PCPCH Standard 3.D

This document provides extra guidance around Standard 3.D under the Patient-Centered Primary Care Home Program's 2020 Recognition Criteria. The full technical specifications for this measure are available in the 2020 PCPCH Recognition Standards Technical Specifications and Reporting Guide (PCPCH TA Guide).

Intent of Standard 3.D

Health-related social needs (HRSN) such as housing instability, food insecurity, and exposure to interpersonal violence directly impact health outcomes. The intent of this standard is for PCPCHs to assess and, when possible, intervene in patients' health- related social needs as part of routine wellness care.

A practice may choose the following strategies to implement health-related social needs at different levels:

PCPCH Measure	Tool or Strategy
3.D.1 - PCPCH has a routine assessment to identify health-related social needs in their patient population.	There are many categories of HRSNs including housing, food insecurity, employment, social isolation, exposure to violence, and other stressors. The categories that the practice chooses to assess should reflect the need of its patient population.[1] The practice may, depending on the resources available, choose to implement 3.D.1 using a written assessment tool. Steps to consider when creating/selecting a tool:[2] 1. Identify the practice's capacity and resources 2. Establish a written strategy/protocol 3. Identify staff responsible and integrate into the practice's workflow 4. Pilot the strategy and, depending on the practice's capacity, make necessary changes 5. Implement Social Needs strategy/tool 6. Make it consistent and routine 7. Continuously evaluate and adjust as needed based on practice's patient population needs and staff capacity
3.D.2 - PCPCH tracks referrals to community-based agencies for patients with health-related social needs	Keeping track of social needs connections helps to ensure that patients can have their needs met effectively. How a practice chooses to do that depends on the practice's capacity (staff included). Clinic staff should be able to describe the process they use during a site visit. The type of tracking tools/process used for community referrals may differ from specialty tracking. Practices attesting to this measure are required to reconnect with patients as needed (i.e. closed-loop referrals). Examples of tracking and follow-up mechanisms include: • EHR, such as utilizing referrals tracking system within the EHR • Spreadsheets, such as using Excel to keep track and updating as relevant • Any other form of document that can keep track and can be updated for ongoing patient/community organization check-ins • Following up through tasks, encounters, and or phone notes

3.D.3 - PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients.	In order to develop the most appropriate intervention(s) for a specific patient population, a practice would want to assess and analyze that patient population's social needs as a whole. There are a few assessment tools of this kind available (see TA guide). Once the needs of the patient population as a whole are identified, the practice should address/intervene with the most appropriate strategies. These intervention(s) could be geared towards the needs that are the most prevalent among the overall population, or target specific subgroups that experience high levels of social need. The following are some strategies to consider:[3] • *Awareness* – identify the health-related social needs within the patient population and the related assets available within the practice or in the patients' communities • *Adjustment* – the practice may not need to create a new intervention program, but rather make an adjustment to an existing program to support patients identified • *Assistance* –build strong (perhaps formal) relationships with local community organizations, including private and governmental agencies. These organizations will help support the practice in engaging patients more quickly and efficiently. The organization could also help the practice keep a record by communicating which patients got the recommended assistance verses those that still need support.[4] • *Alignment* – this strategy may require the practice to assess the assets or services available in their region and determine if the identified social need(s) can be supported by the local community. At times an intervention may have been created by an organization and the practice may choose to support/align with that organization instead of reinventing the wheel.

[1] https://nopren.org/wp-content/uploads/2016/12/Health-Leads-Screening-Toolkit-July-2016.pdf
[2] https://nopren.org/wp-content/uploads/2016/12/Health-Leads-Screening-Toolkit-July-2016.pdf
[3] https://www.healthleadersmedia.com/clinical-care/5-ways-healthcare-organizations-can-address-social-determinants-health
[4] https://www.astho.org/Clinical-to-Community-Connections/Documents/Collaborations-Between-Health-Systems-and-Community-Based-Organizations-to-Address-Behavioral-Health/01-08-19/