

**Question Report**  
**Public Health Grand Rounds - Social Drivers Determine Health: A Technology Response to Health-Related Social Needs**

Question Details		
#	Question	Answer
1	How are we leveraging this for community services? Can this data be gathered via tablet, without a My Chart account?	We use the Community Resource Directory in eRecord (fed by Goodwill/211) to inform patients of community-based organizations that may help address any identified health-related social needs.
2	Are we able to review this data by primary encounter diagnosis?	If data is collected during, and attached to, an encounter, it can be viewed according to that encounter.
3	How do we access the SDOH dashboard for research analysis purposes?	For research and analysis purposes, the SDOH data can be accessed by contacting the IRB and CTSI teams.
4	How are these efforts aligning with the Social Care Network being developed in the Finger Lakes as part of the 1115 Medicaid waiver?	We have been poised for a number of years awaiting this latest Medicaid waiver. We are actively working to support referrals from the medical setting to community-based organizations.
5	Do you have an individual or team dedicated to keeping a directory updated?	The Community Resource Directory currently embedded in our electronic health record is maintained by our local Goodwill/211 community partners.
6	It's very helpful that newborns' charts are now attached to their gestational parents. For how long after birth will they stay attached? Will this also be the case for non-gestational parents? Can you please confirm that the parents' clinicians are allowed to access the baby's chart?	Clinicians who provide care to a patient (newborn or adult) have appropriate access to their chart. If a clinician does not provide care for the patient, they should NOT access that individual's chart.  The connection between newborns' and birthing parents' charts is brief, only lasting a couple of days (maximum). It allows for the SDOH questions to flow from the birthing parent into the infant's chart so the questions do not have to be asked again.
7	The care team has been mentioned several times during the presentation. What is the care team, what is the composition of the team, how to patients learn if they have a care team and how to connect with them?	The care team is comprised of those responsible for treating, diagnosing, and guiding patients during a hospital stay or visit. It can include the physician, nurse, social worker, care manager, dietician, etc.
8	It will be interesting to learn more how the Joint Commission views this work with the updated health equity national patient safety goal standards!	We're excited that this work aligns with the priorities of accrediting agencies, and we're prepared to adapt and respond to future opportunities.
9	Where do we find SDoH in Care Everywhere?	SDOH can be found in the Social History section of the Continuity of Care Document (CCD).
10	Followed up to the care team question: are care teams connected to each other, how are they coordinated to meet the needs of each patient?	Generally, if a patient has an identified need and is already connected with a primary care provider (PCP) at UR Medicine, we will preferentially have the patient secure assistance from a care manager at their PCP's office. When that's not possible, an available care team member (physician, APP, nurse, tech, etc.) at the site where the patient is being seen will be engaged. Inpatient care teams communicate with the outpatient care teams at the time of—and occasionally prior to—discharge.  The patient's information in the electronic record is longitudinal, meaning the patient's information is visible to inpatient and outpatient care team members throughout their care journey.
11	Do we know if those that screen are then those that are connecting patients? I would hate for screening to occur with no resolution.	At the time of screening, all patients are directed to a referral source or 211 to address any needs they have shared. This also applies to those who completed the screening via eCheck-in before a scheduled office visit but ended up not attending the appointment. In addition to referrals, we also advise clinicians to take patients' responses into consideration when making their care plans.
12	do I have to be in a patient chart to access the data?	To see patient-specific information, you would need to be in a patient's chart. To look at population or department data, you do not have to be in a particular patient's chart, but will need access to Epic and Tableau to view the data.
13	Has survey completion become an expectation of all inpatient admissions?	Yes, it is expected that all inpatient admissions are screened for SDOH. The screening questions are part of the admission-required documentation.
14	Does the health related social needs department also work on environmental or sustainability efforts?	The Health Related Social Needs Resource Center is focused on efforts related to the navigation of individuals' social/health needs as outlined in our presentation.
15	Has there been an increase in funding for URMC Social Work to follow up with patients who are screened as having needs?	One of the intentions of this effort is to better understand where resource allocation is appropriate. Continuing this work will help us better identify areas of need and any additional resourcing.
16	I'm a researcher here and would love to work with you! Who should I reach out to?	HealthEquityTechnology@URMC.Rochester.edu
17	Have you been able to address transportation issues with this system? Any changes that you made to address the issue?	We're able to connect patients to transportation resources through 211 and other, ongoing efforts throughout the institution.
18	Schools (school nurses and school health offices) are a key pediatric well-being care setting that with integration supports is also able to further equity and complement/extend the medical care (primary care medical home and speciality care). Can you comment on this?	In a project that exists alongside HEART, the University is working to allow clinicians and school nurses to communicate with more ease via secure messaging. This initiative is also closely collaborating with the Rochester RHIO.

19	This initiative is linked to the Anti-Racism Initiative 2020-2025. Is there a plan to continue after 2025?	The Equity & Anti-Racism Action Plan (EARAP) has served as a blueprint for coordinating equity-focused efforts across our institution over the past five years. Some of the initiatives guided by EARAP, including HEART, are now integrated into our everyday operations. While 2025 marks the end of the original EARAP timeline, our institution's commitment to equity and community health will continue.
20	You mentioned you are making changes to comply with the changing federal guidelines and definitions. How is this going to affect transgender individuals?	In our presentation, we referenced the Office of Management and Budget's updated standards for race and ethnicity collection. To date, we are not aware of any specific requirements around changes to gender identity collection.
21	Can you please clarify if URMC is automatically dropping G Codes on the claim to indicate SDOH screening is taking place? Sorry if I missed this the first time around!	G-codes are collected and added to claims in the hospital and in select ambulatory locations. In the hospital, we also add Z-codes where appropriate.
22	How do you handle or help patients that are too proud or ashamed to admit they have social needs	We understand the SDOH screener can initiate tough conversations between patients and clinicians. To help, we've created a toolkit, titled "Let's Talk about SDOH," that includes a breakdown of SDOH and conversation tips. Similar to some of our peer institutions, we've adopted "We Ask Because We Care" messaging to underscore why we're asking patients about their needs and how we can work together to ensure they live and feel their best. We also have several job aids for clinicians to help with ways to ask the questions and provide assistance.
23	Nurse Navigators in the ambulatory setting can help as our work is centered on removing barriers to care which are many times social detriments of health issues	Nurse Navigators are amazing resources for our patients. In addition to the work they currently do, they can help screen patients for SDOH as well as offer resources using the Community Resource Directory that is housed in the Community Resource Usage Navigator section in eRecord. We would be happy to meet with any team to discuss how their work can support, or be supported by, HEART.