DEPARTMENT: Doylestown Healthcare Partnership

FACILITY:

DATE OF ORIGIN: 11/1/2019 NEXT REVIEW DATE: 11/1/2020

AUTHOR (ROLE): ADM Director DHP

APPROVED BY (ROLE): Network Development / DHP Managing Committee

PURPOSE:

The social determinates of health are the non-medical factors that influence health outcomes. Assessing social determinants of health is fundamental for improving health.

SCOPE:

This policy applies to all Doylestown Healthcare Partnership Primary Providers.

POLICY:

Patients should be assessed for social determinates of health at a minimum of an annual basis and documented in the EMR.

PROCEDURE:

- 1. During an annual visit patients should be assessed for the following items:
 - a. Exercise and Physical Activity
 - b. Bladder Control
 - c. Emotional Health
 - d. Financial
 - e. Medication management
 - f. Social support
 - g. Food insecurity
 - h. Loneliness/lack of primary support group
 - i. Housing instability and problems with economic circumstances

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- a. eCW screenshots for documentation (Appendix A)
- b. Bill appropriate coding
 - i. Z55 Problems r/t education and literacy
 - ii. Z56 problems r/t employment and unemployment
 - iii. Z57 occupational exposure to risk factors
 - iv. Z59 problems r/t housing and economic circumstances
 - v. Z60 problems r/t social environment
 - vi. Z62 problems r/t upbringing
 - vii. Z63 other problems r/t primary support group, including family circumstances
 - viii. Z64 problems r/t certain psychological circumstances
 - ix. Z65 problems r/t other psychological circumstances
- 3. Resources for identified Social Determinants of Health (Appendix B)

References: AHA Resources on Social Determinants of Health

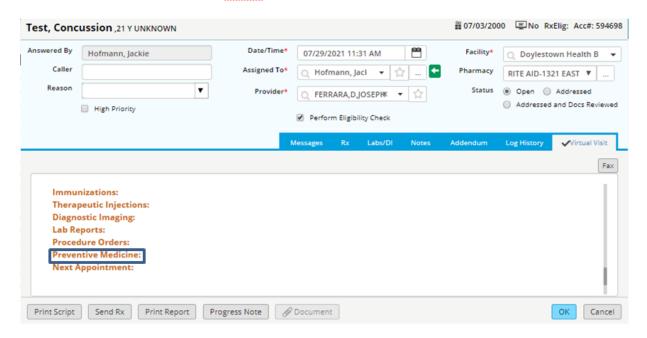
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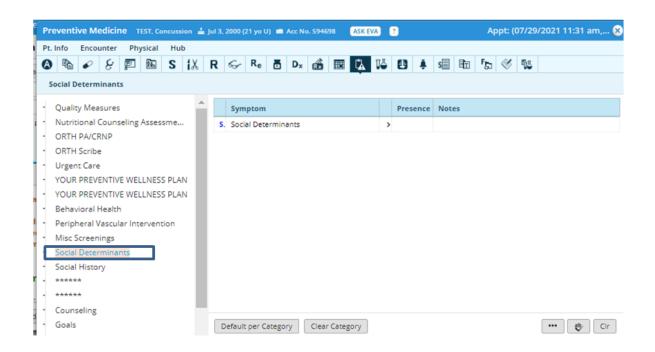
Revised:

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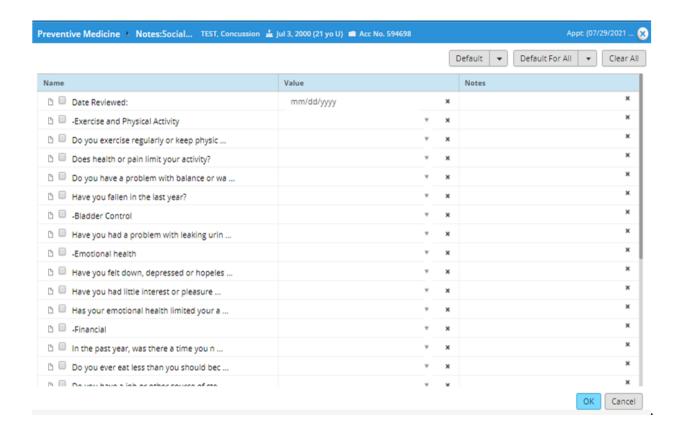
Appendix A

SDOH Questionnaire in eCW





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Appendix B

Resources for Patients for SDOH

Food

Fresh Connect: every Thursday 11am-noon in Ottsville (corner of 611 and 412) – weekly outdoor food pantry/farmer's market. Registration on site. There is also one in Warminster every Tuesday.

Feeding America Food Banks – ww.feedingamerica.org

Women, Infant and Children – www.fns.usda.gov/wic

School Breakfast Program – www.fns.usda.gov/sbp/school-breakfast-program

Supplemental Nutrition Assistance Program (SNAP) -

www.fns.usda.gov/snap/supplemental-nutrition-assistance-program

Anxiety/Mental Health/Loneliness and Social Isolation

Bucks County Covid-19 Behavioral Health Helpline 215-399-5681 (M-F 8:30-4:30)

PA Dept of Health Helpline Text PA to 741-741

Connect2Affect – AARP – *connect2affect.org*

Friendship Line - www.ioaging.org

Senior Citizens

Area Agencies on Aging - Bucks County - 267-880-5700 - buckscounty.org

Eldercare Locator – *elgercare.acl.gov*

General help:

211 Helpline Center – www.helplinecenter.org

<u>www.findhelp.org</u> enter zip code in website, offers help for food, baby products, transportation, etc.

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Payer Resources

Tandigm

All Complex Care Management Referrals go to the Nurse Care Manager (NCM) (NP, Field based RN, Social Worker, Pharmacist, BH, SNF based clinicians)

To Refer:

1.844.TANDIGM or 1.844.826-3446.

Risk Strat Tool in Tandigm Connect (be sure to enter reason for referral & important information in the comment section

Aetna

BH Case Management: 1-866-326-7195 (m-f, 8a-5p)

Resources for Living: 1-866-370-4842 (TTY: 711) (m-f, 8a-9p)

Disease Management program: Member diagnosed with one of four main conditions (DM, CVA, CVD, CHF)

1-866-269-4500, chose option #1

Provider can fax referral to: 1-860-754-5559

AccordantCare program: Call or fax referral to 1-866-247-1150

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