Social Determinants of Health

MINOR REVISION SEPTEMBER 2021

This care process model (CPM) and accompanying patient education were developed by a multidisciplinary team representing Intermountain Healthcare and SelectHealth under the leadership of Intermountain Healthcare's Community Health and Community-Based Care. Based on emerging evidence and shaped by local expert opinion, this CPM provides healthcare providers and care team members with practical strategies for screening, brief intervention at the point of care, and connection to resources to help address the social determinants of health (SDoH).

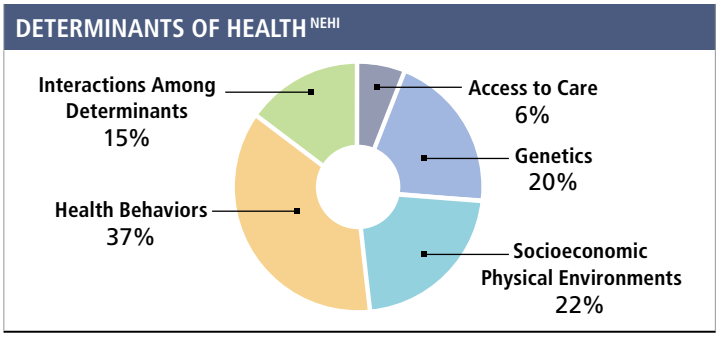
Why Focus ON SOCIAL DETERMINANTS OF HEALTH?

Social determinants of health (SDoH) are defined by the World Health Organization as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness." They describe the non-medical social, economic, and political processes and relationships which can influence key health outcomes.[WHO]

Intermountain has chosen to focus on SDoH for the following reasons:

- **Differences in social, economic, and environmental factors influence health.**
  - SDoH correlate with more- or less-favorable health outcomes in populations and individuals. For example, individuals higher on the social gradient have better health outcomes.[WHO]
  - The Centers for Medicare and Medicaid Services (CMS) defines the primary SDoH as: food insecurity, housing instability, unmet utility needs (e.g., heat, air conditioning, and refrigeration), lack of transportation, and exposure to interpersonal violence.[CMS]
  - Secondary SDoH include lower education level, lack of family and social support, lower income and employment opportunities, and risky health behaviors.[CMS]

  Together, health behaviors and SDoH have the greatest impact on health and life expectancy, representing nearly 60% of the determinants of health.[SCH]



- **Intermountain Healthcare and SelectHealth want all populations (patients, members, caregivers, and community) to be healthier.** To meet the overall health needs of the populations we serve, we must integrate social services support and coordination processes into our model of care. This is especially true for low income populations, as unmet social needs interfere with their ability to lead the healthiest lives possible.

WHAT'S INSIDE?

MEASUREMENT & GOALS

The goals of the CPM include the following:

- **Educate caregivers on the importance of social determinants.**
- **Implement a systematic approach to screening, brief intervention at the point of care, and connection to SDoH resources.**
- **Define roles and responsibilities for the team.**
- **Improve communication and coordination with community partners and payers to address needs.**
- **Provide effective, whole-person care, including assessment and management of unmet social needs.**

Indicates an Intermountain measure

HOW TO USE THIS DOCUMENT

This CPM provides guidance on using this document based on an caregiver's clinical role.

- **Clinical assistants:** Review the clinical workflow, screening tools, and documentation.
- **Physicians, advanced practice providers (APPs), and mental health integration (MHI) professionals:** Review the entire document to learn about your role as a clinical leader in screening, brief intervention at the point of care, and connection to SDoH resources.
- **Enterprise Care Management Staff:** Review the clinical workflow, screening tools, and documentation.
- **SelectHealth Care Management Staff:** Review the entire document to learn about your role in screening and connection to SDoH resources including referral to a community health worker (CHW) where available.
- **Community Health Workers (CHWs):** Review the clinical workflow, screening tools, connection to community resources and communication with clinical partners.

UNDERSTANDING SOCIAL DETERMINANTS OF HEALTH

The primary social determinants associated with poor health include:

- **Food insecurity:** A household-level economic and social condition of limited or unstable access to adequate food.[USDA]
- **Housing instability:** Encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing.[HHS2]
- **Lack of adequate transportation:** Limited access to affordable, convenient transportation with difficulty getting to work, school, daycare, grocery stores, and healthcare appointments, etc.[RWJ1]
- **Exposure to interpersonal violence:** This includes direct victimization, witnessing violence or property crimes personally, or hearing about crime and violence from other residents.[HHS3]
- **Unmet Utility needs:** Low or intermittent access to water, electricity, and gas for the household, including refrigeration. Little or spotty access to a landline or mobile phone service and/or Internet connection also fall under this definition.[ILO]

Secondary social determinants associated with poor health include:

- **Inadequate education:** Lacking access to high-quality and effective educational and community-based programs.[HHS4]
- **Poor income and employment opportunities:** This includes multiple aspects of income and employment including job security, work environment, financial compensation, and job demands may affect health.[HHS6]
- **Environment exposures:** All physical, chemical, and biological factors external to a person, and the related behaviors that result. Healthy People 2020 Environmental Health objectives focus on six themes, each of which highlights an element of environmental health:[HHS5]
  - Outdoor air quality
  - Surface and ground water quality
  - Toxic substances and hazardous wastes
  - Homes and communities (e.g. indoor air pollution, structural problems within the home, lead-based paint)
  - Infrastructure and surveillance (e.g. monitoring and measuring disease outbreaks and public hazards)
  - Global environmental health
- **High-risk health behaviors:** Actions taken by individuals that are predicted to adversely affect health or mortality. These actions may be intentional or unintentional and can detract from the health of an individual or others. Examples of actions that can be classified as high-risk health behaviors include smoking, substance use, non-nutritive diet, low physical activity, lack of sleep, risky sexual activities, lack of healthcare-seeking behaviors, and poor adherence to prescribed medical treatments.[SHO]
- **Lack of family and social support:** Social support stems from relationships with family members, friends, colleagues, and acquaintances. Social capital refers to the features of society that facilitate cooperation for mutual benefit, such as interpersonal trust and civic associations.[RWJ2]

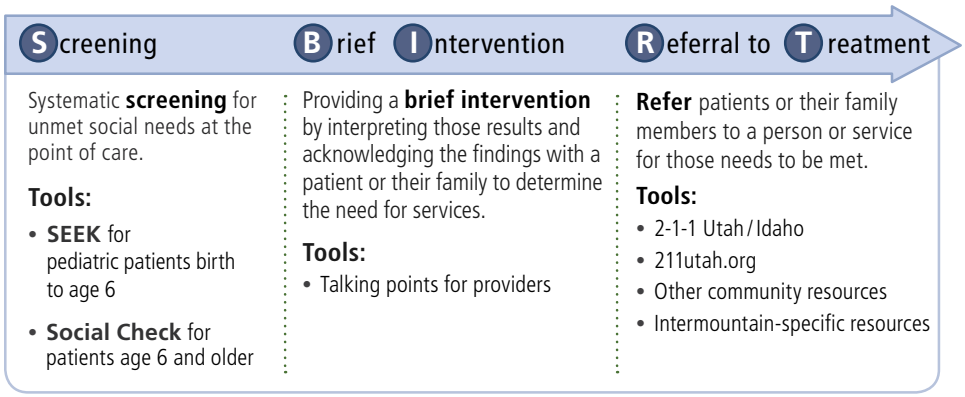
ENTERPRISE CARE MANAGEMENT

Three different entities provide care management services for Intermountain patients. Each addresses SDoH and provides medical care coordination. However, patient populations and care management intensity levels differ in the following ways:

- **Ambulatory Care Management.** This is Intermountain's care management program serving patient-centered medical homes (primary care clinics). Ambulatory care managers (CMs) adhere to NCQA standards and provide in-clinic and telephonic care management. **Patient population:** all payers, especially high- or rising-risk patients.
- **ICCT (Intermountain Community Care Team).** The ICCT is a part of the ambulatory care management program. It is a free service to high- or rising-risk patients who warrant intensive, in-home case management. **Patient population:** high- or rising-risk patients of all payers.
- **SelectHealth Care Management.** SelectHealth performs telephonic care management. **Patient population:** all SelectHealth products and patients, especially high- or rising-risk patients.

THE SBIRT MODEL

SBIRT is an acronym for **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment. This validated approach is routinely used by Intermountain caregivers in the identification and management of risky substance use or substance use disorder (SUD). In the context of SDoH, SBIRT is defined as:



Applying SBIRT in specific care settings

Primary care

Patient-centered medical homes (PCMH) play a critical role in assessing and empowering patients in addressing SDoH.

- Trusted relationships between medical caregivers and patients provide a critical foundation for successfully addressing SDoH.
- Responding to SDoH involves medical home team members collaborating within a clinic (referred to as team-based care) and often extending to key partners in the local community.
- Care managers (CMs) embedded in the PCMH identify at-risk patients and offer them care management services (see sidebar). If not performed by clinical staff, the CMs administer and review the Social Check or SEEK assessments (see pages 6–7) and use 2-1-1 Utah/Idaho (see page 12) for identification of community resources which are provided to the patient and documented in the chart.

SelectHealth

SelectHealth offers SDoH support to members through their Care Management program.

- CMs administer the Social Check assessment for all lines of business as a part of the initial and on-going surveys.
- Members indicating SDoH needs will be referred to 2-1-1 Utah/Idaho. If a member is unfamiliar with 211utah.org, the care manager should demonstrate the platform search process.
- SelectHealth Medicaid and dual-member (Medicare and Medicaid) CMs can make referrals to SelectHealth Community Health Workers (CHWs) to provide additional SDoH support.

Emergency Department

Emergency Department (ED) Care Management staff will screen patients for unmet social needs with the Social Check assessment.

- CMs provide therapeutic interventions and community resource referrals to patients with identified social needs.
- Transition-of-care referrals are also made to CMs within the medical group and SelectHealth, or to a CHW to coordinate care in community settings.

The Intermountain Risk Prediction Model (IRPM) predicts which patients will likely incur high healthcare costs in two of the next three years. The IRPM score calculates based on the patient's chronic conditions, ED and inpatient hospitalizations, and costs.

Applying SBIRT in specific care settings (Continued)

Intermountain's Community Care Team (ICCT):

The ICCT receives patients from two referral sources:

- **The IRPM (Intermountain Risk Prediction Model) list.** Patients with a risk score of 0.7 or higher are included in this report. They are sent an introduction letter which is followed by a phone call from a transition specialist to see if they are interested in having a visit from a CM. The goal is for patients to accept support and work with the CM on their identified health goals. The IRPM list is divided up geographically and administered by teams in Ogden, Central, South, and Southwest Utah. There are established guidelines for contacting patients (e.g., letters and phone calls) and the number of attempts made to engage a patient for a CM visit.
- **Caregivers.** Referrals to the ICCT are also accepted from the hospital CMs, ambulatory CMs, SelectHealth CMs and our community partners or physicians. Social Check is used to identify SDoH needs. Staff use 2-1-1 Utah / Idaho to provide resources for patients.

Intermountain Homecare

Intermountain Homecare offers SDoH support to patients through the Home Health program.

- CMs administer the Social Check upon admission to Home Health. Those indicating SDoH needs are educated on options in the community including 2-1-1 Utah/Idaho.
- CMs also make referrals to social work and community resources as appropriate.

Community-based organizations (CBOs)

CBOs are nonprofit groups that work at a local level to address social determinant needs for patients. They are a valuable resource in providing services and expertise when a patient indicates social needs.

HEALTH LITERACY

Health literacy could be considered a tertiary form of SDoH. Health literacy is defined as:

"The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." [RAT]

While not a primary determinant of health, poor health literacy is considered a stronger factor in a person's health status than any other SDoH. [ADH] Individuals with low health literacy use fewer preventive services, have higher rates of hospitalization, worse health status, and greater health costs.[HHS1]

Health literacy is dependent on individual and systemic factors, including:

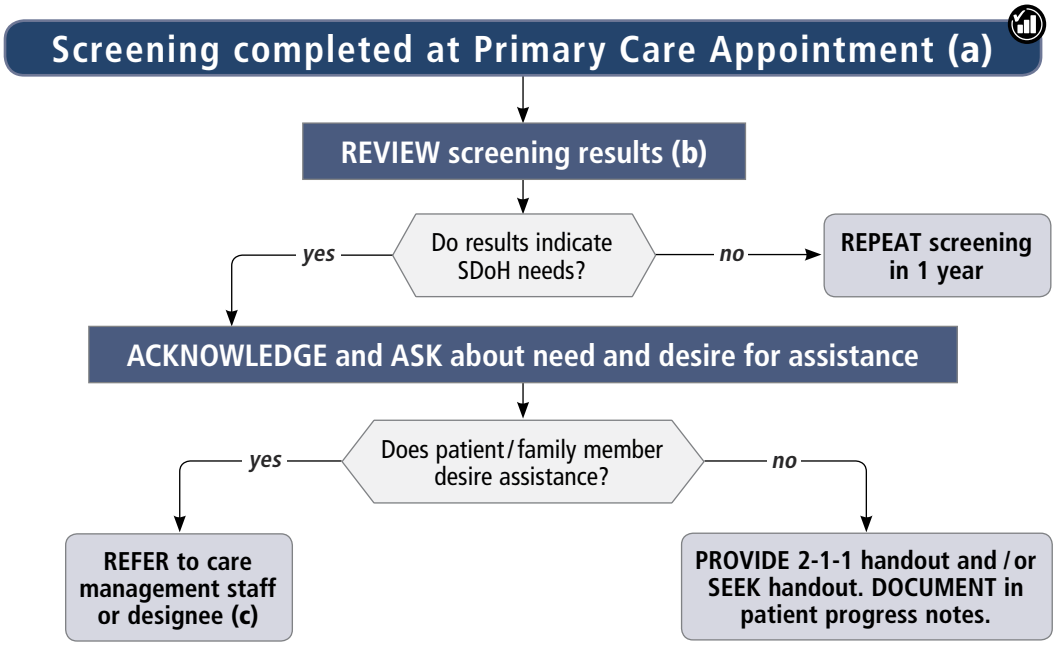
- An individual's ability to read and assess health information
- The ability of professionals to communicate clearly
- The ability to understand and navigate healthcare systems
- The demands of specific health-related situations or contexts [HHS1]

Healthcare providers and systems can mitigate the effects of low health literacy by aligning care with a patient's skills and abilities, making it easier for them to access, understand, navigate, and use health information and health care services.

Health literacy strategies for healthcare providers include:

- Speaking slowly
- Using simple language and defining technical terms
- Breaking complex information into understandable chunks
- Asking patients to "teach-back" key instructions
- Showing examples
- Encouraging questions

ALGORITHM: CLINICAL WORKFLOW



Indicates an Intermountain measure

ALGORITHM NOTES

(a) Clinical workflow

Screening

For specifics of team roles and responsibilities, see page 10.

- Screening should be performed and documented in ALL patients at least 1 time per year.
- Screening is either completed by the patient or family member at clinic check-in, or is performed by clinical assistants.
- The Social Check and SEEK assessments (see page 6–7) are located in the *iCentra Ambulatory Comprehensive Intake* or *Ambulatory Pediatric Form*.
- The results are to be documented in *iCentra Scales and Assessments*.

(b) Screening results and actions

The provider reviews the screening results. If the SEEK or Social Check assessment identifies a need, it is recommended that the provider acknowledge and address the need accordingly:

- **Low-intensity need:** The risk intensity is low. For example, the patient/parent may have recently had food insecurity but is currently doing well and has strong social support. An appropriate response would be to provide the 2-1-1 Utah/Idaho or SEEK handout and add, "Let me know if you'd like to talk about this in the future."
- **Medium-intensity need:** The risk intensity is moderate. For example, a patient/parent may not be out of food but feels uncertain about their future food security due to limited social support. An appropriate response would be to provide the 2-1-1 or SEEK handout and possibly involve the care team.
- **High-intensity need:** The risk intensity is high. For example, a patient/parent may not have food and has limited or no social support. An appropriate response would be to provide the 2-1-1 or SEEK handout and engage the care team.
- **In all cases, attempt to match the level of need with the level of resources available at the point of care.** If no resources exist, then the care team member should explain to the patient that there is not an exact match in the 2-1-1 list, but that they should call anyway to connect with a specialist who can recommend appropriate resources.
- **No SDoH needs:** Recommend using a simple statement while looking at the SDoH screening results such as, "It looks like things are going OK at home. Is that right?" (Patient affirms or discusses.) "Let us know if you would like to talk about any of these challenges in the future."

(c) Referring to care management at the point of care

Care management staff should demonstrate the 2-1-1 Utah/Idaho search process and develop care management goals that include addressing SDoH needs. Referrals to CMs should be based on need and relationship. Patients who have an established relationship with a CM, or have greater needs, (e.g. homelessness, intimate partner violence) should be referred to a CM. Other patients with lower-level social needs can be referred to a care guide or medical assistant.

SCREENING TOOLS

PRAPARE

The **P**rotocol for **R**esponding to and **A**ssessing **P**atients' **A**ssets, **R**isks, and **E**xperiences **(PRAPARE)** is a national effort to help healthcare providers collect the data needed to better understand and act on their patients' SDoH needs. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. PRAPARE emphasizes actionable measures. The full PRAPARE is administered by CHWs to obtain a more detailed assessment of social needs. For more information, visit www.nachc.org/prapare.

Social Check™

This is a short screening tool that SelectHealth and Intermountain Healthcare use at the point-of-care to assess for SDoH needs. Social Check is administered to patients 6 years of age or older on an annual basis. The assessment is available in both English and Spanish. See the examples below.

Social Check

Life is not always easy. We want everyone to be safe and healthy. We're asking about challenges you may be facing and if we may help. Today or in the past year, have you or someone in your household **gone without** any of the following when it was really needed?

- ☐ Food
- ☐ Housing (including rent or mortgage payment)
- ☐ Utilities (such as electricity, water, internet access, or phone)
- ☐ Feeling safe from physical or emotional harm or other threats
- ☐ Transportation (such as a car or bus fare)
- ☐ Resources for school
- ☐ Dental care
- ☐ Medicine or prescriptions
- ☐ Medical services (such as a doctor or hospital)
- ☐ Mental health services (such as treatment for anxiety or depression)
- ☐ Services for substance misuse (such as drugs or alcohol)
- ☐ Other: _____
  _____
- ☐ I'm not experiencing these issues right now.
- ☐ I choose not to answer.

Social Check was derived from the national PRAPARE® social determinants of health protocol developed by the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Organization and their development partners. www.nachc.org/prapare. ©National Association of Community Health Centers. All Rights Reserved.

Social Check (Chequeo Social)

La vida no siempre es fácil. Queremos que todos estén seguros y saludables. Le preguntamos sobre los desafíos que puede enfrentar y si podemos ayudarlo. Hoy o en el último año, ¿usted o alguien de su hogar se ha **quedado sin** alguno de los siguientes cuando realmente lo necesitaba?

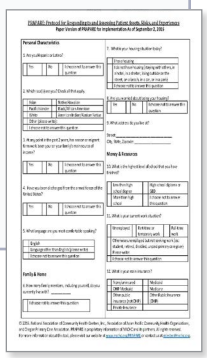
- ☐ Alimentos
- ☐ Vivienda (incluido alquiler o hipoteca)
- ☐ Servicios públicos (como electricidad, agua, acceso a Internet o teléfono)
- ☐ Sentirse a salvo de daños físicos / emocionales u otras amenazas
- ☐ Transporte (como un auto o un autobús)
- ☐ Recursos para la escuela
- ☐ Cuidado dental
- ☐ Medicamentos o recetas
- ☐ Servicios médicos (como un médico u hospital)
- ☐ Servicios de salud mental (como tratamiento para la ansiedad o la depresión)
- ☐ Servicios por abuso de sustancias (como drogas o alcohol)
- ☐ Otro: _____
  _____
- ☐ No tengo estos problemas en este momento.
- ☐ Elijo no responder.

Social Check se derivó del protocolo nacional de determinantes sociales de la salud PRAPARE® desarrollado por la Asociación Nacional de Centros de Salud Comunitarios, la Asociación de Organizaciones Comunitarias de Salud del Pacífico Asiático y la Organización de Atención Primaria de Oregon y sus socios de desarrollo. www.nachc.org/prapare. ©National Association of Community Health Centers. All Rights Reserved.

LOCATING THE ASSESSMENTS

Social Check and SEEK assessments are entered or completed within the *Ambulatory Comprehensive Intake* or *Pediatric Intake*, and results can be found in iCentra in ***Scales and Assessments***.

The full PRAPARE assessment can be found at online at www.nachc.org/research-and-data/prapare/.



SEEK

SEEK (**S**afe **E**nvironment for **E**very **K**id) is an evidence-based method to support a child's home environment and is focused on birth to age 5 years. Primary care teams use the one-page **SEEK Parent Questionnaire-R (PQ-R)** to screen for problems in the family. The questionnaire asks about home safety, food insecurity, housing insecurity, transportation concerns, parenting stress, parental depression, intimate partner violence, and parental substance abuse. After reviewing the results of the survey, the primary care team uses simple motivational interviewing skills to help connect families with resources.

The SEEK model does not aim to solve all problems for families, but to support and empower parents and caregivers. Often, the most useful resources are already known to the parent or caregiver and brief thoughtful questions can build on this insight. Training for brief motivational interviewing is found at the SEEK website (http://www.seekwellbeing.org/seek-online-training-description) and is strongly recommended.

The SEEK process is completed at the 2-month, 9-month, 15-month, 2-year, 3-year, 4-year, and 5-year well-child visits.

Guidance for using the SEEK questionnaire can be found on pages 8–9.

ABOUT THE SEEK MODEL

The **SEEK** model, including the questionnaire, are the intellectual property of The SEEK Project, developed by the Division of Child Protection, Department of Pediatrics, University of Maryland School of Medicine. For more information, visit their website at: seekwellbeing.org/aboutseek.

TABLE 1. SEEK QUESTIONNAIRE GUIDANCE

Topic of SEEK Question	Response	Resources	Follow Up	Coding and Documentation
General Example (for approach to identifying an item)	Motivational interviewing techniques with shared decision making: • Reflect • Empathize • Assess • Plan "I noticed you marked _____. Tell me more about that." Involve Care Management (CM) team and Mental Health Integration (MHI) team as needed.	"What support do you currently have?" "How are you handling this?" "What would be useful for you?" Online SEEK handouts have basic information about a topic with national resources or connection tools. https://www.seekwellbeing.org/the-seek-parent-handouts 211 phone number or http://211utah.org/ for info or live chat, with updated information. Add local resources to SEEK handouts.	Depends on the issue and level of need. CM team phone call follow-up is adequate for many items May involve follow-up with MHI team. Follow-up clinic visit also can be useful to parents.	ICD1-0 Code – See below. Documentation depends on the issue identified – See below.
Poison Control	See general example. Suggest putting phone number into mobile phone.	SEEK handout Poison Control phone number: 800-222-1222	Usually none needed.	ICD-10 Code – None Documentation if desired.
Smoke Alarm	See general example.	SEEK handout Local Fire Department	CM team phone follow-up if desired.	ICD-10 Code – None Documentation if desired.
Tobacco Smoke Exposure	See general example. May be useful to involve CM team.	SEEK handout 2-1-1 Utah / Idaho Resources CDC Quit Now: (800) QUIT NOW or CDC Quit Now website and resources	CM team follow-up if desired.	ICD-10 Code – Tobacco Smoke Exposure (Z77.22) Brief documentation of discussion suggested.
Food Insecurity	See general example. May be useful to involve CM team.	SEEK handout includes information on SNAP (Supplemental Nutrition Assistance — Food Stamps), WIC, Child Nutrition Programs at school, and Feeding America (links to pantries). Faith community resources 2-1-1 Utah / Idaho resources Local food pantries	CM team follow-up suggested. Follow-up appointment with provider may be useful depending on circumstance, child growth / development	ICD-10 Code – Food Insecurity (Z59.4) Brief documentation of discussion suggested. .
Transportation Needs	See general example. May be useful to involve CM team.	2-1-1 Utah / Idaho resources	CM team follow-up may be useful. Follow-up appointment with provider may be useful.	ICD-10 Code – Assistance Needed with Transportation (Z74.8) Brief documentation of discussion suggested.
Housing Insecurity	See general example. May be useful to involve CM team.	2-1-1 Utah / Idaho resources	CM team follow-up may be useful. Follow-up appointment with provider may be useful.	ICD-10 Code – Housing Problems (Z59.9) Brief documentation of discussion suggested.

TABLE 1. SEEK QUESTIONNAIRE GUIDANCE (Continued)

Topic of SEEK Question	Response	Resources	Follow Up	Coding and Documentation
Discipline Concerns	See general example. May be useful to involve CM team. Reporting to child protective services (CPS) as indicated. **Note:** Overall, evidence shows that SEEK methodology reduces needed reports to CPS.	**SEEK handout** includes National Parent Helpline: 1-855-427-2736 www.smarterparenting.com Add local resources.	CM team follow-up may be useful. Follow-up appointment with provider may be useful.	ICD-10 Code – Child behavior counseling (Z71.89) Documentation depends on level and extent of concern. Most often, brief documentation of discussion is adequate.
Major Parental Stress	See general example. May be useful to involve CM team and/or MHI team.	**SEEK handout** includes National Parent Helpline: 855-427-2736 **2-1-1 Utah/Idaho resources** depending on source of stress. **Mindfulness apps** such as Headspace. **Faith community** or other support groups. **Local resources** such as crisis nursery or home visitation programs, if available.	CM team follow-up often useful. MHI follow-up as indicated. Follow-up appointment with provider often useful.	ICD-10 Code – Parenting Stress (Z63.8) Documentation depends on the level and extent of concern. Most often, brief but sensitive documentation of discussion is adequate.
Parental Depression	See general example. Assess for severity and suicidality. May be useful to involve CM team and/or MHI team.	**SEEK handout** includes National Alliance for Mental Illness, National Suicide Prevention Lifeline, Depression and Bipolar Support Alliance. Suicide Prevention CPM if needed. **2-1-1 Utah/Idaho resources** https://www.nami.org/	CM team follow-up often useful for major stress. MHI follow up as indicated. Follow-up appointment with provider often useful.	ICD-10 Code – Other Social Stressor (Z65.9) Documentation depends on the level and extent of concern. Most often, brief but sensitive documentation of discussion is adequate.
Intimate Partner Violence (IPV)	See general example. "Can you tell me what's going on between you and your partner?" "What kind of resources would be useful for you?" May be useful to involve CM team and/or MHI team.	**SEEK handout** includes safety plan information and a link to the National Domestic Violence Hotline. **Utah Domestic Violence Link Line**: 800-897-LINK (5465) **2-1-1 Utah/Idaho resources** https://www.udvc.org/	CM team follow-up often useful for major stress. Follow-up appointment with provider often useful.	ICD-10 Code – Other Social Stressor (Z65.9), **do not use** IPV or domestic violence code. Minimal documentation not directly mentioning IPV.
Parental Substance Abuse	See general example. Report to CPS as indicated. **Note:** Overall, evidence shows that SEEK methodology reduces needed reports to CPS.	**SEEK handout** includes substance Abuse and Mental Health Services Administration (SAMHSA) treatment referral routing service 800-662-HELP (4357). **2-1-1 Utah/Idaho resources** https://www.nami.org/	CM team follow-up often useful for major stress. MHI follow-up as indicated. Follow-up appointment with provider often useful.	ICD-10 Code – Other Social Stressor (Z65.9) Consider brief non-specific documentation if appropriate.

BILLING AND CODING FOR SDOH

There are 88 different ICD-10 codes between Z55 and Z65, all of which refer to SDoH including conditions such as homelessness, low income, literacy, and personal history of abuse. **Providers should not use ICD-10 codes for interpersonal violence as these codes will be visible on the patient portal and may compromise patient safety.** The code "Other Social Stressor" is useful in this case and other similarly sensitive codes. In addition, providers should use sensitivity with documentation.

Most payers (commercial and government) do not reimburse for Z codes; however, providers should consider applying the appropriate Z code and bill for time when additional face-to-face time is required to address SDoH during office visits.

TEAM BASED CARE

Roles and responsibilities

Patient Service Representatives (PSRs)

Clinics may choose to involve PSRs in the workflow to assess SDoH. For example, PSRs may give families the SEEK PQ-R form when checking in for well child visits. Families then fill out the information when waiting to be taken to a clinic room. Similarly, PSRs may give families or patients the Social Check form at annual wellness visits.

Clinical Assistants

Clinical assistants will either:

- Input the information from the paper form filled out by the patient (if the patient is coming to one of the wellness visits designated above)

OR

- Review the patient record and determine if SDoH assessment has been administered in the past year.

If not, then administer one of the two assessments to the patient / parent and document through the *iCentra Ambulatory Comprehensive Intake* or *Ambulatory Pediatric Form*.

In some circumstances, clinical or medical assistants will demonstrate the 2-1-1 Utah / Idaho platform, and provide the 2-1-1 handout.

Physicians, advanced practice providers (APPs), and mental health integration professionals

Review the appropriate SDoH assessment in iCentra *Scales and Assessments*. If needs have been identified, follow the algorithm on page 5. If SDoH assessment is not indicated at the current visit but a need was identified at a prior visit, providers may then assess the current state. See information on appropriate billing and coding in the sidebar at left.

Care Management Staff (Intermountain)

- **Intermountain Care Managers and Care Guides.** Review the Social Check or SEEK assessment results. Individuals who indicate needs should be connected to 2-1-1 Utah / Idaho. If the individual is unfamiliar with 2-1-1 Utah / Idaho, the Care Manager / Care Guide should demonstrate the platform search process on a computer or smartphone. Consider helping patient / parent download the 2-1-1 Utah / Idaho app to their smartphone. Provide the 2-1-1 Utah / Idaho fact sheet. Referrals to CMs should be based on need and relationship. Patients who have an established relationship with a CM, or have greater needs, (e.g. homelessness, intimate partner violence) should be referred to a CM. Other patients with lower-level social needs can be referred to a care guide or medical assistant.

Care Management Staff (SelectHealth)

- **SelectHealth Care Management.** SelectHealth Care Managers will perform the Social Check assessment as a part of the initial and on-going assessments for all members in Care Management. Members indicating needs will be referred to 2-1-1 Utah/Idaho. If a member is unfamiliar with 2-1-1, the Care Manager should demonstrate the platform search process.
- **SelectHealth Community Health Workers.** Medicaid and dual (Medicare and SelectHealth Medicaid) Care Managers can make referrals to CHWs for members needing additional SDoH support using the SelectHealth Community Health Worker Referral form. Community Health Workers will make connections to social services and healthcare providers. Community Health Workers provide outreach services to high-risk members and may be line-of-business based (e.g. Medicaid vs. Medicare vs. commercial) or stand alone. Community Health Workers will communicate a member's progress using the SelectHealth CHW Update form. Documentation will be in the SelectHealth Care Radius platform.

RESOURCE GUIDE

SDOH RESOURCES

Working with Community-Based Organizations (CBOs)

While most patients with unmet social needs will be connected to 2-1-1 Utah / Idaho, there may be times when Intermountain caregivers will connect patients directly to CBOs. Below are some general guidelines when working with CBOs:

- **Understand the limited capacity.** Resources such as staff and money at smaller not-for-profit organizations are limited. They may also have limited technological capabilities for sharing information or communicating.
- **Know who qualifies.** Read about the qualifications and requirements for programs and / or funding. Referring a patient who does not qualify can be time consuming for everyone involved and can delay access to needed resources. Understanding who qualifies for a program prior to a referral is an important step in maintaining relationships with the patient and the CBO.
- **Make a personal connection.** Building relationships with the frontline staff at CBOs when possible will result in more successful referrals. These CBO connections enable warm hand-offs and provide a contact for the patient at the CBO. This also increases the likelihood of the patient following through on the referral.
- **Make sure the resource is still available.** CBO programming is often tied to grant funding or awards that can expire or be exhausted. Resources listed on 2-1-1 Utah / Idaho or CBOs' websites may no longer be available for various reasons.

SDOH RESOURCES (CONTINUED)

2-1-1 Utah / Idaho

2-1-1 Utah / Idaho is a state-wide resource housed at United Way of Salt Lake. It is a free and confidential directory that connects individuals to available community based services. It can be accessed by dialing 2-1-1, visiting the website 211utah.org, downloading the 2-1-1 app, or emailing 211ut@uw.org. One can also text their zip code to **898-211** to connect.

The directory includes programs that are free or offered on a sliding-fee scale. In some instances, a private business will be listed if it's the only resource locally available (e.g. substance use treatment centers)

The resources can be searched by subcategories (housing, mental health, dental, etc.) or by geographic and demographic information. Annual county resource lists can be printed from the website (https://uw.org/211/resources).

Additions to the 2-1-1 Utah / Idaho resource guide can be requested by contacting 211ut@uw.org.

Locally Identified Community Resources

There are many local community organizations that are valuable in connecting patients and their families to resources. Examples of the resources available through 2-1-1 Utah / Idaho are listed below and on the following page.

ADULT / FAMILY HEALTH AND SAFETY

Adult Protective Services: Investigates allegations of abuse, neglect, and exploitation of vulnerable adults.

Family and relationship support: Family support centers, Utah foster care, Centro De La Familia, Assistance League, United Way.

Free or volunteer clinics: Comprehensive care for individuals who are uninsured, low income or homeless.

Court support services: Navigation to community resources for individuals on probation.

Domestic violence shelters: A listing of service providers on the Utah Domestic Violence Coalition website (https://www.udvc.org) or the Idaho Coalition Against Sexual and Domestic Violence website (https://www.idvsa.org)

Federally-qualified health centers: Community-based health centers that offer comprehensive services (medical, mental, dental), accepts all uninsured and insured patients, and offer a sliding-fee scale based on income.

Health management: A list of health education workshops can be found at https://livingwell.utah.gov/.

Planned Parenthood: Eight health centers across the state that provide reproductive and preventive health care. Locations can be found on their website (https://www.plannedparenthood.org/planned-parenthood-utah or https://www.plannedparenthood.org/health-center/id).

Senior centers: Social and wellness activities, bus services, meals, advocacy.

VA Benefits and health care: A list of VA Centers and Services can be located on their website (www.va.gov).

Vocational rehabilitation: Employment services for disabled assistance, gas vouchers, tax assistance.

Local health departments: Immunizations, WIC, Medicaid and CHIP enrollment, Baby Your Baby, car seat safety, tobacco cessation, screenings and disease education, birth and death certificates, wellness and prevention.

CHILDREN'S HEALTH AND SAFETY

Children's Justice Centers: Investigation, prosecution, and treatment for allegations of child abuse.

Crisis nurseries: Emergency childcare for times of family crisis.

Early childhood intervention: Head Start, Parents as Teachers programs, Help Me Grow, school districts.

Homeless or runaway shelters: Defined as adult, or unaccompanied youth ages 12 and older (up to age 17, 21, or 24) who are without family support and who are living in shelters, on the streets, in cars or vacant buildings, or who are "couch surfing," or living in other unstable circumstances.

FOOD SECURITY

Community gardens: Pieces of land gardened by a group of people, utilizing either individual or shared plots on private or public land. The land may produce fruits, vegetables, and/or ornamentals.

Food pantry and food box programs: Find a pantry locator on the Utah or Idaho Food Bank websites: https://www.utahfoodbank.org or https://www.idahofoodbank.org.

Free or reduced meals: Meals on Wheels, school districts, summer lunch programs, soup kitchens.

HOUSING

Habitat for Humanity: Builds and rehabilitates simple, decent houses with the help of volunteer labor and donations of money and materials for the homeowner (partner) families.

Local housing authorities: housing vouchers, database of properties, rental assistance.

Utility payment assistance: HEAT (House Energy Assistance Target) Program administered through Utah Department of Workforce Services.

MENTAL HEALTH AND ADDICTION SERVICES

Addiction recovery support groups: Generally free to join, keep their membership anonymous, and open to anyone wishing to remain abstinent and sober.

Behavioral health networks: Intermountain Healthcare has developed these networks in most hospital communities, which allow uninsured patients follow up mental health care with a funded partner.

Local mental health authorities: Comprehensive mental health and substance abuse service center, and the designated behavioral health provider for all Medicaid enrollees.

National Alliance on Mental Illness (NAMI) Utah/Idaho: Statewide peer-support chapters offer mental health support, education, and advocacy for patients and families.

COMMUNITY ASSISTANCE

Association of Governments: Aging and childcare resources, utility assistance, weatherization and home rehabilitation, housing.

Community Action Partnership of Utah/Idaho (CAP Utah/Idaho): A statewide association for Community Action Agencies. The Community Action network envisions an end to poverty. Member agencies work toward this vision every day by providing services to low-income families and individuals across the state.

Department of Workforce Services: Supplemental Nutritional Assistance Program (SNAP), child care assistance, financial and employment assistance, refugee services, unemployment insurance.

Faith-based organizations: LDS Services, Catholic Community Services, Salvation Army.

Life skills and education: Independent living centers, Utah State University (USU) Extension Services, Idaho State University (ISU) Extension Services, General Education Development (GED) and English as a Second Language (ESL) programs, adult high school, learning centers, continuing or community education programs.

Public libraries: Literacy programs, public computer and internet access, community education.

Public transit: Provide an integrated system of innovative, accessible and efficient public transportation services that increase access to opportunities and contribute to a healthy environment for the people of Utah.

Recreation and fitness: Recreation centers, Boys and Girls Clubs, YMCA.

DIGITAL "UNITE US" PLATFORM

Unite Us is the technology platform that will digitally connect people in need with the healthcare and social service providers who can best help them. Key functions of the platform include:

- Screening individuals for unmet health and social needs.
- Matching individuals to appropriate service providers based on need and eligibility.
- Protecting patient privacy by obtaining a signed release of information before sharing any patient information with a community-based organization through the Unite Us platform.
- Electronically referring individuals to clinical and social service providers.
- Tracking referral status and receiving feedback from service providers to determine if care and services are received.
- Reporting the outcomes of service delivery and reasons why services were denied or not delivered.
- Providing information that will help community-wide care teams coordinate care delivery for the people they serve.
- Collecting data, including structured outcomes, to measure the network's impact, including time to service, effectiveness of care, and gaps in services.

Providers across the patient's entire continuum of care can track a patient's total health journey while reporting on all tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. For more information about Unite Us, visit www.uniteus.com.

SDOH RESOURCES (CONTINUED)

Intermountain resources

The following is a summary of services unique to Intermountain Healthcare:

SelectHealth

Alliance. The Alliance is a demonstration project led by Intermountain Healthcare that is designed to meet the SDoH needs of SelectHealth Community Care (Medicaid) members in Washington and Weber counties. It is a three-year project aimed at improving well-being and reducing health care costs. It supports Intermountain's goal of making healthcare more affordable for all, and becoming a model of change by addressing SDoH in partnership with CBOs.

The Alliance program is based on the Accountable Health Communities model currently under exploration by the Centers for Medicaid and Medicare Services. The model includes awareness, assistance, and alignment.

- Awareness includes screening individuals for unmet social needs.
- Assistance includes navigation to resources. See the side bar at left regarding the digital Unite Us platform.
- Alignment is ensuring the readiness and capabilities of social service providers to meet community needs.

At the conclusion of the pilot project in 2021, successful components will be scaled to other communities in Utah, and best practices will be shared nationally.

Transportation

Non-emergency medical transportation (NEMT): Intermountain has contracted with an outside service, Circulation, to provide **non-emergency** medical transport to qualifying patients. The service removes transportation barriers that patients face in receiving care. Patient rides are given according to the transportation policy and approval of the care manager. Intermountain Healthcare patients who are eligible for NEMT include:

- Patients without viable transportation to access medically necessary care. Care managers screen patients through the NEMT eligibility checklist.
- Patients with an established relationship with an Intermountain Healthcare primary care provider and/or is enrolled in an Intermountain Healthcare care management program.

Where to find NEMT:

- Intermountain's 23 Utah hospitals and emergency departments.
- Intermountain's 83 Utah patient-centered medical homes (primary care clinics).
- Logan and North Cache Valley InstaCare Clinics.

How to use Circulation for NEMT: Visit Intermountain's Enterprise Care Management NEMT wiki (internal access only) for training materials and gaining access to this service.

INTERMOUNTAIN LIVE WELL GARDENS

The following comprises a list of Intermountain-supported community gardens and the individuals each garden serves.

- Orem Hospital: Intermountain caregivers, community members
- Park City Hospital: Intermountain caregivers, community members
- Salt Lake Clinic: Community members
- Primary Children's Wasatch Campus: Patients
- Fillmore Hospital: Intermountain caregivers, community members
- Bear River Hospital: Intermountain caregivers, community members
- Supply Chain Center: Intermountain caregivers
- West Jordan Clinic: Intermountain caregivers, community members

Future gardens are planned for the following facilities:

- Layton Hospital
- TOSH

Food

The individual does not have (enough) food in the home. Utah has an overall food insecurity rate of 11.9%, and a childhood food insecurity rate of 20.4%. Three out of five Utah teachers say their students regularly come to school hungry. In Utah, 177,000 low-income children receive free or reduced-price lunch.

If a patient reports insufficient food in the household, clinical and care management staff are advised to support the patient / family member in accessing 2-1-1 Utah / Idaho to assist in obtaining needed food. The following Intermountain resources can also help:

- **Community Gardens**. Research demonstrates that people who access community gardens eat more fruits and vegetables, are more likely to meet physical activity recommendations, and to be at a healthy weight. Intermountain Healthcare hosts LiVe Well Gardens at five hospitals and two clinics in Utah. (See side bar at left for a list of LiVe Well Gardens.)

  Access to the LiVe Well Gardens differs by facility. Some serve Intermountain caregivers, some are for patients, and others for community members. You can learn more about LiVe Well Gardens at Intermountain facilities, and specifically how patients can access gardens on intermountainhealthcare.org.

- **Green Urban Lunch Box (GULB).** GULB is a local community food producer that uses community resources in new and creative ways to make fresh food affordable and accessible. (See a list of their innovative programs below.)

  Cancer patients at Intermountain's Medical Center have benefited from free, weekly Mobile Farmers Markets in 2017 and 2018. GULB supplied the volunteers who brought these markets directly to Intermountain's Cancer Center through grants, and all food costs were covered by the Intermountain Foundation. During the summer of 2018, between 150–300 pounds of free produce was distributed to about 40 patients at each of the 13 markets.

For 2019, the Foundation has agreed to cover the costs for Cancer Center Mobile Market direct delivery at the following facilities:

- **Intermountain Medical Center:** 12 markets
- **LDS Hospital's Bone Marrow Transplant Unit:** 12 markets
- **McKay-Dee Hosptial:** 6 markets
- **Utah Valley Regional Medical Center:** 6 markets

GREEN URBAN LUNCH BOX PROGRAMS

Innovative programs to improve food security include:

- Back-Farms
- FruitShare
- Small Farm Initiative
- Community Supported Agriculture (CSAs),
- Mobile Markets

Volunteers are welcomed. The program also helps educate through conferences, garden apprenticeships, and farm internships.

For more information, visit the Green Urban Lunch Box website.

UTAH COMMUNITY RESOURCES FOR HOMELESSNESS CONTINUUM OF CARE (COC)

- Salt Lake CoC (Salt Lake County): slco.org/homeless-services/continuum-of-care
- Mountainland CoC (Utah, Summit, and Wasatch Counties): mountainlandcoc.org/index.html
- Balance of Utah State CoC: utahcontinuum.org/ucc/utah-balance-of-state/

Complex patients and families with emergent needs

- **Homeless: The individual does not have a home to go to upon discharge.** Housing is an on going gap in resources in our communities and often there are not resources to fit all the needs of many patients. By focusing on SDoH needs, our system initiative will continue to highlight the need for additional resources. Policies and resources available for youth differ and should be addressed with the family when possible.

  The care teams should help prepare adult patients experiencing homelessness for return to the community by connecting them with available community resources, treatment, shelter, and supportive services. This can be done using the following steps:

  1. Ask the patient about their housing status.
  2. If the patient is homeless, ask if they have any family or friends that the caregiver could assist in contacting.
  3. If the patient does not have anyone to contact, caregiver should ask patient if they would like assistance finding shelter.
  4. If the patient agrees, the caregiver can **use 2-1-1 Utah/Idaho** or the **Utah Community Resources for Homelessness Continuum of Care** to find a shelter close to their facility. (see links on sidebar at left).
  5. If the patient does not want to be housed, the caregiver must be supportive and offer the following, as resources allow:
     - Assist in connecting them to follow-up care (medical, behavioral). If follow-up behavioral health care is required, contact health plan or primary care provider/other provider as needed.
     - Assist in connecting them to 2-1-1 Utah/Idaho to access community resources
     - A meal
     - Weather-appropriate clothing
     - Discharge medications
     - Transportation
- **Not safe: The individual does not have a safe home environment.** To initiate a dialogue around a person's safety at home, Intermountain's Intimate Partner Violence (IPV) advocates recommend starting with a framing statement, then providing the disclosure on reportable events and limits of confidentiality PRIOR to moving to the screening questions. Here are some examples:
  - **Framing statement:** "One in three women in Utah experience very unhealthy relationships with an intimate partner in their lifetime. Since this affects a woman's health (and her children's health), we ask all female patients about this issue. It helps us identify the problem and offer resources which helps decrease violent incidences and improve health outcomes."
  - **Disclosure on reportable events:** "By law, only certain things are reportable to the police or DCFS (Department of Child and Family Services) such as if:
    - We are treating you for an injury caused by a partner.
    - You tell me your children are experiencing or witnessing abuse.
    - You tell me your partner has threatened you with a lethal weapon.

(continued)

DOCUMENTING AND REPORTING IPV

Documentation should ideally be completed by a trained advocate, such as a social worker, care manager, or mental health integration provider.

- **DO NOT** put "intimate partner violence" or "domestic violence" on the patient's problem list unless the patient wants you to do so AND is aware that all problems/diagnoses flow into the Patient Portal where a controlling perpetrator might view, sparking increasing control and/or violence.
- **DO** document past or current IPV incidents (if the patient desires and/or reporting is required) in a Confidential Note Type which doesn't flow into the Patient Portal.

Reporting is REQUIRED if:

- You are treating the patient for an injury caused by a current/former intimate partner. **Call local law enforcement.**
- The patient tells you that children experienced or witnessed abuse. **Call the Utah Division of Child and Family Services (DCFS) Hotline at 855-323-DCFS (3237)**
- The patient tells you his or her current or former intimate partner threatened them with a lethal weapon. **Call local law enforcement**.
- The patient is a vulnerable adult (e.g., 65 or older, developmentally delayed) and is experiencing IPV. **Call local law enforcement or Adult Protective Services at 800-323-7897.**

Additional resources

- Domestic violence crisis hotline (LINK line): **800-897-LINK (5465)**
- Mental health integration, behavioral health, or employee assistance program specialists
- Statewide 24-hour rape and crisis hotline: **888-421-1100**

– **Disclosure on reportable events**

Intermountain's IPV development team recommends the following screening questions (possible answers to each of these questions include no, yes, prefer not to answer, and already addressed with my provider):

- "Are you in a relationship now in which you are often emotionally hurt by your partner, such as being frequently insulted, put down, or controlled?"
- "Are you in a relationship now in which you are physically hurt by your partner such as being hit, shoved, slapped, kicked, or choked?"
- "Are you in a relationship now in which you are forced by your partner to do anything sexually that you do not want to do?"

If the patient answers "no" to all the above, ask the following question: (possible answers are: no, yes - but has been dealt with previously, and yes – this is something I am still dealing with.)

"Have you ever been in a relationship with a partner who hurt you emotionally, physically, or sexually in any of these kinds of ways or who otherwise scared you?"

If the answers to this question is no, respond with,

"I'm glad you're in a safe relationship. Would you like some information in case someone you know needs help?"

Give **Futures Without Violence** cards for at www.futureswithoutviolence.org.

If the answer to any of these questions is yes, listen non-judgmentally and respond empathetically. See the talking points below for possible responses. Refer to social work/care manager if patient interested, especially if IPV is ongoing or there exists the possibility of residual effects of IPV on the patient and/or children, and if the events are reportable. See the requirements for documenting and reporting IVP in the sidebar at left.

Discussing IPV with your patient

Use the following statement when talking with patients who answer positively to questions regarding IPV:

- "You are not alone; help is available."
- "You don't deserve the abuse and it is not your fault."
- "I am concerned for your safety (and the safety of your children)."
- "Stopping the abuse is the responsibility of your partner not you."
- "Violence tends to continue and often becomes more frequent and severe."
- "You are not to blame, but exposure to violence in the home can hurt your children or other dependent loved ones both emotionally and physically."
- "Abuse can impact your health and safety in many ways, including:
  - Exposing you to sexually transmitted infections
  - Causing unintended pregnancies
  - Chronic pain, neurologic disorders, gastrointestinal disorders, headaches
  - Pregnancy problems – preterm birth, low birth weight
  - Depression, anxiety, posttraumatic stress disorder, substance use disorder and suicidal behavior
  - Worsening asthma in children
  - Adolescent health problems – poor self-esteem, drug/alcohol use, eating disorders, obesity, teen pregnancy, depression, anxiety, suicidality
  - Homicide

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PATIENT RESOURCES

The United Way's 2-1-1 Utah / Idaho can help connect patients to resources in the community. The 2-1-1 Fact Sheet is available in English and in Spanish. Hard copies of all patient education materials from Intermountain's Print It! center.

Fact sheets:

211: Guide to Community Resources fact sheet (available in English and Spanish)

PROVIDER RESOURCES

This CPM and others can be found on intermountain.net under Clinical —> Care Process Models —> Primary Care CPMs, or on intermountainphysician.org —> Tools & Resources —> Care Process Models.

Additional CPMs:

Substance Use Disorder CPM

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This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Gene Smith, Community Health Director — Social Determinants of Health (Gene.Smith@imail.org).

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