Addressing Health Equity and Social Determinants of Health (SDOH) In Healthcare Settings

An introductory resource guide for providers and staff

Prepared by the Montana Department of Public Health and Human Services Chronic Disease Prevention and Health Promotion Bureau

Table of Contents

2 Table of Contents

3 DISCLAIMER

4 Introduction to SDOH and Health Equity.

5 Key Definitions

7 SDOH Screeners

9 Social Need Screening Tools Comparison Table Intro

10 Social Need Screening Tools Comparison Table10

11 SDOH Assessment with AWVs

12 Z Codes – Common Z-codes and why they are useful

13 Referral Process for Patient’s Documenting SDOH Need

14 Trainings to fit any work schedule.

Implicit Bias, Cultural Competency, Health Equity Guidance, Health Literacy, Community Relationship Building

17 Health Equity Roadmap

20 Toolkits/Guides

22 Research Articles

23 Medical Coding Guidance

24 Linked Resources

25 General References

DISCLAIMER

The following resource guide is a collection of information gathered from a wide range of respected sources for the purpose of providing education to healthcare professionals on topics associated with health equity and SDOH. We recognize that there is a vast amount of information from which to draw upon and hope that you will see this document as a means for introducing material and encouraging additional research into the topics discussed.

Introduction to SDOH and Health Equity

Being healthy means more than not being sick. Good health begins where we live, learn, work and play. Complex social factors and deeply ingrained systemic barriers are such powerful influences that people in some communities will die 20 years earlier than others living just a few miles away. The risks begin at birth and continue across the lifespan because stable housing, quality schools, access to steady jobs, neighborhood safety and accessible culturally competent healthcare are inequitably distributed. Building a 'Culture of Health' means working together to dismantle barriers so that everyone has the chance to live the healthiest life possible. This means everyone, no matter their background, should have access to the resources they need to create conditions that support good health and well-being (RWJF, n.d.).

In Montana, an added focus is necessary for the most vulnerable populations, which include American Indians, people with low-income, people with disabilities, veterans, the aging population and those living in rural/frontier communities across the state.

When healthcare, public health, and social services work together we have our best chance to fully address the medical, as well as non-medical, factors that contribute to a person's whole well-being. View the Health Equity Scale short video with an overview of how a person's SDOH factors contribute to disparities and health inequities.

Key Definitions

There are three important definitions that will help with one's greater understanding of why health equity and social determinants of health play an important role in healthcare and impact patient outcomes – the terms are equality, equity and justice.

Health Equity (HE): 'The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities' (Healthy People 2030). Care that meets the patients where they are at, regardless of location, socioeconomic status, gender, and many other characteristics and social drivers.

Social Determinants of Health (SDOH): Non-medical factors that influence outcomes. Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. By addressing the underlying issues that prevent people from being healthy, we are working towards health equity.

Health Disparities: Differences in health outcomes between groups that reflect social inequalities (CDC.gov).

Implicit Bias: a.k.a. unconscious bias - operates outside of the person's awareness and can be in direct contradiction to a person's espoused beliefs and values. A negative attitude towards a specific social group. What is so dangerous about implicit bias is that it automatically seeps into a person's affect or behavior and is outside of the full awareness of that person. The National Center for Cultural Competence explains that implicit bias can interfere with clinical assessment, decision-making, and provider-patient relationships such that the health goals that the provider and patient are seeking are compromised. An example of implicit bias is that often, overweight people are labeled as lazy, weak, and lacking self-control. Healthcare professionals may blame serious health issues on weight, therefore, unintentionally ignoring other possible causes. See also **Explicit Bias.**

Patient-Facing: Medical and pharmaceutical materials targeted at patients as end users who may not be familiar with terminology and procedures. The reading level in Montana for patient-facing information is 6th grade or below.

Z-Codes: Z codes (i.e., Z55-Z65) are a set of ICD-10-CM diagnosis codes used in medical billing and documentation to report patient factors that are NOT medical but affect patient health and health-related outcomes. These include social, economic, and environmental determinants.

Priority Populations: Population groups at risk of socially produced health inequities. Examples include American Indian/Alaskan Native, African American/Black, Asian/Pacific Islander, Hispanic/Latino, LGBTQ, veterans, people with disabilities, rural/frontier populations, and those with certain medical conditions.

Health Literacy: For many years, health literacy was defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Healthy People 2010 and 2020). More recent definitions focus on specific skills needed to navigate health information and systems and on the attributes of health organizations and systems to enable understanding and action. Healthy People 2030 defines it as:

Personal health literacy: the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Organizational health literacy: the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

SDOH Patient Screeners

SDOH can contribute to wide health disparities and inequities. A first step towards addressing SDOH in any healthcare setting is learning about the lived experience of patients. Understanding the individual societal risk factors that impact your patients and screening for SDOH can help your team determine the best strategies for addressing them. Healthy People 2030 (HHS) separates social risk factors into 5 domains:

- **Economic Stability**
- **Education Access and Quality**
- **Healthcare Access and Quality**
- **Neighborhood and Built Environment**
- **Social and Community Context**

In healthcare settings, specialized screening tools can allow providers and teams to assess and monitor social needs and risk factors of patients. Validated SDOH screening tools can be used on their own or be a jumping-off point for organizations developing their own customized surveys. Several validated SDOH screening tools that are available for download and printing are described below:

PRAPARE Implementation and Action Toolkit compiles resources, best practices, and lessons learned from health centers focused on how to implement a SDOH data collection initiative. The toolkit is accompanied by an assessment tool.

American Academy of Family Physicians (AAFP) Social Needs Screening Tool is a 15-item questionnaire that assesses housing, food, transportation, utilities, and personal safety. The survey also looks at factors like employment, education, childcare, and financial strain. AAFP also hosts a short-form questionnaire that asks 11 questions. The form is available in English and in Spanish. AAFP also offers an assistive guide in how to implement SDOH screening in a clinic.

The Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool is made by the Centers for Medicare & Medicaid Services (CMS) and has 10 questions. The questions in the AHC HRSN Screening Tool are meant to be used for individual respondents who answer the questions themselves. A parent or caregiver can answer for an individual, too, if that makes more sense. Clinicians and their staff can easily use this short tool as part of their busy clinical workflows with people of all different ages, backgrounds, and settings.

HealthBegins Upstream Risk Assessment Tool is a paper-based tool that comes with suggested workflows. The survey is a free PDF and offers recommendations about screening frequency, scoring instructions, and a framework for getting surveying up and running in clinics. However, it is rated with 11th grade reading level.

The Structural Vulnerability Assessment Tool is a tool developed by researchers at UCLA to help providers screen for and then address SDOH. This survey is 43 questions long and assesses needs across six domains, including economic stability, education, social and community context, health and clinical care, neighborhood and physical environment, and food security.

The WellRx Toolkit was developed as a pilot in the Office for Community Health (OCH) at the University of New Mexico in Albuquerque. The tool can be used within the electronic health record (EHR) or on paper and includes user access to community resources to address identified social needs. It looks at key SDOH domains. It was designed to be offered at a third-grade reading level, poses questions in a yes-or-no format, and has been translated into Spanish.

Kaiser Permanente's Your Current Life Situation (YCLS) Survey is a 32-question survey that looks at six domains of SDOH, including economic stability, education, social and community context, health and clinical care, neighborhood & physical environment, and food security. The survey is available via some EHRs, patient portals, or on paper.

The EveryONE Project Toolkit – A Guide to Social Needs Screening (AAFP) is a very good summary about SDOH screening and steps you can take as you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team

World Health Organization, About Social Determinants of Health

Social Need Screening Tools Comparison Table Intro

Developed by UCSF SIREN (Social Interventions Research & Evaluation Network) Last updated: May 27, 2023.

Visit the SIREN website

The SIREN team has compiled the content of several of the most widely used social health screening tools so that they can be easily compared (see following page). The "Domains" tab summarizes characteristics for each tool, including their intended population or setting, the social health domains they cover, and the number of questions covering each domain. A note on validity: Inclusion of a tool does not necessarily mean that the tool or the questions contained therein has been “validated”. While some questions and tools have been developed more rigorously than others and have some early evidence of validity, validity has many different dimensions (e.g., criterion validity [predictive, convergent], construct [structural]), and none of the tools below has been vetted through all steps of gold standard measure development or had all types of validity assessed. As data about tool validation become available, we will include them in the table below.

	PRAPARE	AAFP- Tool	AHC-Tool	HealthBegins	Structural Vulnerability Assessment Tool	WellRx	Your Current Life Situation
Number of social needs questions	17	15	19	24	37	10	19
Number of non-social needs questions	4	0	8	4	6	1	10
Patient or clinic population	Community Health Centers	Non-specific	Medicare and Medicaid	Non-specific	Non-specific	Primary care	Non-specific
Reading Level	8th grade	7th grade	8th grade	11th grade	6th grade	2nd grade	9th grade
Reported Completion Time	NR	NR	NR	NR	NR	NR	NR
Additional Languages	32 other languages					Spanish	
Scoring	N	Y	Y	Y	N	N	N
Cost	Free	Free	Free	Free	Free	Free	Free
Domains							
Benefits					2		
Caregiver responsibilities							1
Childcare access and affordability	1	1				1	1
Civic engagement				1			
Clothing	1						
Disabilities			2				
Discrimination					4		
Education	1	1	1	3	1	1	
Employment	1	1	1	1	3	2	
Financial strain		1	1	2	3		1
Food insecurity	1	2	2	1	1	1	3
Health care/medicine access and affordability	2						2
Housing insecurity/instability/homelessness	2	1	1	2	2	1	2
Housing quality		1	1	1	1		1
Immigration / Migrant status / Refugee status	2			1	3		
Incarceration	1				1		
Income	1						
Interpersonal violence (IPV)	1	4	4	4	1	2	3
Literacy					3		1
Neighborhood safety	1			1	4	1	1
Power of attorney/guardianship							
Social support	1		2	5	2		5
Stress	1		1	1			2
Transportation	1	1	1	1		1	2
Utilities	2	1	1			1	1
Veteran status	1						
Workplace safety					2		
Health behaviors/behavioral health/ health status			MH, PA, SU	DP, PA		AA, SA	

AU: Alcohol Abuse, DP: Dietary Pattern; DU: Drug Use; HC: Health Confidence; HS: Health/functional status; MH: Mental Health (including depression), PA: Physical Activity
TU: Tobacco Use *Reading level assessed using http://www.readabilityformulas.com/free-readability-formula-tests.php.

SDOH Assessment with Annual Well Visits (AWVs)

CMS has established a G code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an evaluation and management (E/M) visit. The SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using ICD-10-CM Z codes. Required elements would include administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

CPT Code G0136: Providers can receive an additional $18.66 for assessing SDOH during an AWV. For the patient, this assessment is fully covered by Medicare when provided with an Annual Wellness Visit (AWV). To claim this CPT code, providers must:

- Deliver 5-15 minutes of SDOH discussion
- Not assess a patient more than every 6 months
- Administer a standardized, evidence-based SDOH risk assessment

Medicare stresses the importance of following up with patients about SDOH and working to connect them with available resources. (see the section on Referral Process for Patient's Documenting SDOH Need). This reimbursement is not yet available for Medicaid patients in Montana.

Z Codes – Common Z-Codes and why they are useful

The Z-codes (a special group of ICD-10 codes) are surfacing throughout healthcare as one useful option for coding the SDOH that impact a patients' overall health, as identified by conversations with a patient or by use of SDOH screening tools. If this information can be collected and coded, then it is far less complicated for a provider to pull reports and do data analyses – analyses that can hopefully improve the quality of care, provide care coordination involving community services integration and impact social factors that all work in coordination to allow a patient to experience improved health outcomes.

SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data such as housing (Z59.1-Z59.3), food insecurity (Z59.4), and transportation insecurity (Z59.82). These codes should be assigned when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health.

Positive screening results should be entered into the patient's electronic health record (EHR), and there should be follow-up discussions and referrals to social services to meet an individual's needs. There is some skepticism out there around the additional administrative burden of coding SDOH data. While it may be true that Z codes are not reimbursable yet at the healthcare clinic level, many recognize that using Z codes can be an important step and have a big impact on the ability to advocate for changes in billing and payments to support the needs of patients – all while helping health systems to gain insights on patient social risk factors and unmet needs, and community demographics and support systems.

Referral Process for Patient's SDOH Need

Once a patient completes a SDOH screener tool and it is noted that they have a need for a specific social service, a care manager or provider will have a discussion with the patient to further understand that need, then scan their available resources for referral options to specific community services that can help fill the need. Ideally the care manager or provider provides a warm handoff of a referral(s), then follows-up to determine whether the patient accessed the social service and track the process from start to finish.
A provider's office/staff should have a list of services that may benefit patients with social needs, as well as information on reaching general resources via 211 or findhelp.org. A bi-directional referral system (i.e. the CONNECT Referral System), which allows for the provider and community-based organization to communicate directly is the very best action to help a patient as they navigate services. The National Resource Directory is a database of validated resources that supports recovery, rehabilitation, and reintegration for service members, veterans, family members, and caregivers. AAFP's Neighborhood Navigator uses this interactive tool at the point of care to connect patients with supportive resources in their neighborhoods. If done well, referrals provide important and timely recommendations for addressing patient social needs without undue burden for clinicians or patients.

Trainings to Fit Any Work Schedule

Integrating SDOH, Implicit Bias, Cultural Competency, Health Equity Guidance, Health Literacy, Community Relationship Building

Foundational Trainings from the SDOH Academy, a HRSA funded virtual training series. They provide seven video trainings to lay the groundwork for health centers, primary care associations, and health center-controlled networks to integrate SDOH interventions into their clinics and communities. These are older 2018-2020 (approx. 1.0-1.5 hrs each), but contain a lot of useful information.

The SDOH Academy National Webinar Series: These are the more recent webinars (2023-2024) from the SDOH Academy. These four sessions (approx. 1.5 hrs each) will highlight promising practices and increase knowledge around incorporating and scaling innovative approaches to new and emerging issues related to non-medical drivers of health.

Detailed Core Competencies Responding to the Social Determinants: This one page document details four core competencies for health centers and primary care associations to be used as a framework for SDOH training and technical assistance. They reflect research, trends, and expertise in the health center field.

North Dakota Health Equity Training Initiative: Course 2 - Bias: Upon completion of this program, the learner will be able to: define implicit and explicit bias and understand why they are important, list key principles of bias, list types of biases and work through examples, define terms associated with bias, such as microaggressions or stereotypes, and explain the two main strategies for dealing with bias and go through some engaging activities to check your bias. It is a web- based self-study course that is approx. one hour in length.

Project Implicit – The Implicit Associations Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report by measuring the strength of associations between concepts.

Unconscious Bias course to help you address your personal unconscious bias, teach you about microaggressions, provide a solutions toolkit, develop your self- awareness, and discuss bias and disparities; five modules.

Racism, Bias, and Other Determinants of Health: Issues and Actions (On-demand webinar): This webinar discusses racism and social determinants of health, and the role bias plays in healthcare decision making as well as its impact on adverse health outcomes. They discuss how our backgrounds inform our perspectives and how we relate to patients. They explore strategies that students and physicians can employ to mitigate bias. There are two modules: a content module and a resources and evaluation module. After accessing both modules, learners will earn a certificate of completion.
The recording is approximately 90 minutes. There are no prerequisites.

Cultural Competency Training - Understanding, supporting and embracing the social, language and cultural diversity is cultural competency. Cultural competency training for health care professionals focuses on skills and knowledge that value diversity, understand and respond to cultural differences and increase awareness of providers' and care organizations' cultural norms. The Colorado School of Public Health; The Center for Public Health Practice has numerous trainings available that list healthcare providers as a part of their target audience.

Empathic Inquiry: Empathic Inquiry is intended to facilitate collaboration and emotional support for both patients and health center staff through the social needs screening process, as well as evoke patient priorities relating to SDOH needs for integration into subsequent care planning and delivery processes. This resource provides some good background information.

In addition, the Center for Care Innovations (CCI) has an Empathic Inquiry in Clinic Settings free one-hour webinar. It is intended for anyone that is interested in learning how to effectively communicate and engage patients who may have social needs.

Health Literacy 101 – a course offered by the Institute for Healthcare Advancement (IHA) Health Literacy Solutions Center. This session provides an overview of the scope of low health literacy, including frequencies among the general population, general characteristics, abilities, and challenges of persons with low health literacy, and the cost of poor health literacy (both in terms of human suffering and dollars). The pre-recorded course is free, approx. 50 mins in length and they offer 1 CE hour. You may have to create an acct, which is a quick process.

Health Literacy additional information – Definitions, Trainings, Webinars
This takes you to the main page for the Institute for Healthcare Advancement. The drop-down tabs provide many options. Go to the Learning Lab drop down menu and find 'Trainings'. There are numerous courses to choose from. You may need to create an account to get started.

Addressing Health Disparities: This course from the American Heart Association Professional Education Hub Intelligo aims to guide an understanding of holistic community solutions that can increase equity and improve systems of care. The webinar is 1.5 hrs and there is possible CE credit.

The National Center for Cultural Competence created a Front Desk Guide that addresses linguistic barriers, attitudes, knowledge, and more for front desk employees to utilize when addressing social determinants of health and health culture.

Search Engines to find Your Own Training: There are many trainings available online, but one site in particular - called TRAIN - is a national learning network that provides quality training opportunities for professionals who protect and improve the public's health. The site has amazing resources for a variety of SDOH-related topics. Many, but not all, of the courses are free and can be downloaded for easy access to meet different work schedules. The first time you log on you need to create a login – it is well worth the effort! There is a course catalogue so you can see the offerings.

Steps any clinic can take to successfully initiate and maintain SDOH and health equity in a healthcare practice

SDOH screening and the collection of Z codes can play a pivotal role in helping to identify and address social determinants of health for patients. By collecting medical and non-medical data, your practice can make major strides in quality patient care and outcomes. Despite the advances in addressing these issues, there are challenges for healthcare providers and teams. Staff may be hesitant to screen for these needs if they are not adequately trained on responding, or do not feel they have the capacity or referral resource knowledge to address any positive need results they get. By learning more about your population demographics and collecting resources for referrals that are readily available – either locally, or near the closest urban center, you can be more prepared to respond to positive SDOH screener responses you may encounter.

DPHHS created a roadmap for approaching clinical health equity – there are 5 sections that

outline useful steps for a clinic to follow when addressing a patient's social needs and

working towards health equity in your practice and community. Sections include: Overall Workflow, SDOH screener to Z codes to the EHR, Referral Implementation, Data Use, Potential Achievements.

A roadmap for launching a Clinical Health Equity Project

1. Project champion for staff education and buy-in
2. SDOH Screener, z-codes, and EHR Workflow
3. Data Extraction, assessment, use for improvement
4. The Importance of a sound referral process
5. What you can achieve, results you can use

A clinic or hospital may be able to improve health equity and patient health outcomes if they…

- Train staff on health equity.
- Screen patients for social determinants of health (SDOH)
- Enter results as Z codes into the HER.
- Run reports on patient population needs and health disparities.
- Refer patients to community supports.
- Develop internal and external partnerships to address whole patient and population health.
- Change processes and protocols that put certain patient populations at a disadvantage.

Overall Workflow

1. Have a project champion.
2. Educate staff about why this project is important.
3. Train staff on terminology, cultural sensitivity, and warm hand-offs.
4. Identify an existing SDOH screener, build you own with tested questions, or use an HER-embedded screener.
5. Determine how, when, where, and who will administer the screener.
6. Have lists of resources/referrals/information available.
7. Work with community-based organizations (CBOs): share goals; know capacity, referral processes, and program requirements; collaborate.
8. Establish trackable referral process with CBOs.
9. Determine referral follow-up process.
10. Determine HER documentation and use of Z codes.
11. Ensure HER can export population health data.
12. Understand your population health and Z codes data.
13. Review and implement policy/process changes to improve patient health.

SDOH Screener to Z codes to EHR

Screener administration considerations:

- Modality (verbal, paper, electronic)
- Timing (e.g., in waiting room, during rooming, etc.)
- Frequency (e.g., every visit, annual well visit, etc.)
- Staff responsible for administration
- Referral follow-up processes

It's Important to:

- Determine who will carefully review positive responses with patients to discuss needs.
- Ensure information is given to address stated needs.
- Establish workflow for entering information into EHR.
- Ensure population health data (race, gender, ethnicity, etc.) are collected in/extractable from EHR.
- Establish Z code workflow: who will enter the data, attach Z codes to positive screener questions, location in EHR for data (e.g., progress notes).

Carrying Out Referrals

1. Develop positive relationships with CBOs and coalitions to address patient needs.
2. Follow up on referrals.
3. Have list of local referrals available and use other resources, including:
    a. Montana 2-1-1
    b. Findhelp.org
    c. Montana CONNECT (bi-directional resource/referral engine)
    d. Community guides

Data Exploration and Use

1. Determine reporting process to ensure your concerted work is used to improve population health and patient outcomes.
2. Build time into workflow to regularly review and understand population health data.
3. Use data interpretation to guide changes in internal processes and capacity to improve health outcomes and build a sustainable process.
4. Interpret data to build external partnerships and referral connections relevant to patient needs.

Achievements and Results

- Improved understanding of EHR capacities and what can be built within clinic EHR.
- Better understanding of patient needs and barriers to accessing services.
- Learning to work with community-based organizations to address patient needs.
- Improved relationships with patients, patient satisfaction with and desire to remain with clinic.
- Improved community relationships.

Toolkits and Guides

A toolkit is a collection of resources that enables people to learn about an issue and identify approaches for addressing them. They are meant to offer practical advice and guidance regarding an issue of concern or importance—especially when the issue is emerging or evolving, and well-established processes for addressing them are not yet widely adopted. Toolkits can help translate theory into practice. The following are some useful toolkits that may be useful to healthcare providers as they implement SDOH and health equity strategies into practices.

Evidence-Based Toolkits for Rural Community Health: Step-by-step guides to help you build effective community. Resources and examples are drawn from evidence-based and promising programs. By learning from programs that are known to be effective, you can make the best use of limited funding and resources.

Race and Ethnicity Data Improvement Toolkit: Hospital personnel who handle patient registration and admission are on the front lines of R/E/L data collection in hospitals, this provides guided training and scripting for staff to collect race and ethnicity data.

Everyday Words for Public Health Communication: This course offers expert recommendations from CDC's Health Literacy Council and other agency communicators on how to reduce jargon and improve readers' understanding. You can search for public health jargon or plain language words and find alternatives and example sentences.

Community-Clinical Linkages (CCLs) Health Equity Guide: CCLs are connections between community and clinical sectors that aim to improve health within a community. CCLs are an effective, evidence-based approach to preventing and managing chronic diseases such as cardiovascular disease (CVD) and diabetes. The guide is for practitioners in public health, community, and clinical sectors. It aims to help practitioners incorporate health equity when organizing a CCL's structure and supporting its operations, called an operational structure. The guide is not intended to serve as step-by-step instructions. Instead, you can use the guide to help decide what to adapt and use to start a new CCL or strengthen an existing one.

Advancing Health Literacy with Inclusive Communication (mt.gov): The State of Montana's PHSD's guide to promote health literacy in your community and organization.

BRAVE Framework (Build, Respect, Acknowledge, Validate, Emphasize): The BRAVE Framework can be used physically, as a tool to teach teams better communication skills and how to build trust.

Health Equity and Cardiovascular Health: American Heart Association's self- paced trainings prepare healthcare professionals to identify health disparities and integrate solutions that build health equity into clinical practice. Some trainings cost money while others are free. (Portfolio tab provides the training topics. (see Health Equity Portfolio)

CDC's Inclusive Communication -Preferred Terms for Select Population Groups & Communities

There is an ongoing shift toward using non-stigmatizing language in health care and community. This document provides some preferred terms for select population groups that can be used as a guide and inspiration to reflect upon word choice and choose words carefully, inclusively, and appropriately for a specific use and audience. Best practices include engaging people from the population or community of focus to find out what they prefer.

Research Articles

The Social Determinants of Health: It's Time to Consider the Causes of the Causes
Braveman, Paula, and Laura Gottlieb. "The social determinants of health: it's time to consider the causes of the causes."
(Public health reports 129.1_suppl2 (2014): 19-31).

Psychometric and pragmatic properties of social risk screening tools: A systematic review
(N.B. Henrikson, P.R. Blasi, K.D. Mettert, M.B. Nguyen, C. Walsh-Bailey, J. Macuiba, L.M. Gottlieb, C.C. Lewis
Am J Prev Med)

Connecting SDOH and HRSN to Prediabetes and Type 2 Diabetes:
This page summarizes how SDOH and HRSN relate to prediabetes and type 2 diabetes. (Hill-Briggs, F. et al. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. 44 (1): 258–279. https://doi.org/10.2337/dci20-0053)

Social Determinants of Health in Asthma Through the Life Course
There is strong evidence supporting the influence of social determinants of health (SDOH) on the development and progression of asthma. This article describes 2 case-based approaches (pediatric and adult) to assessing and addressing SDOH in asthma across the life course and in community settings. (M. Trivedi; The Journal of Allergy and Clinical Immunology: In Practice, Volume 10, Issue 4, 2022, Pages 953-961,ISSN 2213-2198)

Applying an Equity Approach to Cardiovascular Health
This document informs on the comprehensive process for developing Health Equity Indicators for the CDC CVD Toolkit - a resource for health care and public health professionals who are interested in monitoring and evaluating their CVD work from an equity perspective.

Medical Coding Guidance

For health care providers that have initiated an SDOH Screener and are putting patient Z codes in the EHR – these additional resources may be useful:

Name	Description	URL
Are Physicians Required to Document Time Spent on Each Task Associated With an Outpatient Visit?	Explain how the 2021 revisions to the E/M office visit coding documentation requirements impact how physicians should bill office/outpatient E/M encounters	Are Physicians Required to Document Time Spent on Each Task Associated With an Outpatient Visit? | Guidelines | AMA Debunking Medical Practice Regulatory Myths Learning Series | AMA Ed Hub (ama-assn.org)
SDOH and Medical Coding: What to Know	Evaluation and management (E/M) outpatient and office-visit documentation and Current Procedural Terminology (CPT®) coding guidelines facilitate capturing SDOH data as it relates to the complexity level or length of the office visit	Social determinants of health and medical coding: What to know | American Medical Association (ama-assn.org)
Account for SDOH When Coding Office Visits	The American Medical Association's 2021 medical decision making (MDM) grid for outpatient/office evaluation and management (E/M) services is particularly innovative because it recognizes social determinants of health (SDOH) as a factor for determining level of MDM	Account for Social Determinants of Health When Coding Office Visits - AAPC Knowledge Center
CMS Inpatient Quality Reporting IQR HE Measures	Video explaining CMS' new Inpatient Quality Measure Requirements	A Guide to the CMS Hospital Inpatient Quality Reporting IQR Health Equity Measures - YouTube

QR Code to Resources

To quickly share all linked resources above, scan the QR code below. The QR code will take you to the State of Montana DPHHS SDOH webpage where all the above resources will be linked and maintained.

General References

1. Robert Wood Johnson Foundation. "Why Build a Culture of Health." https://www.rwjf.org/en/building-a-culture-of-health/why-health-equity.html. Accessed January 2024.Vermont Department of Health. "Health Equity – what does it mean." https://www.healthvermont.gov/about/vision/health-equity. Accessed January 2024.

2. Healthy People 2030. https://health.gov/healthypeople/priority-areas/health- equity healthy-people-2030. Accessed January 2024.

3. Centers for Disease Control and Prevention (.gov); https://www.cdc.gov/healthyyouth/disparities/index.htm#:~:text=Health%20disparities%20are%20preventable%20differences,experienced%20by%20socially%20disadvantaged%20populations.

4. Hill-Briggs, F. et al. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. 44 (1): 258–279. https://doi.org/10.2337/dci20-0053).

5. Ahern DK, Woods SS, Lightowler MC, Finley SW, Houston TK. Promise of and potential for patient-facing technologies to enable meaningful use. Am J Prev Med. 2011;40(5 Suppl 2):S162–172. [PubMed] [Google Scholar].

6. Agency for Healthcare Research and Quality. "About Health Literacy." https://www.ahrq.gov/health-literacy/about/index.html. Accessed January 2024.

7. World Health Organization, About Social Determinants of Health www.who.int/social_determinants/sdh_definition/en

8. M. Trivedi; The Journal of Allergy and Clinical Immunology: In Practice, Volume 10, Issue 4, 2022, Pages 953-961,ISSN 2213-2198.