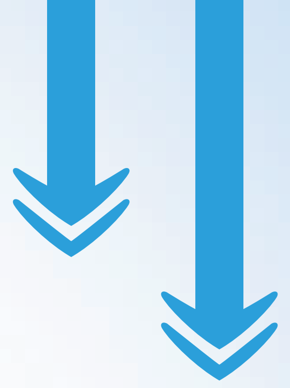

SDOH User Guide

JULY 2025

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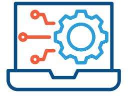
1 Introduction and Overview



1.1 The Importance of SDOH in Coordinated Care

Social Determinants of Health (SDOH) are widely recognized as contributing to a patient's overall health outcomes. Understanding the social, environmental, and economic context in which patients live is critical to delivering effective, whole-person care.

To support this, CRISP Shared Services (CSS) enables the secure exchange of SDOH-related information across clinical providers, social care organizations, and community-based entities. This ensures that all members of a patient's care team, regardless of setting, can be informed and act on the patient's social needs in a coordinated way.

By contributing SDOH data to CSS, your organization helps build a more connected care environment where:

- Social needs assessed in one hospital system or organization can be shared across all care team providers, promoting care coordination and communication
- Referrals to community services can be tracked and managed alongside clinical care.

Resources patients are receiving in the community can be visible to all members of the care team to enhance whole person care.

1.2 SDOH Product Suite of Tools

CSS's SDOH product suite provides tools to support the collection, sharing, and use of social needs data across the care continuum. The suite includes:

1. Assessments

- **Obtain and Enter Assessment Data**
- **Direct Entry Screening Tool:** Enables members of the care team to record SDOH screening results directly into the HIE via the HIE Portal.
- **Data Feeds:** Supports ingestion of templated SDOH data feeds from external systems (e.g., EHRs, care coordination platforms).
- **InContext – Social Needs Display:** Shows real-time, relevant SDOH data at the point of care to all appropriate members of the care team within existing clinical workflows.

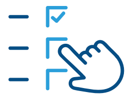
2. Conditions

- **Z-Codes Integration:** Captures social, economic, and environmental needs using ICD-10 Z codes parsed from submitted CCDs.
- **InContext – Social Needs Display:** Displays patient SDOH Conditions identified from ICD-10 Z code parsing.

3. Referral Tools

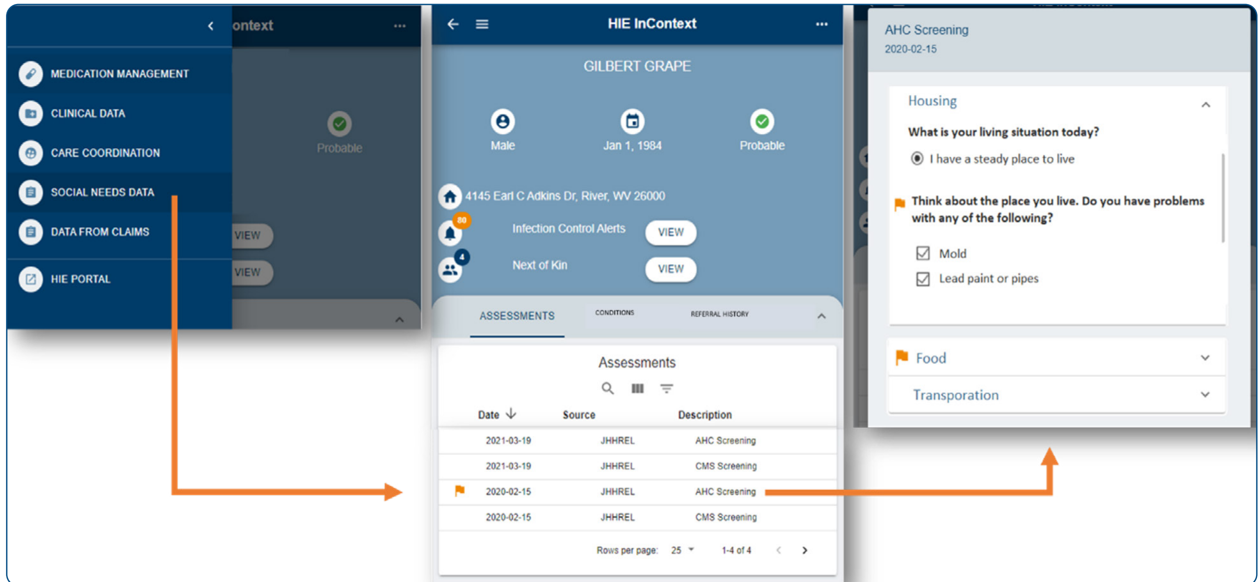
- **Search and Select Resources**
  - **Search Community Programs:** Allows users to search for local programs and services using integrated external databases (e.g., 211s, resource directories).
  - **The availability** of listed community programs is dependent on HIEs facilitating networks with organizations in their region as well as relationships with national registries such as 211
- **Create and Manage Referrals**
  - **Create Referral:** Enables electronic generation of referrals to selected community-based services.
  - **Manage Referral:** Tracks referral status and updates as services are delivered or declined.
  - **The type** of referrals, the referral scenarios, and the organizations engaged depend on HIEs facilitating networks and relationship with organizations in their community.
- **Referral Visibility**
  - **InContext Referral History:** Displays the patient's referral history to care team members, helping to support care coordination, reduce redundancy, and close the referral loop.
- **Referral Data Sharing and Integrations**
  - **Bulk Referrals:** CSS can receive bulk referrals from organizations via MFT/SFTP file sharing. Referral data and updates such as journal/status data should generally conform to the CSS Referral Model but opportunity exists to configure and align with organizations
  - **HL7 ORU feeds:** CSS is developing functionality to receive referral information via HL7 ORU data feeds. This is under exploration and design.
  - **FindHelp:** CSS integrates with FindHelp data in two ways: 1) CSS pulls data from FindHelp whitelabeled databases and imports data into its referral database to share data with the broader care team; 2) CSS is making use of FindHelp webhooks to integrate data sharing with its Referral Models and associated APIs.

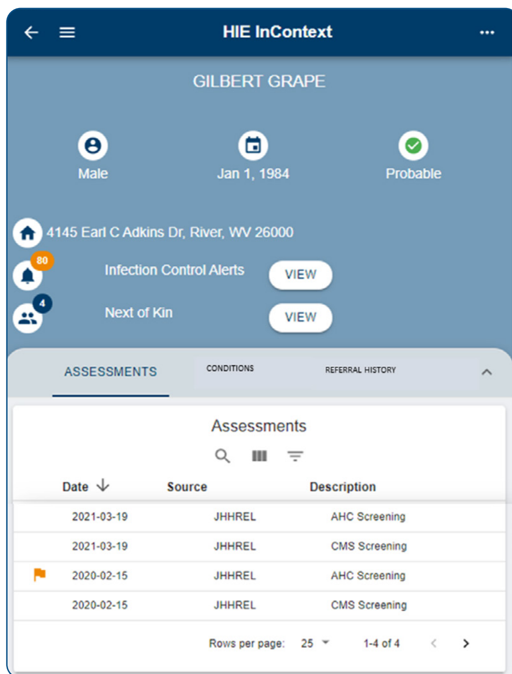
2 Assessments



2.1 Overview

Assessments are structured SDOH questionnaires completed by care team members to screen for social needs such as food insecurity, housing instability, and transportation barriers.





2.2 Sharing Assessments

CSS processes SDOH assessment data through two primary channels:

1. Via Flat File (Data Feed):

- Participant organizations can export assessment data from their native systems (e.g., EHR, care coordination platform) to CSS via nightly SFTP transfers.
- CSS provides a standard flat file template, which allows data sources to:
  - **Map each question** to a corresponding SDOH domain (e.g., housing, food, utilities)
  - **Flag responses** that indicate a social need—these flags trigger visual indicators in the HIE to highlight identified risks

CSS recommends working with data contributors to implement flat file exports and ensure accurate mapping and flagging of responses per the CSS template.

2. Via Direct Entry Screening Tool (InContext App):

- HIE portal users can manually enter assessment responses directly in the screening interface. The most common screening tools are available (AHC, PRAPARE)
- These assessments are automatically incorporated into the patient's record InContext and are displayed in the **Assessments View**, organized **chronologically** and by **social domain**.
- When data is entered here, it is also visible alongside any assessments shared via data feeds.

3 Conditions

3.1 Overview

Conditions are documented **diagnosis codes** that reflect social, environmental, or economic needs—commonly referred to as **ICD-10 Z codes**. These are typically entered by clinical providers in the patient's EHR as part of their medical record.

3.2 Codes

Z codes are **parsed from ADT feeds and CCDs** submitted to CSS. They are then displayed in the **Conditions tab** of the patient's HIE record to make them easier to locate and use in social care decision-making.

This provides additional insight into a patient's social needs, especially when a formal assessment has not been completed, and supports efforts to identify patterns across populations.

4 Referral Management System

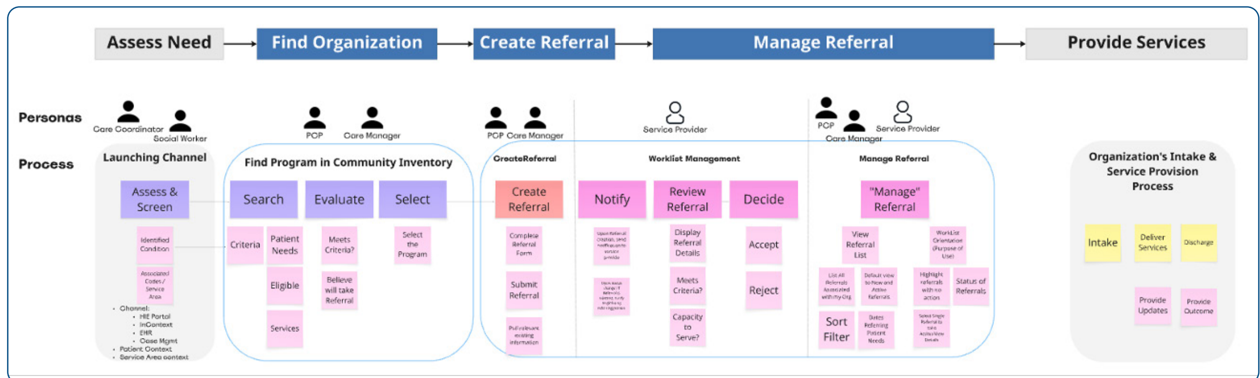
Care teams often face challenges navigating multiple directories and disconnected systems when trying to connect patients to community resources. A centralized, searchable referral management system streamlines this process, making it easier to locate, send, and track referrals in one place. This improves coordination between clinical and social care providers and helps ensure patients receive the support they need.

The Referral Management System is an integrated tool within the HIE that allows users to:

- Search for community programs using up-to-date resource directories (e.g., 211 databases)
- Create and send referrals electronically to onboarded community-based organizations (CBOs)
- View and manage referral status and history at the point of care
- Improve bidirectional communication between clinical and social service providers

4 Referral Management System

The following graphic displays the generalized referral process on which the referral features are based: 1) Assess a Need; 2: Find an organization with programs that can service the needs of the patient; 3) Create a referral to the organization; 4) The referral recipient organization can then manage the referral as part of their patient onboarding.



CSS offers a suite of referral tools as well as bulk referral operations.

- Using the referral tool applications…
  - a single user can work with a patient to find an organization and submit a referral
  - a person at a referral recipient organization can manage their referrals and communicate status in a journal.
- Using the bulk referral operations, organizations can send referral data in bulk via MFT/SFTP
  - Referral data feeds typically require configuring data feeds in order to accommodate participating organizations IT capabilities and conformity to the CSS referral model. As a result, the bulk referral offerings assume scoping and discussion with the HIE and the participating sites to ensure data can be shared effectively.
- CSS is vendor agnostic and seeks to share data with software companies based on their data interoperable capabilities, For example, CSS integrates with FindHelp data in two ways: 1) CSS pull referral data from whitelisted FindHelp databases and stores the data such that it can be shared at the point of care; 2) CSS is making use of FindHelp webhooks to integrate data sharing with its Referral Models and associated APIs.

CSS is developing functionality to receive referral information via HL7 ORU data feeds. This is under exploration and design.

4.1 Search Community Directory

A. Overview

Our referral management system includes a centralized search tool that pulls from trusted community resource directories, allowing users to quickly find relevant services in one place. For users planning to send a referral, it's important to note that referrals can only be sent to community organizations that have been onboarded to the HIE platform.

Referral Program Selection

Organization Name

* Search for Organization Name [Find Organization]

Search Area

Search Resources: * Food | Address, City, or Zip: * 21046 | Search Radius (In Miles): * 10 [Search] [Clear]

Showing results for Search Terms: "Food" in radius "10" around address "21046" Found: 11 Results

Source	Organization Name	Program Name	Contact	Program Description
MD211	None or unknown	Church at Severn Run, The, Food Pantry	410-551-6654	
MD211	Faith-based	Happy Helpers For The Homeless, Food & Clothing Distribution	443-433-2416	
MD211	Government - County	COVID-19 HoCo Farms Connect		
MD211	Faith-based	Open Doors Food Pantry	301-854-2324	

Items per page: 10 1 – 10 of 11

4.2 Create Referral

A. Overview

The Create Referral feature allows users to:

- Select a known CBO from the resource directory
- Complete and submit a referral form directly within the HIE
- Notify the receiving organization and allow them to accept or update the referral
- Monitor the status of referrals (sent, accepted, completed, declined)

Note for HIE Users: Encourage your community partners to onboard to the referral platform in order to receive and respond to referrals electronically. Only onboarded organizations will appear as selectable referral destinations.

4 Referral Management System

B. Create Referral

1. Start with Patient Search, select a Patient, then Select “Search Programs”

CRISP DC

Select App

2. Search for a Program, and identify a relevant Program, Select the Program(s) and click “Create Referral”.

Referral Program Selection

Organization Name

test Find Organization

Search Area

Search Resources Address, City, or Zip Search Radius (In Miles) Search Clear

Showing results for organization name: 'test' Found: 1 Results

	Source	Organization Name	Program Name	Contact	Program Description
☑	HIE Directory	Crisp Referrals Test-DC	Weight Loss Program	333-333-3335	

Description: This is a weight loss program for kids ONLY

Create Referral for Program

Searches Community Resource databases including DC CRI, 211 MD and Connect 211.

Referral Program Selection

Organization Name

* Search for Organization Name Find Organization

Search Area

Search Resources: * housing Address, City, or Zip: * 20905 Search Radius (In Miles): * 15 Search Clear

4 Referral Management System

3. Complete the Referral Form (pre-populated) and click submit.

Referral Program Selection

Back to Program Selection

Patient Information

First Name	Middle Name	Last Name
Anna		Cadence
Date Of Birth	**HomeAddress1**	**HomeAddress2**
11/16/1981	HOMELESS	
City	**State**	**Zip**
UNKNOWN	MD	88888
Gender	**Phone Number ***	**Phone Number Type ***
F	5555551212	Mobile
Alt Phone Number	**Alt Phone Number Type ***	**Email**
3043441601	Mobile	

Spoken Language

Race or Ethnicity

Patient Insurance

4. Receive Confirmation Page and Email notification. If you'd like, you can also download confirmation page to PDF

Referral Program Selection

Confirmation Page
2879bbf9-43eb-41a7-99fd-5ca78005bb58

Patient Information

Referring Provider

Provider Information

Download

Referral Confirmation

HR HIE Referrals
To Naureen Elahi
2:30 PM

Thank you for using CRISP Referral Services. Your referral submission has been sent to the following program(s):

Referral Program: Fitness & Exercise
Program Description: The Richard A. Henson Wellness Center at MAC offers a wide variety of programs and services targeted toward addressing the health concerns and needs of older adults. The centers goal is to enable and to empower members to be physically active and to maintain and enhance their level of independence. Gym offerings include in-person and virtual classes, equipment and personal training. Membership fees are paid monthly and scholarships are available.

Confirmation Number: 2879bbf9-43eb-41a7-99fd-5ca78005bb58

Sincerely,
CRISP - Health Information Exchange

Showing results for Search Terms: "housing " in radius "15" around address "20905" Found: 37 Results

Source	Organization Name	Program Name	Contact	Program Description
HIE Directory	PIMR - Talbot County Health Department	PIMR	333-333-3335	
HIE Directory	Catholic Charities of Baltimore	Senior Housing w/o Congregate Services		

Description: Catholic Charities Senior Communities offers 24 locations of affordable, supportive rental apartments in Maryland – in Anne Arundel, Baltimore, Harford, Garrett Counties and Baltimore City.

Source	Organization Name	Program Name	Contact	Program Description
HIE Directory	Catholic Charities of Baltimore	Senior Housing w/ Congregate Services		
MD211	Nonprofit - Incorporated	Bethesda Help, Financial Assistance	301-365-2022	
MD211	Government - County	Montgomery County Government COVID-19 Information Portal	240-777-0311	

4 Referral Management System

5. Select a program and create a referral with pre-populated patient and program information. Add additional referral information and/or attach supporting documents.

	Source	Organization Name
☑	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well
☐	HIE Directory	MAC Living Well

Create Referral for Program

Referral Program Selection

Back to Program Selection

Patient Information

Patient Insurance

Referral Programs

Referring Provider

Provider Information

4 Referral Management System

6. Upon Referral submission, receive confirmation with email notification and download PDF option

Referral Program Selection

Back to Program Selection

Confirmation Page
2879bbf9-43eb-41a7-99fd-5ca78005bb58

Patient Information

First Name	Middle Name	Last Name
GILBERT		GRAPE

Date Of Birth	HomeAddress1	HomeAddress2
01/01/1984	4145 EARL C ADKINS DRIVE	

City	State	Zip
RIVER	WV	26000

Gender	Phone Number *	Phone Number Type *
M	9999994349	Mobile

Alt Phone Number	Alt Phone Number Type	Email
	OtherPhone	

Spoken Language Documents Race or Ethnicity

Referring Provider

◉ I am referring this patient myself ○ I am referring this patient on behalf of a provider

Provider Information

First Name *	Last Name *	Organization *	NPI *	Phone Number *
Naureen	Elahi	CRISP Internal Users - Break		555-555-5555

Download

Referral Confirmation

HR HIE Referrals
To Naureen Elahi
2:30 PM

Thank you for using CRISP Referral Services. Your referral submission has been sent to the following program(s):

Referral Program: Fitness & Exercise
Program Description: The Richard A. Henson Wellness Center at MAC offers a wide variety of programs and services targeted toward addressing the health concerns and needs of older adults. The centers goal is to enable and to empower members to be physically active and to maintain and enhance their level of independence. Gym offerings include in-person and virtual classes, equipment and personal training. Membership fees are paid monthly and scholarships are available.

Confirmation Number: 2879bbf9-43eb-41a7-99fd-5ca78005bb58

Sincerely,
CRISP - Health Information Exchange

4.3 Manage Referrals

A. Overview

Once a referral is sent, referral recipients (CBOs, Public Health Programs, etc) that are onboarded to the platform can manage it through a simplified referral management tool. This tool allows referral recipients to review incoming referrals, make a referral decision (e.g., accept or decline), and update the participant's status as they engage with services. This ensures care teams stay informed about referral outcomes and supports better coordination between clinical and social care providers.

B. Overview

1. Select "Manage Referrals" from the Portal tiles.

2. Referral recipients view a sortable Referral worklist to identify and select a referral.

CBO WorkList

Name	Gender	Date of Birth	Referring Provider	Referral Date	Referral Status	Last Updated	Organization	Program Name
ULPThree UnifiedLanding?	M	2003-00-00	Janelie Thomas	2024-01-22 11:07:11 AM	Pending	2024-01-22 11:07:11 AM	Test Organizations	Diabetes Self-Management Training
Luke Skywalker	M	1977-01-22	Janelie Thomas	2024-01-22 10:42:27 AM	Pending	2024-01-22 10:42:27 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelie Thomas	2024-01-19 03:58:05 PM	Pending	2024-01-19 03:58:05 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelie Thomas	2024-01-19 03:56:11 PM	Pending	2024-01-19 03:56:11 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelie Thomas	2024-01-19 10:58:20 AM	Pending	2024-01-19 10:58:20 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1984-01-01	Janelie Thomas	2024-01-19 10:52:10 AM	Pending	2024-01-19 10:52:10 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-17 12:13:44 PM	Enrolled	2024-01-17 12:15:52 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1947-06-30	Janelie Thomas	2024-01-11 03:09:45 PM	Pending	2024-01-11 03:09:45 PM	Test Organizations	PMR
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-11 12:20:11 PM	Enrolled	2024-01-11 12:22:00 PM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	M	1984-01-01	Nick Ramsing	2024-01-11 11:50:58 AM	Pending	2024-01-11 11:50:58 AM	Test Organizations	Diabetes Self-Management Training
Gilbert Grape	F	1947-06-30	Janelie Thomas	2024-01-08 03:57:52 PM	Enrolled	2024-01-22 02:17:27 PM	Test Organizations	Monoclonal Antibody Infusion
Gilbert Grape	F	1947-06-30	Janelie Thomas	2024-01-08 03:24:07 PM	Pending	2024-01-08 03:24:07 PM	Test Organizations	Diabetes Self-Management Training

Items per page: 25

4 Referral Management System

3. Referral recipients review referral details to determine whether to Accept or Reject a referral.

4. Referral recipients can update referral status and create journal entries to inform care team members.

Journal Information

Date	Status	Journal	Person who made entry
2024-01-17	Enrolled	person is enrolled	Nick Ramsing
2024-01-17	Accepted	Referral Accepted	Nick Ramsing
2024-01-17	Pending	Referral Created	System

Items per page: 10 1 – 3 of 3

Create new journal

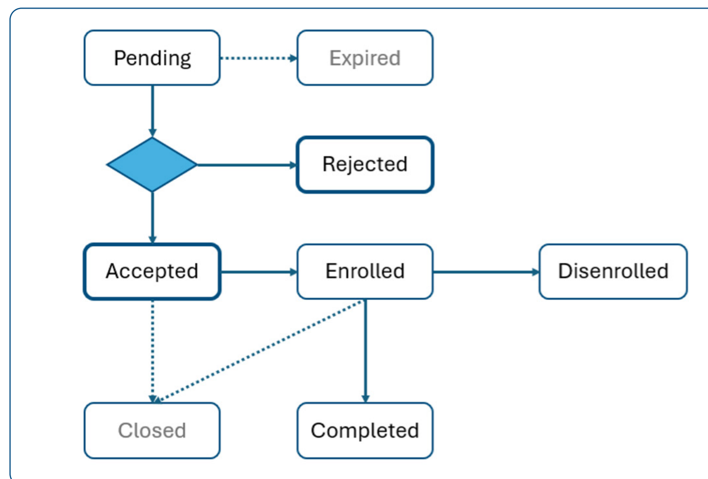
Status *

Journal *

Submit Journal

4 **Referral Management System**

Types of journal status updates:



Referral Status values:

Pending: Initial and default status – awaiting a decision

Accepted: Referral has been accepted by the referral program

Rejected: Referral has been rejected by the referral program

Enrolled: Patient has been enrolled in the referral program

Disenrolled: Patient has been dis-enrolled from the referral program

Completed: Referral activities and lifecycle has been completed

Journal feature menu enables users to access specific functionality, including a status Override that allows a Referral Manager to reset referral status to Pending.

Access Menu:

Print to PDF Download Override

4.4 Referral History : Closed Loop Referral Visibility

The Referral History is a closed-loop referral visibility, displaying a patient's referral history at the point of care, regardless of which system the referral was initiated from. This central view helps **desilo referral data**, ensuring all members of the care team—clinical and social—can see, track, and coordinate around a patient's social care journey, no matter where the referral originated. Referral history is available directly within the HIE's InContext application.

5 Customized Configuration Use Cases

5.1 Overview

- The Base Referral form provides a standardized foundation for sending social care referrals across a range of community-based programs. Built to be configurable, the form supports program-specific requirements by adapting a core data structure. All forms are customized from a single data source, streamlining deployment across an HIE without the need for disconnected or ad hoc formats.

Referral Programs

Organization: Test Organizations

Program Name: SES Test

Source: HIE Directory

Description: Generic Program Description 11

1 Please enter all relevant information that you would like relayed to the accepting provider

2 Choose Files No file chosen

5.2 Examples

- **Diabetes Prevention Program (DPP):** Includes vitals like BMI and A1C needed to assess eligibility.

Referral Programs

Organization: Test Organizations

Program Name: Diabetes Self-Management Training

Source: HIE Directory

Description: Help Medicare patients with diabetes attain the knowledge, skills and support they need to partner with their physician and successfully "self-manage" their condition on a day-to-day basis.

Patient Vitals

BMI* | HbA1c* | Blood Pressure*

Cholesterol* | Fasting Glucose* | Allergies*

5 Customized Configuration Use Cases

Program Name: PIMR
Source: HIE Directory
Description: Test for Second PIMR

Maternal Demographic Information

First Name* | Middle Name | Last Name*
Address*
City* | State* | Zip Code*
Date Of Birth*
Phone Number* | Email
Race*
Communication Barrier* | Primary Language*
Other Barriers

Emergency Contact Information

Name Of Emergency Contact* | Relationship Of Emergency Contact* | Emergency Phone*

Infant Demographics Information

First Name* | Middle Name | Legal Last Name*
Sex* | Date Of Birth* | Gestational Age At Birth*
Birth Weight* | Apgar Score

Maternal Primary Care Fields

Provider/Practice Name
Office Address
City | State | Zip Code

KENTUCKY

HEALTH INFORMATION EXCHANGE

CONNECTING KENTUCKY. IMPROVING HEALTHCARE.

khie.ky.gov

Email us: khie@ky.gov

For general account support, call: (502) 564-7992

For technical user support, powered by CRISP Shared Services, call: 866-441-2966