Case Scenario #3 and Discussion Questions

Scenario: No Provider, Clinical team members involved in intake of patients

- Participants
  - Very small group (1-2) or 1:1 with Medical Assistant or Counselor/Educator
  - Clinical team members involved in intake process of patients, including social determinants of health (SDOH)
- Participants Role
  - To support the provider staff by collecting medical and demographic histories on the patient
- AD Setting
  - Virtual
- Goals of the Academic Detailing
  - Address SDOH and provide referrals as appropriate to improve the overall health and well-being of patients.
  - Define which Healthy People 2030 goals would be most beneficial to your practice.
  - Ensure that the care team is knowledgeable regarding the impact of SDOH has on their patients.
  - Emphasize prevention and primary care, addressing SDOH, identifying patients who could benefit from community health worker (CHW) services.
  - Develop a referral process to CHWs to engage the patients in social determinants and goal setting conversations, to improve health outcomes.
  - Incorporate SDOH screening, choosing a tool based on population and practice needs.
  - Consider integrating SDOH screening into the EHR to improve patient data and quality outcomes.
  - Implement a plan to integrate SDOH screening in the practice, engaging the entire care team.
  - Incorporate SDOH information as part of training and development, including billing and coding for reimbursement.
- Information Presented and Evidence Base
  - Healthy People 2030 organized a framework reflecting five key elements or domains – Economic Stability, Education Quality and Access, Social and Community Context, Health Care Access and Quality, and Neighborhood and Environment.
  - Addressing SDOH is complex. All members of the health care team have unique skills that can help to better address the social barriers to health that your patients face (AAFP, 2018).

- Providers emphasizing prevention and primary care is part of the health care transformation efforts. Utilizing CHWs is an effective strategy for promoting prevention and better management of chronic conditions (DHSS DPH, 2017).
- CHW programs are effective in improving health outcomes and care delivery (decreased wait time, reduced emergency room visits), patient knowledge and behavior (adherence), and sociocultural change (decreased disease-related social stigma) (DHSS DPH, 2017). A 2016 Literature Review from the Minnesota Department of Health, Community Health Workers: A Review of the Literature, looked at evidence of CHW effectiveness and quality of care. The review found eight health outcomes that were improved by CHW programs and six that demonstrated some improvement (including maternal-child health) (MDH, 2016).
- SDOH screening in primary care could improve clinician ability to understand the "upstream" factors impacting patient health, inform care decisions and identify patients in need of referral to resources as well as inform funding of those resources (LaForge, 2018).
- In 2019, the AHA stated that any clinician can document a patient's social needs. As the initial ICD-10-CM Coding Guidelines indicated that only codes supported by physician documentation could be utilized, in 2018, the AHA Coding Clinic published information clarifying the use of Z codes. Many times social needs were unable to be reported in hospitals because they were documented by non-physician providers. The AHA clarified that "codes from categories Z55-Z65 can be assigned based on information documented by all clinicians involved in the care of the patient."

- Barriers Encountered
  - Not everyone on clinical and non-clinical staff is trained on SDOH
  - There is variability among practices in what and how much is asked regarding SDOH
  - What should be done with the SDOH data once is collected; making it actionable
  - Lack of age appropriate referral resources
  - General pushback on timing
- Successes
  - The clinical support staff found the overview and pros/ cons of the SDOH tools beneficial, especially if they did not have one implemented or collect limited data. There are great questions regarding tools for adolescent and young adult populations.
  - The Healthy People 2030 conversations have led to engaged discussions with clinical staff to encourage them to think about their population needs.
  - There have been great conversations about the importance of using Z codes and understanding the population needs. Even if there is not reimbursement for all populations today, data can inform many decisions.

Discussion Questions:

- What are some differences in the detailer's approach to this scenario, as opposed to a detailing session that is 1:1 with a provider?

- Would the same approach to introductions that we discussed apply to a scenario in which you arrive and only other members of the clinical team are present? Would there be other initial considerations?

- How would you utilize evidence-based literature differently? Or, would you use the same literature?

- Would the UNAD and other supporting materials have a more or less supporting role? Or, no change?

- Language and medical terminology may need to be considered, depending on your audience. What is the impact in this scenario?

- How would you change the "asks" for this audience?

- Are there any portions of the detailing that perhaps would not be applicable to this audience? (Review the UNAD)

- Scenario Specific Question: When the team mentioned that they do not know what to do with the SDOH data collected, how would you respond to them? How could you address the barrier that it is not a good time to address SDOH (too much going on at practice)?

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