Unpacking SDOH: Current Perspectives and Changes

Partnership Conference 2024

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AUGUST XX, 2024

Disclosures

No disclosures to make.

Abstract

This session will delve into the complexities and nuances of social drivers of health (SDOH) in the IHS. The session is designed to emphasize the significance of SDOH to the IHS mission including regulatory pressures, examine and differentiate terminology common in SDOH, and examine how historical context impacts this work in the communities we serve. With this comprehensive overview, the session offers a practical and actionable survey of tools, approaches, and strategies to effectively address SDOH within their own communities and organizations.

Objectives

Examine and differentiate between the terminology used in discussing social drivers of health, social risks, and health-related social needs.

Understand the significance of SDOH to the IHS mission in addition to the regulatory pressures shaping SDOH work.

Identify how historical factors have shaped the Social Drivers of Health present in many American Indian and Alaska Native communities and the resultant impacts to health equity.

Implement current strategies and opportunities that the Indian Health Service is engaging to address social drivers of health and health-related social needs including intersection with community-based strategies and organizations.

Agenda

I. What is SDOH and why does it matter?

II. Learning Lab Activities 2023-Now

III. SDOH Structured Data

IV. RPMS Enhancements Update

V. Resources

IHS Mission

To raise the physical, mental, spiritual, and **social health** of American Indians and Alaska Natives to the highest level.

On Terminology: Determinants vs Drivers

The use of “Determinants” versus “Drivers” is generally used interchangeably when discussing SDOH.

However, the use of “Drivers” instead of “Determinants” is increasingly favored as the use of “determinants” implies a finality and immutability that incorrectly reduces the agency of communities and individuals to impact their health.

On Terminology: SDOH, Social Risk, HRSN

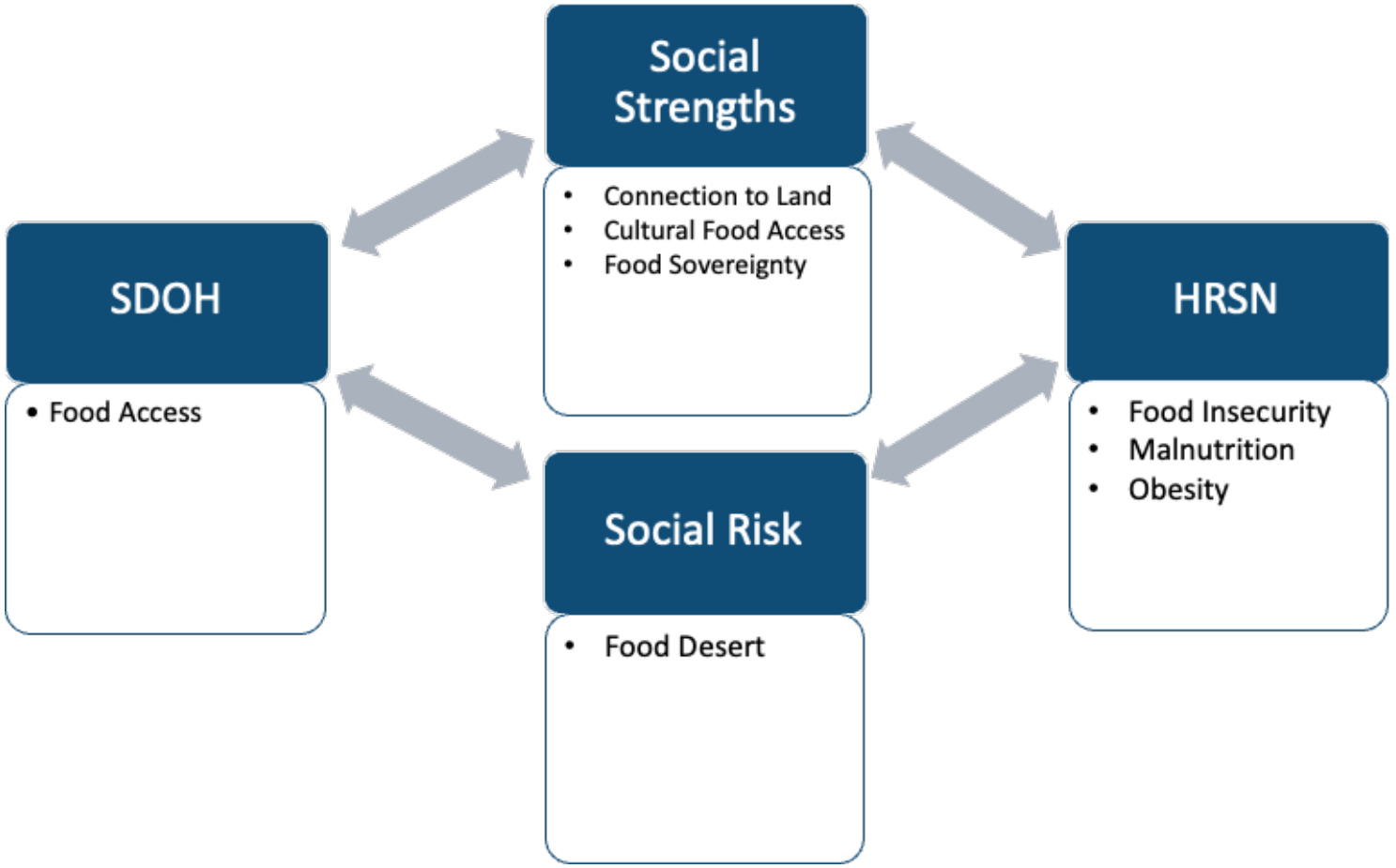
Social Drivers of Health (SDOH)
The conditions in which people are born, grow up, live, work and age which influence a person's opportunity to be healthy, his/her risk of illness and life expectancy.

Social Risk Factors
Adverse social conditions associated with poor health, such as food insecurity and housing instability.

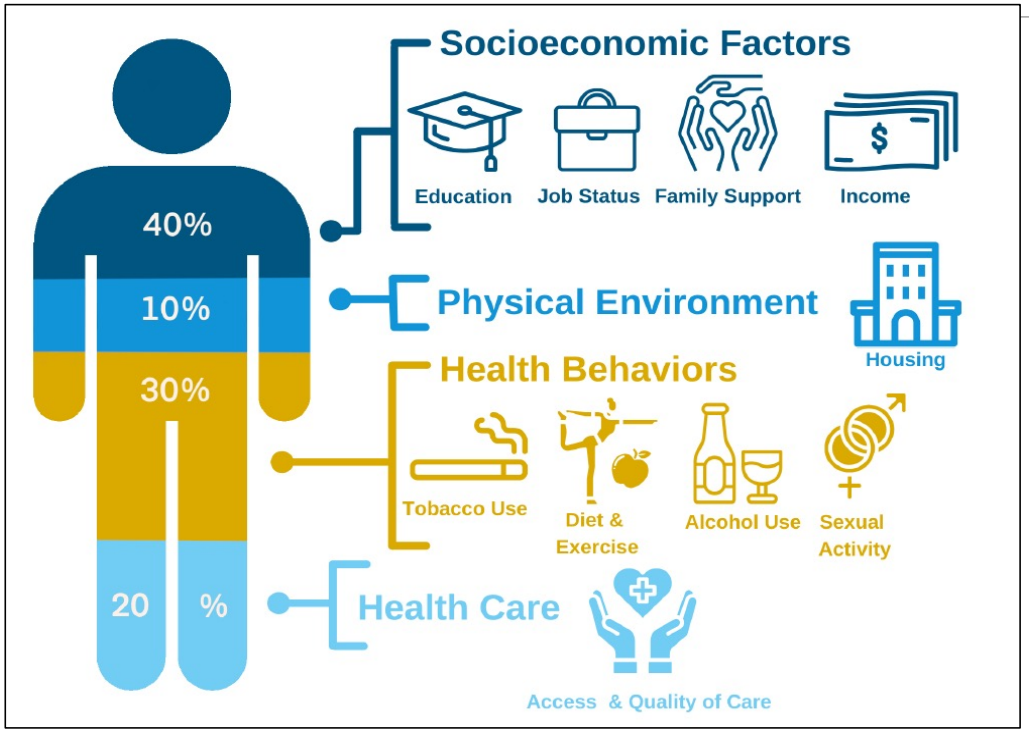
Health Related Social Needs (HRSN)
An individual's unmet, adverse social conditions that contribute to poor health.

https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/

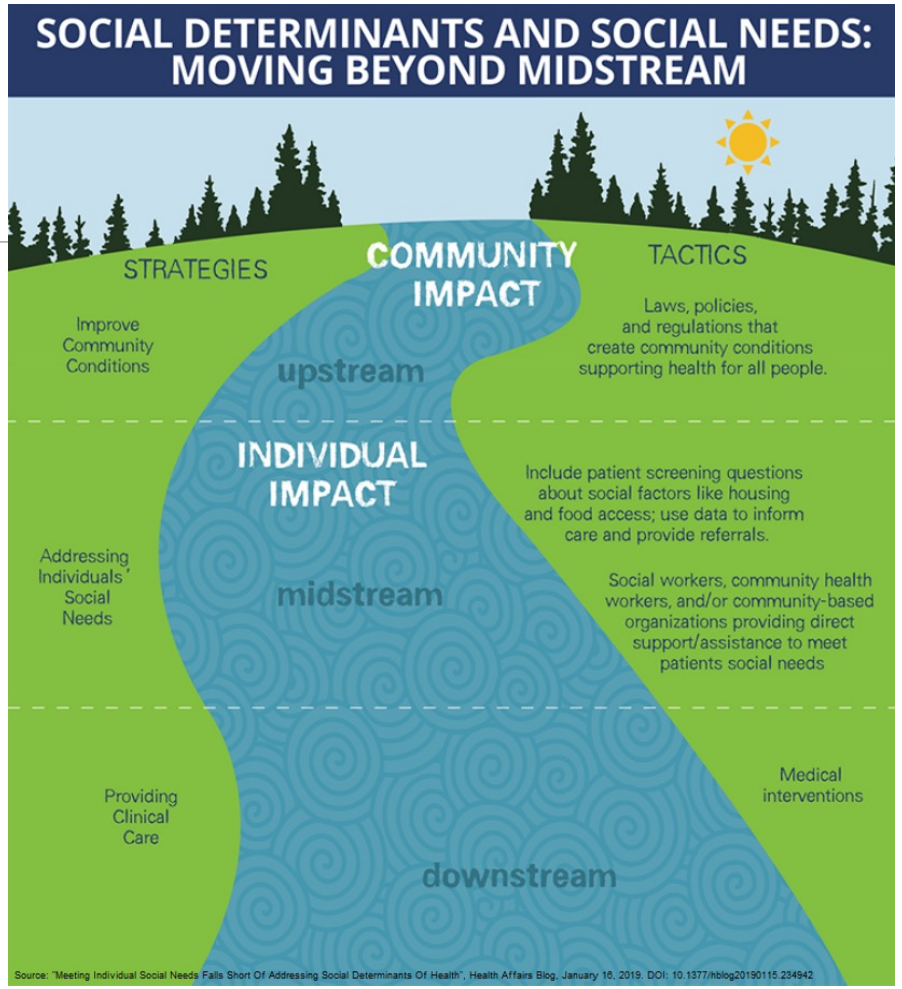
https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/


Social Strengths
Connection to Land
Cultural Food Access
Food Sovereignty
SDOH
Food Access
HRSN
Food Insecurity
Malnutrition
Obesity
Social Risk
Food Desert

Impact on Health Outcomes



Source: https://www.uclahealth.org/sustainability/social-determinants-of-health



Historical Trauma: Rooted in the Past

Neighborhood, As-built and Ambient Environments

- Where we live—geographically remote locations impact access to food, water, utilities, services
- Pollution—affected water sources, particulate matter from dust, smoke
- Transportation limitations
- Ability to own land
- Lack of housing
- Access to broadband—emerging SDOH with impacts for telehealth, virtual education, commerce, access to information

Food/Nutrition Security

- Removal from traditional agriculture, hunting and gathering lands
- Remote locations impact food availability and nutritional quality
- Commodity foods

Social Cohesion/Belonging

- Removal from family, community, and cultural practices integral to who we are as Native People

Education

- Boarding schools
- Limited educational opportunities

Economic stability

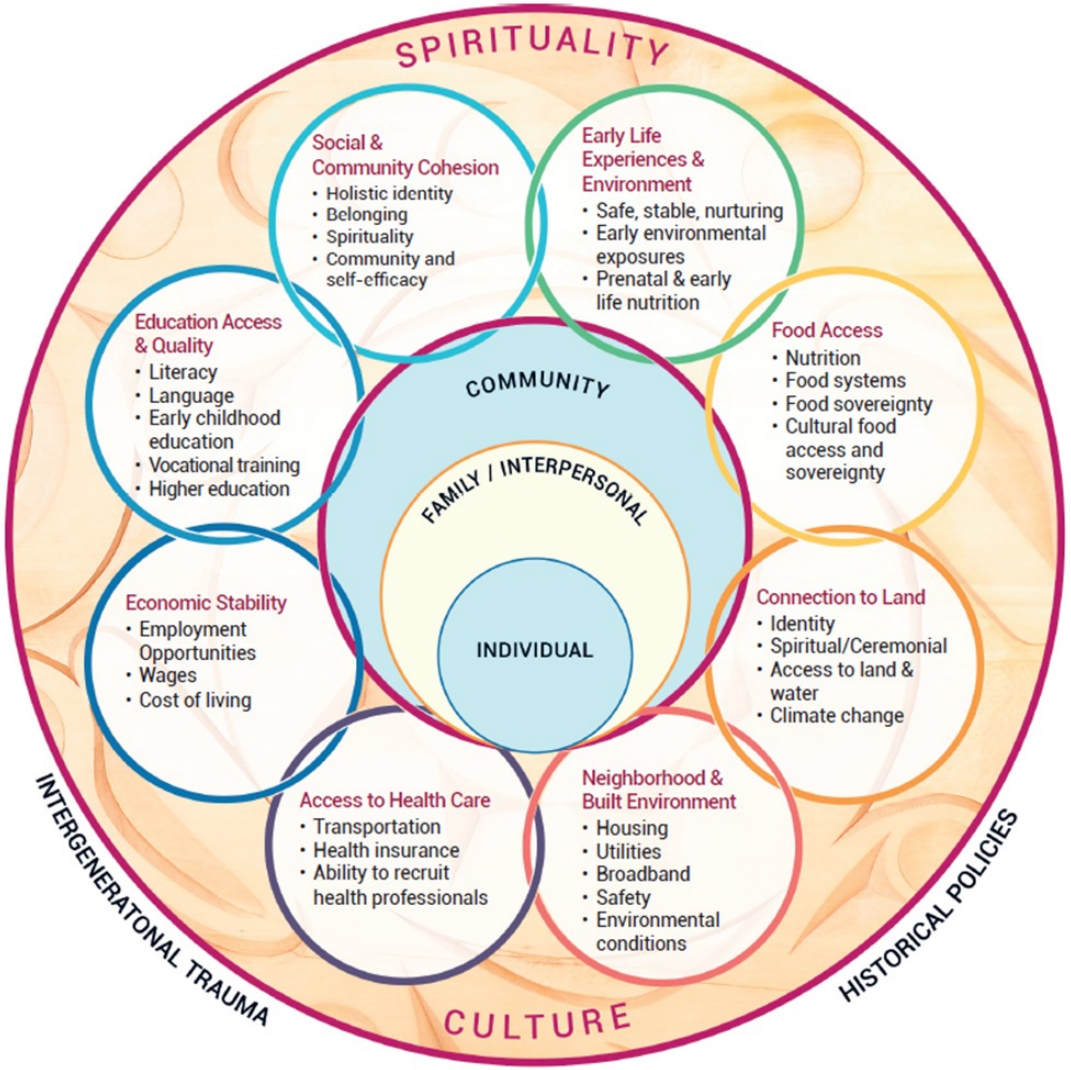
- Ability to work and provide for families historically restricted
- Segregation policies impacted education and employment opportunities

Access to Health Care

- Limited
- Funding challenges


Depression
Anxiety
Diabetes
Obesity
Heart Disease
Cancer
Social Drivers of Health
Intergenerational Trauma: neglect, abuse, unhealthy/harmful coping strategies
Topsoil
Disruption in family, parenting, community, cultural practices & food ways; poverty; lack of opportunity & economic mobility; discrimination; violence
Subsoil
Parent Material
Historical Events, Policies & Trauma
The People: Family, Identity, Community
Bedrock

Indigenous Social Drivers of Health



SDOH: Accreditation and Regulatory Requirements

- **Current:**
  - CMS FY23 Hospital Inpatient Prospective Payment System (IPPS) Inpatient Quality Report (IQR).
  - TJC National Patient Safety Goal 16.
  - ONC USCDI Version 2

- **Anticipated:**
  - CMS plans to maintain IQR SDOH reporting and expand to outpatient, long-term care, and other settings.

CMS IPPS Inpatient Quality Reporting

SDOH-1

- % of patients >= 18 years old admitted to the hospital screened for SDOH in the following give domains: Food, Housing, Transportation, Utilities, Interpersonal Safety.

SDOH-2

- % of patients screened for SDOH (per above) that are positive reported separately for each domain.

TJC: National Patient Safety Goal 16

Summary of Requirements:

1. Designate SDOH Lead.
2. HRSN Screening and Referrals.
3. Data Analysis to identify equity issues.
4. Written action plan to address health care disparities.
5. Follow-up on action plan and address gaps.
6. Annual report to stakeholders and staff.

01.01: Improving health care equity for the [organization's] [patients] is a quality and safety priority.

EP 1: The [organization] designates an individual(s) to lead activities to improve health care equity for the [organization's] [patients].

EP 2: The [organization] assesses the [patient's] health-related social needs (HRSNs) and provides information about community resources and support services.

EP 3: The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

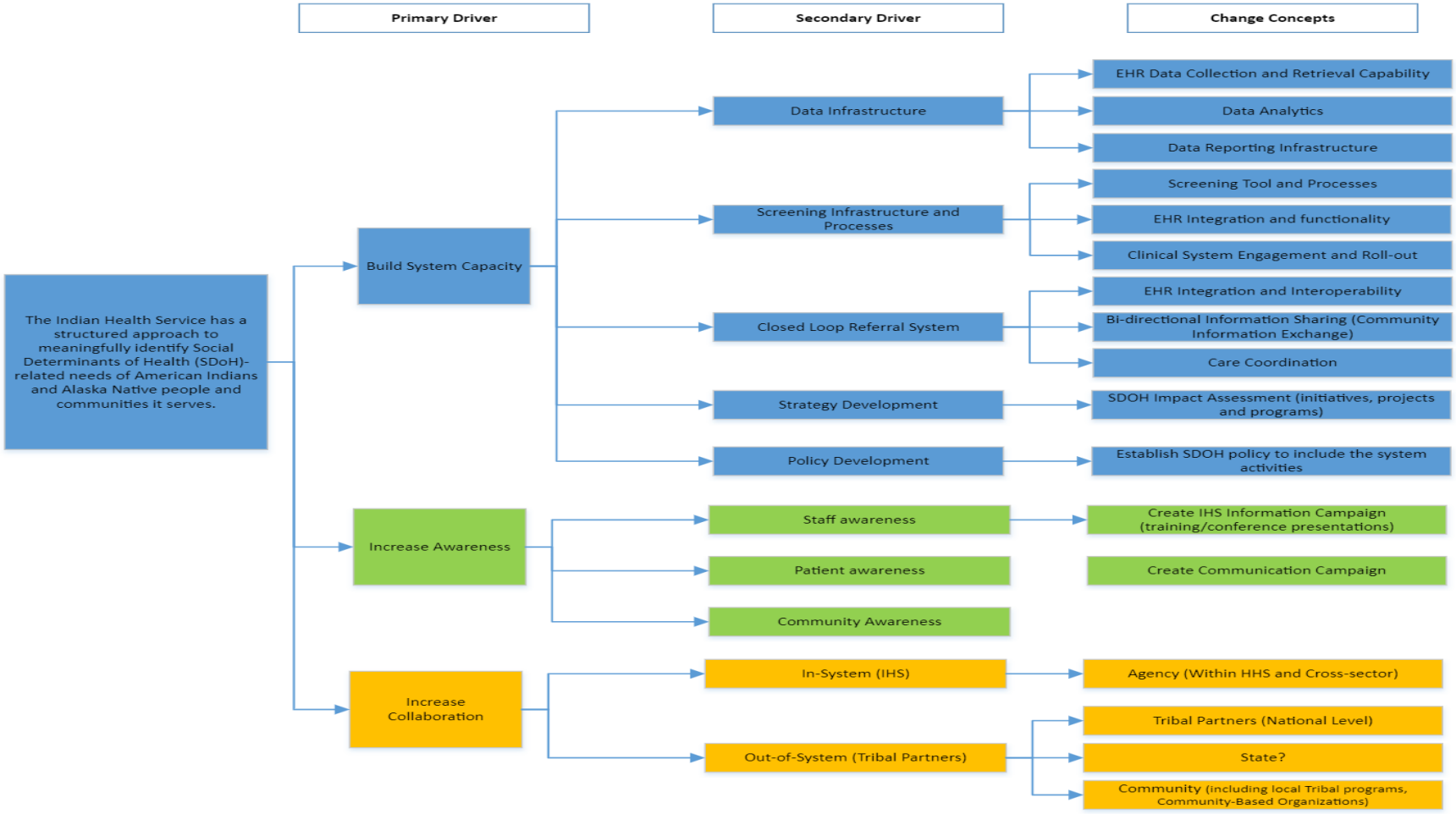
EP 4: The [organization] develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its [patient] population.

EP 5: The [organization] acts when it does not sustain the goal(s) in its action plan to improve health care equity.

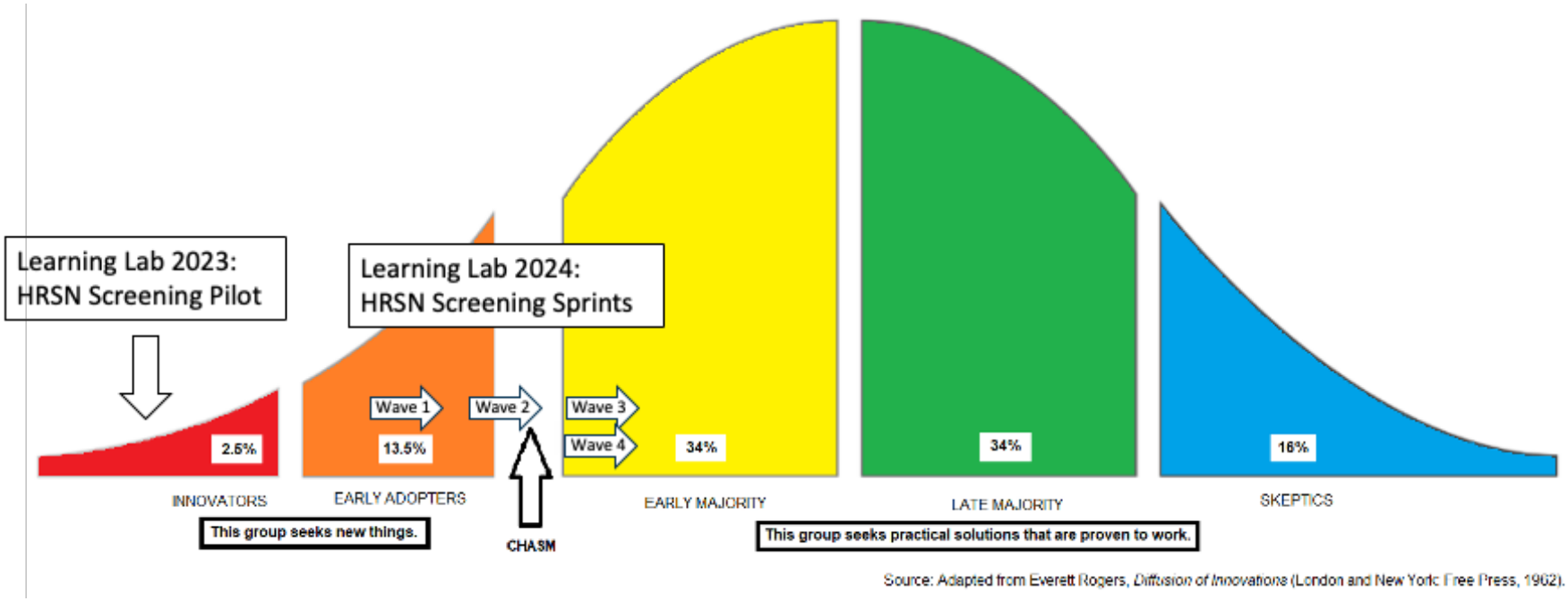
EP 6: At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.

Learning Lab 2023-Now

Understanding the Drivers



Learning Labs: Diffusion of Innovation



Source: Adapted from Everett Rogers, *Diffusion of Innovations* (London and New York: Free Press, 1962).

IHS Office of Quality Improving Patient Care Learning Lab 2023 on SDOH

Aim: Select, test and implement Health Related Social Needs (HRSN) Screening Tools

Four (4) Sites

1. **Zuni Comprehensive Health Center**—Albuquerque Area
2. **Wagner Indian Health Service Clinic**—Great Plains Area
3. **Lawton Indian Hospital**—Oklahoma City Area
4. **Warm Springs Service Unit**—Portland Area

Also a thank you to White River Service Unit Informaticists (Justin Tafoya and Trevor Thompson) who helped immeasurably with designing and testing RPMS workflows.

Learning Lab 2023 Summary

- A single tool will not meet all needs
- Sites prefer autonomy over tool and questions used to match community needs
- Community resource lists need to be developed to facilitate referral
- Although staff is initially hesitant to screen (workload, lack of interventions for positive screening), overall process is well received by patients and staff
- Patients overwhelmingly support HRSN screening
- Documentation and data work (aggregation, analysis) is time-consuming as a manual process
- Limited Clinical Informaticist bandwidth will require central support to accelerate development

Learning Lab 2024: HRSN Screening Sprints

- Weekly sessions x 10 weeks that step through the steps of implementing HRSN screening program with peer learning and sharing.
  - Wave 1: February – April 2024; 10 sites.
  - Wave 2: May – July 2024, 14 sites.
  - Wave 3+4: August – Oct 2024.

Learning Lab 2024 Summary

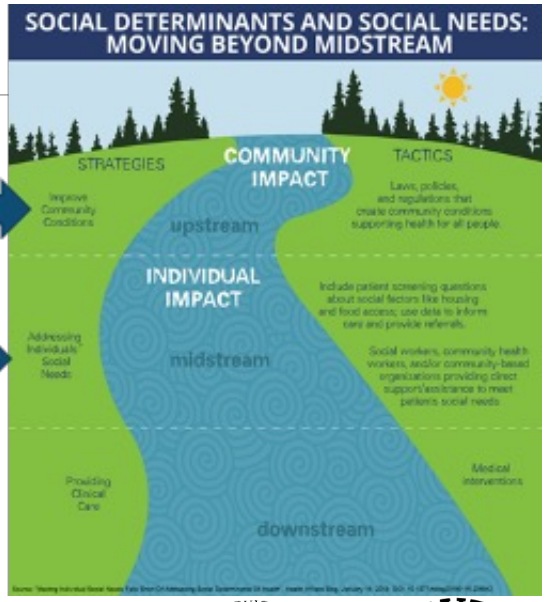
- Expanded scope from outpatient primary care to include inpatient, community health, tribal, and urban programs.
- The IHS cannot use PRAPARE questions due to being unable to license the questions by signing an agreement. AHC tool uses PRAPARE questions (question 1 and 4) and so any site using AHC tools must substitute questions for those.

Learning Lab 2025: Reshaping the Drivers (ReD) of Health Collaborative

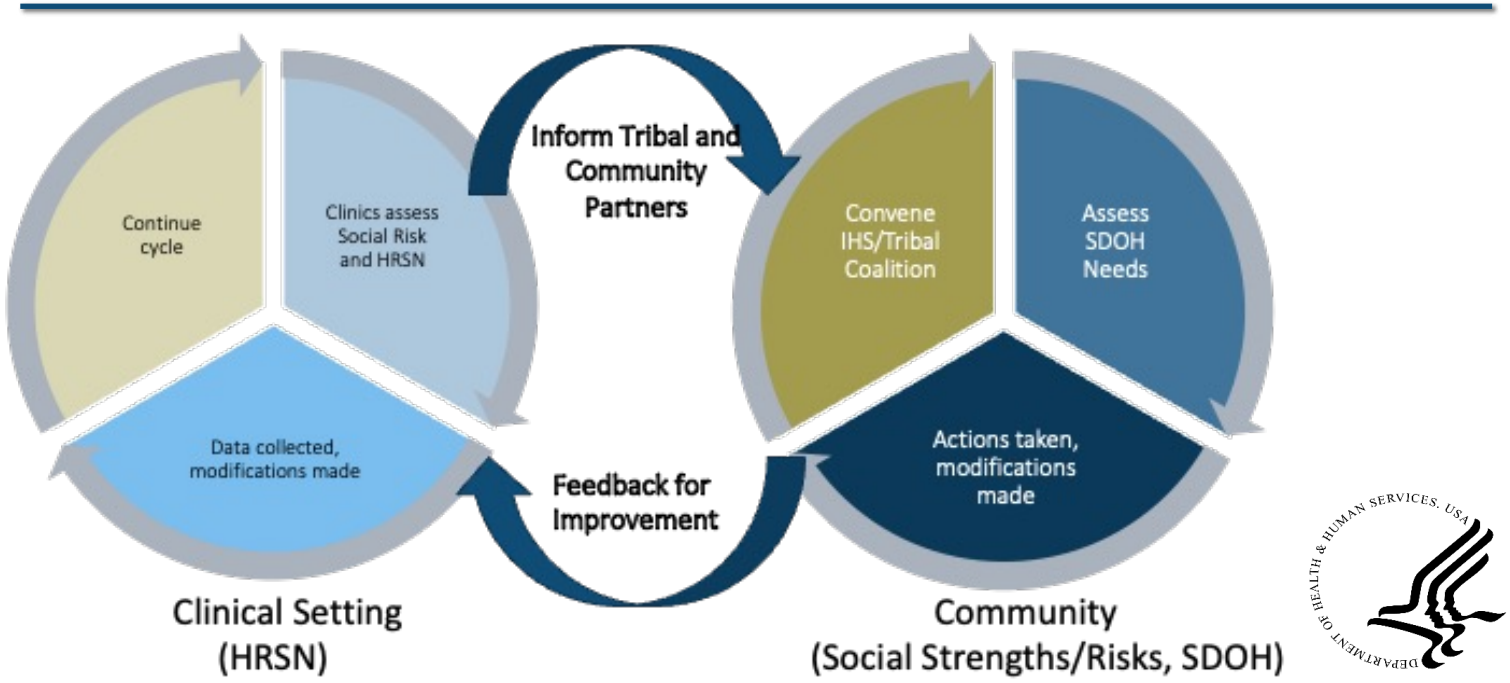
- 12-month collaborative with service units AND at least one tribal or community partner working together to identify best practices in community health needs assessment and co-designing and implementing upstream solutions.
- Starts September 2024.

Reshaping the Drivers (ReD) of Health Collaborative (2025)

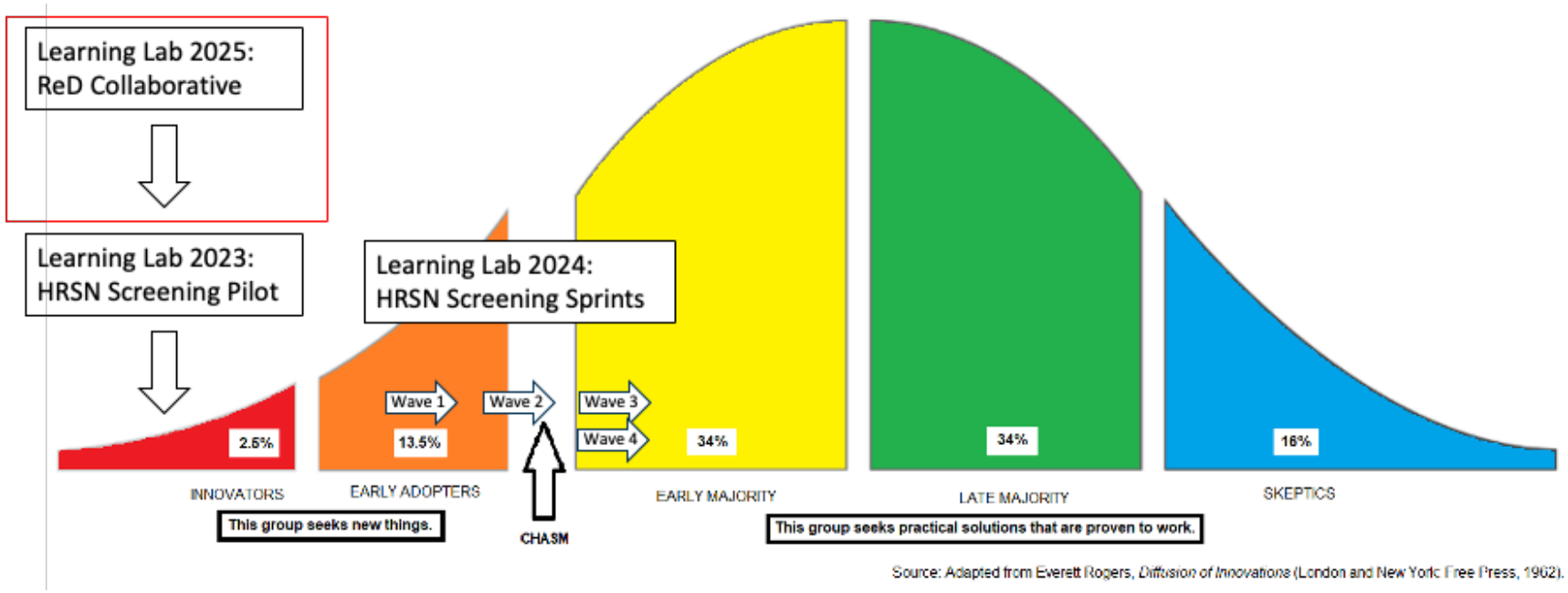
HRSN Screening Pilot (2023) and Sprints (2024)



Next Steps: SDOH Cycles of Improvement



Learning Labs: 2025 ReD Collaborative



Structured SDOH Data

Type of Structured Data	Example - SDOH	Example - Depression
RPMS Exam Codes Documents results of a *screening* for Food, Housing, Utilities, Transportation, or Interpersonal Safety.	SDOH Food: Positive	PHQ9: 25
Integrated Problem List (IPL) – SNOMED Documents HRSN *diagnosis, problem or activity.* -Pick lists already exist. -Education, visit instructions, goal notes, and care plans can also be documented by problem.	Food insecurity	Severe major depressive disorder, recurrent
ICD-10 Z-Codes Document HRSN *diagnosis or problem.* -May be needed for payers like CMS (e.g. G0019/G0022).	Food insecurity Z59.41	Major depressive disorder, recurrent severe without psychotic features F33.2

ICD-10 Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy
- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW • Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)
- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW • Z58.8 – Other problems related to physical environment
  - NEW • Z58.81 – Basic services unavailable in physical environment
  - NEW • Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances
- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW • Z59.10 – Inadequate housing, unspecified
  - NEW • Z59.11 – Inadequate housing environmental temperature
  - NEW • Z59.12 – Inadequate housing utilities
  - NEW • Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
    - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing
- Z62.2 – Upbringing away from parents
  - NEW • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW • Z62.814 – Personal history of child financial abuse
    - NEW • Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

go.cms.gov/OMH

Use Cases and Value of SDOH Data

Customer	Use Case/Value
Clinical Teams	Improved individualized patient care, Panel management (e.g. iCare), Population Health
Business Office/Revenue Cycle	Revenue capture for SDOH activities (e.g. G0136, G0019, G0022)
Service Unit Leadership/Governing Body	Compliance with accreditation (e.g. NPSG 16 EP2-6) and regulatory standards (e.g. CMS IQR Reporting SDOH-1/2), Community Health Needs Assessment, Tribal and Community Partnership, Governance about services provided and future development strategy
Area and HQ Leadership	Policy, Advocacy, Interagency or governmental coordination, Upstream interventions
Tribes	Data sharing, cooperation and coordination

Billing Codes

Code	Name	Description	Stipulations
G0136	SDOH Risk Assessment	Administering evidence-based SDOH assessment	• Can be provided during E/M, behavioral health office visit, or annual wellness visit. • No more than once every six months.
G0019	Community health integration, first 60 minutes per calendar month	Auxillary staff providing incident-to the services of a physician or other billing clinician.	• Community health integration (CHI) services include addressing SDOH needs, health system navigation, or facilitating access to community-based resources. • Unmet social need services are addressing must be document (e.g. ICD-10 Z-code).
G0022	Community health integration, each additional 30 minutes		

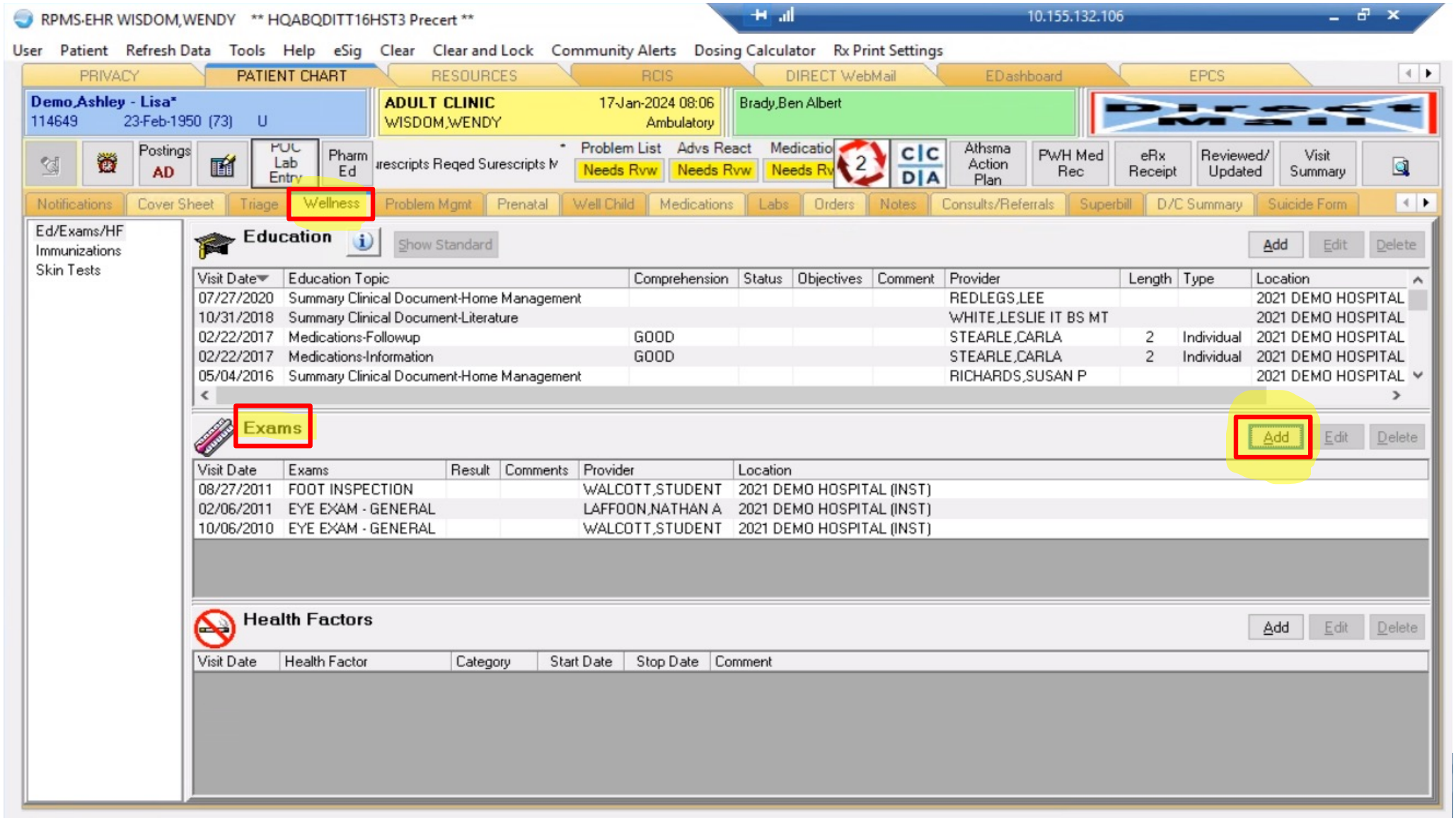
RPMS Enhancements 2024 for SDOH

2024 RPMS Enhancements Timeline

January 2024	Fall 2024 (Beta)	End of 2024 (Dev)

• AUM Patch
• Addition of SDOH Screening Exam Codes
  • Food
  • Housing
  • Transportation
  • Utilities
  • Interpersonal Safety
• Captures positive, negative, refusal, or unable to assess
	• Clinical Reminder (Outpatient: annual; Inpatient: with ever admission)
	• Clinical Reminder Dialog
	  • Documents screening by domain, not individual questions to allow flexibility at each facility to use that tool they wish
		• Reporting – PCC/VGEN

RPMS: Exam Codes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Advs React Needs Rvw
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PWH Med Rec
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Reviewed/ Updated
Visit Summary
Notifications Cover Sheet Triage Wellness Problem Mgmt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form
Ed/Exams/HF
Immunizations
Skin Tests
Education
Show Standard
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07/27/2020 | Summary Clinical Document-Home Management | | | | | REDLEGS,LEE | | | 2021 DEMO HOSPITAL
10/31/2018 | Summary Clinical Document-Literature | | | | | WHITE,LESLIE IT BS MT | | | 2021 DEMO HOSPITAL
02/22/2017 | Medications-Followup | GOOD | | | | STEARLE,CARLA | 2 | Individual | 2021 DEMO HOSPITAL
02/22/2017 | Medications-Information | GOOD | | | | STEARLE,CARLA | 2 | Individual | 2021 DEMO HOSPITAL
05/04/2016 | Summary Clinical Document-Home Management | | | | | RICHARDS,SUSAN P | | | 2021 DEMO HOSPITAL
Exams
Add Edit Delete
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02/06/2011 | EYE EXAM - GENERAL | | | LAFFOON,NATHAN A | 2021 DEMO HOSPITAL (INST)
10/06/2010 | EYE EXAM - GENERAL | | | WALCOTT,STUDENT | 2021 DEMO HOSPITAL (INST)
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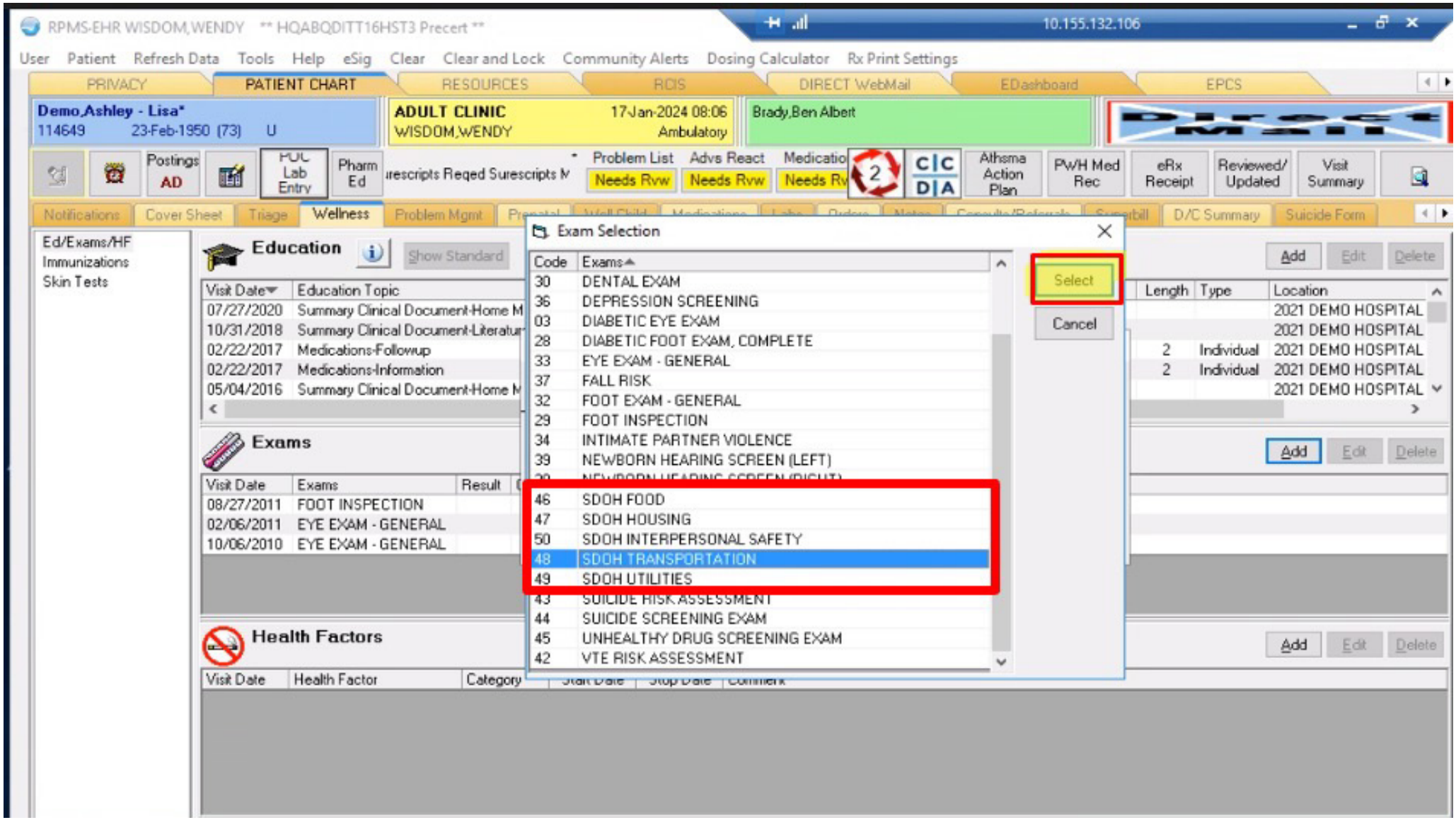
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Visit Summary
Notifications Cover Sheet Triage Wellness Problem Mgmt D/C Summary Suicide Form
Ed/Exams/HF
Immunizations
Skin Tests
Education
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10/31/2018 Summary Clinical Document-Literatur 2021 DEMO HOSPITAL
02/22/2017 Medications-Followup 2 Individual 2021 DEMO HOSPITAL
02/22/2017 Medications-Information 2 Individual 2021 DEMO HOSPITAL
05/04/2016 Summary Clinical Document-Home M 2021 DEMO HOSPITAL
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02/06/2011 EYE EXAM - GENERAL
10/06/2010 EYE EXAM - GENERAL
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Code Exams
30 DENTAL EXAM
36 DEPRESSION SCREENING
03 DIABETIC EYE EXAM
28 DIABETIC FOOT EXAM, COMPLETE
33 EYE EXAM - GENERAL
37 FALL RISK
32 FOOT EXAM - GENERAL
29 FOOT INSPECTION
34 INTIMATE PARTNER VIOLENCE
39 NEWBORN HEARING SCREEN (LEFT)
46 SDOH FOOD
47 SDOH HOUSING
50 SDOH INTERPERSONAL SAFETY
48 SDOH TRANSPORTATION
49 SDOH UTILITIES
44 SUICIDE SCREENING EXAM
45 UNHEALTHY DRUG SCREENING EXAM
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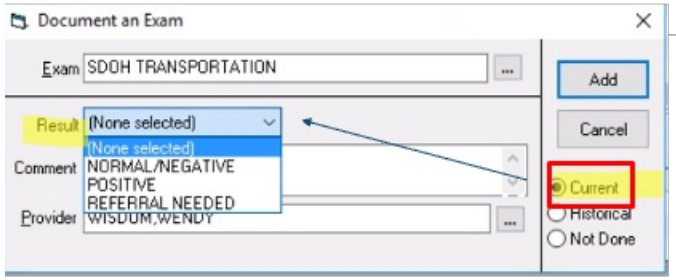
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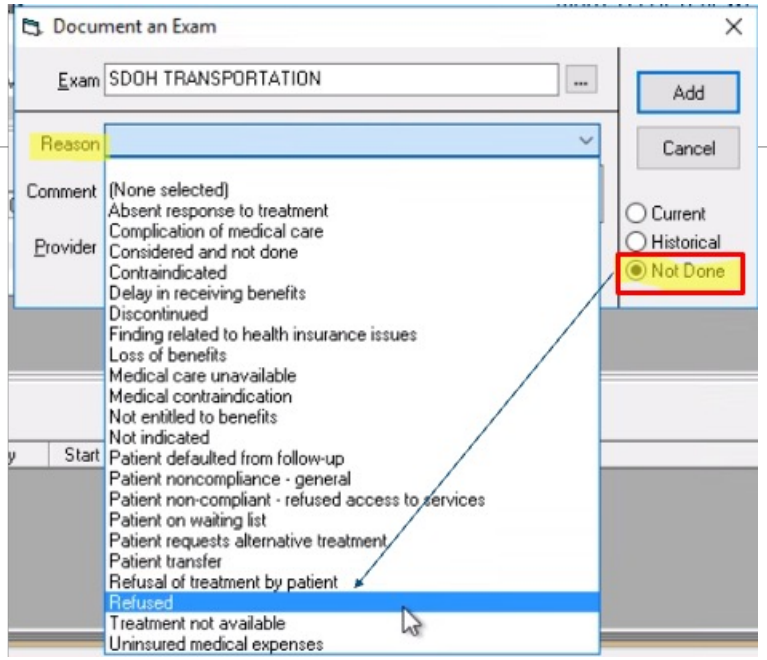
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Reason
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Complication of medical care
Considered and not done
Contraindicated
Delay in receiving benefits
Discontinued
Finding related to health insurance issues
Loss of benefits
Medical care unavailable
Medical contraindication
Not entitled to benefits
Not indicated
Patient defaulted from follow-up
Patient noncompliance - general
Patient non-compliant - refused access to services
Patient on waiting list
Patient requests alternative treatment
Patient transfer
Refusal of treatment by patient
Refused
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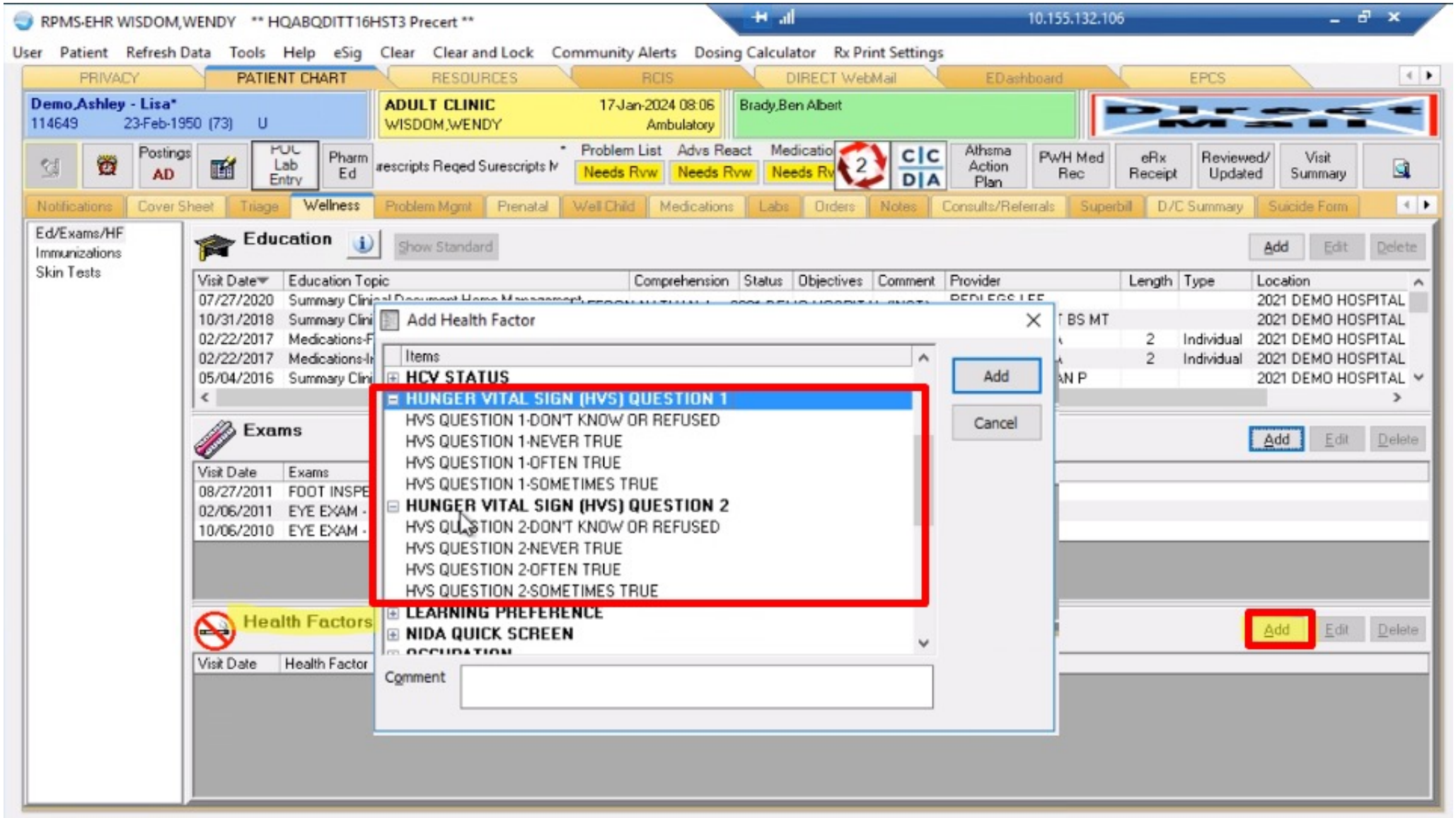
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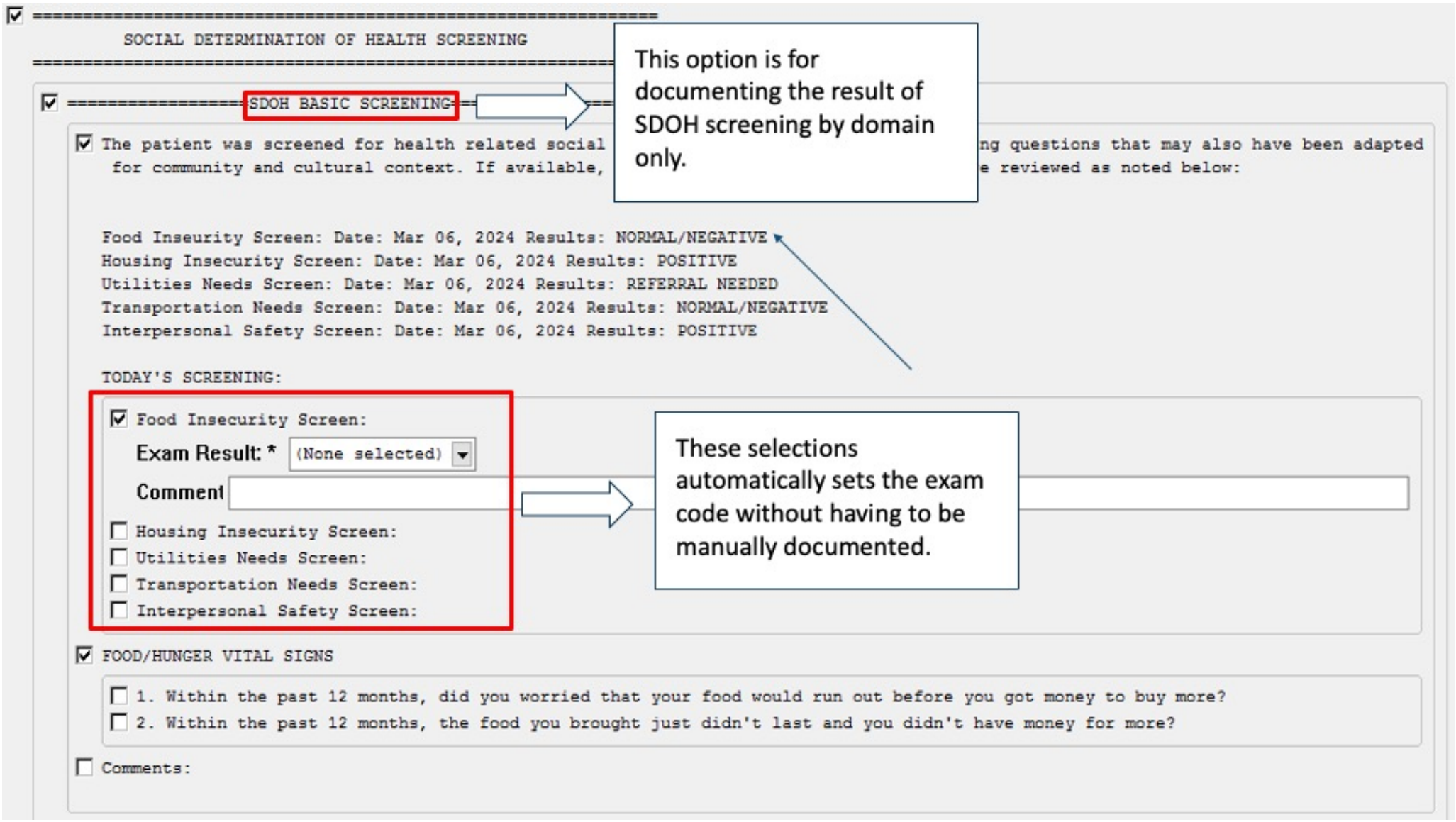
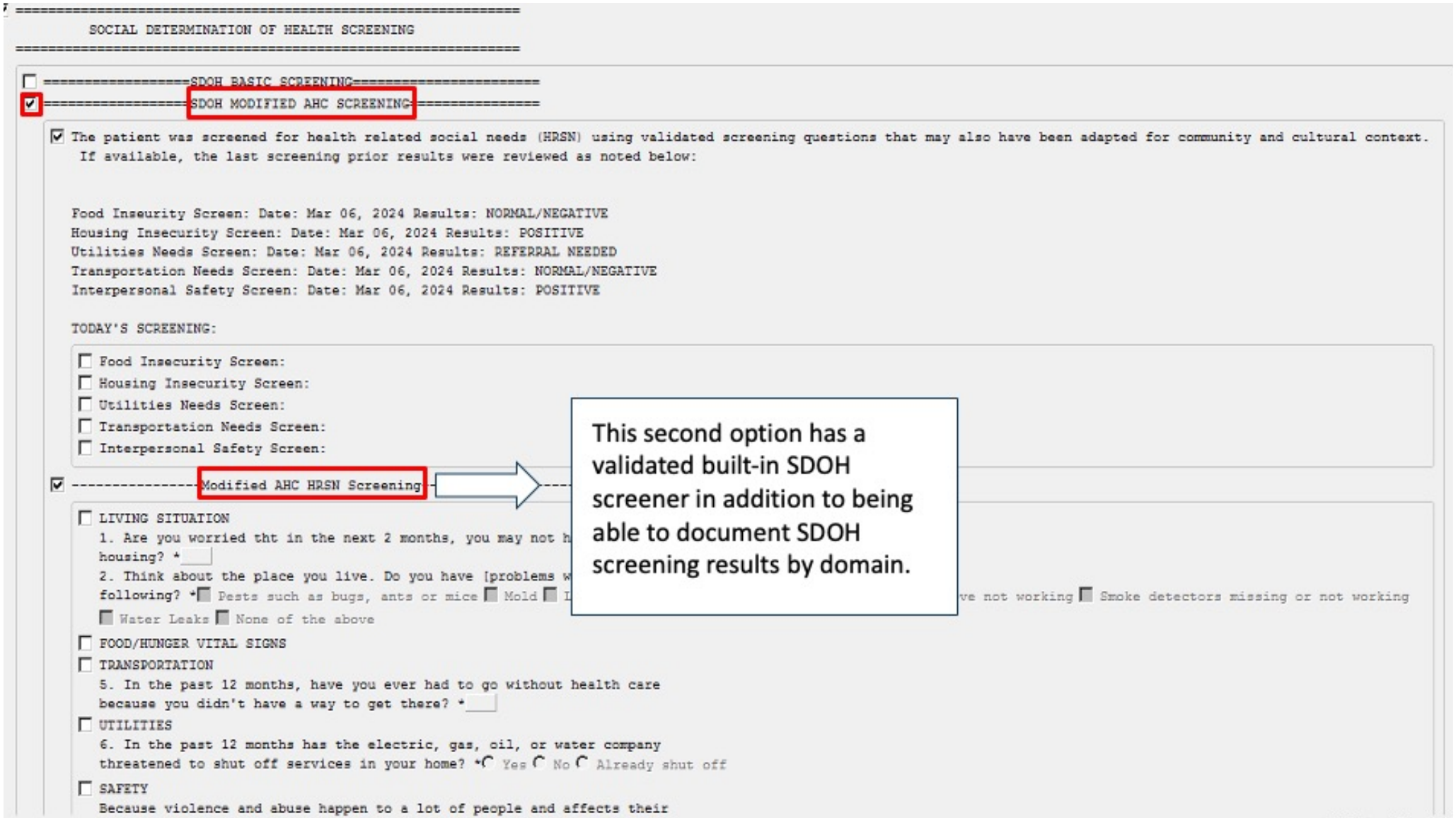
HUNGER VITAL SIGN (HVS) QUESTION 1
HVS QUESTION 1-DON'T KNOW OR REFUSED
HVS QUESTION 1-NEVER TRUE
HVS QUESTION 1-OFTEN TRUE
HVS QUESTION 1-SOMETIMES TRUE
HUNGER VITAL SIGN (HVS) QUESTION 2
HVS QUESTION 2-DON'T KNOW OR REFUSED
HVS QUESTION 2-NEVER TRUE
HVS QUESTION 2-OFTEN TRUE
HVS QUESTION 2-SOMETIMES TRUE
LEARNING PREFERENCE
NIDA QUICK SCREEN
Add
Cancel
Comment

RPMS: Reminder Dialog (Beta)


SOCIAL DETERMINATION OF HEALTH SCREENING
SDOH BASIC SCREENING
This option is for documenting the result of SDOH screening by domain only.
The patient was screened for health related social
for community and cultural context. If available,
ng questions that may also have been adapted
e reviewed as noted below:
Food Inseurity Screen: Date: Mar 06, 2024 Results: NORMAL/NEGATIVE
Housing Insecurity Screen: Date: Mar 06, 2024 Results: POSITIVE
Utilities Needs Screen: Date: Mar 06, 2024 Results: REFERRAL NEEDED
Transportation Needs Screen: Date: Mar 06, 2024 Results: NORMAL/NEGATIVE
Interpersonal Safety Screen: Date: Mar 06, 2024 Results: POSITIVE
TODAY'S SCREENING:
Food Insecurity Screen:
Exam Result: *
(None selected)
Comment
Housing Insecurity Screen:
Utilities Needs Screen:
Transportation Needs Screen:
Interpersonal Safety Screen:
These selections automatically sets the exam code without having to be manually documented.
FOOD/HUNGER VITAL SIGNS
1. Within the past 12 months, did you worried that your food would run out before you got money to buy more?
2. Within the past 12 months, the food you brought just didn't last and you didn't have money for more?
Comments:


SOCIAL DETERMINATION OF HEALTH SCREENING
SDOH BASIC SCREENING
SDOH MODIFIED AHC SCREENING
The patient was screened for health related social needs (HRSN) using validated screening questions that may also have been adapted for community and cultural context.
If available, the last screening prior results were reviewed as noted below:
Food Insecurity Screen: Date: Mar 06, 2024 Results: NORMAL/NEGATIVE
Housing Insecurity Screen: Date: Mar 06, 2024 Results: POSITIVE
Utilities Needs Screen: Date: Mar 06, 2024 Results: REFERRAL NEEDED
Transportation Needs Screen: Date: Mar 06, 2024 Results: NORMAL/NEGATIVE
Interpersonal Safety Screen: Date: Mar 06, 2024 Results: POSITIVE
TODAY'S SCREENING:
Food Insecurity Screen:
Housing Insecurity Screen:
Utilities Needs Screen:
Transportation Needs Screen:
Interpersonal Safety Screen:
Modified AHC HRSN Screening
This second option has a validated built-in SDOH screener in addition to being able to document SDOH screening results by domain.
LIVING SITUATION
1. Are you worried tht in the next 2 months, you may not h
housing? *
2. Think about the place you live. Do you have [problems w
following? * Pests such as bugs, ants or mice Mold
ve not working Smoke detectors missing or not working
Water Leaks None of the above
FOOD/HUNGER VITAL SIGNS
TRANSPORTATION
5. In the past 12 months, have you ever had to go without health care
because you didn't have a way to get there? *
UTILITIES
6. In the past 12 months has the electric, gas, oil, or water company
threatened to shut off services in your home? * Yes No Already shut off
SAFETY
Because violence and abuse happen to a lot of people and affects their

☐ SAFETY

Because violence and abuse happen to a lot of people and affects their health, we are asking the following questions:

7. How often does anyone, including your family and friends, physically hurt you? * ○ Never ○ Rarely ○ Sometimes ○ Fairly often ○ Frequently

8. How often does anyone, including your family and friends, insults or talk down to you? * ○ Never ○ Rarely ○ Sometimes ○ Fairly often ○ Frequently

9. How often does anyone, including your family and friends, threaten you with harm? * ○ Never ○ Rarely ○ Sometimes ○ Fairly often ○ Frequently

10. How often does anyone, including your family and friends, scream or curse at you? * ○ Never ○ Rarely ○ Sometimes ○ Fairly often ○ Frequently

☐ SUMMARY

11. Are any of your needs urgent? No

12. Would you like to receive assistance with any of these needs? No

☐ Comments:

CITATIONS:

Question 1,5,11,12: Health Leads. (2018). Social needs screening toolkit. https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Question 2: Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

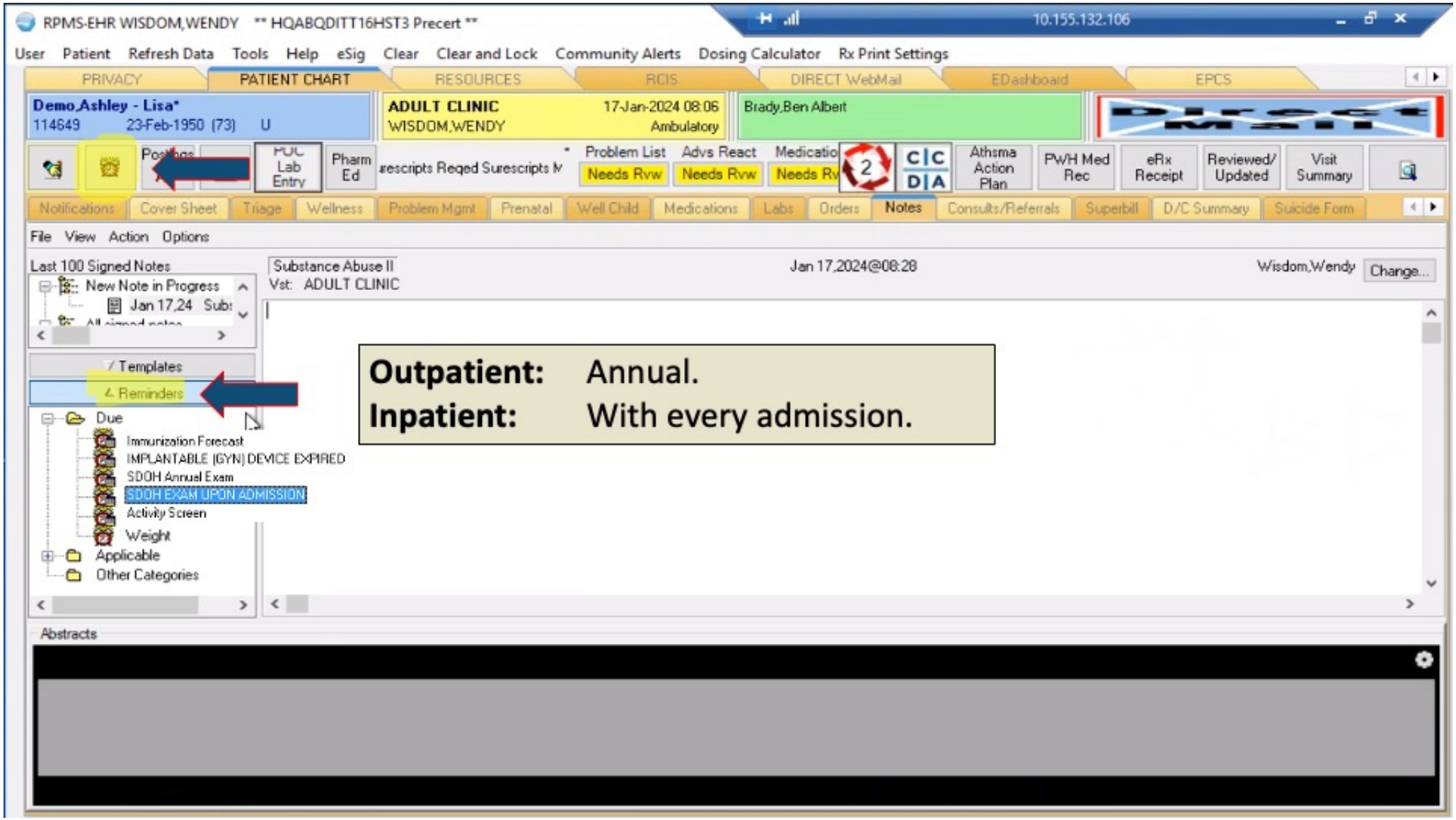
Question 3,4: Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

Questions 6: Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286

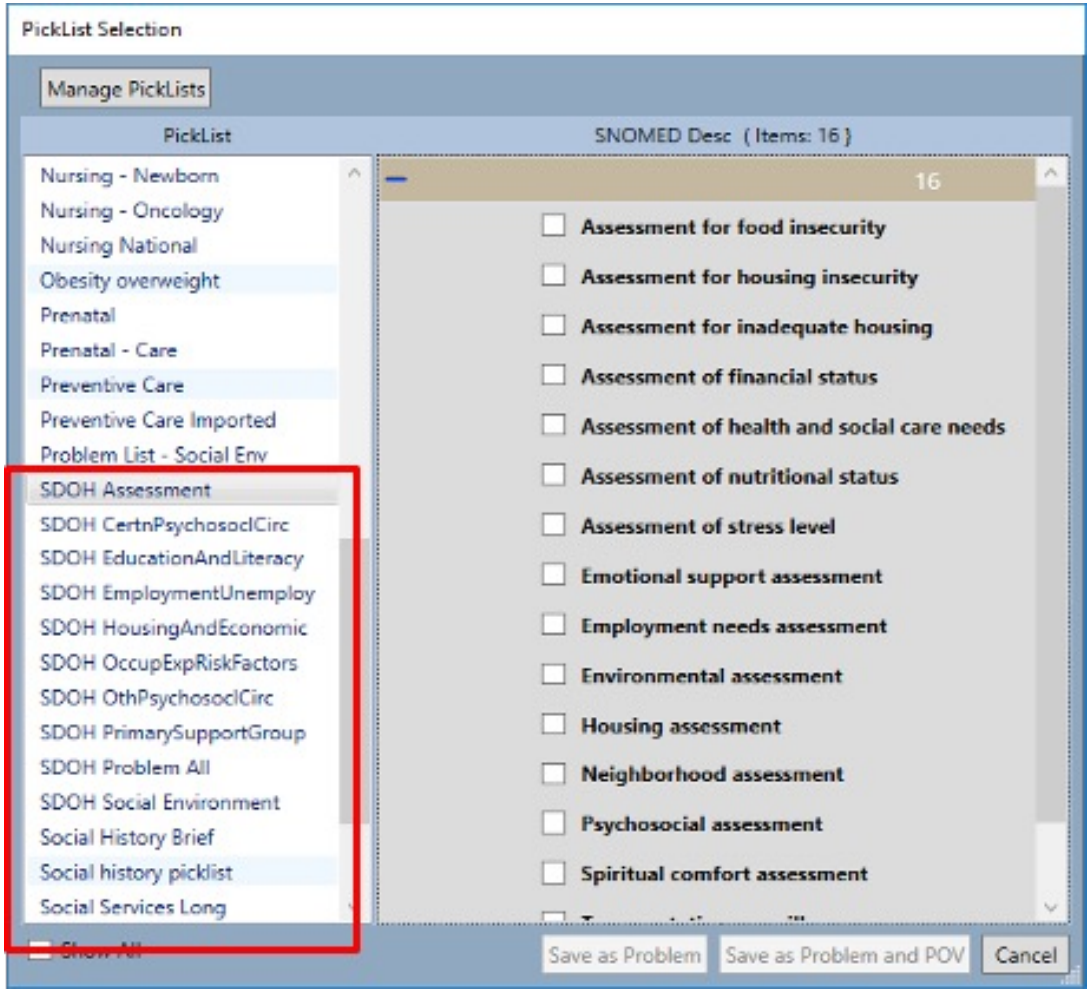
Questions 7-10: Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

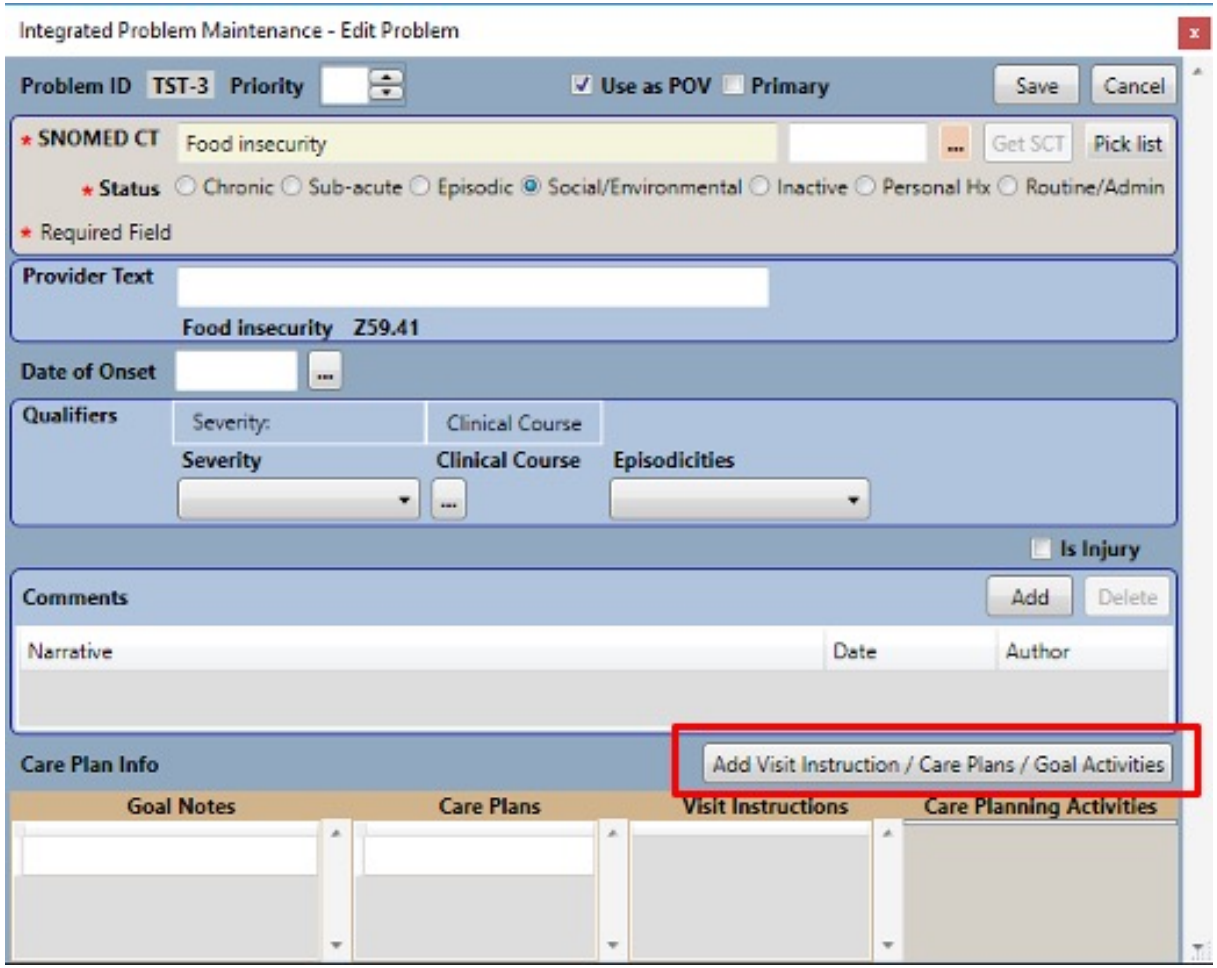
AHC Tool: Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wpcontent/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

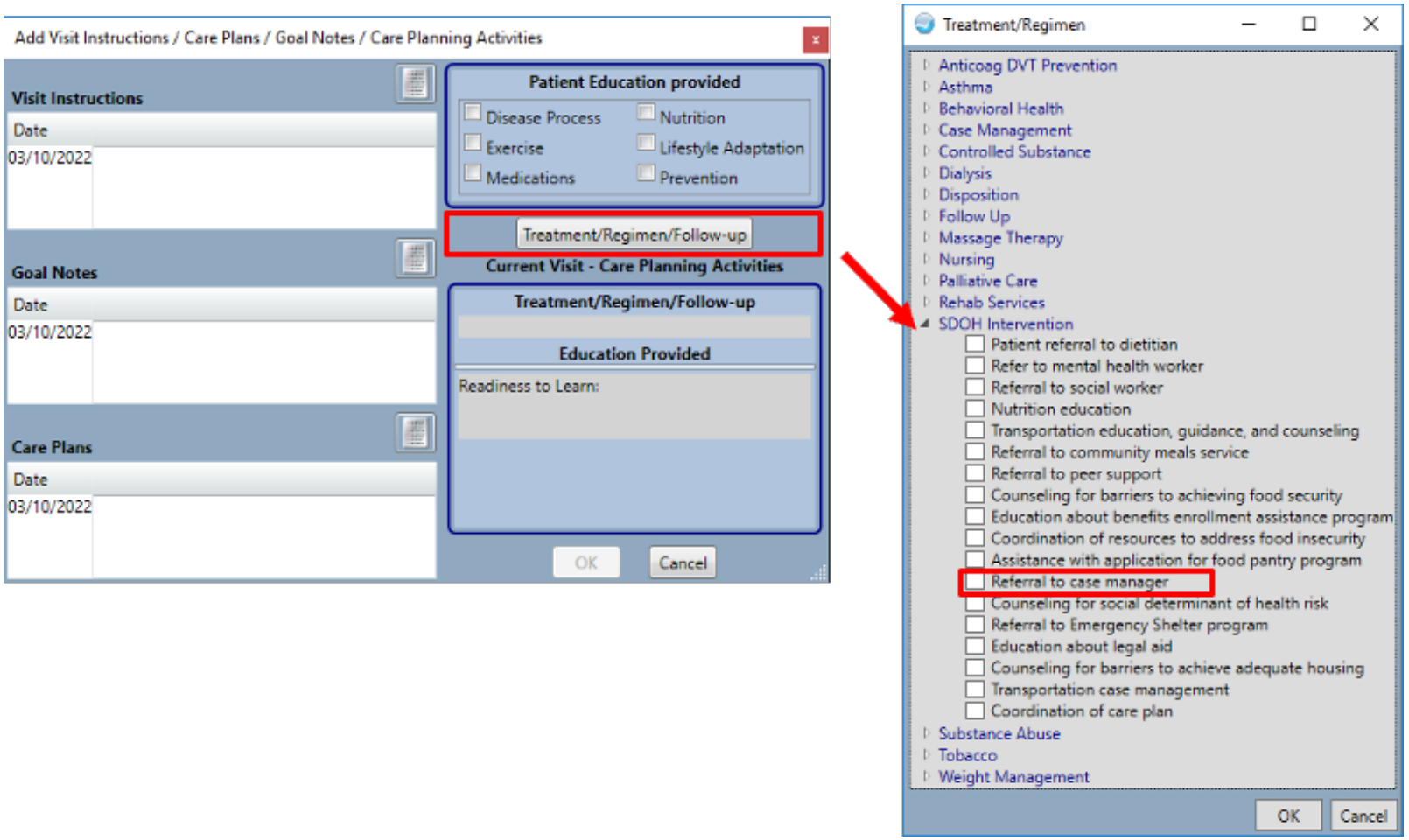
RPMS: Clinical Reminders (Beta)

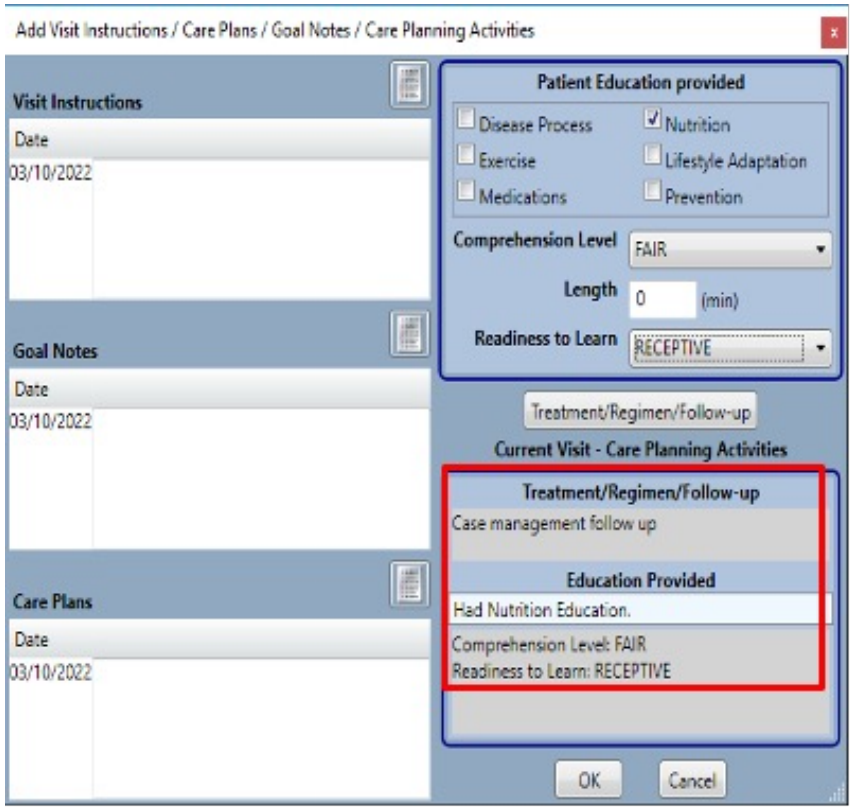

RPMS-EHR WISDOM,WENDY ** HQABQDITT16HST3 Precert **
10.155.132.106
User Patient Refresh Data Tools Help eSig Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings
PRIVACY PATIENT CHART RESOURCES RCIS DIRECT WebMail EDashboard EPCS
Demo,Ashley - Lisa*
114649 23-Feb-1950 (73) U
ADULT CLINIC
WISDOM,WENDY
17-Jan-2024 08:06
Ambulatory
Brady,Ben Albert
Direct Mail
POC Lab Entry
Pharm Ed
Problem List
Advs React
Medicatio
Needs Rvw
Needs Rvw
Needs Rv
CIC DIA
Athsma Action Plan
PWH Med Rec
eRx Receipt
Reviewed/ Updated
Visit Summary
Notifications Cover Sheet Triage Wellness Problem Mgmt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form
File View Action Options
Last 100 Signed Notes
New Note in Progress
Jan 17,24 Subs
Templates
Reminders
Due
Immunization Forecast
IMPLANTABLE (GYN) DEVICE EXPIRED
SDOH Annual Exam
SDOH EXAM UPON ADMISSION
Activity Screen
Weight
Applicable
Other Categories
Substance Abuse II
Vst: ADULT CLINIC
Jan 17,2024@08:28
Wisdom,Wendy
Change...
Outpatient: Annual.
Inpatient: With every admission.
Abstracts

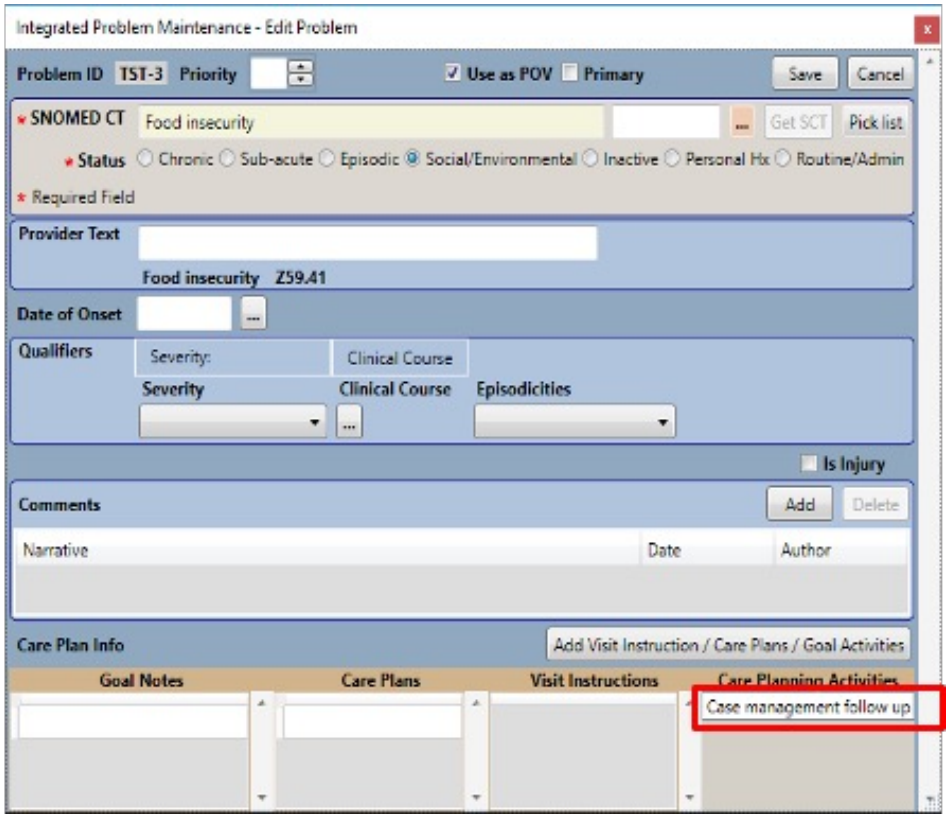
RPMS: Integrated Problem List Pick List


PickList Selection
Manage PickLists
PickList
SNOMED Desc (Items: 16)
Nursing - Newborn
Nursing - Oncology
Nursing National
Obesity overweight
Prenatal
Prenatal - Care
Preventive Care
Preventive Care Imported
Problem List - Social Env
SDOH Assessment
SDOH CertnPsychosocICirc
SDOH EducationAndLiteracy
SDOH EmploymentUnemploy
SDOH HousingAndEconomic
SDOH OccupExpRiskFactors
SDOH OthPsychosocICirc
SDOH PrimarySupportGroup
SDOH Problem All
SDOH Social Environment
Social History Brief
Social history picklist
Social Services Long
16
Assessment for food insecurity
Assessment for housing insecurity
Assessment for inadequate housing
Assessment of financial status
Assessment of health and social care needs
Assessment of nutritional status
Assessment of stress level
Emotional support assessment
Employment needs assessment
Environmental assessment
Housing assessment
Neighborhood assessment
Psychosocial assessment
Spiritual comfort assessment
Save as Problem
Save as Problem and POV
Cancel


Integrated Problem Maintenance - Edit Problem
Problem ID TST-3 Priority
Use as POV Primary
Save
Cancel
* SNOMED CT
Food insecurity
Get SCT
Pick list
* Status
Chronic
Sub-acute
Episodic
Social/Environmental
Inactive
Personal Hx
Routine/Admin
* Required Field
Provider Text
Food insecurity Z59.41
Date of Onset
Qualifiers
Severity:
Clinical Course
Severity
Clinical Course
Episodicities
Is Injury
Comments
Add
Delete
Narrative
Date
Author
Care Plan Info
Add Visit Instruction / Care Plans / Goal Activities
Goal Notes
Care Plans
Visit Instructions
Care Planning Activities

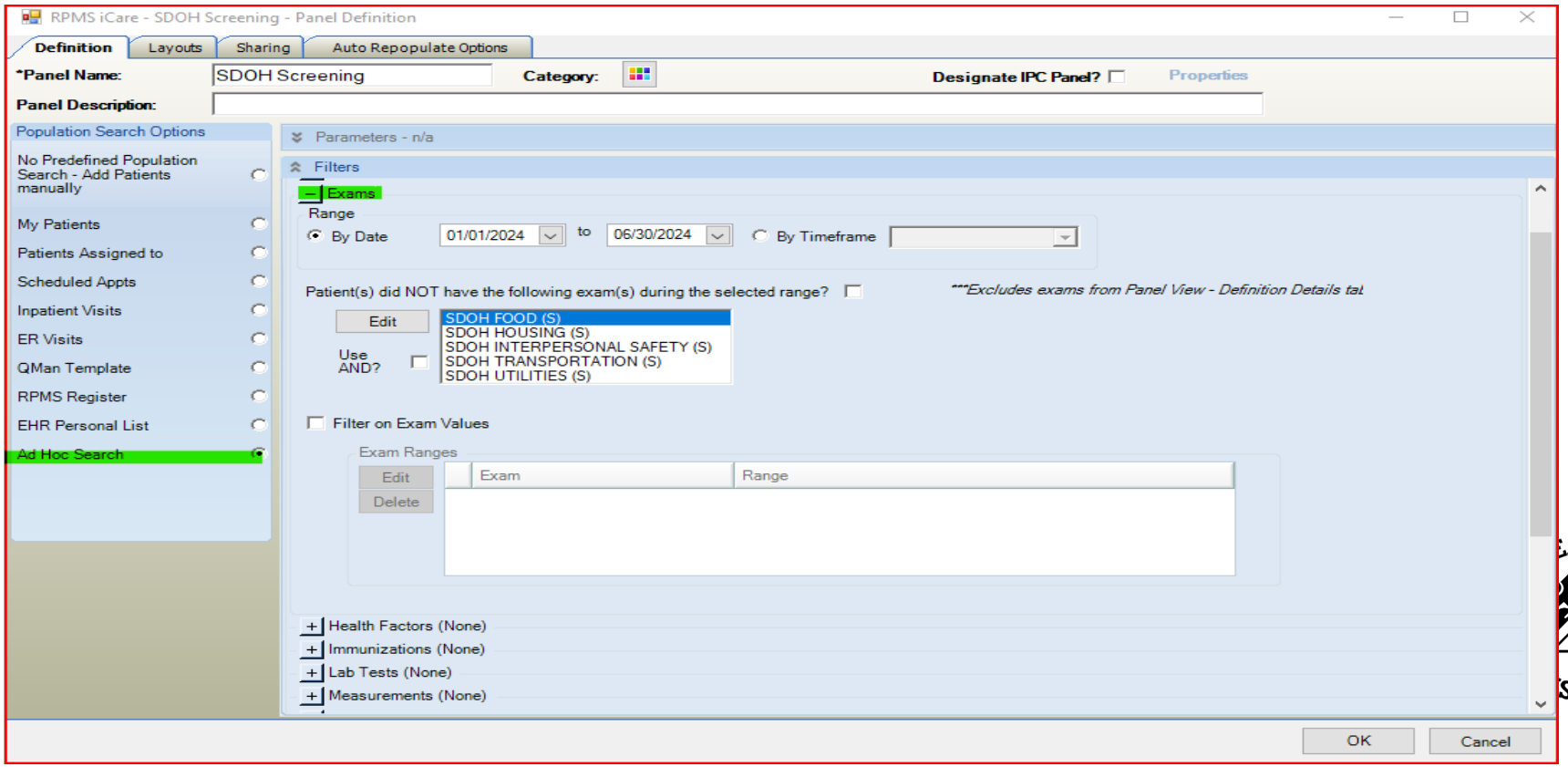

Add Visit Instructions / Care Plans / Goal Notes / Care Planning Activities
Visit Instructions
Date
03/10/2022
Goal Notes
Date
03/10/2022
Care Plans
Date
03/10/2022
Patient Education provided
Disease Process
Nutrition
Exercise
Lifestyle Adaptation
Medications
Prevention
Treatment/Regimen/Follow-up
Current Visit - Care Planning Activities
Treatment/Regimen/Follow-up
Education Provided
Readiness to Learn:
OK
Cancel
Treatment/Regimen
Anticoag DVT Prevention
Asthma
Behavioral Health
Case Management
Controlled Substance
Dialysis
Disposition
Follow Up
Massage Therapy
Nursing
Palliative Care
Rehab Services
SDOH Intervention
Patient referral to dietitian
Refer to mental health worker
Referral to social worker
Nutrition education
Transportation education, guidance, and counseling
Referral to community meals service
Referral to peer support
Counseling for barriers to achieving food security
Education about benefits enrollment assistance program
Coordination of resources to address food insecurity
Assistance with application for food pantry program
Referral to case manager
Counseling for social determinant of health risk
Referral to Emergency Shelter program
Education about legal aid
Counseling for barriers to achieve adequate housing
Transportation case management
Coordination of care plan
Substance Abuse
Tobacco
Weight Management
OK
Cancel


Add Visit Instructions / Care Plans / Goal Notes / Care Planning Activities
Visit Instructions
Date
03/10/2022
Goal Notes
Date
03/10/2022
Care Plans
Date
03/10/2022
Patient Education provided
Disease Process
Nutrition
Exercise
Lifestyle Adaptation
Medications
Prevention
Comprehension Level
FAIR
Length
0
(min)
Readiness to Learn
RECEPTIVE
Treatment/Regimen/Follow-up
Current Visit - Care Planning Activities
Treatment/Regimen/Follow-up
Case management follow up
Education Provided
Had Nutrition Education.
Comprehension Level: FAIR
Readiness to Learn: RECEPTIVE
OK
Cancel

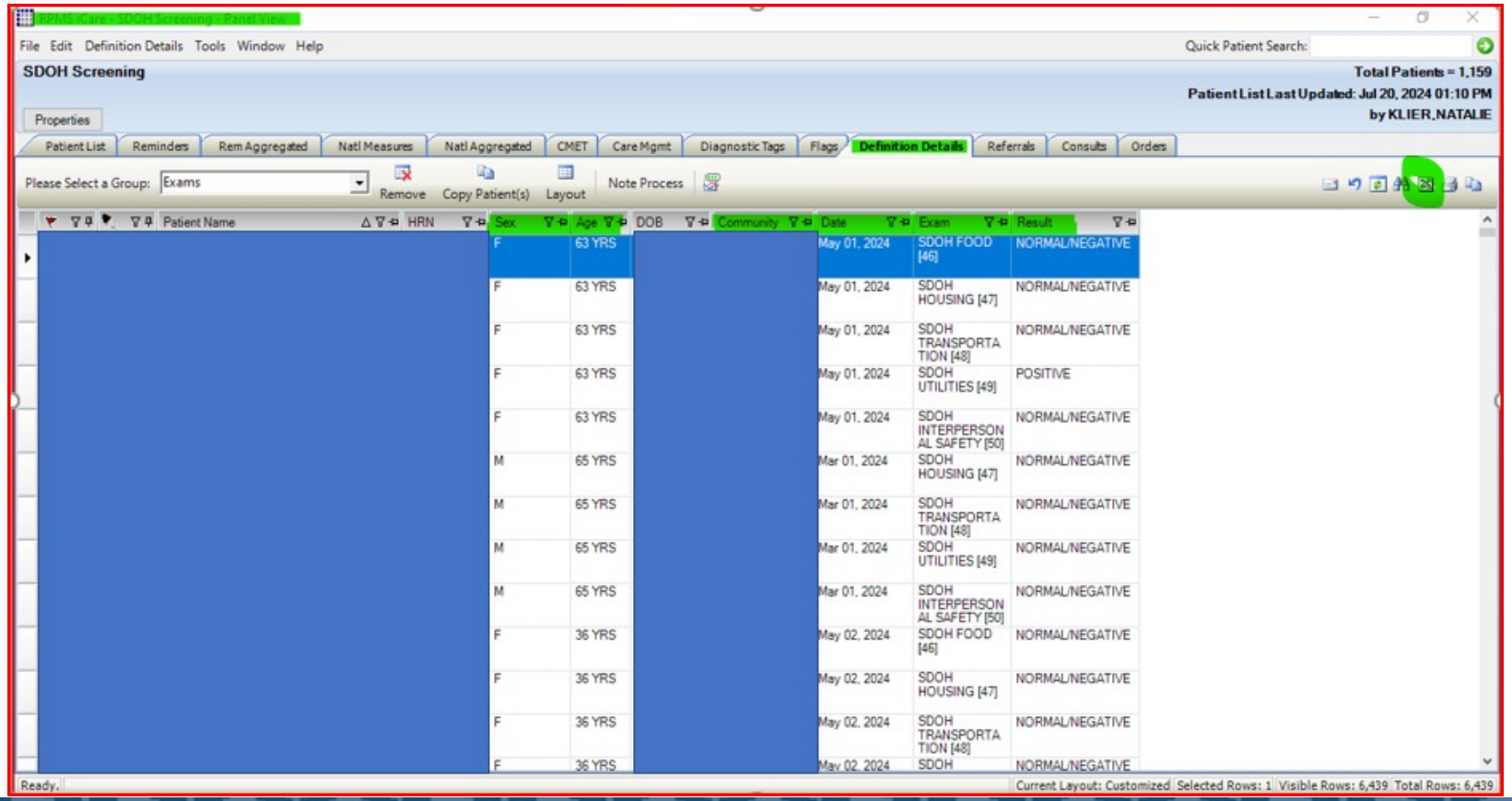

Integrated Problem Maintenance - Edit Problem
Problem ID
TST-3
Priority
Use as POV
Primary
Save
Cancel
SNOMED CT
Food insecurity
Get SCT
Pick list
Status
Chronic
Sub-acute
Episodic
Social/Environmental
Inactive
Personal Hx
Routine/Admin
Required Field
Provider Text
Food insecurity Z59.41
Date of Onset
Qualifiers
Severity:
Clinical Course
Severity
Clinical Course
Episodicities
Is Injury
Comments
Add
Delete
Narrative
Date
Author
Care Plan Info
Add Visit Instruction / Care Plans / Goal Activities
Goal Notes
Care Plans
Visit Instructions
Care Planning Activities
Case management follow up

Reporting

Utilizing I-Care – SDOH

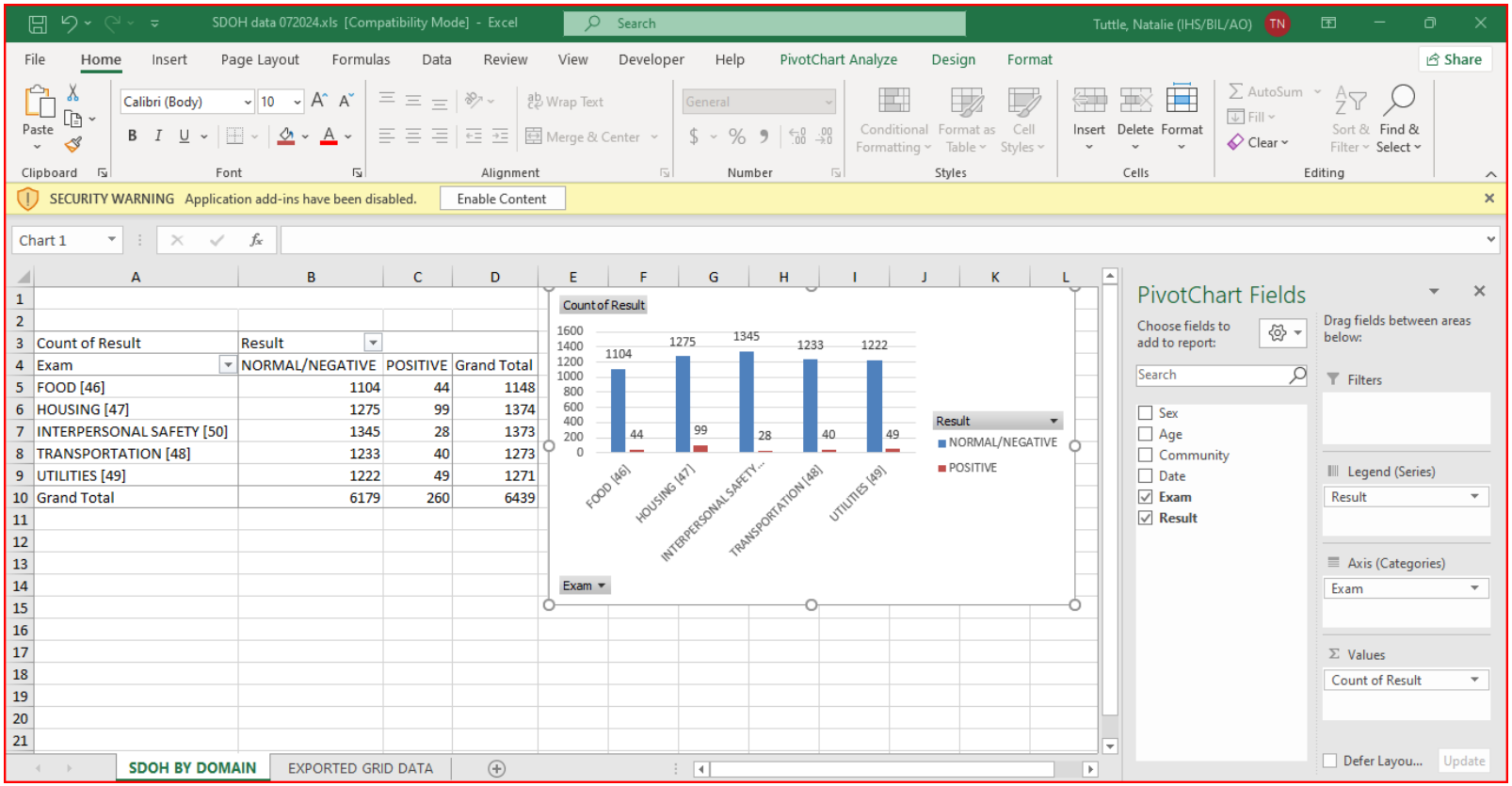


I-Care Panel Definition



SDOH by Domain Results

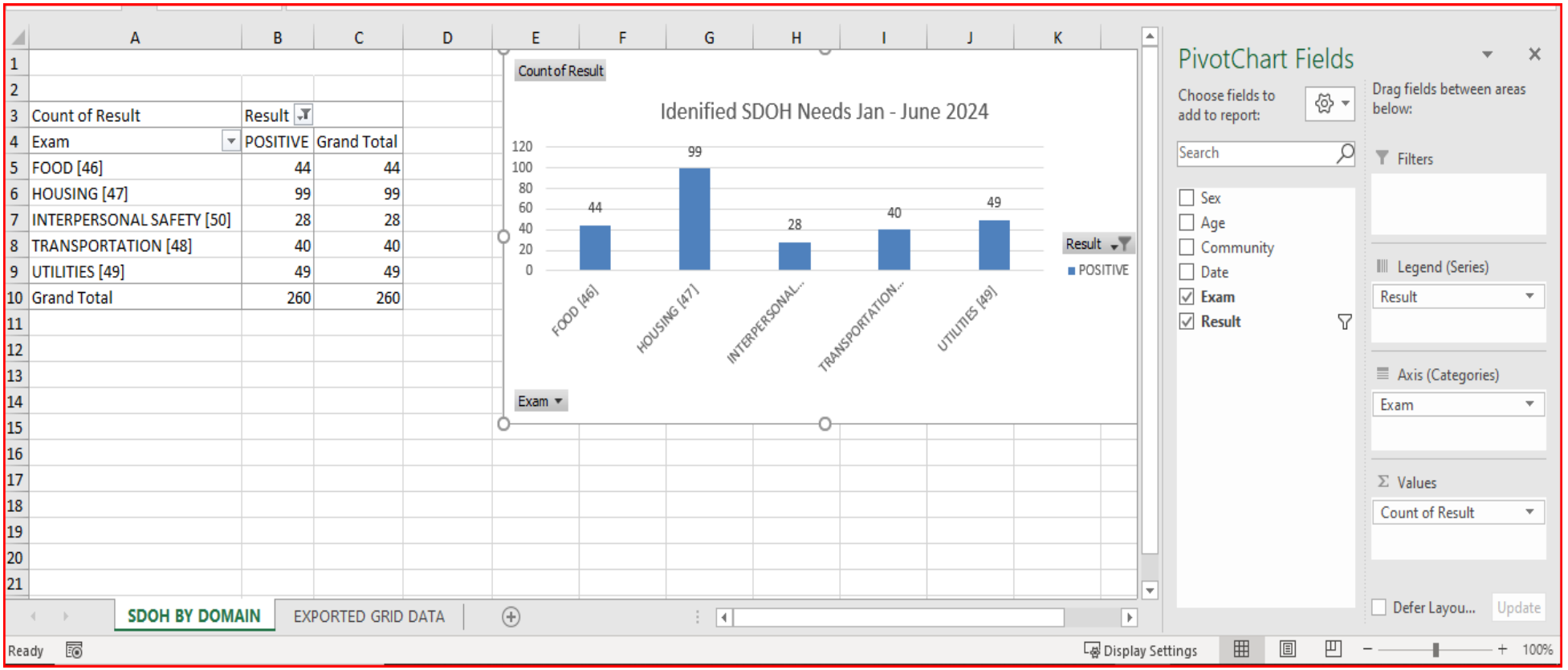
(Jan – June 2024)



Count of Result	Result		
Exam	NORMAL/NEGATIVE	POSITIVE	Grand Total
FOOD [46]	1104	44	1148
HOUSING [47]	1275	99	1374
INTERPERSONAL SAFETY [50]	1345	28	1373
TRANSPORTATION [48]	1233	40	1273
UTILITIES [49]	1222	49	1271
Grand Total	6179	260	6439

SDOH by Domain Needs (Positive Exams)

(Jan – June 2024)

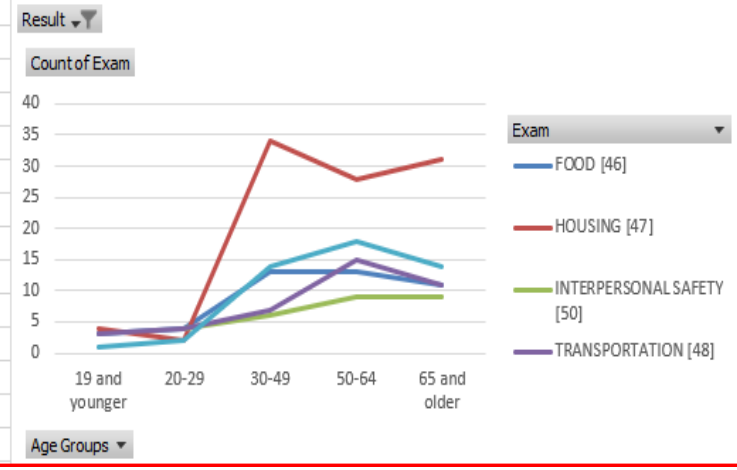


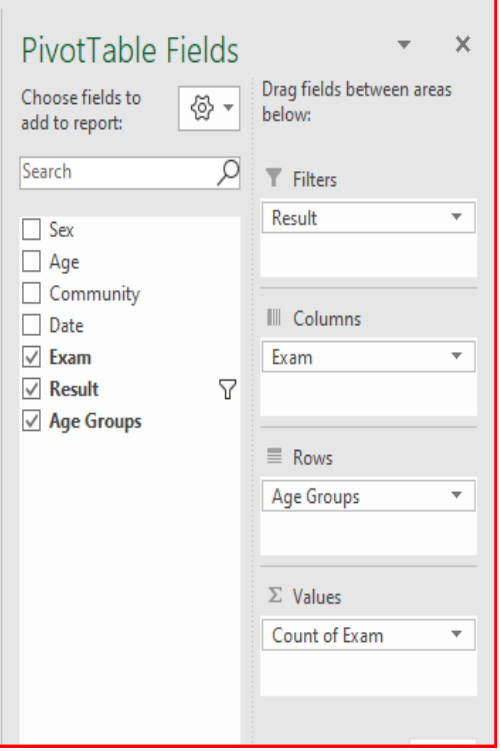
Count of Result	Result	
Exam	POSITIVE	Grand Total
FOOD [46]	44	44
HOUSING [47]	99	99
INTERPERSONAL SAFETY [50]	28	28
TRANSPORTATION [48]	40	40
UTILITIES [49]	49	49
Grand Total	260	260

SDOH Domain Needs by Age Groups

(Jan – June 2024)

Age Groups	FOOD [46]	HOUSING [47]	INTERPERSONAL SAFETY [50]	TRANSPORTATION [48]	UTILITIES [49]	Grand Total
19 and younger	3	4		3	1	11
20-29	4	2	4	4	2	16
30-49	13	34	6	7	14	74
50-64	13	28	9	15	18	83
65 and older	11	31	9	11	14	76
Grand Total	44	99	28	40	49	260





Plans for FY 2025

- Pilot moving upstream for community health needs assessment and community-based interventions using the Learning Lab ReD Collaborative.
- Adding exams codes for additional optional SDOH domains and to reminder dialog.
- Adding SDOH-1 and SDOH-2 logic to CRS.
- (Tentative) Development of SDOH Data Mart

Resources

- SDOH Intranet: home.ihs.gov/sdoh
- SDOH Screening Toolkit
- Learning Lab HRSN Screening Sprints
- Learning Lab ReD Collaborative

Thank you/Attribution

Many thanks to CAPT Jana Towne/OCPS/DDTP, Ms. Wendy Wisdom, and CAPT Katie Johnson for slides and screenshots.

Questions/Comments/Discussion?