ADDRESSING SOCIAL DETERMINANTS OF HEALTH WITHIN YOUR PRACTICE

For Providers

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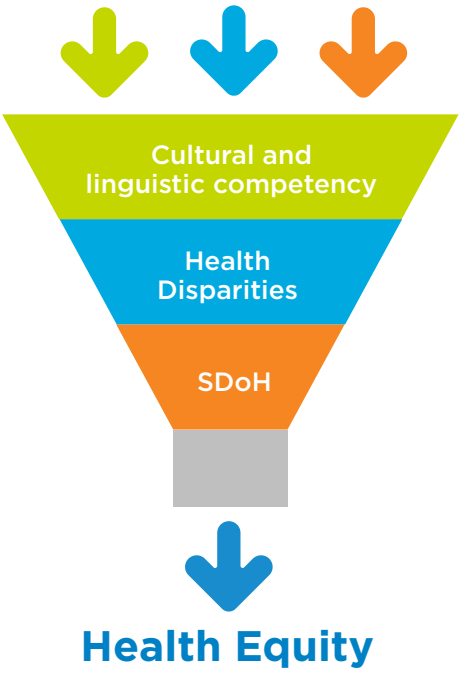
EXECUTIVE SUMMARY

There is growing awareness among providers regarding the impacts that health inequities have on patients – an urgent need to consider the real-life social and environmental challenges facing patients every day. Providers are recognizing the importance of stepping beyond the one-size-fits-all approach to health to improve health outcomes.

Up to 80% of a person's health is tied to behaviors impacted by environmental, economic and social conditions – where they are born, live, work, and play – known as the social determinants of health (SDoH). But only a fraction of health investment is focused on addressing these SDoH, leading to health disparities. To read more, visit this white paper.

A health disparity is an avoidable and unfair difference in health status between segments of the population. Health disparities negatively affect groups of people who have experienced greater obstacles to health based on their race, ethnicity, education, and literacy, among numerous other factors. Health equity, in turn, is the attainment of the highest level of health for all people. When culturally competent skills are leveraged, we can recognize and proactively address SDoH, reducing health disparities, transforming these challenges into opportunities for health equity.



In this paper we will:

- Level-set regarding the importance of health inequities;
- Share data-driven insights on the need for addressing SDoH in practice;
- Highlight how a provider can address these health inequities;
- Discuss how a provider can engage the community around them to establish a network of support for the patients they serve;
- Supply quick access to health equity resources.

Providers are in a unique position to help identify risks and incorporate SDoH into medical care decision-making. Working together, we can improve health outcomes and drive down the cost of care by addressing these unmet environmental, economic, and social needs. You can view Cigna's dedicated page for providers regarding health disparities. Continue reading to learn more.

Table of contents

Fundamentals of Health Equity

Patients matter. That's why recognizing and acknowledging the challenges they face is crititcal. Offering them the support they need to be healthy and successful can significantly impact health outcomes. The environment where patients live, work, and play can influence their ability to be productive in both their jobs and their communities.

Here are some definitions of key terms to enhance understanding.

Health equity

is achieved when no one is disadvantaged from achieving their full health potential due to social position or circumstances. Health inequities are reflected in different lengths of life, quality of life, rates of disease, disability, and death, severity of disease, and access to treatment.

Achieving the highest level of health for all people

Health disparities

are defined as avoidable and unfair differences in health status between segments of the population. Health disparities negatively affect groups of people who have experienced greater social and/or economic obstacles to health based on:

- Race
- Ethnicity
- Education
- Literacy
- Income level
- Language
- Culture
- Age
- Sexual orientation
- Gender identity/expression
- Cognitive, sensory or physical disabilities
- Geographic location

Health disparities can lead to a state of health inequity in one's business, community, region, or country.

Hispanic women:
40% more likely to have cervical cancer and **20%** more likely to die from cervical cancer than non-Hispanic White women[1]

African Americans:
Highest mortality rate for all cancers combined compared with any other racial and ethnic group[2]

Single parents:
Employed single mothers are **40% more likely** to have cardiovascular health problems and **74% more likely** to have a stroke compared to employed married mothers[3]

Children:
Children from lower-income families have **higher rates of health problems** such as heart conditions, hypertension, obesity and some cancers[4]

Native Americans:
(American Indians and Alaska Natives) have a **greater chance** of having diabetes than any other U.S. racial group[5]

Asians/Pacific Islanders:
Highest hepatitis B related mortality rates, historically[6]

1. "Cancer and Hispanic Americans," U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=61. 2. "Cancer and African Americans," U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16. 3. Merschel, Michael, The heart health risks of being a single parent, heart.org, December 2, 2020. 4. Children in Poverty, Poverty and its Effects on Children, All4kids.org, January 28, 2019. 5. Native Americans with Diabetes - Vital Signs, CDC. 6. CDC. Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB: Asians. https://www.cdc.gov/nchhstp/healthdisparities/asians.html.

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Social determinants of health

SDoH are the conditions and environments in which people are born, grow, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. They help us to understand the factors affecting an individual's health. **Up to 80%** of of an individual's health is determined by these non-medical factors.[1]

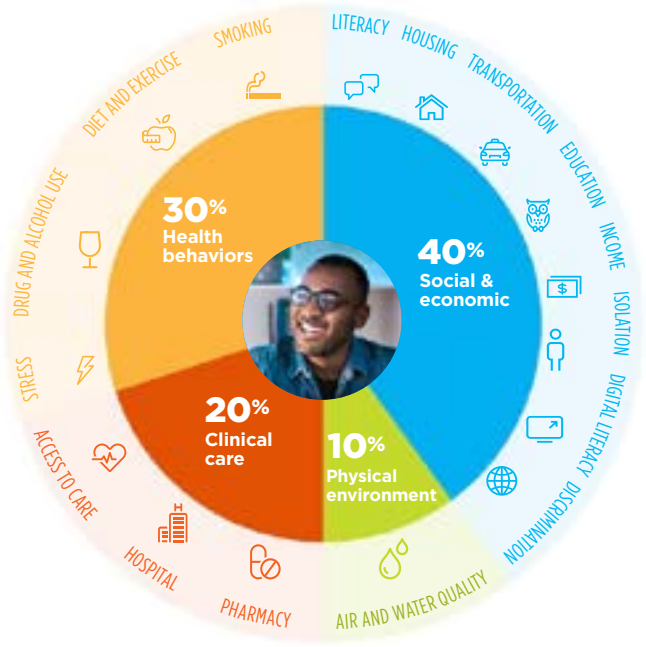
Studies have shown that people with unmet social needs:

- Experience nearly twice the rate of depression[2]
- Have a greater likelihood of having chronic conditions[2]
- Have more than double the rate of emergency department visits and no-shows to clinic appointments[2]
- Have a 60% higher prevalence of diabetes and more than 50% higher prevalence of high cholesterol and elevated blood sugar levels[2]

Food Insecurity
People with low income and who are part of racial/ethnic minorities are **more likely to live near unhealthy food stores** than high-income, non-minority groups.[3]

Transportation
5.8M people in the U.S. did not have access to medical care due to transportation **barriers**.[4]

Physical Environment
Substandard living conditions (e.g., water leaks, poor ventilation, pest infestation, etc.) can lead to an increase in mold and other allergens associated with **poor health**.[5]



Cultural competency

Cultural competency is the ability to understand, communicate with, and effectively interact with people across cultures. Key attributes of cultural competency include:

- Being aware of one's own world view
- Developing positive attitudes toward cultural differences
- Increasing knowledge of different cultural practices and world views
- Evolving skills for communication and interaction across cultures

Since health care is a cultural construct based on beliefs about the body and nature of disease, cultural issues are important to the delivery of health services.[6] All health care should be culturally competent to ensure all people are assisted equitably. Culture affects health care by informing:

- Concepts of health and healing
- Attitudes toward health care providers
- How illness, disease and their causes are perceived
- The behaviors of people who are seeking health care

Click here to learn more about how Cigna is addressing cultural competency.

1. County Health Rankings & Roadmaps: A Robert Wood Johnson Foundation Program (2019). County health rankings model. https://www.county-healthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model. 2. Berkowitz, Seth, et al. "Addressing basic resource needs to improve primary care quality: a community collaboration programme," BMJ Quality & Safety Journal, accessed February 23. 2021. https://qualitysafety.bmj.com/content/25/3/164 3. Hunt, Alcott et al., "Food Deserts and the Causes of Nutritional Inequality," NBER Working Paper Series - National Bureau of Economic Research, revised November, 2018. https://www.nber.org/system/files/working_papers/w24094/w24094.pdf. 4. Wolfe, Mary et al., Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997–2017, American Public Health Association Report, May, 6, 2020. https://ajph.aphapublications.org/ doi/10.2105/AJPH.2020.305579#:~:text=In%202017%2C%205.8%20million%20persons,window%20within%20our%20study%20period. 5. Braveman P, Dekker M, Egerter S, Sadegh-Nobari T, and Pollack C. How Does Housing Affect Health? Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2011/05/housing-and-health.html. 6. "What does it mean to be culturally competent?" Australian Children's Education and Care Quality Authority, accessed February 23, 2021. https://wehearyou.acecqa.gov.au/2014/07/10/what-does-it-mean-to-be-culturally-competent/#_ftn3.

Meet Marisol

58-year-old Hispanic female

Marisol has been on your patient panel for 5 years. She has a 20-year history with diabetes Type II, and often struggles getting her blood sugar under control. Insulin has been the best treatment for keeping her Hemoglobin (Hgb) A1c close to her goal, but she often cannot afford the copays, so you supply her with samples when you can. In addition, she does not always follow your diet suggestions, nor does she check her blood sugars as frequently as you prescribed. Throughout this paper, we'll learn more about Marisol and what's keeping her from following her treatment regimen.

Why should providers address SDoH?

Rising health care costs

The financial figures are staggering. In 2017, the U.S. approached nearly $3.5 trillion in health care expenditures, and it is estimated that by 2026 costs will increase to $5.7 trillion, representing almost 20% of the economy.[1] Homelessness has been correlated with greater use of the emergency department (ED), food insecurity has been shown to precede diabetes-related hospital admissions and social isolation can place a patient at greater risk of strokes and heart attacks.[2] Therefore, helping a patient with their social needs can lead to improved patient health outcomes and cost savings.

Patient satisfaction

According to a 2019 Kaiser Permanente® study,[3] a substantial number of Americans want their doctors to ask them about their social needs.

> Roughly 93 percent believe their doctors should ask about their access to food and meals.

> Around 83 percent believe their doctors should ask them about affordable, consistent housing.

> Nearly half stated they would turn to their doctor or medical team when seeking community resources to address social needs.

> 30 percent stated they would turn to their insurer for the same information.

Most Americans recognize the vital role non-medical factors play in managing their health and well-being. In the same Kaiser Permanente survey:

> One third frequently or occasionally struggle with SDoH, with individuals facing barriers with housing, food, transportation, and social support needs.

> 89 percent think safe and stable housing is very or extremely important to health.

> 35 percent said they are not confident in how to identify best resources if they or a family member needed assistance with a social need.

Impacts on patient longevity

A 2016 article in the *Journal of the American Medical Association* (JAMA) observed that, in the U.S., the life expectancy of 40-year-old men in the poorest 1% of the income distribution was reduced by 14.6 years compared to males in the richest 1%; for females, the variance was 10.1 years,[4] further strengthening the belief that poverty and health outcomes are linked.

1. https://healthpayerintelligence.com/news/addressing-the-real-implications-of-social-determinants-of-health
2. https://www2.deloitte.com/us/en/insights/industry/health-care/applying-social-determinants-of-health-mcos.html
3. https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2019/06/KP-Social-Needs-Survey-Key-Findings.pdf
4. https://jamanetwork.com/journals/jama/article-abstract/2556011

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Opportunities to engage patients and address SDoH during office visits

Addressing health inequities within one's practice requires thoughtful preparation, including the creation of a sustainable infrastructure and the development of workflows that can ensure patients are properly identified, referred for intervention, and outcomes are evaluated. We recommend the following step-wise approach when considering how to address health inequities within your practice setting.

Step 1: Identify health equity champions

Providers navigate within an interdisciplinary team environment every day. Therefore, it is critical to identify which clinical team members will be championing work focused on addressing health inequities, specifically SDoH. Staff members will be intricately tied to actions, participating in the development and execution of workflows, the implementation of screening tools, and potentially assisting patients with referrals to community-based organizations (CBOs). Identifying the right staff and creating a robust training program are important.

Step 2: Identify your target population

It is imperative in early discussions with the health equity champions to determine the target population. Will patients be targeted who:

- ☐ Have had 2 or more ED visits within 3 months?
- ☐ Have had 2 or more inpatient stays within the last 6 months?
- ☐ Have transitioned from hospital or skilled nursing facility to home within last 30 days?
- ☐ Have specific chronic disease states (e.g., COPD, diabetes, liver cirrhosis, chronic kidney disease [CKD])?
- ☐ Have a behavioral health diagnosis (e.g., substance use disorder)?
- ☐ Are over 65 years of age?

The above list is not all-inclusive, and providers may even choose a combination of several populations. However, it is important that this conversation occurs first with the clinical team before embarking on a journey to address SDoH.

Step 3: Identify the screening tool that will be implemented

Once you have identified your population, you must consider their specific needs. There are many publicly available tools in use across the health care industry that can help you get to the heart of the challenges affecting your patients. Several of the following tools have been established as validated and vetted. Each tool has unique features that can help you to determine which one is best for you and your practice setting.

Available screening tools	
National Association of Community Health Centers (NACHC) PRAPARE Survey Action and Implementation Toolkit	• This tool is already available in most electronic health records. • Categories include ethnicity/race, migrant worker, job status, housing, income, veteran status, education level, language preference, insurance status, access to basic needs, stress, and safety.
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	• This tool screens for five core health-related social needs – which include housing, food, transportation, utilities, and personal safety – using validated screening questions, as well as the additional needs of employment, education, child care, and financial strain. • It asks the patient if they're interested in addressing any of the identified needs. • It was developed for physicians by physicians.
CMS Accountable Health Communities Health-Related Social Needs Screening Tool	• This tool was developed by the Centers for Medicare & Medicaid Services (CMS) with input from a panel of national experts and after a review of existing screening instruments. This is a 10-item screening tool used to identify patient needs in five different domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). • Read the Standardized Screening for Health-Related Social Needs in Clinical Settings for more information.
The Hunger Vital Sign™ – Children's HealthWatch (childrenshealthwatch.org)	• Children's HealthWatch has developed the Hunger Vital Sign, a two-question screening tool used to identify young children and mothers at risk of food insecurity in order to help them obtain assistance if needed.

How to know which tool best fits specific practice needs

- **Referral generation:** How will this information inform referrals to local community resources?
- **Anecdotal evidence:** Will it be used to review known community needs (economic, transportation, housing, health care access, education, food access, community/social context) and match them up with the tool that covers those domains?
- **Colleague feedback:** What top domains are provider colleagues hearing from their patients? What needs are apparent based on community factors and historical situations?
- **Ease of implementation:** How easy is it to integrate the tool into the existing electronic medical record? Does the existing medical record already include a question set? Could the amount of questions be overwhelming for patients, or even clinic staff?
- **Overcoming stigmas:** Many patients are very private. Are the questions able to capture the facts needed without patients feeling embarrassed or offended?
- **Language availability:** Is the tool available in languages other than English? If not, do you have interpreter or translator services available? Can staff interpret?
- **Accessibility:** Is the tool only available online, or can it be printed and the font size enlarged?

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Following Marisol

Marisol has been scheduled for a follow-up. You were very concerned when her last HgbA1c result, which you received 1 week ago, was 11.6%. Her HgbA1c 6 months ago was 9.9%. Your office called the pharmacy to inquire of her refill history, and they indicated she has missed her refill for her long-acting insulin for the last 2 months; she has not refilled her test strips either. She visited your office 2 weeks ago for an acute illness, stating "I just don't feel well." At that time, your office had not implemented any SDoH screenings, so you decide at this visit to conduct the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool to get to the root cause of her inconsistent refill history and pinpoint what might be impacting her health.

Step 4: Create a workflow for implementation

Creating an end-to-end workflow that outlines exactly how patient social needs will be identified, who will identify them, where will they identify them, and what will they do with the information gathered is vital for a program focused on addressing social needs to be successful.

Patient encounter engagement

The clinical team must determine how to best capture the patient screening information.

Consider the following options for completing an SDoH screening:

- Online, prior to appointment?
- Waiting room?
- Medical Assistant (MA) completes during vitals?
- Provider completes in patient room?

Consider the options for screening format:

- Online fillable form
- Software application (app)
- Within medical chart
- Paper form

It must also be determined how the provider will be notified of the needs. Consider developing a notification system (e.g., chart flagging? completed screening-tool pass-off?) that works best for the practice setting.

Design a workflow outline

Once the method for obtaining the information has been decided, the plan must be clearly outlined for all staff as soon as the patient arrives. The next page outlines an example workflow with the consideration for a medical assistant or nurse to capture the screening information during vitals.

Documentation

Documentation helps with aggregate analysis and planning for the future. Therefore, consider documentation through the use of Z-codes to capture social need requests. Providers can review CMS's latest guidance on documentation; we provide a link in the "Additional Resources" section.

Follow-up process

Developing a process for follow-up is imperative to ensure patients receive the assistance requested. Having staff make outreaches 1–7 days from the office encounter, depending on the need identified, is recommended. For example, if a patient indicates they are homeless, clinic staff may outreach within 1 day after referring to a local religious organization, versus if a patient is having trouble affording their medication (which they have in their possession because samples were provided), clinic staff may outreach in 3 days to ensure the patient has connected with a pharmacist and filled out the necessary patient assistance program paperwork. Identifying "urgent" versus "standard" follow-up procedures must also be discussed with the clinic team.

Please review the sample workflow, including documentation and follow-up process:

Patient Action	Provider SDoH Action
Patient checks in, either • Online. • In waiting room.	**Staff member identifies patient for screening of SDoH need(s).** • Note: staff must ask if patient is willing to take a survey.
Patient is brought back for vitals, height and weight.	**Patient agrees to participate in screening.** • Staff screens patient using survey instrument identified, in the patient's language of preference. • If the survey was supplied prior to the office visit OR while the patient is in the waiting room, now is the time to obtain it.
Patient meets with Provider.	**Provider reviews the survey results before room entry, discusses barriers identified with patient, and makes appropriate referrals, as needed.** • Provider supplies list of community resources, as needed. **Provider uses appropriate Z-code(s) for documentation purposes.**
Patient visit concludes. **Patient checks out and leaves.**	**Provider/staff ensure appropriate steps were taken on behalf of the patient, such as making appropriate referrals or supplying a resource list, before the patient leaves the office.** **Patient will be followed-up telephonically within 1-7 business days by clinic staff.** • *Before* the patient leaves the office, staff must ensure the most appropriate phone number is in the EMR to enhance success of the follow-up outreach.

Step 5: Develop a communication strategy

If patients are pre-identified for screening, having a communication strategy focused on why and how screening information will be utilized is recommended, as some patients may be cautious of sharing personal information. Whether staff are calling in advance of an office visit, having a conversation during an office visit, or calling to conduct a follow-up, scripting is very helpful to ensure the messaging from the provider's office is consistent.

Sample script to include with the screening tool, or it can be verbalized during the office visit:

We're asking that you provide us with some non-medical information to help us better understand any needs we may be able to help support you with, or resources we can help get you connected to. This information may be securely shared with members of your extended care team, including care managers and specialists, to help determine if there are any additional services we can connect you with for better care. Your decision to answer, or to not answer, will not impact your ability to receive care. Please let us know if you have any questions, concerns, or suggestions about this questionnaire.[1]

1. https://prapare.org/knowledge-center/prapare-implementation-and-action-toolkit/https-prapare-org-wp-content-uploads-2021-10-full-toolkit_june-2022_final-pdf/

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If requesting screening completion prior to an office visit

If the clinic team decides to screen *prior* to the office visit using a paper form, developing a letter explaining to the patient what the information is being utilized for, and having it accompany the mailed-out tool, must be considered. The language above, adapted from the NACHC, can be further adapted for the purposes of a letter. The letter will also carry more weight for a patient, especially if the provider signs the letter.

Considering patient preferences

When implementing the screening tool, whether within the office setting or prior to the office visit, patient preferences must be considered. For example, does the patient speak English but prefer to read in Spanish? In addition, are they able to read 12-point font, or do they require larger 18-point font? Are they able to read at all? Do they have access to a smart phone or the internet to fill out a form online? This information must be captured and included in the patient chart to ensure that the information the provider's office is supplying is able to be communicated as effectively as possible. Review this provider toolkit on how to offer linguistic and culturally competent care.

Following Marisol

On the day of Marisol's follow-up visit, your Medical Assistant (MA) brings her back to check her vitals. As she's checking Marisol's blood pressure, she asks Marisol if she is willing to answer some questions that are non-medical in nature. The MA discovers that Marisol prefers to discuss these questions in Spanish, so the MA proceeds with communicating in Marisol's preferred language. The MA asks questions from the PRAPARE survey instrument, and Marisol hesitates to provide this information. The MA indicates that these questions will help her doctor better understand how to help her achieve her best health. Marisol agrees to proceed with the survey.

Step 6: Identify Community-based Organizations (CBOs)

CBOs operate at the local level to address community needs. They can include nonprofit organizations, formal and informal community groups (e.g., neighborhood groups, recreational or special-interest clubs), and social service agencies. CBOs are important stakeholders in the health care system, and they must be recognized as a supplementary service provider that aids in the delivery of quality care for patients.

It is recommended to identify and establish a relationship with local CBOs. Here are some local organizations providers may wish to partner with:

- Health departments
- School districts
- Colleges and universities
- Hospital systems
- Library systems
- Food banks
- Churches

Agreement on referral process with CBOs

Once CBOs are identified for referral, conversations must take place to solidify the referral process. Expectations must be clearly set so both providers and the CBOs can understand the potential volume, what types of interventions can/will occur, and when the referrals will begin.

Development of patient local CBO guide

Provider offices can create handouts to give patients that list CBOs in top domains (e.g. food, transport, utilities assistance) they have connected with to verify services and referral protocols.

Read more about how to establish a partnership with a CBO through a real-world example: Establishing Partnerships between Health Systems and Community-Based Organizations to Address Social Needs: First-Hand Perspectives from New York City | Playbook (bettercareplaybook.org)

Step 7: Create a workflow for referral to CBOs

After the CBO partners have been identified, you should develop a specific workflow for referral to CBOs.

Physician office direct referrals

Consider the following step-wise approach for a provider to address an issue with a patient, then carry out a referral to a CBO:

1. Based on the results of the SDoH Screening, the patient should be asked if they would like a list of community resources that could help.

   Sample script

   "Thank you for providing us with this information. I see that you need _____. Our office can connect you with a local organization that could potentially help. Are you interested in this?"

2. One or two of the clinic staff can serve as responsible parties when conducting CBO referrals. Staff can use CBO aggregators like Findhelp.org or refer directly to identified local CBOs. These staff can also make the follow-up calls on the patients to ensure they received the needed service/support.
3. The patient can be supplied with a local CBO guide as well if additional needs arise.

Patient self-referral

If a provider's office does not have staff to support carrying out referrals to CBOs, providers can consider having the patient self-refer, using the following step-wise approach:

Sample script

"Thank you for providing us with this information.
I see that you need _____. How can I best assist you?
I can provide you with a list of community resources that could potentially help"

1. The patient can be supplied with a local CBO guide.
   a. The patient should be informed that resources offered by a state may be lengthy, and may take many months to receive.
   b. Services provided by local CBOs are dependent on the resources/funding that the CBO has access to, so they may not always have the funding to carry out interventions.
2. Patients require follow-up at the next office visit to ensure they connected with the CBO.

Sample script for communicating with patients about social needs assistance, in general

Before we get started, I want to ask about any challenges you and your family are presently facing. What have you found most difficult?

Thank you for providing us with this information; I appreciate your honesty. Based on your responses, I see that you may need <resource(s)>. You are not alone; nearly everyone I talk with has been impacted by events such as the pandemic in some way, and many are finding it hard to stay on top of normal activities.

How can I best support you? I can provide you with a list of community resources that can address your needs. Many of my patients have found these options to be helpful. If you are interested in learning more, we can talk further. I'd like to help you in getting connected to these resources.

Check out this resource from AAFP which offers a practical approach to screening and addressing SDoH, end to end.

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Following Marisol

The MA shares the results of the PRAPARE survey with the doctor. It shows that Marisol struggles with paying for bills, as she lives in a multigenerational home where she is both the sole breadwinner and a caregiver for her elderly parents. Marisol feels she must prioritize her parents' needs above hers, and purchases their medications and food before her own. Marisol's job is hourly, and she cannot afford to miss work, so she often "pushes through" when she feels ill. When you visit with her, she begins to cry, as she doesn't know "what to do" about her health and meeting all the demands in her life.

You notice she is not in Cigna's Case Management program, so you refer her. Your office has built a relationship with a few local CBOs, so you refer her to a food bank and a short-term bill pay program. You help her sign up for a patient financial assistance program through the manufacturer of her insulin. Because she has internet access, you also tell her about Findhelp.org, which can help aid her with any additional needs. Finally, you are aware of a free local diabetes program led by a Spanish-speaking diabetes educator, so you refer her to their evening class. She indicates she prefers to read in Spanish as well, so you ensure all materials are supplied to her in her preferred language.

Step 8: Generate a quality improvement strategy for sustainability

When providers reflect upon their health equity strategy, they must consider the future state. How will this initiative look in 6 months? 12 months? Are there opportunities to become more efficient? Improve their strategy? Providers should consider developing a plan for ongoing evaluation and data collection. Quality-check systems should be put into place to recognize and overcome barriers to allow for the ability to be nimble and make changes quickly, as needed.

Partnering with Cigna

At Cigna, we have developed Care Management programs and initiatives to help address health disparities and SDoH. Read more in the "Employing significant solutions" section of this white paper. Also watch this short video.

Concluding thoughts

Follow-up with Marisol

Marisol agrees to participate in Case Management. She also agrees to seek support from the CBOs your office refers her to. She commits to making better decisions for her health so she can stay well to care of her ailing parents.

Fast-forward 3 months

Marisol has engaged with a Cigna Case Manager and has attended one of the diabetes education classes you recommended. She now understands the value of taking her medication regularly and receives help adapting her dietary habits. She has obtained a 3-month supply of insulin through a patient assistance program. Her HgbA1c is trending in a positive direction – at her lab draw last week, it was 9.8%. She thanks your team for the referrals to the local CBOs. Marisol received the assistance she needed to get back on track, and now feels more equipped knowing there are local resources available. She appreciates that she can search on FindHelp.org in the future as needs arise – especially as the listings in the site can also support her parents as well.

Everyone – no matter where they live, work, and play – deserves the opportunity to find their best path to health and wellness. Efforts to improve health in the U.S. have traditionally looked to the health care system as the key driver of health outcomes. But let's consider a simple truth with this metaphor: **Fish are only as healthy as the aquarium in which they live**. We must identify and address the inequities that influence health if we want everyone to thrive.

As providers, you are on the front lines engaging your patients every day. We applaud you for your tireless efforts to improve health care quality for everyone. At Cigna, we, too, are taking the challenge head-on by doing more to address health inequities in our solutions and the services we offer.

Together, we are stronger. We can change lives for the better. Join us.

Additional resources

AAFP Social Needs Guide	These tools can be used by physicians and their practice teams to screen patients for SDoH, identify community-based resources to help them, and work with patients to develop an action plan that encompasses social needs to help them overcome health risks and improve outcomes. The Social Needs Patient Action Plan is easy to print for patients, and available in multiple languages. https://www.aafp.org/family-physician/patient-care/the-every-one-project/toolkit/assessment.html
AAFP Checklist for Clinic Readiness to Implement SDoH Screening	https://www.aafp.org/fpm/2019/0900/fpm20190900p13-rt2.pdf
National Association of Community Health Centers	Designed to provide interested users with the resources, best practices and lessons learned to guide implementation, data collection, and responses to social determinant needs. https://www.nachc.org/research-and-data/prapare/toolkit/
Office of Minority Health	https://www.minorityhealth.hhs.gov/
National Committee for Quality Assurance (NCQA)	https://www.ncqa.org/white-papers/sdoh-resource-guide/
Harvard University	Helps providers assess unconscious bias. https://implicit.harvard.edu/implicit/
Cigna Provider Resources	• https://www.cigna.com/health-care-providers/resources/topic-cultural-competency-health-equity
U.S. Department of Health and Human Services	• Health Literacy Universal Precautions Toolkit: Can help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels. • Social Determinants of Health: A resource to help create social and physical environments that promote good health for all.
CDC	• SDoH: Know What Affects Health: CDC resources for SDoH data, research, tools for action, programs, and policy. • Advancing Health Equity and Preventing Chronic Disease
Health Equity-Centric Motivational Interviewing	• 17 Motivational Interviewing Questions and Skills (PositivePsychology.com) • Motivational interviewing: four steps to get started (AAFP.org)
Z-codes	• Z-codes are non-billable codes that can offer insights into population management priorities. According to CMS guidelines, they should only be reported as secondary diagnoses, and they may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's primary provider since this information represents social information, rather than medical diagnoses. • Z-code look up: CDC ICD-10-CM • CMS infographic: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes (cms.gov)

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UNIVERSAL ASSISTANCE – HOUSING, FOOD, BILL PAY, ETC.	
United Way's 2-1-1	2-1-1 is a vital service that connects millions of people to help every year. To get expert, caring help, simply call 2-1-1 today or search via the website. 2-1-1 has a comprehensive list of available resources for the following needs (list not all inclusive): • Health insurance and medical expenses • Mortgage, rent, and utilities payment assistance • Supplemental Nutrition Assistance Program (SNAP)/Food Stamps • Mental health and crisis Visit https://www.211.org
Cigna Community Resources	Cigna is making it easier to access a social care network that connects people with programs. Users can search for a variety of services in their local communities, including free or low-cost medical care, food, transportation, housing assistance, and more. Visit https://cignacommunity.findhelp.org Want a brief demo? Click on this short 1 minute, 30 second video: https://www.youtube.com/watch?v=RsBvox9E9C4 Want more guided, narrated videos for different steps in the process? Check this out: https://support.findhelp.com/hc/en-us/articles/360000198631-Training
Salvation Army	The Salvation Army meets human need without discrimination. They provide disaster relief, LGBTQ support, homeless shelters, food pantries, and alcohol/drug rehab, among other services. Access the platform at https://www.salvationarmyusa.org/usn/
MENTAL HEALTH	
National Alliance on Mental Illness (NAMI)	NAMI (https://www.nami.org/Home) provides advocacy, education, support and public awareness so that all individuals affected by mental illness can build better lives through a hotline, as well as text and chat options. 800.950.NAMI (6264) Text NAMI to 741-741 Chat at Info@nami.orgs
FOOD	
Feeding America	Feeding America is a United States–based nonprofit organization that is a nationwide network of more than 200 food banks that feed more than 46 million people through food pantries, soup kitchens, shelters, and other community-based agencies. Visit https://www.feedingamerica.org/