Implementing a Social Determinants of Health Program

A Community Pharmacy Driven Toolkit

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Executive Summary

Social determinants of health (SDoH) have a large impact on the health and wellbeing of all patients, and may result in many preventable, expensive healthcare costs. Community pharmacists are accessible and local and are well-positioned to address these SDoH. In this section you will find evidence of improvements in outcomes or broad, population-level cost savings and a basic description of the different domains of SDoH and how they relate to pharmacy.

In adopting a new SDoH program in the pharmacy, there will be several new roles for existing pharmacy staff, as well as the potential need for hiring newer pharmacy staff. One approach is to develop the role of an SDoH specialist, a designated employee who identifies and responds to potential SDoH needs. Another is to simply hire a Community Health worker, a professional who is embedded in the community and aware of the individual health needs. We have included the different skills, training requirements, and possible certification programs that the pharmacy will likely need to employ to effectively implement an SDoH program.

Regardless of the elements you choose to incorporate into your SDoH program, implementing the program from start to finish is a complex process. Conducting a thorough needs assessment of the patient population is important to ensure that the program is successful and effective in alleviating the SDoH needs of your pharmacy's unique patient population and will assist in effectively drafting a service cycle workflow. Choosing elements that complement the expanded clinical services you already offer will not only improve patient care, but also allow for an easier implementation into your pharmacy's pre-existing workflow.

It is also important to conduct a thorough readiness assessment to determine what your pharmacy needs to ensure the success of the program. We have included a detailed, individualized implementation template, blank resource tables to include in your pharmacy's references, and we describe some additional legal and financial considerations for improving the viability of the program. We recommend researching the local charitable organizations and state laws that could allow reimbursement for the SDoH services you would like to provide.

What pearls can I gain from each section?

Overview

- A basic understanding of SDoH and how they impact the pharmacy

New Roles for Pharmacy Staff in an SDoH Pharmacy

- Skills and proficiencies, training requirements
- Description of a community health worker

Development of Key Skills for CHW and SDoH Specialists

- Examples of training programs and SDoH community programs

Implementation Plan – Phase I and II; Additional Considerations

- How to gauge pharmacy readiness for program implementation
- A detailed implementation template that shows examples of resource tables, service cycles, and delivery driver assessments.
- Additional legal and financial considerations

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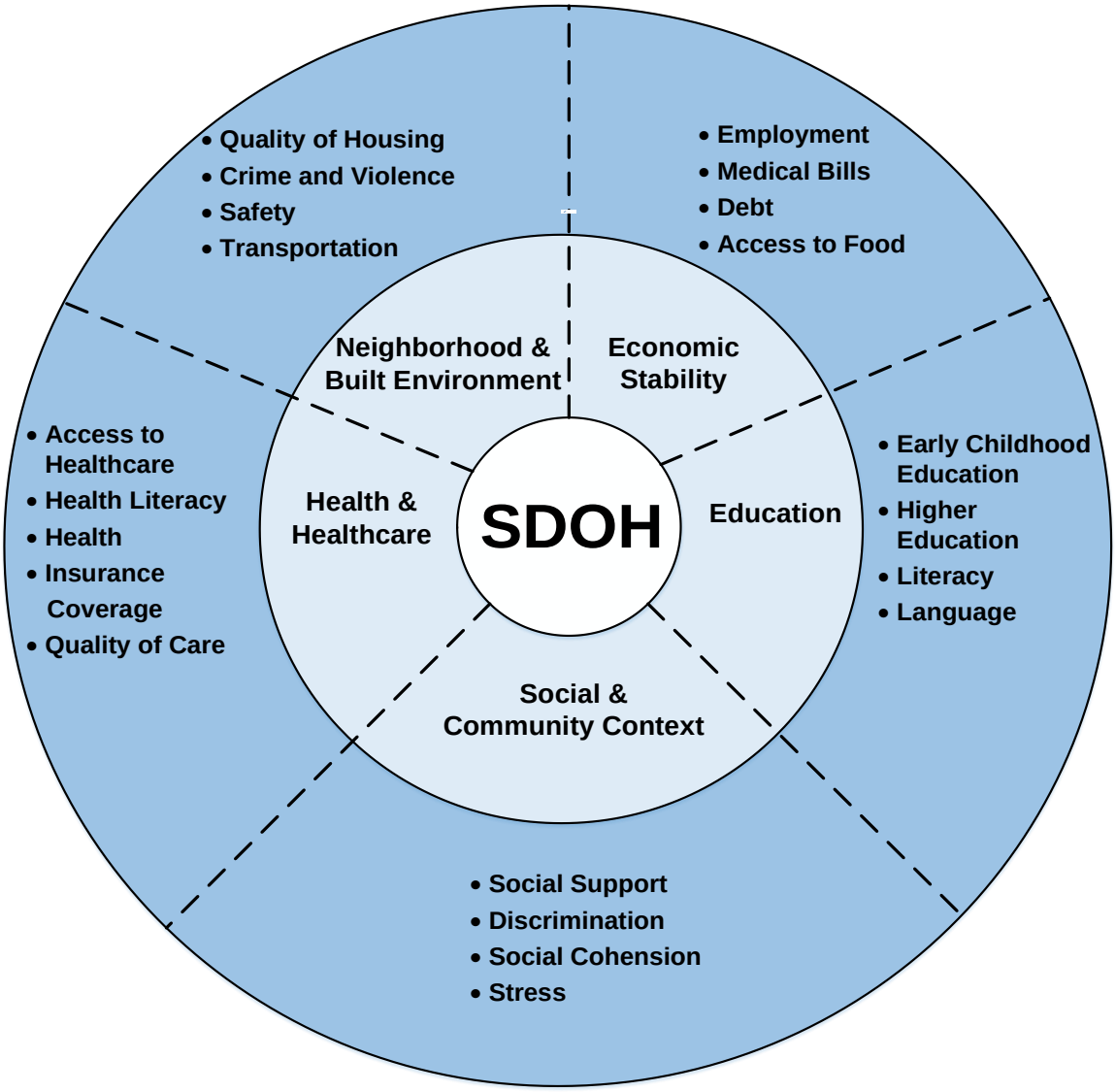
I. Overview

Social Determinants of Health (SDoH) are defined as the conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes.[2] The United States generally recognizes those conditions into five broad categories[2]:

1. **Economic Stability**
2. **Education**
3. **Social & Community Context**
4. **Health & Healthcare**
5. **Neighborhood & Built Environment.**

Each category reflects several key factors that build up the underlying elements of SDoH. The vast majority of U.S. healthcare dollars and efforts are spent on clinical care instead of addressing the underlying socioeconomic and behavioral factors that greatly impact patients' health.[3]



Source: Healthy People 2020; Kaiser Family Foundation

Figure 1. Social Determinants of Health[1]

Why are Social Determinants of Health Important in Healthcare?

Patient health outcomes are determined in most part by social determinants of health (SDoH), rather than actual clinical care[4]. Poor social and economic circumstances may lead to negative health outcomes throughout life. People at the bottom of the social gradient have a higher risk of serious illness and shorter life expectancy than those near the top.[5] The number of deaths related to poor diet in the United States is increasing.[6] In addition, lower socioeconomic status (SES) has a strong link to poorer outcomes in many disease states such as chronic obstructive pulmonary disease, cardiovascular disease, and diabetes.[7, 8] All healthcare workers should consider SDoH as important factors to provide personalized care management. In addition to optimizing patient care, implementation of personnel, such as community healthcare workers has had a significant financial benefit on participating organizations. SDoH programs have demonstrated an average savings of $2,245 per patient service, in addition to a return of $2.28 for every $1.00 invested by hospitals and healthcare systems.[9, 10] A study conducted at the University of South Florida concluded that referral of Medicare and Medicaid beneficiaries to a social worker in order to address social barriers and SDoH resulted in a 10% reduction in total health care costs. This equated to more than $2,400 per person per year in savings for people who were successfully connected to social services compared to a control group of members who were not.[11] Moreover, a recent study done by Humana in collaboration with OutcomesMTM indicated that a pharmacy SDoH screening tool could save an average of $1500 per patient in overall medical spending per year.[12] Investment in personnel specializing in SDoH is not only beneficial for patient outcomes but also economical for the healthcare system. An example of how targeting SDoH factors can benefit economic and clinical outcomes is A Colorectal Cancer Male Navigation Program designed for men in the Hispanic community demonstrated an increase in life expectancy by six months for those who participated in the program that targeted SDoH factors compared to those who did not participate in the program.[13] The program also generated a health care savings of $1,148 per program participant.[13] In a pilot program focused on improving Asthma outcomes in African American children utilizing a community healthcare worker led to a 35% reduction in symptom frequency.[14] In addition, the program lead to an additional savings of $5.58 per dollar invested on SDoH interventions.[14]

Relationship Between Community Pharmacy Practice and Social Determinants of Health

Embedded in the community, pharmacists are uniquely positioned to connect individuals to community resources and organizations. They have been proven to be one of the most accessible healthcare providers, with 90% of Americans living within 5 miles of a pharmacy.[15] A cross-sectional study of a representative nationwide sample of Medicare beneficiaries showed that patients visited community pharmacies twice as frequently as they visited primary care providers (median 14 vs. 7, $p<0.001$).[16] In addition, patients have more immediate access to their community pharmacist compared to their primary care physician, with patients visiting their pharmacist 35 times per year versus visiting their primary care provider 3 times per year.[17, 18] Efforts to address SDoH can be strengthened by a greater utilization of community pharmacies. Through additional training in SDoH, a community pharmacy can become the service referral destination for every high-risk patient with clinical and social needs. Community pharmacies can provide individualized patient centric support through ***local*** care and coordination.

How Can Community Pharmacies Address Patients' Needs Related to SDoH?

1. ***LOCAL*** Community Pharmacy services promote personalized care management that aims to help patients and families navigate the health care system.

2. ***ACCESSIBILITY*** of services to patients in transition and/or in need of services beyond standard prescription dispensing.

3. ***ADVOCATE*** for patients needing local and non-local resources to direct services and referrals when needed.

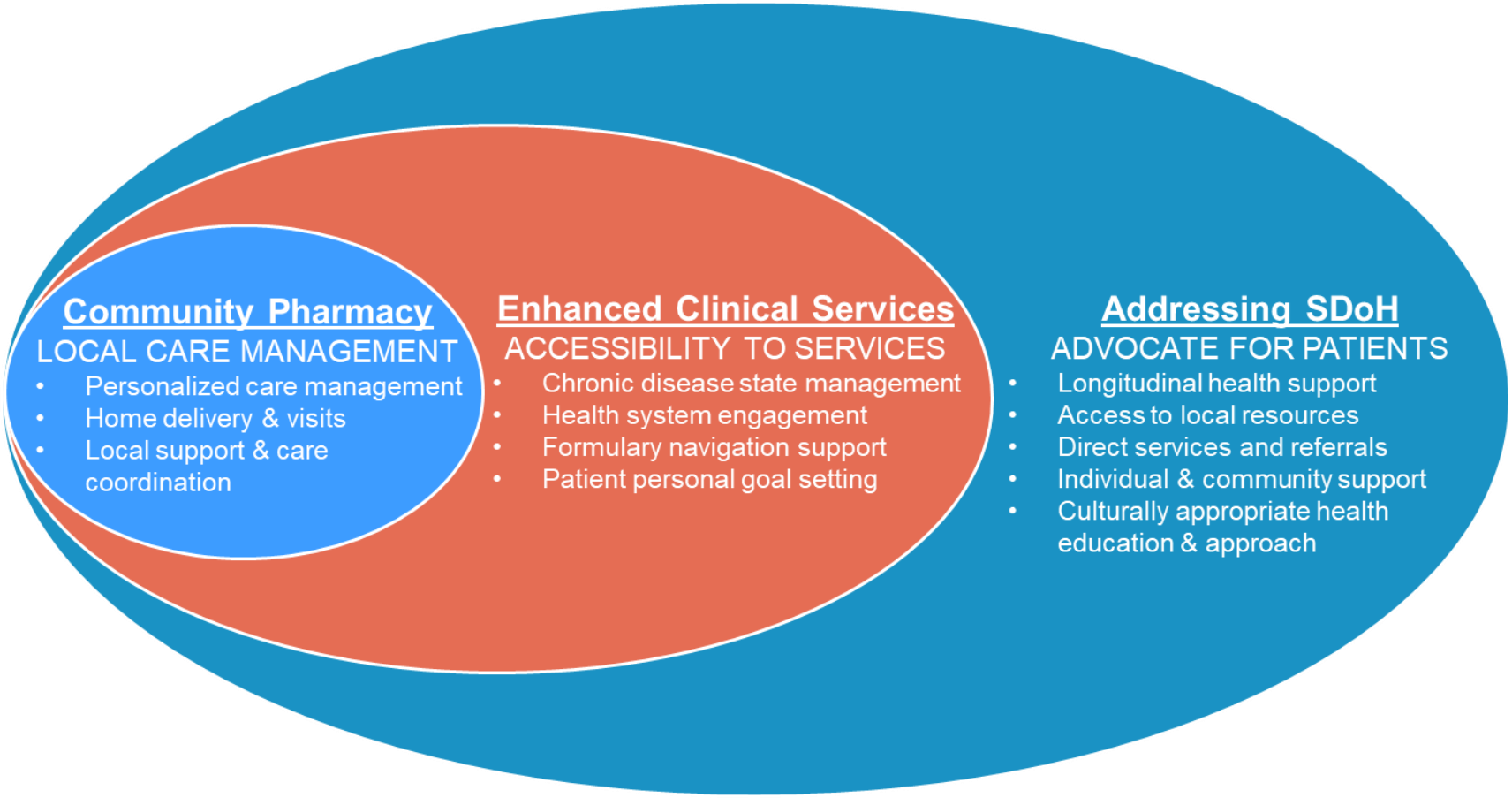


Figure 2. SDoH Program Value Proposition

Integrating the five parameters of social determinants of health to a community pharmacy can be manipulated to fit the needs of the pharmacy. **Table 1** below will pair enhanced services that may be in a pharmacy work flow and categorize them to the SDoH they would fall under as well as examples of how the services could be conducted.

Table 1: SDoH Parameters within Community Pharmacies

SDoH Parameters	Enhanced Services	SDoH Program Staff Roles
Neighborhood / Built Environment	**Hand Delivery** **Home Visits** **Neighborhood Health** **Face to Face Access**	Hand Delivery: • Delivered in person, verbal offer to counsel and facilitate connection to pharmacist from pharmacy location Home Visits: • Assessments of the home and evaluating home stability to prevent health hazards: working heat/AC, mold, garbage buildup Neighborhood Health: • Connections that help with services with built environment such as: transportation, neighborhood watches (safety), availability of health needs near the home (pharmacy, hospital, urgent cares) Face to Face Access: • Initiating and maintaining face to face access to medical services by helping patients locate and contact proper services
Economic Stability	**Cost Effectiveness Evaluation** **Discount Prescription Coupons**	Cost: • Aid in patient cost burden by performing medication review and optimizing medications for cost within medical and pharmacy benefit parameters (Medicaid, Medicare, privately funded programs, subsidy programs, 340b programs, etc.) Coupons: • Utilize services that help with financial benefits in regards to purchasing medications (e.g. GoodRx, Scriptsave, NeedyMeds, RxAssist)
Education	**Health Literacy** **Chronic Disease State Education and Management** **Comprehensive Medication Reviews**	Health Literacy • Pharmacy team mediate for patients during or after a medical appointment to clear up possible confusion or questions such as: -New or existing medication regimen, -Using medication devices (ex. nebulizers) -Educational information on any conditions discussed (pamphlets, forums, websites) Chronic Disease State Education and Management • Pharmacy team in an individual or group setting educates patients on their chronic disease states and how to better manage them -Diabetes self-management education and support -Smoking cessation -Asthma management -COPD management Comprehensive Medication Reviews • Pharmacy team provides a systemic assessment of medications to identify medication-related problems, prioritize those problems, and create a patient-specific plan to resolve them working with the extended healthcare team

Social/Community	**Social Support**	• Connection to the community for the patient such as help groups, forums, clinics that they would need involving the healthcare system • Formulation of a community-specific resource table for local references. See Section 5 for more detail and Appendix E as an example resource table Maintaining a positive relationship can lead to patient improvement in patient self-efficacy and self-confidence
Health Care Access / Accessibility	**Care Management Program** **Adherence Program** **Immunization Delivery**	Care Management Program • Care management to monitor patients on medical appointments, medication pick-up, and follow-up patient and home assessments • Optimization of patient accessibility to care through the process of identification, screening, assessment, referral, and follow-up (See table 3). Adherence Program • A continuous service whereby the pharmacy facilitates a comprehensive medication review to determine an optimal regimen working in collaboration with the patient's prescriber to maximize patient adherence. • May lead to patient enrollment in additional adherence services, including: -Medication synchronization -Adherence packaging -Automatic refill Immunization Delivery • Pharmacist administers Advisory Committee on Immunization Practices (ACIP)-recommended immunizations to patients after assessment of patient's immunization and medical history

II. New Roles for Pharmacy Staff

Emerging Roles for the Community Pharmacist

Through practice transformation, community pharmacies are leading the development of team-based care by integrating pharmacists into the patient centered medical home model. Critical community-clinical links of interactions with the patient extend beyond a single clinical setting. Collaboration highlights an integral part of improving chronic disease management in population health.

Community Pharmacy collaborations will promote team-based care by completing the following:

- Leverage an existing clinically integrated network of community-based pharmacies to facilitate enhanced services which can document improved, measurable patient health outcomes and lower overall healthcare costs.
- Promote a consistent process in the delivery of pharmacists' patient care services across health care settings.
- Build and strengthen collaboration, communication, and documentation with other health care professionals.
- Develop a framework for integrating clinical pharmacy services into the medical model.
- Reinforce the need for payment reform to include remuneration for pharmacy care management services that are integrated with the larger care team.

According to the Community Pharmacy Enhanced Services Netowrk (CPESN), enhanced clinical services are defined as, "…services that address the unique medication use needs of complex

patients, thereby helping them achieve the best possible results from medication use."[19] Through the provision of enhanced services, community pharmacies are committed to **improving health outcomes** and **decreasing total healthcare costs** for patients in their care.[19] Examples of these services include face-to-face access, medication reconciliation, immunizations, medication delivery services, clinical medication synchronization and more.[20] By engaging in enhanced clinical services, a pharmacy has the opportunity to improve its patient's access to higher quality healthcare and achieve a better state of health as a result.

As pharmacies look to pull in new ideas, they will begin to realize the traditional dispensing profitability model is no longer sustainable. Chronic conditions dominate the demand for health care delivery as the healthcare system transitions to a value-based care model. With a mindset to transform pharmacy workflow and business modeling towards the whole patient, longitudinal orientation information and education sessions will need to be provided to match the need. **Figure 3** conceptualizes how current pharmacy staff roles can be utilized to meet the demands of a SDoH program. This pathway allows for current pharmacy staff to be utilized in an ever more increasing fashion to meet clinical program demands, particularly related to SDoH programs. The next sections will take you through the patient care process of the SDoH patient and how each staff role may come into play.

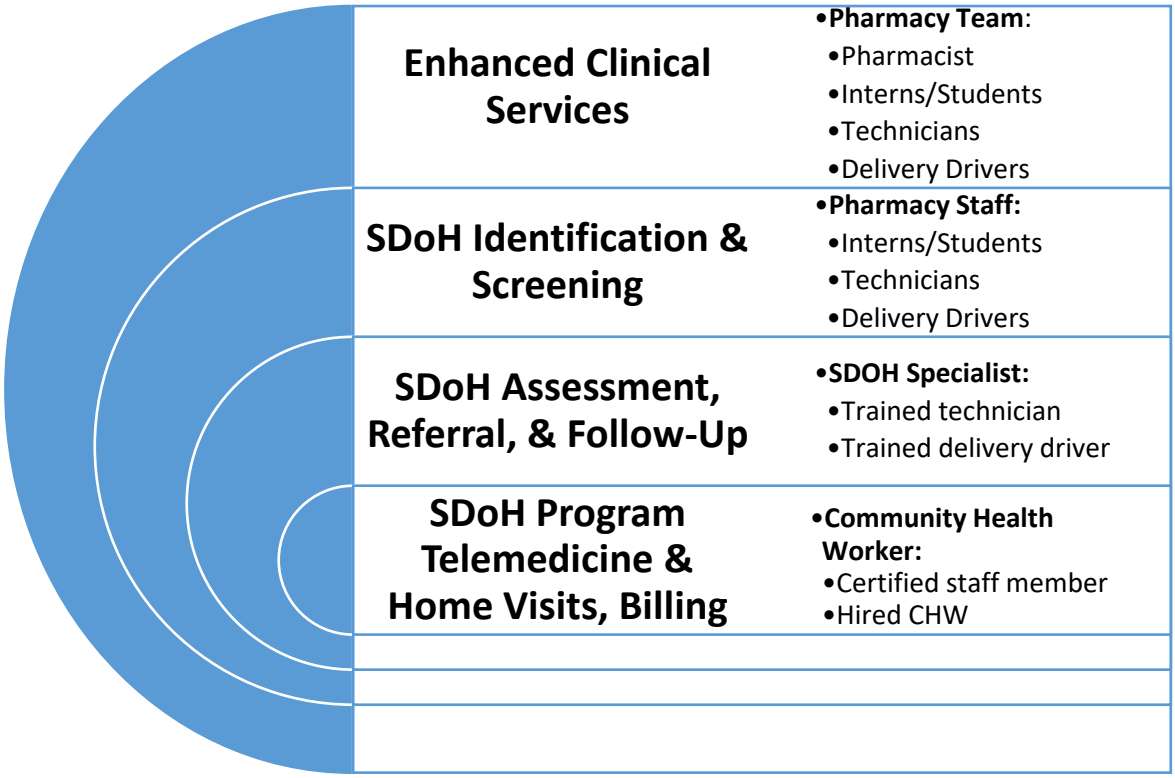


Figure 3. Community Pharmacy SDoH Program Layered Staff Roles

Introducing the SDoH Specialist Role in a Community Pharmacy

Figure 4. Integration of Community Healthcare Workers into Community Pharmacy

A **Social Determinant of Health (SDoH) Specialist** is a member of the pharmacy team who is trained to have substantial knowledge of the five social determinants of health. They utilize this knowledge to connect pharmacy patients to community specific resources and to be an advocate for patients in at-risk populations. SDoH Specialists can integrate enhanced clinical services with community services in order to give patients access to a higher quality of care. A SDoH Specialist's role in a pharmacy is to assess patients for opportunities for intervention, implement a patient-specific plan, refer the patient to community specific resources, and follow-up to ensure that the patient was able to obtain access to these services. **Figure 4** shows that this skillset bridges both the pharmacy team and CHW.

The addition of SDoH services into a pharmacy workflow should be integrated into pre-existing workflow in order to optimize the potential impact of having an SDoH specialist. Utilization of established technicians and delivery drivers to increase patient identification and screening will expand the service scope that the SDoH Specialist is able to reach. These opportunities for identification and screening can be assimilated into ongoing tasks being performed by the pharmacy staff. Incorporation of additional training for proper execution of patient identification and screening should be administered so that the pharmacy team has the resources to contribute to the productivity of the SDoH Specialist. Additional training elements of these individuals will be covered in a later section of this toolkit.

Integrating an SDoH Specialist may not require additional personnel to be hired within the pharmacy team, however a motivated individual's responsibilities could be expanded to take on the role of the SDoH Specialist. For example, technicians are often cross-trained to be inventory specialists or lead technicians. In an SDoH program, the technician role would be leveraged to the SDoH Specialist role. The SDoH Specialist would require a higher level of training in order to be productive in this role. Cross training individuals to this role may enhance motivation to ascertain and make a meaningful impact on the patients they serve. The SDoH Specialist would need an allocated time during their shift to rotate into assessing patient screening, making patient specific plans, referrals, and following-up with the patients. This would be an additional station in the pharmacy, much like there is a triage station, counting/production station, compounding station, etc. However, since this individual is also a part of the pharmacy team, they are also available to conduct regular tasks when not scheduled at the SDoH Specialist station as needed depending on volume.

The Roles Pharmacy Staff May Play in SDoH Patient Services

To start, while it is important that all pharmacy staff receive basic training on SDoH and the SDoH program, not everyone on the pharmacy staff will have extensive training. The SDoH patent service cycle includes the following aspects: patient identification, screening, assessment, referral, and follow-up. The ability to coordinate community resources for patients is key in the assessment and referral steps. **Figure 3** shows how a layered staffing model can influence a team-based approach. The pharmacy staff, composed of pharmacists, interns, technicians, delivery drivers, and others, have the unique opportunity to interact with a patient at various pharmacy workflow steps. The face-to-face interaction allows for this key exchange of information.

It is during these key patient interactions that a patient can be identified as a member of an at-risk population who would benefit from the resources the SDoH Specialist can provide. Whenever a member of the pharmacy staff is interacting with a patient, they should always be monitoring for visual, verbal, or environmental clues that may trigger a need for patient SDoH screening to be conducted. For example, when a delivery driver is making a routine delivery to a patient, this is an optimal opportunity to assess the patient's environment for triggers for screening. This will identify the patient as a benefactor of additional screening. The delivery driver may then follow the "Delivery Driver Screening Assessment" protocol and submit the results for the SDoH Specialist to review. **Table 2** describes possible categories of SDoH issues that would lead to screening in a SDoH program.

Table 2. Patient Identification and Screening Services

Patient Identification	Screening
• Medication adherence barriers • Socioeconomic status and financial stability issues • Environmental instability • Lack of social support • Low health literacy	• Conduct screening assessment • If it is determined there is a SDoH issue, advance patient to assessment step

Once a patient has been identified and screened for intervention by the SDoH Specialist, the results of the screening need to be interpreted for positive indications of beneficial intervention opportunities. If a screening outcome is positive, a patient specific plan will be drafted in order to make optimal referrals of services on behalf of the patient. Once a referral is made it is vital that an action plan is executed and that the SDoH Specialist follows-up with the patient in order to assess for additional barriers and referral outcomes. The patient action plan can then be refined as necessary to best fit the patient's specific needs. **Table 3** further breaks down the SDoH Specialist workflow steps.

Table 3. Assessment, Referral, and Follow-up Services

Assessment	Referral	Follow-up
• Interpretation of screening results for positive outcomes • Identification of necessary action • Development of patient specific action plan	• Identification of community specific resources • Collaboration and coordination of resources • Connecting the patient to appropriate resources • Devise a patient action plan	• Communicate with patient • Assess referral outcomes • Assess efficacy of patient plan • Refine patient action plan

What is a Community Health Worker?

Community Health Workers (CHWs) are considered frontline public health workers with extensive knowledge of the community they serve.[21-23] CHWs are trained to be the link between necessary health and social services and the community to provide aid in the accessibility of these services to individuals in high risk populations.[21-23] They utilize their knowledge of the competencies of SDoH to manage the diversity of complex patient care regimens.[21-23] Common CHW-patient interactions can be accomplished in the form of health coaching, care management, health screening, or referrals.[21, 23] CHWs are able to use their advocacy role to build solidified relationships with patients and build patient self-efficacy in the current services they are in as well the transition of initiating new services.[23] **Table 4** provides further details regarding a CHW job description. There is not a current universal certification to become a CHW, yet CHWs are typically required to have completed either a college health degree or an extensive training workshop to be able to deliver their services and be recognized by the healthcare system. **Appendix A** provides a further description of CHW training requirements by state.

Community Health Workers in Community Pharmacies

Community pharmacies are one of the most frequent patient-visited health care entities currently, which makes them a suitable setting for patient interactions. CHWs could be the most effective tool for the community pharmacy concerning mediation between patients and health or social services to avoid issues such as barriers to care, literacy barriers, and medical coverage. CHWs may also help ease the effect of "white coat scare" by presenting themselves as normal workers and members of the community, which could make patients more willing to interact without hesitation to receive information.

Table 4. Community Health Worker Role at a Glance[24, 25]

Community Health Workers (CHW) are considered a frontline public health worker with extensive knowledge of the community they serve in. CHWs are trained to be the link between necessary health and social services and the community to provide aid in the accessibility of these services to individuals in high-risk populations.	
Minimum Qualifications/Experience:	1-2 years of health care experience with their designated healthcare system. Field experience with patient initiatives. A degree or training in a health and social service discipline.
Target Population:	High risk patients with complex health and social care regimens
Roles/Responsibilities:	Health coaching, care management, health screening, referrals, informal counseling, health education, or patient advocate
Case Management Capacity:	25-30 cases at once
Average Salary:	$41,500 ($35,000-$48,000)

Table 5. Potential CHW Roles in a Community Pharmacy Setting

CHW Role in the Pharmacy	Description
Service Coordination	Aid with finding health and social services for patients Walks patients through how to initiate the services (phone calls, forms, financial means)
Informal Counseling	Creating health and behavioral goals with patients Developing a relationship as a health coach for the patient Crucial for situations such as “white coat scare”
Health Education	Can deliver appropriate health education such as disease prevention, medication maintenance, proper health promotion
Community Advocate	Can speak on behalf of the patient when needed for health and social services Provides a loyal support system for the patient
Care Management	Managing complex care programs involving doctors’ visits, in-home care, or medication pick-ups/adherence Coordinates follow-ups via email, home visits, or phone call to monitor health and social service interactions

III. Development of Key Skills for CHW and SDoH Specialists

CHW and SDoH Specialist Training Key Skills

To become a proficient SDoH Specialist or certified CHW, certain key skills should be developed as part of a core curriculum. These may range in hours, degrees, or certification details. As one example, the New Mexico Department of Health has created a CHW curriculum in collaboration with the University of New Mexico and several community colleges. The university system operates didactic training through weekly night classes over the course of six months, followed by six months of field work. The following domains in **Table 6** were created as part of a more robust program.

Table 6. New Mexico Department of Health's Office of Community Health Workers Certification Curriculum[26]

CHW profession	Communication skills
• Scope of practice • History of the profession and the code of ethics • Setting professional boundaries and practicing self-care • Cultural humility • Organization and professional skills	• Observation skills • Verbal and non-verbal communication • Active listening • Negotiating, mediating, and resolving conflict • Documentation protocols
Health coaching	**Service coordination skills**
• Health promotion and disease prevention tactics • Behavior change strategies • Maintenance and relapse prevention	• Case finding and recruitment • Navigation and linking to services • Case management
Advocacy skills	**Technical teaching skills**
• Speaking on behalf of individuals and organizations • Educating health and social service systems • Working for change in practices and policies	• Adult learning principles • Health education for individuals and groups • Running effective meetings
Community knowledge	**Clinical support skills**
• Gathering community knowledge and strengths • Identifying community needs and priorities • Sharing results with care teams	• Health coaching and interpretation of test results for blood pressure, blood glucose, cholesterol, and BMI • Identifying oxygen saturation, pulse, respiration rate, and temperature
Interpersonal skills	**Capacity-building skills**
• Establishing trust • Building relationships • Demonstrating empathy and compassion	• Strengths-based approach to patient management • Health literacy • Community organizing • Leadership development
Health outreach skills	
• Opportunities for performing outreach • Planning and conducting health outreach • Home visits • Safety protocols	

Examples of SDoH and CHW Training Modules

The National Community Pharmacists Association (NCPA) educational series below in **Table 7** is a 3-hour self-paced activity, in which each module discusses the roles of CHWs, including first-hand experiences from community-based pharmacists and CHWs. This is available to CPESN USA and NCPA members.

Table 7. SDoH and CHW Example Training Program

Facilitator: NCPA Learning Center
Website: https://ncpa.org/education
Program Title: Community Health Workers in Community-Based Pharmacy Care Delivery
Program Description: The Community Health Workers (CHWs) in Community-based Pharmacy Care Delivery educational modules are intended to help community-based pharmacists and staff members gain an understanding of how CHWs can be a health resource to individuals in their communities in addition to assisting them with their medication needs.

CHW Training Requirements Appendix

The **Appendix A** training modules vary in the encompassing the roles and skills of a community health worker. This toolkit is intended to provide information about applying basic skills of a SDoH Specialist or CHW, but not meant to replace any current CHW certification that is required by individual states.

After referencing these sections, we encourage those interested to seek out local CHW workforce associations, training, or certificate programs that will complement your local program.

Example SDoH Community Programs

Review the components of SDoH programs listed below in **Table 9** to understand the range of possible models. Information provided includes programs within community pharmacy, other pharmacy settings, and general medical centers.

Table 9. Example SDoH Community Programs

Organization	Community Pharmacy Settings		Other Pharmacy Settings	General Medical Centers	
	L&S Pharmacy[a]	South Carolina CPESN®	Flip the Pharmacy [b]	University of New Mexico Health System [c]	Mercy Health System[d]
Pharmacy Involvement	Yes	Yes	Yes	No	No
Address SDoH Needs	Yes	Yes	Yes	Yes	Yes
How Services Offered	• CHWs in pharmacy	• SDoH questionnaire	• New staff in pharmacy	• CHWs in health system	• CHWs in health system
Target Population	• Delivery recipients • Other pharmacy patients[e]	• Patients of community pharmacies across South Carolina	• Patients enrolled in the pharmacy MS program	• Higher-risk members in local MCO • Vulnerable populations[h]	• Recently discharge high-risk patients
Referral Strategy	• CHWs review delivery needs assessment form	• Filling questionnaire with patients	• Identifying target patients from MS program. • Identifying patients filling diabetes medications	• Local MCOs contact CHWs	• Referring highest-risk patients to CHWs from team
Care Setting	• Meet patients after evaluating forms and review forms weekly	• Scoring the questionnaire • Create care plan using standard codes	• Offers support in community pharmacies	• Offers support in the community, primary care clinics, and the ED	• Patient home visits • Personalized psychosocial support
Program Outcomes	Early results:[f] • >200 referrals to CHWs • Saving > $87K in estimated annual out of pocket Rx to patients	-[g]	-[g]	Pilot study results: • ↓83% inpatient admissions • Saving $2M to MCO in 6 months	Pilot study results: • Healthcare quality improvement[i] • Saving $170K to healthcare system in eight months
Current Status	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

Abbreviations. CHW = community health workers; CPESN = Community Pharmacy Enhanced Services Networks; ED = emergency department; MCO = Managed Care Organizations; MS = Medication Synchronization; Rx= prescription; SDoH = social determinants of health

[a] https://www.semorx.com/L-and-S/Services/

[b] https://www.flipthepharmacy.com/

[c] https://hsc.unm.edu/community/chwi/index.html

[d] https://www.advisory.com/-/media/Advisory-com/Research/PHA/Resources/2019/PHA_CHW-Case-Study-Compendium.pdf

[e] Patients with chronic diseases (e.g., high blood pressure, high cholesterol, & diabetes), patients in transitions (e.g. healthcare settings, providers, insurances, housing, employment and social transitions, etc.), patients at risk of falling or with special needs

[f] This is unpublished data and the data range is Q1-Q2 in 2019

[g] No public data available yet

[h] Medicaid beneficiaries, citizens returning from incarceration, undocumented immigrants and children at risk for abuse

[i] 31% reduction in ED use and 32% reduction in inpatient use

IV. Implementation Plan – Phase I

Program Scope of a SDoH Community Pharmacy Plan

Developing a SDoH-Community Pharmacy Program's Scope, Mission Statement, and Objectives

Common Drivers for a SDoH-Community Pharmacy Program

There are various areas where a SDoH Specialist can make a difference and common needs that can be met by such a program. Addressing social determinants of health is a major component of any program, yet additional goals or areas of focus may include:

a. Different chronic diseases (e.g., diabetes, hypertension, cholesterol, asthma);

b. Addressing the needs of high-risk or at-risk populations (e.g., older adults with multiple chronic diseases and polypharmacy, patients undergoing opioid dependency treatment);

c. Decreasing inappropriate emergency department and/or hospital utilization;

d. Transitions of care from health system, long term care, or assisted living;

e. Working to improve outcomes for vulnerable and underserved populations;

f. Focus on patient's social needs such as housing transition, employment transition or social transition (e.g., barriers to care such as health literacy, nutrition, housing, transportation, etc.)

Once the program driver is determined then the mission statement and objectives of the SDoH program can be developed. Some additional elements to consider during program development include target patients, panel sizes, patient management timelines, services offerings, and referral strategy.

Developing a SDoH-Community Pharmacy Program Mission Statement

There is no standard job description for SDoH Specialists or CHWs within a community pharmacy, therefore your program scope should be modeled to your specific needs and the general focus of your organization. A first step for developing a program scope can be to develop a mission statement for your SDoH program. *A mission statement describes what the program is going to do and why it is going to do that.* For a mission statement consider the big picture for your program and what you want to achieve. Guiding principles for the development of a mission statement include:

1. **Concise**: A mission statement should get their point across in one sentence,
2. **Outcome-oriented**: Explain the fundamental outcomes your program is working to achieve, and
3. **Inclusive**: Make broad statement about the key goals of the program but not limiting to specific strategies.

The following is an example program mission statement developed by L&S Pharmacy in Charleston, MO for their Community Health Worker program.

"Through our pharmacy's CHW initiative, we believe we can better serve our community, connect more patients to the local services they need, and create new opportunities for our local community pharmacy practice."

Dissection of a SMART Objective[27]

When implementing your program to your pharmacy you are going to need measurable components to track progress. Objectives can be developed for the program with the help of the S.M.A.R.T framework. This framework can be utilized to create objectives that monitor those components of your pharmacy such as program participation or optimization in medication use.

When developing these objectives, you will use the SMART components with parts being highlighted in the verbiage and the others are more of a concept:

Specific - Objective should be well defined and clear to your team (e.g., name of clinic, name of program)

Measurable - What will be measured to show improvement, impact, and success (e.g., quantity, frequency, costs, etc.)

Achievable - The objective should be within reach for your pharmacy and possible to achieve

Relevant - The objective should align your pharmacy's overall mission, vision, and goals

Time - Refers to the fact the objective has endpoints

When referring to the **achievable** and **relevant** elements, you will use these more as concepts that align with your current program's visions/goals when forming these objectives. The below example displays the dissection of **specific, measurable,** and **time,** and how they could be organized in a program objective:

By the year 2022 (Time), the total number of referrals from SDoH staff to RPh (Specific) will increase by 20% (Measurable)

Examples of Objectives for Pharmacies:

- By the year 2022, the total number of patients enrolled in the pharmacy enhance service program will increase by 20%
- By the year 2022, the total number of patients in the pharmacy enhance service program receiving immunization will increase by 20%
- By the year 2022, the total number of hospitalization/ER visits of diabetic patients enrolled in enhance service program will decrease by 20%
- By the year 2022, the total number of initial assessments of pharmacy enhanced service program will increase by 20%

Service Cycle Workflow of an SDoH Patient

How can the implementation of an SDoH Specialist model fit into an established pharmacy workflow? The first step in the integration of an SDoH Specialist in pharmacy workflow is establishment of enhanced clinical services such as comprehensive adherence counseling, medication reconciliation, home delivery services, etc. Once these services are being provided, patient identification can be integrated into these services.

For example, if a patient suffering from asthma chooses to use home delivery services to have their medications delivered, the delivery driver has the opportunity to assess the patient's environment and identify adherence barriers the patient may be facing that cannot otherwise be identified in the pharmacy setting. Upon delivery, the driver may notice that the patient lives in an older residence that contains carpeting that may contribute the exacerbations of the patient's asthma. This should trigger the delivery driver to identify this patient as a potential benefactor of SDoH Specialist intervention. Upon identification that the patient is a candidate for screening, the delivery driver can then proceed to conduct the "Delivery Driver Screening Assessment" **(Appendix D).** The results of the screening can then be uploaded into the pharmacy SDoH program tracker and analyzed for indications for SDoH Specialist intervention. If a positive outcome is determined, the SDoH specialist can create a patient-specific action plan utilizing community resources available to the patient to address their social barriers. Collaborating with the patient, the SDoH Specialist can refer the patient with asthma to a social service who can remove carpeting for patients suffering from pulmonary conditions.

In this example, the SDoH Specialist was the link between the pharmacy, patient, and community resources that will address/benefit the patient's health outcomes. Finally, the SDoH specialist will follow-up with the patient and assess the outcomes of the referral and amend the patient's plan as necessary should additional barriers/concerns arise. Please refer to **Figure 5** and **Table 10** below for additional information on roles of the pharmacy team and the SDoH Specialist throughout the patient care process.

Figure 5. Example Service Cycle Workflow of an SDoH Patient

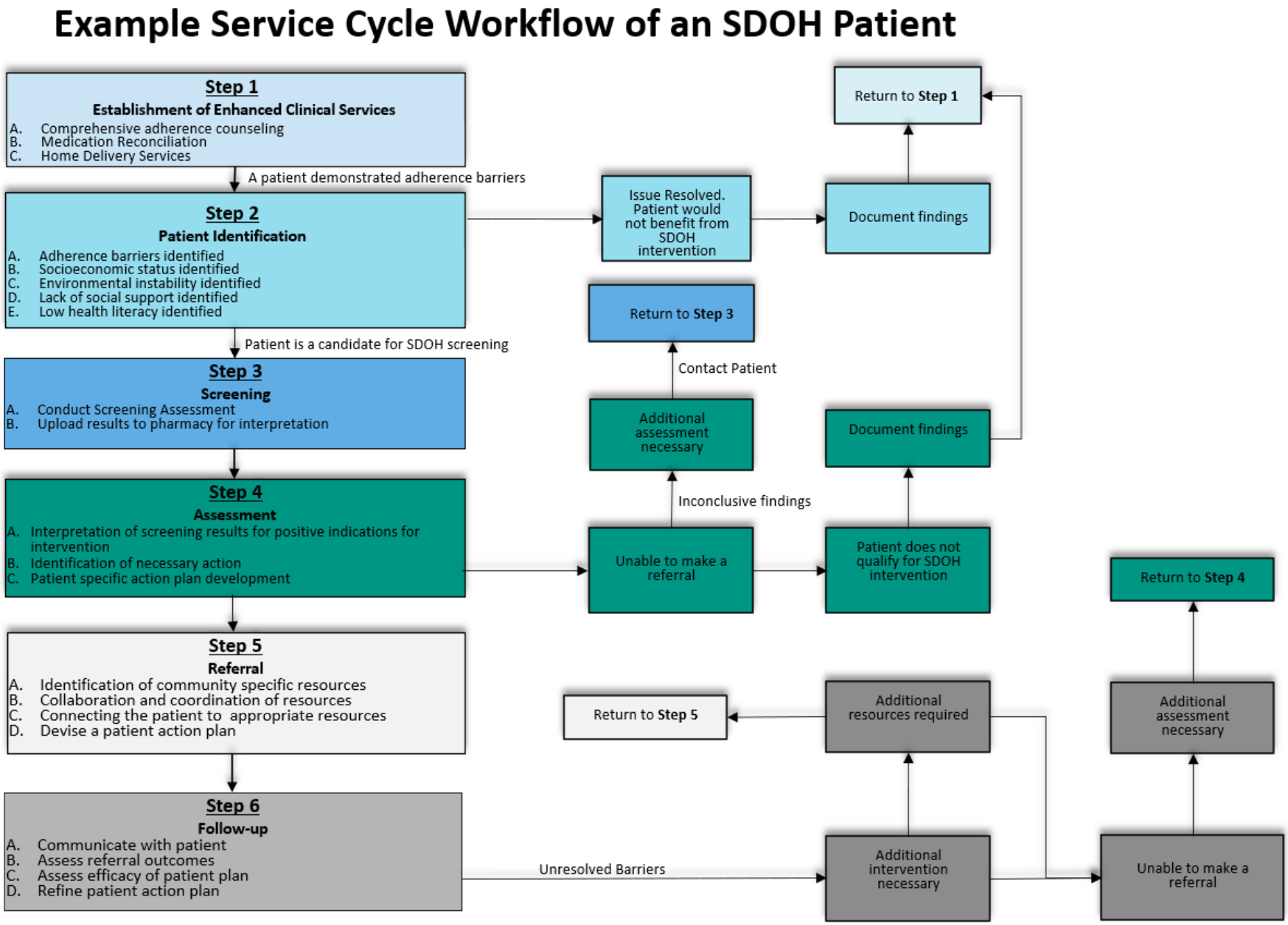


Table 10. SDoH Program Pharmacy Staff Roles

SDoH Service Cycle Roles		
STEP	**ACTIVITY**	**ROLES**
1	Comprehensive Counseling Services	Primary Role: Pharmacist and Intern
	Medication Reconciliation	Primary Role: Pharmacist and Intern
	Home Delivery Services	Primary Role: Delivery Driver Secondary Role: CHW/ SDoH Specialist – additional delivery training
2	Identify Adherence Barriers	Primary Role: CHW/ SDoH Specialist Secondary Role: Pharmacist, Intern, Technician, and Delivery Driver through routine patient interactions
	Socioeconomic Status Identification	
	Environmental Instability Identified	
	Lack of Social Support Identified	
	Low Health Literacy Identified	
3	Conduct Screening Assessment	Primary Role: CHW/ SDoH Specialist Secondary Role: Delivery Driver while performing routine services
	Upload Patient Results into the HUB	
4	Interpretation of Screening Results	Primary Role: CHW/ SDoH Specialist Secondary Role: Pharmacist and Intern- through collaboration with the CHW/ SDoH Specialist
	Identification of Necessary Action	
	Development of Patient Specific Action Plan	
5	Identification of Community Specific Resources	Primary Role: CHW/ SDoH Specialist
	Collaboration and Coordination of Resources	
	Connecting the Patient to Appropriate Resources	
	Devise a Patient Action Plan	Primary Role: CHW/ SDoH Specialist Secondary Role: Pharmacist and Intern- through collaboration with the CHW/ SDoH Specialist
6	Communicate with the Patient	Primary Role: CHW/ SDoH Specialis Secondary Role: Pharmacist, Intern, Technician, and Delivery Driver
	Assess Referral Outcomes	Primary Role: CHW/ SDoH Specialist Secondary Role: Pharmacist and Intern- through collaboration with the CHW/ SDoH Specialist
	Assess Efficacy of Patient Plan	
	Refine Patient Action Plan	

Pharmacy-Based Needs Assessment for SDoH Program

This tool is designed to give you a preliminary gauge of readiness to provide SDoH services. It is not intended to be a comprehensive assessment of an individual pharmacist's or a site's readiness to provide SDoH services. Consider the local programs and patient population of your pharmacy as you explore new opportunities. Now is the time to start making the changes to your practice to incorporate new SDoH services. You are trying to incorporate some changes to your pharmacy practice and workflow to prepare yourself for these new services. Keep pushing forward and make sure you continue to evaluate your strengths, weaknesses, opportunities, limitations, and targeted patient population while you are incorporating new SDoH services into your practice.

Implementation Template

The following domains in **Table 11** will need to be addressed before starting a SDoH program. This is a basic checklist and should not limit the development of practice transformation. It is also recommended to consider the questions in **Appendix B** while developing your SDoH program.

Table 11. Implementation Domains

Domain	Example Items to Consider
Program Scope	• Development of Mission Statement
Training Programs (SDoH Expertise)	• Affordable, Legal, Accessible, Adaptable from pharmacy to pharmacy, other
Staff Development	• Conduct initial meeting with staff • Explain mission and vision of program • Provide training on social determinants of health and health equity • Assess implicit biases among the health care team • Provide training for cultural proficiency
Workflow	• Create flags, prompts, and templates for electronic health records or paper charts • Formalize protocol for addressing social determinants of health • Provide staff training on new protocols • Make staff assignments • Define roles of pharmacy staff
Technology	• Track the patient experience and highlight opportunities for addressing social determinants of health • Create and implement a system to track and communicate interventions • Documentation of SDoH services via e-care plan utilization and submission
Resource Development	• Create a list of community-based resources, or incorporate use of outside services

V. Implementation Plan – Phase II

Example SDoH Program Forms

The following are helpful, example resources designed to help you implement and maintain a SDoH program that meets the needs of your pharmacy and your community. Patient screening tools, inclusion/exclusion criteria, documentation forms, and other data collection and tracking forms are necessary to manage a SDoH program. **Table 12** details many of the forms currently in use by the toolkit partners and community pharmacies.

Table 12. Example SDoH Resources for a Community Pharmacy Practice

Form	Description	Toolkit Appendix Reference
Patient Needs Assessment and Consent[1-2]	• A document for screening clients for potential needs, issues, and appropriateness for the SDoH program. The tool details the inclusion and exclusion criteria and identifies needs (socioeconomic, housing, and social support) and areas for possible intervention (health conditions, medication compliance, mental health, and falls). • Also obtained consent is a vital process for permission to enter home and engaged the patient in case management.	Appendix **C**. L&S Example of Patient Needs Assessment and Consent Forms
CHW/SDoH Specialist Driver From[1]	• Initial screening for clients for potential needs. Can be done by any pharmacy employee that engaged patient in home environment (e.g. – delivery driver) • This is meant to be entry level, and a source for referrals to SDoH specialist and CHW.	Appendix **D**. L&S Example of Driver Form for Home Visit Needs Assessment
Resource Packet Examples[1]	• Provides information on local and accessible resources within neighborhood that address social determinants of health. • Development of a resource table is one of the first steps a community pharmacy should take to start addressing patient needs related to SDoH.	Appendix **E**. L&S Example of Resource Packet
Intervention Worksheet[1, 3]	• A tracking form to identify services, referrals, and client aids needed to be deployed in the home.	Appendix **C & E**
1. L&S Pharmacy 2. FtP 3. CPESN SC / University at South Carolina		

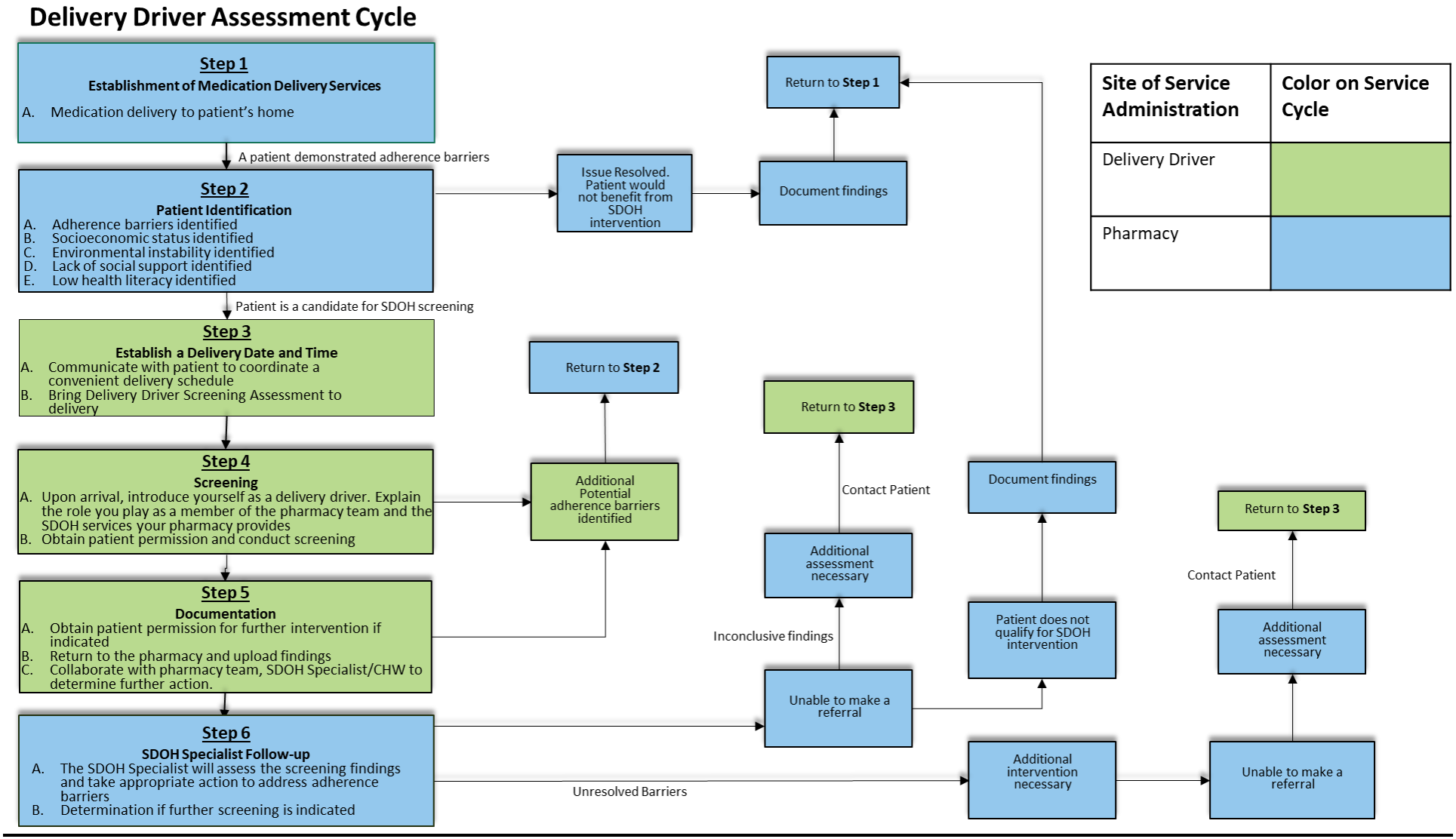
Delivery Driver assessment

Delivery drivers could integrate the pharmacy SDoH services into their daily duties. They have a unique role in interacting with patients outside the pharmacy which creates a potential for identification and screening of SDoH barriers patients may have that would otherwise go unnoticed by the pharmacy. They can assist SDoH Specialists in the identification of patients who would benefit from SDoH services based on their field screening. Delivery drivers could meet patients' needs by coordinating their delivery schedules to conjointly screen a patient for a SDoH issue while delivering their prescriptions. Drivers can report their findings to the pharmacy SDoH program database and collaborate with the rest of the team for further actions. This enhanced clinical service offering increases the impact potential the SDoH Specialist has on the at-risk patient populations the pharmacy serves. Please refer to **Table 13** and **Figure 6** for more information on aspects of delivery driver SDoH program involvement.

Table 13. Delivery Driver Home Visit Process

Delivery Driver Home Visit Process	
1) Patient Identification / Assignment	This process will be identification of patient by the pharmacy team for a variety of reasons but not limited to: 1. Adherence barriers identified: example- patient is unable to afford medications and refuses them when delivered 2. Socioeconomic status identified: example- patient expresses an inability to afford their bills/expenses 3. Environmental instability identified: example- changing addresses or telephone numbers often 4. Lack of social support identified: example- patient is unable to drive and has no one to help them make doctor's appointments or get groceries 5. Low health literacy identified: example- patient is unaware what their medications are for when delivered/ communicating with pharmacy staff
2) Pharmacy personnel (e.g., delivery driver) will establish a delivery date and time with the patient that is mutually convenient and perform the delivery service.	The Delivery Driver or Pharmacy Technician will establish a delivery date and time with the patient that is mutually convenient and perform the delivery service. ▪ Bring the Delivery Driver Screening Assessment to the delivery.
3) Pharmacy personnel (e.g., delivery driver) performs screening assessment	1. Upon arrival, introduce yourself as the delivery driver. Explain your role in the pharmacy and as a Social Determinates of Health Specialists, what it means to be an SDoH Specialist and what services you can provide them in addition to delivering their medications. 2. Observe the patient's overall health and environment for any "triggers" that may indicate further screening is indicated: example- the delivery driver may observe that a patient with asthma is living in a home with old carpeting and cannot afford to replace it. 3. Document findings to the pharmacy: Return to the pharmacy and upload findings, collaborate with Pharmacist and
4) Determine if the patient is a candidate for further intervention and obtain patient permission	This is done by the SDoH Specialist / CHW back at the pharmacy
5) SDoH Specialist/CHW to follow-up with patient as needed and determine if further intervention is needed	This is done by the SDoH Specialist / CHW back at the pharmacy

Figure 6. Delivery Driver Assessment Cycle



Development of a SDoH Resource Table

What is a SDoH Resource Table?

A resource table provides information on local and accessible resources within your neighborhood that address social determinants of health. These local resources can then be provided to your patient for referral and support. Development of a resource table is one of the first steps a community pharmacy should take to start addressing patient needs related to SDoH. Next, we provide an example of how a resource table can be utilized as well as templates/examples to help you create one for your pharmacy.

Example of how information on the resource table can be utilized.

Case Study: Jane Smith participates in a community pharmacy SDoH program at Pharmacy X. The SDoH Specialist at Pharmacy X identifies that Jane Smith has difficulty obtaining food. The SDoH Specialist utilizes the Resource Table within the pharmacy to identify a local resource that can assist with food access and insecurity. An example of a food access resource is provided below. The SDoH Specialist follows the Referral Guidelines and provides this resource to Jane Smith.

Agency	Information
Food Bank	**Address:** 0001 Blue Lane
	Phone Number: (888) 888-8888
	Website/Phone Resources: www.fddbnk.com
	Services Provided: Child Feeding Programs and Senior Feeding programs
	Contact Person: Edgar Allen Poe
	Preferred Referral Procedure: Email - Edgar.AllenPoe@XYZ.org

Resource Table Template

A blank Resource Table template is provided below in **Figure 7**. We recommend the following guidelines for completion of the Resource Table at your community pharmacy:

1. Identify 2-3 key resources related to pertinent social determinants of health in your area including:
    i. Resources to meet daily needs (e.g., safe housing and local food markets),
    ii. Community-based resources in support of community living,
    iii. Transportation options,
    iv. Social support.
2. Call the organization and establish contact with them about their services and the appropriate contact person. Ask the organization what the most appropriate procedure and person would be for referrals. Indicate the preferred mode of contact (e.g., email, phone call).

Figure 7. Resource Table Template

Agency	Information
[Organization Name]	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
	Contact Person:
	Preferred Referral Procedure
[Organization Name]	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
	Contact Person:
	Preferred Referral Procedure:
[Organization Name]	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
	Contact Person:
	Preferred Referral Procedure:
[Organization Name]	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
	Contact Person:
	Preferred Referral Procedure:

Financial Reimbursement

Currently, there are no uniform billing or reimbursement models for community pharmacy services focused on social-related issues. Existing programs are supported by four major, but temporary, financing models: charitable foundations and government agencies; Medicaid; federal, state, or local governments; and private organizations. In order for community pharmacy SDoH programs to be sustainable, a more permanent model of funding needs to be developed. Toolkit collaborators are currently investigating the methods described in below sections and how to make these methods more permanent for community pharmacy SDoH programs.

Potential Sources of Income for a Community Pharmacy SDoH Program

Community pharmacies commonly find that reimbursement for providing additional clinical services is challenging. A practical approach to obtaining reimbursement for clinical services may be a "start small and expand" model, where community pharmacies would obtain buy-in and patient engagement from their surrounding community, then expand that buy-in to county, region, state, then finally national stakeholders. The reverse-pyramid diagram in **Figure 8** further depicts this concept. The flowchart in **Figure 9** demonstrates the type of reimbursement models most likely to be found, how different payers may fit into these models, and how CHW's and SDoH specialists could receive reimbursement in these models. It would be envisioned that the SDoH program would have certain services that meet fee-for-service criteria while other services would meet value-based care criteria, with an ultimate goal of reaching the hybrid model payment structure. **Table 14** below describes how all three of these payment models may be utilized by community pharmacies to obtain reimbursement for their SDoH programs.

Along with the ideas mentioned above, community pharmacies should also consider Z code billing, defined as coding for SDoH-related problems that cannot be documented under a specific disease state, applying to all healthcare settings and being accompanied by any performed procedure codes.[28] While pharmacists are not yet recognized as healthcare providers, Z codes may be an answer in the meantime to sustain community pharmacy SDoH program services. In 2020, Medicare reported that there is current underutilization of Z codes, with only 1.4% of Medicare beneficiaries having Z code claims in 2017, providing an opportunity for community pharmacies to take advantage of these underutilized funds.[28]

Positioning of Community Pharmacy in Reimbursement Systems for a SDoH Program

As discussed in the section above, it is suggested that community pharmacies start local and expand their reimbursement requests for services thereafter (local → national). It is crucial that community pharmacy move from a fee-for-service model to a value-based care model and/or hybrid reimbursement model in order to thrive in the clinical-based services arena. **Table 14** below describes what SDoH activities may fit under fee-for-service or value-based care payment models. The overall goal would be to bundle both of these sections to enter the hybrid payment model arena.

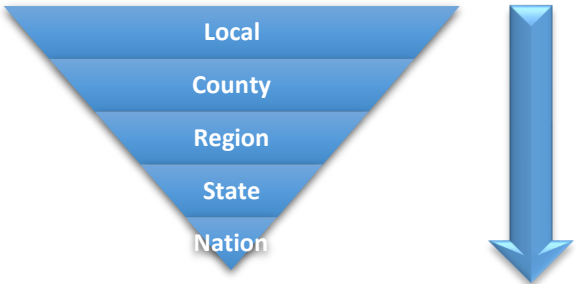
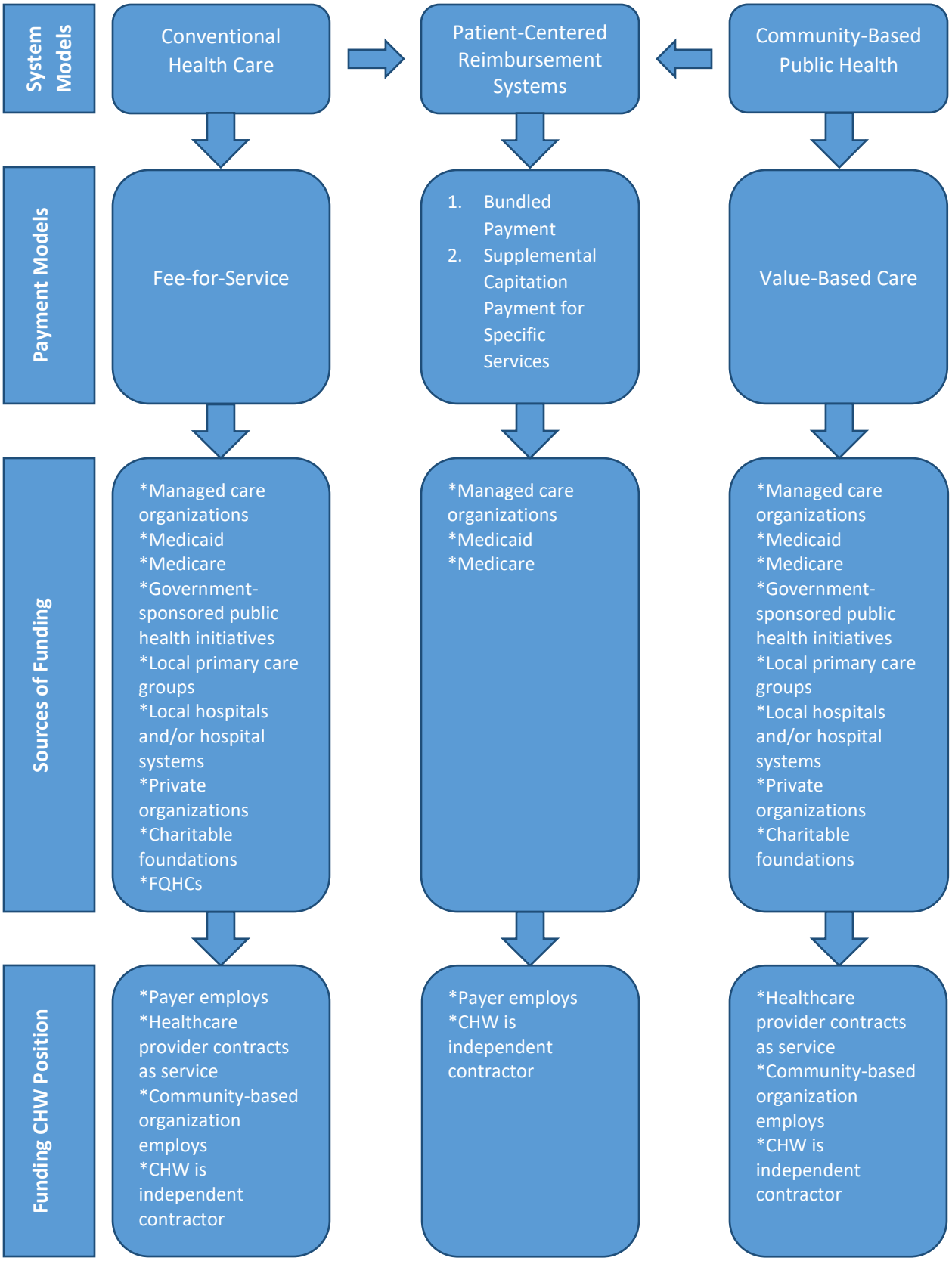


Figure 8. Potential Layers of SDoH Program Reimbursement Relationships

Table 14. Layers of SDoH Program Intervention Team

Layer	Organization	Western New York Examples
Community	Local CHW Group	Community Healthcare Worker Program (Catholic Charities)
	Local hospital systems	Hospital Systems (Catholic Health, ECMC, Kaleida Health)
	Local primary care groups	Buffalo Medical Group, UBMD Physician's Group
	Local Federally Qualified Health Center	Jericho Road Community Health Center, Neighborhood Health Center, Community Health Center of Buffalo
	Local CHW Group	Community Health Worker Network of Buffalo
County	Department of Health	Community Wellness Division
	Department of Health	Community Health Education and Outreach Division
	Department of Health	The Healthy Neighborhoods Program
	Legislative Group	Erie County Board of Health
Region	Department of Health	New York State Western Region Department of Health (Counties Served: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming)
	Regional CHW Group	Community Health Worker Network of WNY
	Regional Community Health Initiative Group	Population Health Collaborative of WNY
	Regional Community Health Initiative Group	The WNY Healthy Communities Coalition
	Local Third Party Payer	Independent Health
	Local Third Party Payer	Blue Cross Blue Shield of WNY
	Regional Community Health Initiative Group	WNY Healthcare Association
	Regional Health Data Collection System	HEALTHeLINK
	Regional Community Health Initiative Group	WNY Public Health Alliance
	Regional Community Health Initiative Group	Community Action Association of WNY
State	Department of Health	Department of Health
	State Community Health Initiative Group	NYS Health Foundation
	State Healthcare Professional Group	New York Alliance for Careers in Healthcare
	State Community Health Initiative Group	Community Health Care Association of NYS
	State CHW Group	Community Health Worker Network of NYC
National	National CHW Group	National Association of Community Healthcare Workers
	National Public Health Initiative Group	Centers for Disease Control and Prevention
	National Public Health Group	American Public Health Association
	National Public Health Initiative Group	Commonwealth Fund
International	International Public Health Initiative Group	CHW Central

Figure 9. Possible Pathways for SDoH Program Reimbursement



SDoH Reimbursement Based Upon Stages of Care

A care model is critical for effective cycles of clinical patient care but may also provide a framework for pharmacies to bill for the services they provide. In **Figure 10** below, the CPESN Care Model shows the individual steps in the patient care workflow through which patients are cared for and is applicable to a wide range of patient care domains. Applied to SDoH, one can see how each individual step in the process provides opportunities for reimbursement, both through a fee-for-service model and a value-based care model. For more detailed examples, see **Table 15** below.

Figure 10. CPESN Care Model

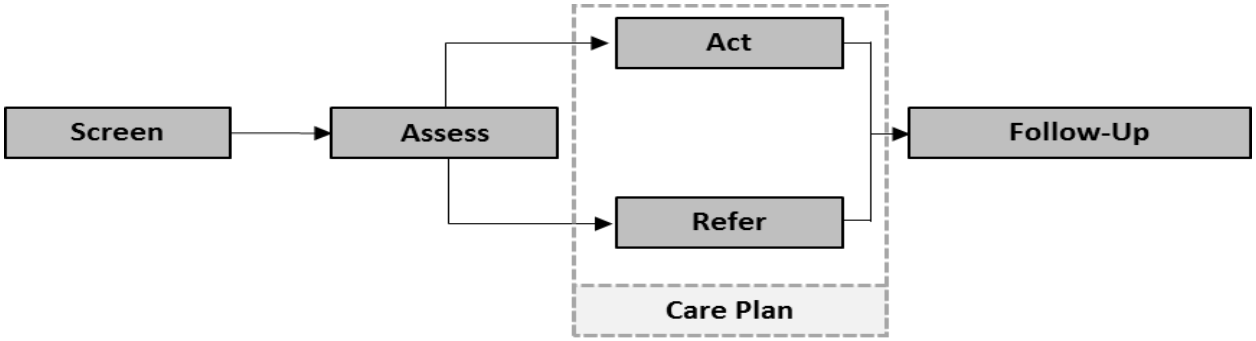


Table 15. Potential Models for Reimbursement by CPESN Care Model Workflow Step

SDoH Workflow Step	Fee-for-Service	Value-Based Care
Screen	Screening forms complete	Predetermined quality metrics are screened for based on patient responses to general questionnaire (Ex: further questions regarding a specific disease state or SDoH))
Assess	Patient assessment complete	Predetermined quality metrics are assessed based on patient screening results (Ex: further work up regarding a specific disease state or SDoH)
Care Plan: Act	Patient provided with action plan	Predetermined quality metrics are basis of patient action plan, that if followed will lead patient to meeting metrics (Ex: action plan to better manage a specific disease or improve SDoH)
Care Plan: Refer	Patient provided with referrals	Predetermined quality metrics are basis of patient referrals, that if followed will lead patient to meeting metrics (Ex: patient referred to receive screening for specific disease state or to receive counseling for improvement of SDoH)
Follow-Up	Patient contacted at pre-specified time frames based on assessment and care plan	Predetermined quality metrics are basis of patient follow-up conversations to ensure patient is trending towards reaching metrics and/or is staying at goal with metrics (Ex: patient reports values taken at home for specific disease state or improves score on SDoH questionnaire)

VI. Additional Considerations

Contracting

Financing Models

There are four generally recognized models associated with financing CHW programs:[29]

1. Charitable foundations and government agencies
   While these are the most common type of funding, contracts with these types of organizations typically have strict requirements and are often disease specific.
2. Medicaid
   Under Medicaid regulations, CHWs are recognized as billable providers of preventative services. However, they may not bill directly, and must do so through a recognized program. Furthermore, the guidelines regarding the disbursement of Medicaid funds to CHWs varies from state to state. On the other hand, CHWs may also form a Managed Care Contract, and receive reimbursement based upon the number of enrollees in the CHW program.
3. Federal, state, or local government
   Funded by taxes and found in budgets that fund local/state/county hospitals and health departments.
4. Private organizations
   Typically, hospitals or health systems, managed care organizations, insurance companies, and employers. In these cases, CHWs are either reducing inappropriate healthcare utilization, or maintaining a healthy workforce.

Legal Considerations

Scope of Practice

Many pharmacists and support personnel have the opportunity to participate in these interventions. However, SDoH programs must be financially sustainable. Billing in this regard is a concern for pharmacy and is dictated by scope of practice. Therefore, the credentialling of pharmacists and/or support personnel, either with additional CHW training or medical contractor training, will be required.

Consenting Patients

Many SDoH programs require pharmacies to collaborate with other healthcare entities (local department of health, social service organizations, community organizations, etc.). Therefore, protected health information needs to be transferred between two or more HIPAA-covered entities. The current national standard is to obtain permission or consent from the patient as part of the screening process before referral to the service entities that provide these social care services. Therefore, pharmacies need to be aware that there potentially legal details that need to be worked out before an individualized SDoH program can be activated. For an example of a patient consent form, see **Appendix C.**

VII. Pharmacy Spotlight

L&S Pharmacy

Charleston, MO
Website: www.semorx.com

Tripp Logan, PharmD **Richard Logan, Jr., PharmD**

SDoH Model: Community Health Worker

About

L&S Pharmacy has been a community institution in Charleston, Missouri for over 40 years. It was founded in 1976 by Richard Logan, Jr., but more recently hi son Tripp has been carrying the torch. Their CHW services complement the extensive offering of clinical services they have already offered for years. They continue to tailor their services to best fit the needs of their community, and ensure they provide the best possible care for all their patients.

SDoH Program

A part of the SEMO Rx family of pharmacies, L&S has been a pioneer in the implementation of SDoH screening. The success of the program success of the program has been built on integrating into current clinical workflow while developing, enhancing, and maintaining relationships with community members and organizations. Their approach, to screen for SDoH among home delivery recipients, has so far resulted in over 200 referrals to CHWs and over $87,000 in annual out of pocket Rx costs to patients. Delivery drivers provide an SDoH screening form to patients, which is then reviewed by a trained CHW. The CHW, a cross-trained pharmacy technician may then choose to meet with the patient one-on-one if they screened positive for any SDoH needs. Guiding their program is their mission statement: “Through our pharmacy’s CHW initiative, we believe we can better serve our community, connect more patients to the local services they need, and create new opportunities for our local community pharmacy practice.”

Rather than refer out to a third-party service, L&S has CHWs employed directly at the community pharmacy level, and offer a cassette of individualized care coordination services including medication scheduling and refills, help navigating the healthcare system, communicating with prescribers, and connection to local care services that meet the patient’s individual need

Services Offered

- Appointment Based Medication Therapy Management
- Asthma Support
- Chronic Care Management
- Chronic Disease Self-Management Classes
- Comprehensive Medication Reviews
- Depression Screenings
- Diabetes Support Group
- Free Blood Pressure Checks
- Free Blood Glucose Checks
- Free Prescription Delivery
- Medication Adherence Packaging
- Schedule Immunizations
- Pediatric Asthma Support
- Pharmacogenetic Counseling
- Pre-Diabetes Prevention Program
- Self-Monitoring Blood Pressure
- Vaccinations

Lincoln Pharmacy

Albany, NY
Website: https://www.albanylincolnpharmacy.com/

SDoH Model: Social Determinant of Health Specialist

Zarina Jalal, PharmD

About

Lincoln Pharmacy has been an Albany institution since 1935. In that time, they have broadly expanded their clinical services and continue to serve the health of Albany, NY. Their SDoH referral program complements the range of clinical services they offer, and furthers their goal of treating the whole

SDoH Program

Lincoln Pharmacy been leader in optimizing the role of the SDoH specialist. These trained individuals (e.g. – delivery drivers, technicians, etc…) utilized a trigger assessment, followed by an SDoH questionnaire. Patients who meet any of the "triggers" are asked to complete a short questionnaire about various SDoH needs. Initially the screening was performed as part of a monthly behavioral health check-in. The screening form is reviewed, and those who were identified to have an SDoH need were consented and referred through the Alliance for Better Health (ABH) Hub which made use of the Unite Us software platform in a closed-loop communication. Targeted referrals are also made to specific organizations or resources if the person reviewing the form believes it would be an especially good fit.

This program has evolved to incorporate a bidirectional referral process where the ABH caseworker would refer into the pharmacy for patients needing assistance with disease state education or medication adherence/education etc. Targeted referrals are more likely to result in a meaningful interaction between the patient and social support, though patients referred in this way are more likely to be lost follow up.

Services Offered

- Comprehensive medication counseling
- COVID-19 rapid testing
- Free prescription delivery and pickup
- Immunizations
- Individualized medication adherence packaging
- Medication coordination

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Appendix A. Community Health Worker Training Recommendations/Requirements by State as of June 2018

State	Certification/Training	Cost, Format
Alabama	The Wellness Coalition Training	In person training
Alaska	Community Health Aide Program (CHAP) Training Certification Board	4-week course, completion of number of practice hours, patient encounters, clinical village experience, at least an 80% on final exam, 100% on mathematics exam. *Reimbursement available for CHAP services, Physician supervision required.
Arizona	Legislation passed in 2018 for Voluntary Certification of CHWs overseen by the Arizona Department of Health Services. This process is not yet active. Current certificate and training programs include Certificate of Higher Education from a Community College with a CHW Program, and Certificates of Completion from professional development workshops and trainings. Arizona CHW Association	Voluntary Certification from ADHS will have a cost once process is final, Community College tuition rates apply.
Arkansas	Arkansas CHW Association has adopted the national C3 Core Competencies CHWs complete the Healthy Homes for CHWs course from the National Healthy Homes Training Center Medicaid does not currently reimburse for CHW services	Face to face, self-paced online and instructor led online courses available
California	California Association of CHWs, San Diego County Promotores Coalition, Vision y Compromiso Currently no state process for training or curricula	--
Colorado	Colorado Departments of Healthcare Policy and Financing & Department of Public Health and Environment Health Navigator Training Program not required by state Limited funding for CHW work may be funded through Medicaid Regional Care Collaborative Organizations Colorado Community Health Worker & Promotor de Salud Alliance	Accountable Care Collaborative program provides grant funds for CHW training programs

State	Certification/Training	Cost, Format
Connecticut	Colorado Department of Public Health State Innovation Model Director currently creating a CHW certification plan CHW Association of Connecticut, Connecticut Areas Health Education Center Program	Southwestern Connecticut Area Health Education Center (AHEC) provides CHW Training
Delaware	Delaware Center for Health Innovation & Division of Public Health Establishing a CHW Training Program To Be Determined Providers working with CHWs in Delaware include Christiana Healthcare System, La Red Health Center, and Beebe Healthcare	Recommendations are being made by the CHW Subcommittee CHW services are currently not reimbursed
Florida	Florida Department of Health Division of Community Health Promotion & Division of Disease Control	Florida CHW Coalition offers voluntary certification administered by Florida Certification Board Florida Area Health Education Center and Community College provide training Many programs have also developed their own training programs like Rural Women's Health Project, Healthstreet and Connect Families
Georgia	Georgia Department of Public Health Section of Chronic Disease Prevention Georgia CHW Advisory Board Georgia Clinical & Translational Science Alliance (Georgia CTSA) Morehouse School of Medicine Prevention Research Center	Payment/Reimbursement models are currently being explored Training available on competency-based curriculum and chronic disease areas
Hawaii	University of Hawaii - Maui College	Community Health Worker Certificate of Competence

State	Certification/Training	Cost, Format
Idaho	Idaho Department of Health and Welfare Idaho State University	Idaho Medicaid's Primary Care Case Management program incentivize providers to include CHWs in care coordination. For per member, per month payment. Not yet utilized by providers. CHW Training Course No cost for Idaho residents
Illinois	Illinois Department of Public Health CHW Advisory Board has created core competencies for CHWs	South Suburban College
Indiana	Indiana State Department of Health Indiana Community Health Worker Association (INCHWA) certified CHW training vendors	Indiana Medicaid does not reimburse for CHW services INCHWA is currently creating a certification exam
Iowa	Iowa Chronic Care Consortium & Community Health Worker Alliance of Iowa have developed C.O.R.E skills development training for CHW workforce	Iowa Medicaid does not reimburse CHW services $300.00. Discounted rate if working in specific counties
Kansas	Kansas Department of Health & Environment Bureau of Community Health Systems Kansas CHW Coalition	Medicaid Managed Care Organizations employ CHWs Currently state training process if being developed.
Kentucky	Kentucky Cabinet for Health and Family Services - has a CHW State Workgroup who is developing a curriculum and certification plan	University of Kentucky Center for Rural Health. Kentucky HomePlace Program trains CHWs on social, environmental, medical and health education services
Louisiana	Louisiana Community Health Outreach Network	Louisiana Community Health Worker Training Institute offers training on core competencies. A state approved training is available for peer support specialist

State	Certification/Training	Cost, Format
Maine	MCD Public Health Maine State Innovation Model created the Maine Health Homes program for Community Care Team to include CHWs Maine Community Health Worker Initiative have developed training recommendations	Online CHW Training $80
Maryland	Maryland Office of Minority Health & Health Disparities Maryland Health Education Center	CHW Training Institute offers training on core competencies
Massachusetts	Massachusetts Department of Public Health Office of Community Health Workers defines the workforce. MA Association of Community Health Workers	Training covering core competencies is available through local health departments, community organizations, colleges and universities. Contact CHW Certification Board
Michigan	Michigan Community Health Worker Alliance created training standards State Division of Chronic Disease and Injury Control	Michigan Community Health Worker Alliance holds trainings in mid-Michigan about twice a year.
Minnesota	Minnesota Department of Health and the Medicaid Agency Department of Human Services CHW services are reimbursed by Medicaid for certain services on a fee-for-service model MN CHW Peer Network and MN CHW Alliance	Post-secondary schools that are under the state college and university system offer CHW Training Programs
Mississippi	Tougaloo College, State Department of Health and Area Health Education Center developing certification process.	Currently CHW training is provided at Tougaloo College
Missouri	Department of Health & Senior Services Statewide CHW Advisory Committee, no current state CHW Association Medicaid reimburses for home-based asthma services.	CHW training programs are provided at local community colleges CHW ECHO (Extension for Community Healthcare Outcomes) program is being developed for more education opportunities for CHWs d
Montana	No state certification requirements currently. Training overseen by: Montana Office of Rural Health and their AHEC	7 weeks to complete and includes of five online Learning Modules and 25 hours *Supervised Experience* conducted in a facility/agency.

State	Certification/Training	Cost, Format
Nebraska	IHS certified CHRs (certified Health Representatives) NO other state certification currently, but heavy focus on workforce development and competency alignment Free training until SEPT 2018 here at Public Health Association of Nebraska: LINK	On-line
Nevada	State requires CHW "pool" certification for agencies who hire CHWs. Nevada Division of Public and Behavioral Health oversee CHW policy issues Training resources: Nevada Community Health Worker Association under "Workforce Development"	Curriculum is offered by several sources "as needed". In person and online formats
New Hampshire	No certification currently. Training: S. New Hampshire Area Health Education Center at set dates/times New Hampshire Community Health Worker Coalition	7-day course.
New Jersey	Certification - Yes if meets training requirements set by New Jersey Dept of Labor Training: Rutgers CHW Training Program	On-line training via NJ Public Health Training Center/Rutgers
New Mexico	Certification is voluntary and managed through the NM Dept of Health, Office of Community Health Workers. Training resources: New Mexico Community Health Workers Association Training: New Mexico School of Medicine	Face to face training, video modules, weekly tele-conferences.
New York	Certification - not currently Training resources: Community Health Worker Network of New York City	Community Health Worker Network of NYC curriculum (used state-wide) is available as a 35-hour and 70-hour course of study. In addition to the core competencies, training in disease-specific topics is available in modules of up to 35 additional hours. The disease-specific training includes Diabetes, Asthma, Hypertension, Cardio-Vascular Disease and Nutrition.
North Carolina	Certification: None currently offered by the state Training: not offered by the state - good place to start: Foundation for Health Leadership and Innovation Another good resource: North Carolina Area Health Education Center	--
North Dakota	--	--

State	Certification/Training	Cost, Format
Ohio	Certification - yes Link Training resources Link The Chicago CHW Local Network	In Ohio the Ohio Revised Code outlines competencies, performance standards, and curricular content to be included in education/training programs for CHWs. Training must be state approved; at least 100 hours of classroom instruction and 130 hours of clinical instruction, standard training exam.
Oklahoma	NO certification or formal training oversight	--
Oregon	Oregon State University CHW program Certification is voluntary but required to qualify for reimbursement - LINK Oregon Community Health Worker Association Oregon Dept of Human Services offers free training for CHWs LINK	CHW's must complete 80 hours of training from an approved training program and meet required competencies to become certified. On-line and on-site
Pennsylvania	No certification currently. Penn Center for Community Health http://chw.upenn.edu/about/Workers offers training and resources. "Advanced" CHW Training	Online and on-site. Appears very flexible.
Rhode Island	RI has CHW Certification - not mandatory - recommended. CHW state-level work overseen by coalition sponsored by RI. CHW training is largely subsidized by a variety of RI state departments (health, labor & training, Medicaid, and higher education), private foundations and some employers. There is no standardized curriculum for CHWs in RI.	Rhode Island College CHW program – 72-hour curriculum is aligned with the RI Department of Health standards and competencies. The program meets the 70-hour education requirement for RI CHW certification. Offered through Health Jobs R.I. with rotating class offering dates. Access: HERE
South Carolina	South Carolina Community Health Worker Association - primary contact for training and certification information.	240 hours in classroom or "experimental" formats authorized
South Dakota	No formal certification at state level currently. Training program recently developed at: Lake Area Tech	--
Tennessee	No formal certification/training program at state level. They are utilized by healthcare organizations LINK	Recommend online resources
Texas	State level certification and training requirements exist. Texas Health and Human Services oversee certification and training program HERE Also: Texas A&M CHW Cert Course	Multiple formats and locations. Training site info available at TXHHS and HERE Texas A&M course is very comprehensive -in person - 24 weeks
Utah	No formal state certification yet. Utah did approve core competency and curriculum requirements (first step towards certification) Utah CHW Coalition	Currently there is a Workforce Development group looking into training and certification - a great contact source for info LINK

State	Certification/Training	Cost, Format
Vermont	No Certification required at this time	None as of yet - however a recent (2016) study had been conducted and is a good resource to discuss efficacy of this program
Virginia	Institute for Public Health Innovation has training programs that cover certain areas in Virginia	IPHI has developed an accessible, comprehensive CHW training program that incorporates adult learning methods and meets the needs of diverse learners.
Washington	Washington State Department of Health	The Community Health Worker Training is a free eight-week combination of online and in-person training designed to strengthen the common skills, knowledge and abilities of the Community Health Worker. This training is offered quarterly in multiple locations around the state.
West Virginia	No state certification process or training approval currently. Training support offered through multi-state group: Institute for Public Health Innovation	Multi-format training
Wisconsin	No state certification currently. Training resources: Milwaukee AHEC. Another good resource for CHW support: United Voices	In person - but may discuss alternative options
Wyoming	No state certification or training oversight for new/grant opportunities check with Wyoming Dept of Health	Recommend national online resources that are competency-based

Appendix B. SDOH Community Pharmacy Self-Assessment for SDOH Program

1. How does your community pharmacy currently identify patient's social determinants of health (SDoH)? a. Collaborative approach with patient's doctor office b. SDoH transaction survey at the end of every receipt c. Verbal face-to-face inquires with open ended questions d. Observations from delivery drivers and technicians e. Patient self-reporting for need of assistance with their social life f. Our pharmacy currently does not identify patient's SDoH	**2. How does your community pharmacy document patient's SDoH?** a. Prompts in electronic health record (EHR) system b. Flags or stickers on patient's prescription c. Hard copy binder of high "need of assistance" patients d. We are interested in obtaining a third party CHW platform in the future e. No, our pharmacy does not document patient's SDoH
3. Whose responsibility is it to document patient's SDoH in your pharmacy (Select all that apply)? a. The supervising pharmacists b. The staff pharmacists c. The technicians d. The drivers e. The patient's doctor	**4. How does your practice currently help address patient's SDoH (select all that apply):** a. Screening for SDoH b. Maintain up-to-date records of community-resources c. Refer patient to community-based resources d. Engage patient about how to overcome their SDOH e. We do not address SDoH in our pharmacy
5. Does your practice provide patients with any of the following extra care services? (select all that apply) a. Encourage and practice patient-focused care b. Medication reconciliation/medication management c. Chronic disease state education and management d. Assist with patient medication refills e. Translator readily available to facilitate patient communication with pharmacist f. Assist patients with co-pay by finding coupon cards or discount cards g. No, our pharmacy does not identify patient's SDoH	**6. What systems does your pharmacy have in place to make sure SDoH are addressed at patient visits?** a. Soft/hard stops during POS transaction b. Alerts on patient's electronic health records c. Recall memory from technicians and staff members d. Emails the patient received from the pharmacy alerting them to speak to pharmacy staff e. Paper reminders at the front counter of specific patients to create an intervention with f. No, our pharmacy does not have a system in place
7. What are some of the challenges you and your pharmacy practice team face in identifying and addressing patient's SDoH? 1. Lack of available SDOH tool kit 2. Lack of time in workflow 3. Shortage of staff 4. Unorganized workflow 5. Increased documentation required 6. We do not face any challenges	**8. What has worked in the past to help identify and address patient's SDoH?** a. Referrals b. Coupon cards c. Hand Delivery of Medications d. Multi-lingual capabilities e. CHW on staff f. Medication synchronization program g. Medication adherence packaging h. Automatic refill program
9. Whose responsibility is it to work with patients to address SDoH (Selection all that apply)? a. The supervising pharmacists b. The staff pharmacists c. The technicians d. The drivers e. The community f. We currently don't address SDoH	**10. Is there a resource packet available in your community pharmacy that your patients could access to help address their SDoH?** a. Yes b. No
11. Does your practice site have resources of social services for the pharmacist to utilize? a. Yes b. No	**12. Does your pharmacy staff have a broad understanding of what Social Determinants of Health (SDoH) factors are and its importance?** a. Yes b. No
13. Does your pharmacy practice any outreach activities or services that fulfill social needs of patient's health? a. Yes b. No	**14. Does your practice site have an efficient system for storing individual records or have an open organized area to file paper records?** a. Yes b. No
15. Do pharmacists in your practice site document patient care/interactions, patient/provider communication and social worker/pharmacist interactions? a. Yes b. No	**16. Does your practice site have adequate workflow and time to provide SDOH program?** a. Yes b. No
17. Does your practice site have adequate staff to provide SDOH program? a. Yes b. No	**18. Does your practice site have wellness/social worker services in place already?** a. Yes b. No
19. Does your practice have delivery drivers or technicians that are multilingual? a. Yes b. No	**20. Does your practice site currently employ minority groups or refugees or plan to in the near future?** a. Yes, we currently employ minority groups/refugees b. No, but we are planning to in the near future c. No, we do not employ minority groups/refugees
21. Do pharmacist in your practice site market/promote existing patient care services? a. Yes b. No c. No, we do not have any additional patient care services	**22. Does your pharmacy have educational material available in multiple languages?** a. Yes b. No c. Yes, but only in limited number of languages d. Yes but we are not sure how to access it electronically to print out

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1st: VERIFY that we have a signed: Authorization for the release of protected health information (PHI) / HIPAA release on file at the pharmacy before moving forward. If not, have the patient sign our HIPAA release.

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CONSENT FOR SERVICES

CONSENT TO SERVICES: I hereby consent to and authorize such services as prescribed and fully explained to me by the Community Health Worker (CHW). It is not possible to make guarantees concerning the results of services. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss all care and/or services proposed to me with the CHW and I may refuse to consent for care services if I do not want to proceed with such course of services. I will provide the CHW with accurate information regarding my medical, sexual, drug and/or alcohol history, and personal or social concerns which may impact my health or medical care to ensure proper service, care, and referral for needed services.

I understand that if I am more than 15 minutes late for my appointment or home visit I may not be seen and will need to reschedule my appointment. I am responsible for notifying the appropriate CHW –at least 24 hours in advance – if I am unable to keep my scheduled appointment. To the best of my ability, I will be an active participant in my care. I am responsible for reporting any changes in my health status to my CHW so that I can receive prompt and appropriate education and referral services.

_____ INITIAL

If during an appointment of home visit with a CHW my situation is an emergency I will call 911 for assistance or go to the nearest emergency room.

_____ INITIAL

I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT AND AGREEMENT. I HAVE RECEIVED A COPY OF THIS CONSENT/ AGREEMENT, AND AM DULY AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT THE TERMS AS DESCRIBED. I UNDERSTAND THIS CONSENT/AGREEMENT IS EFFECTIVIE UNTIL REVOKED IN WRITING.

Signature of Client/Parent/Legal Representative _____ Date _____

Witness _____ Date _____

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INFORMED CONSENT FOR CASE MANAGEMENT

Your healthcare case management is voluntary and confidential. No information will be given out about you without your written permission except as required by law or to provide services to you in compliance with federal privacy and security standards.

Please note:

1. We are mandatory reporters of Statutory Sexual Seduction (N.R.S. 200.364). This means that if you are 15 years of age or younger and are having sex with someone 18 years of age or older and you tell us, we must report it to law enforcement.

2. We are also mandatory reporters of Child Abuse and Neglect (N.R.S. 432B.220). This means that if we have cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.

3. We are also mandatory reporters of lewdness (sex) with a child under the age of 14 (N.R.S. 201.230). This means that if we have a cause to believe that there are any kinds of vulgar or indecent activities occurring involving a child under the age of 14, we must report it to law enforcement.

I have the right to know everything about my care and am encouraged to ask questions.

I understand that in order for us to provide the services I request, I may need to disclose information of a personal nature and regarding my medical history. These may include:

- Date of birth
- Contact information
- Medications
- Past/Current medical issues
- Tobacco/alcohol/substance use
- Family dynamics

I have read (or have had read to me) the above information, understand this information, and give my permission for case management from the Community Health Advocate.

Signature:_____ Date: _____

Witness:_____ Date:_____

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NEEDS ASSESSMENT

A CHW provides a wide array of comprehensive services to assist clients with their healthcare needs. These services include: Behavioral Health; Social Services/Case Management; HIV, Hepatitis C, Diabetes, and Cancer Testing. To better assist you in accessing these services we respectfully request the following information:

First Name (first letter): _____

Last Name (first 3 letters): _____ _____ _____

Birth Year (last 2 digits): _____ _____

Birth Month: _____ _____

Zip Code (last 3 digits): _____ _____ _____

Client ID: _____

DO YOU NEED ASSISTANCE ACCESSING ANY OF THE FOLLOWING?		
	YES	NO
1. Health insurance (such as Medicaid)	☐	☐
2. Social Security Disability	☐	☐
3. Food	☐	☐
4. Department of Social Services	☐	☐
5. Housing	☐	☐
6. Employment training	☐	☐
7. Medication Services	☐	☐
8. Health Care Services	☐	☐
9. Emotional support	☐	☐
10. Translation/ Interpretation	☐	☐
11. Education/ School	☐	☐
12. Transportation	☐	☐
IN THE LAST 6 MONTHS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?		
	YES	NO
13. Homelessness or couch surfing	☐	☐
14. Unsteadiness, light headedness, or an accident that resulted in a fall		
15. Difficulty affording monthly rent and bills	☐	☐
16. Difficulty affording prescription medications and /or medical supplies	☐	☐
17. Difficulty affording or scheduling a doctor's visit	☐	☐
18. Are you interested in diabetes testing?	☐	☐
19. Are you interested in blood pressure screening?	☐	☐
20. Please indicate any other needs with which you would like assistance:		

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MEDICAL HISTORY

CLIENT NAME:_____

Home Phone:_____Birth Date: _____
Month Day Year

Spouse/Partner's Name: _____

Residence Street Address: _____
City, State, ZIP Code

Cell Phone:_____Work Phone:_____

Marital Status:	☐	Married	☐	Divorced	☐	Single	☐	Separated	☐	Widowed	☐ Engaged ☐ Domestic Partner
Employment Status:	☐	Full Time	☐	Part Time	☐	Self-Employed	☐	Stay at Home/ Homemaker	☐	Retired	☐ Unemployed
Student Status:	☐	Full Time	☐	Part Time	☐	N/A					

1. How would you rate your physical health?
   Excellent Very good Good Fair Poor Not sure

2. Are you now under the care of a physician? ☐ Yes ☐ No
   If yes, who is your physician?_____
   If no, date of last primary care provider visit: Month_____Day_____Year_____

   Have you been hospitalized in the past 6 months? Yes No

   If yes, when, where, what for?

   Date: Month_____Year_____

   Hospital:_____City, State: _____

   Diagnosis: _____

3. Do you utilize a pharmacy for your prescription and OTC medication needs?
   -If yes, which pharmacy? _____

4. How long has it been since you last visited a dentist or a dental clinic for any reason?
   (Include visits to dental specialists, such as orthodontists)

   ☐ Within the past 6 months ☐ Within the past 2 years ☐ Six or more years ago
   ☐ Within the past year ☐ Within the past 5 years ☐ Have never visited a dentist

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5. Height:_____ft_____inches Body Weight:_____lbs

6. Other than work, how many minutes of physical activity would you say you do each week? _____ minutes

7. Do you have access to fresh fruits and vegetables?

8. Do you currently use tobacco products such as cigarettes/cigars, e-cigarettes, chewing tobacco or hookah?

9. During the past 30 days, how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

10.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Medical Conditions

☐ **A-fib**	☐ **End Stage Renal Disease (Kidney Failure/Dialysis)**	☐ **High Blood Pressure**	☐ **Thyroid Disorder**
☐ **Anxiety**	☐ **End Stage Liver Disease**	☐ **High Cholesterol**	☐ ***Other:***
☐ **Asthma**	☐ **Enlarged Prostate**	☐ **HIV/AIDS**	
☐ **Bipolar Disorder**	☐ **Fluid Retention**	☐ **Memory Disorder**	
☐ **Bladder Control**	☐ **Gout (Arthritis)**	☐ **Mood Disorder**	
☐ **Blood Clot Prevention**	☐ **Heart Failure**	☐ **Nerve Pain**	
☐ **Cardiovascular Disease**	☐ **Heart Attack**	☐ **Osteoporosis**	
☐ **Chest Pain Constipation**	☐ **Heartburn**	☐ **Pain**	
☐ **COPD**		☐ **Seizures**	
☐ **Depression**		☐ **Sleep Disorder (Insomnia)**	
☐ **Diabetes**		☐ **Stroke**	

Notes:

Appendix D. L&S Example of D

Logan & Seiler, Inc
406 South Main St
Charleston, MO 63834
www.semorx.com
contactus@semorx.com
573-683-3307

BILLING CODE 32 FORM

PHARMACY DELIVERY/HOME VISIT NEEDS ASSESSMENT CHECKLIST (NON-CHW)

Affix Rx Label Here As Patient Identifier	Notes to Driver

Questions			Comments
Y	N	Does the patient live alone?	
Y	N	Have you ever seen the patient to have visitors? Friends or family	
Y	N	Is there an accessible walkway for entry? (ramps or rails)	
Y	N	Are windows and doors in proper working conditions?	
Inside the Home			**Comments**
Y	N	Have you observed clutter, trash or any obscene findings?	
Y	N	Is there electricity service inside the home?	
Y	N	Proper A/C or heat inside the home?	
Y	N	Does the home smell of smoke? (Tobacco, marijuana, other)	
Y	N	Have you observed smoke detectors in the home?	
Y	N	Are you able to visibly see any illicit drugs?	
Medications			**Comments**
Y	N	Did the patient ask you any questions about medications?	
Y	N	Are medications visible in the house?	
Community			**Comments**
Y	N	Does the patient ask you for assistance outside of the job description? Ex. transportation, financial assistance, cigarettes	

Driver Name:_____ **Date:**_____

Appendix E. L&S Example of Resource Packet

Agency	Information
American Cancer Society	Address: 2409 Hyde Park Rd, Jefferson City, MO 65109
	Phone Number: 573-635-4839
	Website/Phone Resources: Cancer.org/about-us/local/Missouri 660 resources in MO 59 events in MO 800-227-2345
	Services Provided: Breast cancer support, TLC Hair Loss & Mastectomy Products, Hope Lodge Lodging, rides to treatment, online support, Look Good Feel Better, understanding your diagnosis, finding and paying for treatment, treatment and side effects, children and cancer, help for caregivers and family, nearing the end of life
American Lung Association	Address: 7745 Carondelet Ave, Suite 305, Clayton, MO 63105
	Phone Number: 314-645-5505
	Website/Phone Resources: Lung.org missouri@lung.org
	Services Provided: Tobacco cessation, Better Breathers Club, Lung Force Expo, asthma home assessments, Asthma Educator Institute, asthma basics, lung health outreach, spirometry trainings, advocacy, research
American Heart Association	Address: HQ – 7272 Greenville Ave, Dallas, TX
	Phone Number: 800-242-8721
	Website/Phone Resources: heart.org
	Services Provided: Heart and stroke research, CPR and first aid, donations, equitable health for all, healthy communities, quality healthcare
United Way	Address: 1417 D, N. Mount Auburn, Cape Girardeau, MO 63701
	Phone Number: 573-334-9634
	Website/Phone Resources: unitedwayofsemo.org
	Services Provided: Educate help, income help, health, Read to Succeed Program
Local Housing Authority	Address: 700 S. Elm St, Charleston, MO 63834
	Phone Number: 573-683-2172
	Website/Phone Resources: N/A
	Services Provided:

Salvation Army	Address: 701 Good Hope St., Cape Girardeau, MO 63703
	Phone Number: 573-335-7000
	Website/Phone Resources: usc.salvationarmy.org/capegirardeau
	Services Provided: Addiction recovery, community care ministries, older adult ministries, missing persons, Salvation Army Camps, social services, women's ministries, youth ministries, emergency disaster services, Meals with Friends, family store
Domestic Violence Shelter/Assistance	Address: 601 W. Marshall St, Charleston, MO 63834
	Phone Number: 573-233-8391
	Website/Phone Resources: Swflc.com SWFLC Hotline: 800-382-7294 East Prairie Office: 573-649-3731
	Services Provided: Victim services, mental health counseling and trauma informed services, advocacy, supervised exchange and visitation, emergency shelter, 24-hour crisis line, violence prevention, batterer intervention
Local/County Health Department	Address: 1200 E. Marshall St, Charleston, MO 63834
	Phone Number: 573-683-2191
	Website/Phone resources: Misscohealth.org
	Services Provided: Immunizations and vaccinations, women's health, lab services, Show-Me Healthy Women, Wise Women, tuberculosis testing, STD/HIV testing, blood pressure counseling, lead testing, head lice treatment
Missouri Department of Social Services	Address: 718 N. Martin Ave, East Prairie, MO 63845
	Phone Number: 573-649-3091
	Website/Phone Resources: Dss.mo.gov/cd/office/Mississippi
	Services Provided: Home and family, work, government, education, health, safety, outdoors, businesses, job seekers, veterans, individuals with disabilities, teens, college students, moving to Missouri, state employees
Mental Health Services	Address: 1012 N. Main St, Sikeston, MO 63801
	Phone Number: 573-471-0330
	Website/Phone Resources: www.furgusonmedicalgroup.com
	Services Provided: Behavioral Health Department, 2 psychologists, 4 clinical social workers. Areas: Sikeston, East Prairie, Dexter, Charleston, Kennett Rural Health Clinics. Medicaid patients, generalist clinic, will not turn away patients, children and adults 2-92, psychological evaluations, pain stimulator, disability, autism clinic

Southeast Missouri Behavioral Health New Era Center	Address: 3150 Warrior Ln, Poplar Bluff, MO 63901
	Phone Number: 573-785-5333
	Website/Phone Resources: Semobh.org
	Services Provided: Psychiatric evaluation, medication management, co-occurring counseling, family therapy, trauma therapy, care coordination, peer support, group counseling, group education, detox services. Accepts: private insurance, Medicaid, self-pay options. Open 24 hours
Bootheel Counseling Services	Address: 760 Plantation Blvd, Sikeston, MO 63801
	Phone Number: 573-471-0800
	Website/Phone Resources: Bootheelcounseling.org Mental Health Crisis Line: 800-356-5395
	Services Provided: Outpatient counseling, crisis, psychiatric, community psychiatric, rehab program, adult and youth 'Clubhouse Model' CPRP, psychosocial rehab program (PSR), targeted case management, Treatment Family Home Program, employee assistance programs
Charleston Nutrition Center	Address: 205 W. Commercial, Charleston, MO 63834
	Phone Number: 573-683-6115
	Website/Phone resources: Facebook – Charleston Nutrition Center Betty Oliver
	Services Provided: Free/prorated lunch Monday through Friday
AEOC Homeless Shelter	Address: 820 Anderson St, Sikeston, MO 63801
	Phone Number: 573-471-6014
	Website/Phone Resources: Daeoc.com/homelessness
	Services Provided: Emergency shelter, transitional and permanent housing, education opportunities
Kenny Rogers Children's Center	Address: 300 Floyd Ave, Sikeston, MO 63801
	Phone Number: 573-472-0397
	Website/Phone Resources: Kennyrogerscenter.org Facebook – Kenny Rogers Children's Center
	Services Provided: Adaptive dance class, constraint-induced movement therapy, equipment, gait and motion analysis center, intensive suit therapy, interactive metronome, PEERS Training, sensory processing disorder, therapeutic listening, vision therapy, vital stimulation therapy

Southeast Missouri Food Bank	Address: 600 State Highway H, Miner, MO 63801
	Phone Number: 573-471-1818
	Website/Phone Resources: Seemofoodbank.org
	Services Provided: Hunger relief for Southeast Missouri counties, Good Neighbor Pantry, "Truck to the Table" mobile food pantry
Shining Light Baptist Outreach Food/Clothing Pantry	Address: 721 W. Marshall, Charleston, MO 63834
	Phone Number: 573-683-2555 Richard Dean Wallace
	Website/Phone Resources:
	Services Provided: Food pantry every month, clothing pantry once a large amount has been gathered, faith counseling whenever needed
Bootheel Babies and Families	Address: 107 W. Center St, Suite A, Sikeston, MO 63801
	Phone Number: 573-475-8688
	Website/Phone Resources: Bootheelbabies.org Call 2-1-1: Bootheel Community Guide
	Services Provided: Safe sleeping classes, family counseling, prenatal care
Bowden Center	Address: 732 S Elm St, Charleston, MO 63834
	Phone Number:
	Website/Phone Resources:
	Services Provided: Free meals for those who meet the requirements supper only during the school year, lunch and supper during the summer, job readiness training (adult and youth), volleyball team, basketball team, Kiddie College, classroom activities, formerly incarcerated transitional program
Susana Wesley Family Learning Center	Address: 601 E Marshall, Charleston, MO 63834
	Phone Number: 573-233-8391
	Website/Phone Resources: Swflc.com SWFLC Hotline: 800-382-7294 East Prairie Office: 573-649-3731
	Services Provided: Victim services, mental health counseling and trauma informed services, court advocacy, supervised exchange and visitation, emergency shelter, 24-hour crisis line, violence prevention, batterer intervention, triage center for batter spouses, safe house availability

Regional Healthcare Foundation	Address: 215 W Grant St, Dexter, MO 63841
	Phone Number: 573-624-1607
	Website/Phone Resources: www.regionalhf.org
	Services Provided: Prescription drug assistance, fitness challenge, Mother-to-Mother (mentoring program that pairs young mothers with experienced mothers), License to Care, scholarship
Southeast Missouri Regional Arthritis Center	Address: several locations throughout SE Missouri
	Phone Number: 888-702-8818
	Website/Phone Resources: http://moarthritis.typepad.com/southeast_Missouri_rac/ https://www.facebook.com/pg/MOArthritis/about/?ref=page_internal
	Services Provided: Seven regional arthritis centers, Arthritis Foundation Exercise Program, Enhance Fitness, Arthritis Foundation Self-Help Program, chronic disease self-management program, Walk with Ease Program. Non-profit organization.
Smiles of Hope: Dental Outreach Ministry	Address: 18555 Lighthouse Dr, Dexter, MO 63841
	Phone Number: 573-624-2500
	Website/Phone Resources: info@lighthouseofdexter.org
	Services Provided

Appendix F. Trigger Assessment and Screening Questions

Health Leads SDOH Tool Environmental Watchlist/Triggers

Purpose: This document will assist you in identifying when a patient hasa social determinant of health need while you are in the home

What to look for to trigger you to complete the screening tool:

1.) Food Insecurity

- Lack of food in refrigerator, freezer, cabinets
- Lack of pots, pans, silverware, etc.
- Loss/Gain Weight

2.)Utilities/Bill Payments

- No electricity
- Complaints of weather, humidity, etc.

3.)Stable Housing

- House is unkept
- Clothes/Attire is not appropriate for the weather (wearing awinter coat during summer)
- Does not meet standards for human habitation
- Change of address4.)Childcare
- Lots of children in home
- Complaints of no childcare (“I can’t get to the pharmacybecause I’m watching my kids”)

5.)Healthcare Costs

- Unable to pay small copays
- Complaints about insurance

6.)Transportation

- Complaints of transportation
- No vehicles/money for transportation

7.)Health Literacy

- Client does not understand their medications
- Client is confused by healthcare documents/orders
- Client adherence packing is on the wrong day

8.)Safety

- House is unkept
- Domestic violence- a partner being controlling while you arethere
- Cluttered
- Bugs, pest, animal hair, etc.
- Disability Accommodating