

AHN Successful Implementation of SDOH Screening and Follow-Up

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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.



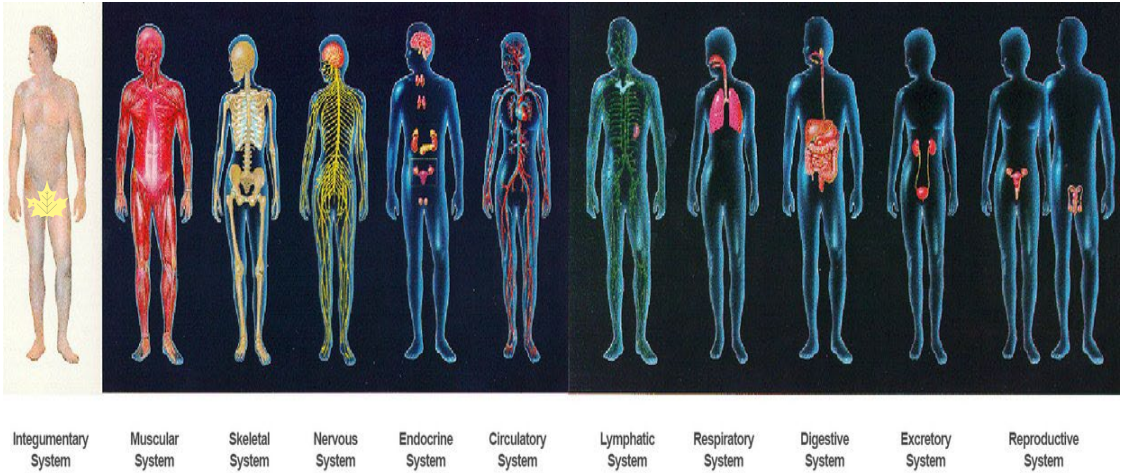
Using PCMH Concepts as a Guide to SDOH Screening

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 AHNoutcomes.

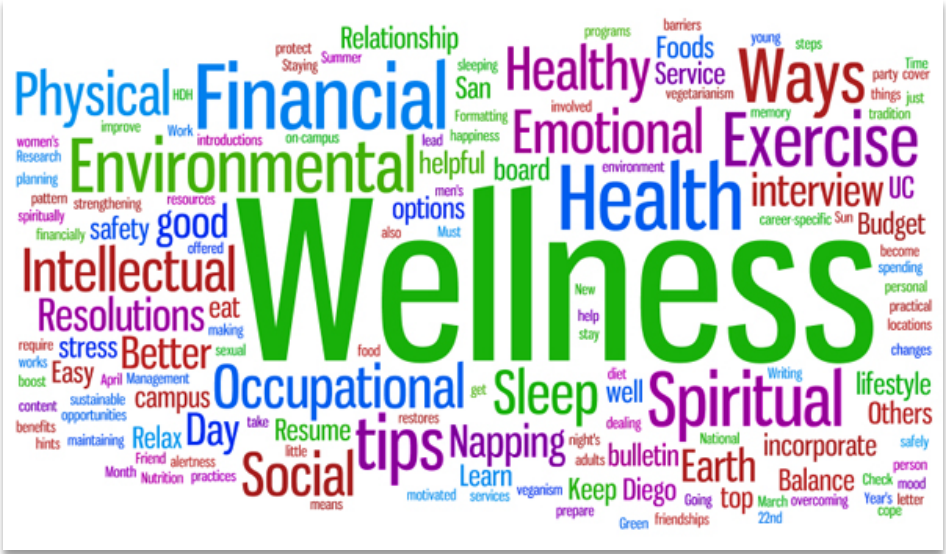
Staff Education

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

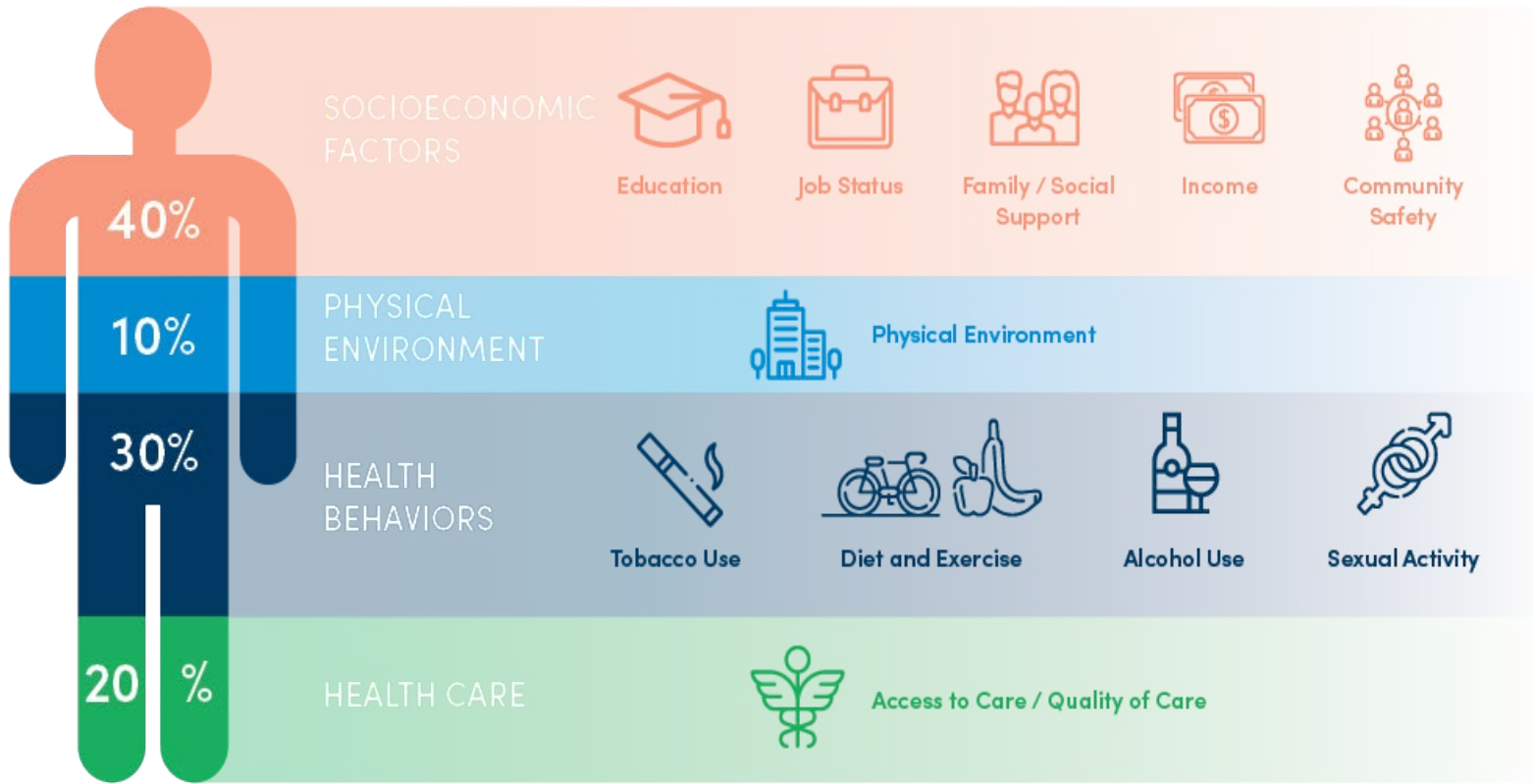


Our aim for viewing health



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.

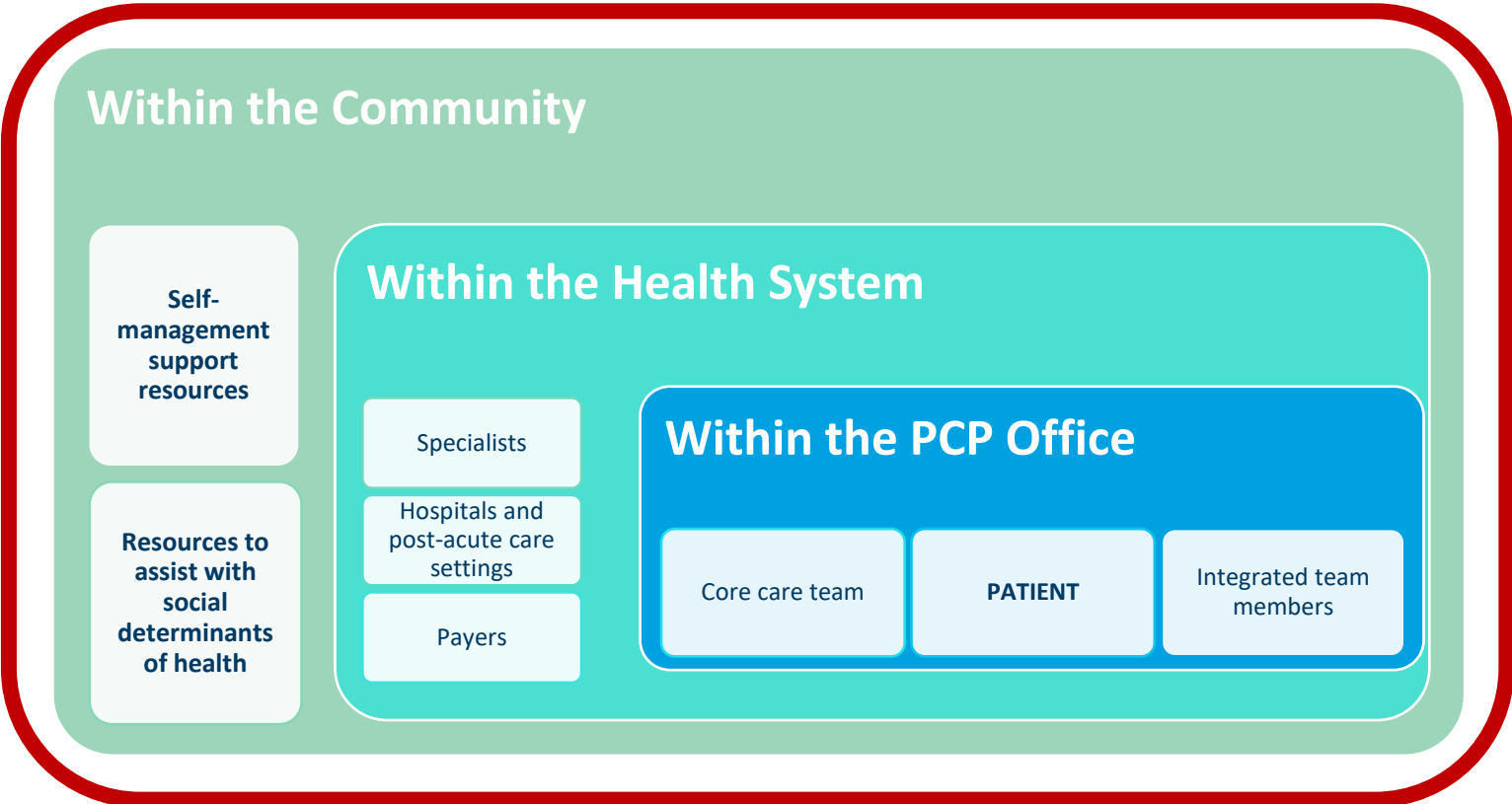
Everything appears normal

Access to appropriate clothing
Access to healthcare needs
Substance and alcohol overuse
Transportation Barriers
Housing Instabilities
Financial struggles
Health literacy barriers
Social Isolation
Childcare barriers
Food insecurity
Safety Concerns

- **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

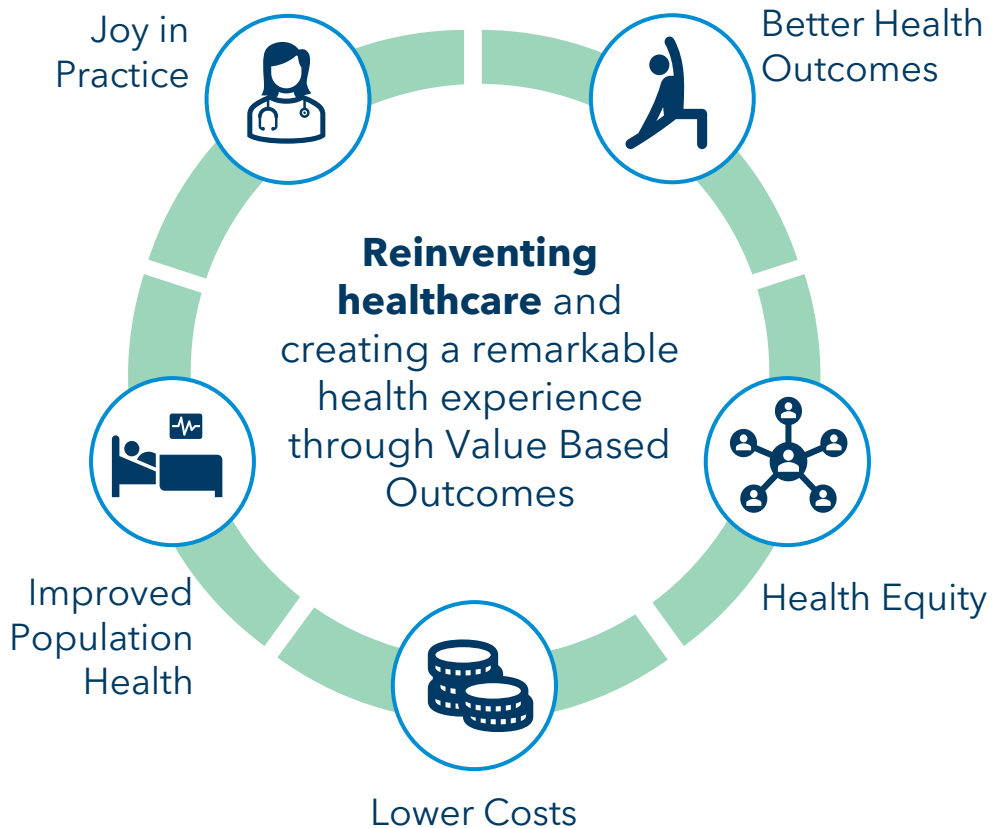
- Discuss barriers and health related outcomes with patients
- Connect patients to appropriate resource for continued support



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

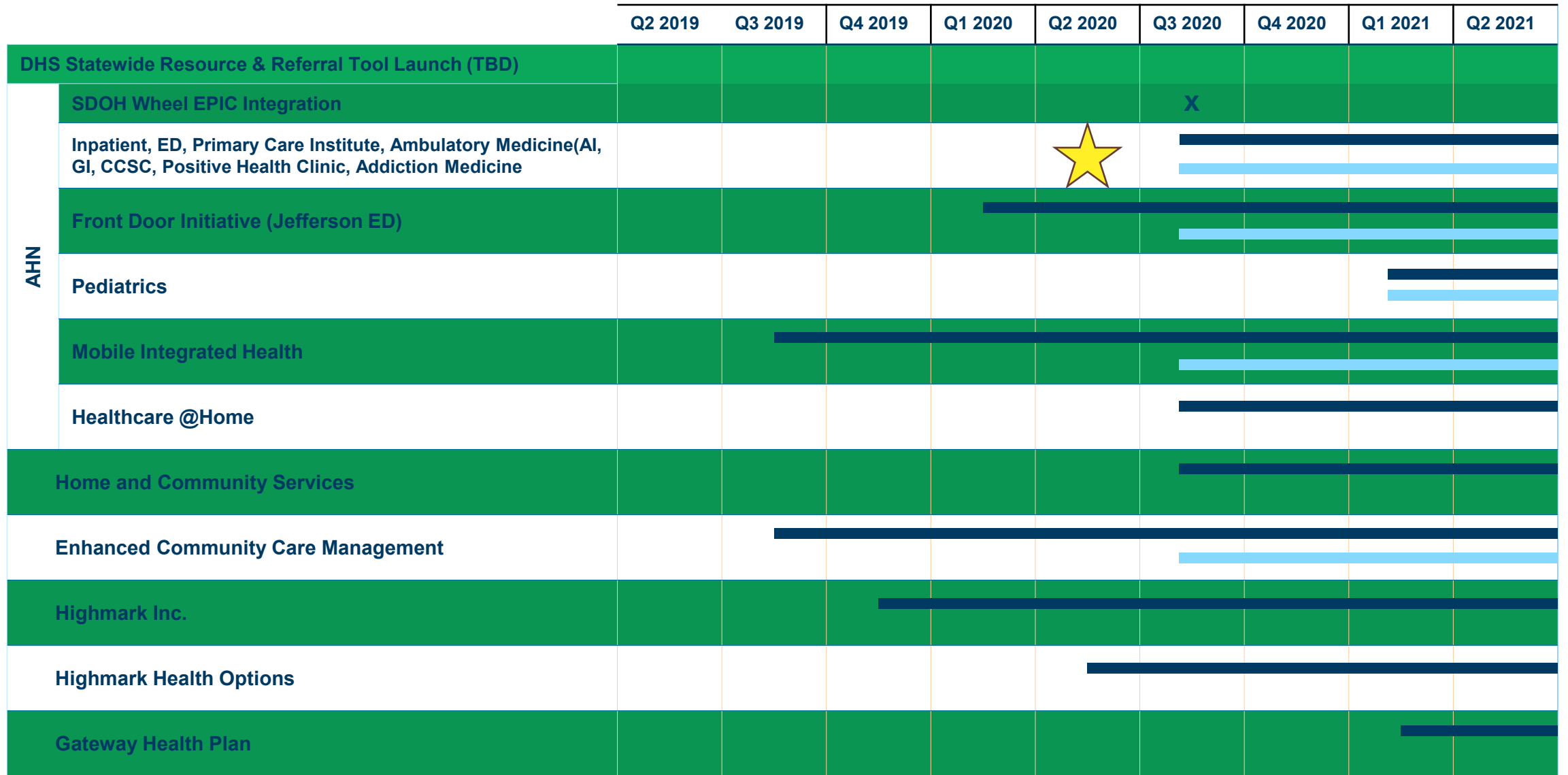
Increase continuity in care for our members, increasing care coordination and engaging high risk patients

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

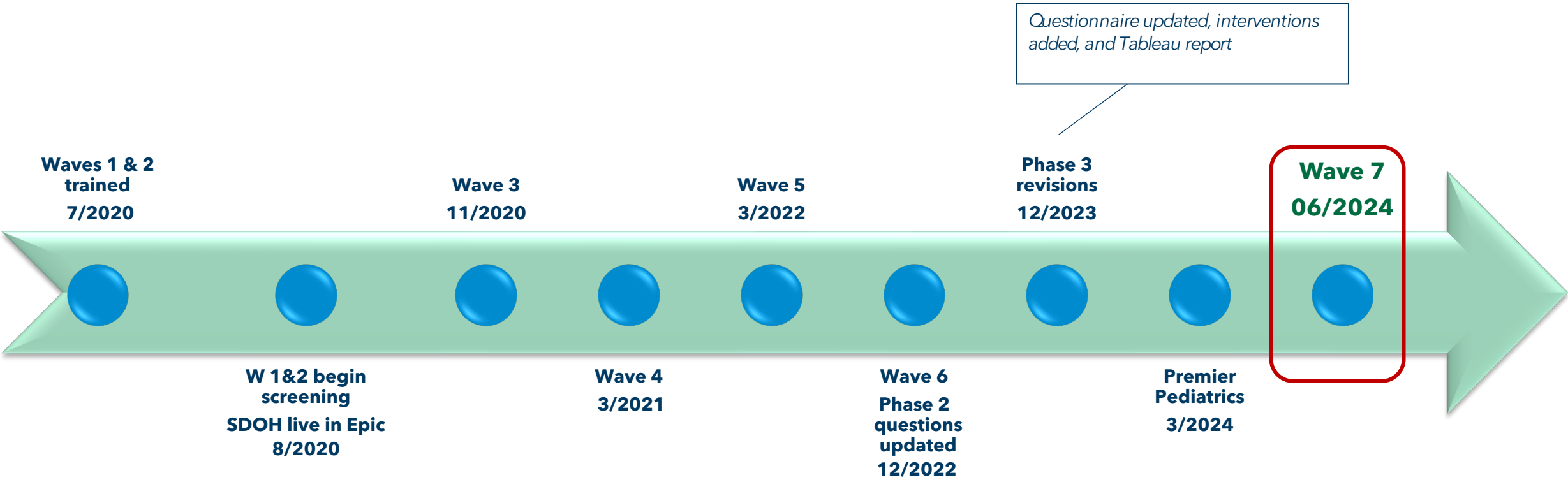
Optimize team-based care and focus on health maintenance, proactive outreach, and empowering patients to take control of their health

Assessment Implementation Road Map

- SDOH Assessment
- DHS questions included
- Non-SDOH Assessment



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 caregivers 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
- **Paper forms are prohibited from use**
- 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.



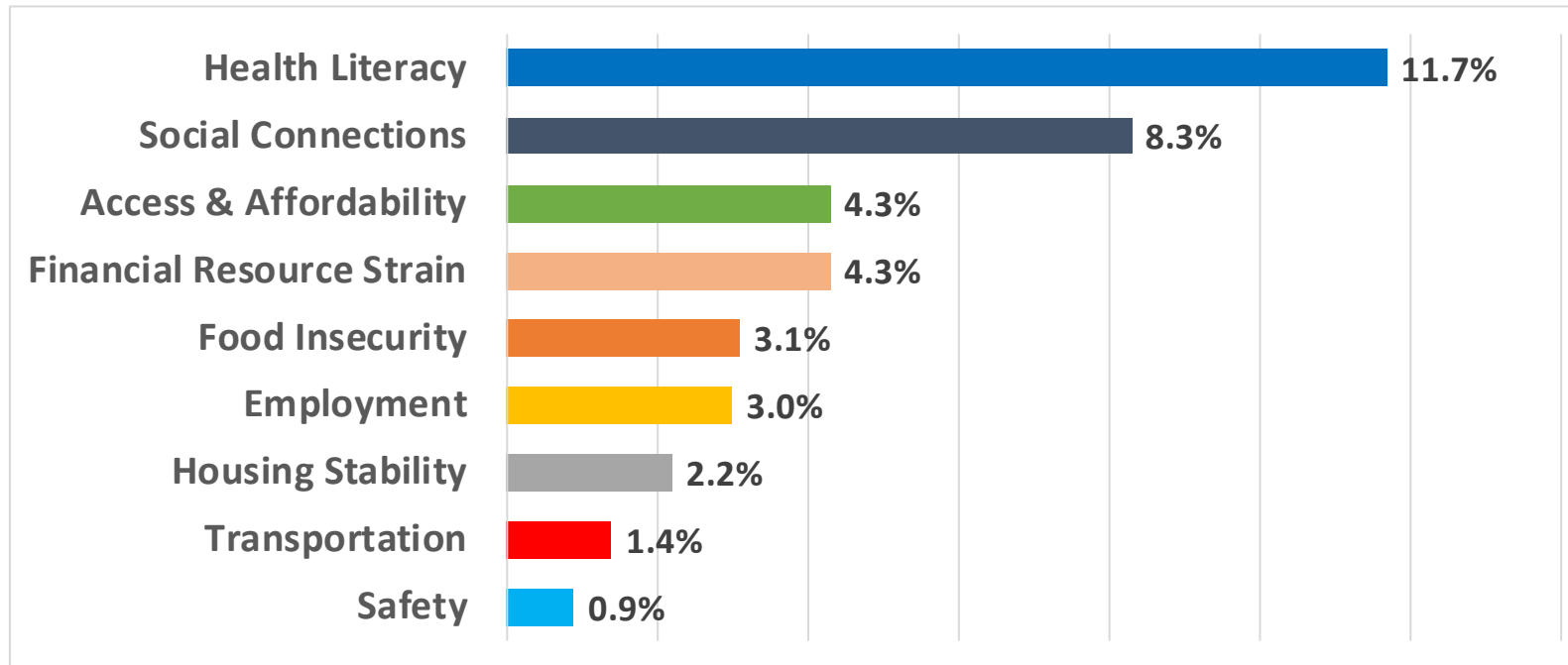
- Monitors outpatient SDOH questionnaire compliance of Core questions monthly
- Considered compliant if all questions within the Core domain are complete for specific visit types
- Identifies positive SDOH screenings from a geographical perspective to monitor resource availability in high volume zip 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?

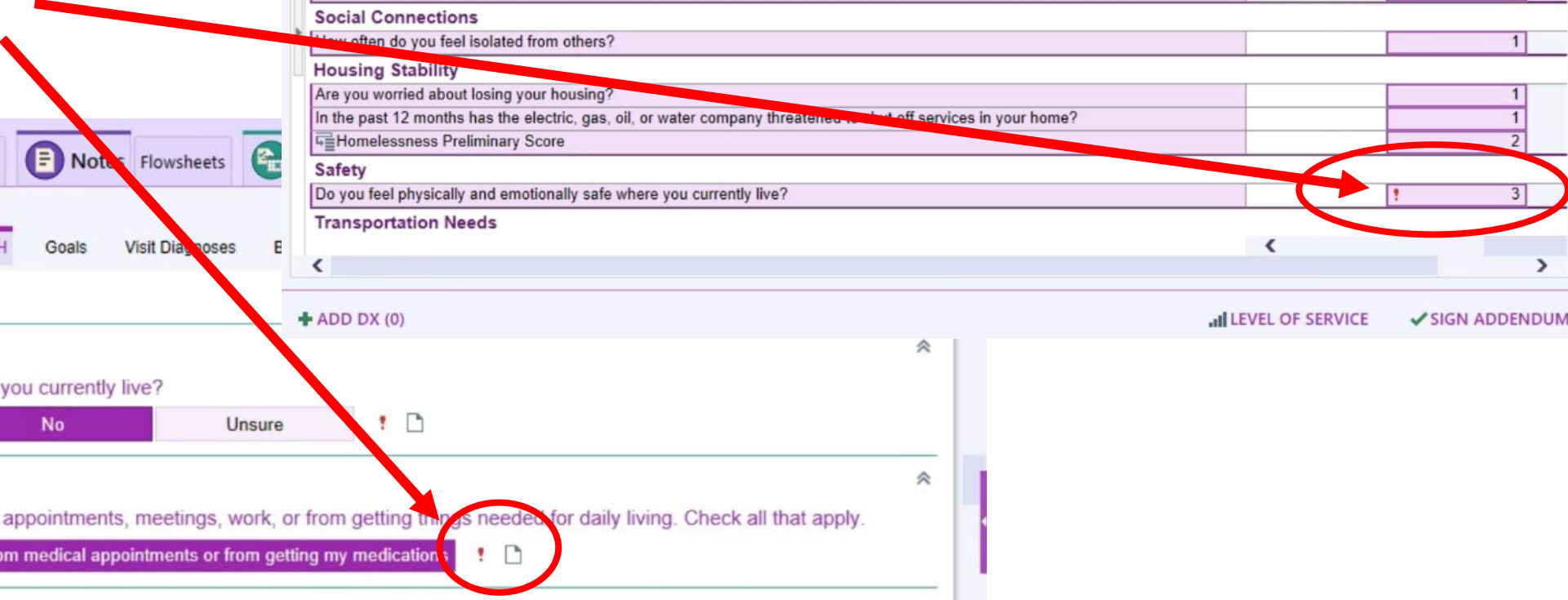
Response Display

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

The screenshot shows a clinical flowsheet with several sections. The 'Safety' section has a question: "Do you feel physically and emotionally safe where you currently live?" with options: "I choose not to answer", "Yes", "No", and "Unsure". The "No" option is selected and highlighted in red, with a red circle around it. The 'Transportation Needs' section has a question: "Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living. Check all that apply." with a checked option: "Yes, it has kept me from medical appointments or from getting my medication" highlighted in red, with a red circle around it. The 'Financial Resource Strain' section has a question: "What is your current work situation?" with options: "I choose not to answer", "Full-time work", "Part-time or temporary work", "Unemployed, and not seeking work (ex: student, retired, disabled, unpaid primary care giver)", and "Unemployed". The "Part-time or temporary work" option is selected and highlighted in red. Below it, another question: "Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you?" has the "Yes" option selected and highlighted in red.

This screenshot shows a detailed assessment table with the following categories and items:

- Health Literacy**
 - How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor ...: 4
 - I know how to find helpful health resources on the internet.: 2
- Social Connections**
 - How often do you feel isolated from others?: 1
- Housing Stability**
 - Are you worried about losing your housing?: 1
 - In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?: 1
 - Homelessness Preliminary Score: 2
- Safety**
 - Do you feel physically and emotionally safe where you currently live?: 3 (highlighted in red with a red circle and an exclamation point icon)
- Transportation Needs**



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

PRIMARY CARE VISIT
No visits
No results

CARE GAPS
MEDICARE ANNUAL WELLN...
+3 awaiting completion

PROBLEM LIST (22)
Pt List Reminders: None +

Start Review

SOCIAL DETERMINANTS 2A

Recent concerns: 3 1A

♥ Social Determinants of Health

- Stress** ⚡
Oct 17, 2023: Low Risk
Jul 21, 2023: High Risk
- Social Connections** 👤
Oct 17, 2023: High Risk
- Food Insecurity** 🍴
Oct 17, 2023: Low Risk
- Safety and Environment** 🌱
Oct 17, 2023: Low Risk
- Transportation** 🚗
Oct 17, 2023: Low Risk
- Childcare Access and Affordability** 👶
Oct 17, 2023: Low Risk
- Health Literacy** 🎓 4
Oct 17, 2023: Low Risk
Jul 21, 2023: High Risk 1B
- Alcohol and Drug Use** 🍷
Oct 17, 2023: High Risk
- Housing Stability** 🏠
Oct 17, 2023: Low Risk
- Financial Resource Strain** 🏛️
Oct 17, 2023: Low Risk
- Depression** 🧠
Oct 17, 2023: Not at risk
Jul 31, 2023: At risk

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

Test II, Patient
Female, 64 y.o., 11/14/1959
MRN: 11835297
CPR: Not on file

COVID-19 Vaccine: Unknown
Care Team: No PCP
Coverage: Bankers Fidelity/Bank...
Allergies: No Known Allergies

Active Therapy Plans

Weight: 50 kg (110 lb 3.7 oz) >7 days
BMI: 22.25 >1 day
BP: 122/80 >1 day

SINCE LAST PRIMARY CARE VISIT
No visits
No results

CARE GAPS

- HIV SCREEN
- LIPID PANEL
- HEMOGLOBIN A1C
- 14 more care gaps
- +2 awaiting completion

PROBLEM LIST (2)

Pt List Reminders: None +

SOCIAL DETERMINANTS

Health Maintenance

Topic	Due Date	Frequency	Date
Current Care Gaps			
HIV SCREEN	Overdue - never done	1 year(s)	
Breast Cancer Screening	Ordered on 6/13/2023	1 year(s)	
LIPID PANEL	Overdue - never done	1 year(s)	
HEMOGLOBIN A1C	Overdue - never done	6 month(s)	
COVID-19 Vaccine (1)	Overdue - never done	Imm Details	
Pneumococcal Vaccine: Pediatrics (0 to 5 Years) and At-Ris...	Overdue - never done	Imm Details	
DIABETIC RETINAL EXAM	Overdue - never done	1 year(s)	
FOOT EXAM	Overdue - never done	1 year(s)	
URINE MICROALBUMIN	Overdue - never done	1 year(s)	
HEPATITIS C SCREEN	Overdue - never done	Once	
Social Determinants of Health	Overdue - never done	1 year(s)	
Annual Creatinine	Overdue - never done	1 year(s)	
Annual Depression	Overdue - never done	1 year(s)	

Health Maintenance Plans

- AHN AMB DTAP/TDAP/TD VACCINE
- AHN INFLUENZA VACCINE ALL AGES >6 MONTHS
- COVID-19 Vaccine: Phase 2A (Ages 16-64)
- COVID-19 Vaccine: Phase PA 1A (Increased Risk Medical Condition)
- Colorectal Cancer Screening
- DEPRESSION SCREEN
- DIABETES MELLITUS FOOT EXAM
- DIABETES MELLITUS URINE MICROALBUMIN
- DIABETIC RETINAL EXAM
- HEMOGLOBIN A1C EVERY 6 MONTHS
- HIV SCREEN - HIGH RISK
- HYPERTENSION MONITORING
- Hepatitis C Screening
- LIPID PANEL EVERY 12 MONTHS
- MAMMOGRAM EVERY 1 YEAR
- Meningococcal B Vaccine
- Monkeypox Vaccine
- PAP SMEAR EVERY 3 YEARS

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.

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

PROVIDERS ONLY--Was a recommendation for treatment/follow up provided for their positive SDOH results today?

PROVIDERS ONLY--Did you provide an intervention today?

Referred to BHC or other Behavioral Health Professional Referred to Social Worker/Community Health Worker

Referred to AHN Community Support/Find Help Referred via other method

Domains Addressed

HL=Health Literacy SC=Social Connections HS=Housing Stability S=Safety

TN=Transportation N... FRS=Financial Resou... FI=Food Insecurity AD=Alcohol & Drug Use

St=Stress A=Access PHQ=PHQ-9 Other=Other

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

BestPractice Advisory - Test, bobby

⚠ Patient has indicated a positive response to questions regarding SAFETY. Please follow up accordingly.

[Go to Social Determinants of Health](#)

Acknowledge Reason

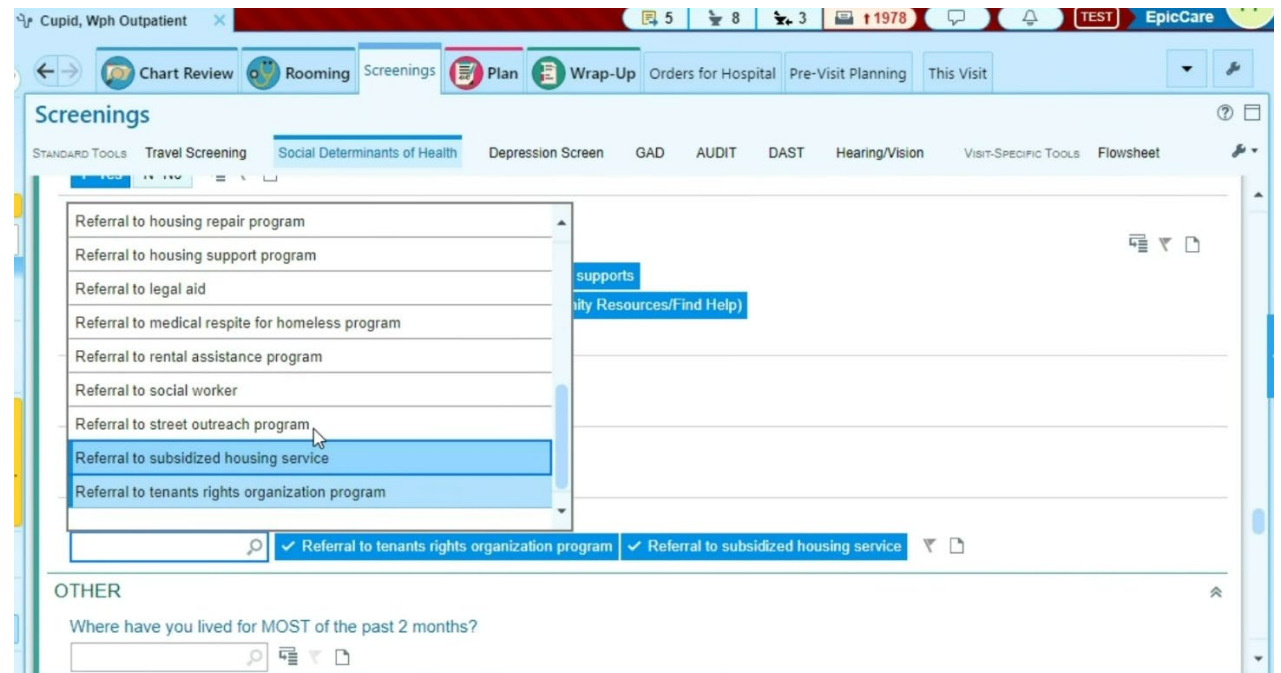
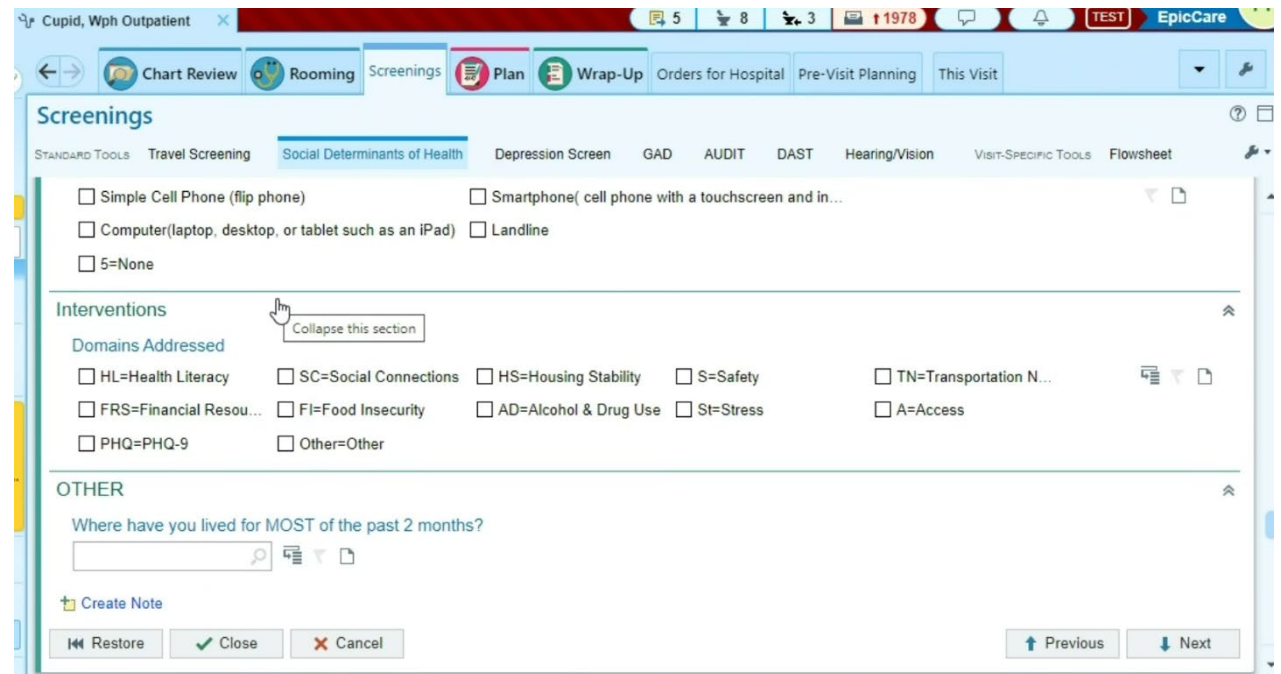
⚠ Patient has indicated a desire to potentially harm themselves. Please follow up accordingly.

[Go to Social Determinants of Health](#)

Acknowledge Reason

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.

The screenshot displays a software interface for 'Screenings'. At the top, there is a navigation bar with icons and labels for 'Chart Review', 'Rooming', 'Screenings', 'Plan', 'Wrap-Up', 'Orders for Hospital', 'Pre-Visit Planning', and 'This Visit'. Below this, the 'Screenings' section is active, with sub-tabs for 'STANDARD TOOLS', 'Travel Screening', 'Social Determinants of Health', 'Depression Screen', 'GAD', 'AUDIT', 'DAST', 'Hearing/Vision', 'VISIT-SPECIFIC TOOLS', and 'Flowsheet'. The 'Social Determinants of Health' sub-tab is selected, showing a list of interventions with checkmarks, such as 'Referral to Community Resources Network Program (ie. AHN Community Resources/Find Help)' and 'Education on social work support through medical practice'. Below the list, there are two questions: 'Did you provide an intervention today for social connections?' and 'Did you provide an intervention today for housing?'. The 'Did you provide an intervention today for housing?' question has 'Y=Yes' selected. A red circle highlights a document icon next to the 'Y=Yes' button, with a red arrow pointing to a modal window titled 'Intervention(s) Housing'. The modal window contains a 'Comment:' text box and 'Accept' and 'Cancel' buttons. Below the modal, there is a search box for 'Intervention(s) Housing' and a list of interventions with checkmarks, including 'Referral to tenants rights organization program', 'Referral to social worker', 'Referral to rental assistance program', 'Referral to medical respite for homeless program', 'Referral to legal aid', 'Referral to housing support program', and 'Referral to housing repair program'. At the bottom, there is an 'OTHER' section with the question 'Where have you lived for MOST of the past 2 months?' and a search box.

— 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

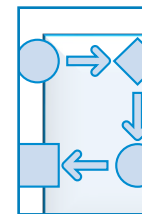


Practice active listening techniques (eye contact, head nodding, affirming statements of understanding)

- 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)

How do I explain this to patients?

Depression, tobacco, drugs, alcohol, and certain behaviors affect your health. To provide the best health care possible, we need to ask about them. So, we ask everyone. The conversation can also start with you. We are here to help!

WE ASK EVERYONE

“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!

Adapted with permission from Indiana SBIRT by the Pennsylvania Department of Drug and Alcohol Programs.

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Z 6/19 HC4062v



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.

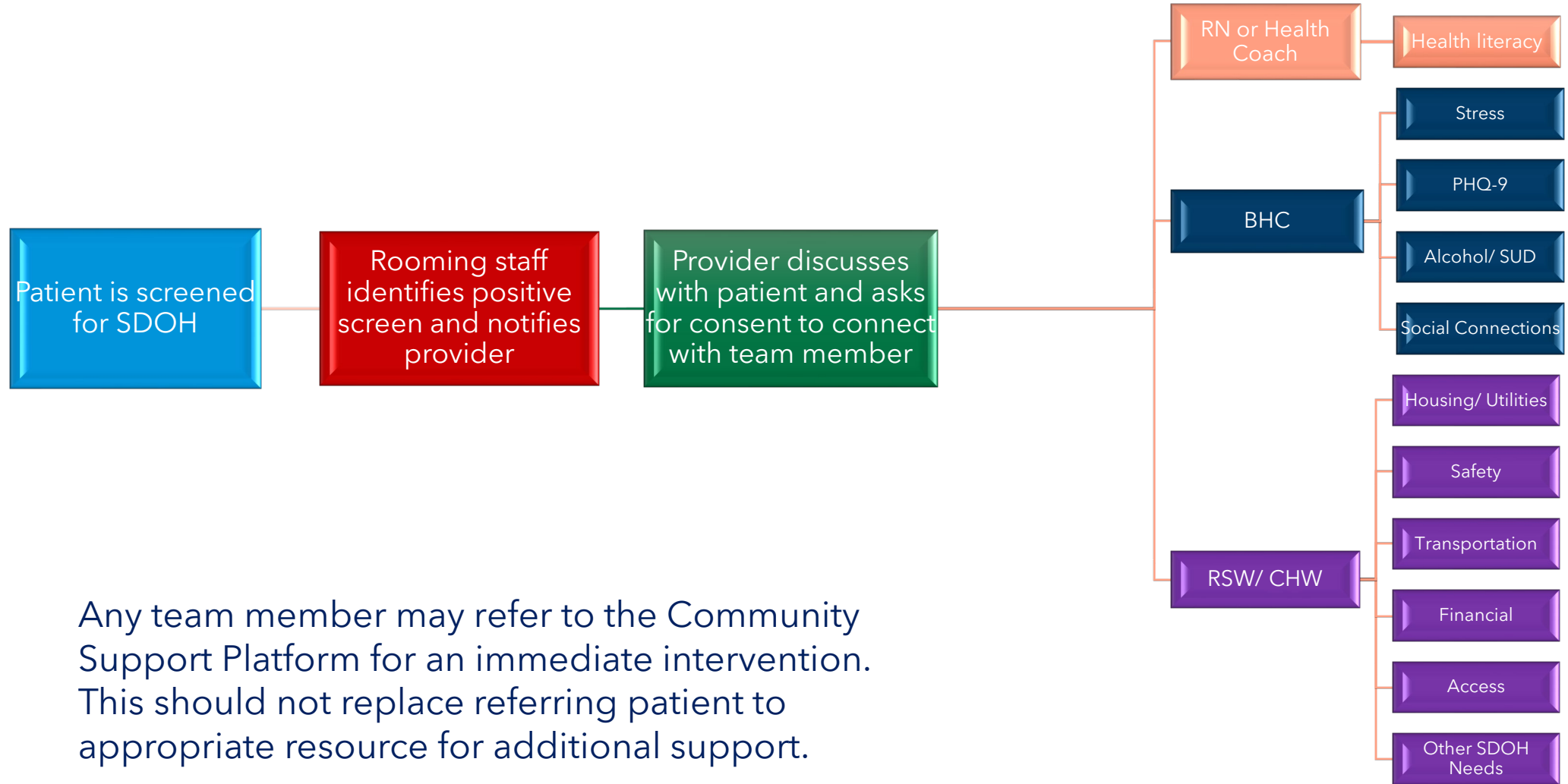
Do we still complete the SDOH screen if the patient has completed the screen within the past year at another site or if their annual wellness visit/physical is within a year of their first visit?

- 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?

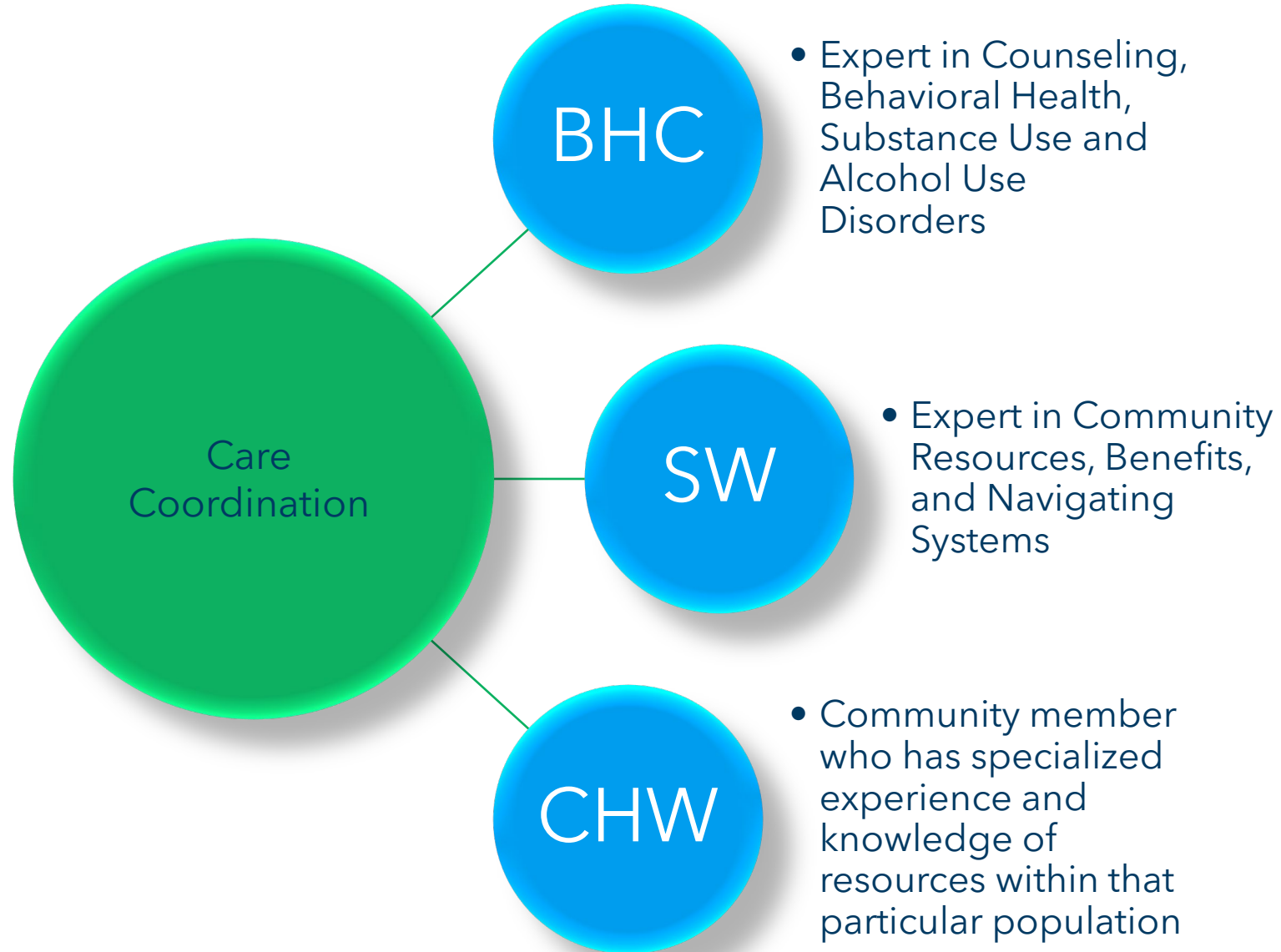
- Document "Chooses not to answer." By documenting it in this way, the screening will show as completed.

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?



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

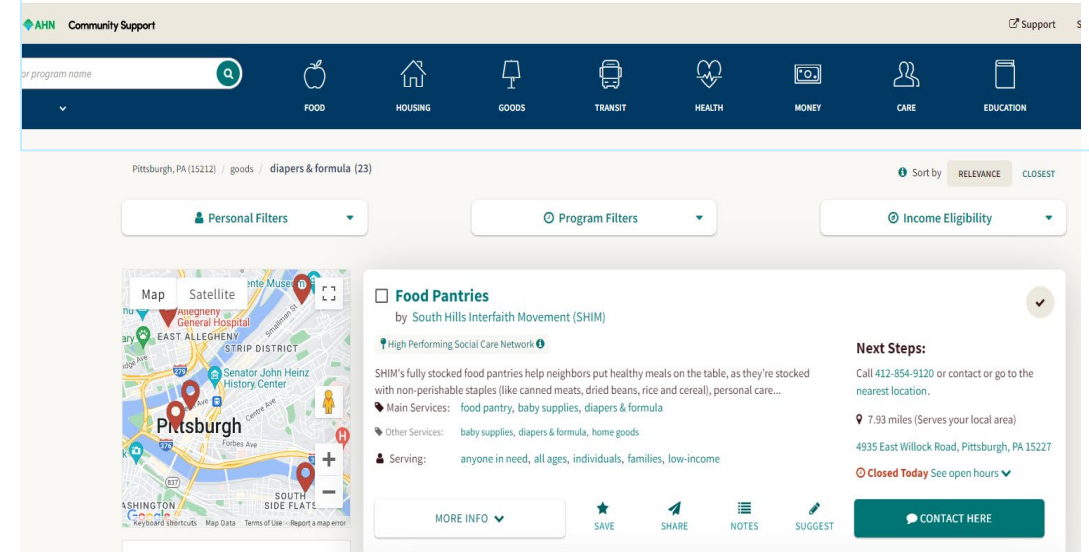


1. AHN Community Support- Patient Search

- 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.



Here to help

Social Determinants of Health PFAC Update 2023



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.

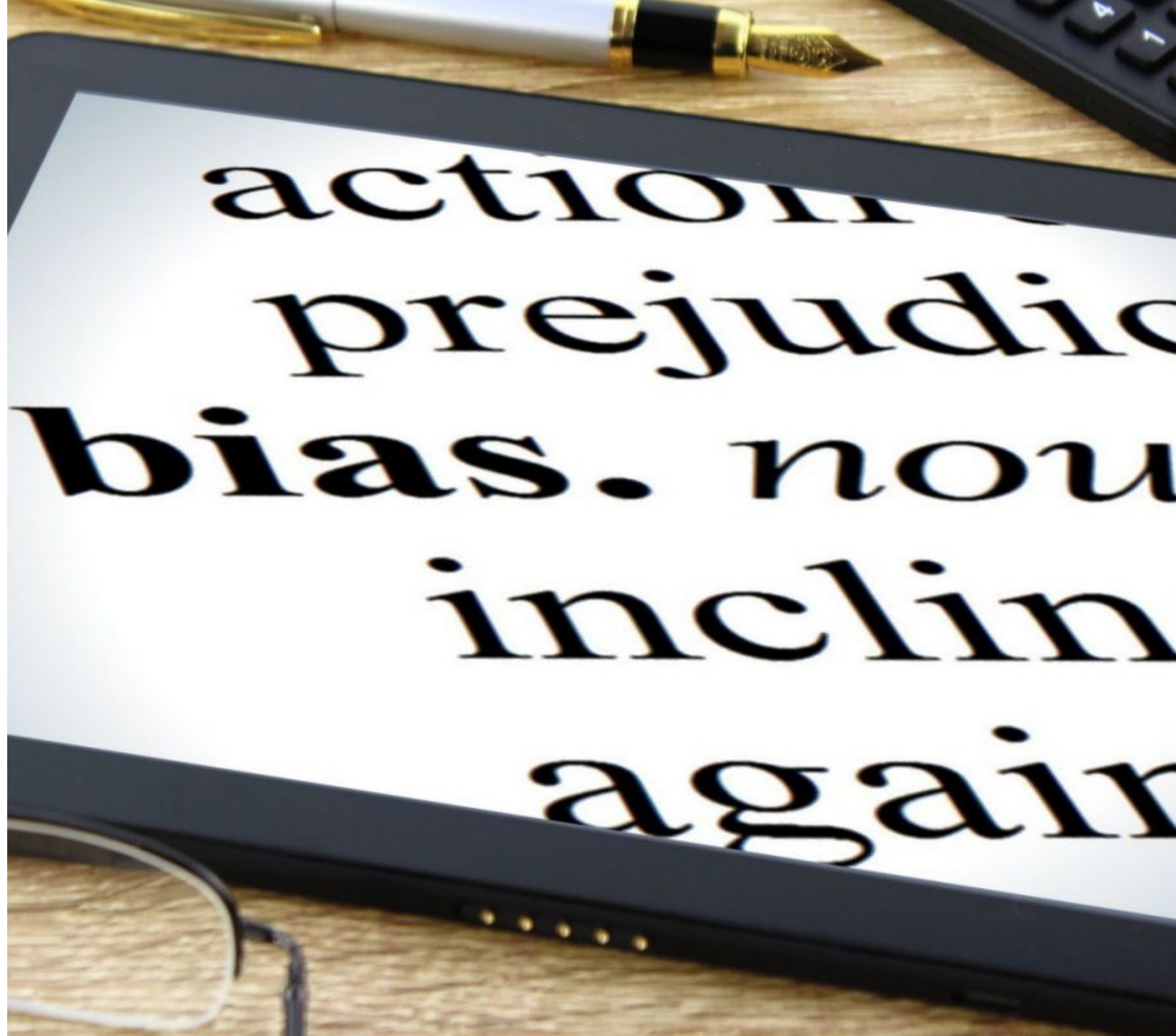
- **Unconscious Bias:**

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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