The Social Determinants of Health: Integration into clinical practice

Session 3: SDOH screener use, a practical perspective

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National Center for Health in Public Housing (NCHPH)

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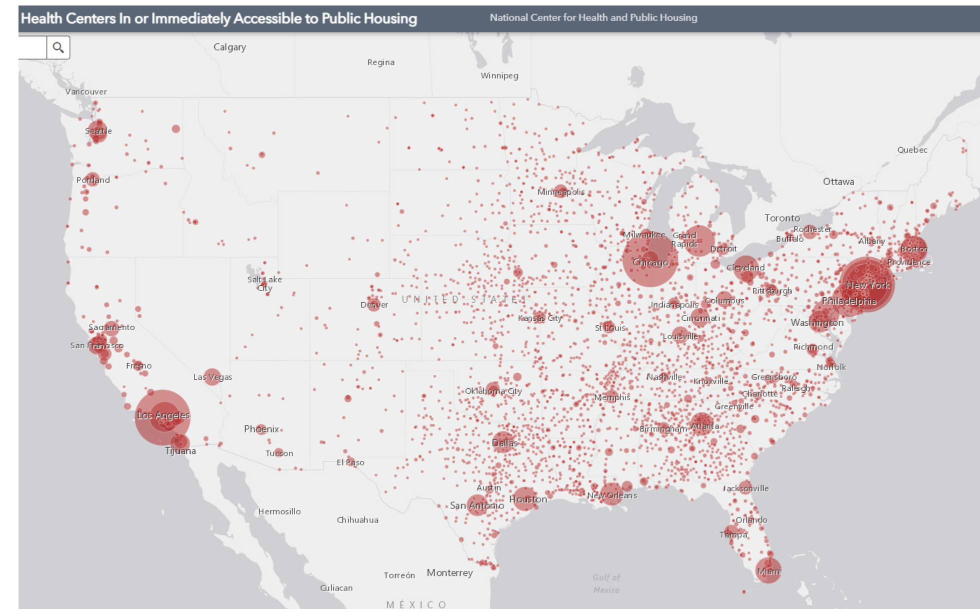
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

Health Centers Close to Public Housing

- 1,373 Federally Qualified Health Centers (FQHC) = **30 million patients**
- 458 FQHCs In or Immediately Accessible to Public Housing = **5.7 million patients**
- 108 Public Housing Primary Care (PHPC) = **911,683 patients**

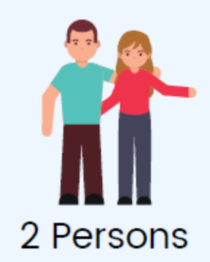
Source: [2021 Health Center Data]



Source: [Health Centers in or Immediately Accessible to Public Housing Map]

Public Housing Demographics

1.5 Million Residents



2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

Session content objectives

Through an examination of the literature and engagement in case studies we will review the following:

1. **Discuss the uses of SDOH Screeners.**
2. **Review key SDOH Screeners and their applications.**
3. **Examine ways to modify SDOH Screeners to meet community needs.**

The SDOH: Conceptual Overview

Social Determinants of Health

Education Access and Quality
Health Care Access and Quality
Economic Stability
Neighborhood and Built Environment
Social and Community Context

Social Determinants of Health
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Healthy People 2030

Link to resource: [Healthy People 2030]()

Discussion Question:

SDOH Screeners are used by organizations in a variety of different settings and patient care scenarios.

Please take 2 minutes to answer the following:

"In what situations does your organization utilize SDOH Screeners?"

"For which scenarios is your organization considering use of SDOH Screeners?"

The use of SDOH Screening tools

We want to make sure that you know all the community resources that are available to you for problems. **Many of these resources are free of charge.** Please answer each question and hand it to your child's medical assistant at the beginning of the visit. Thank you!

Question	Response	Follow-up	Follow-up response
Do you have a high school degree?	Yes No	If NO, would you like help to get a GED?	Yes No Maybe Later
Do you have a job?	Yes No	If NO, would you like help with finding employment and/or job training?	Yes No Maybe Later
Do you need daycare for your child?	Yes No	If YES, would you like help finding it?	Yes No Maybe Later
Do you think you are at risk of becoming homeless?	Yes No	If YES, would you like help with this?	Yes No Maybe Later If yes, is this an emergency? Yes* No
Do you always have enough food for your family?	Yes No	If NO, would you like help with this?	Yes No Maybe Later If yes, do you need food for tonight? Yes* No
Do you have trouble paying your heating bill and/or electricity bill?	Yes No	If YES, would you like help with this?	Yes No Maybe Later If yes, are you at risk of having your utilities shut off in the next week? Yes* No

Link: To Publication

Please take 3 minutes to consider the following:

"What question(s) is missing from this screener that would be helpful in my community?

Screener Questions:

1. Do you have a high school degree?
2. Do you have a job?
3. Do you need daycare for your child?
4. Do you think you are at risk of becoming homeless?
5. Do you always have enough food for your family?
6. Do you have trouble paying your heating bill and/or electricity bill?

We want to make sure that you know all the community resources that are available to you for problems. **Many of these resources are free of charge.** Please answer each question and hand it to your child's medical assistant at the beginning of the visit. Thank you!

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	Do you have a high school degree?	Yes No ↓ If NO, would you like help to get a GED?	Yes No Maybe Later
	Do you have a job?	Yes No ↓ If NO, would you like help with finding employment and/or job training?	Yes No Maybe Later
	Do you need daycare for your child?	Yes No ↓ If YES, would you like help finding it?	Yes No Maybe Later
	Do you think you are at risk of becoming homeless?	Yes No ↓ If YES, would you like help with this?	Yes No Maybe Later ↓ If yes, is this an emergency? Yes* No
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Social Determinants of Health

Case Study: SDOH Screeners

An Ohio-based primary care clinic is considering screening for SDOH at their office. Currently, these data are collected by nurses or physicians during the patient visit.

An internal review of SDOH policies was performed by the office's health system and the following conclusions were made:

1. Patient surveys indicate SDOH needs were not being met.
2. Social Services staff were experiencing high levels of burn-out.
3. Nurses and Doctors often do not coordinate who collects these data, so the collection is often rushed or ad-hoc.
4. Medical records could be submitted without collecting these data.
5. Failure to collect SDOH data was leading to lower Medicaid billing and reduced system revenue.

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Case Study: SDOH Screeners

Please take 3 minutes to consider the following:

"What are some actions this organization could make to improve their use of screeners?"

Recommended remedial approach:

1. Integrate the screener firmly in a step-by-step workflow.
2. Ensure accountability in collection and submission quality.
3. Ensure appropriate use of information.
4. Perform regular audits of data collection and use.

The use of SDOH Screening tools: Application

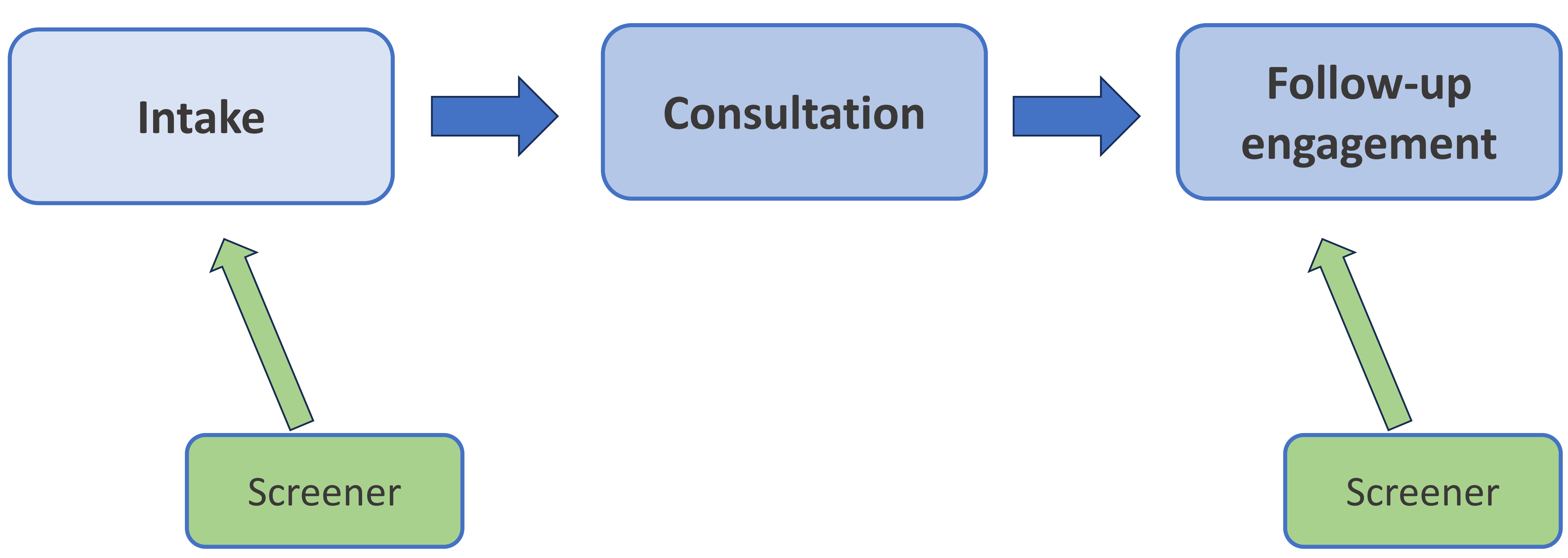
When planning implementation of a new screener:

1. Examine organization structure and workflow.
2. Identify key patient care interactions.
3. Consider data collection.
4. Consider workflow integration.
5. Consider screener design.

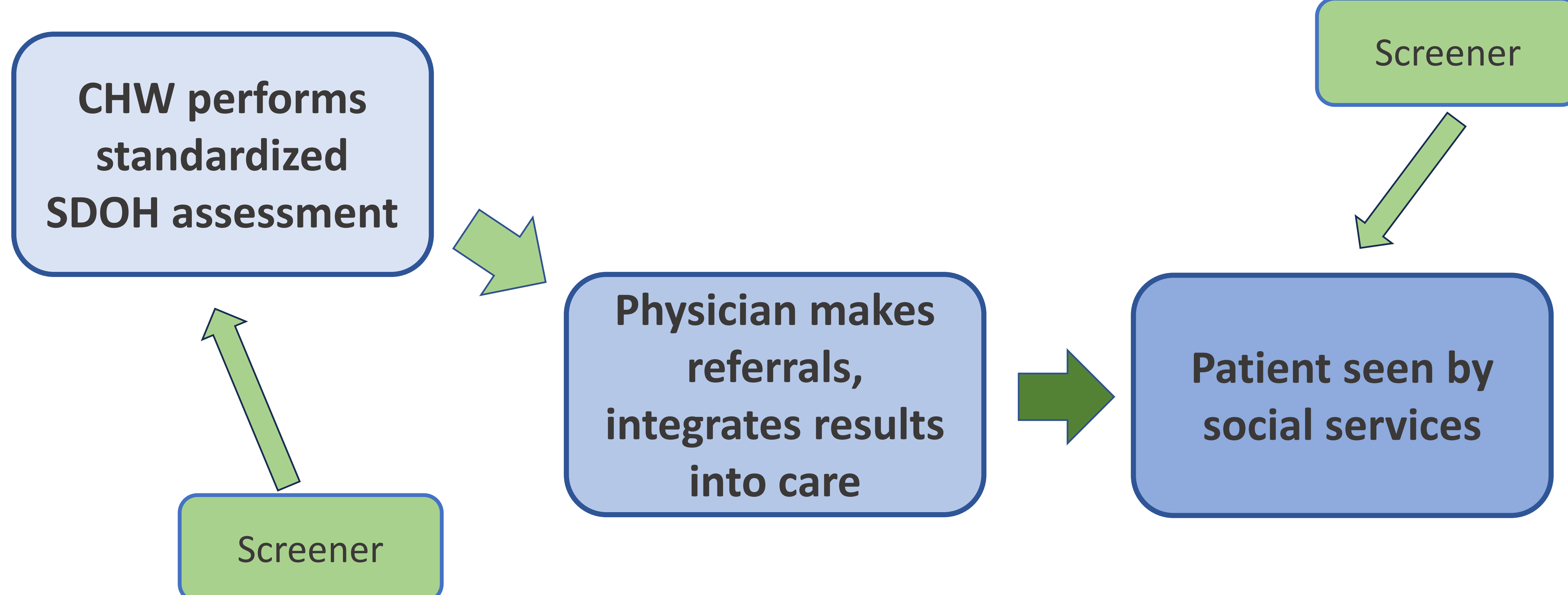
When planning revision of an existing screener:

1. Examine organization structure and workflow.
2. Examine locations where SDOH data is collected.
3. Examine impact of SDOH screener on workflow and patient care

The use of SDOH Screening tools: Application



The use of SDOH Screening tools: Application



How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care

An Overview

Kate LaForge, MPH, Rachel Gold, PhD, MPH, Erika Cottrell, PhD, MPP, Arwen E. Bunce, MA, Michelle Proser, PhD, MPP, Celine Hollombe, MPH, Katie Dambrun, MPH, Deborah J. Cohen, PhD, and Khaya D. Clark, PhD, MA

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Abstract

Go to:

Little is known about how health care organizations are developing tools for identifying/addressing patients' social determinants of health (SDH). We describe the processes recently used by 6 organizations to develop SDH screening tools for ambulatory care and the barriers they faced during those efforts. Common processes included reviewing literature and consulting primary care staff. The organizations prioritized avoiding redundant data collection, integrating SDH screening into existing workflows, and addressing diverse clinic needs. This article provides suggestions for others hoping to develop similar tools/strategies for identifying patients' SDH needs in ambulatory care settings, with recommendations for further research.

Keywords: ambulatory care, community health centers, data collection, electronic health records, patient-reported outcome measures, primary care, screening, social determinants of health

Link: To Publication

Takeaways:

1. Institutions have wide breadth to improve on existing tools.
2. Customizability of tools to local SDOH concerns is key to program strength.
3. Organizational culture is a key component of promoting SDOH policies.

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:________________________________
City, State, Zip code: ____________________

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work

Additional considerations for community use of PRAPARE:

1. Housing details related to health and safety.
2. Access to transportation.
3. Location data.
4. Community-specific trauma-informed care.
5. Eviction and debt collection risk.

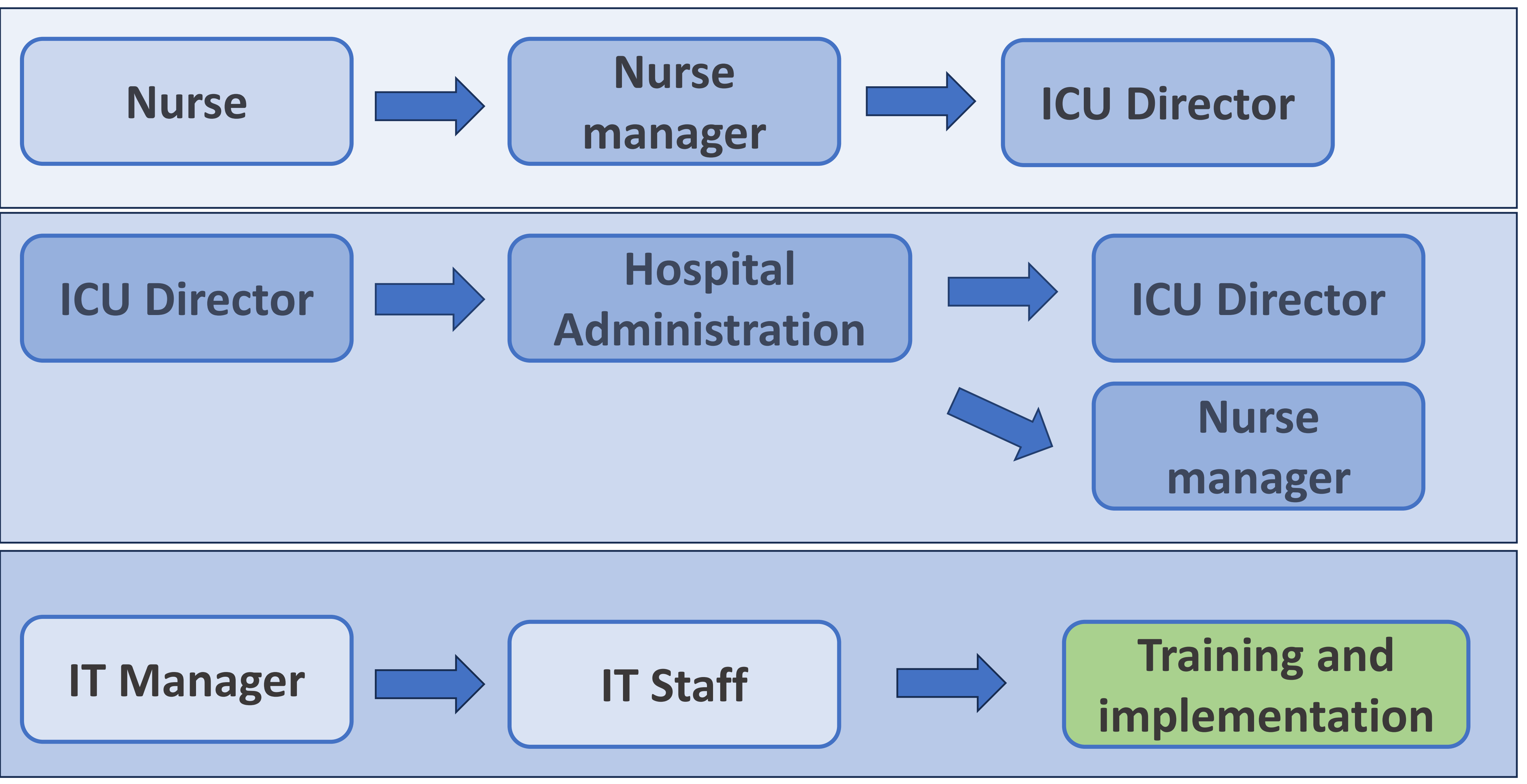
When altering a screener, be sure to consult your data steward.

Link to resource

Categories Consistent with OMB 2+5 Standards

- Ethnicity
  1. Hispanic or Latino.
  2. Not Hispanic or Latino.
- Race
  1. American Indian or Alaska Native.
  2. Asian.
  3. Black or African American.
  4. Native Hawaiian or Pacific Islander.
  5. White

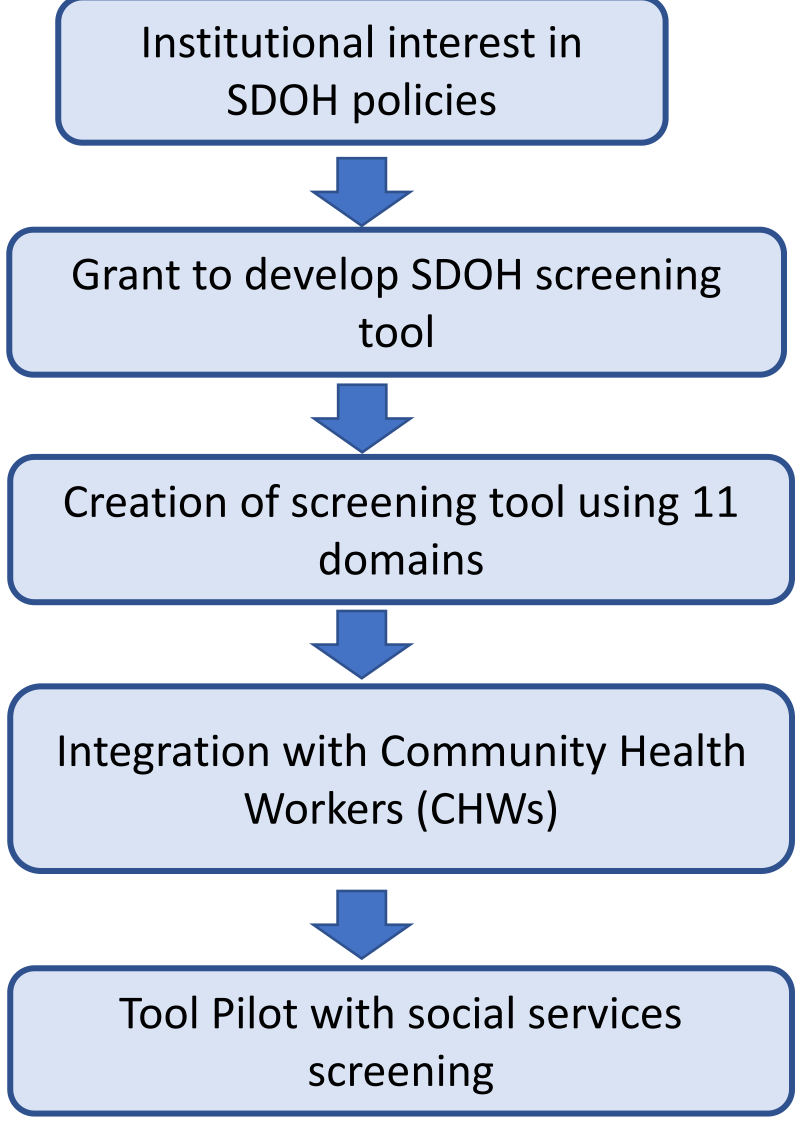
EHR intervention and remediation



WellRx Pilot, University of New Mexico

Utilities 22%
Income 22%
Employment 15%
Education 13%
Food 12%
Housing 11%
Transportation 9%
Safety 6%
Subst. Abuse 4%
Childcare 3%
Abuse 1%

0 100 200 300 400 500 600 700 800



Link: To Publication

Please contact us if you are interested in any of the following:

- Improving access to legal services through person-centered delivery models.
- Integrating the SDOH into health center management and workflow.
- The impact of the SDOH on FQHC workforce retention.
- Training and patient-facing materials for Haitian Creole speaking patients/workforce.

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Wrap-up:

Please take this time to mention anything you would like to address further related to the SDOH, clinical practice and health center management.

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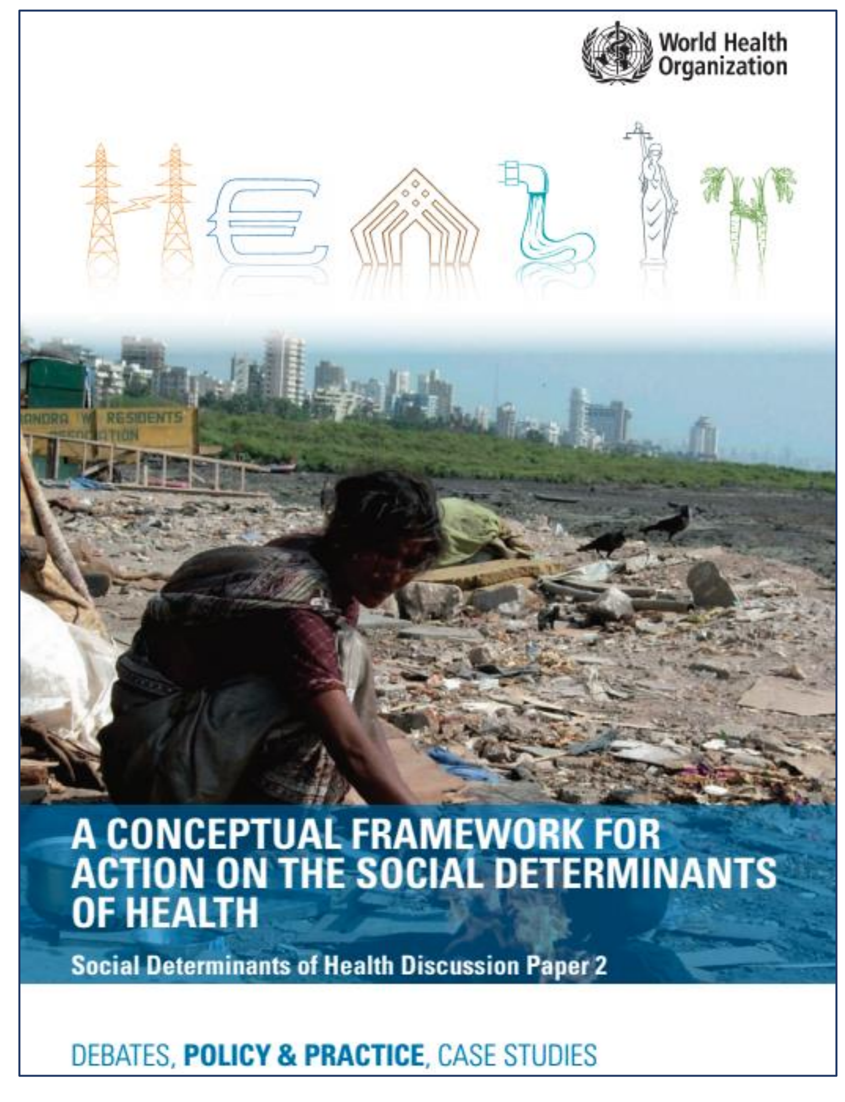
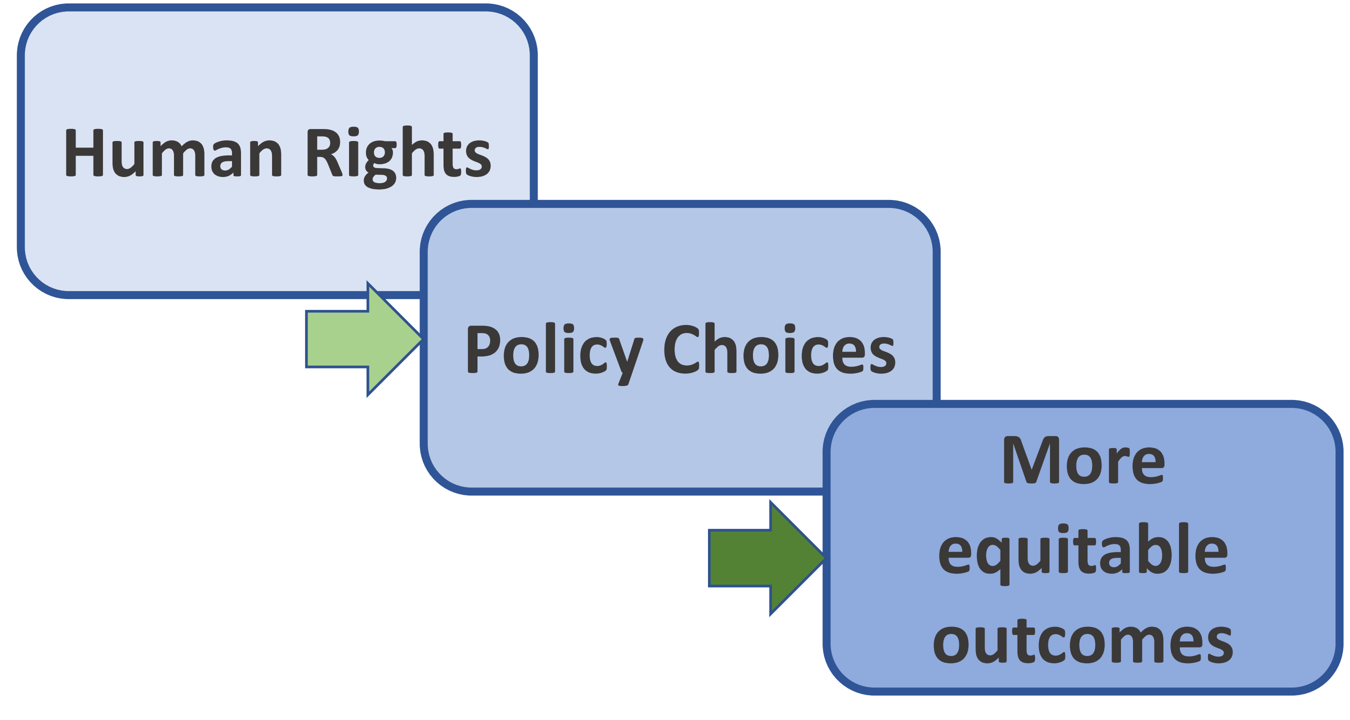
WHO Conceptual Framework





Link to Resource: WHO Conceptual Framework

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Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper FREE

Hilary Daniel, BS, Sue S. Bornstein, MD, and Gregory C. Kane, MD, ... View all authors +

Author, Article, and Disclosure Information

https://doi.org/10.7326/M17-2441

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ACP Policy Recommendations:

1. Increased efforts to evaluate and implement public policy recommendations.
2. The SDOH should be integrated into medical education at all levels.
3. Increased use of interprofessional and collaborative models that encourage a team-based approach to patient care.
4. Investment in SDOH-focused programs.

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Author, Article, and Disclosure Information

https://doi.org/10.7326/M17-2441

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ACP Policy Recommendations:

5. Increased SDOH research.
6. Integration of health considerations into community planning.
7. Best practices for using EHR's to improve individual and population heath.
8. Adjusting quality payment models and performance measurement assessments to reflect increased risk associated with caring for disadvantaged populations.
9. Increased screening and collection of SDOH data to aid in health impact assessments and support.

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Link: To Publication

Takeaways:

- 6 in 10 physicians have little to no time to address the SDOH in the exam room.
- 89% indicated lack of staff to address the SDOH.
- 8 in 10 physicians believe not integrating SDOH into care contributes to burnout.
- 6 in 10 report burnout when addressing SDOH.

BRIEF | OCTOBER 2017

CHCS Center for Health Care Strategies, Inc.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

By Caitlin Thomas-Henkel and Meryl Schulman, Center for Health Care Strategies

IN BRIEF

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes,[1] particularly among low-income populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). This brief examines how organizations participating in *Transforming Complex Care* (TCC), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Compared to other industrialized nations, the United States spends much less on social services, and much more on health care.[2] This is true despite evidence that social determinants of health (SDOH) — including income, educational attainment, employment status, and access to food and housing — affect an array of health outcomes,[3] particularly among low-income populations.[4] Individuals with unmet social needs are more likely to be frequent emergency department (ED) users, have repeat 'no-shows' to medical appointments, and have poorer glycemic and cholesterol control than those able to meet their needs.[5]

Link: To Publication

Takeaways:

Screening tools should be adapted to meet the following:

- Capacity to address specific SDOH needs.
- Availability of local resources and referral networks.
- Ease of use within clinical setting (workflow).
- Ability of tool to capture needs the organization can realistically address.

Integration of SDOH policies and frameworks into health center management, workflow and patient care is complex and difficult.

A body of research has indicated that evolving workplace culture to place greater value on the SDOH can lead to more comprehensive care of patients, and less burnout in our workforce.

Please take 3 minutes to consider the following:

How has your organization, or individuals in your organization helped to aid this evolution?

How can workplace culture be altered to further advance the SDOH in your community?

Your participation and opinion are greatly appreciated.

Q&A Session

Next Session Reminder

- **Session 4: Next Wednesday, June 21st at 1:00 pm EDT.**
- **Use the same registration link for today's session.**
- **Registration link:** https://us06web.zoom.us/meeting/register/tZwodeyprTwsH9Sn6Dcc5wd6H2AcaZ9u4sno#/registration

Complete our Post Evaluation Survey

https://www.surveymonkey.com/r/FD83NGL

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Thank you!