

SDOH Workflows & Interventions

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AHN SDOH Screening and Intervention Process

A simple 4-step workflow with demonstrated success over 5 years.
Network-wide initiative, all specialties are screening for SDOH.

01

Check

For completion
via MyChart or
tablet

02

Screen

If not completed

03

Intervene

If positive,
someone must
do something

04

Document

the intervention
for each domain
that is positive

Universal SDOH Assessment



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

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



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.



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.



PHQ-9: REQUIRED IN PRIMARY CARE

- ☐ 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?



SAFETY

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



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?



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?**



SOCIAL CONNECTIONS

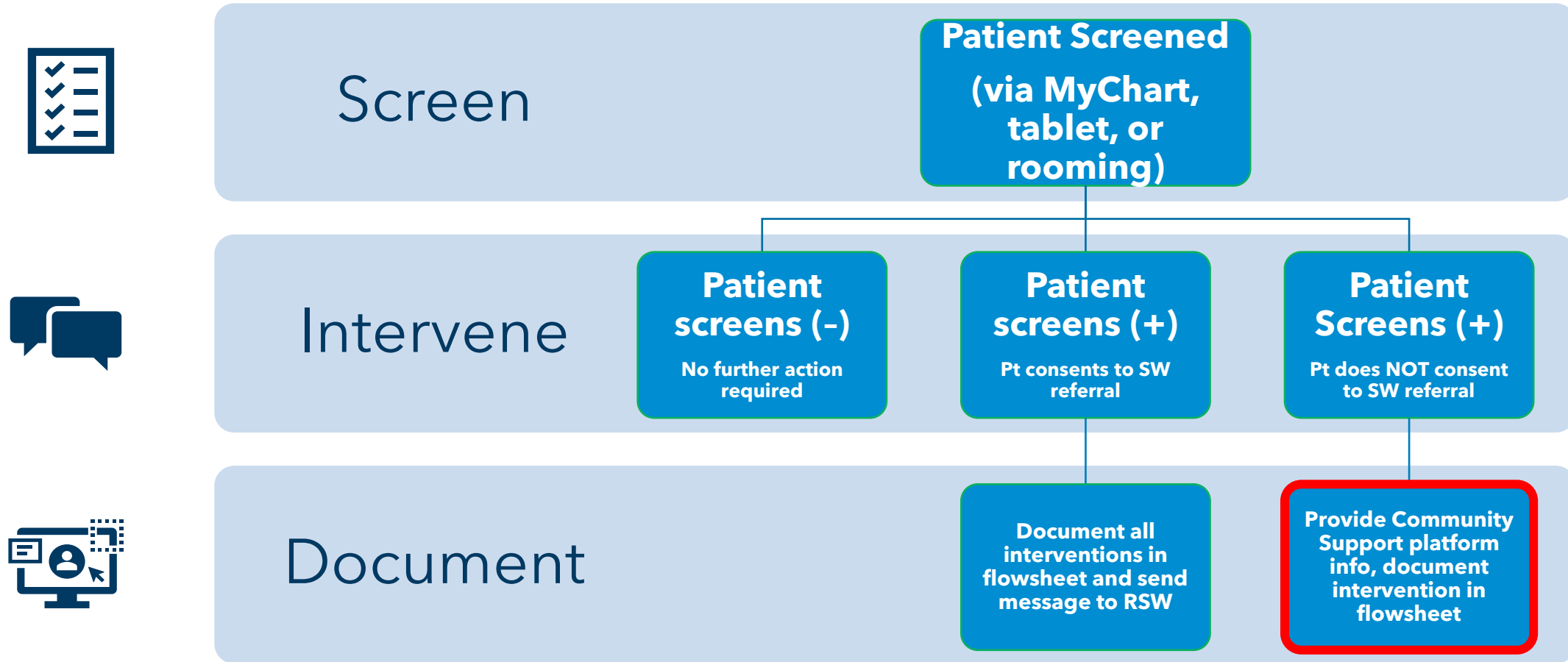
How often do you feel isolated from others?



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?

PCI Care Team SDOH Workflow



Decision needs to be made on who is responsible for each of these steps and create a consistent workflow

Care Team Intervention Documentation=Green

1 Select the positive SDOH domain

2 Select "Yes"

3 Click the magnifying glass and select any interventions that you provided to the patient (can select multiple)

Chart Review Communications Screenings Call Intake Take Action Flowsheets Documentation MyChart Administration

Screenings

Do you have access to any of the following devices?
Simple Cell Phone (flip phone); Smartphone(cell phone with a touchscreen and internet); Computer(laptop, desktop, or tablet such as an iPad) taken 6 days ago

☐ Simple Cell Phone (flip phone) ☐ Smartphone(cell phone with a touchscreen and in... ☐ Computer(laptop, desktop, or tablet such as an iPad) ☐ Landline ☐ None

Provider Interventions

AMBULATORY PROVIDERS ONLY--Was a recommendation for treatment/follow up provided for their positive SDOH results today? **Providers only is for another type of G code- this has nothing to do with SDOH intervention compliance**

Y=Yes N=No

Interventions

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

Did you provide an intervention today for Health Literacy?

Y=Yes N=No

Intervention(s) Health Literacy

Referral to Community Resources Select an entry program (ie. AHN Community Resources/Find Help)

Counseling for social determinant of health risk

Declined Services

Education on health insurance benefits

Educate on how to/where to find valuable and validated health information on the internet

Educate on medical and/or pharmaceutical needs

Education on social work support through medical practice

Medical assistance (MA) application

Other services provided

Refer to clinical supports

Referral to benefits enrollment assistance program

Previous Next

Flowsheets

ADD ORDER ADD DX (0)

LEVEL OF SERVICE SIGN ENCOUNTER

Care Team Intervention Documentation

Every positive domain requires a documented intervention within 30 days of screen

Example:

Pt is positive for food insufficiency, housing, safety and financial. An intervention, even if the same, must be documented in each of these categories.

The screenshot displays the 'Screenings' section of an EHR system. The interface includes a top navigation bar with tabs for Chart Review, Flowsheets, Rooming, Screenings, Notes, and Wrap-Up. Below this, a sub-navigation bar lists various screening categories: STANDARD TOOLS, Travel Screening, Social Determinants of Health (selected), Depression Screen, GAD, AUDIT, DAST, Hearing/Vision, VISIT-SPECIFIC TOOLS, Columbia, Adult ASQ, and Flowsheet.

The main content area is titled 'Screenings' and contains a section for 'AMBULATORY PROVIDERS ONLY--Was a recommendation for treatment/follow up provided for their positive SDOH results today?'. This section includes a table of domains with checkboxes for 'Yes' (Y) and 'No' (N). The domains are: HL=Health Literacy, SC=Social Connections, HS=Housing Stability (checked), S=Safety (checked), TN=Transportation N..., FRS=Financial Resou... (checked), FI=Food Insecurity (checked), and AD=Alcohol & Drug Use. Below this, there are sections for 'Interventions' for each domain, with a 'Did you provide an intervention today for...' question and a text box for the intervention. The interventions listed are: 'Referral to community resource network program' for Housing, Safety, and Financial Strain, and 'Education on social work support through medical practice' for Food Insecurity.

The left sidebar contains patient information: COVID-19 Vaccine: Unknown, Isolation: None, William Getson, MD, PCP - General, PPWPA PCP: Yes, Primary Cvg: Cigna/Health Partn..., Allergies: No Known Allergies, Active Treatment/Therapy Plans, 12/16 ESTABLISHED PATIENT PHYSICAL for Annual Exam, Weight: 98.2 kg (216 lb 6.4 oz), BMI: 33.88 >1 day, BP: 118/62 >1 day, LAST VISITS: Cntrl Sched (3), MedOnc (7), No results, CARE GAPS: COVID-19 Vaccine (1), Pneumococcal Vaccine: Pedi..., Hepatitis B Vaccine (1 of 3 - ...), INFLUENZA VACCINES (1) +1 awaiting completion, PROBLEM LIST (20), Pt List Reminders: None +, Reviewed, and SOCIAL DETERMINANTS.

The bottom of the screen shows a status bar with '2 E/M, 25', 'REPRINT AVS', '3', and 'SIGN ADDENDUM'.

Care Team Intervention Documentation

What should I select if my patient is SDOH positive but does not want a referral to the Regional Social Worker?

Each SDOH domain drop down offers a combination of the following options:

- Referral to community resource network program (i.e. AHN Community Support/FindHelp)
- Counseling for social determinant of health risk
- Education on social work support through medical practice

AHN Community Support



Real support for the challenges of real life

The AHN Community Support online platform can connect you with local programs and resources based on your needs and location.

Our free, anonymous search feature can help you with:

- Food
- Goods
- Housing
- Work
- Education
- Transit
- Legal aid
- Financial assistance
- Care and support services



Start searching for resources by visiting ahn.findhelp.com and entering your ZIP code.



Community Support

Real support for the challenges of real life.

The AHN Community Support Platform can assist you in connecting with social programs based on your unique needs and locations.

Our free anonymous search feature can help you with: Food, Housing, Transportation, Goods, Education, Legal Assistance, Finances, Health Care, and Work.



Connect with resources in your community by visiting AHNCommunitySupport.com and entering your ZIP code.

Caring People, Caring for You

We want to improve, and you can help. You may receive a survey from Press Ganey asking about your visit. Please complete the survey and we will use your feedback to make improvements.



Challenges & Solutions

- Data shows that there are many patients screening positive that we are likely not reaching
 - Data and RSW reports indicate that providers are likely not having conversations with patients regarding SDOH-related concerns frequently
 - Providers have communicated that SW referral processes do not fit well into their documentation workflow
 - Care teams are not routinely documenting interventions in Epic
 - Previously we have not had a way to measure interventions documented by RSWs or care teams consistently
 - Providers have identified SDOH needs outside of screening and during conversation with the patient. Interventions can be documented outside of the screening being completed in its entirety.
- ✓ Additional training for care teams – training provided to providers/clinical staff in Q1 2025 on appropriately documenting interventions
 - ✓ Referral workflow improvement – SW order/dashboard approved and in-process
 - ✓ Ongoing support for care teams from RSWs on having important SDOH+ conversations and implementing intervention documentation practices
 - ✓ Referral to RSW or CSP is appropriate and should be documented accordingly.



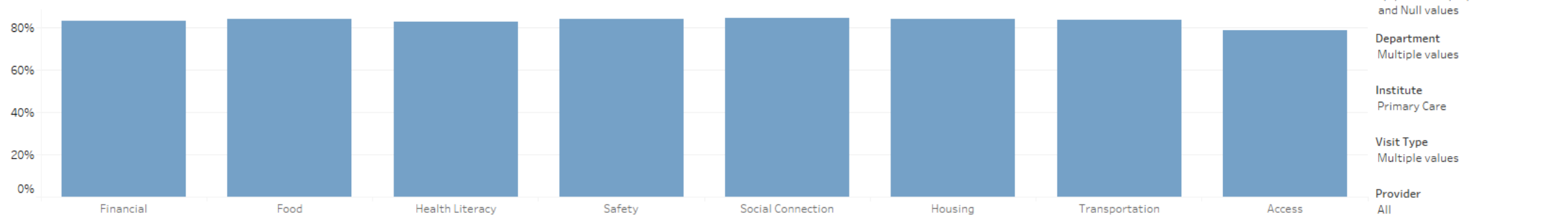
Compliance reporting over 1.5 years demonstrates steady increase. Currently screening at 93%.



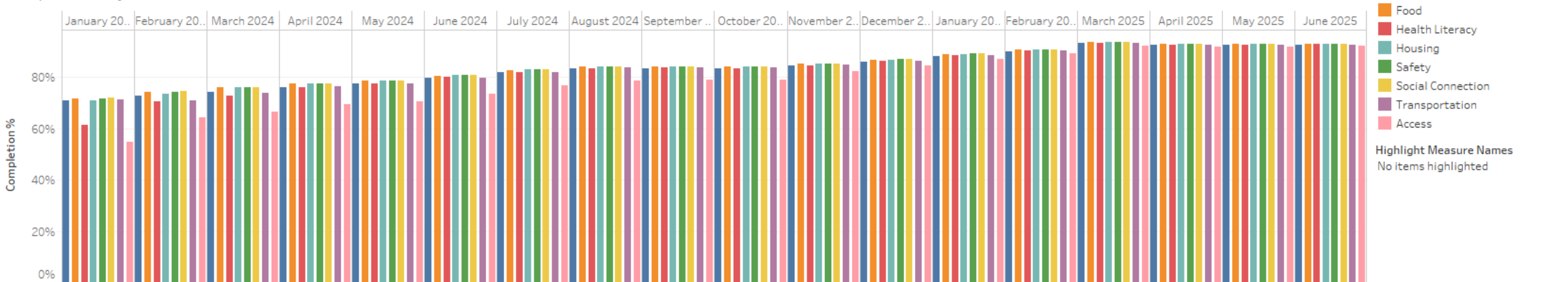
OP SDOH Adult Mandatory Compliance

Total Patients	SDOH Completed	SDOH Not Completed	SDOH Completed%
419,658	316,157	103,501	75%

Compliance by Domain



Compliance by Month



Intervention Compliance 2024 - PCI



OP Adult Mandatory Interventions

Total Positive

65,933

Total Intervention

745

Intervention Compliance%

1.13%

Appointment Date
1/1/2024 to 12/31/2024
and Null values

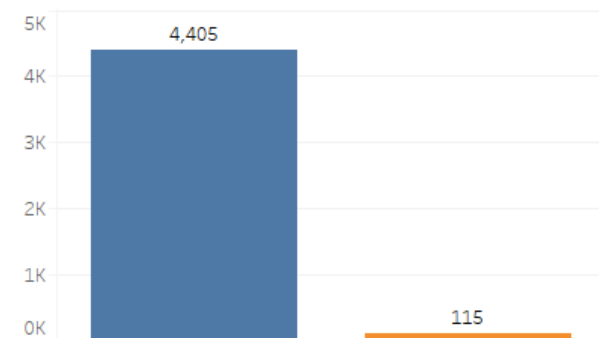
Department
Multiple values

Institute
Primary Care

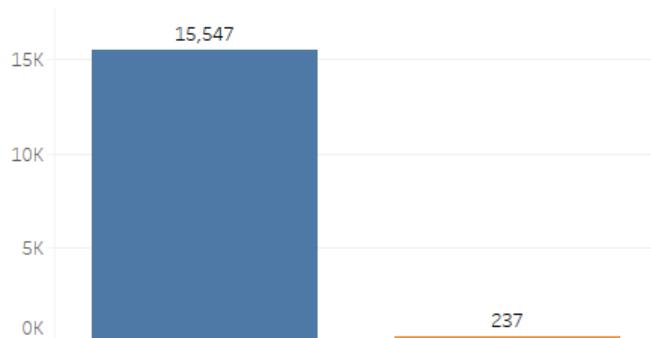
Visit Type
Multiple values

Measure Names
■ # Positive
■ # Intervention Provided

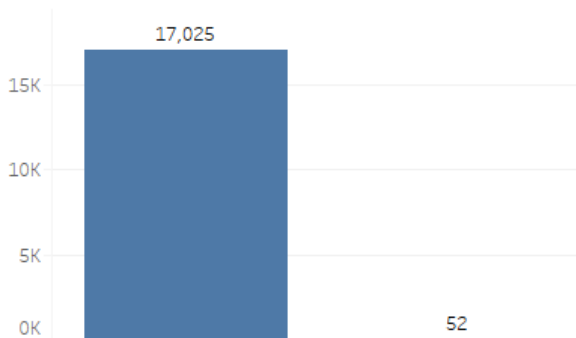
Housing Stability



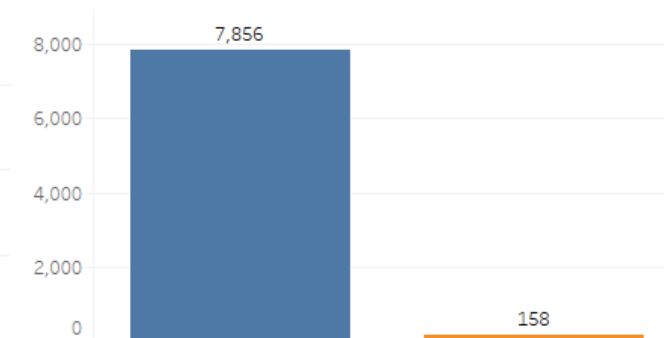
Financial Resource Strain



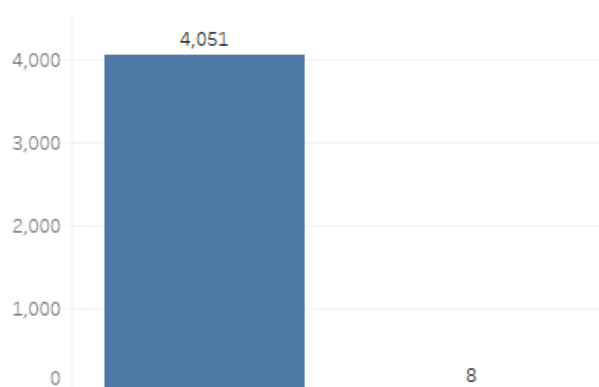
Health Literacy



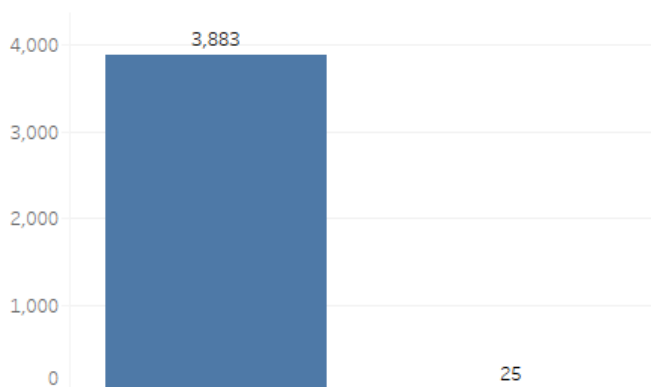
Food Insecurity



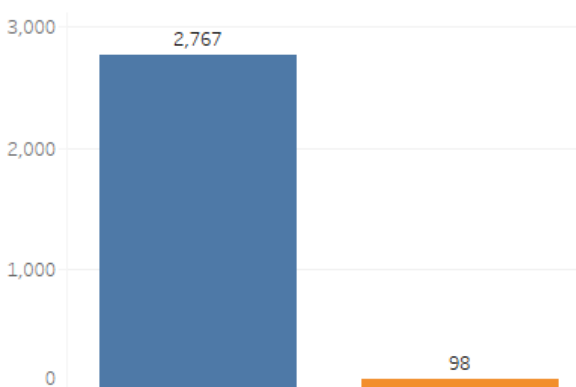
Social Connections



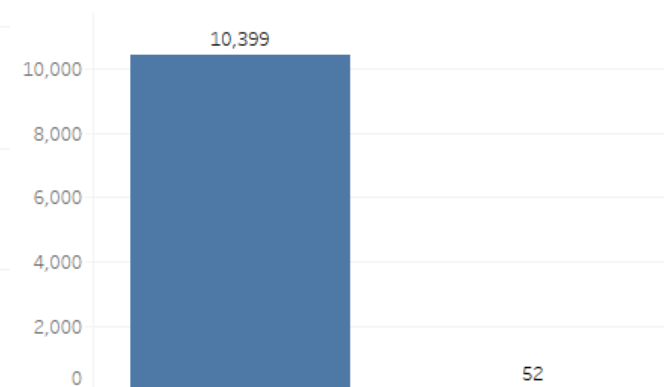
Safety



Transportation



Access



Intervention Compliance 2024 - Peds



OP Caregiver Mandatory Interventions

Total Positive	Total Intervention	Intervention Compliance%
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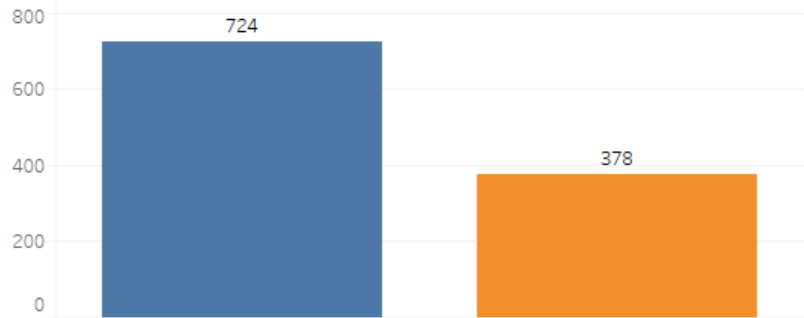
8,691

2,833

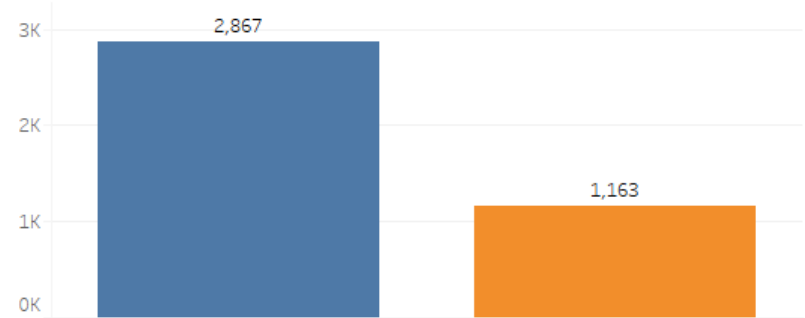
32.60%

Appointment Date 1/1/2024 to 12/31/2024 and Null values	Department All	Institute Pediatrics	Visit Type Multiple values	Age Multiple values	Measure Names # Positive # Intervention Provided
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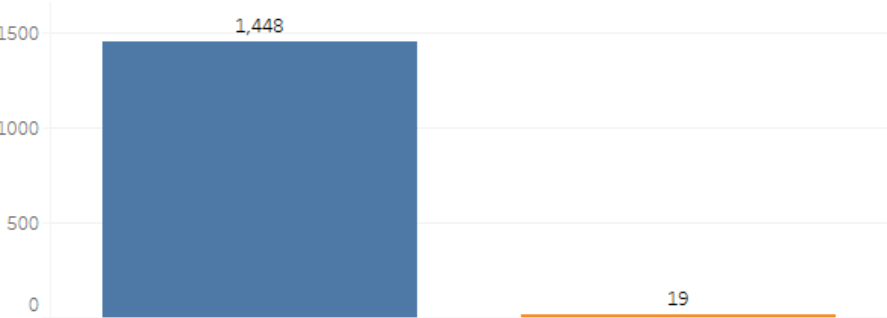
Housing Stability



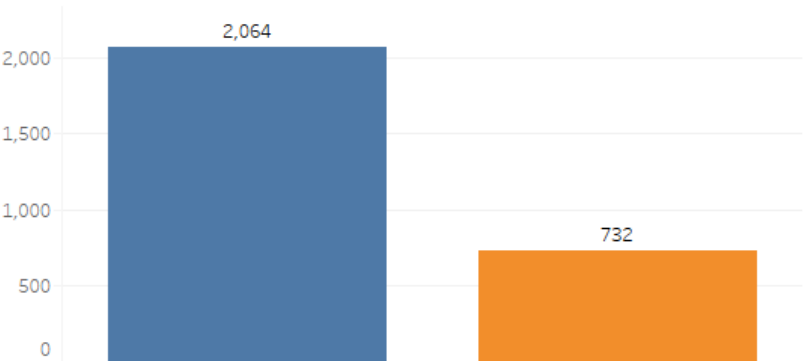
Financial Resource Strain



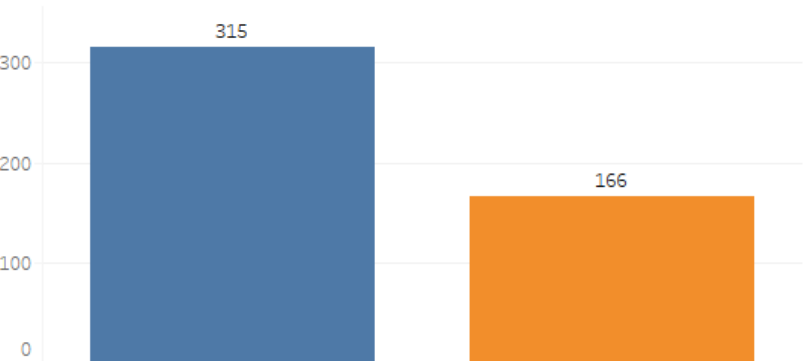
Health Literacy



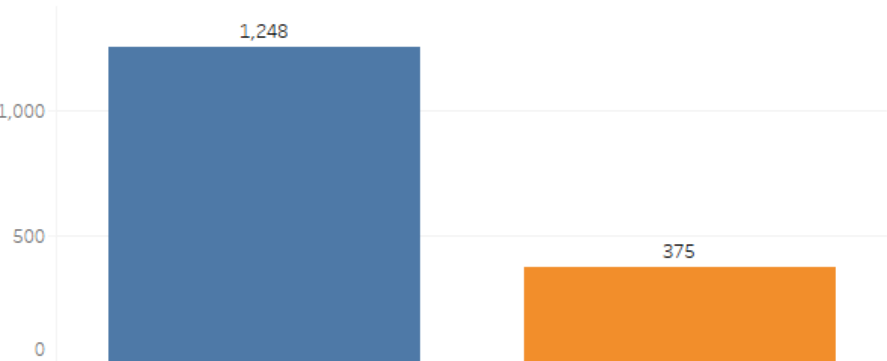
Food Insecurity



Transportation



Access



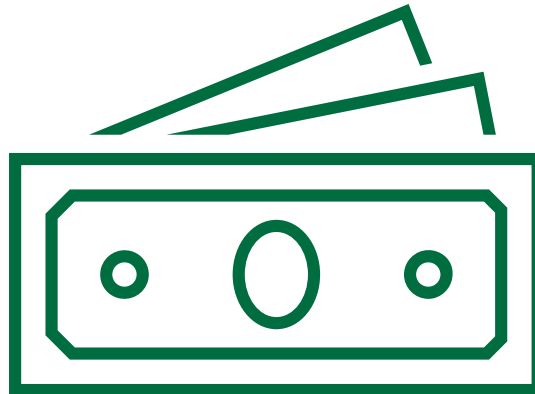
Do you know?

SDOH Assessment & AWW Billing 00136

Specific billing code automatically applies during Medicare Annual Wellness Visit when:

- ✓ Check box on the AWW note template is checked that the SDOH was completed as part of the AWW
- ✓ Requires: Checkbox confirmation AND documented time (5+ minutes) for SDOH discussion and care plan integration

Eligible health professionals including those working under the supervision of a provider.



Thank you!

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