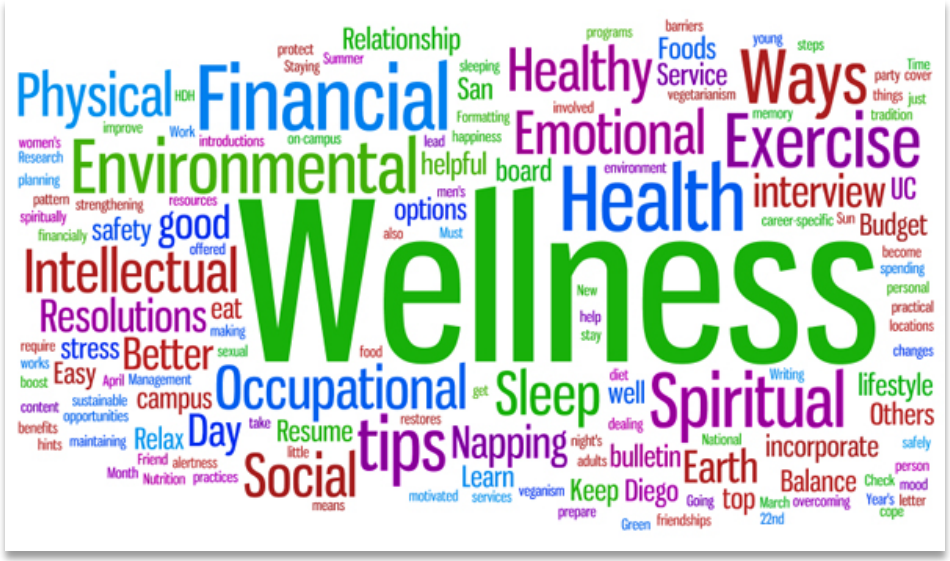
Staff Education

Through a series of cohort learning collaboratives, we educated staff on what SDOH is and discussed how we are shifting our view as healthcare continues to evolve. This was supported by the Highmark Enterprise.

Traditional view of health

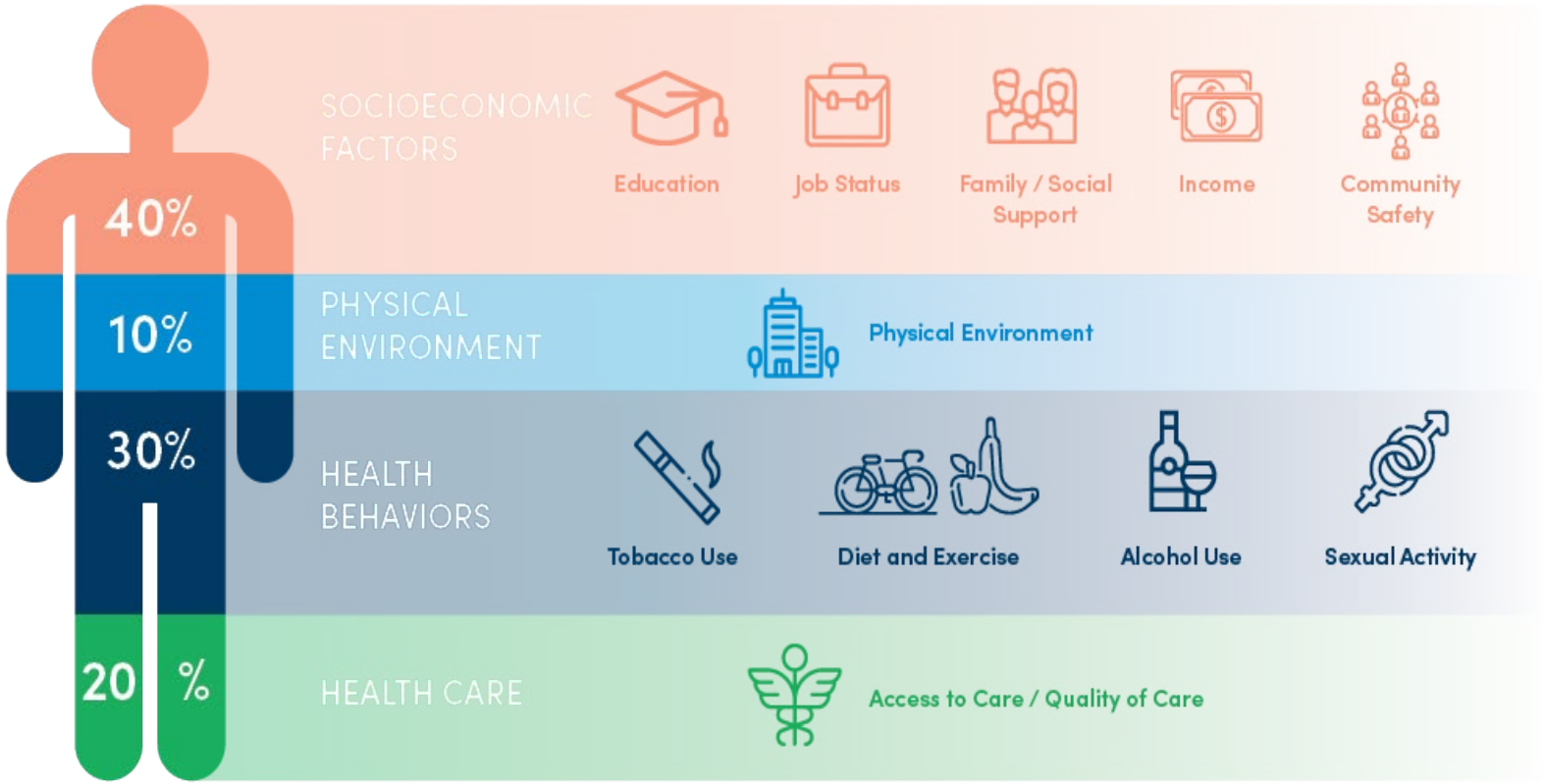


Our aim for viewing health



Why are Social Determinants of Health Important?

We anticipated that staff would take some time to adjust to a new way of thinking about healthcare. Ensuring that they understood the **"why"** and **"how this relates"** was a key component to training. We used existing data to support our strategic plan.



SDOH Impact

- **20%** of a person's health and well-being is related to **access to care and quality of services**
- The **physical environment, social determinants, & behavioral factors** drive **80%** of health outcomes

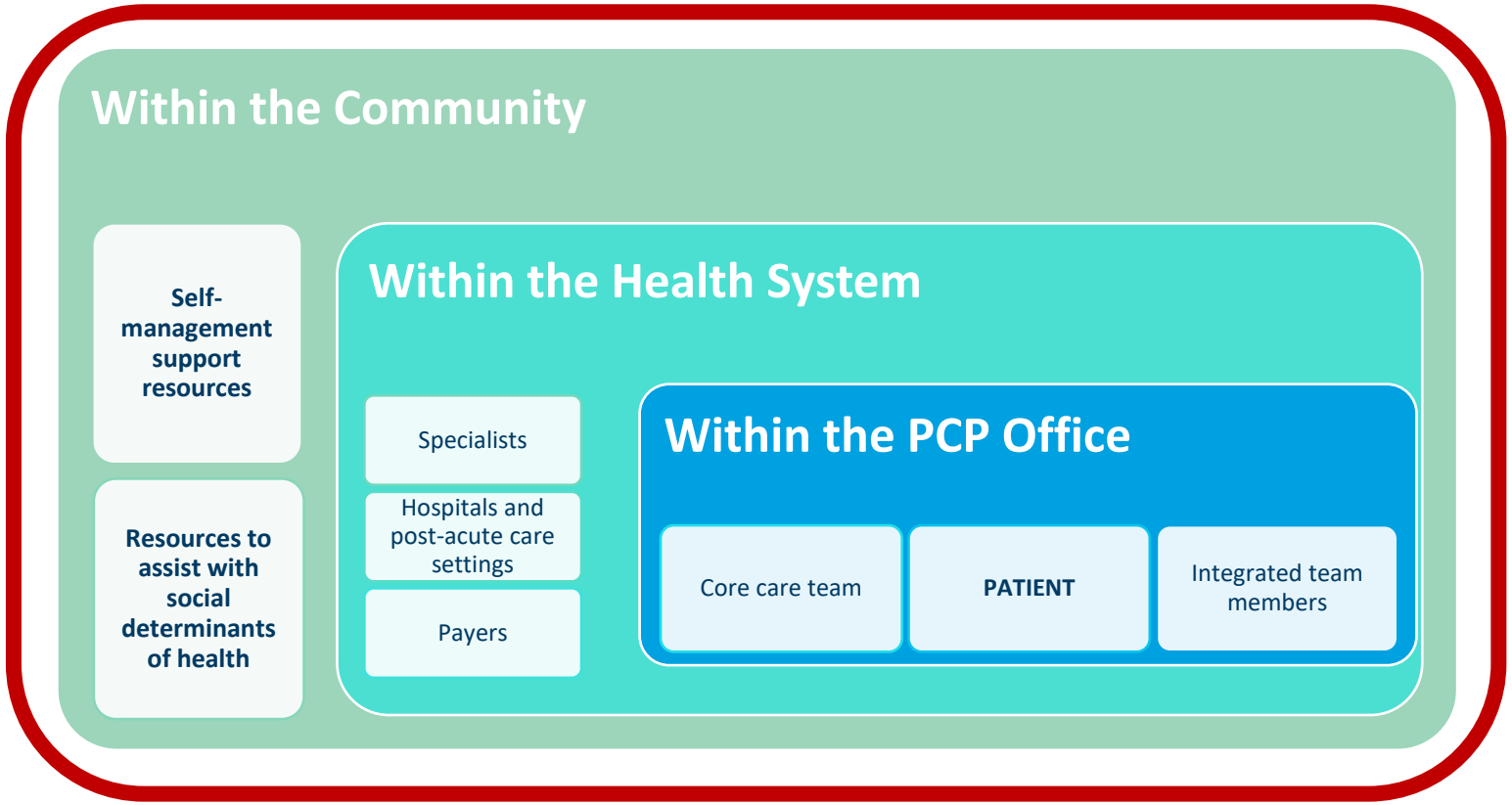
Iceberg Theory

We needed to make this relatable and center realistic discussions when teaching.

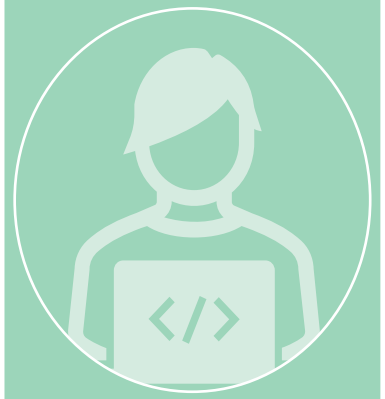
- **We don't always know until we ask.**
- We screen for things we cannot see, such as blood pressure. Sometimes we can see indicators, such as redness in the face and sweating. Other times, we cannot. These are all things "below the surface."
- What is a person really bringing with them when they come to their appointment? Are they able to be fully present for their exam or are there other factors tugging at them? We screen for SDOH because there may be factors that are not visible that will indicate poor outcomes.
- SDOH is similar. We may have indicators that are obvious, but often we have to screen to find out what is not seen.
- Screening needs to be done regularly, just like physical medicine, because situations can occur and we are unaware. Our patients' lives can be altered in a moment.

Defining Care Coordination

We recognize our limitations within the Primary Care setting and utilize existing resources to extend our reach. We wanted our staff to know that there are supports available externally and meeting every SDOH need is not our expectation, but screening and connecting patients, is our expectation and our responsibility.



Reflecting on the **Team-Based Care** approach, we applied responsibilities to each role of our care teams. We began using **"Everyone has a role to play"** in much of our training materials to reduce any one role from feeling the weight of implementing changes. And regardless of that role, we're all responsible to identify issues concerns, barriers that are impacting a patient's overall health including outside of physical health.



Registration

- Notify clinical team if patient is unable to pay for services

Medical Assistant

- Complete screening assessment and notify provider of any concerns and/ or positive results

Health Coach

- Be aware of any recent changes and listen for indicators when completing outreach. Notify appropriate resource with support needs.

RN

- Complete Transition of Care and be aware of vulnerabilities during transitional periods

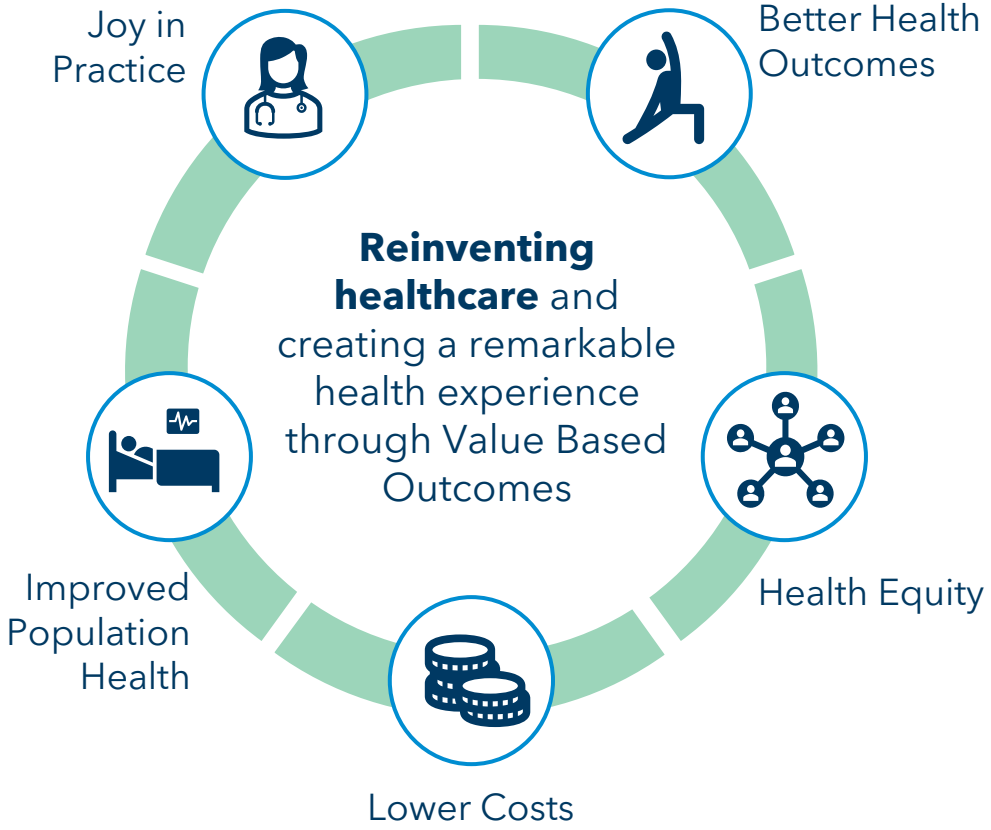
Provider

- Discuss barriers and health related outcomes with patients
- Connect patients to appropriate resource for continued support

RSW and BHC

- Provide care to patients supporting behavioral health or social barriers and monitor the effectiveness of the support
- Notify provider/ care team of interactions/ outcomes, by documenting in Epic and closing referral loop

Addressing SDOH Supports Achievement of the Quintuple Aim



The goals of value-based medicine include…

Improve the provider experience, returning joy in practice for all team members

Care for the whole person, dedicating more time to improve patient outcomes, experience, and population health

Increase continuity in care for our members, increasing care coordination and engaging high risk patients

Champion appropriate utilization and ensure patients get the right care at the right location and at the right time

Optimize team-based care and focus on health maintenance, proactive outreach, and empowering patients to take control of their health

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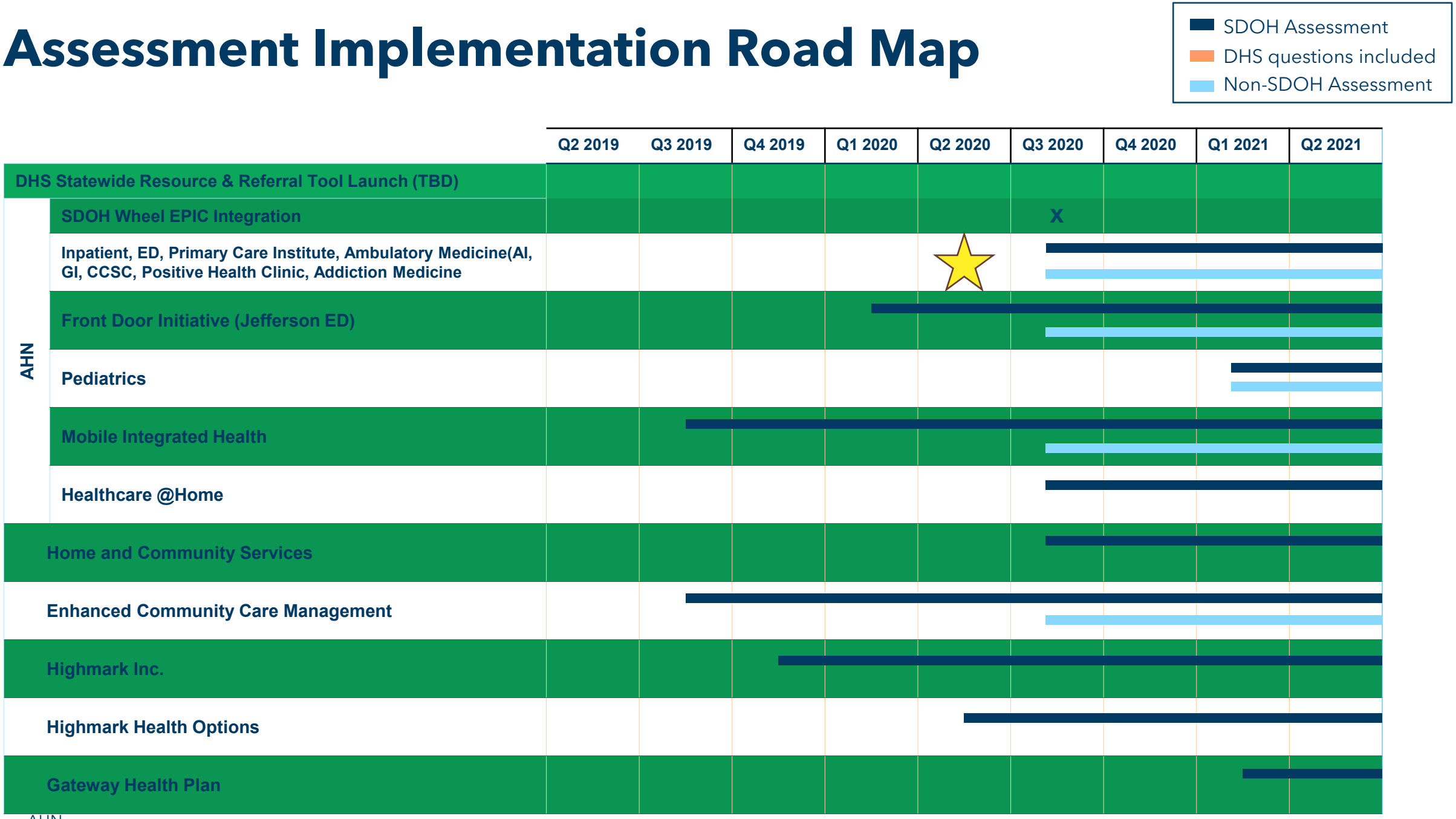
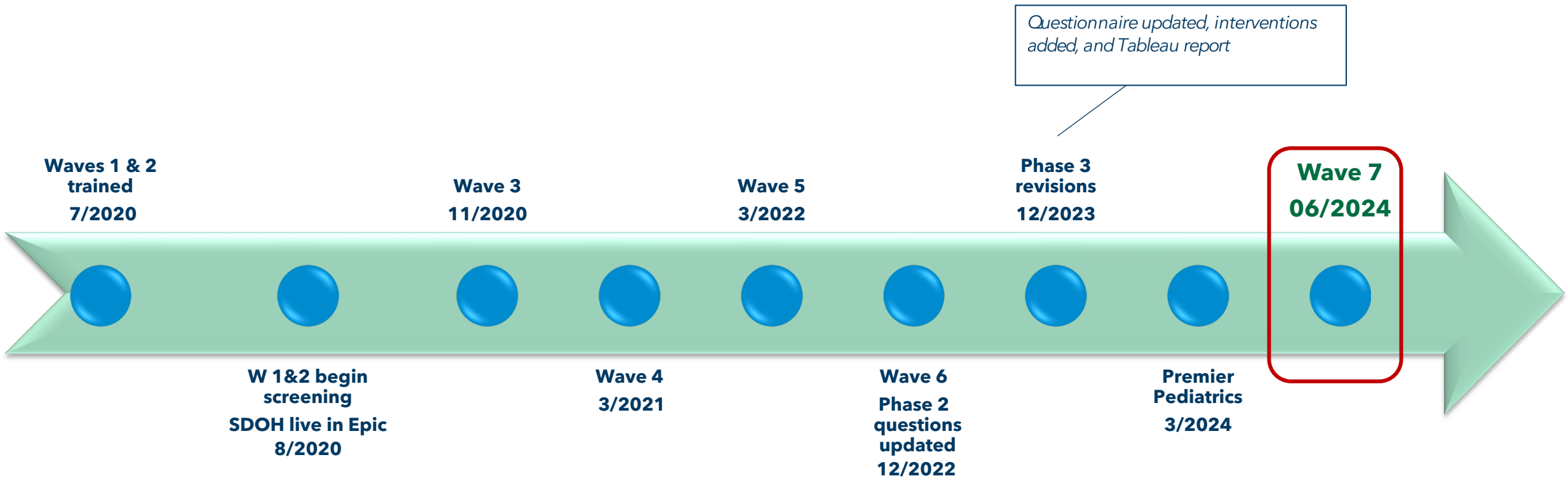
https://jamanetwork.com/journals/jama/fullarticle/2788483

Assessment Implementation Road Map



Primary Care SDOH Implementation Timeline



AHN Universal SDOH Assessment:
Administered Across the Care Continuum

- **Expectation during annual primary care visits-** Annual Wellness visit, Annual physical and New Patient visit
  Regardless of manner of appointment ie. in-person, telemedicine or phone
- Family Medicine and Pediatrics ask <u>caregivers</u> a reduced list of SDOH questions annually

- In-patient hospital stay

- Inclusion Health
- AHN Cancer Institute
- AHN Rheumatology
- AHN Transgender Health

All introduced in 2023; Expectations for screening frequency may differ from Primary Care

Delivery methods

- In-person (patient's home or within hospital/doctor's office)
- Self-assessment via Welcome Tablet
- Same day phone call if this is part of practice's typical rooming process
- **<u>Paper forms are prohibited from use</u>**
- Restricted from MyChart at this time, but work in progress to integrate

SDOH Reporting via Tableau Dashboard – Primary Care Institute

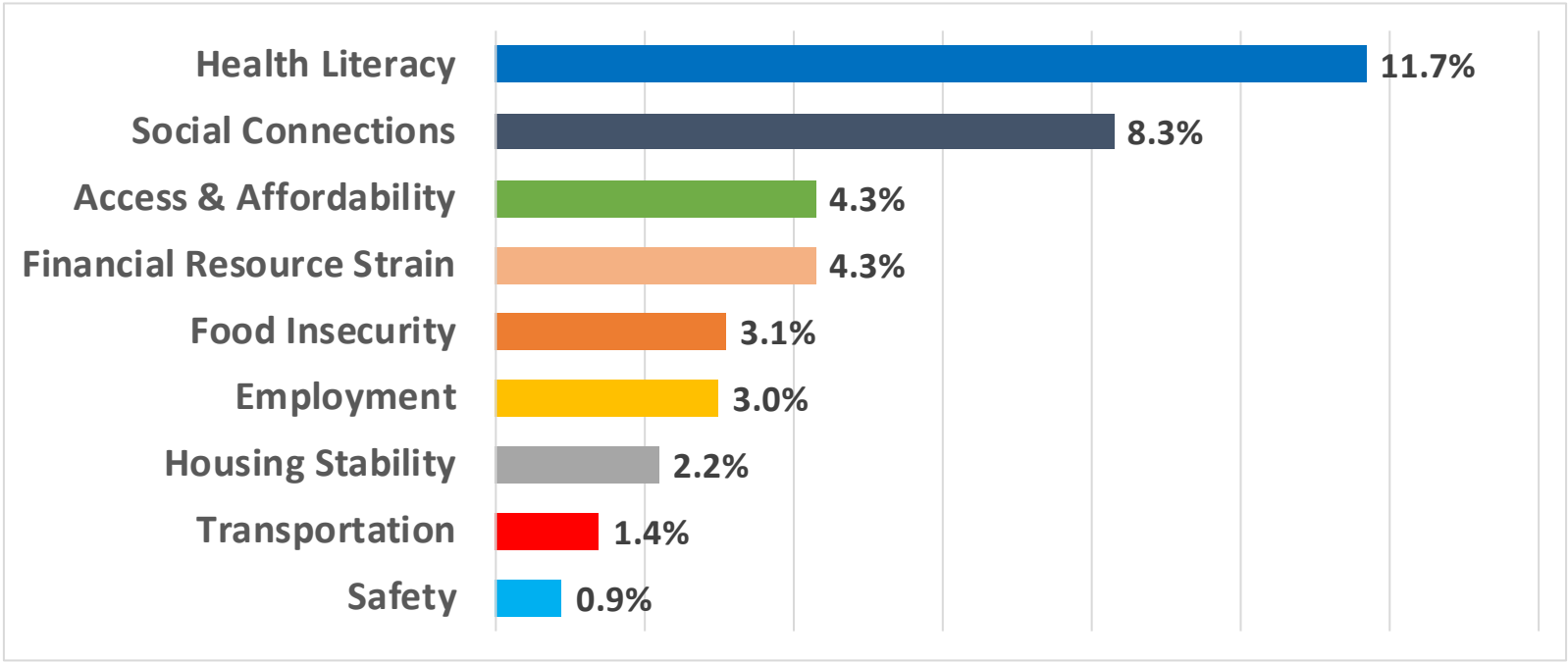
- **PCI screened over 16,000 patients, at a 76% completion rate, in 6/24.**
- Took years to accomplish and much patience in watching the number slowly progress.
- Goal was increased annually upon waves implementing SDOH. 2024 goal= 75%.
- It is unreasonable to expect 100% due to the human component.

- Monitors outpatient SDOH questionnaire compliance of Core questions monthly
- Considered compliant if all questions within the Core domain are complete for specific visit types
- Identifies positive SDOH screenings from a geographical perspective to monitor resource availability in high volume zip codes.
- Compares questionnaires completed on Tablets vs flowsheets in clinician workflows, and trend the positive, negative and no responses by device type.

Universal Assessment: AHN – Epic*

May 2024

Unique Individuals Assessed	Unique Individuals with Needs	Assessments Started	Assessments Completed	Completion Rate
57,596	9,073	63,881	25,040	39.2%



*Inclusive of all payers, not just Highmark

Universal SDOH Assessment

Current assessment. This has changed three times since 2019 to comply with changing Medicaid, CMS and Joint Commission regulations. With each update, we provided education and support for the practices and continued to monitor progress. The assessment needed to meet the requirements for all departments (inpatient & outpatient) as part of a large health system.

HEALTH LITERACY

- ❑ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist?
- ❑ I know how to find helpful health resources on the Internet.

SOCIAL CONNECTIONS

- ❑ How often do you feel isolated from others?

HOUSING STABILITY

- ❑ In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- ❑ Are you worried about losing your housing?

SAFETY

- ❑ Do you feel physically and emotionally safe where you currently live?

TRANSPORTATION NEEDS

- ❑ Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

FINANCIAL RESOURCES STRAIN/ EMPLOYMENT

- ❑ What is your current work situation?
- ❑ Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you?

FOOD INSECURITY

- ❑ Within the past 12 months we worried whether our food would run out before we got the money to buy more.
- ❑ Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

ALCOHOL & SUBSTANCE USE

- ❑ Females: In the past year, have you had more than 7 drinks in one week?
  - ❑ Males greater than 65 years of age: In the past year, have you had more than 7 drink in one week?
  - ❑ Males less than or equal to 65 years of age: in the past year, have you had more than 14 drink in one week?
  - ❑ In the past year, have you used any drugs other than those prescribed by your doctor?

PHQ-2: REQUIRED EVERY PATIENT EVERY VISIT

- ❑ Over the last 2 weeks, how often have you been bothered by the following problems: Little interest in doing things? Feeling
- ❑ Over the last 2 weeks, how often have you been bothered by the following problems? Feeling down, depressed or hopeless?

STRESS

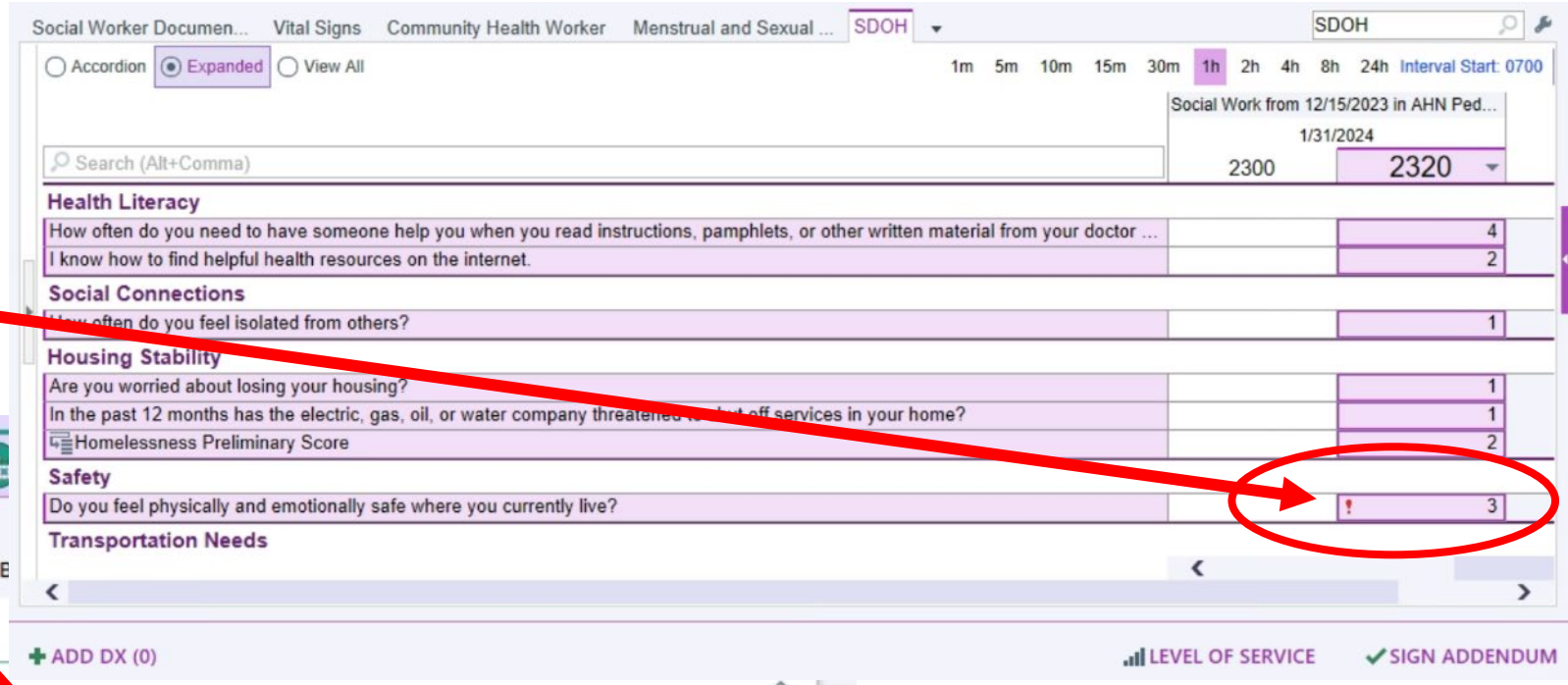
- ❑ Over the last 2 weeks, how often have you been bothered by the following problems: feeling nervous, anxious, on edge?
- ❑ Over the last 2 weeks, how often have you been bothered by the following problems, not being able to stop or control worrying?

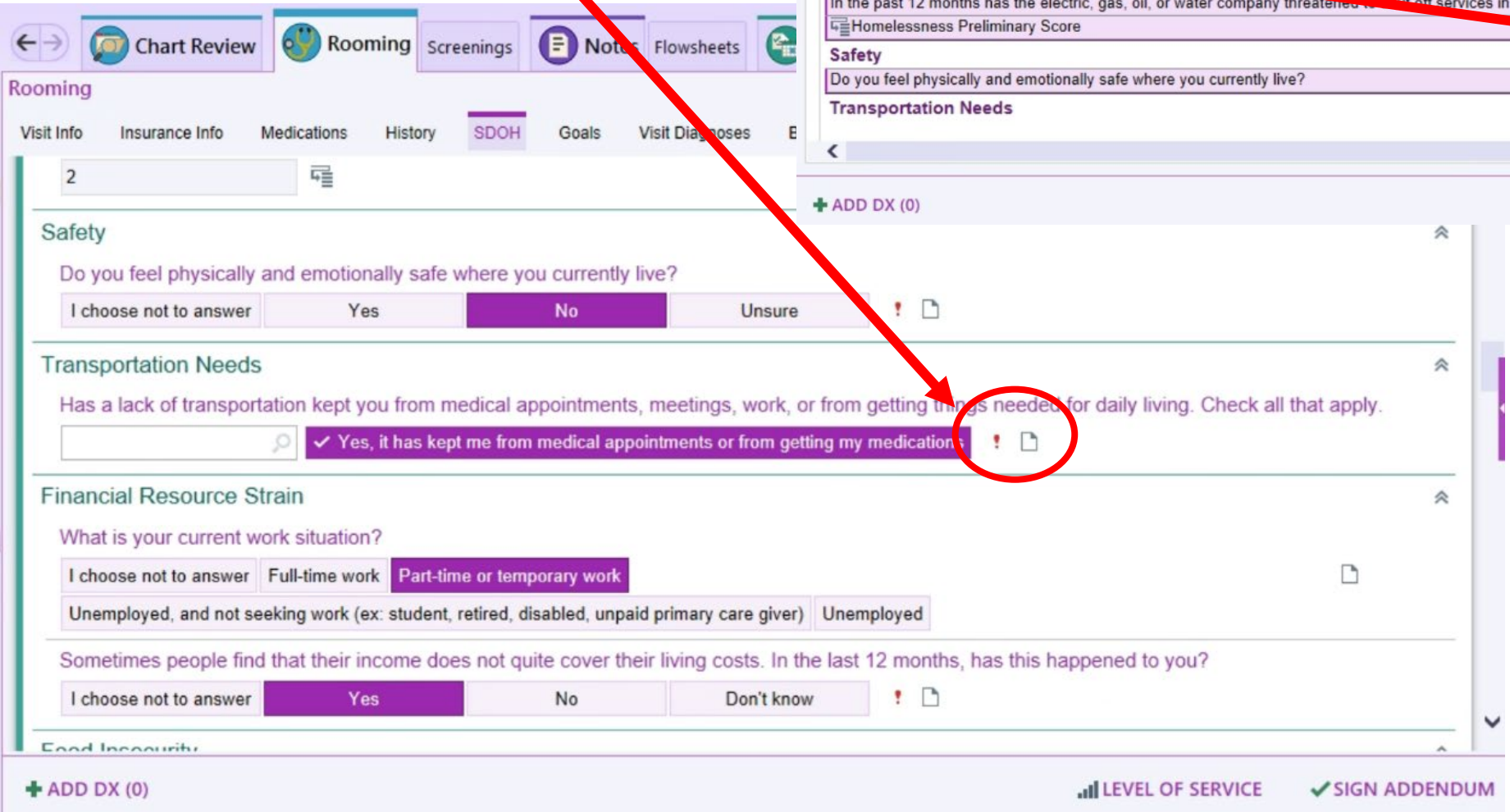
ACCESS

- ❑ In the past year, have you been unable to get medicine or any health care when it was really needed?
- ❑ In the past year, have you been unable to get clothing when it was really needed?
- ❑ In the past year, have you been unable to get childcare when it was really needed?
- ❑ Do you have access to any of the following devices?

Response Display

Abnormal responses in flowsheets will be displayed in red and will be flagged with an exclamation point.



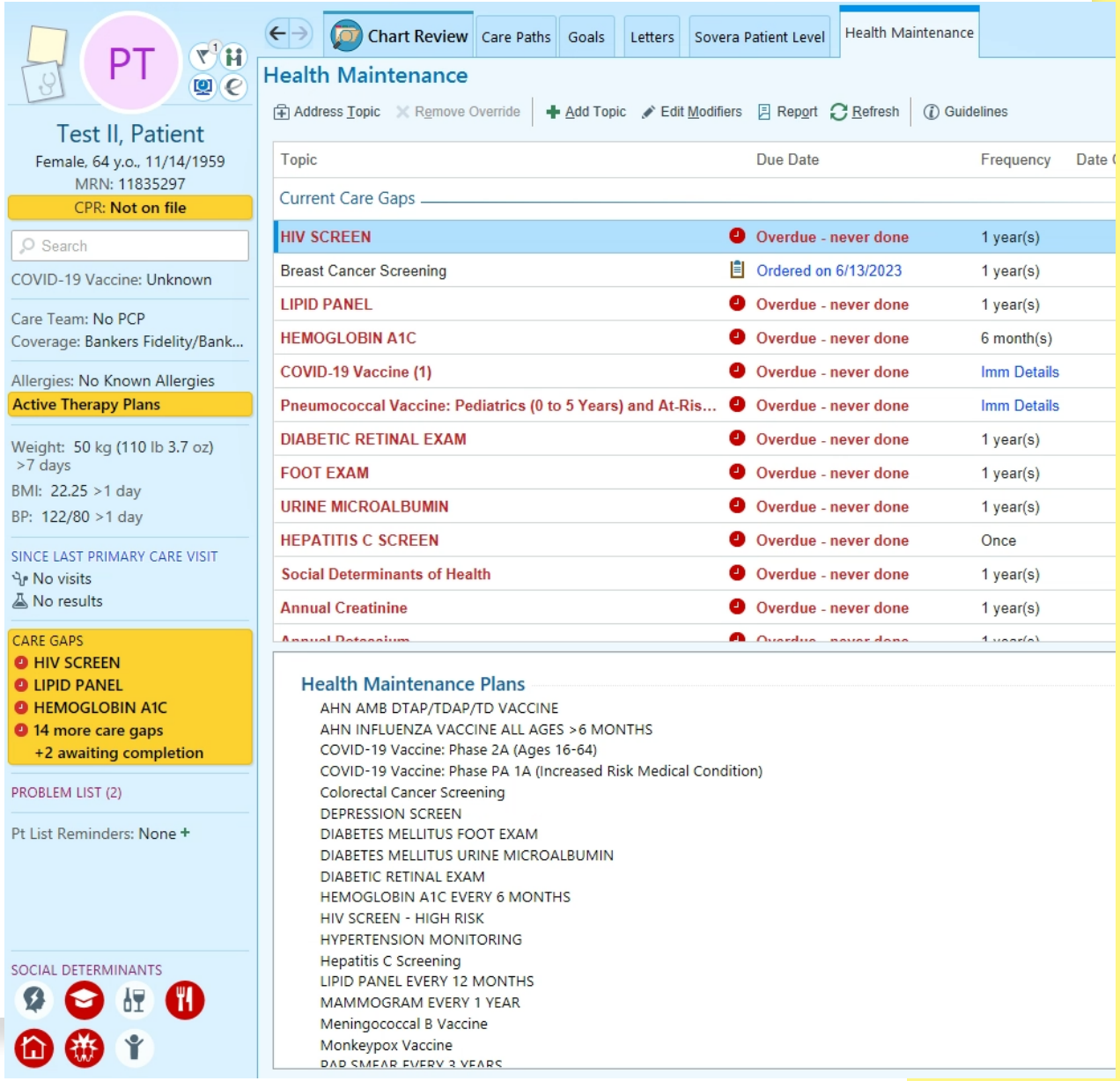


SDOH on the Story Board/ Response Display

1. Positive results and at risk will display in the following ways:
   A. As red icons on the Story Board
   B. When hovering over the Social Determinants section, the box will appear with red font and the words "High Risk."
   C. In the flowsheet with a red exclamation point.
2. Domains without documented response will show as gray icons ("not on file").
   A. This is for blank answers, not for "I choose not to answer."
3. Recent concerns will be highlighted. If a patient's last screening was positive, but most recently screens negative they will show as a Recent Concern. This is indicated by a red exclamation point.
4. Blue hyperlink used to review responses in flowsheet can be accessed from Story Board and LPOC

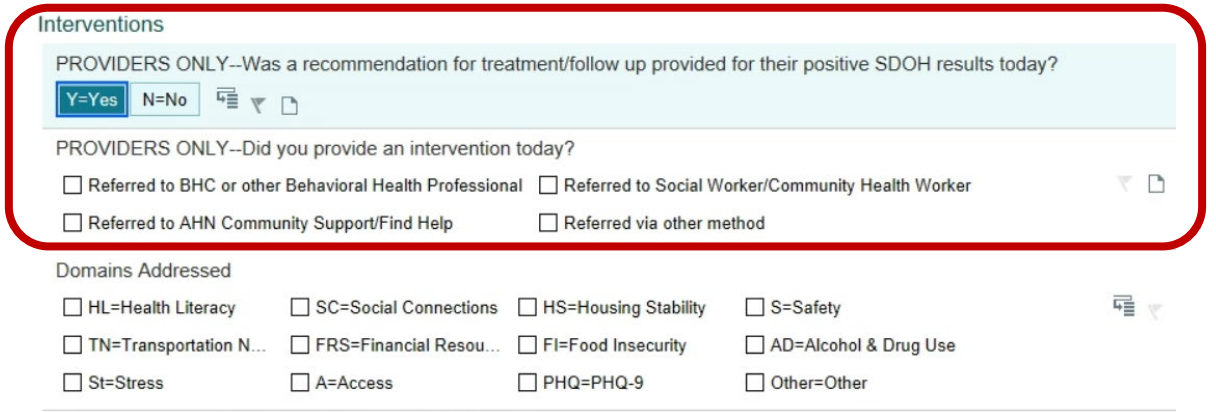
Health Maintenance Topics/ Care Gaps

- Due annually beginning at 18 years old
- Care gap will close when all questions of the SDOH screening are completed
- Will show on Story Board and under Health Maintenance within the chart
- Clinical staff can postpone screening if necessary
    - Example: Patient presents for AWV, but is acutely ill and unable to answer appropriately



Provider Workflow

- **Only the provider** should complete "Did you provide an intervention today?"
  - An intervention includes referral to an appropriate professional or community resource.
  - **You must refer using the proper process. Documenting here will not send a referral to your social worker.**
- G-codes will automatically drop when the provider section is completed. This satisfies a screening and intervention requirement by some payers. Please do not remove the G-codes.



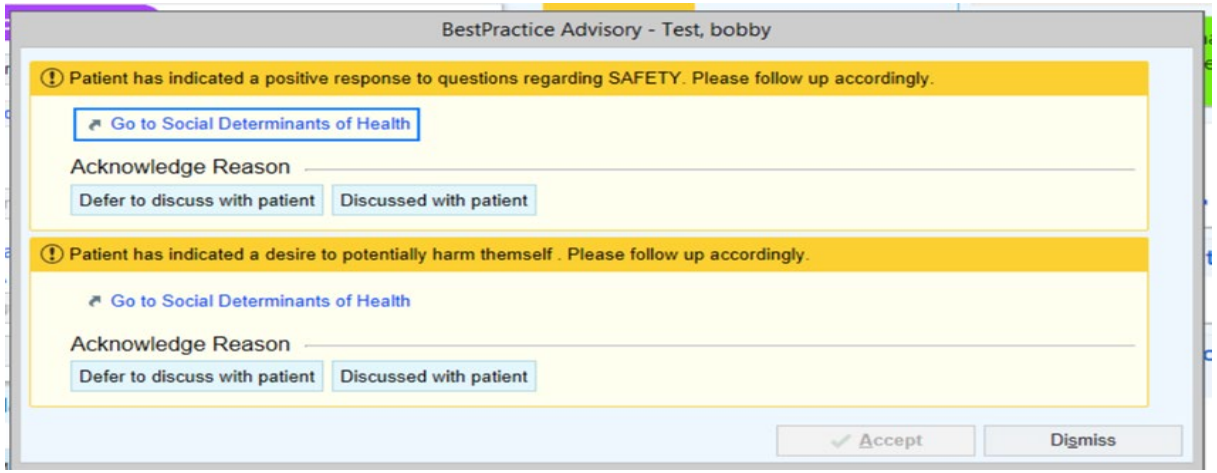
- A positive screen for safety will be flagged for the provider as a yellow BPA box.

Recommended Best Practices

To inform continuous improvements to screening and follow-up processes, internally track the percentage of all adult and adolescent patients with at least one office or telemedicine visit who completed at least one SDoH assessment (i.e., G9919 or G9920) within the past year. **Because patients may only complete some sections of the SDoH assessments, a "completed" screen can be defined as an assessment with at least one of the 2022 Domains answered/completed.**

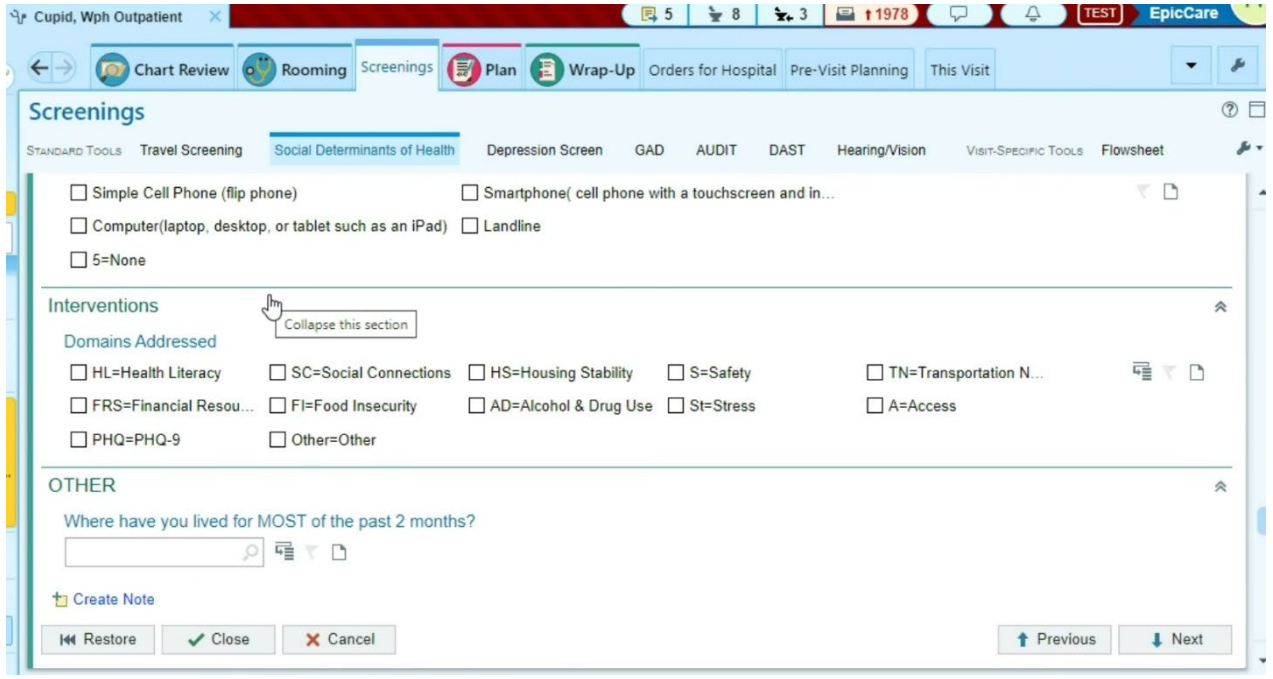
For billable office and telemedicine visits:

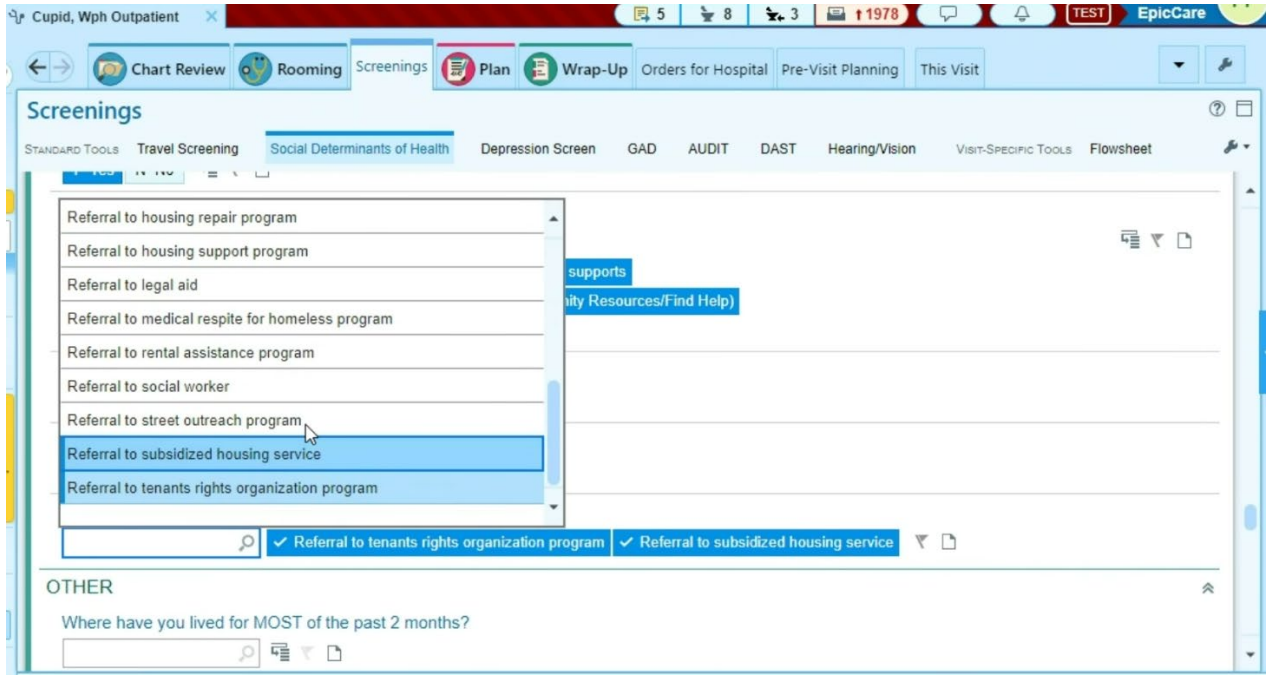
- Submit G9920 in the claim to the PH MCO for **negative** SDoH assessments (for documentation and tracking purposes)
  - For assessments completed in which no barriers have been identified, submit HCPCS code G9920 only.
- Submit G9919 in a claim to the PH MCO for **positive** SDoH assessments (for documentation and tracking purposes)
  - With the G9919 code (positive screen), submit ICD-10 diagnostic codes for all patients with identified SDoH needs. Please see below for existing ICD-10 Z codes that your clinicians may deem appropriate for the identified SDoH need.



Interventions

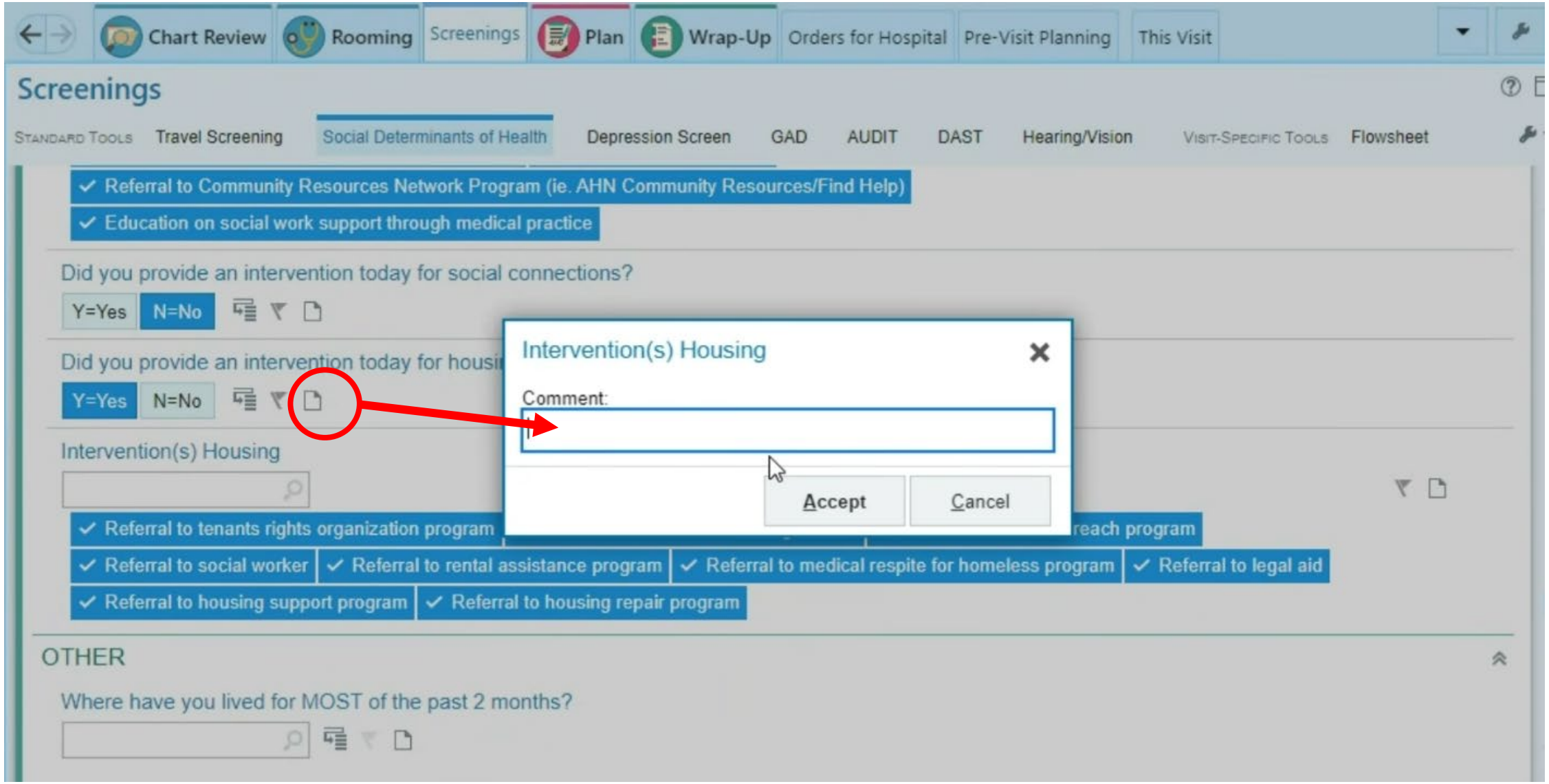
- Epic has capability to select the interventions provided and add comments to comply with CMS requirements. These appear at the bottom of the assessment tool.
- First, the domain(s) addressed will be clicked. Then, the appropriate corresponding interventions will be selected via the drop down box. You may choose all that apply.
- If referring patient to **social worker, CHW** or BHC, **they** will document the interventions.
- If you are referring to the Community Support platform, you will select that intervention. The information will print on the AVS.





Interventions:

Manual comments can be added if “Other services provided” is selected.
Click on the note and enter the comment and then click accept.



Supporting Staff is a Key Component to Success

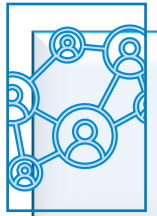
Just as we expect appropriate follow-up care with a medical specialist, we expect appropriate follow-up care for social concerns. By ensuring staff are supported with the right resources, implementing SDOH has been successfully achieved.

Tips to Delivering the Screening

Use exact language provided for questions and answers

Remind patients we are concerned about their overall wellness

- We ask everyone these questions



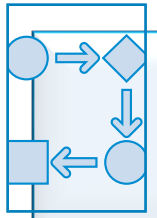
Redirect patient to provided answers

- Mention available resources will be provided

Practice active listening techniques (eye contact, head nodding, affirming statements of understanding)

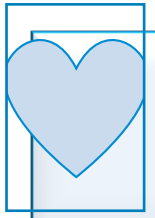
- BHC can support and guide development of listening skills

Utilize BHC/ SW for guidance on intent of questions, continue to use specific language given

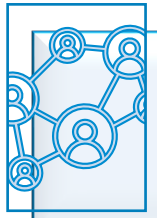


Make it a standard part of your office workflow

Avoid showing judgement, remain professional



Show empathy, patients may feel vulnerable



Be prepared to connect patients to additional resources (AHN Community Support, SW, BHC)

AHN

How do I explain this to patients?

"We ask everyone."

"We want you to remain independent for as long as possible."

"Your provider is interested in how things are going in your life"

"Dr. Smith is/we are/I am concerned about your overall health."

"We ask these questions for all of our patients because we care about how you're doing in all areas."

"We have resources that can be helpful when we know our patients are in need."

Ask your transformation specialist for this poster!

Barriers to Delivering the SDOH Screening

Using language different than what is in EPIC

- Asking open-ended questions, asking leading questions, asking yes/no questions, combining questions to screen quicker

Dealing with resistance

- "Why are you asking me this?"

Allowing the patient to tell you a story for each question without asking for a specific answer

- This may be a diversion technique

Non-verbal cues (expression, tone, and body language) influence how they respond- If you look uncomfortable, uninterested, or smiling inappropriately

Misinterpreting the questions when patients ask for clarification

Staff bias- lack of belief that SDOH impacts your patients or geographical region or that this is an important part of health care

Frequently Asked Questions

How long does the screening take?

- Practices who have fully implemented screening can conduct in under 5 minutes on average

Can we ask the questions prior to the visit?

- The questions should be asked during Rooming or on Welcome tablets while patients are in the waiting room. If your office rooms patients telephonically same day, you may ask them at that time. Questions can only be asked same day, due to safety and depression screenings. A quick response must occur for positive screenings. Paper screening forms are prohibited in Primary Care.

Is the SDOH screen just for adults?

- Currently, we are only asking adults (over 18) the SDOH questions. There will be a transition as we move into pediatrics, but we are not asking minors the SDOH screen in Primary Care at this time. We recommend caregivers are asked annually for minors.

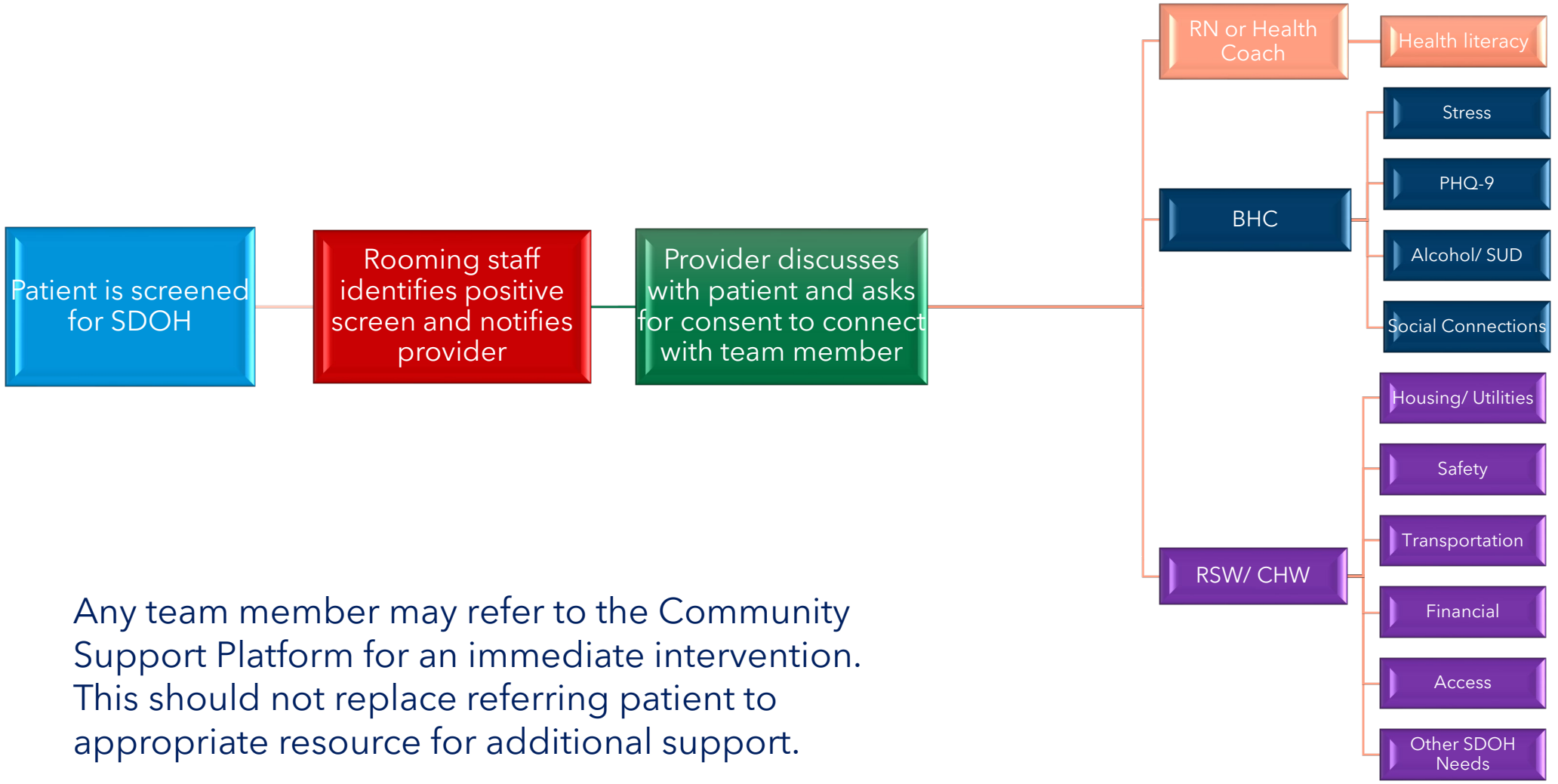
Do we still complete the SDOH screen if the patient has completed the screen within the past year at another site or if their annual wellness visit/physical is within a year of their first visit?

- In Primary Care, the SDOH screen should always be given to new patient's first visit at the practice and during the yearly physical/annual wellness visit. This may result in multiple screens throughout the year (at least for the first year).

What should we do if a patient refuses to answer?

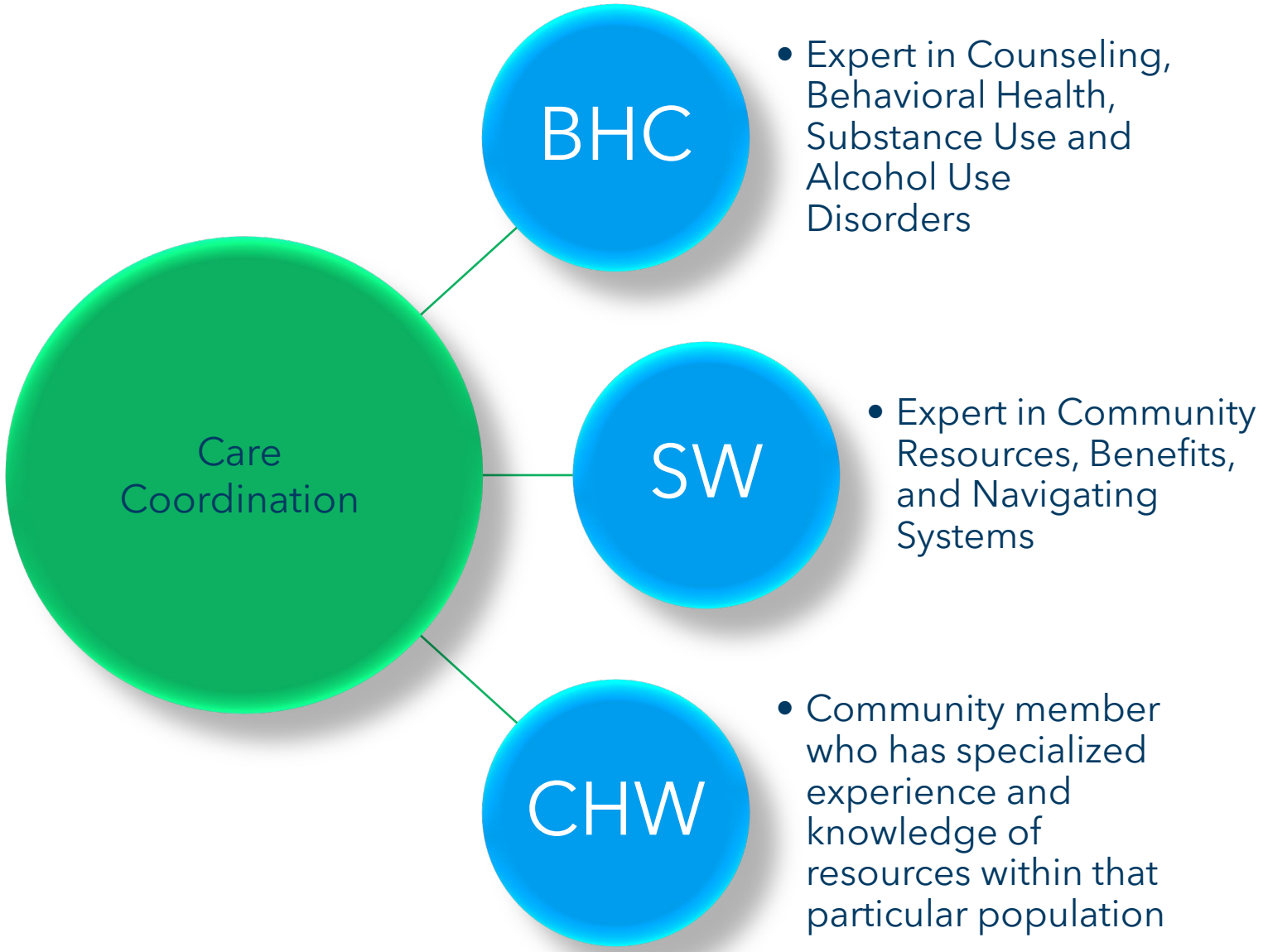
- Document "Chooses not to answer." By documenting it in this way, the screening will show as completed.

Workflow for Positive Screenings



Any team member may refer to the Community Support Platform for an immediate intervention. This should not replace referring patient to appropriate resource for additional support.

How do SWs, BHCs, and CHWs differ?



- Expert in Counseling, Behavioral Health, Substance Use and Alcohol Use Disorders

- Expert in Community Resources, Benefits, and Navigating Systems

- Community member who has specialized experience and knowledge of resources within that particular population

AHN Community Support (aka FindHelp)

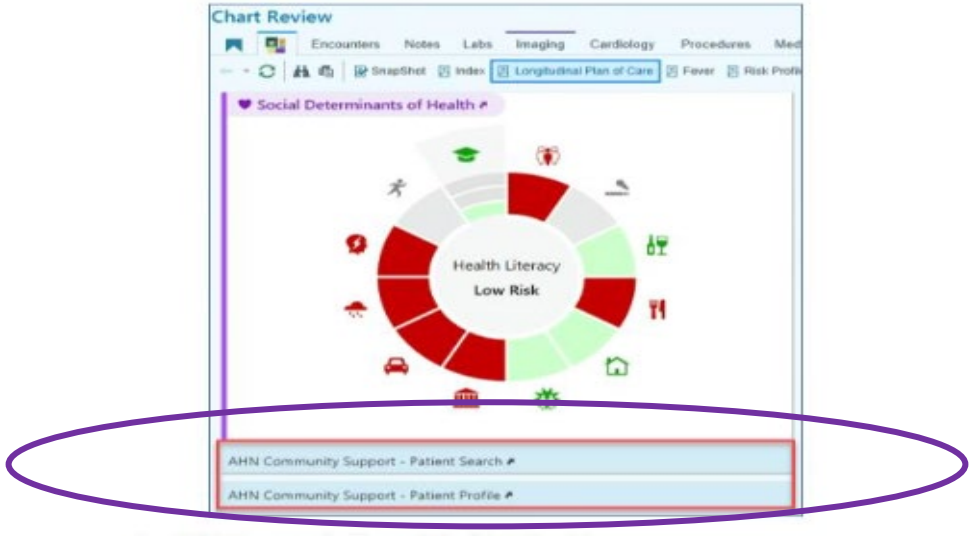
Opening the AHN Community Support *within* a Patient's Chart

Opening the link from within the chart will open to that specific patient's profile in FindHelp. You will find these links in the LPOC and under the More Activities arrow.

a. Longitudinal Plan of Care (LPOC)

i. Navigate to the **LPOC** and locate the SDOH Wheel

ii. Select one of the two hyperlinks located under the SDOH Wheel to open AHN Community Support

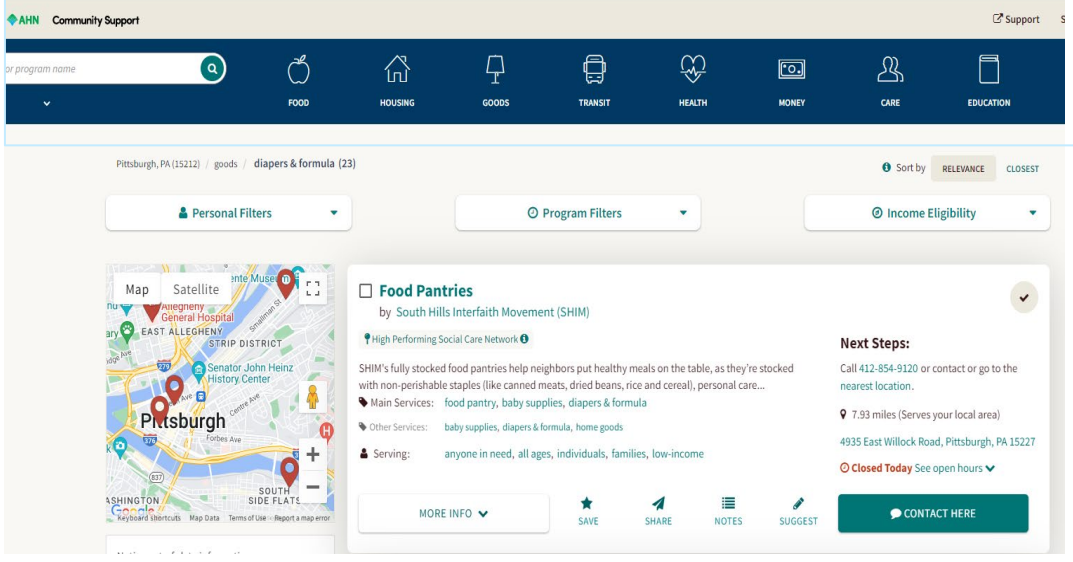


1. AHN Community Support- **Patient Search**

a. This will link you to the search page where you will be navigating for referrals on behalf of the patient

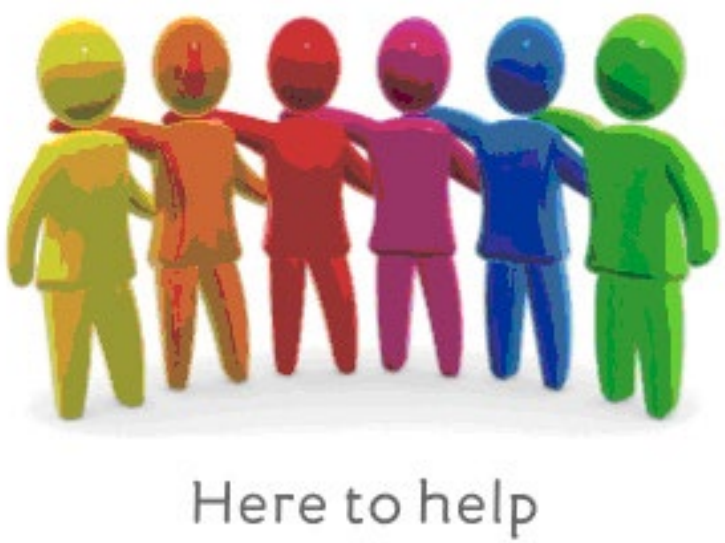
Community Support Site

- Online repository of free or reduced cost services
- Able to search anonymously
- Free for nonprofits to help manage their programs and referrals to those programs
- Patient search to create referral or search for a service
- Patient profile for home page for specific patient and status of referrals
- Single Sign On using Link in the Longitudinal Plan of Care
- Patient can access Community Support via MyChart and QR code is also located on After Visit Summary.



Support for Staff

- **Regional Social Worker**
  - The RSW is able to provide support with the SDOH screening and coordination to resources.
- **Behavioral Health Consultant**
  - The BHC will be able to provide support with the PHQ-9. substance and alcohol use portion of the screening.
- **Transformation Specialist**
  - The Transformation Specialist will provide support in implementing the SDOH Screen at the practice if available.



Social Determinants of Health PFAC Update 2023

HIGHMARK HEALTH

2023 SDoH PFAC Engagement

Assessment & Community Support

- Allegheny Valley Hospital (5/1)
- Jefferson (5/2)
- Canonsburg (5/23)
- Forbes (5/17)
- Allegheny General Hospital (5/25)
- Wexford (5/30)

Portion Balance Coalition

- Grove City (5/23)
- Saint Vincent (5/24)
- West Penn (5/24)

2023 SDoH PFAC Engagement

SDoH Assessment and Community Support Follow Up

- Considerations for large senior/elder population
  - Social Isolation, Health Literacy, Transportation
- SDoH Assessment Training
  - Unconscious bias
    - Asking **all** patients the full assessment
  - Introduction scripting (“We ask these of everyone”; “We care about you”; “We want you to maintain your independence”)
- Engagement with Women’s Health/Maternity Floors/Centering Pregnancy

Biases

- Conscious Bias:

Biased attitudes about a group we are aware of, can be (in)visible; can be accessed.

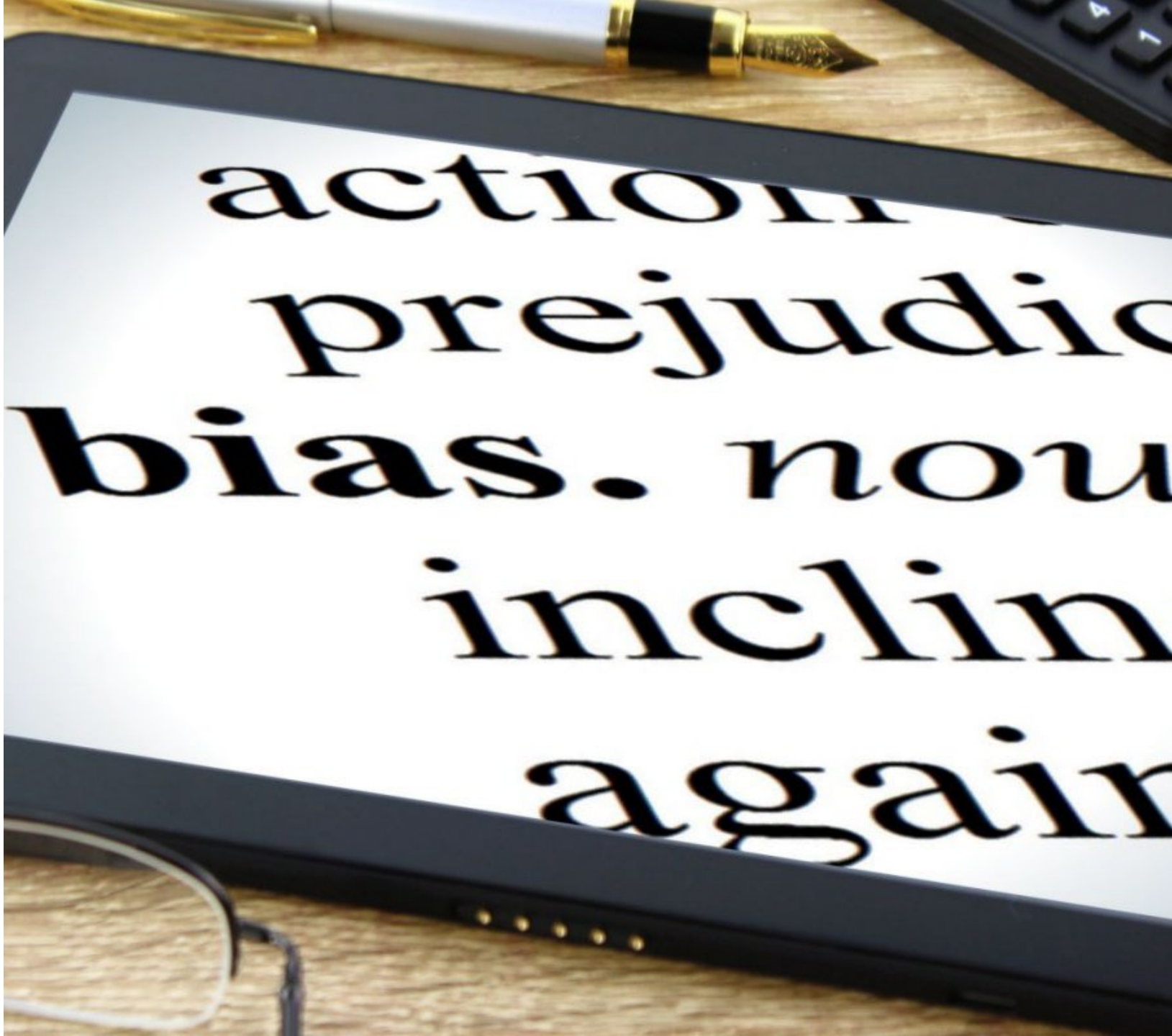
- Unconscious Bias:

The brain's automatic, unconscious sifting and sorting of visual, verbal and behavior cues to determine whether people are friendly or not means that we all develop unintentional people preferences.

- Recognized Bias from PFAC

The Patient Family Advisory Council has notified us that a number of patients have recently reported feeling bias when being screened for SDOH.

- Diversity Microsessions



2023 SDoH PFAC Engagement

SDoH Assessment and Community Support Follow Up

- Include CS Platform Link from AHN website and/or highlight in some way
- Provide Community Support postcards to provider offices
- Develop printed posters/visuals for the offices that address the questions are asked of everyone (possible collaboration with EEHI/Marketing)

2023 SDoH PFAC Engagement

Portion Balance Coalition Follow Up

- Provide materials to PFAC
- Share launch date of materials in practices
- Revisit food items in the backpack program (feedback was that the items were not necessarily helpful and/or that people didn't know how to prepare/use the foods)
- Opportunity to place recipes and other budget food ideas in the food bags/boxes

Response to PFAC Feedback

Primary Care

- We've worked collaboratively with the Highmark team to incorporate steps based on feedback from the PFAC.
- Bias training and opportunities for education and discussion.
- Community Support QR code is now available on all After Visit Summaries for patients to privately access the website at their convenience.

Next Steps…

Pro Tip: Moving the finish line helps you to continue to grow!

Currently working to integrate assessment into MyChart.

This will allow patients to complete the assessment in advance of the appointment.

Current limitation is that we do not have a system in place for crisis response to safety and self-harm questions.

New process will include pop up box that will direct to call 911, 988, Domestic Violence National Hotline, or other emergency line.

Thank you!

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AHN