MN DEPARTMENT OF HEALTH

StratisHealth

Minnesota Critical Access Hospital Social Drivers of Health (SDOH) and Health-Related Social Needs (HRSN) Toolkit

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Overview

Welcome to the Critical Access Hospital (CAH) Social Drivers of Health (SDOH) and Health-Related Social Needs (HRSN) Toolkit. This toolkit is intended for critical access hospitals in Minnesota to support development and implementation of SDOH/HRSN strategy.

Who this toolkit is for

We designed this toolkit for CAHs and their community partners working to address community SDOH and individual or family HRSN in Minnesota's rural communities.

What you will learn in this toolkit

Users of this toolkit will gain an understanding of:

- Health disparities challenging Minnesota's rural communities.
- Tools and resources to develop and implement processes to address individual HRSN that would impact community SDOH, including screening, referrals to supportive services, data collection and reporting, improvement action planning, and ongoing progress monitoring.
- The role community resources play in addressing SDOH and HRSN and how to connect patients to them.

How this toolkit is structured

We structured this toolkit around the six cyclical steps for CAHs to develop, implement, and sustain an intentional and focused strategy to address SDOH/HRSN:

Step 1: Set up Governance
Step 2: Engage Partners
Step 3: Screen Patients
Step 4: Review the Data
Step 5: Act on the Data
Step 6: Stay Accountable

Key terminology used in this toolkit

The following are terms used throughout this toolkit and their definitions.

Community resource is any service or organization available in a community that can potentially improve the quality of life for community members. Examples include organizations, services, and individuals such as:

- Behavioral and mental health providers
- Community health workers and social workers
- Community pharmacies
- Dental and vision care providers
- Faith-based institutions that provide spiritual, emotional, and social needs support
- Food banks and nutritional support programs
- Local businesses
- Local government agencies (e.g., social services, public health)
- Local government elected officials and other leaders

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including

powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[1] To achieve health equity, we need to eliminate health disparities.

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations disadvantaged by their social or economic status, geographic location, and environment.[2] Limited access to the resources people need to be healthy causes these disparities.

Health-related social needs (HRSN) are the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. These individual-level, short-term, or long-term factors put individuals and/or their families at risk for worse health outcomes and increased health care use, such as lack of access to healthy food, affordable and stable housing and utilities, health care, and transportation.[3] An individual's experience of HRSN are often impacts of the community-wide SDOH and disparities – while addressing health disparities and SDOH look for improvement in health outcomes at a community level, addressing HRSN improves health outcomes at an individual level based on a person's immediate needs.

Social drivers of health (SDOH), sometimes referred to as social determinants of health, are non-medical conditions that have been shown to have a greater influence on health than either genetic factors or access to healthcare services.[4] They include:[5]

- Economic stability (e.g., food, affordable and safe housing)
- Education access and quality (e.g., high school graduation rates, literacy levels)
- Health care access and quality (e.g., distance to nearest provider, provider availability and scheduling, insurance coverage)
- Neighborhood and built environment (e.g., violence, air and water quality)
- Social and Community Context (e.g., incarceration, social cohesion).

Figure 1. Source: Healthy People 2030

[1] What is Health Equity? (rwjf.org)
[2] What is Health Equity? | Health Equity | CDC
[3] Social Drivers of Health and Health-Related Social Needs | CMS
[4] Social Determinants of Health (SDOH) | About CDC | CDC
[5] Social Determinants of Health Literature Summaries - Healthy People 2030 | health.gov

Health Disparities in Minnesota's Rural Communities

Rural communities enjoy many unique strengths and assets. However, rural communities in Minnesota experience health disparities at a greater rate compared to their urban counterparts and within the communities themselves. The charts below from "Rural Health Care Minnesota: Data Highlights Chartbook" demonstrate some of the inequities in SDOH/HRSN and other issues that rural Minnesotans face.[6]

Travel time and/or distance from health care services can impact health outcomes. As demonstrated in Figure 2, Minnesotans in rural areas must travel farther and longer for many health care services than their urban counterparts. Individuals living in rural Minnesota may also have issues finding transportation, especially if services are further away from home, making accessing needed health care difficult.

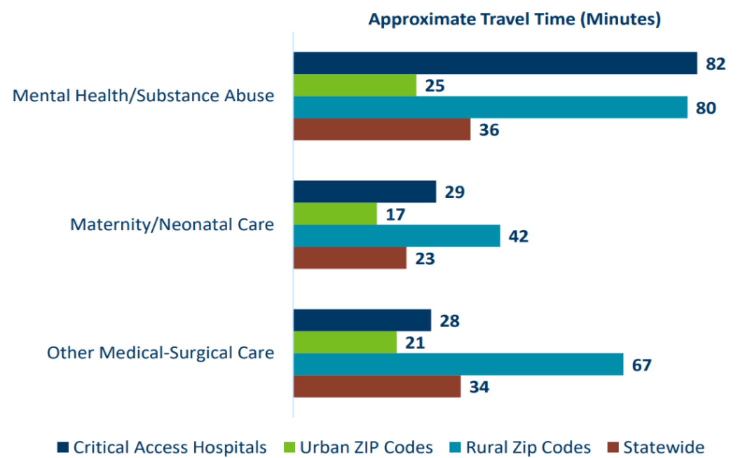

Figure 2: Graph of approximate travel time for specialty services throughout MN

Data show income levels are highly correlated with health outcomes; on average, those with higher income levels have better health outcomes. Figures 3 and 4 show that people living in rural Minnesota are more likely to have household incomes below the statewide median income.

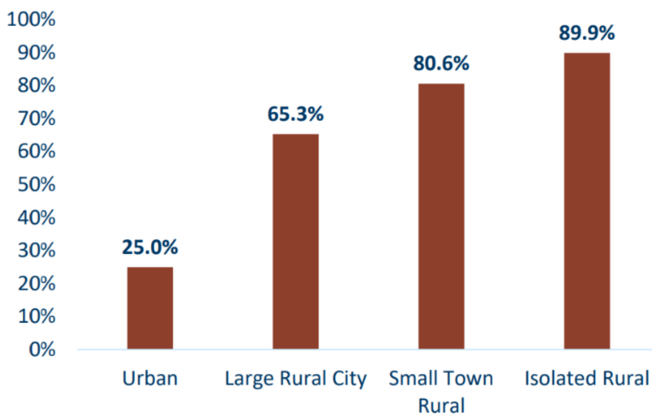

Figure 3: Percent of household incomes below the statewide median in MN

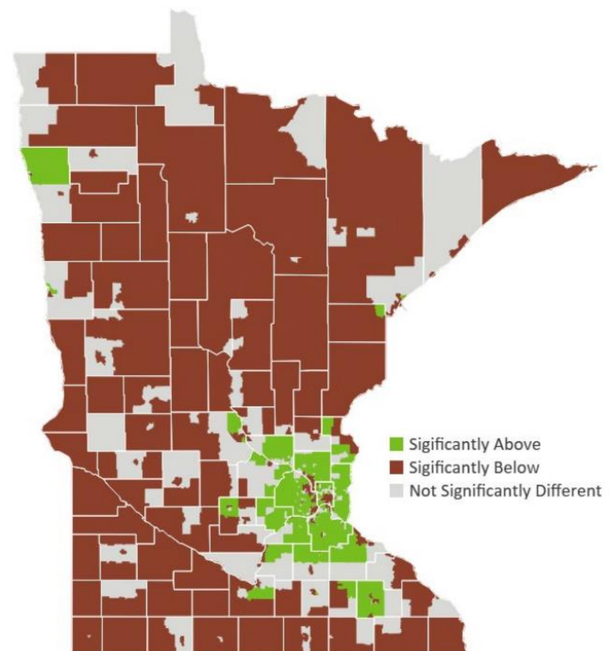

Figure 4: Map of MN that shows maldistribution of household incomes below median income

[6] MN Rural Health Care Chartbook - MN Dept. of Health (state.mn.us)

An estimated 122,000 Minnesotans live in concentrated poverty areas in rural Minnesota. Figure 5 shows a percentage comparison of people living below poverty in urban vs. non-urban areas.

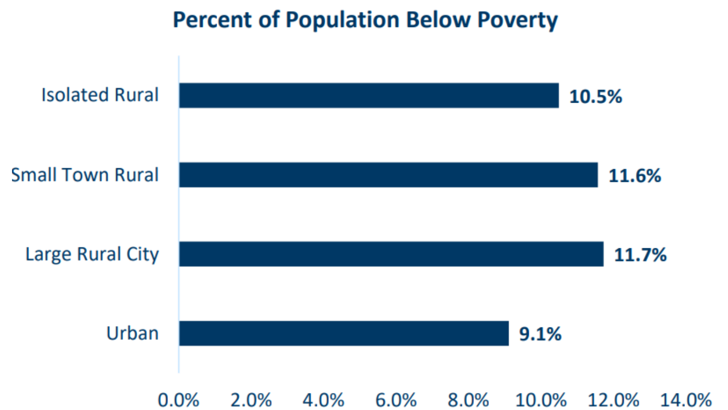

Figure 5: Percent of population below poverty

The data above are just a few examples of real disparities that rural Minnesotans face just based on where they live.

Health equity is an issue for all Minnesotans, and health care providers and community partners should work together to identify and address local disparities and improve priorities. This toolkit provides a step-by-step structure to develop, implement, and sustain processes to improve individual health-related social needs and impact community-wide SDOH.

For more information on rural disparities, see the following resources from the National Rural Health Resource Center and Rural Health Information Hub:

- Population Health Toolkit
- Social Determinants of Health for Rural People
- Rural Health Disparities Overview
- How does Rural America differ when it comes to SDOH

Developing and Implementing an SDOH/HRSN Strategy

The following six steps guide CAHs in developing, implementing, and sustaining a strategy to address SDOH/HRSN. This is a cyclical and ongoing process and is not meant to be a one-time activity.

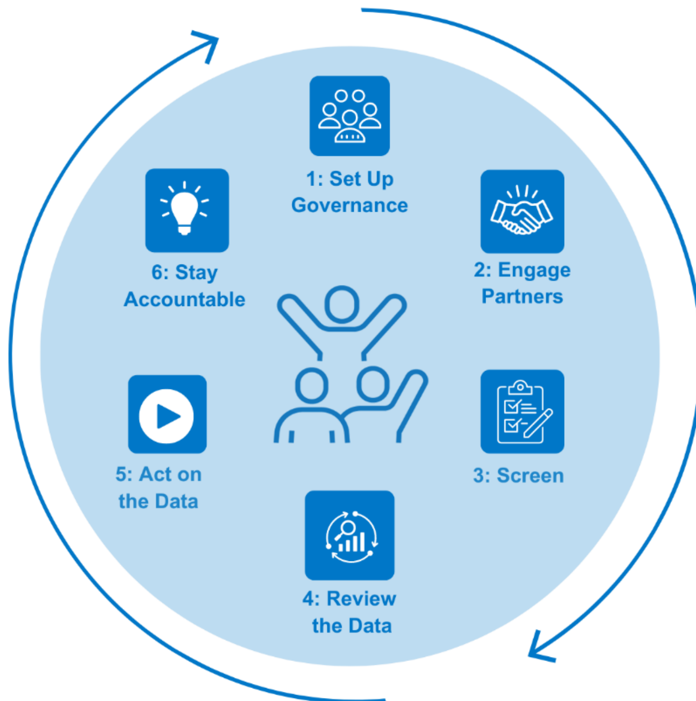

Figure 6: Steps to develop and implement a SDOH/HRSN Strategy

Step 1: Set Up Governance: Assemble a working group or committee to guide your SDOH/HRSN strategy.

Step 2: Engage Partners: Identify and partner with community services and resources that support SDOH/HRSN and establish processes to connect patients to those resources as needed.

Step 3: Screen Patients: Ask patients if they are currently experiencing any SDOH/HRSN.

Step 4: Review the Data: Review the aggregate and stratified screening data to understand the SDOH/HRSN of your patients and set goals to track progress.

Step 5: Act on the Data: Identify ways to support your patients' SDOH/HRSN needs.

Step 6: Stay Accountable: Share the data and your SDOH/HRSN strategy, action plans, and progress with your staff and community, and invite their feedback and support.

Stratis Health's Quality Improvement Basics resources provide a list of resources and tools for team concepts and communications including sample project charter, work plan, and meeting agendas.

Step 1: Set Up Governance

An SDOH/HRSN governance workgroup or committee may be part of an existing quality, patient experience, health equity committee or a new committee focused solely on developing and implementing an SDOH/HRSN strategy. The primary responsibilities of this team are to:

- Understand if/how your CAH and community are currently addressing SDOH/HRSN.
- Establish a shared purpose, vision, and strategy for screening for HRSN, connecting patients to community resources as needed, and addressing community SDOH issues.
- Provide support and advocacy for resources to implement the strategy.
- Review data and develop and monitor action plans and timelines to meet implementation goals.
- Develop and implement a communication plan to share progress with staff and the community.
- Strengthen existing and new partnerships with community resources and points of contact.
- Explore funding streams to further advance the work.

Committee Membership

Each CAH should decide on the size and which roles or individuals are best suited for the SDOH/HRSN committee, depending on CAH and community needs, staffing structure, and individual skills and interests. The team should aim for diversity of perspectives across job duties, departments, position levels, age, race/ethnicity, and other lived experiences or identities. The committee should include, but is not limited to, the following team roles:

- **An organizational leader will** provide sponsorship and advocacy for the committee and its strategy. This role is critical in garnering buy-in across the facility and community, obtaining and retaining resources, and strengthening community engagement and relationships.
- **Committee lead** to organize and facilitate the team, including meetings, goal setting, action planning, and progress reporting. This role may be held by the organizational leader or someone designated by the organizational leader.
- **Direct care staff** to advise on and implement SDOH/HRSN strategy such as departmental leads, clinicians, nurses, care managers, ancillary services staff, and quality, safety, and patient experience improvement leaders.
- **Community resources member(s)** to represent community-based organizations and services that help address SDOH/HRSN seen as a critical partner for your local SDOH/HRSN needs and strategy, including local public health, faith-based organizations, cultural groups, food banks, housing and transportation authority, and/or organizations serving under-represented individuals in the community.
- **Patients and/or their family members impacted by SDOH/HRSN** to describe the lived experience dealing with SDOH/HRSN, the health care facility's screening and referral processes, and receipt of supportive community resources. Rotating these members to obtain as many stories and perspectives as possible may be helpful.

Figure 7: Key roles and representation for a SDOH/HRSN committee

Step 2: Engage Partners

Create a Community Resource Guide

The first step to connecting patients to community resources to address their health-related social needs is knowing what resources are available and how to contact them. Here are a few things to get started:

1. **Appoint a lead.** Ask someone familiar with referral resources and processes (e.g., a nurse, case manager, or social worker) to serve as the task lead. Include staff from across service lines to help create or update your facility's community resource guide as appropriate.
2. **Compile a list of your community's resources.** Complete the following steps and consider using the Social Determinants of Health Community Resource Directory Tool for Minnesota Critical Access Hospitals as a template and starting point for your community resource guide:
   a. Ask all staff to share formal or informal lists of community resources and contacts they currently use.

b. Compile a single draft list and ensure each resource's contact information is accurate and complete.
c. Brainstorm and add any additional resource categories, services, providers, or community points of contact missing from the list.
d. Share the list with other community resource services and providers to see if they have any recommendations or revisions.
e. Consult and consider adding existing Minnesota online resource directories such as:

Directories for multiple or broad health and human services topics	Directories for specific areas, issues, or groups
MinnesotaHelp.Info – aging, disability, transportation, Medicaid waivers, etc.	HelpMe Connect – resources for moms and babies
MN Disability Hub – resources for people living with disabilities	MN Quality Perinatal Collaborative – perinatal resources listing by location, for families and for health care professionals
United Way 211 – comprehensive resource covering a variety of needs	LawHelpMN.org – legal aid
Disability Benefits 101 – resources on benefits related to work.	The Native American Community Development Institute Indigenous Resource Directory – listing of the Indigenous and indigenous-facing organizations and businesses
Housing Benefits 101 – resources on affordable housing and support services.	Resourceful - Duluth area community resources
	Violet – LGTBQ+ focus

f. Decide if only staff and community resource providers will use your resource guide or if you will also share it with patients and community members. Design formatting, accessibility, and language accordingly.
g. Finalize the list and share it broadly across your facility and community. Ensure it is accessible in multiple locations and formats (e.g., binders readily available in each hospital unit, brochures to give to patients and families, intranet or public-facing website, embedding into electronic health record and/or after-visit summary, etc.).

3. **Create an annual review and revision process** to ensure that the community resource guide is updated.

Create or Strengthen Relationships Between Your CAH and Community Resources

The SDOH/HRSN committee and the facility's executive leadership are responsible for fostering collaborative working relationships with community resources and other key partners. Get to know your community partners and let them get to know you and your organization. Ask them for input on your planning and processes and incorporate the feedback they offer as appropriate. Trust and relationships will build over time with consistent kindness, inclusion, and follow-through.

Consider the following activities to build relationships with community resources:

- Refer to your community resource guide and evaluate your current working relationship with each listed resource and/or point of contact.
- Draft and implement a plan to reach out to community resources with new or weaker relationships.

- Send a letter informing community resources and potential partners of your CAH's goal to address SDOH/HRSN and invite them to share their feedback and join your committee.
- Seek opportunities to participate in meetings and events with community partners.
- Invite community resources to join 1:1 meetings or present to your SDOH/HRSN committee to share more about their organization and services to learn more about them, identify alignment in goals and activities, and opportunities to collaborate.
- Transparently share data and improvement progress. Ask for feedback and impressions of the data and explore the extent to which it aligns - or not - with other community data (e.g., the community resource's programmatic data, most recent community health assessment results, county-level health data, county-level data sets, etc.).
- Check-in with community resources on a regular and ongoing basis.
- Build public awareness of your community partnerships and progress - others may want to help!

Connect Patients to Community Resources

There are different ways to connect patients to the community resources they need. CAHs likely have different relationships with community resource providers, so referral processes may initially vary.

The following spectrum describes different referral process options to consider:

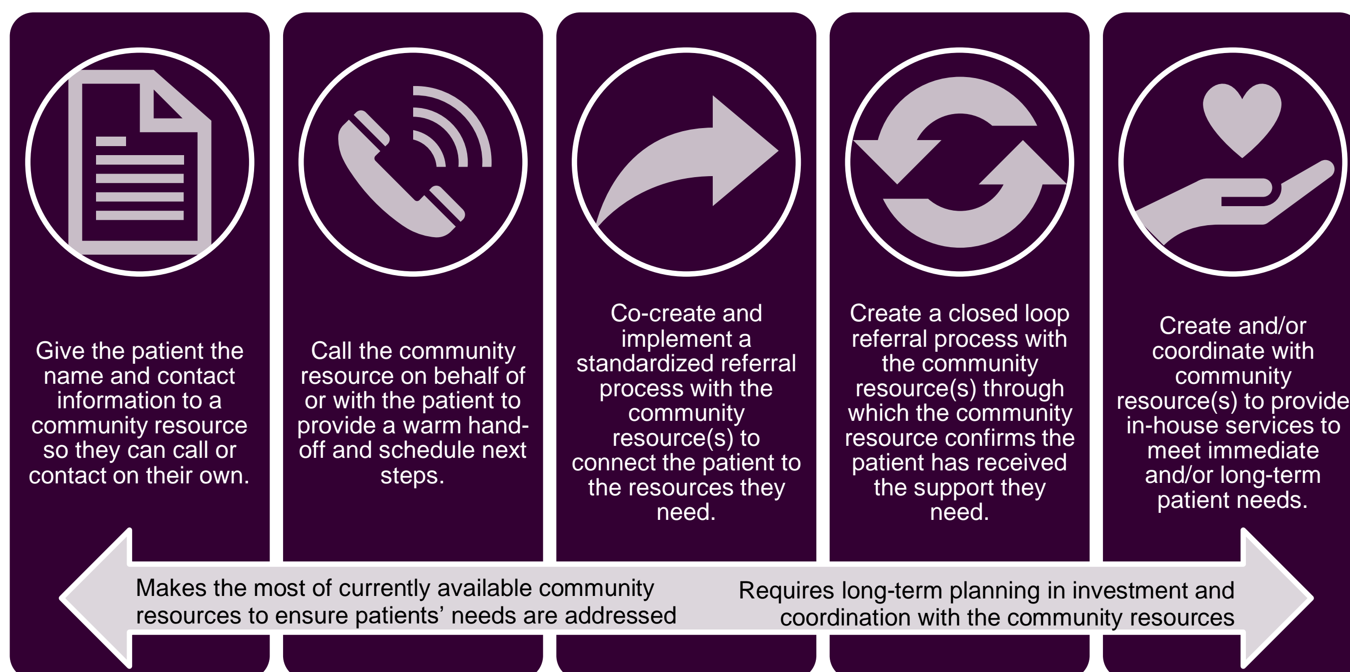

Figure 8: Spectrum of patient referral process options

Step 3: Screen Patients

The screening process asks patients to respond to questions that capture the information needed to understand current individual or family SDOH/HRSN.

Recommendations for developing a screening strategy:

- Start by selecting and implementing a widely used screening tool. Avoid wasting time searching for or creating a "perfect" tool - just get started, learn from the process, and adapt it to your specific needs in the future.

- At a minimum, start screening for the five needs required by the CMS SDOH measures that are now part of MBQIP and consider adding other questions as appropriate:

Figure 9: Five SDOH/HRSN screening domains now required by CMS

- Integrate your screening tool(s) into the electronic health record (EHR)
- Create private self-reporting processes and train staff to ask screening questions in ways that ensure patients feel safe to answer openly and honestly. Consider scripting and practicing a brief standard explanation for why you are asking these questions. See this Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) implementation toolkit for tips for staff on asking the screening questions.
- Consider the diversity of your patient population and plan ways to adapt your screening processes to accommodate needs. Common considerations include disability status, health and technology literacy level, language translation, cognitive or mental health needs, and more.
- Decide if you will roll out new screening processes broadly in all departments or if you will start with a single department or service line. If starting with one department, begin with the inpatient department to align with MBQIP reporting expectations.

Select a Screening Tool

There are many SDOH/HRSN screening tools available. Included here are three that are publicly available, cover the five domains required by CMS, and are commonly used by many health care providers:

- National Association of Community Health Centers (NACHC) and partners **-** Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)
- American Academy of Family Physicians (AAFP) - Social Needs Screening Tool
- Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) - Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool

The following table compares the three most widely used screening tools (Adapted from The Social Interventions Research & Evaluation Network (SIREN) screening tool comparison)

Screening Tool Characteristics	AAFP	AHC	PRAPARE
# of SDOH needs questions	15	19	17
# of non-SDOH needs questions	0	8	4
Reading Level	7th grade	8th grade	8th grade
Additional Languages	Yes (1)	No	Yes (25)
Scoring	Yes	Yes	No

Table 1: Comparison of three common SDOH/HRSN screening tools

Developing the Screening Process

Plan your screening processes, including how it will be conducted and documented, by whom, where, and when. Your processes may vary between departments and/or as they adapt them to individual patient needs.

Consider the following questions as you design your processes and adaptations:[7,8]

- What information is already collected during registration or through other assessments?
- How will we notify people they will be screened: Text or patient portal message? Letter? News/media? Posters/flyers? Verbally by staff?
- How often will we screen: Annually? Only certain types of visits/encounters? Every encounter?
- When will patients be screened: Before a visit/encounter? At the beginning? At the end? After a visit/encounter is complete?
- Who will screen: Patient/caregiver self-screen? Registration? Nursing? Provider? Care manager?
- How will we screen: Paper form? Electronic form? Verbally by staff in-person or via phone call?
- Where will the screening be conducted? Will it be at the registration desk? In waiting rooms? Inpatient or exam rooms? In staff offices? At home?
- How will the screening results be documented in the EHR? Will they be directly documented into the EHR by staff? Scanned or transcribed by other staff? Linked via patient portal or other survey application?
- How will we ensure the whole care team knows the screening results: Huddle? Electronic messaging? Referral entry? Notes/flags in EHR?
- Who and/or what will be available if patients have questions when filling it out?
- What workflow changes will be needed and/or what existing workflows will be impacted?
- How and when will you ask for input and feedback from impacted staff in designing processes?

Figure 10 is one example of a simple workflow depicting the process for screening patients admitted to a hospital.

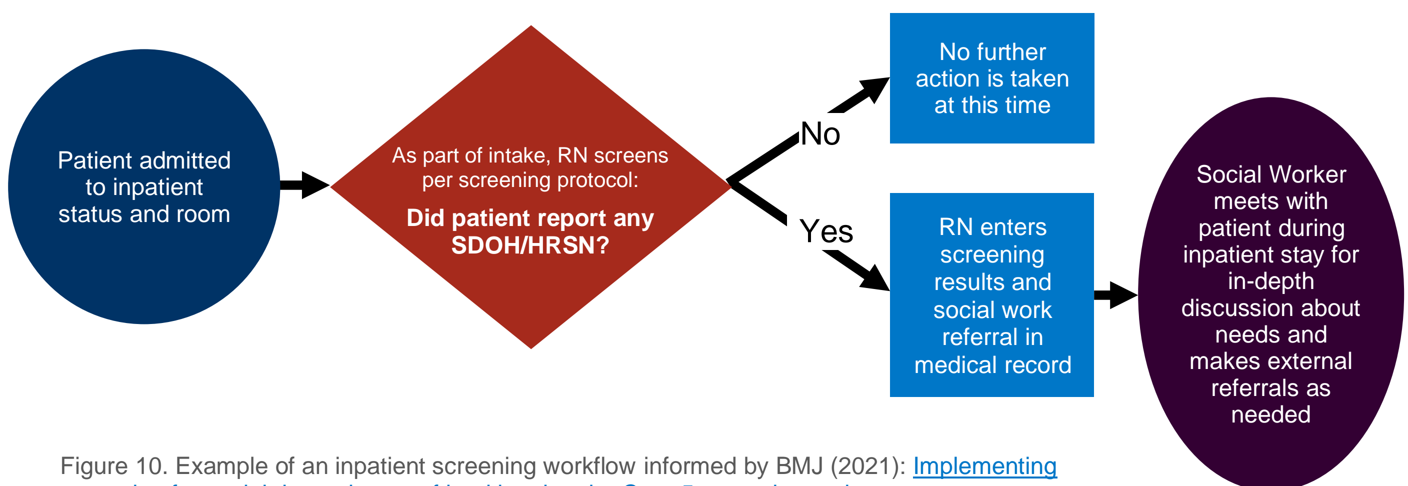

Figure 10. Example of an inpatient screening workflow informed by BMJ (2021): Implementing screening for social determinants of health using the Core 5 screening tool.

[7] Informed by the PRAPARE Toolkit.

[8] A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (cms.gov)

Implementing Your Screening and Referral Processes

Change can be difficult for some people to adapt to. Still, it is made easier by anticipating potential concerns, preparing responses and/or processes to address them, and continuously checking in with staff throughout the implementation process to see what needs to be adjusted. Be patient and supportive, reassuring others that improvement is an iterative learning process.

Consider the following questions as you begin implementing your screening processes:

- How and when will you communicate to staff that there will be a new process?
- How can the screening and referrals be positioned not as something new but as a way to better serve?
- How will you make it easy for staff to support, learn, and do consistently?
- How and when will you check in with staff to see what adaptations might be needed?
- How and when will you check in with patients and caregivers to understand their experience of this screening and referral process? See sample questions for process debrief: SDOH Pilot Debrief Sample Questions (Word)
- As you screen patients and SDOH/HRSN identified, how will you understand the experience and impact of referral processes from the perspective of the community resources? What's working? What can you improve upon? Is there anything you're surprised by?

Step 4: Review Data

Through MBQIP and other quality data reporting programs, CAHs have started or will be starting to report data on SDOH/HRSN screening and positive screens. Data collection, aggregation, and stratification, presentation (e.g., tables, graphs, real numbers, rates, etc.), and analysis are important to internal quality improvement so that a CAH can understand and address SDOH/HRSN for individual patients and specific patient populations. You will also likely need to develop additional process measures to monitor your implementation.

Stratis Health's SDOH Measurement Plan and Tracking Tool provides a dashboard of the two MBQIP measures (SDOH-1 for screening rate and SDOH-2 for screen positive rate) to track rates over time.

Questions you might consider as you review your CAH's screening data:

- What are the most common needs? Are there needs to be reported you are not currently capturing?
- How does the data change over time? Are there identifiable increases or decreases in specific needs? Are any changes cyclical or predictable? Are there changes with the seasons or week of the month?
- How do our community's resources align with the needs reported by patients? Do we have access to what people need?
- What adjustments might we make to our screening or referral processes to impact the data?
- How does our data compare to and impact community-level data such as:
  - Your facility's and/or county's community health needs assessment(s)
  - County Health Rankings: County Health Rankings & Roadmaps
  - USDA County Level Data Sets: includes poverty, population, unemployment, education; Atlas of Rural and Small-Town America: USDA ERS - County-level Data Sets

Step 5: Act on the Data

Quality improvement (QI) tools and processes can help your CAH take action. Once you have collected your baseline data, the next step is articulating an improvement goal. Formatting your goals as "SMARTIE Goals" will help you ensure they are specific, measurable, attainable, relevant, time-bound, inclusive, and equitable. This is especially important for projects meant to improve outcomes for underserved or marginalized populations.

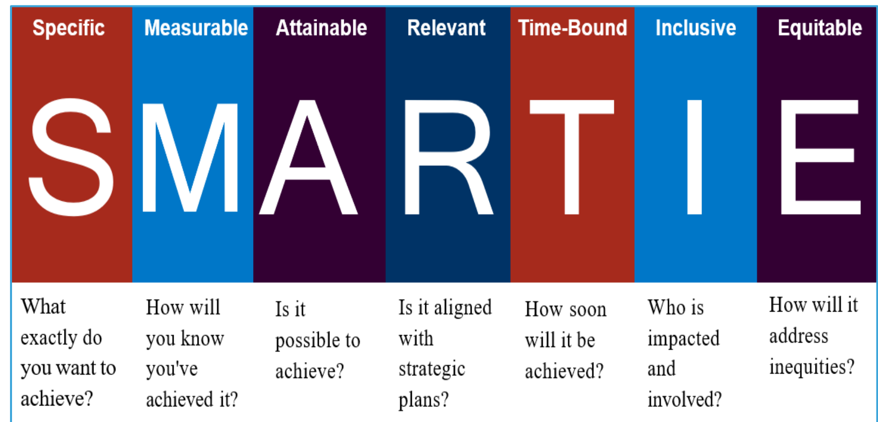

Figure 11: SMARTIE Goals components

Stratis Health's Quality Improvement Basics resources include education and tools for quality improvement in health care settings including information on QI processes, using data, and change management.

Create, monitor, and adjust your improvement action plan regularly as your implementation progresses. Use structured work plans to ensure the whole team knows who is doing what and by when. Hold each other accountable for completing tasks and offering support and assistance to others when needed. Document when changes are made to your processes so you can clearly monitor the impact on your process and outcome measures.

Step 6: Stay Accountable

You can stay accountable to your goals to improve health equity by being transparent about your activities, sharing aggregate data with your staff, partners, and the community, and inviting others into dialogue about what is working, what is not working, and what could be done differently for even better results. Share any constraints or realities related to your improvement activities, data, and goals. This will help your CAH committee and community partners share informed and realistic feedback.

Other considerations include:

- Share your goals openly with others. Include them on your website or publish them. Invite the community and key partners to discuss them.
- Share your aggregate screening and other data broadly. For example, you might share a data dashboard or other summary on your public website. Data can be beneficial in securing funding, partners, and support to sustain, establish, or expand services.
- Get creative about engaging the broader community. Use many different techniques such as community liaisons, open houses, focus groups, other community coalitions and workgroups, etc. While it is important to invite the community and partners to your table, it is also important to go to where people are already convening and to seek out opportunities to meaningfully engage with the community where they are.
- Explore the funding mechanisms to support your CAH's partnerships with community resources to sustain existing programs or develop new programs needed to address SDOH/HRSN. See examples of funding programs: Grant Funding for Programs that Address Social Determinants of Health.

What does addressing SDOH/HRSNs look like in action?

Various communities in Minnesota have responded creatively to addressing SDOH. Below are a few examples that demonstrate some of what some rural communities across Minnesota have done:

- goMARTI in Grand Rapids addressing transportation needs
- Riverwood Connects (they even won an award for it!) addressing housing and utility needs
- Lakewood Health System – Food Access Initiatives and Riverwood Health System and Food R.X./Food Access Program addressing food insecurity
- M.N. Path to Value projects addressing interpersonal safety