DRIVERS OF HEALTH – DATA COLLECTION AND SHARING INFORMATION

HMO and Partner Clinic Toolkit

Drivers of Health (DoH) Screening Toolkit

Table of Contents

Drivers of Health (DoH) Screening Toolkit

I.   INTRODUCTION

State Medicaid agencies are in consensus the impact that non-medical social risk factors have on health outcomes and health equity. For the purpose of this exercise, Drivers of Health (DoH), or social determinants of health, are "conditions under which people are born, grow, live, work, and age." Social risk factors are the adverse impacts that individuals encounter that may be identified through asking questions about DoH.

HMOs and providers play an important role in promoting screening of their members and patients through conducting their own screening. Organizations can use this information to implement mitigation strategies for members and patients with social risk factors and needs, including care coordination and management. To effectively coordinate non-medical interventions and services intended to address DoH, there is a general process needed to achieve this, including:

1) Identifying members who are likely to have multiple health and social needs;
2) Screening members for social risk factors and strategically storing, sharing, and tracking screening data;
3) Connecting members with community organization identified to best address their health-related social needs;
4) Following up to ensure members are connected and facilitate completion of the DoH intervention or activity;
5) Tracking outcomes of members receiving community based services.; and
6) Analyzing aggregate data to inform decision making.

> **Drivers of Health:** The conditions in which people are born, grow, live, work and age," which are "shaped by the distribution of money, power and resources" and may be negative or positive. Examples include income, education, employment, housing, neighborhood conditions, transportation systems, social connections, etc.
>
> **Social Risk Factors:** Individual-level adverse drivers of health. Examples include social isolation or housing instability
>
> **Health Related Social Needs**: Individually identified needs related to a social risk factor. Examples include homelessness or domestic abuse.

As mentioned, identification of social risk factors is an essential first step toward fulfilling unmet social needs and improving health. Though there are many promising practices for identifying social risk, there is not yet a best practice or standard. However, initial efforts have led to key learnings that can inform future development of social risk assessments and integration of social needs screening into health care in a way that does not place additional burden on payers, providers, or patients.

DHS encourages the use of a standardized screening tool for DoH, or an internally developed and validated screening tool that addresses DoH domains beyond housing and food security. To develop a better understanding of current practices and procedures, this self-assessment tool was developed by DHS for HMOs and their partner clinic to complete in 2021 as part of the Health Disparities Reduction PIP. The purpose of this tool is to assess and document the current state of how the HMO and partner clinics:

- Screen members for drivers of health;
- Acts on information about drivers of health; and
- Shares information with the member's providers, care team, community based organizations, and/or incorporates into the care plan.

It is DHS' intention for these documents to be informative and interactive as we understand that HMOs and providers are at different crossroads as it relates to DoH. Therefore, within each section of this toolkit, DHS provides background information, relevant resources, and examples to reflect on before completing the accompanying workbook. Finally, there will be space at the end of the self-assessment for the HMOs and partner clinics to describe changes they are interested in exploring in the future to contribute to this important work.

STOP

Complete Section I of the Workbook.

Drivers of Health (DoH) Screening Toolkit

II.   DRIVERS OF HEALTH DOMAINS

Drivers of Health are historically categorized by multiple domains. To most effectively capture the social risk factors associated with DoH, evidence suggests that screening should focus its attention on more common social risk factors that impact the health of members. Based on findings from the Institute of Medicine, CMS, and Health Leads suggest there are "essential" domains that should be included in all screenings and "supplemental" domains that may be included in a screening depending on the goals of an initiative or the target population. These two categories are in Table 1.

Table 1. DoH Domains	
Essential	**Supplemental**
Food	Childcare
Housing	Education
Financial Resources	Employment
Transportation	Health Behaviors
Safety	Social Supports
Demographic Information	Behavioral/Mental Health

There may be several social risk factors within each determinant of health and those social risk factors may be defined differently. Table 2 provides a non-exhaustive list of examples of DoH and their corresponding social risk factors.

| Table 2. DoH and their Corresponding Social Risk Factors (SRFs)	
Housing	
SRF 1. Homelessness	Lack of housing (sheltered or unsheltered)
SRF 2. Housing insecurity	An unstable housing condition, which may be caused by being rent burdened, experiencing overcrowding, frequent moves, or other conditions.
SRF 3. Poor-quality housing	Poor physical condition of the home
Employment	
SRF 1. Unemployment	An active job seeker cannot find a job
SRF 2. Underemployment	Involuntary part-time employment, poverty-wage employment, or insecure employment
Education	
SRF 1. Low educational attainment	Often defined as less than a high school diploma
SRF 2. Low health literacy	An inability to obtain, process, and/or utilize information to make health decisions
Financial Resources	
SRF 1. Financial strain	Inability to pay for utilities, child care, or other essential items
SRF2: Medical Debt	Incurred debt due to high costs of health care, potentially leading to postponed care
Food	
SRF 1. Food insecurity	An absence of reliable access to food
SRF 2. Low-quality nutrition	A diet lacking the appropriate nutrients
Safety	
SRF 1. Interpersonal violence	Abuse within personal, intimate relationships
SRF 2. Neighborhood safety	The presence of crime or violence within one's neighborhood that makes it unsafe

Drivers of Health (DoH) Screening Toolkit

Social Support	
SRF 1. Social isolation	Lack of social contact or support
SRF 2. Loneliness	The feeling of being alone or isolated
Transportation	
SRF 1. Lack of medical transportation	Lack of transportation to medical appointments or to get medication
SRF 2. Lack of nonmedical transportation	Lack of transportation to nonmedical activities, such as for work

*Adapted from State Health and Value Strategies (SHVS)

Race and ethnicity, gender, sexual identity, age, disability, language, and geographic location also contribute to an individual's ability to achieve good health. It is important to recognize the impact that driver of health have on health outcomes of specific populations to examine and address health disparities. Healthy People 2020 defines **health disparity** as "… a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." The definition can be applied to any demographic group, not just racial/ethnic minorities. CMS, through the Medicaid Managed Care rule, specifies six disparity factors – race, ethnicity, age, gender, language, and disability status.

Health equity is the principle to pursue the highest possible standard of health for all while focusing on those with the greatest obstacles. Therefore, health equity is when every person has the opportunity to achieve their full capabilities and potential for health and well-being. (NACCHO, 2015). DoH have a large impact on disparities and health equity and identifying health disparities can help us determine if we are on our path to achieving health equity. Finally, in order to improve health outcomes for those with disparities, social risk factors often need to be targeted for intervention and prevention efforts. Analysis of which social risk factors disproportionately affect which populations helps inform decisions makers on where to focus efforts. The figure to the right displays how these concepts interact with one another.
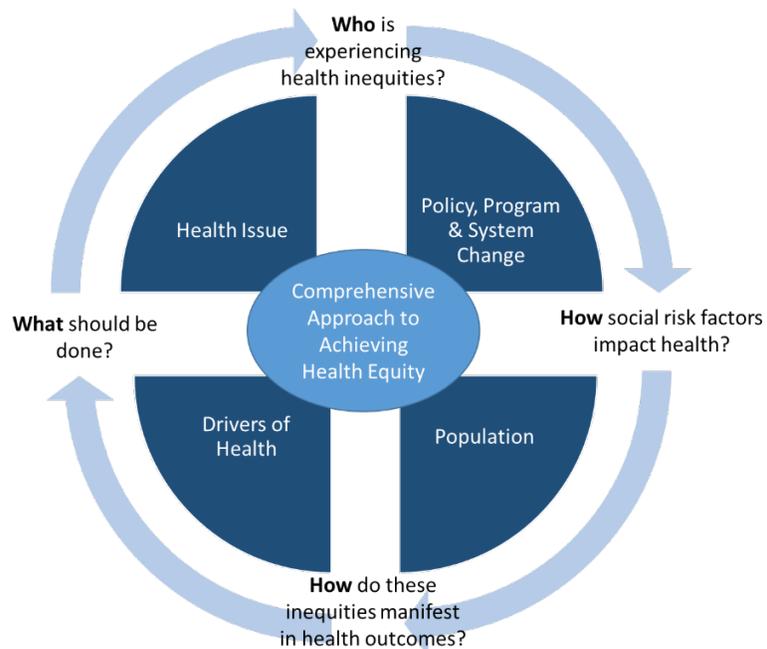
Drivers of Health (DoH) Screening Toolkit

Resources to Learn More

Healthy People 2030: Features many objectives related to DoH. These objectives highlight the importance of "upstream" factors — usually unrelated to health care delivery — in improving health and reducing health disparities.

CDC's Office of Minority Health and Health Equity: Advances health equity and women's health issues across the nation through CDC's science and programs.

County Health Rankings: By ranking the health of nearly every county in the nation, the County Health Rankings help communities understand what influences the health of residents and identify challenges and opportunities to improve these outcomes for all.

KIDS COUNT Data Center: Focuses on developing a brighter future for millions of children at risk of poor educational, economic, social and health outcomes through families, building stronger communities and ensuring access to opportunity.

Communities in Action - Pathways to Health Equity: Considers and provides solutions that could be identified, developed, and implemented at the local or community level to advance health equity.

National Center for Complex Health and Social Needs: Collaborates with experts nationally to develop best practices, inform policy, and foster an engaged and accessible community to develop the field of complex care.

STOP

Complete Section II of the Workbook.

Drivers of Health (DoH) Screening Toolkit

III.   SCREENING TOOLS

Screening tools vary in their reliability and validity to accurately identify social risk factors and their pragmatic properties such as cost, language, and length. Ideally, screening questions will have both strong reliability, validity, and pragmatic properties. Screening tools further vary in the number of domains included, which domains are included, translation options, the population for which they were designed, and reading level. Screening tools may include essential and supplemental domains.

The Social Interventions Research & Evaluations Network's (SIREN) is a comprehensive resource that has compiled information from several of the most widely used screening tools. Below describe three common tools used for adults:

1. **Accountable Health Communities (AHC) Health-Related Social Needs:** The AHC tool was developed by the Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation (CMMI) originally for the screening of social needs among individuals eligible for Medicare and Medicaid. The core domains included in AHC HRSN include housing, food, transportation, utilities, and interpersonal violence, along with eight supplemental domains.
2. **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE):** PRAPARE was developed by the National Association of Community Health Centers. The core domains included within PRAPARE are housing, education, employment, transportation, food, financial strain, and social support. PRAPARE also includes questions on incarceration and safety as supplemental domains. The questionnaire has been translated into twenty-six languages and comes with a companion implementation toolkit.
3. **Health Leads' Social Needs Screening Tool:** Health Leads developed a 10-question screening tool available in English and Spanish. Core domains include food, housing, financial strain, transportation, and safety, with supplemental domains that include education, employment, and social support. Health Leads' Social Needs Screening Tool is available with an implementation toolkit that is updated annually.

Table 2 below is a comparison from SIREN of these three, free tools, examining characteristics and domains included in each.

Table 2. SIREN Screening Tool Comparison			
Characteristics			
	AHC-Tool	**Health Leads**	**PRAPARE**
Number of social needs questions	19	10	17
Number of non-social needs questions	8	0	4
Patient or clinic population	Medicare and Medicaid	Non-specific	Community Health Centers
Reading Level	8th grade	6th grade	8th grade
Additional Languages			Spanish
Scoring	Y	N	N
Domains/Risk Factors (# of questions)			
Childcare access and affordability		1	1
Clothing			1
Disabilities	2		
Education	1		1
Employment	1		1
Financial strain	1		
Food insecurity	2	1	1
Health care/medicine access and affordability		1	2

Drivers of Health (DoH) Screening Toolkit

Housing insecurity/ instability/homelessness	1	1	2
Housing quality	1		
Immigration / Migrant / Refugee status			2
Incarceration			1
Income			1
Interpersonal violence (IPV)	4		1
Literacy		1	
Neighborhood safety			1
Social support	2	1	1
Stress	1		1
Transportation	1	1	1
Utilities	1	1	2
Veteran status			1
Behavioral Health	3		
Desire for assistance / urgent needs	Integrated into some domains	2 stand-alone questions	

Adapted from: https://sirenetwork.ucsf.edu/siren-resources/screening-tool-comparison-table-0

It is important to strategically consider which tool best aligns with your organization. To determine the best tool and practices, organizations should:

1) Understand the population. Knowing your population is essential to identifying priority social risk factors and being able to address them without further exacerbating inequities. Data that highlight potential disparities, perception of issues and values held by members, and mapping resources and gaps in resources are all part of this knowledge.

2) Align with current internal and external priorities. Driver of health initiatives many times can be misperceived as "one more thing to do" or a trend that will soon evaporate. Aligning with current efforts and ensuring stakeholders understand that this will directly impact goals is key to success and to stakeholder buy in.

3) Assess internally your readiness. An internal assessment will guide which areas your organization should focus more on to understand what may be the greatest impact for the target population. One tool for analyzing this is an Upstream Readiness Assessment Tool. We encourage you and relevant staff and leadership to consider the following questions together, answering each question as "limited or unclear," "moderate," or "robust."

- Is the environment favorable for your organization to address DoH?
- What's the perceived value of a change to assess and address DoH?
- Do you have executive sponsorship to advance DoH screening and interventions (i.e. initiatives)?
- How established are team roles and ownership for your DoH initiatives?
- How well defined is (are) the scope of your DoH initiatives?
- How well managed is (are) your DoH initiatives?
- How well integrated are DoH with care delivery?
- How mature are your information and data sharing systems?
- What is your financial readiness for DoH initiatives?

Finally, one emerging trend is using z codes to document and aggregate screening results and health related social needs throughout health systems. Z codes are a subset of ICD-10-CM codes, used to capture "factors that influence health status and contact with health services." They apply to all health care settings and must be accompanied by

Drivers of Health (DoH) Screening Toolkit

any performed procedure codes. Some health systems locally and across the country have implemented or are currently planning leveraging z codes to standardize capturing DoH and social risk factor screenings within their electronic health records (EHRs). Table 3 below describes how each group of these specific z codes relate to DoH and social risk factors. In addition, a high level overview with more information regarding z codes can be found here.

Table 3. Z Codes Related to Socioeconomic and Psychosocial Circumstances (Z55-Z65)			
Z55-Z55.9	Illiteracy and low-level literacy; schooling unavailable and unattainable; failed examinations; school underachievement; educational maladjustment and discord	**Z61-Z61.9**	Problems related to negative life events in childhood; loss of love relationship; removal from home; altered pattern of family relationships; events resulting in loss of self-esteem; problems related to alleged sexual abuse; problems related to alleged physical abuse; personal frightening experience
Z56-Z56.9	Unemployment, unspecified; change of job; threat of job loss, stressful work schedule; discord with boss and workmates; uncongenial work; other physical and mental strain related to work	**Z62-Z62.9**	Other problems related to upbringing; inadequate parental supervision and control; parental overprotection; institutional upbringing; hostility towards and scapegoating of child; emotional neglect of child; other problems related to neglect
Z57-Z57.9	Occupational exposure to risk-factors; exposure to noise; exposure to radiation; exposure to dust; exposure to other air contaminants; exposure to toxic agents; exposure to extreme temperature; exposure to vibration; exposure to other risk factors; exposure to unspecified risk-factors	**Z63-Z63.9**	Other problems related to primary support group, including family circumstances; problems in relationship with spouse or partner, parents and in laws; inadequate family support; absence of family member; disappearance and death of family member; disruption of family by separation/divorce
Z58-Z58.9	Problems related to physical environment; exposure to noise; exposure to air pollution; exposure to water pollution; exposure to soil pollution; exposure to radiation' exposure to other pollution; inadequate drinking-water supply; exposure to tobacco smoke	**Z64-Z64.9**	Problems related to certain psychological circumstances; problems related to unwanted pregnancy; seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful; seeking and accepting behavioral and psychological interventions known to be hazardous and harmful; discord with counsellors
Z59-Z59.9	Problems related to housing and economic circumstances; homelessness; inadequate housing; discord with neighbors/lodgers/landlord; problems related to living in institutions; lack of adequate food; extreme poverty; low income; insufficient social insurance and welfare support	**Z64-Z65.9**	Problems related to other psychosocial circumstances; conviction without imprisonment; imprisonment and other incarceration; problems related to release from prison; problems related to other legal circumstances; victim of crime and terrorism; exposure to disaster, war, and other hostilities
Z60.-Z60.9	Problems related to social environment; problems of adjustment to life-cycle transitions; atypical parenting situation; living alone; acculturation difficulty; social exclusion, rejection, discrimination		

Adapted from Oregon's Social Determinant of Health Workgroup Final Report

Drivers of Health (DoH) Screening Toolkit

Resources to Learn More

SIREN: Compiled information from several of the most widely used social health screening tools (in adults and pediatric populations) for stakeholders interested in comparing these instruments and also provides both peer-reviewed publications and other types of resources such as webinars and screening tools/toolkits on medical and social care integration.

Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health: This calculator is designed to help community-based organizations and their health system partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost patients.

Social Determinant of Health (SDH) ICD-10 Z Codes: This tool outlines existing ICD-10 z codes that are a close match to social needs responses identified through use of the PRAPARE tool.

STOP

Complete Section III of the Workbook.

Drivers of Health (DoH) Screening Toolkit

IV.   SCREENING TOOL BEST PRACTICES

Understanding a member's health related social needs can be challenging: your member may have a language barrier, may be uncomfortable providing sensitive information, or may have previously had a negative experience in attempting to address their needs. Research suggests that members who are screened for social risk factors by providers believe screening is important, particularly when screening is conducted in a compassionate and patient-centered manner. Screening alerts a person's care team to the presence of any health needs, thereby helping them to feel "cared for" by their provider. If organizations conduct screenings, strengthen data-sharing and communication mechanisms between HMOs and providers, then screening results may be used for better informed clinical decision-making.

Regardless if a provider or HMO is conducting a screening, there are several recommended best practices to overcome barriers and to ensure your screening process is patient-centered (adapted from Health Leads Screening Toolkit):

1. **Keep it short and simple.**
   Patients have so many forms and questionnaires to complete when they visit a doctor these days, so we recommend that you keep your tool brief to ensure it is completed fully. We recommend your tool be:
   - Short, with a maximum of 12 questions
   - Written at a 5th-6th grade reading level to accommodate low literacy populations
   - Translated into other languages, ideally those that are most prevalent in your practice

   Keeping your screening tool brief may be easier if you leave out benefits assessments or full intake questions. Follow the example of depression screening: your initial screening helps identify the potential need, while follow up questions with a clinician diagnose if the patient has depression and how to address it.

2. **Choose validated questions.**
   Identify targeted questions that match the need for your initiative and population. Watch out for broad questions that may generate false positives, narrow questions that do not catch enough patients, or questions that are relevant to specific member demographics (e.g., pediatric or senior populations).

3. **Integrate into workflows.**
   Organizations administering DoH assessments often establish workflows to track member needs and referrals. This helps standardize the process of screening members and referring them to services, and allows the care team to better understand team members' roles and responsibilities. Workflows typically include: (1) time frame for administering an assessment (2) care team member(s) responsible for conducting assessments and subsequently making referrals; and (3) tracking of necessary referrals and follow up.

4. **Ask members to prioritize.**
   Just because a member screens positive for social needs doesn't mean they would like help working on those needs. Talk to your members about their priorities, goals and strengths to clarify whether there are useful ways for your health system to provide support services.

5. **Prioritize target population and pilot before scaling.**
   Given that there is no one standardized screening tool used by all health systems today, you may find yourself designing a tool that takes questions from multiple instruments. To confirm your screening tool is truly patient-centered, it is recommended to conduct a short evaluation to test the tool with members before offering the tool to your broader member population.

A final piece after selecting a tool or questions and the process is in place is practicing asking the questions to achieve a patient-centered atmosphere. This is a very important step to a DoH initiative – being able to

communicate effectively with members is key to accurate identification of social risk factors and resolution of health related social needs. The next section will discuss principles and provide resources regarding staff training to appropriately administer DoH screening tools.

Resources to Learn More

Implementing a Social Determinants Screening and Referral Infrastructure During Routine Emergency Department Visits: Developed and evaluated a process for identifying social needs among emergency department patients, for facilitating access to community-based resources, and for integrating clinical and community-based data.

Health Leads Social Needs Screening Toolkit: Building on Health Leads' 20+ years of experience implementing these programs, as well as guidelines from the Institute of Medicine and CMS, this Social Needs Screening Toolkit shares the latest research on how to screen patients for social needs.

Complete Section IV of the Workbook.

V. SCREENING PROCESS

There are several decisions organizations need to consider as they design their screening process. The State Health and Value Strategies (SVHS) has identified the following key decisions:

1. **Who to screen:** Screenings can be focused on all members or on specific high-cost, high-needs populations.
2. **Which staff is responsible for screening:** The staff member screening the member should have the appropriate background, education, and training. Utilizing staff with lived experience (ex: community health workers) may help members feel more comfortable answering sensitive questions.
3. **The appropriate training for staff conducting the screening:** A member's social needs can be challenging: and they may be concerned about divulging sensitive information, or they may have previously had negative experiences in attempting to address their social needs. Staff should be "trauma informed" if engaging with members on sensitive topics.
4. **Where the screen should occur:** Consider your current processes and workflows to determine where this screening should occur and if it could at multiple touch points and through which mechanism (i.e. telephonically, in person, or electronically).
5. **If the screen should be conducted for individuals or for families:** Screening could be conducted on an individual level or a household level- nationally some organizations screening for households if the member is a young child.
6. **At what frequency should screening occur:** Most common practice is for screening to occur annually, however it is important to continue the conversation with a member if a social risk factor is identified and the member is interested in addressing any health related social need.
7. **Whether the screen should be stand-alone:** Most DoH screens are performed apart from other screens, but may also be part of a care management assessment or health risk assessment.
8. **Whether there will be a standardized screening tool**: As previously discussed.
9. **How to document, aggregate, and analyze screening results:** Determine the system changes needed to electronically document the screening results. Include how the results will be used practically to help the member with identified needs and how the results can be used for data analysis to examine prevalence, disparities, and other metrics.

> **Principles for Patient-Centered Approaches to Social Needs Screening**
>
> ✓ Support autonomy and respect privacy
> ✓ Provide a clear explanation for conducting the screening, how information will be used and options for follow up.
> ✓ Share power by asking about member priorities
> ✓ Account for the stigma associated with experiencing social needs, as well as personal assumptions about the experiences and capacities of patients.
> ✓ Ask about strengths, interests and assets
> ✓ Test screening workflows with members before standardizing approach
> ✓ Ensure that information disclosed by members through social needs screening is shared with and acknowledged by all staff of the care team.
> ✓ Select a care team staff with sufficient time and empathy to connect with members about social needs.
> ✓ Minimize member and staff distress and trauma.
>
> Visit this link for more information.

Selecting a tool or questions and integrating it into the workflow and screening process are important but irrelevant if the DoH data collected is not integrated in a meaningful way. For example, integrating the screening process into an accessible care plan can open up accessibility of the member's needs to the care team at both the community and provider level. This enables relevant people to track member's needs and progress towards achieving their goals. Finally, as previously mentioned, if health systems are assigning z codes to screening questions then coding these z codes during encounters, HMOs and providers across systems can see that members may have a need. However, there must be a shared understanding of defining z codes and next steps to take to better serve members and patients.

Drivers of Health (DoH) Screening Toolkit

Finally, as noted above, staff and providers whom are administering screenings need to conduct screenings in a trauma informed, empathic manner. To support your staff and providers and enhance services for culturally and linguistically diverse populations, organizations need to incorporate cultural competence from the top down. The National Center for Cultural Competence provides tools and resources for organizations to assess their current practice and policies to plan for and incorporate cultural competence within an organization and to determine the needs, preferences, and satisfaction of the people they serve. Table 4 below provides a non-exhaustive list of inclusion and equity frameworks that can be adapted to achieve health equity.

Table 4. Inclusion and Equity Frameworks	
Framework	**Description & Resources**
Participatory Action Research (PAR)/Community-based Participatory Research (CBPR)	PAR is a type of research framework that allows the community under investigation to actually participate in the research by guiding it and being the knowers and teachers of knowledge. PAR removes the researcher from the center of focus and replaces it with the community, while trusting the community knows better than the investigator about their needs. PAR can equip these communities with power to change their social situations by having community members actively engage in research in a meaningful way that includes the community's desires and knowledge. PAR allows for deep reflections, rich data, and potential honest conversations and actions that can be transformative. Activities Using Community-Based Participatory Research to Address Health Care Disparities
Cultural Humility	Involves "self-introspection to better understand one's own identity and how they influence our values, perceptions, and behavior. This framework provides a guiding structure that surfaces in individuals and teams the necessary awareness, desire, and ability to relate to any person's essence. Relating to the essence of a person requires seeing beyond appearance and presentation." Cultural Humility to Cultural Reverence
Critical Reflexivity	Critically interrogates and or suspends ones understanding on knowledge, values, norms, assumptions, behaviors, and thinking that any public health professional can practice individually or at an organizational level. Critical reflexivity "embraces subjective understandings of reality as a basis for thinking more critically about the impact of our assumptions, values, and actions on others." Critical Reflexivity of Community on Their Experience to Improve Population Health On Becoming a Critically Reflexive Practitioner
Anti-racism Praxis	Explores how systemic oppression of marginalized persons are rooted in the construction of race and racism. The framework provides approaches to address and undue the harmful societal effects caused by racism. Race Forward Tools The public health critical race methodology: praxis for antiracism research
Social Ecological Model	Helps "describe the interactive characteristics of individuals and environments that underlie health outcomes." Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education & Behavior Health Promotion Interventions
Beloved Community	Provides a framework and serves as a toolkit for individuals working within systems and with communities to courageously combat racism and other forms of discrimination, while building a community rooted in forgiveness, reconciliation, and restoration for the greater good. Beloved Community Talks Beginner Toolkit
Human Rights Framework	"Internationally recognized norms applying equally to all people everywhere in the world. International human rights law is a set of legal standards to which governments have

| | agreed with the purpose of promoting and protecting these rights. International treaties not only prohibit direct violations of human rights but also hold governments responsible for progressively ensuring conditions enabling individuals to realize their rights as fully as possible.

The right to health, i.e. the right to the highest attainable standard of health, makes governments responsible for prevention, treatment and control of diseases and the creation of conditions to ensure access to health facilities, goods and services required to be healthy. Because all human rights— economic, social, cultural, civil and political— are considered interdependent and indivisible, governments are accountable for progressively correcting conditions that may impede the realization of the "right to health", as well as related rights to education, information, privacy, decent living and working conditions, participation, and freedom from discrimination. "
Poverty, equity, human rights and health

World Health Organization - Human Rights Approach to Health |
|---|---|

Resources to Learn More

Empathic Inquiry: A conversational approach to social needs screening that was developed by the Oregon Primary Care Association (OPCA) to promote partnership, affirmation and patient engagement through screening.

Roadmap to Trauma Informed Care: Despite a clear need for trauma informed care (TIC), it can be challenging to know what to do or where to start. Trauma Informed Oregon (TIO) has created a roadmap and toolkit to guide implementation efforts.

Think Cultural Health: Features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS.

American Hospital Association: Screening for Social Needs: Although tailored towards hospitals, this tool may help guide health care entities as they navigate the best way to engage their members in screening conversations to address social needs of individuals in a dignified and culturally competent manner.

STOP

Complete Section V of the Workbook.

VI. COMMUNITY BASED ORGANIZATION PARTNERSHIPS

Partnerships are essential to addressing social risk factors and health disparities. The ability to respond to identified health related social needs relies on the ability of health systems to link members to the appropriate resources. Integral to this process is the willingness of HMOs, providers, and community based organizations (CBOs) to share data and results with one another to facilitate effective handoffs. This can only be achieved through developing relationships that promote trust among all parties. Further, responding to identified needs requires a process for assessing internal capacity of an organization to address certain needs, understanding the resources available in a given community, and determining the appropriate path forward whether that involves expanding internal capacity, referring members externally, or a combination of the two. Table 5 below showcases common approaches that organizations are taking to work together to improve health outcomes.

Community Based Organization is a public or private entity that works to generate improvements within a community on the local level.

Table 5. How Services within a Partnerships Function and Relate to Each Other			
	Referral Service	**Coordinated Services**	**Joint Service**
Description	Partners link clients to services through sharing client information with each other, and/or providing clients with information about partner services that meet their needs.	Partners coordinate delivery of a complementary set of services for shared clients. Partners actively connect their services, often through roles that strengthen service linkages.	Partners provide services that are co-located and/or jointly staffed and together strengthen care connections and/or service linkages.
Examples	In the Health Access Nurturing Development Services (HANDS) partnership, the Louisville Metro Department of Public Health and Wellness (LMDPHW) makes referrals to Family and Children's Place (F&CP) for home visitation services for new or expectant parents. F&CP assesses and addresses parents' needs as a family, develops a family plan, and makes home visits until the child turns three to provide information and linkages to services that support positive birth outcomes and healthy child development.	In the Transitional Respite Care program, Catholic Charities Spokane and Volunteers of America provide transitional care services for patients from Providence Sacred Heart Medical Center. When Medical Center providers discharge patients, social workers connect eligible patients to Catholic Charities, a community-based organization providing short-term housing, meals, and other services to individuals who are homeless. Each partner exchanges health and program-level information with the other in order to tailor care to the specific needs of individuals.	The Ruth Ellis Health and Wellness Center provides co-located services for the LGBTQ community through a partnership between the Ruth Ellis Center (REC) and Henry Ford Health System (HFHS). Primary care, behavioral health, and social services are located in a newly built site where staff from REC and HFHS work together to identify and address patient needs. Both partners participated in developing the center and planning the services provided.
Adapted from CHCS: Integrating to Improve Health			

There are thousands of community based organizations, local health departments, and nonprofits throughout Wisconsin that deliver state programs, privately funded initiatives, or other services that benefit their community. Organizations and agencies such as the Wisconsin Community Action Program, United Way's 2-1-1, DHS, or the Department of Family and Children keep a robust list of resources that may address various social risk factors. Within those lists are the specific organizations delivering the interventions or programs associated with different drivers of health domains. Table 6 below is an example of these various organizations and potential partners that

address social risk factors within these domains. The table is not exhaustive but rather displays that there are opportunities statewide to partner with different organizations.

Table 6. Organizations Addressing DoH	
Domain	**Local or Statewide Organizations**
Food	• Green County Women Infant and Children • Bloomer TEFAP Food Pantry
Housing	• Integrated Community Solutions Wisconsin Rental Assistance Programs • Wisconsin Balance of State Continuum of Care
Financial Resources	• Low-Income Energy Assistance Program
Transportation	• Work-N-Wheels
Safety	• End Domestic Abuse
Childcare	• Childcare Subsidy Programs
Education	• Workforce Connections: • Literacy Green Bay
Employment	• Complete Milwaukee Transitional Job Program • Job Center of Wisconsin • Workforce Resource
Health Behaviors	• Juneau County Nurse Family Partnerships Home Visiting Programs • Polk United
Social Supports	• Family Connects Racine County • Sheboygan County Aging and Disability Resource Center • Area Agency on Agency of Dane County
Behavioral/Mental Health	• NAMI Southwestern Wisconsin Peer Support Groups • Parents Place Triple P Program

Many HMOs and other health care organizations lack a formal inventory of available resources in the community to address social risk factors as well as a process for tracking what happens after referrals. Often there is a lack of coordination or communication between CBOs and health systems that are serving the same person. This is where strategically thinking about what relationships need to be established or nurtured with CBOs will be crucial to address needs and reduce disparities. Ultimately the relationships between the health and social sector could impact community-driven solutions (see figure) to improve health equity for all.

Drivers of Health (DoH) Screening Toolkit

Resources to Learn More

Partnership Assessment Tool for Health (PATH): This resource is intended for community-based organizations (CBOs) that provide human services and healthcare organizations currently engaged in a partnership. The objective of the PATH is to help partnering organizations work together more effectively to maximize the impact of the partnership.

Tools for Supporting Social Service and Health Care Partnerships to Address Social Determinants of Health: Provides a set of practical resources and tools to help emerging and existing partnerships address common barriers to partnering and strengthen their collaborative activities.

Building Effective Health System-Community Partnerships: This brief shares considerations for health care organizations and government entities seeking to build effective partnerships with the individuals and communities they serve to better address their health and social needs.

Complete Section VI of the Workbook.

Drivers of Health (DoH) Screening Toolkit

VII.   REFERRALS & INTERVENTIONS

After screening for social risk factor, organizations should identify if members would like assistance addressing their health related social needs and which to prioritize. This includes receiving consent from the member to document these needs electronically, whether it be in their care plan or in their EHR through z codes or other mechanisms. Allowing members to decide if they would like these addressed supports shared decision-making and confirms that the social risk factor is, in the eyes of the member, an actual social need.

Before asking about a member's needs, however, it is necessary to know what resources are available to address those needs. If a member screens positive for a social risk factor and would like to address it, then the organization serving the member needs to have designated person within the organization with a keen awareness of available services – both internally or externally with community partners – to appropriately refer member's to relevant resources. Referral in this context does not simply mean suggesting the member calls 2-1-1.

While outgoing referrals to community based organizations or to resources such as 2-1-1 or the Well Badger Resource Center are important and could address some needs, simply providing a number or a list of resources will not guarantee that assistance was sought or provided to the member. A better practice is to engage in a "closed-loop referral" meaning the ability to receive information back from the entity the referral was sent to regarding the outcomes of the referrals. Referrals for social services that CBOs provide can be fairly complex and may involve many steps with different stakeholders, such as state agencies, counties, or Community Action Programs (nonprofits that address poverty). Therefore, the partnerships building among CBOs and other entities serving the same population will continue to be important to achieve closing the referral loop.

A coordination process that integrates healthcare with social services is the most effective and sustainable method for implementing closed-loop referrals. This involves closing the referral loop through a bidirectional process in which care team members follows up with members and/or CBOs to see if the referral was received and then again in 1-2 weeks to ensure member needs were met.

Developing a bidirectional system to track referrals and measure the success of the screening and referral process can be achieved through ever evolving technology that is being developed to connect people with the resources they need. There are many referral platform organizations that participate in this work such as NowPow, Healthify, UniteUs, HealthBridge, and more. Many leverage the resources from 2-1-1 or other regional resource databases to help connect the dots between healthcare and social services. Some have the capability to integrate with EHRs so providers can directly refer their patients to services.

Just as EHRs have multiplied over the years, creating an urgency for Health Information Exchanges, referral platforms are also exponentially growing. So much, that some states and health systems are using Community Information Exchanges (CIEs). CIEs are "an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care." See the "CIE Core Competencies" visual representing what this can look like, as adapted from 2-1-1 San Diego.

CIE Core Competencies

Network Partners + Shared Language + Resource Database and Bi-directional Referrals + Technology Platform and Data Integration
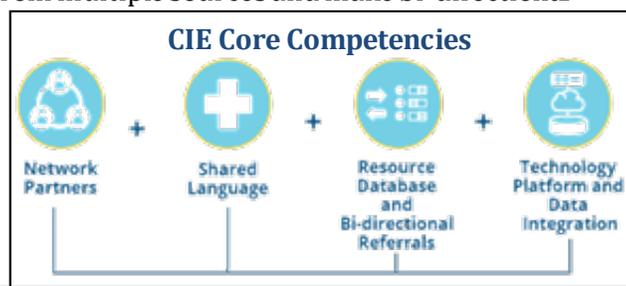
Drivers of Health (DoH) Screening Toolkit

The task of implementing a referral platform or the more advanced option of a CIE can be overwhelming. There are other opportunities for HMOs and providers to intervene after screening their members. This may include considering different types of community care coordination (i.e. bridging the gap between needs and referrals) and value-added services your HMO may consider to meet the needs of their members and target population. For example, in Ohio, most Medicaid HMOs reimburse for community care coordination through the Pathways Community HUB Model (see callout box for more information) using value based purchasing.

Outcomes-based payments in the Pathways Community Hub

The Pathways Community Hub program uses an outcomes based payment method in which at least 50 percent of program payment is based upon outcomes achieved, which are defined as a mix of health outcomes and social service outcomes. There are 17 pathways, each of which correspond to a predefined, specific DoH need. Clients may be enrolled in more than one pathway, depending upon their needs. Each "pathway" is the primary unit for billing and is considered "complete" when a specific outcome is reached. For the majority of pathways, a fixed outcomes-based payment is made when the pathway is completed. The amount of payment is driven by a fee schedule, which is based upon the average cost per pathway. For certain pathways, bonus payments are made for achieving a predefined set of health outcomes, such as delivering a healthy birthweight baby.

Other potential strategies include pay for performance with partner organizations, shared savings based on DoH interventions, pay for success for achieving a desired outcome, or capitated/bundled payments to CBOs to cover community care coordination activities.

Resources to Learn More

Community Resource Referral Platforms: A Guide for Health Care Organizations: Guide developed to help health care organizations understand the referral platform options available with recommendations on how to select and implement platforms.

Collaboration and Cross-Sector Data Sharing to Create Healthier Communities: A toolkit designed to assist communities interested in learning how to harness the value of cross-sector collaboration and data sharing to develop a Community Information Exchange (CIE) that enables a network of health, human, and social service providers to deliver coordinated, person-centered care to address drivers of health.

Great Rivers HUB and UniteWI HUB: Certified HUB Pathways models in Wisconsin with a foundation relying on the understanding that addressing the issues that prevent individuals from accessing health care, housing, food, employment, education, and other critical supports directly impacts health outcomes. HUB Pathways provide documentation and accountability for the social factors that need to be addressed in order to achieve health equity, including utilizing Community Health Workers (CHWs) to establish the community engagement necessary to build trusting relationships with community members served.

STOP

Complete Section VII of the Workbook.

VIII.   DATA ANALYSIS

While collecting and measuring social risk factors periodically at the individual level is important to assess member's progress, this section primarily focuses on aggregating DoH data across the people organizations serve. As previously mentioned, screening results and members needs should be used for data analysis to examine prevalence, disparities, and other metrics such as screening validation. CMS recently published guidance confirming that analyzing DoH data is critical in determining differences in quality of care and utilization, underlying reasons for variations in care among members, and identifying and measuring disparities in health services and outcomes through stratifying subpopulations and groups. HMOs and health systems can use this information to develop an action plan and timeline to address the DoH and health disparities identified through targeted interventions. The interventions may address the workforce (such as increasing CHW use), implementing programs that focus on identified disparities, or offering community events related to findings - all of which should aim to improve health equity.

To review, the equity measures identified by CMS include race, ethnicity, age, gender, language, and disability status. As organizations determine how DoH data will be stored, strategizing how to view this data will be pertinent. For instance, does your organization want to analyze if members whose main language is not English have more social risk factors associated with the DoH "safety' domain? Organizations across the country are beginning to analyze equity measures in the context of DoH domains, not just different health conditions or outcomes. They are also visualizing these results through dashboards to efficiently review where gaps are occurring. Below are examples of dashboards:

1) King County Health Disparities Dashboard. Documents how much specific disparities affect communities of color in King County, WA. It shows health-related rates for the following groups compared to whites (or the county average, if you prefer): American Indian/Alaska Native, Asian, Black/African American, Hispanic, and Native Hawaiian/Pacific Islander.

2) Healthy North Texas Disparities Dashboard. A web-based source of community health and population data to be used as a tool for community assessment, strategic planning, identifying best practice for improvement, collaboration and advocacy.

3) CMS Office of Minority Health Medicare Disparities Tool. Designed to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending as a starting point to understand and investigate geographic and racial and ethnic differences in health outcomes. This information may be used to inform policy decisions and to target populations and geographies for potential interventions
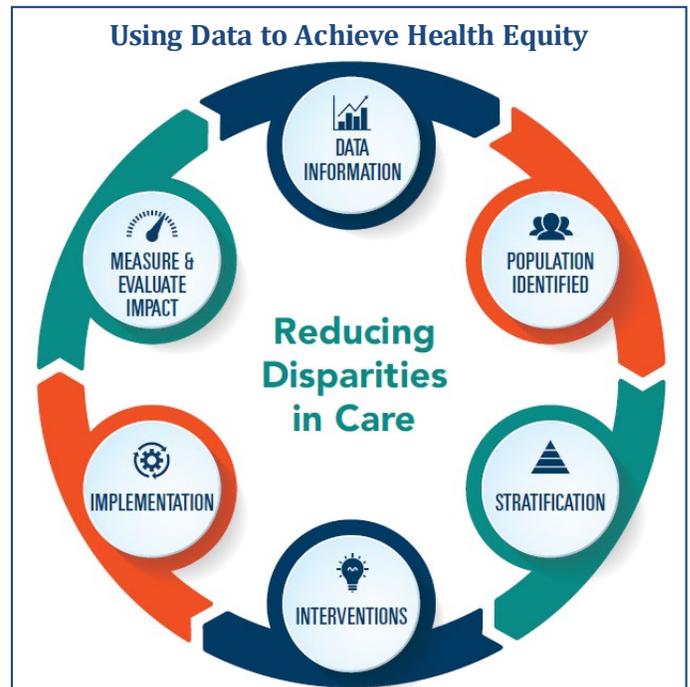
Drivers of Health (DoH) Screening Toolkit

Another important data element to consider stratifying is zip code. Evidence is growing in demonstrating the correlation between the zip code in which people live and their quality and length of life. For instance, in La Crosse County one zip code has a life expectancy of 68 years versus a neighboring zip code in that county with a life expectancy of 82.5 years. Data collection and analysis will continue to be a key component in reducing health inequities through the lenses of clinical, social, and demographic factors, including zip code.

> ## Resources to Learn More
>
> Eliminating Disparities to Advance Health Equity and Improve Quality: Guide designed to provide practical guidance for healthcare organizations seeking to eliminate disparities in care to advance health equity.
>
> Life Expectancy at Birth for U.S. States and Census Tracts: This interactive United States map shows estimates of U.S. life expectancy at birth by state and census tract for the period 2010-2015.
>
> Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017: In light of the growing awareness of the importance of SDOH in patient health outcomes, and the need for the collection and documentation of this data in clinical settings to improve patient care, this study analyzes the utilization of Z codes in 2016 and 2017 among Medicare fee-for-services (FFS) beneficiaries.
>
> The Gravity Project: The Gravity Project seeks to identify data elements and associated value sets to represent DOH information documented in electronic health records (EHRs) across four clinical activities: screening, diagnosis, goal setting, and intervention activities.

STOP

Complete Section VIII of the Workbook.

IX. CHALLENGES & LESSONS LEARNED

HMOs and health systems may face several barriers and challenges in implementing strategies to assess and address DoH. These may include:

1. **Communicating appropriately with members about DoH, without jeopardizing the member/provider relationship**. This is especially true during the initial stages of a relationship, when trust and therapeutic rapport have yet to be established. If a provider is viewed as presumptuous or judgmental, the provider-patient relationship could be unintentionally damaged. Care team members who have not been adequately trained on how to discuss DoH with patients may feel uncomfortable asking personal questions that expose social barriers such as housing instability, domestic violence, or financial insecurity. Training care team members in techniques such as motivational interviewing and empathic inquiry as previously discussed help empower staff and build confidence.

2. **Building an adequate referral network of agencies that offer expertise, services, or resources that address identified social needs can be complex and time consuming.** This network of services should be based on data reflecting the member population's most urgent needs and cataloguing the inventory of community resources. Health care organizations should dedicate resources to not only ensure that members are referred to appropriate services, but also to build in consistent follow-up mechanisms to track connections to care and offer alternative options when necessary.

3. **Integrating electronic assessment tools and resource inventories appropriately into existing EHR or care management systems**. Some tested assessment tools such as PRAPARE include guidance and templates for its integration into an organizations existing EHR or care management system. Embedding a homegrown tool into an existing system may require extra time and resources.

4. **Breaking down silos between health and CBOs, which typically have vastly different financing and IT systems.** Health care organizations may need assistance in forming partnerships with CBOs, developing strategies to align their systems, and building a streamlined referral process to track and deliver comprehensive resources to patients with complex needs.

Finally, lessons learned from other state and organizations experience is invaluable when embarking on or improving upon DoH initiatives. The following is a verbatim list of lessons learned from Rhode Island Medicaid as it relates to implementing a DoH screening and referral process for all Medicaid members:

✓ **Lesson 1:** SDOH Screening processes need to be universal. To avoid stigmatizing anyone – and to avoid dangerous assumptions about patients – it is important to screen all patients, not just those thought to be "high risk."

✓ **Lesson 2:** Information technology needs to be an integral part of the planning process. Social services and clinical settings often have different systems (or none at all) so addressing the quality and cost of the data connections they need is a crucial step.

✓ **Lesson 3:** To screen for DoH, we need:
   – High-quality referral resources;
   – Prompt access to those resources (knowing who/what/where they are and the ability to see if the resource (i.e. bed, appointment, etc.) is available before the connection is made);
   – The ability to track the referral process and close the loop between the referring provider, the service provider, and the patient.

✓ **Lesson 4:** If possible, screening tools should be the same within a health system, but if they cannot be identical, they should be similar enough using common domains – to help align quality measures, reporting, and search terms in common directories.

Drivers of Health (DoH) Screening Toolkit

- ✓ **Lesson 5:** The existence of multiple databases in an organization or health system, which all need to be updated, is burdensome to users. Aligning to a single database, and combining resources to update it, is a much more efficient use of time and money.
- ✓ **Lesson 6:** As always, it is useful to share and learn from best practices, such as the examples from San Diego and North Carolina.

To learn more about Rhode Island's experience, access the article here.

STOP

Complete Section IX of the Workbook.

Drivers of Health (DoH) Screening Toolkit

X. CONCLUSIONS & NEXT STEPS

By July 15th, 2021, HMOs and their partner clinics will submit the DMS-provided DoH Screening Toolkit Workbook to DMS. Based on the current state documentation of the self-assessment results, the HMO & clinic will develop a plan by the end of 2021 to make improvements to screen members for more comprehensive screenings across DoH domains, improved policies and procedures, enhanced data sharing, and improved partnerships with community organizations.

Collaboratively developing a plan to screen members may include decisions such as screening:

- By the HMO for the entire membership (e.g. increasing the screening completed for all new members as part of the health needs screening to include drivers of health or partnering with the Pathways Hub or another hub model)
- By the HMO for a subset of their membership (e.g. targeted outreach to those underrepresented members in each PIP focus area)
- By the clinic level (e.g. adopting a standardized tool used in conjunction with other interventions)
- Or another arrangement (e.g. perhaps different interventions for the BadgerCare Plus PIP vs. the SSI PIP).

DHS will provide more guidance about the plan development in 2021. However, HMOs should expect to describe in their plan to screen/assess members for DOH including: when screening may occur with the member (including workflows), the DOH tool or assessment used, training requirements for staff administering the screening, interventions to meet member health related social needs, a description of where the DOH data will be stored and how and when DOH data will be updated and analyzed for disparities, and what partnerships will be necessary to effectively refer members. Finally, HMOs will describe how/if they use DoH assessments conducted by their providers' in-network if available, such as incorporating into the member's care plan and/or chart.

Drivers of Health (DoH) Screening Toolkit

XI.   ADDITIONAL SOURCES

Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Memorial Fund.

Social Determinants of Health Guide to Social Needs Screening. American Academy of Family Physicians.

When Talking About Social Determinants, Precision Matters. Health Affairs.

The Accountable Health Communities Health-Related Social Needs Screening Tool. CMS.

Social Risk Factor Screening in Medicaid Managed Care. State Health and Value Strategies.

Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value-Based Purchasing. Academy Health.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Center for Health Care Strategies.

Innovation Station Practice Summary and Implementation Guidance: Pathways Community Hub. Association of Maternal Child Health Programs.

Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). CMS.

Public Health Indicator Based Information System (IBIS). Utah Department of Public Health.

Communities in Action: Pathways to Health Equity. National Academy of Sciences, Engineering, and Medicine.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Center for Health Care Strategies.

Developing a Social Risk Factor Screening Measure. State Health and Value Strategies