Health Systems Can Address Patients' Needs by Screening for Social Determinants of Health

Introduction

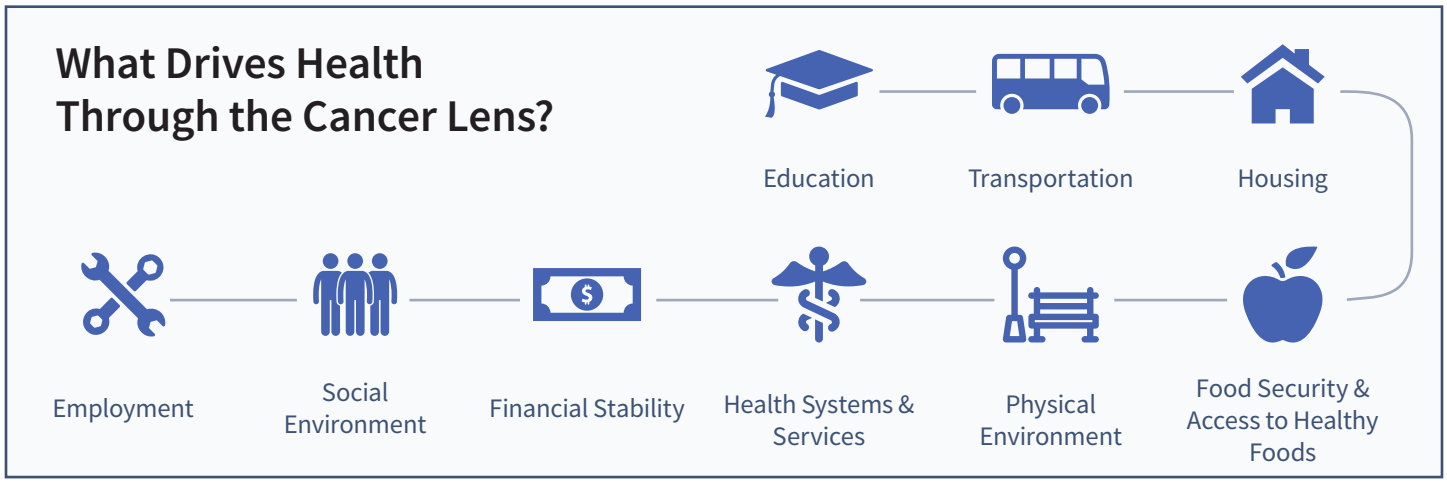
This document is an overview for health systems to help implement the screening of patients for Social Determinants of Health (SDOH) in their clinical intake procedures.

The five core SDOH factors include a patient's:

- Economic stability
- Neighborhood and built environment
- Social and community context
- Educational level
- Access to healthcare

Other important factors that affect a patient's health include access to transportation, food security, and personal safety.

Health systems play an important role in the health of their patients and communities. Addressing the nonmedical social needs, or SDOH, of their patients through screening and referral is vital to reaching positive health outcomes.



Understand the Reasons for Screening for SDOH

The Case For SDOH

Social Determinants of Health (SDOH) are conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.[1]

The main goal of screening patients for the social determinants of health is to improve their overall health by identifying the patient's nonmedical social needs and connecting them with local community services.

Evidence gathered over the past 30 years supports the substantial effect of nonmedical factors on overall physical and mental health.[2] Research also suggests that interventions to address social determinants of health, such as housing, income support, and access to healthcare, yield positive outcomes for patients.[3]

80%

Medical care accounts for around only 20% of the variation in health outcomes for a population, whereas 80% can be traced back to the social determinants of health.[4][5]

Understand the Reasons for Screening for SDOH

Benefits of Screening for SDOH

Health systems can benefit from SDOH screening because it can help them to reduce costs and disparities by implementing programs that address nutrition, food security, shelter, and other barriers to overall health.[6] Screening for SDOH is recommended by leading health organizations including the National Academies of Science, Engineering, and Medicine, American Academy of Family Physicians, American Medical Association, and American College of Physicians.[7][8][9][10]

Cancer prevention and screening interventions that address SDOH are cost-effective approaches associated with improved screening rates, health outcomes, and increased quality adjusted life years.[11]

Community Health Needs Assessments (CHNA), performed every 3 years by charitable hospital organizations, can help identify and prioritize health needs in the community and inform strategies and policies to address SDOH factors specific to the populations your system serves. Screening for Social Determinants of Health can be integrated into CHNA implementation plans to improve data-driven decisions to address patient and service area needs.

A Closer Look

- In Chicago, Advocate Health Care saved nearly $5 million by developing an "enhanced nutrition care program" and screening for "malnutrition risk factors".[12][13]
- The University of Illinois at Chicago identified homeless patients that needed housing support resulting in an 18% cost reduction.[13]
- Hennepin County Medical Center partners with a local non-profit to support employment and housing needs resulting in "decreased health care costs for program participants by 60%".[14]

85%

of physicians in a national poll agreed that unmet social needs lead directly to worse health.[15]

Understand the SDOH Screening Process and Clinical Workflow

The Screening Process

The screening process is done at specific time intervals to evaluate and respond to changing SDOH factors in the patient's life.

- Patients are first screened at the time of clinical intake by asking them to complete an assessment to identify their nonmedical social needs.
- Follow-up assessments can be done several months later, as needed, to identify and document changes in the patient's status.

Process Design Considerations

It is helpful to consider these factors when you design your SDOH screening process.

- Create a favorable environment for screening. Patients can be reluctant to share their social needs because of shame, fear, trauma, and other emotional, non-medical factors.
- To reduce stress for everyone, plan to give patients enough time to fill out the assessment form before beginning their visit with the provider.
- A list of community resources should be available for clinical team members making referrals.

Understand the SDOH Screening Process and Clinical Workflow

Clinic Workflow

The clinical workflow of SDOH screening involves multiple clinical team members.

Each team member can fill one or more roles in obtaining and distributing educational information, gathering and reviewing SDOH screening assessment forms, performing patient interviews and facilitating shared decision-making with patients, and creating and following up on SDOH action plans for patients.

A typical SDOH workflow might include:

A receptionist or assistant gives the SDOH intake screening tool to the patient to fill out before the provider visit.

A nurse or assistant reviews the screening results, formulates an action plan, and updates the patient records.

Community health workers or medical assistants facilitate referrals to community resources and provide case management services for patients.

A provider reviews the screening results and suggested action plan before the patient visit and decides on referrals or plan modifications during the patient visit.

Workflow Tips

Self-administered assessments can be helpful because patients are more likely to disclose sensitive information in self-administered settings.[16]

Short-form assessments are quick for patients for investigating the five core SDOH factors.

Long-form assessments take more time but can explore additional SDOH factors in more depth.

Understand the SDOH Screening Questions

Screening Questions

Screening questions work best when they are well-matched to patient demographics, health system capabilities, and community-based support systems.

Good screening questions identify patient SDOH needs that can be addressed locally, without asking broad questions that cannot be addressed by local community services.

Consider these factors for your questions:

- What community resources are available to help in the five SDOH areas?
- Are there community supporting services for each question in your assessment?
- Is staff training required to complete and interpret the assessment?
- If a charitable hospital organization, what does your Community Health Needs Assessment tell you about the population your system serves?

Best Practices for Question Design

A best practices checklist for screening questions might include questions that are:

- Sourced from validated tools or measures
- Simple
- Readable (at fifth-grade level)
- Visually appealing
- Accessible (508 compliant)
- Use similar response options (yes/no or Likert scale (strong no, no, neutral, yes, strong yes)

Questions should be designed to open a conversation with patients and should separate the concepts of the prevalence of need (“Have you experienced this issue?”) from the desire for program enrollment (“Would you like help with this issue?”).

Compare Existing SDOH Screening Tools

Five example screening tools are summarized below and in the table on the following page. Each tool is free, available online for download, and was developed by a public health organization for SDOH screening. The questions in the example tools go beyond the five core SDOH factors and can be easily adapted by excluding or modifying questions to develop a new survey to meet the needs of a specific community project or setting.

5 Example Screening Tools

2018

EveryONE Project Toolkit. The EveryONE project toolkit was created by the American Academy of Family Physicians to help physicians identify and address social determinants of health to achieve optimal health outcomes for people.

2017

HRSN Health Related Social Needs Screening Tool. This tool was developed by the Centers For Medicare & Medicaid Services for use in their Accountable Health Communities model. Providers can use the results from the HRS in the screening tool to inform treatment plans for patients and make referrals to community services.

2016

PRAPARE Assessment Tool. The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences toolkit was created by the National Association of Community Health Centers (NACHC) to help providers collect and respond to the SDOH needs of their patients. PRAPARE aligns with the Healthy People 2020 initiative goals.

2016

HEALTH Leads Social Needs Screening Tool. This toolkit was developed by Health Leads, a national organization that runs community-based programs. The toolkit includes comprehensive best practices on how to develop a set of SDOH questions and provides recommended questions from their screening questions library.

2010

CLEAR Toolkit. This toolkit by McGill University is a clinical decision aid to educate health workers about addressing the SDOH needs of community members. It is available in 10 languages, includes a training manual, and defines a four-step process (Treat, Ask, Refer, Advocate) to help professionals identify and respond to underlying causes of poor health.

Compare Existing SDOH Screening Tools

The following table compares key aspects of some existing screening tools.

Comparison of SDOH Screening Tools

Feature	EveryONE	HRSN	PRAPARE	Health Leads	CLEAR
Publication Year	2018	2017	2016	2016	2010
SDOH #1 Economic Stability	●	●	●	●	●
SDOH #2 Neighborhood & Physical Context	●	●	●	●	●
SDOH #3 Social Context	●	●	●	●	●
SDOH #4 Educational Level	●		●	●	●
SDOH #5 Access to Healthcare			●		●
Food Insecurity		●	●	●	
Self-Administered	●	●	●	●	
Training Required					●
Number of Questions	11 (short form) 15 (long form)	26	21	10	9
Multiple Languages	●		●	●	●
Other	Action plan templates available	Supplemental questions available	Uses actionable measures	A How-To guide is available	

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