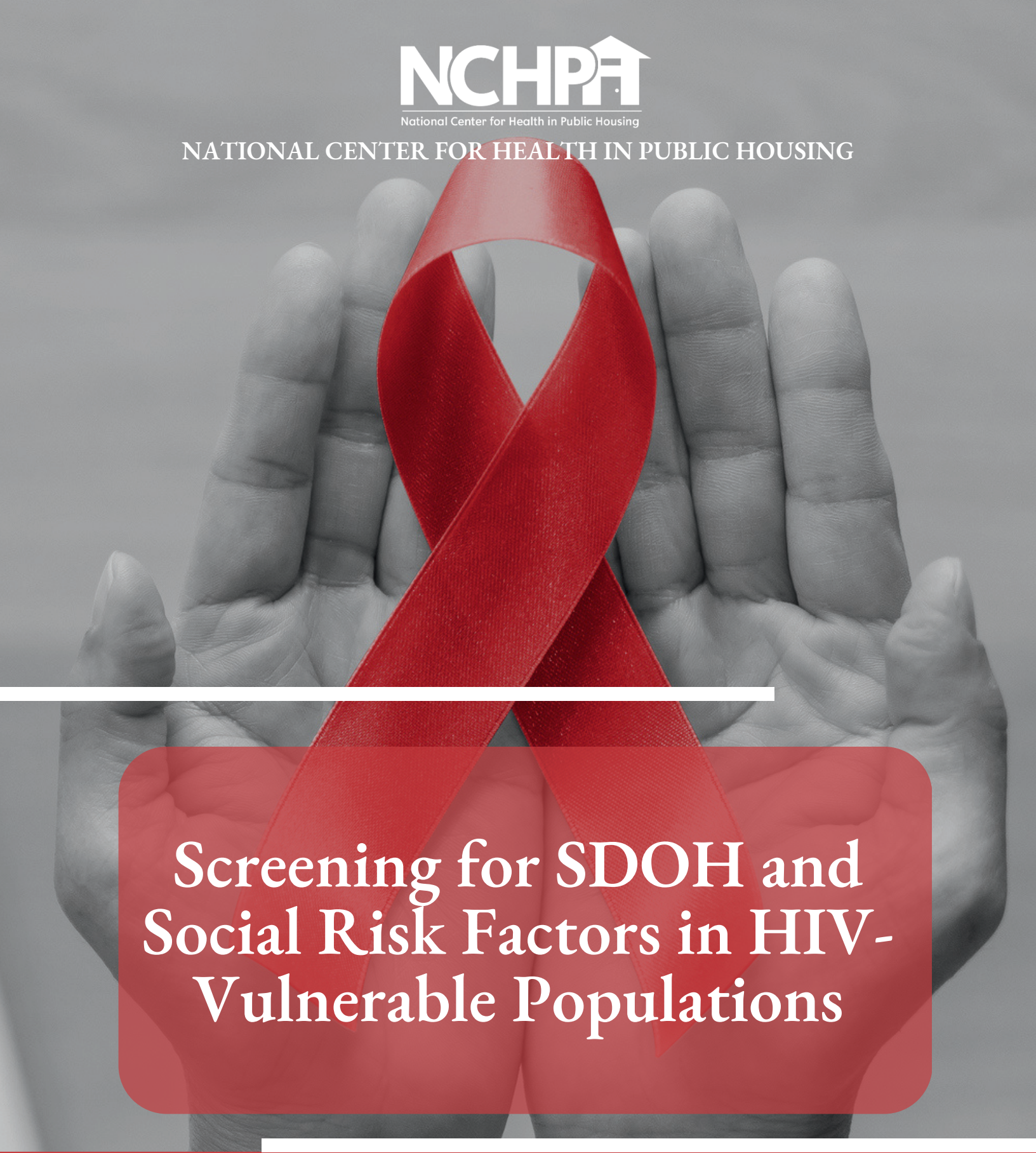

NATIONAL CENTER FOR HEALTH IN PUBLIC HOUSING

Screening for SDOH and Social Risk Factors in HIV-Vulnerable Populations

A Guide for Health Centers Serving Residents of Public Housing and HUD-Assisted Individuals

Screening for SDOH and Social Risk Factors in HIV-Vulnerable Populations: Guide for Health Centers Serving Residents of Public Housing and the HUD-Assisted

I. Forward

HIV+ patients and individuals from HIV-vulnerable populations often experience barriers when accessing needed medical care, including key services such as primary and preventative medicine, prescribed medications and behavioral health care. These patients are also more likely to exhibit socioeconomic factors which are linked to poor health outcomes, such as low income, limited formal education, and experiencing unstable housing or living in public or assisted housing.

Research has consistently indicated that providing non-medical support to HIV+ patients and those at risk for HIV, such as IV-drug users and Men Who have Sex with Men, leads to better health outcomes[1]. Changes in housing status have specifically shown to significantly reduce risk of behaviors associated with HIV such as drug use, needle sharing and unprotected sex[2]. Additionally, according to the Centers for Disease Control and Prevention (CDC), in 2020 17% of U.S. adults with HIV experienced homelessness or unstable housing[3]. Health centers, Public Housing Authorities (PHAs), and partner organizations can support the non-medical needs of their patients and community by implementing policies that address the Social Determinants of Health (SDOH).

Health centers can support HIV+ patients and those vulnerable to HIV by integrating screening for the SDOH into their standard operating procedures. In this reference guide, we present a step-by step approach to integrating SDOH screening into the clinical and social support operations of health centers and PHAs and it is designed for use by both organizations that have existing social support infrastructure and wish to review their current delivery model and by those with limited social support infrastructure who are interested in expanding their SDOH program footprint.

II. SDOH and HIV

Health centers, PHAs and partners play a significant role in HIV care on both the individual and population level. These organizations provide critical services to patients and clients, which have significant impacts on patient care and outcomes. Through public health initiatives, health centers and PHAs provide a critical role in maintaining community health and resilience. These organizations can support HIV+ patients through a variety of different initiatives, including:

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[1] Also commonly referred to as Federally Qualified Health centers and look-alikes.

[2] Edwards AE, Collins CB Jr. Exploring the influence of social determinants on HIV risk behaviors and the potential application of structural interventions to prevent HIV in women. J Health Dispar Res Pract. 2014 Winter;7(SI2):141-155. PMID: 27134801; PMCID: PMC4848455.

[3]Issue Brief: The Role of Housing in Ending the HIV Epidemic, U.S. Centers for Disease Control and Prevention, https://www.cdc.gov/hiv/policies/data/role-of-housing-in-ending-the-hiv-epidemic.html

1. **Trauma-informed care:** Providing high quality clinical care and successfully meeting client needs successfully both require a strong commitment to providing trauma-informed care. Ensure that clinical and non-clinical staff members have been trained in the provision of trauma-informed care.
2. **Culturally competent care:** When patients feel understood, valued, and respected by their provider, they are more likely to remain in care. Clinicians and staff members who maintain high levels of cultural competency maximize their abilities to communicate with and serve their patients. Health centers and PHA's should be trained in the provision of culturally competent care, including care for communities disproportionately affected by HIV such as migrant populations and those who identify as LGTBQIA+. Resources such as the **Fenway Institutes Guide to Lesbian, Gay, Bisexual and Transgender Health, 2nd Edition** can be utilized to identify and integrate best practices into staff training and organizational policies.

Figure 1 Cultural competency at health centers: *Steps for improving health center orientation towards cultural competency are detailed.*

Key Resources:

- **Compendium of Evidence-Informed Approaches to Improving Health Outcomes for People Living with HIV:** This guide, Centers for Innovation and Engagement, presents evidence supporting a range of interventions to improve culturally competent care for patients with HIV. This includes detailed implementation guides for bilingual/bicultural care teams (page 3).
- **Fenway Institute's Guide to lesbian, Gay, Bisexual and Transgender Health, 2nd Edition:** Includes best practices for a range of public health intervention efforts designed to improve LGTBQIA+ health. This includes guides for sexual health and HIV prevention.
- **The New England AIDS Education and Training Center**, hosted by UMass Chan Medical School houses offers a variety of resources. These include AETEC New England's Cultural Competence and HIV education packet and guidelines outlining models tailored to health center operational needs, tools for reducing stigma and discrimination among providers and a pocket guide for facilitating conversations about stigma.

3. **Primary care:** Thanks to antiretroviral medications, patients with HIV can live long and healthy lives. Helping patients reach these milestones requires the provision of consistent longitudinal medical management. The composition of the care team of each patient with HIV will vary according to that individual patients' needs but will include a primary care physician and an infectious diseases specialist. Because of the high risk of comorbidities such as heart and renal disease in HIV positive patients, primary care fulfils a particularly important preventative role in these patients. Especially in the early stages of diagnosis, patients have frequent medical appointments and a significant number of new medications. Health centers can support HIV-positive patients by ensuring they have the navigation, transportation and other needed social support resources needed to access these services easily.

   Key Resources:

   - America's HIV Epidemic Analysis Dashboard (AHEAD): The AHEAD tool provides live data tracking the six public health indicators (including SDOH indicators) in areas with the highest burden of HIV.

III. Screening for SDOH

The Social Determinants of Health (SDOH) refers to the non-medical factors that influence health outcomes. These factors, including housing and financial stability, also provide a framework for intervention. Assessing patients for SDOH needs is a critical component to providing comprehensive care at both the individual and population-levels.

Screening for SDOH allows organizations an efficient method for determining patient non-medical needs and providing referral to needed services. When utilized correctly, SDOH

screening can improve the efficiency of service delivery through the reduction of redundancies and complexities in existing referral networks.

1. **What are the screening tools?** There are a variety of SDOH screening tools that are publicly available and have been validated for health center use (see resources section below). SDOH screening tools can be programmed directly into facility electronic health records and should be selected based on the specific needs of health centers and the patients they serve.

2. **How is screening performed?** Generally, SDOH screening is completed prior to patient clinical interaction, such as during patient intake. The patient is provided with a paper copy of the SDOH screening instrument. Upon completion, the results are given to the patient's provider and entered into the facility's electronic health record.

3. **Integrating screening into social support**: Organizations should not screen for SDOH without an adequate network of social support services available for referral. Utilizing SDOH screening instruments such as the Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE) allows health center social support staff, such as social workers and community health workers, to direct patients to services that align with the SDOH domains where they would benefit from support. When evaluating their SDOH footprint health centers and PHAs should consider the potential to initiate, grow, or maintain inter-organizational partnerships with organizations such as local nonprofits and faith-based organizations, hospital networks, and local government agencies. Through relationships with these organizations, health centers can expand SDOH program offerings and reduce costs associated with SDOH and social support program provision and administration. Through integration into facility electronic medical record (EMR) systems, patient SDOH data can be easily viewed by the patient's provider, who can refer the patient to social support services when appropriate.

4. **Supporting HIV+ patients in your community:** A diagnosis of HIV is a life-changing event. Fortunately, with early diagnosis and antiretroviral treatment, patients can live otherwise long and healthy lives with HIV. There are a number of ways Health Centers can support these patients, especially in the initial stages of diagnosis, when patients have frequent medical appointments and a significant number of new medications. They also often have a number of lifestyle changes to support their health. Support these individuals by ensuring they have the navigation, transportation and other needed social support and resources. For example, many health centers utilize Community Health Workers and patient support groups to help patients navigate the complexities of their new diagnosis and increase the likelihood of positive patient outcomes.

Key Resources:

- PRAPARE: Designed and validated by the National Association of Community Health Centers (NACHC), Association of Asian Pacific Community Health Organizations (AAPCHO), and the Oregon Primary Care Association (OPCA). The

SDOH screening tool most commonly used by health centers can be easily integrated into electronic health record systems and modified as necessary to meet the specific needs of each health center.

- Upstream Risks Screening Tool and Guide: Contains questions about 14 different SDOH domains.
- WellRx: A validated 11-question SDOH screening tool.
- Your Current Life Situation (YCL) survey: Captures a range of economic needs, including living situation, housing, food, utilities, childcare, debts, medical needs, transportation, stress, and social isolation.
- HHS Electronic Health Record SDOH Strategies: Publication by the U.S. Department of Health and Human Services (HHS) recommendations for integrating SDOH data into electronic health records.

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