Workflow Modifications: Action Steps to Address Social Determinants of Health (SDOH)

Providers and practices who are actively engaged in the Delaware Department of Public Health's Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke program have the benefit of **scheduling a no-cost workflow assessment (WFA)** with a local Quality Insights Practice Transformation Specialists (PTS). WFAs are completed annually and designed to initiate a future state of processes that will move the needle on clinical quality improvement activities.

The following list of workflow modification options can be used in combination with Quality Insights 2022 Social Determinants of Health (SDOH) Practice Module to help reduce health disparities in your clinical setting. **We encourage you to partner with your Quality Insights PTS to discuss scheduling a WFA and implementing at least ONE of the recommendations listed below.** If you are not currently working with a PTS and would like assistance, please email Ashley Biscardi or call 1.800.642.8686, ext. 137.

Electronic Health Record (EHR) Actions

	Assess your EHR's capability of running reports based on clinical quality measures. Determine ability to collect and report patient race, ethnicity, and preferred language data.
	Review and implement the PRAPARE tool or other SDOH EHR templates. Review available PRAPARE EHR templates and demo videos.
	Review Quality Insights' Quick Guide to Social Determinants of Health ICD-10 Codes as a starting point to evaluate and report ICD-10 Z codes to link SDOH and diagnoses/problem lists.

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	Develop and implement structured data fields to track referrals to community resources and ensure feedback is received. If your practice is participating in the CMS Quality Payment Program (QPP), consider monitoring Clinical Quality Measure (CQM) *Closing the Referral Loop: Receipt of Specialist Report* (for EHR or registry collection and submission only).

Protocol & Workflow Actions

	Determine an implementation plan for SDOH assessment, including staff roles and training, team communication, data collection and analysis, and referral to community resources.
	Utilizing Chapter 5 of the PRAPARE Implementation and Action Toolkit, build workflows to connect patients with resources and follow up.
	Develop external partnerships and refer patients to social resources. Start with state-based resources linked in the practice module.
	Initiate a process for addressing SDOH at both patient and population levels.

Practice & Clinical Solutions

	Partner with Quality Insights to identify patients with hypertension and Medicaid. Utilize Unite Delaware (Unite DE) to provide referrals to community support organizations.
	Use the electronic PRAPARE tool or implement a paper form to identify your patients' social needs, such as housing status and stability, neighborhood safety, income, educational attainment, transportation needs, and employment. Consider assessing social and emotional health measures such as Social Support and Stress, as well as Substance Use Disorder.
	Review Chapter 9 of the PRAPARE Implementation and Action Toolkit to learn more about how you can act on your SDOH data and think through possible services and interventions you can provide or build based on the needs in your patient population.

Patient Education Actions

	Plan and implement communications with your patients to help them understand why they are being asked about SDOH and ways in which they can benefit from the assessment.
	Survey and/or follow up with patients to get feedback about their experiences with referrals.

Contact your Quality Insights Practice Transformation Specialist for NO-COST implementation assistance for any of these workflow modifications.

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