Housekeeping Reminders

Please submit questions via the Zoom chat during the presentation.

For attendance, please type in your name and organization in the chat.

Attendees are muted upon entry. Click “Unmute” when you would like to speak. Please mute yourself after speaking.

The presentations are posted on Tomorrow’s HealthCare www.tomorrowshealthcare.org

2025 PCMH Learning Network SDOH Sprint Session #1

February 26, 2025

Pittsburgh Regional Health Initiative

Robert Ferguson, MPH, Chief Policy Officer, Pittsburgh Regional Health Initiative

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.5 continuing education credits**.

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Learning Objectives

- ✓ Describe the goals of the Social Determinants of Health (SDOH) Intervention sprint
- ✓ Describe effective strategies for making referrals, closing the loop, and care plan adjustments for those with identified SDOH needs.
- ✓ Discuss how PCMHs in Pennsylvania are implementing key interventions for SDOH

SDOH Intervention Sprint

Robert Ferguson, MPH
Chief Policy Officer
Pittsburgh Regional Health Initiative

HealthChoices PCMH Program

The **PH-MCOs** contract with high volume providers who meet the PCMH requirements, reward PCMHs with quality-based enhanced payments, and develop a **learning network**

PCMH SDOH Screening and Intervention Requirements:

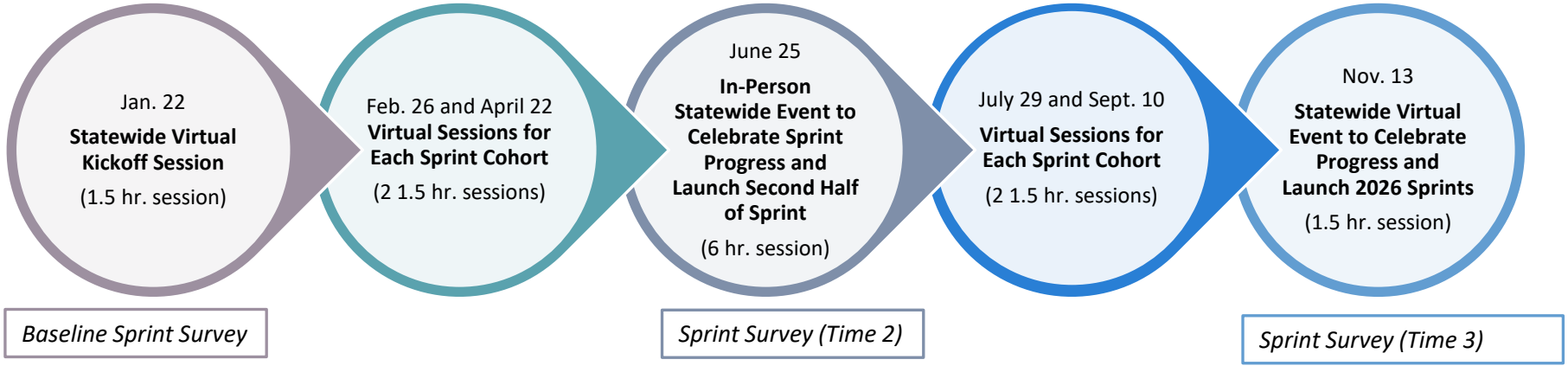
- ✓ Complete SDOH assessments
- ✓ Submit G9920 for negative screens
- ✓ Submit G9919 for positive screens and ICD-10 diagnostic codes for identified SDOH needs
- ✓ Assist with obtaining the needed services
- ✓ Deploy a Community-Based Care Management Team to connect individuals…to community resources and social support services through “warm hand off” referrals…
- ✓ Track referrals and outcomes

See Exhibit DDD

Physical Health MCOs

2025 PCMH Learning Network

Sessions Dates for SDOH Sprint



Optional Case-Based Learning Sessions on Clinical Topics Offered throughout the Year

SDOH Interventions Sprint

AIDS Care Group
Allegheny Health Network (Physician Partners of Western PA LLC)
Guthrie Medical Group
Independence Health System Butler Memorial Hospital
Keystone Rural Health Center
Lancaster General Health Physician Practices
Lebanon Valley Family Medicine
Leigh Valley Health Network Physician Group
Main Line Healthcare
Primary Care Health Services Inc.
Prospect Crozer Health
Public Health Management Corporation
UPMC Children's Community Pediatrics (Children's CIN/PA Pediatric Health Network PPHN)
UPMC Children's Primary Care Center - General Academic Pediatrics (PA Pediatric Health Network PPHN)
UPMC Susquehanna
Pediatric Care Specialists (PA Pediatric Health Network PPHN)

SDOH Referrals and Care Adjustment: What Do We Know?

Arwen Bunce, MA

Qualitative Research Scientist

OCHIN

Social determinants of health referrals and care adjustment: What do we know?

ARWEN BUNCE

2/26/2025

Pittsburgh Regional Health Initiative

PCMH PATIENT-CENTERED MEDICAL HOME Learning Network

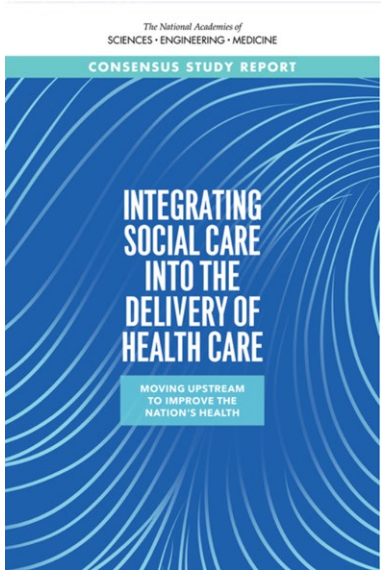
HEALTH FEDERATION OF PHILADELPHIA

How do social risks impact health?

- Access to affordable care
- Exposure to risks, e.g.:
  - Stress
  - Discrimination
  - Unsafe jobs
  - Lower health literacy
  - Adverse childhood events, conditions
- Ability to engage in healthy behaviors
- Ability to act on care recommendations
- These impacts interact and are cumulative

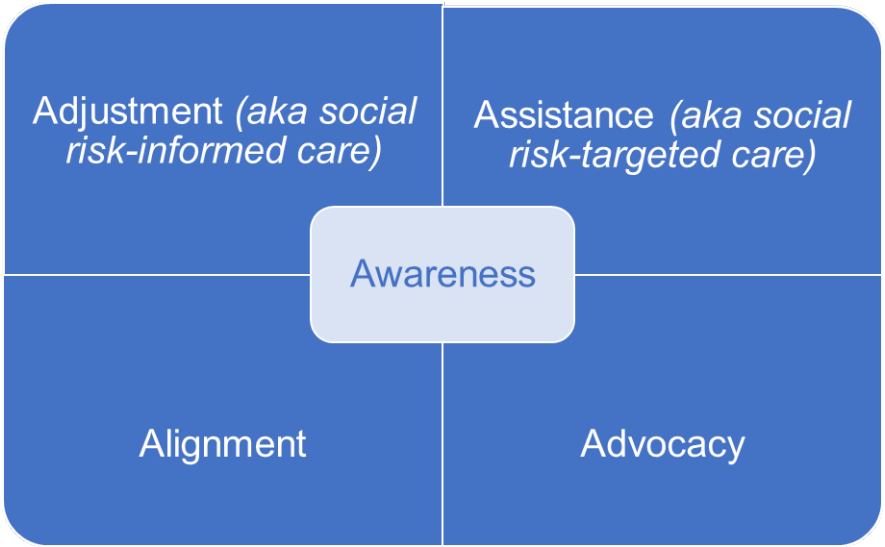
What Can Health Care Providers Do About This?

2019 NASEM Report: ‘5 As’ of social care integration



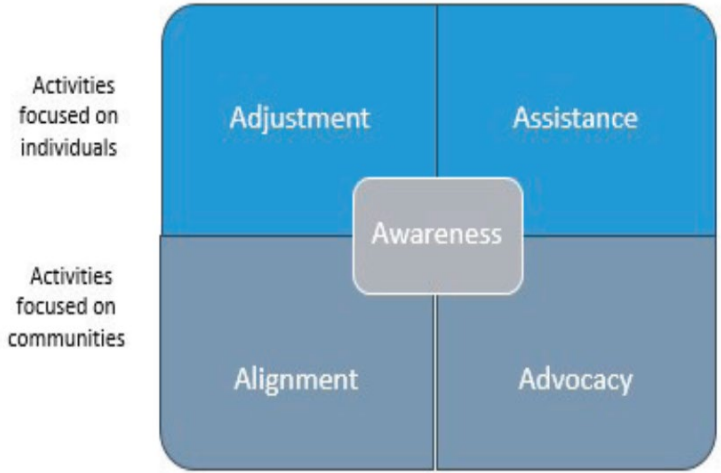
Activities focused on heath care delivery →

Activities focused on communities →



What do we know about Assistance?

- Emerging evidence: **internal** / **external** assistance referrals *can* modestly improve health outcomes
- Gottlieb et al 2017 evidence review found Assistance associated with improved:
  - Child health / health behaviors
  - Adult physical health or quality of life
  - Adult health-related behaviors (e.g., diet, smoking, and medication adherence)
  - Adult mental health outcomes
- But some studies found no or mixed health improvements associated with social risk intervention



What do we know about Assistance?

- Assumption (per Gottlieb et al 2024):
  - Screen for social risks → refer patients with social risks to social services → patients receive social services → which help reduce or resolve social risks → changes in social risks will → improved health
- Is this true?
  - Maybe, but **no strong evidence** yet supports this pathway
  - Rather, emerging evidence suggests a **more complex pathway** linking social risk screening and outcomes
  - Navigation (support accessing social services) may be key
  - Just increasing screening does not automatically increase referrals (Gold et al 2023)

What do we know about Assistance?

There are barriers to implementing Assistance …

- Patients offered assistance interventions **do not always want them**
  - Already tried them
  - Fear of stigma, discrimination re pursuing resource referrals due, e.g. due to immigration policies (Steeves-Reece, 2022)
  - Our team found:
    - **79%** of CHC patients with reported social risks declined referrals
      - Likelihood of declining varied by # positive domains, gender, race / ethnicity
  - Others found:
    - Food insecurity referral acceptance: 21-90%, housing referral acceptance: 12-20% (De Marchis, 2020)

What do we know about Assistance?

There are barriers to implementing Assistance …

- **Who do you refer to when social risk is reported?**
  - Are resources **available**?
  - Inadequate / restrictive community resources local to the patient?
  - Inaccessible resources, e.g., for patients with mobility / transportation barriers?

- **Who does the referring and when?**
  - Staff must have **time, workflows** to conduct referrals (*which* staff?) … and follow up, if desired
  - **Staff** must know local CBOs and who they serve; and / or
  - List of service agencies must be kept **up to date …**

What do we know about Assistance?

There are barriers to implementing Assistance …

- **Use Social Service Resource Locators?**
  - Can be **costly**
  - May not work well - depends on SSRL, region, how fast updated
  - Low-cost SSRLs accessed **outside** of EHR; inefficient + requires user to know where located
  - **EHR-based** SSRLs
    - Involve multiple steps / **clicks**
    - Present referral **options** - user needs to know how to choose
    - Referral-making **separate** from documentation
    - CBOs must be **willing** to engage ….
- **How best to 'close the loop'?**
- **CBO barriers** = capacity, technology, engagement …
  - So clinics can not just use SSRLs b/c referrals require **relationships** with CBOs, and **understanding** how to best work with them for effective referrals, e.g., How best to send referrals? What capacity to address referrals?

EHR Social Risk Diagnosis (Z code) Tools

Scenario: New positive social risk screening

- **Alert pops up for rooming staff***
  - Shows the positive domains (e.g., food insecurity) including Qs and As
  - Pre-checked selected Z code (e.g., Z59.41 Food Insecurity)
    - clinic can customize specific Z code or add additional options
  - Pre-checked to Add to Problem List
  - Can choose to also add to Visit Diagnosis

- **Similar alert to take a Z code off the Problem List is screening shows issue resolved.**

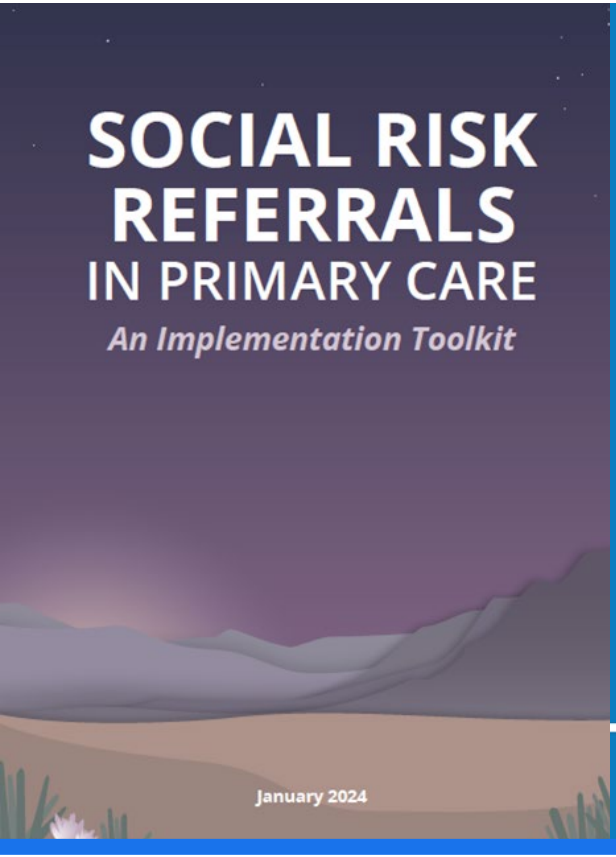
Reactions to Z code alerts

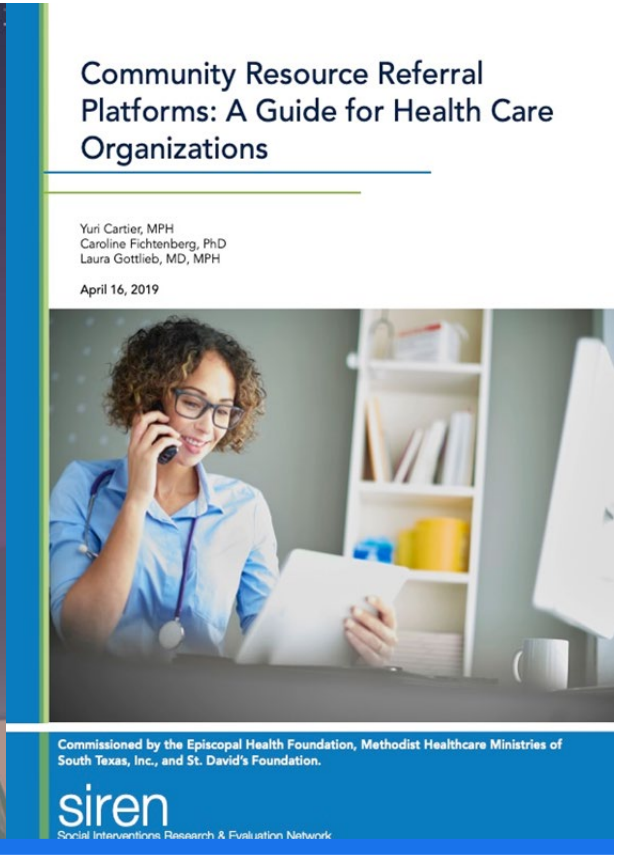
(Almost) everybody loved it:

- efficient (done by rooming staff; pre-populated = no extra time to think of correct code)
- ability to tailor means can meet clinic needs (ACO requirement, etc.)
- visibility on PL means can be used for referrals, reporting, adjustment by multiple staff roles
- standardization makes easier to collate & report out

Providers that didn't:

- cluttered problem list (&, don't need to know specifics, just that have SRs – refer to CHW/support staff no matter what
- uncomfortable with support staff adding diagnoses to PL

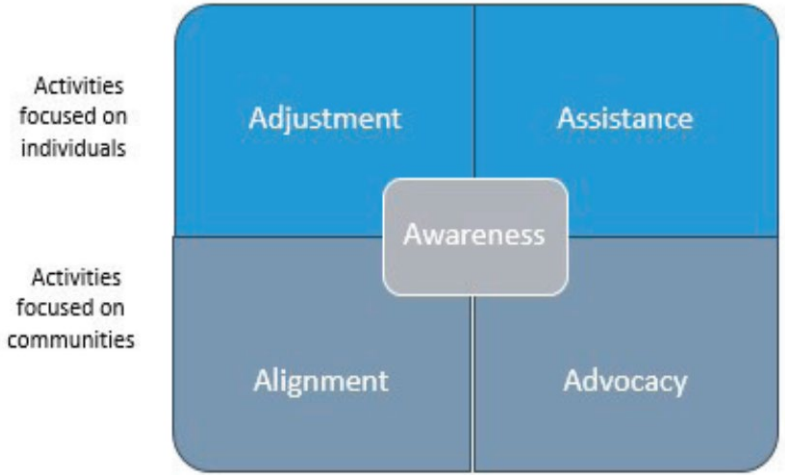




Resources for Assistance implementation

What do we know about Adjustment?

- Social risk adjustments might include:
  - Generic rxs, polypill, etc.
  - Mail rx to home
  - If transportation insecure: Follow-up care - pacing of visits, telehealth, etc.
  - If houseless: avoid refrigerated medications
  - If food insecure (DM): modify insulin doses based on monthly food benefit schedules
- Nascent evidence: better clinical outcomes associated with adjustments … But adjustments occur <25% of the time in diverse settings
- **How best to present social risk information to increase adjustments?**
- Might **EHR-based tools** help? E.g., reminders, summaries, recommendations? …



What do we know about Adjustment?

- Do social risks influence safety net primary care clinicians' decisions at the point of care? How?
- Survey: 38 CHC clinicians at point of care
- Social risks reported to influence care in 35% of surveyed encounters
- Sources of information on social risks:
  - conversations with patients (76%)
  - prior knowledge (64%)
  - EHR (46%)
- Significantly more likely to influence care among male and non-English–speaking patients, and those with discrete screening data in the EHR

Patient-Reported Social Risks and Clinician Decision Making: Results of a Clinician Survey in Primary Care Community Health Centers

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VISUAL ABSTRACT

Conflicts of interest: authors report none.

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ABSTRACT

PURPOSE To assess the extent that patients' social determinants of health (SDOH) influence safety-net primary care clinicians' decisions at the point of care; examine how that information comes to the clinician's attention; and analyze clinician, patient, and encounter characteristics associated with the use of SDOH data in clinical decision making.

METHODS Thirty-eight clinicians working in 21 clinics were prompted to complete 2 short card surveys embedded in the electronic health record (EHR) daily for 3 weeks. Survey data were matched with clinician-, encounter-, and patient-level variables from the EHR. Descriptive statistics and generalized estimating equation models were used to assess relationships between the variables and the clinician reported use of SDOH data to inform care.

RESULTS Social determinants of health were reported to influence care in 35% of surveyed encounters. The most common sources of information on patients' SDOH were conversations with patients (76%), prior knowledge (64%), and the EHR (46%). Social determinants of health were significantly more likely to influence care among male and non-English–speaking patients, and those with discrete SDOH screening data documented in the EHR.

CONCLUSIONS Electronic health records present an opportunity to support clinicians integrating information about patients' social and economic circumstances into care planning. Study findings suggest that SDOH information from standardized screening documented in the EHR, combined with patient-clinician conversations, may enable social risk-adjusted care. Electronic health record tools and clinic workflows could be used to support both documentation and conversations. Study results also identified factors that may cue clinicians to include SDOH information in point-of-care decision-making. Future research should explore this topic further.

Ann Fam Med 2023;21:143-150. https://doi.org/10.1370/afm.2953

INTRODUCTION

Despite increasing national interest in social risk screening in primary care settings[1-7] and the potential for contextual information to influence care in ways that improve patient outcomes,[8,9] little is known about whether and how social risk (adverse social determinants of health) information influences clinician decisions at the point of care. Few prior studies have explored the extent to which social determinants of health (SDOH) data informs care, and diverse definitions and measurement approaches make comparisons difficult. Broadly speaking, use of SDOH in care planning varies by practice specialty, clinician, and patient situation.[10-13] Studies that quantified the impact of SDOH on care have reported use rates of 22% to 59%,[9,11-13] and all concluded that missed opportunities are common.[9,10,11,14-16]

Social risk data could influence point of care activities in multiple ways. A 2019 National Academies of Sciences, Engineering, and Medicine report suggested 5 ways in which social care can be integrated into health care, 2 of which are applicable to actions at the point of care (assistance and adjustment).[17] Assistance, sometimes called social prescribing, involves connecting patients to community resources. Adjustment entails adapting medical care to accommodate social risk. Evidence is gradually mounting that assistance and adjustment interventions can improve health.[6,14,18-21] A recent United States Preventative Services Taskforce brief called for more high-quality research in this area.[22]

EHR Adjustment Tools

Tailored based on SR screening results & medical red flags

Available as in-line alerts or as a smartlist that can be embedded in note templates or added manually using a dot phrase/macro (.sdhadjust).

"Patient has recent [HbA1c >=9%, BP >140/90, hx of no-shows], and known socioeconomic barriers. Patient and [username] discussed: [checklist]"

- Clinical provider will follow up on this topic (for support staff)
- Titrating insulin based on food availability
- Possible medication substitutions, alternative dosing, and / or home delivery options to reduce medication costs
- GoodRx discount
- 30- vs 90-day prescription(s)
- Longer interval follow up
- Following up via telemedicine
- Other barriers to the patient taking medications as prescribed;***
- Patient should consult with pharmacist re: lowering medication costs (e.g. medication, dosing, or delivery changes)
- *** (Wildcard; allows for free text)

What do we know about Adjustment : Hot (not quite) off the press

In a recent trial:

- EHR tools co-created with CHC partners **significantly increased screening and Z code documentation, but did not impact clinical outcomes.**

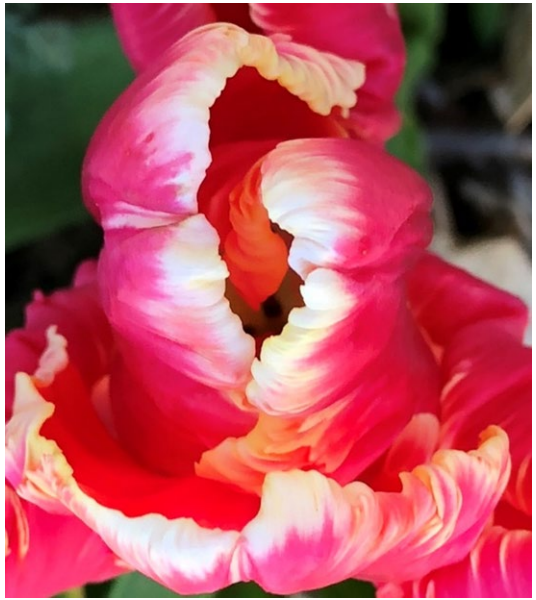
- Main qualitative findings: Must **align technology to the values** underlying professional identity → in CHCs = **patient-centered care**.
  - SR screening & Z code alerts perceived as enhancing ability to provide patient-centered care = high uptake
  - Care adjustment recommendations perceived as patronizing & superseding clinician autonomy = low uptake

BUT, increasingly required/paid to document/report these actions – what to do?

What do we still need to know?

- Through which **pathways** do social risk screening, referrals impact health outcomes?
- Which **approaches** to addressing social risks are most effective for which patients?
- What methods for conducting social risk screening, referrals, navigation are most effective **in CHCs**?
- Given resistance to care recommendations & additional documentation requirements – is there a way to automate documentation of actions taken in response to social risks?

  → such documentation increasingly required



Thank you! Questions?

Arwen Bunce

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Resources

- Social Needs Referrals in Primary Care: An Implementation Toolkit: https://sirenetwork.ucsf.edu/tools-resources/resources/social-needs-referrals-primary-care-implementation-toolkit
- Community Resource Referral Platforms: A Guide for Health Care Organizations: https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations
- Guide to Implementing Social Risk Screening and Referral-making: https://sirenetwork.ucsf.edu/guide-implementing-social-risk-screening-and-referral-making
- Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health (2019): https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health

Publications with screenshots of EHR Adjustment tools discussed:

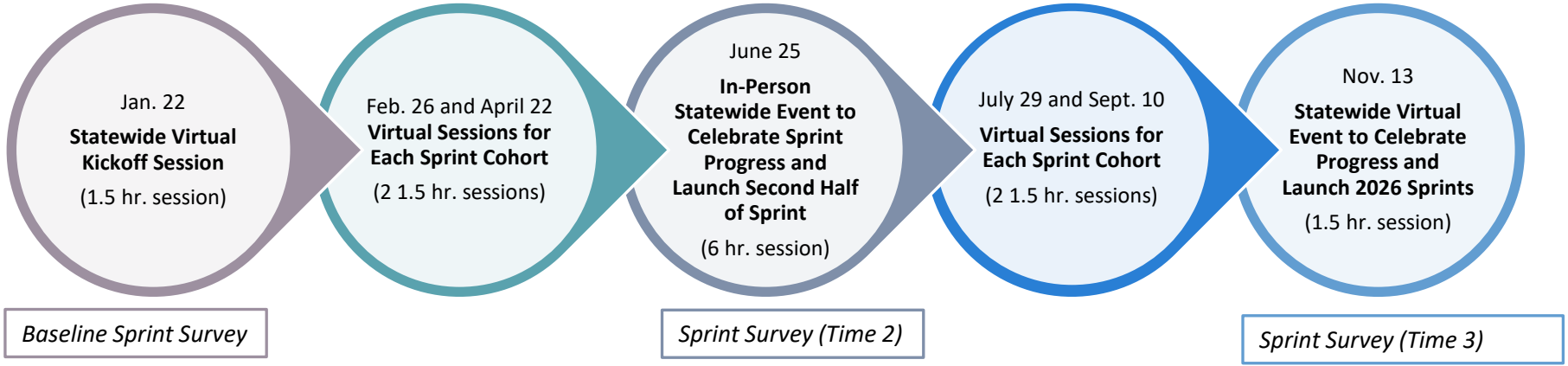
- Pisciotta et al. Help us document what we already do: Pilot study of clinical decision support tools targeting social risk-informed care. JAMIA Open (in submission)
- Bunce et al. “The start of something that I hope could be greater”: Health information technology tools for social care. SSM Qualitative Research in Health (in submission)
- McGrath et al. Impact of Clinical Decision Support for Social Care: COHERE Trial Results (in preparation)

Publications referenced in slides

- Gottlieb et al. A Systematic Review of Interventions on Patients' Social and Economic Needs. Am J Prev Med. 2017 Nov;53(5):719-729.
- Gottlieb at el. Revising the Logic Model Behind Health Care’s Social Care Investments. Milbank Quarterly. June 2024.
- Gold et al. Implementation Support for a Social Risk Screening and Referral Process in Community Health Centers. NEJM Catalyst. 2023.
- Steeves-Reece et al. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022 May;62(5):e303-e315.
- De Marchis et al. Do Patients Want Help Addressing Social Risks? J Am Board Fam Med. 2020 Mar-Apr;33(2):170-175.

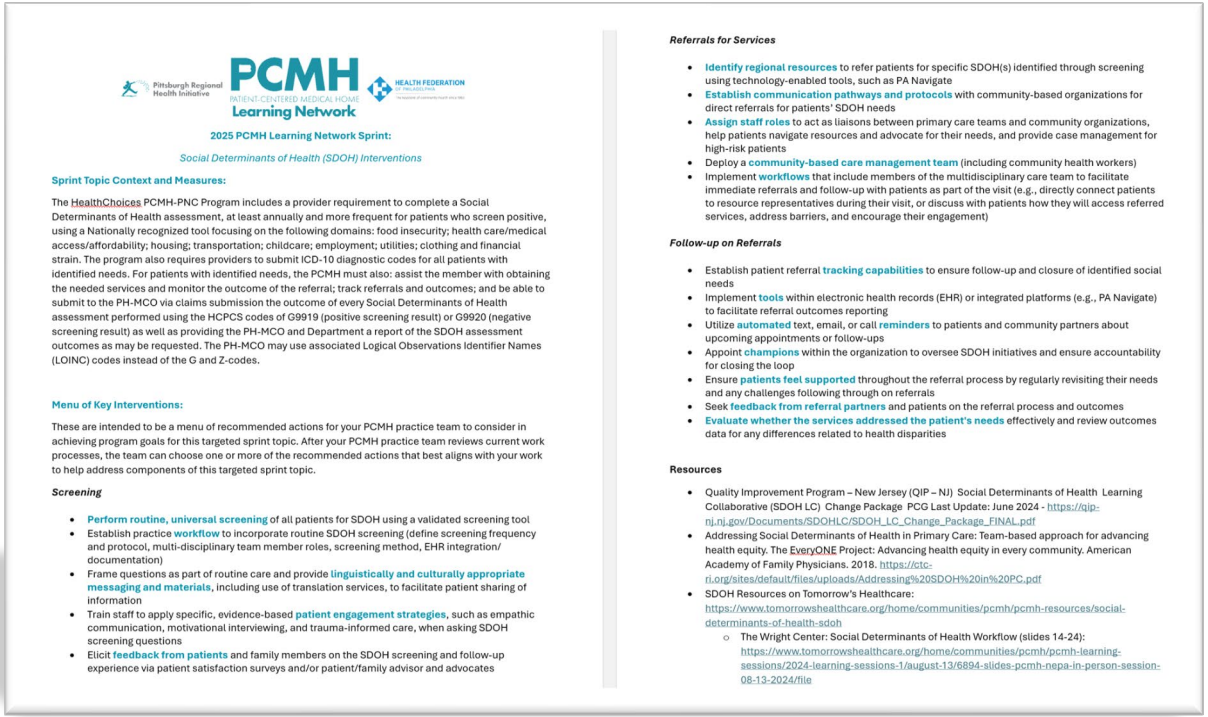
2025 PCMH Learning Network

Sessions Dates for SDOH Sprint



Optional Case-Based Learning Sessions on Clinical Topics Offered throughout the Year

SDOH Interventions Sprint



Pittsburgh Regional Health Initiative | PCMH Patient-Centered Medical Home Learning Network | Health Federation

2025 PCMH Learning Network Sprint:

Social Determinants of Health (SDOH) Interventions

Sprint Topic Context and Measures:

The HealthChoices PCMH-PNC Program includes a provider requirement to complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain. The program also requires providers to submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must also: assist the member with obtaining the needed services and monitor the outcome of the referral; track referrals and outcomes; and be able to submit to the PH-MCO via claims submission the outcome of every Social Determinants of Health assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as providing the PH-MCO and Department a report of the SDOH assessment outcomes as may be requested. The PH-MCO may use associated Logical Observations Identifier Names (LOINC) codes instead of the G and Z-codes.

Menu of Key Interventions:

These are intended to be a menu of recommended actions for your PCMH practice team to consider in achieving program goals for this targeted sprint topic. After your PCMH practice team reviews current work processes, the team can choose one or more of the recommended actions that best aligns with your work to help address components of this targeted sprint topic.

Screening

- **Perform routine, universal screening** of all patients for SDOH using a validated screening tool
- Establish practice **workflow** to incorporate routine SDOH screening (define screening frequency and protocol, multi-disciplinary team member roles, screening method, EHR integration/ documentation)
- Frame questions as part of routine care and provide **linguistically and culturally appropriate messaging and materials**, including use of translation services, to facilitate patient sharing of information
- Train staff to apply specific, evidence-based **patient engagement strategies**, such as empathic communication, motivational interviewing, and trauma-informed care, when asking SDOH screening questions
- Elicit **feedback from patients** and family members on the SDOH screening and follow-up experience via patient satisfaction surveys and/or patient/family advisor and advocates

Referrals for Services

- **Identify regional resources** to refer patients for specific SDOH(s) identified through screening using technology-enabled tools, such as PA Navigate
- **Establish communication pathways and protocols** with community-based organizations for direct referrals for patients' SDOH needs
- **Assign staff roles** to act as liaisons between primary care teams and community organizations, help patients navigate resources and advocate for their needs, and provide case management for high-risk patients
- Deploy a **community-based care management team** (including community health workers)
- Implement **workflows** that include members of the multidisciplinary care team to facilitate immediate referrals and follow-up with patients as part of the visit (e.g., directly connect patients to resource representatives during their visit, or discuss with patients how they will access referred services, address barriers, and encourage their engagement)

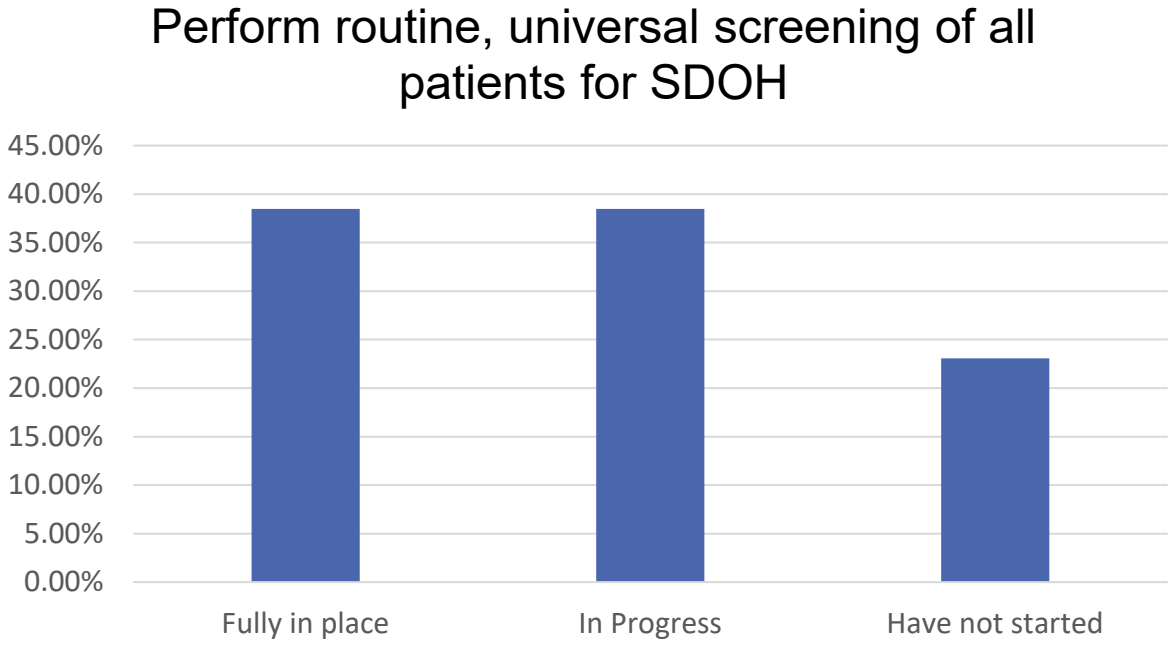
Follow-up on Referrals

- Establish patient referral **tracking capabilities** to ensure follow-up and closure of identified social needs
- Implement **tools** within electronic health records (EHR) or integrated platforms (e.g., PA Navigate) to facilitate referral outcomes reporting
- Utilize **automated** text, email, or call **reminders** to patients and community partners about upcoming appointments or follow-ups
- Appoint **champions** within the organization to oversee SDOH initiatives and ensure accountability for closing the loop
- Ensure **patients feel supported** throughout the referral process by regularly revisiting their needs and any challenges following through on referrals
- Seek **feedback from referral partners** and patients on the referral process and outcomes
- **Evaluate whether the services addressed the patient's needs** effectively and review outcomes data for any differences related to health disparities

Resources

- Quality Improvement Program – New Jersey (QIP – NJ) Social Determinants of Health Learning Collaborative (SDOH LC) Change Package PCG Last Update: June 2024 - https://qip-nj.nj.gov/Documents/SDOHLC/SDOH_LC_Change_Package_FINAL.pdf
- Addressing Social Determinants of Health in Primary Care: Team-based approach for advancing health equity. The EveryONE Project: Advancing health equity in every community. American Academy of Family Physicians. 2018. https://ctc-ri.org/sites/default/files/uploads/Addressing%20SDOH%20in%20PC.pdf
- SDOH Resources on Tomorrow's Healthcare: https://www.tomorrowshealthcare.org/home/communities/pcmh/pcmh-resources/social-determinants-of-health-sdoh
  - The Wright Center: Social Determinants of Health Workflow (slides 14-24): https://www.tomorrowshealthcare.org/home/communities/pcmh/pcmh-learning-sessions/2024-learning-sessions-1/august-13/6894-slides-pcmh-nepa-in-person-session-08-13-2024/file

SDOH Interventions - Baseline Sprint Survey



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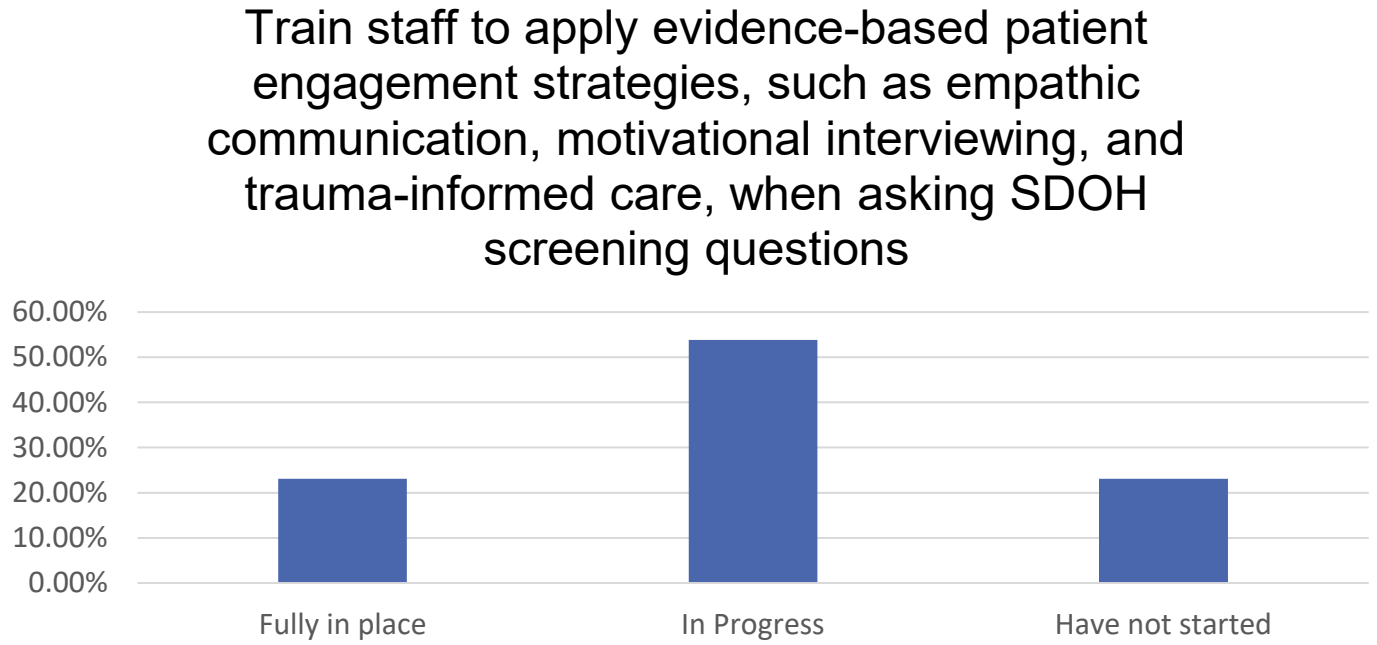
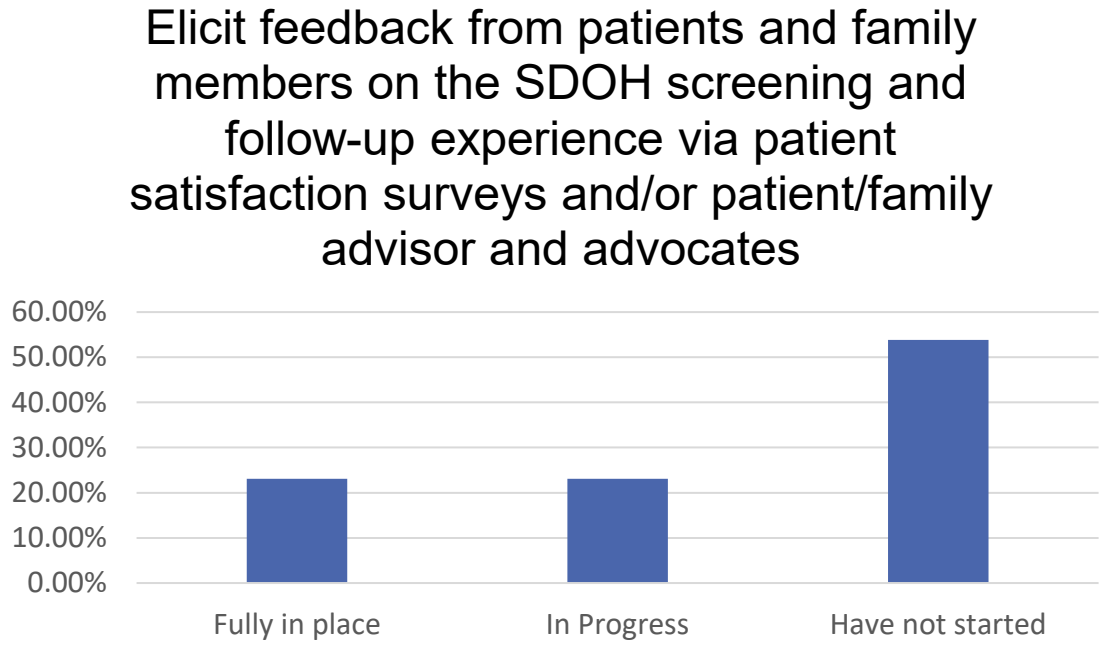
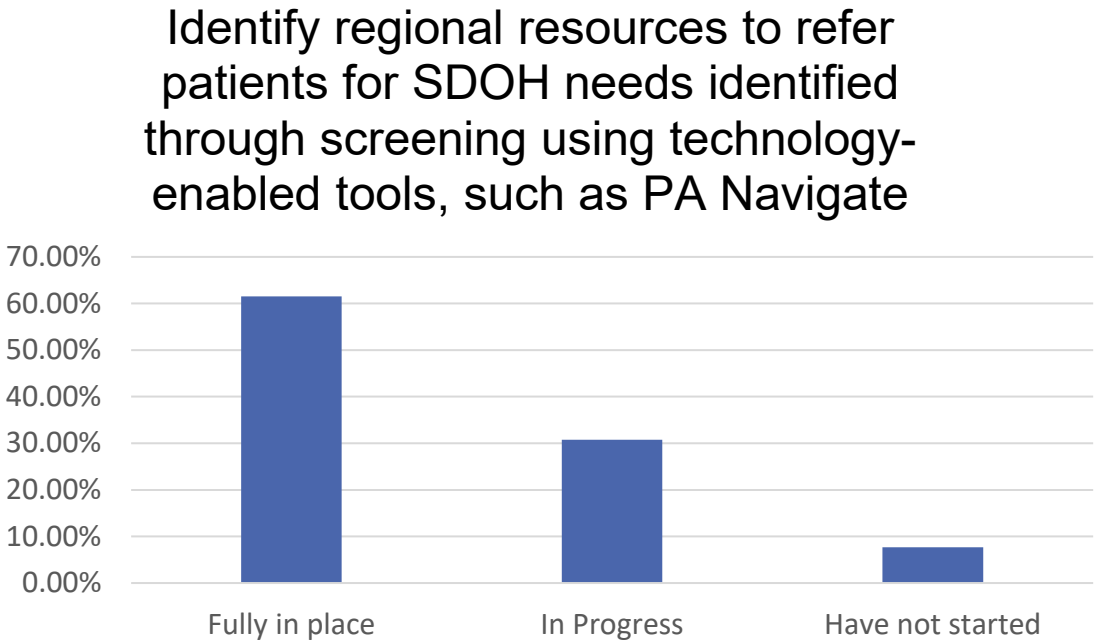


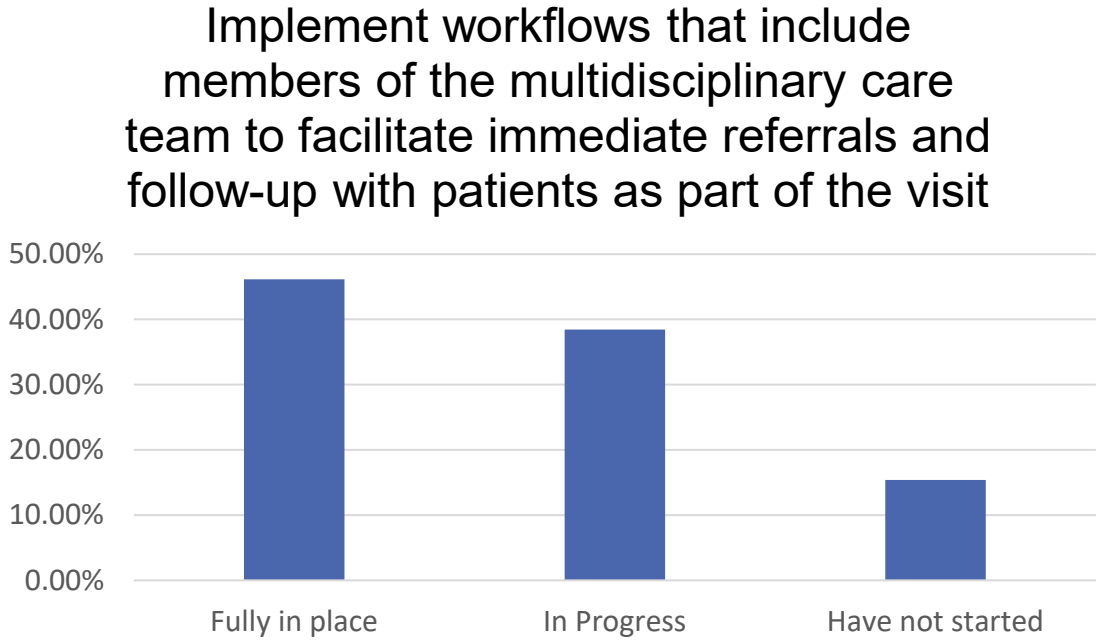
SDOH Interventions - Baseline Sprint Survey



SDOH Interventions - Baseline Sprint Survey



Interventions - Baseline Sprint Survey



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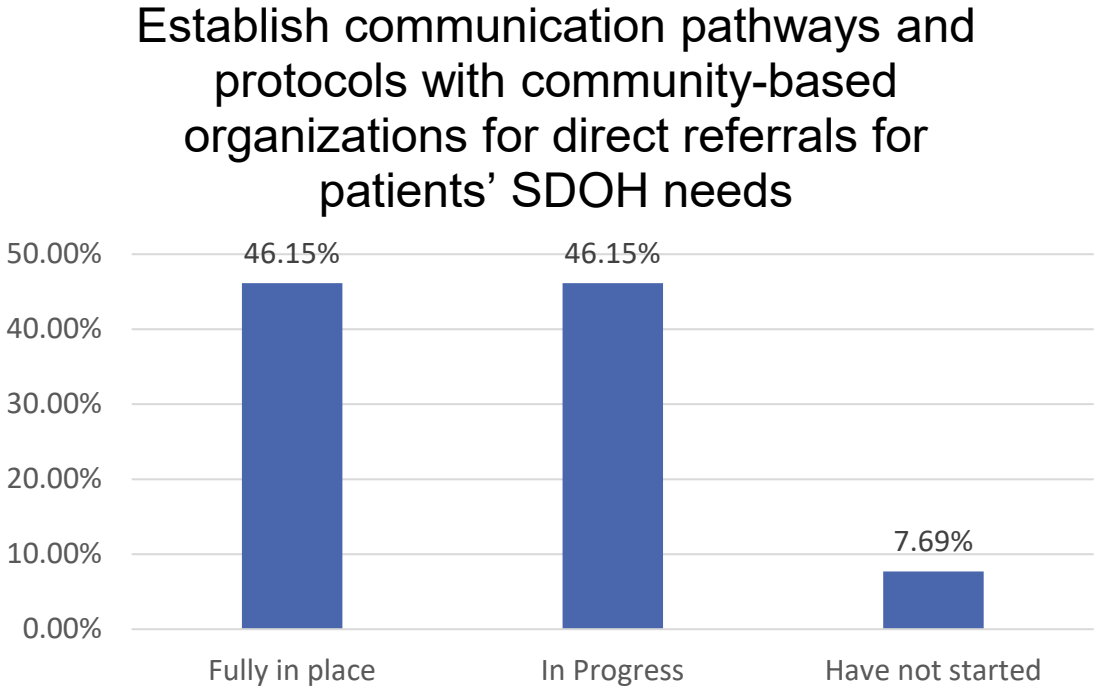
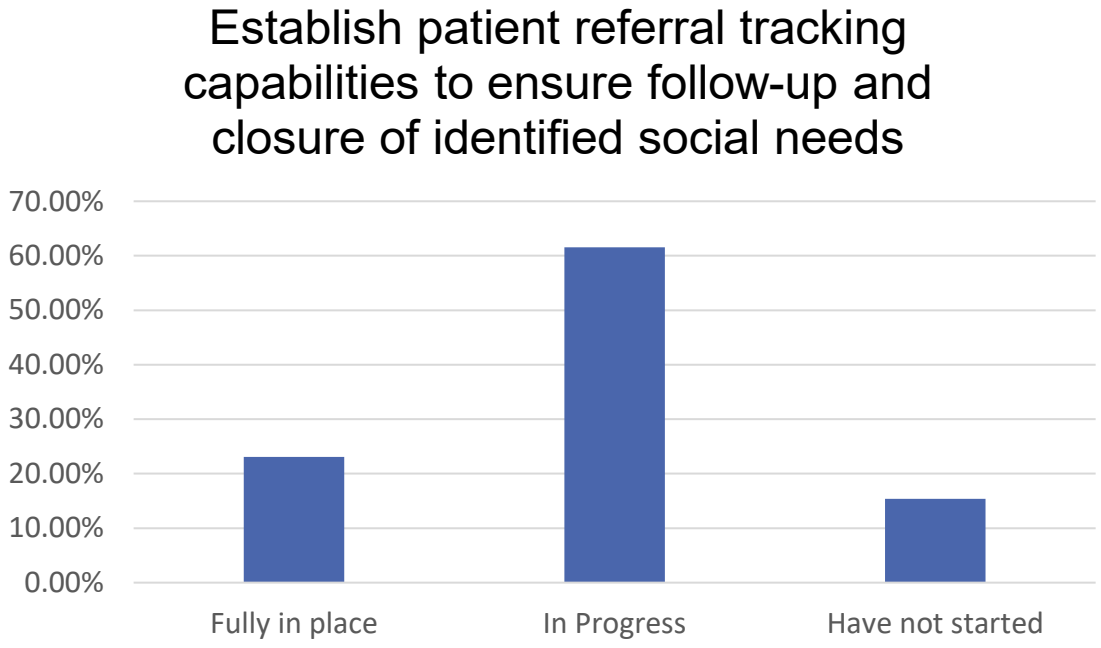
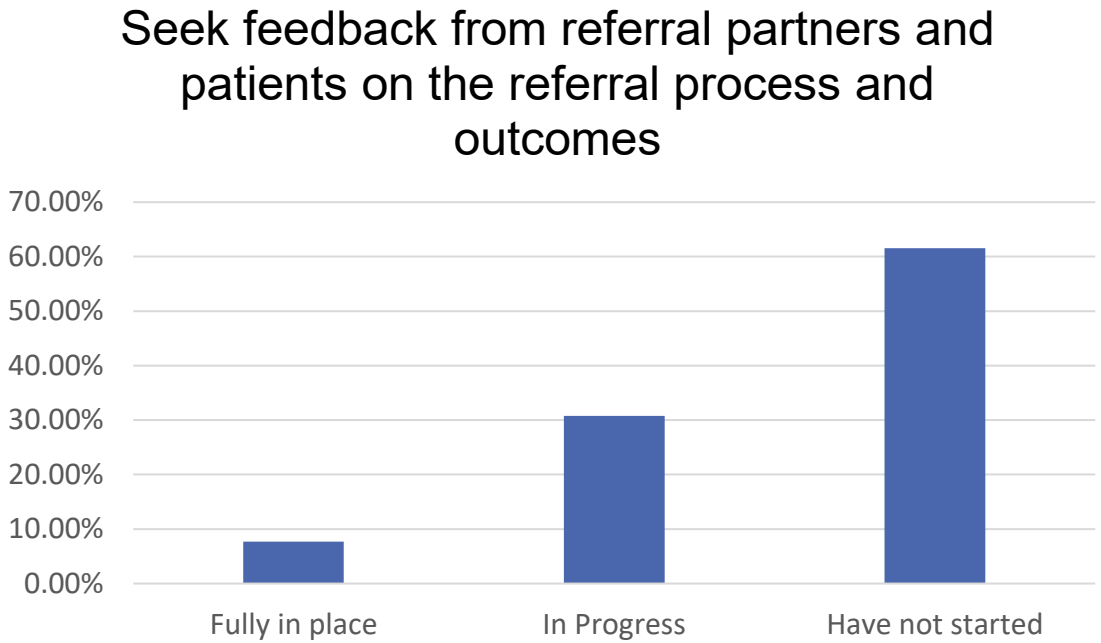


Interventions - Baseline Sprint Survey



** Most PCMHs are prioritizing this key interventions for their QI plans*

Interventions - Baseline Sprint Survey



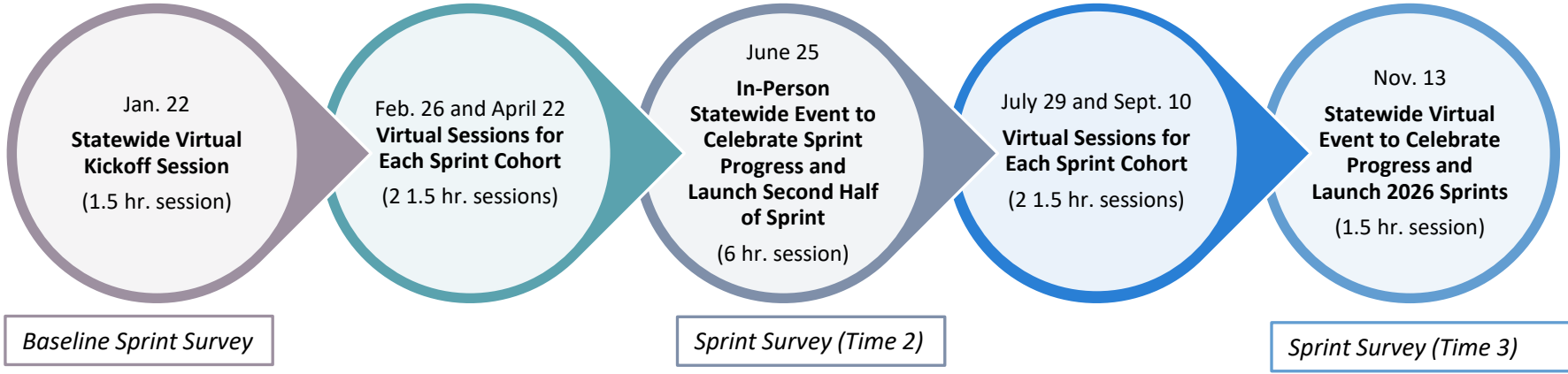
PCMH Peer-to-Peer Learning Discussion

- What steps is your PCMH currently taking to establish SDOH referral tracking processes, team roles, and tools to ensure follow-up and closure of identified social needs?
- What has worked well?
- What challenges are you experiencing?
- To inform your team's next steps, what would your PCMH team like to learn at the next SDOH Interventions Sprint session?

Wrap Up & Session Evaluation

Lisa Boyd, Program Specialist, Pittsburgh Regional Health Initiative

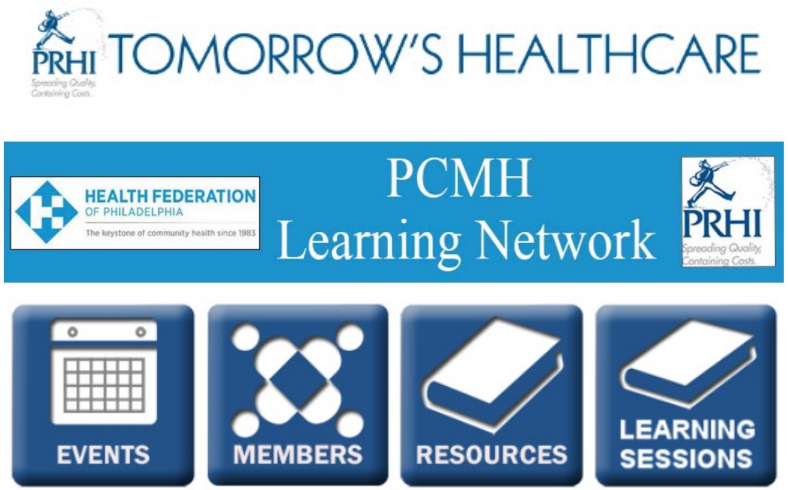
2025 PCMH Learning Network



PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/S28MNH9 by Wednesday, March 5

1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, please be sure the email you enter on the survey matches the UPMC CCE account email that you create.

2. The UPMC Center for Continuing Education will follow up with you via email after **March 5th** with instructions on how to claim your credits.
   - ❑ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

Thank You!