Let's Take 5

TO ADDRESS DRIVERS OF HEALTH

Take 5 Steps
Implementation Guide

Addressing drivers of health (DOH) requires a physician's full team to prepare, connect with patients, offer resources and follow-up. While it may seem daunting, having the right strategies and structures in place can help health care teams to effectively support patients.

Explore the *Let's Take 5 Steps Implementation Guide* to integrate clinically validated workflow approaches for DOH patient screenings and navigation in your practice that may be factored into reimbursement for your time spent addressing DOH.

The 5 Key Types of Drivers of Health

Food Security

Housing Stability

Transportation Access

Utilities Access

Interpersonal Safety

1. PREPARE YOUR PRACTICE FOR INTEGRATION
2. DESIGN YOUR SCREENING PROCESS
3. ESTABLISH A REFERRAL PROCESS
4. IMPLEMENT YOUR DOH SCREENING PROCESS
5. SUBMIT TO THE CMS MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

1 PREPARE YOUR PRACTICE FOR INTEGRATION

DOH screening will involve multiple members of your staff. It is important to discuss screening with everyone to set expectations and create an efficient and effective process. Be sure to assign roles and responsibilities, including identifying organization leaders and clinic champions, for each team member based on their expertise.

Part of this preparation should include understanding your current state, defining scope and establishing specific process and outcome goals. Start with a series of questions to determine what is possible for your practice and the community that makes up your target population.

For more recommendations, view the American Hospital Association's toolkit on guiding teams to engage patients.

Refer to The U.S. Playbook to Address Social Determinants of Health for more information on gathering and sharing data related to DOH (pages 19-23).

Learn about more structural factors that influence a patient's health with the Structural Vulnerability Assessment Tool (SVAT).

2 DESIGN YOUR SCREENING PROCESS

To begin, select an existing, validated screening tool(s) for your practice and educate staff to ask these questions. Next, establish your data collection method for this process.

To help standardize the DOH data that you collect, several EHR vendors have integrated various validated screening tools in their platforms, such as Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE®) screening tool. Also, keep in mind that there are DOH-related Z-codes that you may be able to input into your EHR that may help you to be reimbursed for your time and further establish the clinical complexity of your patients. See a list of these Z-codes here.

There are a lot of screening tools out there. Pitch the model that will work best for your practice and community. Here are some templates:

- PRAPARE®'s Implementation and Action Toolkit
  - Chapter 4, which begins on page 34, covers EHR systems that have PRAPARE implemented for digital collection.
  - Additionally, page 36 includes a link to an Excel data collection template for manual compilation.
- Health Leads: Social Needs Screening Toolkit
  - This toolkit includes a free, editable screening template.
- SIREN Social Needs Screening Tools Comparison Table (Pediatric Setting)

3 ESTABLISH A REFERRAL PROCESS

For the referral process, it is essential for your team to know the resources that are available in your community to address the key five DOH areas. It is also critical to develop relationships with community organizations to enable referral. This process may include identifying a Community Health Manager/Worker who can help patients navigate and access community resources and social services.

As part of setting up referral workflows, select an existing referral platform or database to streamline this process for your practice and patients. These platforms or databases often include validated lists of community-based organizations and may also offer care management and data collection functionalities.

SIREN has developed a guide that explores the landscape of community resource referral platforms, including recommendations to implement a community resource referral platform.

4 IMPLEMENT YOUR DOH SCREENING PROCESS

As your team begins your implementation process, start small. Use your existing quality improvement processes for your DOH screening process. Be open and flexible to modifying your workflows.

A critical step in implementation is having empathetic conversations with patients to collect data, offer community resources and empower patients to address their needs. After assigning who from your team will be leading these conversations, they should start connecting with patients one-on-one. View our Let's Take 5 Conversation Starter to prepare teams to have empathetic and empowering conversations with patients about DOH.

As your team begins your process to scale your screening, consider your patient population, your workflows, the capabilities of your technology and the capacity of your team, so you can make this a positive experience for your practice and patients. Be sure to refer to your process measures and goals established during the preparation stage to understand how your screening process is working and if your organization is ready to scale.

5 SUBMIT TO THE CMS MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Physicians have the option to report administering and screening for DOH measures through quality payment. As an alternative to reporting six individual measures, practices, medical groups, hospitals and health systems may report DOH measures within one Specialty Measure Set.

Physicians can report DOH screenings to quality payments through two measures: Screening for Social Drivers of Health and the newly finalized Connection to Community Service Provider. Detailed information on these measures can be found here.

Physicians may now bill for administering a DOH risk assessment with a new stand-alone G code from CMS (G0136). CMS also created two Community Health Integration service codes for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs (G0019 and G0022). CMS Medicare Learning Network provides detailed information on these codes here (pages 5-9).

The Physician Advocacy Institute (PAI) offers a MIPS Pathway resource that provides on general reporting mechanisms and the various specialty measure sets that you can submit.

CMS continues to improve DOH measurement and to evolve the submission process. Follow The Physicians Foundation to stay informed about our continued efforts around DOH reimbursement and to help eliminate burdens that many physicians face.