American Cancer Society®

Building Capacity to Address Social Determinants of Health: A Resource Guide

Index

Introduction

Health systems are key contributors to the well-being of the communities they serve. Population health and cost-effective health care depend on appropriate measures being taken to mitigate preventable negative health outcomes. In clinical practice, it is important to recognize the societal conditions that impact health outcomes, known as **social determinants or drivers of health (SDOH)**, and associated **health-related social needs (HRSN)**.

SDOH are the nonmedical factors that influence an individual's health, well-being, and quality of life. They are the conditions in which people are born, live, learn, work, play, worship, and age. SDOH are often influenced by long-standing policies and systems that are outside an individual's control, including structural racism and discrimination.

HRSN are an individual's unmet, adverse social conditions (including food or nutrition insecurity, housing instability, unemployment, economic instability, and/or lack of reliable transportation) that contribute to poor health and are a result of underlying SDOH.

SDOH and Cancer

The World Health Organization reports that SDOH drive 30%-55% of health outcomes.[1] This impact is significant across the cancer continuum. Barriers to SDOH can lead to delayed screening and diagnosis, impact treatment access and affordability, and result in increased morbidity and mortality.[2] In addition, SDOH often cluster together, which can further drive negative outcomes. In fact, individuals experiencing a greater number of SDOH experience higher rates of cancer mortality. These effects of SDOH on people with cancer have become widely recognized by oncologists and care teams in recent years.[3]

Organizations such as the American Cancer Society (ACS), the American Society of Clinical Oncology (ASCO), and the National Comprehensive Cancer Network (NCCN) have highlighted the need to address the social needs of patients in the context of cancer care.[2,3] In 2023, screening for SDOH domains, including food insecurity, housing insecurity, interpersonal safety, transportation insecurity, and utilities, became required by the Centers for Medicare and Medicaid Services (CMS) for systems participating in the Enhancing Oncology Model (EOM).[4] As government and other health care organizations expand their focus on SDOH, it is important for health systems to understand and broadly strategize interventions to address SDOH-associated needs to help advance health equity and improve delivery of cancer care.[2–9]

How should health systems use this guide?

This guide was compiled to help health systems access current and relevant information related to implementing SDOH screening and referral workflows. The guide consolidates resources to help health systems:

- Understand SDOH and HRSN in the communities they serve.
- Screen for SDOH, and get reimbursed for screening.
- Access helpful resources and information to address HRSN.

We suggest that you focus on the topics relevant to your health system at any given time. **Case studies** testing SDOH screening and referral workflows from six partners are available for reference at the end of this document.

Understanding SDOH

Community Assessment

Identifying the SDOH and HRSN most prevalent in the area served by your practice is key to improving health equity and lowering health care costs. Below are resources that can assist with this process. Individual counties or cities may maintain their own databases. Consider reaching out to your local health department to learn about other available resources.

Before you begin: Consider reviewing How Geographic Data Can Help Address Social Determinants of Health, which can provide a helpful starting point for determining how to filter data.

211 Counts: Provides information on the top identified needs in individual communities based on United Way 211 call data. Filters are available for ZIP code, county, school district, region, and congressional district. An Instructional Guide is available to provide further directions on use.

American Community Survey Data (Census): Releases new data tables and tools related to social, economic, housing, and demographic characteristics annually

City Health Dashboard: Offers data on various measures for 500+ large cities and several small cities from across the United States

County Health Rankings & Roadmaps: Allows users to search data based on county, state, or ZIP code. The site provides a rank for the specified area as it relates to other counties in the state. It also provides information on health-related outcomes, factors, and behaviors, along with data on demographics, socioeconomic factors, and physical environment.

Food Environment Atlas (US Department of Agriculture Economic Research Service): Provides county-specific information related to food environment factors. This includes access and proximity to grocery stores, store and restaurant availability, food assistance programs, local food availability, food insecurity measures, and socioeconomic characteristics.

Healthiest Communities (U.S. News & World Report): Ranks critical health-related and social determinant factors based on county. The metric-level data explorer tool offers a detailed look at the data that drove the rankings.

PLACES: Local Data for Better Health (Centers for Disease Control and Prevention [CDC]): Provides health data for small areas across the country based on county, census tract, or ZIP code. The site offers a better understanding of the burden and geographic distribution of health metrics, regardless of population size and rurality.

Social Vulnerability Index (Agency for Toxic Substances and Disease Registry/CDC): Uses 16 US census variables to identify communities that may need support before, during, or after disasters based on their social vulnerability. The site also discusses how external stresses on human health may negatively affect communities.

Vulnerability Index (Vizient): Identifies SDOH through a comprehensive database inclusive of most ZIP codes

Education and Relevant Organizations

Gaining a deeper understanding of SDOH can aid your health system in implementing the most appropriate practices to improve patient outcomes and reduce costs. Below you will find a list of organizations that offer opportunities to learn more about SDOH. These organizations provide resources that may assist in increasing your knowledge of SDOH history, causes, research, screening opportunities, and best-practice interventions. Please note that most are not specific to cancer.

ACS: Provides a learning framework called Project ECHO (Extension for Community Healthcare Outcomes) that reaches across disciplines for sustainable and profound change. The reducing disparities series identifies and discusses relevant disparity-reducing issues in cancer risk and prevention.

Agency for Healthcare Research and Quality: Provides SDOH studies, researcher resources, practice improvement tools, datasets, and analytics

American Hospital Association: Supports health systems in understanding and addressing SDOH by providing reports, case studies, webinars, and videos

CDC: Provides information about SDOH and their framework related to improving health equity through SDOH, motivated by the Department of Health and Human Services' Healthy People 2030 initiative. You can also find information specific to Health Equity in Cancer Prevention and Control.

National Alliance to Impact the Social Determinants of Health (NASDOH): Provides numerous publications, blog posts, and articles related to SDOH. The site also offers an overview of promising practices and resources related to assessing community health, predicting social risk, screening tools and toolkits, digital navigation, developing interventions, and program evaluation.

National Cancer Institute: Offers webinars related to addressing social risks, including the Addressing Social Risks in Cancer Care Delivery Webinar Series and the Addressing Social Risks in Cancer Care Delivery Virtual Workshop

PAN Foundation: Provides an infographic and guide about SDOH Among Seniors & Adults showcasing the results of a research related to SDOH needs and demographics

Rural Health Information (RHI) Hub: Provides information related to SDOH in rural populations. This includes the SDOH in Rural Communities Toolkit, which includes resources and program models to address a variety of SDOH needs in rural areas. It also includes the Rural Health Literacy Toolkit, which highlights strategies for improving health literacy. In addition, RHI Hub offers other resources, including case studies, a podcast, data, graphics, and more.

The Root Cause Coalition: A national alliance of more than 90 health systems, hospital associations, foundations, businesses, academic institutions, insurers, nonprofits, and policy centers that work to identify, reverse, and eliminate the systemic root causes of health inequities. The site also offers a weekly newsletter, a regular podcast, and a yearly summit.

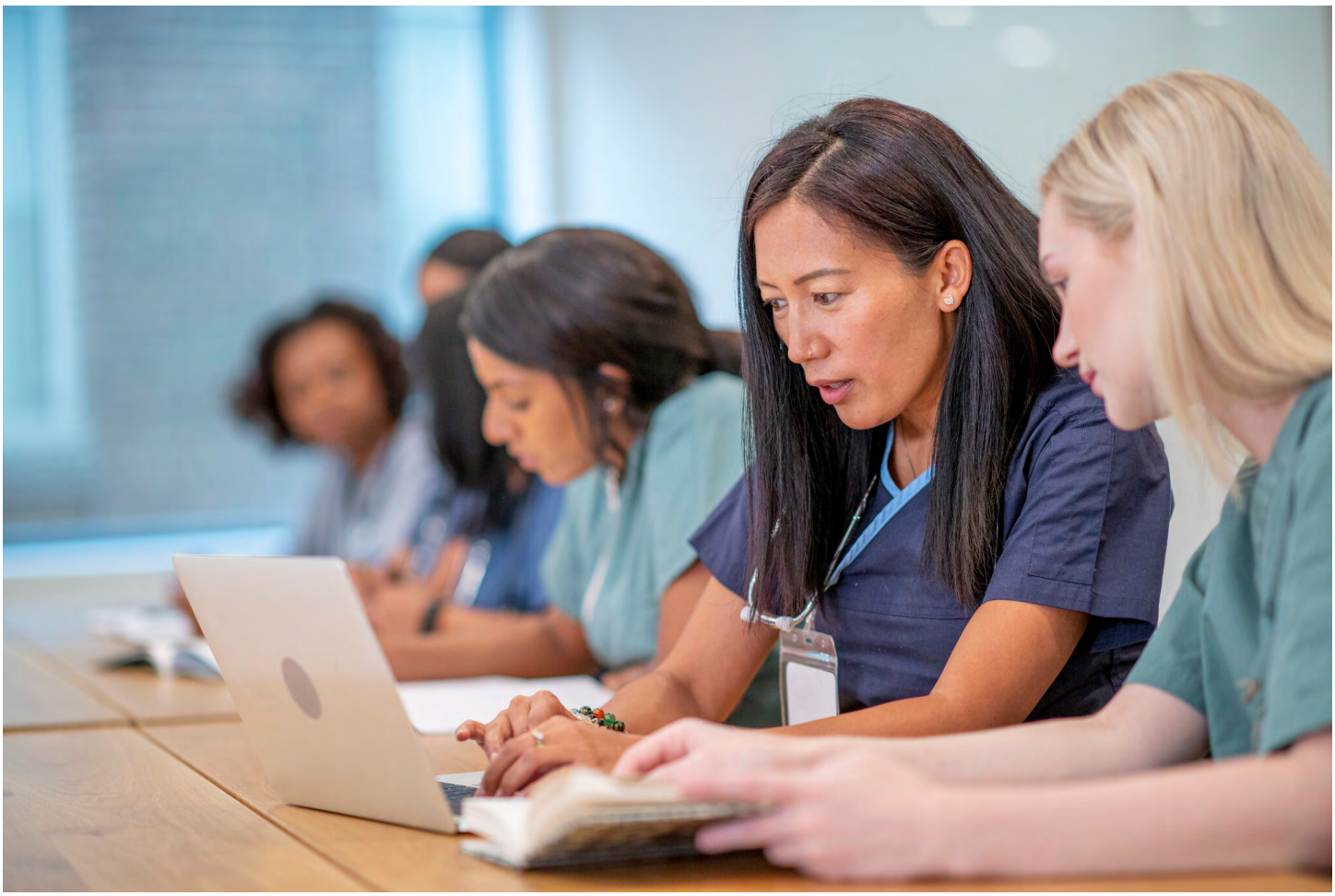
Triage Cancer: Provides webinars that discuss SDOH-related topics

Staff Training

It is important that all staff engaged in the process of SDOH screening are equipped with tools to ask about and assess needs appropriately. Foundational to this is helping colleagues understand what SDOH and corresponding HRSN are, how they impact individuals with cancer, and why it's important to ask about and respond to them. Below are training modules and resources intended to assist team members in expanding their understanding of SDOH and ensure that screening efforts are intentional, responsive, and demonstrate cultural humility.

Health-Related Social Needs: How to Identify and Address the Needs of Your Patients:
This presentation offered by the NCCN discusses the core measures of HRSN and how oncology care team members can address them in clinical practice.

Screening for Social Needs: Guiding Care Teams to Engage Patients: This tool offers guiding principles and strategies for engaging and screening patients for SDOH. It includes a review of important communication skills, developing cultural competence, and considering the location, mode, and method of screening.



Screening for SDOH

Health systems should be aware of salient SDOH that can impact health outcomes to identify the most impactful interventions and resources needed to improve health equity and lower costs. To best understand how the impact of barriers to SDOH can impact cancer health outcomes in your health system, they must be carefully measured across the cancer continuum.

This section offers information to help your health system train staff on SDOH screening, select an appropriate screening tool, and sustain screening efforts through reimbursement.

Selecting a Screening Tool

There are several items to consider when selecting an SDOH screening tool. These include:

- **Desired Domains**: Determining the SDOH domains you want to screen for is an important first step when selecting a screening tool. Sometimes, this may be driven by value-based care agreements or other contracting. The NCCN HRSN Working Group Recommendations suggest screening, at minimum, for four core measures:
  1. Transportation Access
  2. Housing Security
  3. Access to Food
  4. Financial Security

  They also recommend that health systems consider screening for additional measures based on the results of the initial screening. These additional measures include social and caregiver support, utilities, employment challenges, neighborhood and community safety, health insurance status, health literacy, and digital connectivity.
- **Mode of Screening**: It is helpful to determine if screening will be administered on paper or through an electronic platform. It's also helpful to consider which team members/departments will support this process.
- **EHR Integration**: Consider how the completed tools will be integrated into the EHR system.

The following resources may be helpful in selecting an SDOH screening tool:

A Review of Tools to Screen for Social Determinants of Health in the United States: A Practice Brief: A consolidated review of the most utilized SDOH screening tools, including an assessment of the 15 most common domains

Systematic Review of Social Risk Screening Tools: A resource that allows the user to search for screening tools by filtering by domain and construct

Social Needs Screening Tool Comparison Table: A summary of characteristics of many SDOH screening tools, including information on the intended population, number of questions, domains covered, and measures used. Screening tools can be abstracted for review and comparison.

Case Study: Texas Oncology

Project Goals:

- Patients with a positive SDOH screening have a documented intervention plan.
- Develop the Patient Resource Coordinator role so that staff can fully address patient practical needs without referring them on to other team members.

View a Case Study

ICD-10 Z Codes

Assigning ICD-10 Z codes to SDOH can help a health system identify the top SDOH experienced by the individuals they care for. This can also be a useful way to identify trends and can inform pertinent interventions and quality improvement initiatives. Included here is information related to SDOH Z code integration. Please note that this is an emerging field with frequent updates. Therefore, this information is subject to change.

ASCO

- From ASCO to Z Codes: What ASCO Members Must Know About Coding for Social Determinants of Health

American Hospital Association

- ICD-10-CM Coding for Social Determinants of Health: An extensive overview of ICD-10-CM coding and resources related to SDOH
- Using Z Codes to Address Patient Needs: A podcast that discusses the benefits of using SDOH Z Codes

CMS

- Improving the Collection of SDOH Data with ICD-10-CM Z Codes: An infographic providing an overview of SDOH Z-Code integration and process improvement, along with a list of updated SDOH Z Codes
- Data Highlight: An overview of the use of Z-Codes among a sample of Medicare Advantage enrollees, which includes a review of the top reported codes based on multiple factors
- Using Z Codes: An infographic detailing how to use Z codes to collect SDOH data and identify patient needs to enhance quality improvement initiatives

PRAPARE

- PRAPARE ICD-10-CM Z Codes: Provides a crosswalk between the PRAPARE SDOH screening tool and available ICD-10-CM Z codes. This can be used for SDOH needs identified by other methods as well.

Case Study: Froedtert & the Medical College of Wisconsin Cancer Center

Project Goals:

- Implement SDOH assessment workflows within gastrointestinal and breast cancer clinics.
- Utilize EHR push for patients to complete SDOH assessment electronically.

View a Case Study

Reimbursement

The CY2024 Medicare Physician Fee Schedule (PFS) introduced new billing codes that allow providers to be reimbursed for certain SDOH activities, which can enhance the cost-saving benefit of these services. Below you will find a brief summary of these codes and supportive resources. It may also be helpful to check for SDOH reimbursement opportunities with any commercial payors you partner with.

SDOH Risk Assessment: G0136

A new stand-alone G-code for the administration of a standardized, evidence-based SDOH screening tool

- 5-15 minutes; not billed more often than every six months
- Furnished as an add-on to an annual wellness visit or in conjunction with an evaluation and management (E&M) or behavioral health visit (must be performed by a psychologist; social workers ineligible)
- Cost sharing applies if not billed adjacent to annual wellness visit.
- Encouraged (not required) to bill with ICD-10 SDOH Z Codes
- Included on telehealth services list

Community Health Integration: G0019, G0022

New G-codes for services performed by certified or trained auxiliary personnel (including community health workers), under the direction of a physician or other practitioner, to address SDOH-related needs

- **G0019:** 60 minutes per calendar month
- **G0022:** Each additional 30 minutes
- Requires annual wellness visit or evaluation and management visit to initiate community health integration services
    - Must obtain verbal or written consent.
- Unable to bill when patient has home health plan of care

Resources

- 2024 CMS Physician Fee Schedule Final Rule Updates: An ASCO-produced video that gives an overview of the 2024 PFS updates, including the codes listed above.
- ASCO Care Management Services and Patient Navigation Services: A Comparison: A review of the similarities and differences between the Care Management CPT codes and the new SDOH-related codes
- Federal Register: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies: Official CMS document providing information on new codes

Identifying Resources to Address SDOH

Tailored resources may be needed to address SDOH/HRSN, enhance health equity, and lower health care costs. Many organizations have developed programs and resources to help people access health care, medicine, housing, lodging during treatment, affordable food, and legal services. Some of these resources are tailored to specific populations like veterans or children with cancer.

National Organizations by Category

Recognizing that every health system has resources that are unique to the communities they serve, this list is intended to provide an overview of national resources that can help supplement local services. Please note that organizations may have specific eligibility requirements, such as income level, for qualifying for support and that availability may change frequently.

General Resources

- ACS CARES™ (Community Access to Resources, Education, and Support): A mobile app that provides people with cancer and their families curated content, programs, and services to fit their specific cancer journey
- ACS National Cancer Information Center: Provides 24/7 support to help guide people through their cancer experience. They can help connect people with cancer to free lodging and transportation and help them make decisions about cancer care.
- ACS LION™ (Leadership in Oncology Navigation): A standardized training and credentialing program that helps navigators deliver evidence-based interventions that can help improve cancer outcomes from screening through survivorship to individuals, caregivers, and families experiencing cancer.
- Family Reach: Provides financial assistance, resource navigation, and financial tips and guidebooks to families facing cancer
- Findhelp: A database of resources for anyone in need based on ZIP code that can be filtered by category
- NeedyMeds: Offers information on how to find affordable health care or medications and a database of general resources that be searched by location and diagnosis
- United Way 211: A comprehensive directory of local organizations. Individuals can call 211 and connect with live agents who are available 24/7 and can assist with locating resources.

Employment and Job Training Services

- Cancer + Careers: Provides education, expert advice, and interactive tools to assist individuals with cancer in navigating employment-related issues
- CareerOneStop: The US Department of Labor provides a state resource directory, assistance with navigating unemployment benefits, job and training program search portal, and an employment toolkit.

Food Security

- Feeding America: Provides a directory of food banks that can be searched by ZIP code or state. It also provides information on senior and youth food programs, as well as Supplemental Nutrition Assistance Program (SNAP) assistance.
- Meals on Wheels America: Supports seniors via free home delivered or congregate meals, food pantries, and liquid nutritional supplement assistance
- US Department of Agriculture: Provides information on qualifying and applying for governmental programs that help people afford food, along with a directory of retailers

Case Study: Sidney Kimmel Cancer Center – Jefferson Health

Project Goals:

- Patients will respond to the four health-system identified priority domains on the SDOH screening tool (transportation, housing, food, and social connections) at least once per year.
- Patients with positive SDOH needs will receive at least one referral to a supportive resource.

View a Case Study

National Organizations by Category

Housing and Utility Assistance

- US Department of Housing and Urban Development: Housing Counseling Services: Provides information on the Housing Choice Voucher and contact information for housing-related counseling agencies. It also offers a searchable directory of shelters, food pantries, health clinics, and clothing providers, along with other resources related to housing stability.
- Legal FAQ: Resources related to housing assistance and housing, eviction, rent, and landlord-tenant laws
- Low Income Home Energy Assistance Program (LIHEAP): Information on qualifying and applying for utility cost assistance and other aid programs that can be searched by state
- The Salvation Army USA: Offers rent, mortgage, and utility assistance, along with temporary and transitional housing, food assistance, and clothing support. Programs vary by area.
- USAGov: Provides resources to help locate subsidized rental housing, home repair, energy assistance, home buying assistance, emergency housing, and eviction or foreclosure help

Insurance Navigation

- The American Cancer Society provides helpful information related to Health Insurance Options, Patient Bill of Rights, Getting Medical Pre-approval or Prior Authorization, and Insurance Claim Denials. It also provides links to external resources.
- Accessia Health: Provides phone- and web-based assistance with navigating health insurance options. It also provides webinars, an insurance terminology guide, and other related resources.
- ACS Health Insurance Assistance Services (HIAS): Provides service to eligible constituents to help identify health insurance options for which they might be eligible. Accessible via the ACS main toll-free line 800-227-2345
- Medicare Rights Center: Helps individuals with Medicare understand their rights and benefits, work through the system, and get quality care. It also provides support in applying for programs that can help reduce medical and prescription drug costs.
- Patient Advocate Foundation: Provides a Medicare Resource Center and National Financial Resource Directory. It also provides a Case Management program, which can help in understanding coverage options and providing additional support to individuals in select ZIP codes.

Legal Assistance

- Immigration Advocates Network: Provides a National Immigration Legal Services Directory that can be searched by ZIP code or detention facility
- Legal Services Corporation: Provides a searchable directory of civil legal aid organizations
- Triage Cancer: Provides a legal and financial navigation program and Cancer Rights Guides

National Organizations by Category

Medical Lodging

- The American Cancer Society provides more than 30 Hope Lodge® communities, which offer a home away from home for people facing cancer and their caregivers. Through a partnership with Extended Stay America®, they also connect eligible individuals with reduced-rate hotel stays in more than 600 locations across the country.
- Joe's House: Provides a directory of temporary lodging for those traveling for cancer treatment
- Ronald McDonald House Programs: Provides rooms for families of pediatric patients in active treatment 21 years old or younger

Transportation Assistance

- The American Cancer Society Road To Recovery® program provides free transportation to and from cancer-related medical appointments for people with cancer who do not have a ride or are unable to drive themselves.
- Air Charity Network: Provides free flights to medical appointments across all 50 states
- Mercy Medical Angels: Provides free non-emergency medical transportation via gas cards, bus, train, or air travel

Case Study: Phelps Health Delbert Day Cancer Institute

Project Goals:

- Eligible patients completed an SDOH assessment using an electronic tool.
- Patients with a positive SDOH assessment who request assistance receive a referral to at least one supportive resource.

View a Case Study

Supplemental Financial Support by Diagnosis and Treatment Modality

- NMDP: Helps individuals undergoing a bone marrow transplant with medical copays, housing, food, transportation, fertility preservation and more
- Cancer*Care*: Helps those undergoing cancer treatment with gas, home care, and childcare costs
- Colorectal Cancer Alliance: Provides one-time $200 checks to help with household bills, including childcare, transportation, and food costs
- Dollar For: Helps patients apply for hospital discounts or bill forgiveness
- Glenn Garcelon Foundation: Financial assistance for individuals diagnosed with a primary brain tumor
- HealthWell Foundation: Helps reduce financial barriers to care for underinsured patients with chronic or life-altering diseases
- HNC Living Foundation: Helps individuals diagnosed with head and neck cancer with travel costs, nutritional supplements, and copays
- Kidney Cancer Association: Helps those diagnosed with kidney cancer with transportation and general living expenses
- Lazarex Cancer Foundation: Helps individuals enrolled in any phase of a clinical trial with lodging and transportation costs
- Leukemia & Lymphoma Society: Helps individuals diagnosed with all types of blood cancer with the cost of medical copays, transportation, utilities, housing, childcare, food, and other costs
- Mesothelioma Applied Research Foundation: Helps those diagnosed with mesothelioma with travel expenses
- National Ovarian Cancer Coalition: Helps those diagnosed with ovarian cancer with household expenses and other non-medical costs
- National Pancreatic Cancer Foundation: Helps those diagnosed with pancreatic cancer with rent and utility assistance
- Sarcoma-Oma Foundation: Helps those with sarcoma with travel expenses
- Susan G. Komen: Helps individuals diagnosed with breast cancer with daily living expenses

Demographic-specific Organizations

- Alex's Lemonade Stand: Helps families with children diagnosed with cancer with treatment travel costs
- Allyson Whitney Foundation: Helps young adults diagnosed with cancer with daily living costs
- B+ Foundation: Helps families with children diagnosed with cancer with medication, travel, and basic living costs
- Compass to Care: Helps families with children diagnosed with cancer with medical travel costs
- USAging: Information for seniors on local aging programs that provide transportation, homecare, and other support
- Veterans Affairs: Provides comprehensive support to veterans, including help with housing, transportation, medical and mental health care, and disability compensation

Miscellaneous

- Social Security Administration: Information on applying for social security benefits and signing up for Medicare.
- Department of Health and Human Services: Information on qualifying and applying for social service programs (TANF, SNAP, etc.)

Building Community Partnerships

Developing sustainable, equitable partnerships with community-based organizations can allow for a greater understanding of needs, opportunities, and barriers to programs and interventions. Involving patients and/or community members in this process works to ensure inclusive representation and provides crucial insight.

Below you will find resources that can be useful in building community partnerships to address SDOH. This includes planning documents related to membership, design, and vision.

- A Playbook for Fostering Hospital-Community Partnerships: This comprehensive guide to developing community collaboratives was developed by the American Hospital Association, Health Research & Educational Trust, and the Robert Wood Johnson Foundation. It includes worksheets that can assist in determining partnership opportunities, meeting facilitation, and more.
- A Toolkit for Increasing Food Security Efforts Across the Cancer Continuum: Developed by the American Cancer Society, this tookit is designed to assist comprehensive cancer control organizations in focusing their efforts on food insecurity, including partnerships with community-based organizations.
- Addressing Social Determinants of Health in Your Community: Part of the University of Kansas Community Toolbox, this resource provides an overview of community relationship building opportunities along with ways to structure partnerships with community-based organizations
- Best Practices for Convening a Consumer Advisory Board: Developed by the Center for Health Care Strategies (CHCS), this infographic provides key considerations for creating an advisory board comprised of patients and community members.
- How Should Health Care Organizations and Communities Work Together to Improve Neighborhood Conditions?: This American Medical Association Journal of Ethics article discusses ethical considerations health systems should be mindful of when partnering with community-based organizations.
- Leveraging Community Expertise to Advance Health Equity: Principles and Strategies for Effective Community Engagement: This brief from the Urban Institute summarizes interviews with national organizations, health equity experts, and stakeholders investigating ways in which community engagement is being used to advance health equity, and the factors that can enhance or prohibit this.
- Value Proposition Tool: Articulating Value within Community-Based and Health Care Organization Partnerships: Created by the CHCS, this question-and-answer tool was designed to measure the ways in which community-based organizations and health care systems can provide value to one another and align shared goals through partnership.

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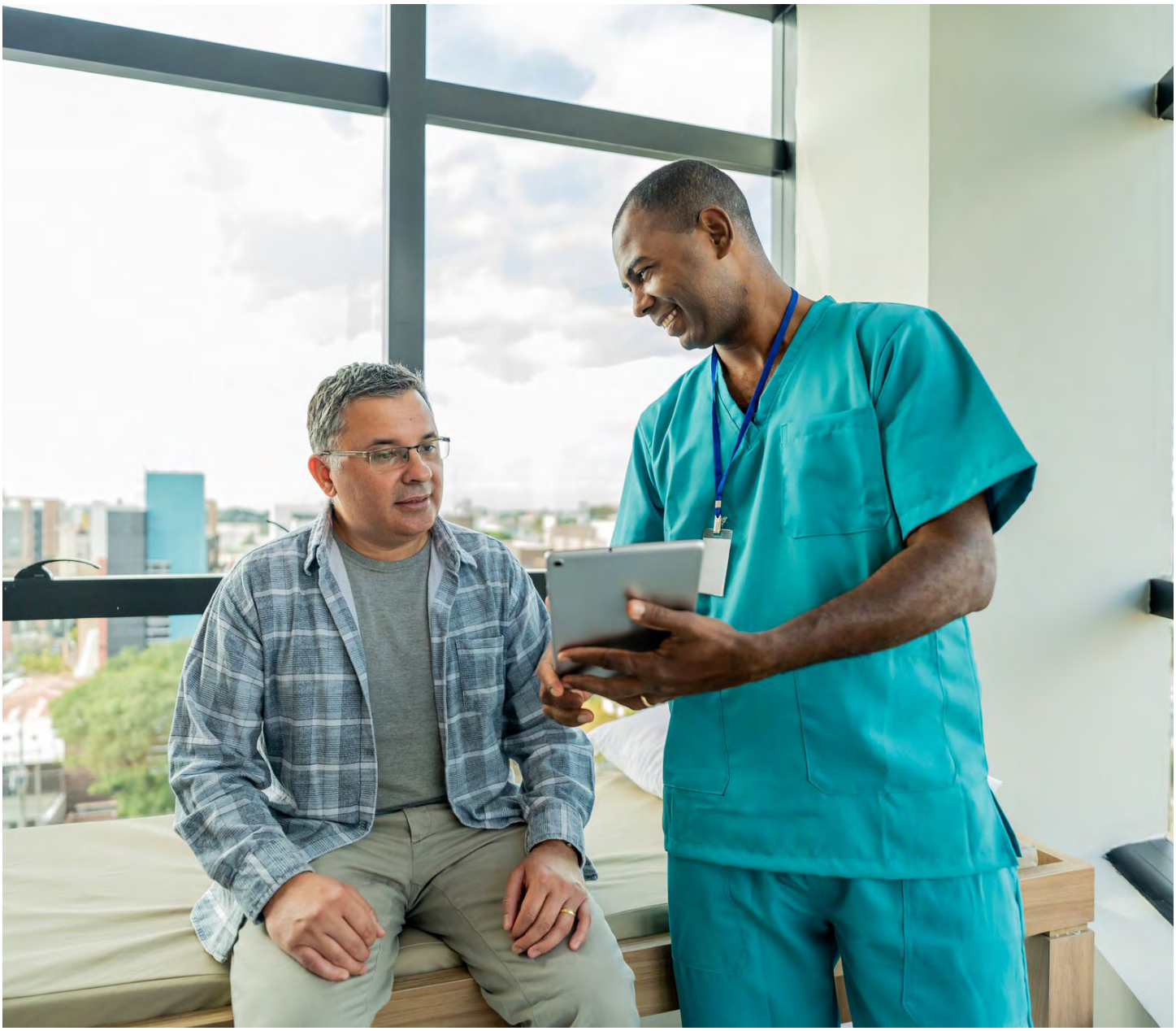
To learn more about the health equity efforts at Bristol Myers Squibb, visit https://www.bms.com/content/bms/our-stories/en_us/home/bms-foundation.html

Case Studies

From August 2023 to January 2025, the American Cancer Society partnered with six health systems to support the development of SDOH assessment and referral workflows, improve resource networks, and form community partnerships to address SDOH. Each health system assembled a multidisciplinary project team and received monthly 1:1 coaching from American Cancer Society team members. Every other month, all project participants took part in a virtual learning community to learn from subject matter experts and one another.

These health systems were geographically, structurally, and culturally diverse. Some organizations served large rural populations, while others represented very urban areas. Some were academic, some NCI designated, and one was a private community oncology practice. This diversity provided great insight into the challenges and opportunities related to implementing this work in a variety of settings.



Case Study

Froedtert & the Medical College of Wisconsin

Organization Overview: NCI and Commission on Cancer accredited, located in Wauwatosa, Wisconsin, serving patients residing in urban and suburban areas

SDOH Assessment and Referral Workflow

Population: Adults who received care within the gastrointestinal (GI) and breast cancer clinics

Tool: Epic SDOH Questionnaire

How Tool Is Administered: GI clinic: Registered nurse administers questionnaire following first health care provider visit. Breast cancer clinic: Registration administers questionnaire at check-in. Current work is being done to implement an electronic push through electronic health records (EHRs) for patients to complete pre-visit.

Frequency: At new patient visit, then every six months

Resource Referrals: Resources are automatically populated and listed on after-visit summary for individuals with positive SDOH screening. Clinical team/health care providers place electronic referral to support teams (social work, dietitian, psychology/psychiatry, etc.) for further support and assessment.

Project Goals:

- Implement SDOH assessment workflows within GI and Breast cancer clinics.
- Utilize EHR push for patients to complete SDOH assessment electronically.

Wins:

- Identified discrepancies in assessment/referral workflows throughout the larger health system/within other departments
- Increased accessibility to SDOH assessment by implementing electronic screening processes
- Created staff survey to better understand current knowledge and beliefs related to SDOH and followed this up with an educational module on what the SDOH domains are, screening tools utilized within the health system, and some resources area organizations provide

Advice for Other Organizations

Acquire health system leadership buy-in early as this will make the process of implementing change much easier to navigate and carry out.

Community Collaborative

Focus: Expanding health system knowledge of community resources to address SDOH and improving referral pathways with community partners

Partners: Local nonprofit and public housing, health, social support, and faith-based organizations that work to address social determinants of health

Wins:

- Receiving real-time feedback from community partners, and understanding barriers at grassroots level
- Identifying community priorities and challenges, and providing a foundation to build stronger collaborations and better connect patients with resources in the future

Project Team:

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Advice for Other Organizations

- Start by actively listening to community organizations to understand their priorities, challenges, and strengths. Recognize that building effective partnerships takes time and requires sustained effort to achieve meaningful outcomes.
- Build trust by consistently engaging and demonstrating a genuine commitment to addressing shared goals; focus on creating clear, actionable plans for collaboration that align with both the health system's objectives and the community's needs.
- Create partnerships with minority and faith-based organizations, which will be invaluable in learning ongoing needs and demands of diverse populations.
- Understand patient navigation and community health workers' role in assisting those with language and cultural barriers.

Case Study

Phelps Health Delbert Day Cancer Institute

Organization Overview: Member of National Cancer Institute Community Oncology Program. American Society of Clinical Oncology QOPI certified. Commission on Cancer and American Society for Radiation Oncology (ASTRO) accredited. Serving patients residing in rural communities in Rolla, Missouri.

SDOH Assessment and Referral Workflow

Population: Adults who received care in the outpatient medical oncology and/or radiation oncology clinic

Tool: Epic SDOH Tool (Health Leads)

How Tool Is Administered: Upon scheduling initial visit, patients receive education regarding the SDOH assessment process. An alert is sent through MyChart asking patients to complete the SDOH questionnaire prior to their first visit. If not completed electronically, registration staff provide patients with a tablet for completion at their visit. Unanswered questions are asked by nursing staff during the rooming process.

Frequency: Radiation Oncology and Medical Oncology: All new patients

Resource Referrals: If screening is positive, the nurse alerts the provider and generates an order in the EHR for ancillary team in real time. The appropriate team member then contacts the patient to discuss needs and offer resources (within five business days). SDOH assessments are discussed weekly during multidisciplinary team meetings. This includes a review of oncology patients receiving active treatment.

Project Goals:

- Eligible patients complete SDOH assessment using electronic tool.
- Patients with a positive SDOH assessment who request assistance receive a referral to at least one supportive resource.

Wins:

- Developing a comprehensive SDOH assessment process
- Meeting goals of electronic SDOH assessment completion
- Providing timely resources to patients/families

Advice for Other Organizations

- Start by focusing on one goal.
- Be intentional with selecting SDOH assessment questions, and limit the number asked when needed.

Community Collaborative

Focus: Patients face unique challenges related to transportation as Phelps Health serves a large, rural area, and Medicaid does not reliably transport eligible members. Transportation is regularly reported as a primary SDOH need among Phelps Health oncology patients. Community collaborative efforts were centered on improving transportation access. This included meetings with a nonprofit transportation organization serving 21 counties in Missouri. There were attempts to explore the possibility of becoming a Medicaid-accredited transportation provider, but there were significant barriers to moving this forward.

Partners: Transportation providers

Wins:

- Discovered a new opportunity to improve transportation access: A nonprofit transportation provider picks up every hour on a public route, and will make a stop at any Phelps Health entrance. Phelps now disseminates this information to patients.

Project Team:

Rhonda Teague, MSN, RN, OCN – Clinical Director

Susan Buhr, MSW – Oncology Social Worker

Lorie Bourne, RDN, CSO – Oncology Dietitian

Kevin McDonough, BSN, CAC – Oncology Financial Navigator

Nicole Miller, BSN, RN, OCN – Oncology Nurse Navigator

Hillary Black, RN, OCN – Medical Oncology Services Manager

Dana Weaver, BS, RT(T) – Radiation Oncology Services Manager

Jodie Sapaugh, MHSM, MBA – Director Clinical Quality and Measurement

Nicole Pigg, MA, CCM – Senior Epic Analyst

Advice for Other Organizations

- Think big!
- Be open to new ideas.

Case Study

Sidney Kimmel Cancer Center – Jefferson Health

Organization Overview: NCI and Commission on Cancer accredited, serving patients residing in urban, suburban, and rural areas in Philadelphia, Pennsylvania and surrounding communities

SDOH Assessment and Referral Workflow

Population: Adults who received care at designated Sidney Kimmel Cancer Center clinics

Tool: Epic SDOH Tool (Health Leads)

How Tool Is Administered: New patients are assessed by social workers. Existing patients in active treatment receive the assessment via MyChart prior to established oncology visits. Oncology social workers also look for missing SDOH assessments and complete them as part of routine practice.

Frequency: Upon diagnosis, and annually thereafter

Resource Referrals: Patient-reported outcome questions are integrated into the oncology navigation care plans, and risk scores feed directly into the Epic SDOH dashboard. Oncology navigators make referrals to social workers and other internal team members. Social workers provide additional support and complete external referrals.

Project Goals:

- Patients will respond to the four health-system identified priority domains on the SDOH screening tool (transportation, housing, food, and social connections) at least once per year.
- Patients with positive SDOH needs will receive at least one referral to a supportive resource.

Wins:

- Collaboration with Ambulatory IT to create a portal push assessment and referral workflow
- Prioritization of SDOH as a quality metric, and elevation of health equity as a priority within the health system
- Further development of a robust, supportive oncology care team

Advice for Other Organizations

- Collaborate across multiple departments; this is key. This could include quality improvement, health informatics, health equity officers, etc.
- Consider who is missing in screening (i.e., non-English speaking patients).
- Determine how other existing tools will be impacted by SDOH assessment tool/ workflows (i.e., NCCN distress thermometer).

Community Collaborative

Focus: Partnered with a local nonprofit organization to implement and evaluate a culinary medicine program called Come Sano, Se Feliz (Eat Healthy, Be Happy). This 12-week class focused on nutritional, plant-based cooking; the promotion of healthy eating habits; and education on how diet can lower an individual's risk for developing cancer. The entire class was held in Spanish. The evaluation (also provided in Spanish) included measures of cancer-preventive dietary choices, cooking confidence, and cooking behavior.

Partners: Local nonprofit organization that focuses on improving the health of underserved families through the integration of health education, mental and physical wellness services, spiritual enrichment, and community referrals

Wins:

- The partner organization was so appreciative and wants to expand this partnership to include routine culinary medicine programs.
- Further expansion of this program concept is planned for the Chinese community.

Project Team:

Munjireen Sifat, PhD, MPH – Assistant Professor, Assistant Director of Community Outreach and Engagement for Sidney Kimmel Cancer Center

Rebecca Cammy, MSW, LCSW – Program Director Psychosocial Care and Oncology Social Work

Advice for Other Organizations

Forming a community advisory board is key to ensuring any activities are successful; they are the ones who know their community's needs.

Case Study

Texas Oncology

Organization Overview: An Enhancing Oncology Model participant, serving patients residing in urban, suburban, and rural areas across the entire state of Texas and southern Oklahoma

SDOH Assessment and Referral Workflow

Population: Adults who received care at any Texas Oncology clinic

Tool: Screening adapted from the National Comprehensive Cancer Network Distress Thermometer and Problem List and PHQ-2

How Tool Is Administered: Medical Assistants run reports from the EHR identifying which patients need to be screened. Once identified, patients are provided the assessment tool at the time of their visit with the provider.

Frequency: Every three months

Resource Referrals: Patients with identified SDOH are referred through the EHR to the social work team (patient resource coordinators or master's level social workers) for additional support. The extent of social work support provided is determined in some part by availability and accessibility to appropriate community resources. At locations where patients do not have access to social work support, positive screenings are addressed by nursing staff by relying on a behavioral health partner and an internal resource database.

Project Goals:

- Patients with a positive SDOH screening have a documented intervention plan.
- The Patient Resource Coordinator role should be developed so that staff can fully address patient practical needs without referring them to other team members.

Wins:

- Created an interdisciplinary team to review and address the SDOH workflow process in order to increase efficiency and productivity, improve patient outcomes, and provide adequate resources to patients
- Piloted electronic SDOH assessment to improve patient accessibility

Advice for Other Organizations

- Survey staff regarding current and potential assessment tool(s) to be utilized to ensure understanding and uncover barriers to use.
- Shadow staff to observe how assessment tool(s) is/are being administered and interpreted in real time.
- Include the staff responsible for executing workflows in the planning, implementation, and revision of workflow processes.

Community Collaborative

Focus: Structured round table discussions and vendor fairs in three different communities to explore barriers to accessing oncology care, examine existing community resources, and identify gaps in resource offerings

Partners: Other health systems, home health agencies, and a wide variety of public health, government, and nonprofit organizations

Wins:

- Establishing a safe environment for community agencies to network and form partnerships, and uniting key community stakeholders
- Providing internal and external education on resource availability

Project Team:

Jazmin Graham, LCSW-S – Manager of Patient & Community Engagement

Emily Pearcy, LCSW-S, OSW-C – Director of Social Work

Lance Ortega, MBA, BSN, RN, OCN – Executive Director

Advice for Other Organizations

- Start by conducting a needs assessment.
- Engage with the community to understand existing resources and promote education and awareness.

Case Study

UCSF Health

Organization Overview: NCI and Commission on Cancer accredited, serving patients residing in urban settings within the greater San Francisco area

SDOH Assessment and Referral Workflow

Population: Adults who receive care at the Berkeley Outpatient Center (BOPC). The BOPC patient population is primarily breast medical and surgical oncology, gynecologic medical and surgical oncology, head & neck, and endocrine.

Tool: SDOH survey with targeted domains: financial, food, housing, and transportation. Patient responses are captured in Epic SDOH screening wheel.

How Tool Is Administered: The SDOH survey is sent to new patients through Epic and to existing patients annually after last completion date.

Frequency: At initial diagnosis, and annually thereafter
Resource Referrals: All patients screened for SDOH needs receive a message with information about how to search for SDOH resources on the UCSF Findhelp platform and how to reach out for help – by contacting either the Patient Navigator, Social Work, and/or Cancer Support Center. The Patient Navigator uses the patient's SDOH survey responses to address their needs by providing a list of resources or making a referral. The Patient Navigator will triage patients with complex needs to relevant departments – Social Work, Financial Services, Psycho-Oncology, etc.

Rather than focusing on improving SDOH survey completion rates, efforts were focused on reaching all patients screened for SDOH needs with clear messaging about how to search for resources and seek help.

Project Goals:
- Proactively reach out to new and existing patients who are screened for SDOH needs, regardless of survey completion.
- Provide tailored support to patients who request post-assessment help.

Wins:
- Standardization of scripting for communication to ALL new patients regarding resources
- 769 patients contacted to follow up on SDOH needs
- Established pilot workflow used as framework for organization-wide expansion of SDOH efforts

Advice for Other Organizations

- Be willing to experiment and try new strategies, depending on what your findings show.
- Ensure organizational buy-in for BOTH screening AND connection to resources.
- Find ways to protect time for dedicated staff to focus on efforts, especially early on.

Community Collaborative

Focus: Community Advisory Board (CAB) affiliated with the UCSF Office of Community Engagement

Partners: CAB membership includes 14 community-based organizations (CBOs) from UCSF areas focused on serving cancer population and improving access to resources and support.

Wins:

- Presentations at the Office of Community Engagement meeting to CAB partners
- An in-person presentation at the Women's Cancer Resource Center, one of the partner CBOs, to approximately 100 attendees, most of whom are leaders in other community organizations
- Working collaboratively with community partners to put together a list of low-cost and free therapy resources that was shared with Psycho-Oncology Department

Project Team:

Katherine Chang, MBA, BSN, RN – CPHQ Associate Director of Clinical Operations (Co-Lead)

Keren Stronach, MPH – Cancer Services Patient Experience Manager (Co-Lead)

Sarah Francke, BSN, RN, OCN – (Co-Lead)

Audrey Connell – Patient Navigator

Erin Schwartz, LCSW – Social Work Manager

Sam Walker – Data Warehouse Manager

Kim F. Rhoads, MD, MS, MPH – FACS Associate Director, HDFCCC (PI)

Advice for Other Organizations

Explore forums where partnerships already exist, and ask to join to harness and strengthen existing connections.

Case Study

UF Health Jacksonville

Organization Overview: Serving patients in urban, suburban, and rural communities within the greater Jacksonville, Florida, area. UF Health Jacksonville is accredited through the Commission on Cancer and the National Accreditation for Breast Cancer Program.

SDOH Assessment and Referral Workflow

Population: Adults who received medical oncology, radiation oncology, or surgical oncology care at the main UF Health campus (located in downtown Jacksonville) or at any of five other off-site oncology clinics covering a broad geographic location and community type

Tool: The NCCN distress thermometer with a customized problem list

How Tool Is Administered: All new patients are given an iPad by registration at their first outpatient consult visit for completion of the SDOH assessment (a paper copy is provided as needed). Results automatically populate in Epic if completed via iPad and are scanned into the chart if completed on paper. Established patients identified as needing reassessment are screened by the nurse or medical assistant.

Frequency: At first visit, then at any point during care where staff feels they may have additional needs or are experiencing distress

Resource Referrals: The Medical Assistant reviews the results of the SDOH assessment when completed by a new patient. Any identified clinical needs are addressed immediately by the provider. Automatic referrals populate for certain physical concerns, such as rehab/PT. Patients with needs that cannot be addressed immediately, or who need additional resources, are referred to social work for review and referral.

Goals:

- Eligible patients complete the SDOH assessment
- Improved completion rate of SDOH assessment using EMR to facilitate automatic referrals

Wins:

- High SDOH assessment rate across all clinics
- High electronic versus paper screening rates
- Increase in referred services made available to help patients with identified SDOH needs

Advice for Other Organizations

- Get key stakeholder buy-in first to champion project (i.e., IT, providers).
- Have a plan for addressing a broad range of SDOH needs prior to implementing an SDOH assessment workflow, and don't be afraid to think outside the box with how needs can be addressed.

Community Collaborative

Focus: Collaborated with a variety of community partners to host health fairs and cancer screening events. Attendees were able to receive information on community and hospital resources geared toward cancer prevention and treatment. In addition, attendees were asked to complete a modified SDOH assessment focused on resource needs and gaps. This allowed for comparison of reported community needs with those identified in the clinics.

Partners: Nonprofit and faith-based organizations, public health entities

Wins:

- Increasing total breast cancer screening and event attendance by 30%
- Offering a broad range of programming to identify and address the needs of the community

Project Team:

Miki McClain RN, BSN, MHA, MBA – Project Lead

Faith Higgins, MPA – Co-Lead & Community Collaborative Coordinator

Valisa Owens, LCSW-QS – Social Services

Janice Hargrove, CTR – Data Management

Advice for Other Organizations

- Be open to unique partnerships and collaborations.
- Do not get discouraged by expected attendance (or lack thereof).
- Have incremental goals within partnerships that recognize and strive toward meeting both; this helps to build a more cohesive and lasting partnership.
- Continue partnership and learning with other health systems to ensure the success and continued care of patients, which is why this type of collaborative project is so beneficial.