Social Determinants of Health (SDOH):
Identifying Documentation Gaps in Workflow

A guide focused on a “Team-Centered Approach” to collection of SDOH data!

SDOH Definition

- World Health Organization (WHO) defines social determinants of health (SDH) as the non-medical factors that influence health outcomes (*note WHO's acronym is SDH vs SDOH).
- Centers for Disease Control and Prevention (CDC) defines SDOH as nonmedical factors that influence health outcomes and are conditions in which people are born, grow, work, live, worship, and age.
- AHIMA Data for Better Health (DB4H) refers to SDOH as circumstances that significantly affect quality of life, health, and healthcare outcomes.

Simply stated, SDOH refers to non-medical social factors that impact a person's health or access to healthcare services and include where people are born, live, learn, work, play, **worship, and age.**

Why Collect/Importance of Collection

- *"We ask because we care!"*
- Focus on holistic picture of patients, guiding all interventions
- Address health inequalities
- Assist policymakers and government in planning for adequate resources to help provide community members with healthcare
- Assist healthcare facilities in planning for community resources
- SDOH are one of three priority areas for Healthy People 2030, which sets data-driven national objectives to improve health and well-being over the next decade

How SDOH Impact/Influence Health

Food

Limited access to healthy food makes managing conditions like diabetes or heart issues difficult, worsening overall health outcomes.

Transport

Lack of a personal vehicle and care outside public transit zones leads to missed appointments and worsened chronic conditions.

Utilities (Economics)

Low-wage jobs without paid leave or inability to pay for utilities result in delayed care, improper medication storage, and worsening chronic illnesses.

Interpersonal Safety

Exposure to violence at home or in the community causes post-traumatic stress disorder (PTSD), anxiety, and depression while limiting access to healthcare, education, and social services.

Housing Instability

Homelessness or unsafe housing exposes individuals to health risks like mold, pests, or extreme temperatures, exacerbating chronic conditions.

Regulatory Requirements for SDOH

CMS	Requires screening for 5 Health Related Social Needs (HRSN) for admitted patients: food insecurity, interpersonal safety, housing insecurity, transportation insecurity, and utilities. Some factors collected are incentivized under Inpatient Prospective Payment System.
ONC ASTP	USCDI v3 standardized data elements relating to SDOH must adopt as part of the certification process by 1.1.25
The Joint Commission	Accredited organizations must adhere to a set of standards effective 1.1.23 as part of the health care equity certification program.

Potential Factors/Barriers Impacting Collection

Due to a lack of:

Standardization

Organizations may not have standard operational processes for documentation in patient records that seamlessly allows the information to (manually or electronically) flow to a designated area where providers can review and sign-off, and the information may not be easily viewable to coders for coding and delivery to the claim. There is not a standard "team-centered approach".

Understanding

Staff may not fully understand that the purpose of collecting this data is not to resolve all the negative factors patients face. Instead, the goal is to guide patients toward available community resources.

Leadership Involvement

With the absence of leader oversight, processes and staff tasks may be unclear, which directly impacts collection and workflow.

Follow-up Process

Resources unavailable regarding social needs and/or no follow-up analysis of information that is captured to measure success.

Training

Organizations focus training efforts on a select group of staff (e.g. clinical only) and sometimes there may not be a focus on addressing "implicit bias," which refers to unconscious attitudes and stereotypes that people hold towards members of other groups.

Leadership and Committee Involvement

Chief Medical Officer/Chief Operating Officer	Chief Nursing Officer (Leader, Director)	Patient Access/ Registration Leaders	Health Information Management/ Coding/CDI	Case Management/ Social Worker Directors
Admin Oversight	Clinical Oversight	Deliver Questionnaire	Code Capture	Referrals

Quality Director	IT/System Leader (Portal/EHR)	Revenue Cycle/ Business Office Leaders	Community Health Leaders
Data Capture/ Reporting	System/Template Build	Billing/Claim	Resource Availability

Operationalizing Collection of SDOH Data

WHO

- Medical Assistants
- Nurses
- Providers
- Social Workers
- Non-Clinical Staff
- Case Managers
- Interns/Volunteers
- Patient Navigator
- Community Health Workers
- Patient Self-Assessments

WHAT

Data collected will depend on several factors such as organizational requirements (see regulatory section of guide) and could include other factors such as staff bandwidth, facility initiative, or community challenges. It is not a "one-size-fits-all" approach.

WHEN

Patients should be screened annually but could be more often as determined by facility. This could be based on admission type, diagnoses, etc.

WHERE

Outpatient, inpatient, and ER settings, but could also take place in other settings within a healthcare system, including before patient presents for care.

HOW

Verbal/In person: provider screens at appointment

Verbal Remote: provider calls prior to appointment

Kiosk/Tablets: individual completes in waiting room

Written/Portal: individual completes assessment form in office or online prior to appointment

Sample Visit Workflow

Walk-through of SDOH information that is Gathered, Documented, Coded & Submitted to Claim

1 Pre-Admission

Patient receives screening tool via portal or mail and completes prior to visit.

2 Patient Check-In on Day of Visit

TIP: *SDOH Posters located in waiting room and pamphlets at Registration Desk.*

3 Patient in Waiting Room

Additional paperwork is completed and patients gain the ability to review SDOH responses previously submitted and add/modify responses via a patient kiosk or a tablet.

4 Height/Weight Checked in Hall

Medical Assistant confirms specific entries/needs according to system prompts.

5 Patient Enters Exam Room

TIP: *SDOH Posters in room & pamphlets/brochures made available on wall for review prior to visit.*

6 Patient Meets Clinician/Provider

Clinician/Provider discusses social needs (based on sensitivity training). Positive responses are confirmed, which auto-prompts need for Case Manager/Social Worker.

7 Meets Case Management/ Social Worker

Case Manager/Social Worker visits with patient and assesses SDOH issues based on positive screening responses, addressing new concerns patient has shared.

8 Social Worker Initiates Referral

Referral is initiated to Community Based Organization (CBO) and plans are finalized.

9 Nurse Discharges Patient

Discharge Nurse closes out visit and gives patient Discharge Summary or Summary of Visit note that includes referral info, along with other pertinent visit information.

10 Patient Stops at Scheduling Desk

Patient schedules follow-up (at this visit, results of referral can be documented).

11 Clinician/Provider Signs Note

Note is reviewed, including positive SDOH responses entered by patient on the pre-admission screening form and signed off by the provider. Other concerns shared with Social Worker will auto-flow into visit note based on note template.

12 Post Discharge Coding

Encounter or discharge records flows into work queue for coders to review. Documentation made by non-physician providers can be coded as well as self-reported SDOH data, as long as the provider has *signed off on the data*. These should be documented in a designated area of the provider visit note, making it easy and efficient to code. Codes then flow to billing and appear on the claim. Submission of codes can help influence policy and gain valuable resources in the community.

13 Transition of Care/Follow-Up

Patient uses this information to obtain resources to which they are referred. *Transitions of Care/Case Management* follow-up ensures that the patient obtains resources they need (e.g. another facility, food pantry, utility help, etc.). Information should be in discrete data fields in EHR for pulling reports.

Staff Frequently Asked Questions (FAQs)

WHO	Who determines what SDOH factors we need to collect?	Regulatory guidelines like CMS and The Joint Commission standards define collection of specific SDOH factors, but healthcare organizations may require additional SDOH factors be collected based on their patient population and the community they serve.
WHAT	What do I do if a patient refuses to answer?	Participation is voluntary. Document their refusal in a discrete data field for reporting purposes.
WHEN	When should we screen?	Screen annually or more often, depending on patient or facility requirements.
WHERE	Where in the patient's record is the best place to document data?	Use your facility's designated sections in the EHR to ensure SDOH data is accessible for coding, billing, and referrals.
WHY	Why are we focusing on non-medical issues so much now?	Non-medical issues like housing, food, and transportation significantly influence medical outcomes and overall patient health.
HOW	How do I start conversation with patients?	**In person:** *"I'd like to ask a few questions to understand how non-medical factors may affect your health and the care we provide."* **Electronically:** *"We recognize social factors may impact your health, so we'll ask some questions to serve you better."*

Conversation Scripts with Patients

WHO	Who else are you asking these questions to?	*"We screen all of our [inpatients, outpatients] every [year, six months, every visit, etc.]"*
WHAT	What will happen if I do not want to answer?	*"Your response will be documented as 'declined,' but answering can help us connect you with support resources."*
WHEN	When will I get referral information?	*"Our case manager will initiate referrals within [a set number of hours], or we'll provide a resource list before you leave."*
WHERE	Where will my responses go after I share them with you?	*"Your responses will be documented in your record and shared with referral sources with your permission. Coding your responses may also inform insurance and policy decisions."*
WHY	Why are you asking me these questions?	*"These questions help us understand areas in your life that may affect your health, allowing us to provide better care."*

Community Referral Resource Databases

Aunt Bertha (now - findhelp) | Neighborhood Navigator (The EveryONE Project) | Helpline Center | 2-1-1 | UniteUs | Local Health

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