BEYOND THE PRESCRIPTION:

BEST PRACTICES FOR CHWS CONDUCTING **SOCIAL DETERMINANTS OF HEALTH** SCREENINGS IN PHARMACY SETTINGS

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KPERF is accredited by ACPE as a provider of continuing pharmacy education.

DISCLOSURES

Faculty

Angela and Treva, for this activity, have no relevant financial relationship(s) with ineligible companies to disclose.

Angela and Treva, faculty for this activity, have been a consultant since 2026.

Planners

None of the planners for this activity have any relevant financial relationships with ineligible companies to disclose.

PHARMACIST OBJECTIVES

- Apply strategies to support stigma-free, culturally responsive conversations about social needs within pharmacy settings.
- Identify how social determinants of health (SDOH) can impact medication adherence, chronic disease management, and overall patient health outcomes.
- Describe strategies for collaborating with Community Health Workers to identify social barriers, connect patients to community resources, and support whole-person care.
- Utilize SDOH screening information to develop more comprehensive care plans and improve medication-related outcomes.

TECHNICIAN OBJECTIVES

- Demonstrate effective strategies for conducting person-centered SDOH screenings.
- Identify how social determinants of health (SDOH) can impact medication adherence, chronic disease management, and overall patient health outcomes.
- Apply strategies to support stigma-free, culturally responsive conversations about social needs within pharmacy settings.
- Identify opportunities to support Community Health Workers (CHWs) and pharmacists by recognizing potential social barriers and facilitating referrals to appropriate resources and support services.

PRE-TEST

1. Which of the following best describes Social Determinants of Health (SDOH) and the impact on patient health?

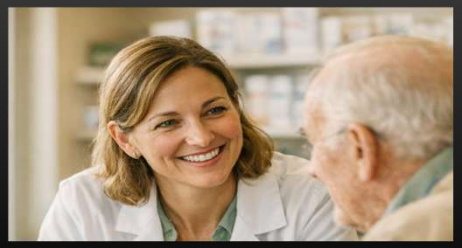
2. How can Social Determinants of Health (SDOH) surveys support patient-centered care within a pharmacy workflow?

PRE-TEST

3. How can addressing patients' social needs improve patient care and health outcomes?

4. Which of the following is the BEST way a pharmacy team can connect patients to community resources and support services?

UNDERSTANDING **SOCIAL DETERMINANTS OF HEALTH** SURVEYS IN PHARMACY PRACTICE



A practical session for practicing Pharmacists and Pharmacy Technician

What we'll cover in the next hour

01 **The foundation**
What social determinants of health are and why they shape outcomes

02 **The tools**
The standardized surveys pharmacists encounter most often

03 **The workflow**
Screening, documenting, and acting on results at the pharmacy

04 **Barriers & best practices**
Making screening sustainable in a busy practice

LEARNING OBJECTIVES

What you'll be able to do

By the end of this session, you will be able to:

Patient care & outcomes

Explain how addressing social needs can improve patient care, communication, and overall health outcomes.

Connecting to resources

Recognize ways pharmacy teams can connect patients to available community resources and support services.

THE FOUNDATION

What are social determinants of health?

SDOH are the conditions in which people are born, live, learn, work, and age — the non-clinical factors that shape a wide range of health outcomes and risks.

1	2	3	4	5
Economic stability	**Education access**	**Health care access**	**Neighborhood & environment**	**Social & community context**
Income, employment, medication affordability	Literacy, health literacy, schooling	Coverage, transportation to care	Housing, safety, food access	Support, isolation, discrimination

30–55% of health outcomes are driven by social and environmental factors far more than clinical care alone (WHO).

WHY IT MATTERS

Pharmacists sit at the front door of health

As one of the most accessible and frequently visited members of the care team, pharmacists are uniquely positioned to surface unmet social needs that derail medication therapy.

~50%	of health outcomes tied to social & behavioral factors
27%	of practices systematically screen for social risks
1.4%	of Medicare claims captured SDOH Z codes (2017)

THE INSTRUMENT

So what exactly is an SDOH survey?

A short, standardized set of questions that asks patients directly about non-clinical needs — turning an invisible barrier into actionable, documentable data.

Standardized

Validated, evidence-based questions used consistently across patient and visits

Brief

Most core tools take only 5–15 minutes to administer

Actionable

Maps needs to referrals, interventions, and documentation.

One key distinction

Screening casts a wide net for everyone; **risk assessment** is a focused follow-up when an unmet need is likely to affect care.

COMMON TOOLS

The surveys you'll encounter most

Tool	Developer	Focus / domains	Length
PRAPARE	NACHC	15 core measures: housing, income, transportation, social support, stress	~15 items
AHC-HRSN	CMS / CMMI	5 core needs: housing, food, transportation, utilities, safety	10 items
Health Leads	Health Leads	Essential social needs + customizable optional domains	Flexible
Gravity Project	HL7 / SIREN	Data standards (ICD-10, LOINC, SNOMED) for sharing SDOH data	Standards

PRAPARE and AHC-HRSN are the two most widely adopted screening instruments; Gravity standardizes how the data is coded and exchanged.

TOOL SPOTLIGHT

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks & Experiences

A nationally standardized, stakeholder-driven assessment from NACHC, paired with an implementation and action toolkit and available in 25+ languages.

- 15 core measures + optional community questions
- Standardized to ICD-10, LOINC and SNOMED
- EHR templates for major systems; free to use under license
- Designed for underserved and diverse populations

Core domains it captures

- Housing status & stability
- Income & material security
- Employment & education
- Transportation
- Insurance & language
- Social integration & support
- Stress
- Safety (optional)

TOOL SPOTLIGHT

AHC Health-Related Social Needs (HRSN)

CMS's 10-item screening tool — the shortest path into systematic social needs screening, and the model behind Medicare's reimbursable assessment.

FIVE CORE DOMAINS

1. **Housing** instability
2. **Food** insecurity
3. **Transportation** problems
4. **Utility** help needs
5. **Interpersonal** safety

Plus 8 supplemental domains — financial strain, employment, education, family & community support, physical activity, substance use, mental health, and disability.

TOOLS & STANDARDS

Health Leads & the Gravity Project

Health Leads

A screening toolkit, not a fixed form

- Essential domains: food, housing, utilities, transportation, finances, violence
- Customizable question library by literacy level
- Built for workflow integration and program design

Gravity Project

The data backbone for SDOH

- HL7 FHIR standards for sharing social-risk data
- Maps tools to ICD-10 Z codes, LOINC & SNOMED
- Reflected in CMS policy, USCDI and NCQA measures

THE PHARMACY WORKFLOW

From a few questions to a closed-loop intervention

1 SCREEN
Offer a standardized survey at an appropriate touchpoint a CMR, refill, or wellness check.

2 DOCUMENT
Record findings with structured Z codes so the need is visible and trackable.

3 ACT
Counsel, adjust therapy, and address cost or adherence barriers within your scope.

4 REFER
Connect the patient to community-based organizations and close the loop on the referral.

The value isn't the survey itself — it's the action and follow-up it triggers

IN PRACTICE

Administering the survey well

Normalize it
Explain you ask everyone, so no one feels singled out.

Choose the moment
A CMR, new start, or private consult beats a busy counter.

Offer options
Paper, tablet, or verbal - meet literacy and language needs.

Lead with empathy
Ask permission, listen, and respond without judgment.

Referrals & community partnerships

Identifying a need only helps if it leads somewhere. Build bidirectional referral pathways so needs are met and outcomes return to the pharmacy.

- **Map local CBOs** — Know your food banks, housing aid, and transportation services.
- **Get consent** — Use patient authorization before sharing information.
- **Make the warm handoff** — Send a structured referral, not a vague suggestion.

Follow up — Confirm the connection and revisit at the next encounter.

MAKING IT STICK

Barriers & best practices

Common barriers

- Limited time and staffing
- Discomfort raising sensitive topics
- Few referral pathways set up
- Uncertainty about documentation
- Worry about patient privacy

What works

- Start with one validated tool
- Build referrals before you screen
- Train and empower the whole team
- Embed screening in existing workflows
- Track findings, actions, and outcomes

KEY TAKEAWAYS

Bringing it back to your practice

1 SDOH drive outcomes

Social factors shape up to half of health — they belong in pharmacy care.

2 Use a standardized tool

PRAPARE and AHC-HRSN turn social needs into actionable data.

3 Screening is step one

The payoff is documentation, action, and closed-loop referrals.

Questions & discussion

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THANK YOU!

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