

Considerations for Organizations and Healthcare Professionals When Screening for the Social Determinants of Health

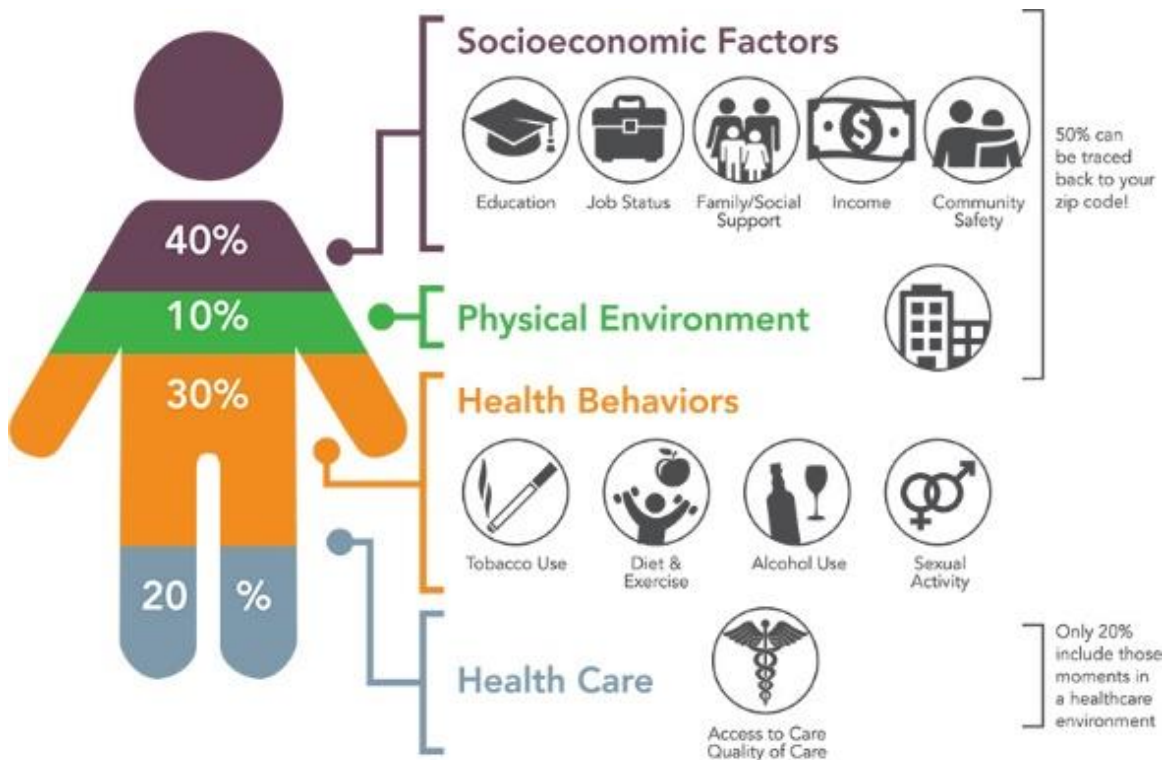
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Introduction

Approximately 80% of patient health outcomes are determined by the “social determinants of health” (SDOH) or the conditions in which people are born, grow, work, live, and age.¹ This is in comparison to only 20% from health care, as seen in [Figure 1](#).² Therefore, it is crucial that SDOH are considered by health care professionals to better inform and amplify the effectiveness of patient care. If SDOH are addressed, we can achieve better health and health equity, along with cost savings for health care organizations—for instance, related to a decrease in readmission rates and length of stay.

Figure 1: Factors Contributing to Health Outcomes



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

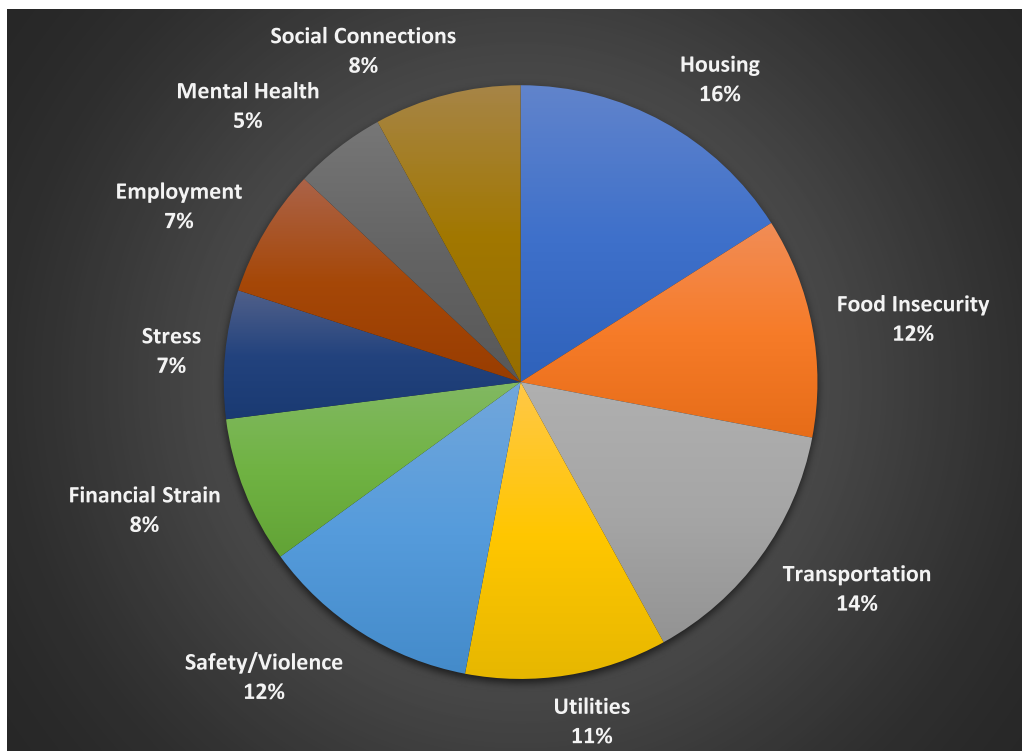
SDOH and Social Needs

SDOH are slightly different and more expansive than the often interchangeably used term “social needs.” SDOH are the underlying conditions that affect *entire groups* of people, while social needs are the needs of *an individual*. (See [Appendix A](#).) For example, one person may need housing, while a community may need an affordable housing policy. Therefore, to address SDOH, we change systems and policies that ensure groups of people get the resources they need and want. Meanwhile, offering these resources to one individual without changing structures and policies to assist those in similar circumstances addresses social needs.³ For this paper, “social needs” and “SDOH” are used interchangeably since our focus is on improving the health outcomes of populations and the individuals of which they are comprised in both the short and long term. Further, this paper focuses on the importance of screening, which will initially address social needs but can be seen as a starting point for establishing changes in systems and policies that improve population health.⁴

Many different tools have been developed to screen for SDOH, none of which is scientifically validated or standardized for universal use.⁵ In a review of 20 screening tools easily accessible online (See [Appendix B](#)), we found that questions related to housing were included in 16, transportation in 14, food insecurity in 12, safety in 12, and utilities in 11, as seen in [Figure 2](#). While “economic stability” and “education” are two of the five key areas of SDOH, they are not as frequently or as explicitly included in the screening tools analyzed.⁶ For example, we see that only 7%-8% of the 20 tools ask about employment or financial strain, and none about education. Other upstream, macrolevel factors, such as implicit bias and racism, are also absent from these screening tools, although they are known to have a significant impact on health outcomes.⁷ For example, education affects a person’s health knowledge and behaviors, changes

access to different employment opportunities and income, which themselves can entirely change one's living conditions.⁸ Oftentimes disparities exist along racial lines, and people of color experience discrimination in the delivery of health care as well as access to communities with adequate resources, high quality schools and safe living conditions.⁹ Finding ways to measure these is imperative in designing care plans that take a full account of a patient's lifestyle, priorities and needs.

Figure 2: Percentage of Tools Analyzed with Questions By SDOH



Source: Created by Authors

Nurses Leading the Charge

Screening for and attending to gaps in SDOH and social needs requires a team effort. This means having the organizational support necessary within health care systems to establish screening protocols. This also means collaborating with community-based organizations to link patients to the resources that meet their needs. But, the first step is screening. Nurses are only

one part of the care team, but have a natural advantage to lead in this effort. This is because they are the largest segment of the health care workforce, frequently are the ones with the most direct patient contact and have often built trust with patients that can support empathic inquiry and uncomfortable dialogue. If organizations take the time to increase SDOH awareness among their nurses, and buy-in for designing and implementing a protocol or tool, screening has the potential to improve health outcomes among the patients served.¹⁰ Moreover, nurses can use this power to advocate for their patients by changing the systems and policies that affect upstream factors.

Barriers to Screening at the Bedside

No matter what tool a facility may use or protocol it may put in place to screen their patients for SDOH, obstacles will arise. For example, health care professionals may lack the time to screen and address patient needs beyond acute concerns, which some believe is unethical—particularly when coupled with limited resources to address needs that are identified.^{11, 12} This was a common concern found among participants in a recent WCN qualitative research study done in partnership with the [Washington Nursing Action Coalition](#) (WNAC) and its partners. Over the course of conducting nearly 40 focus groups around Washington, researchers spoke with nurses and other health care professionals (e.g., physicians, social workers) who echoed this sentiment: They did not have the time to ask more questions and did not want to ask without knowing what to do after “opening Pandora’s box.”¹³ They wanted to know what to ask, how and when, and then what to do to help their patients live well—and on their own terms. While many felt they could build trust to overcome the intrusion of these questions and integrate what they learned into plans of care, few wanted to limit their help to showing concern through inquiry; they wanted actionable strategies to stop the revolving door of readmissions. It is important to note that, while these participants expressed concern about standardized SDOH or social needs’

screening, many were already seeking the answers to these questions through informal conversation over the course of a visit or multiple visits as they built trust and saw patterns in their patients' health needs. Further, participants rated housing a major obstacle to improving health, a belief supported by research.¹⁴

How Washington Health Systems Are Screening

WCN and WNAC have continued to seed the path to screening. Through a [*Campaign for Action*](#) Innovations Fund, we have gone beyond talking to bedside and frontline health professionals and have included administrators in order to find out what they are doing for patients' social needs and SDOH. Through this outreach, we found that facilities understood how important screening is but had not yet put any protocol or tool into practice systemwide. One of the participants in the qualitative research study mentioned previously was a nurse at Virginia Mason Medical Center. She signed on to implement a screening tool she learned of in the focus group—the “Core 5”—within willing departments at Virginia Mason.¹⁵ Over the course of this grant period—2019-2021, WCN and WNAC will work with Virginia Mason to see if any short-term indicators of health or health equity are improved through screening, such as clinical indicators, readmission rates or the successful provision of resources to patients with social needs.

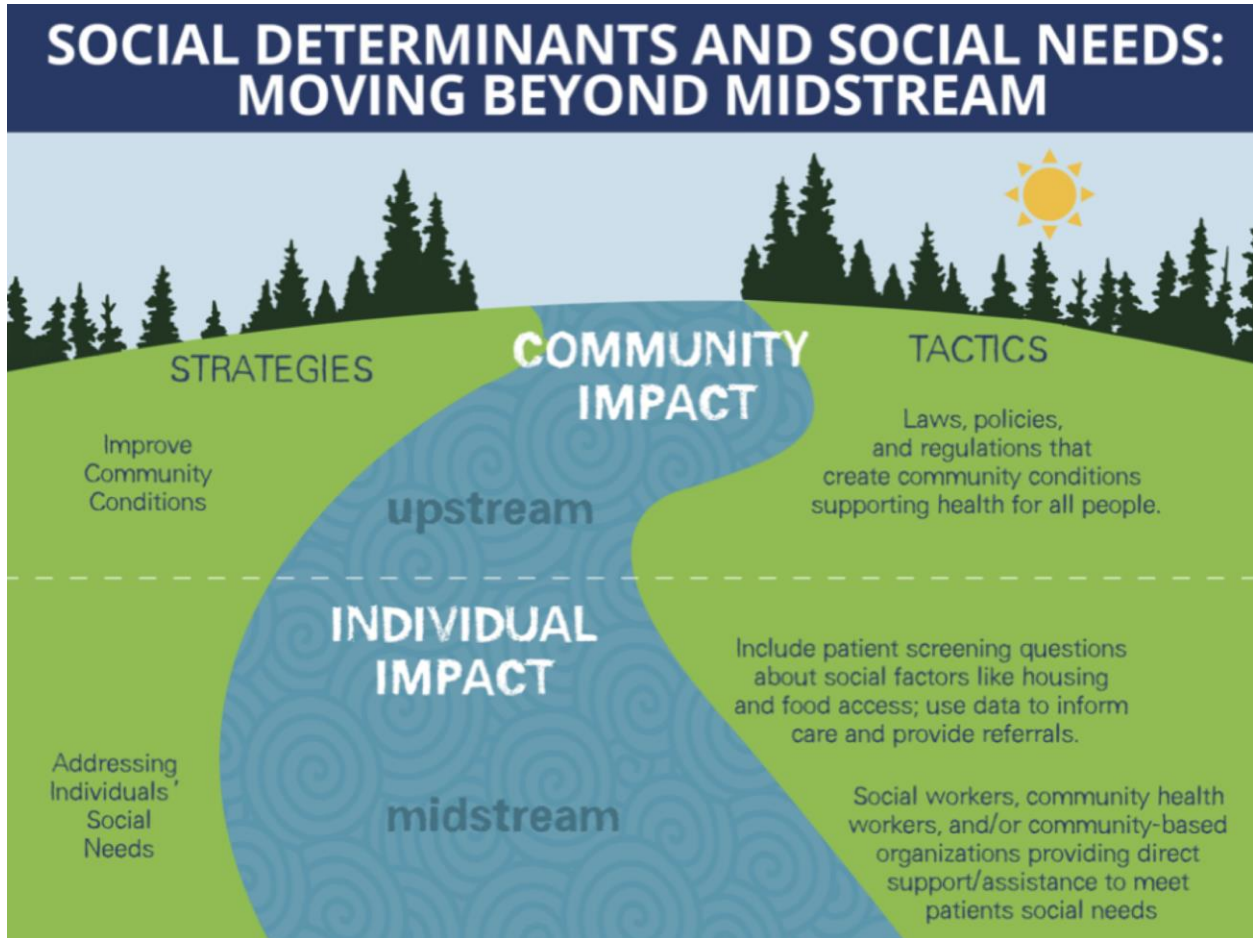
Conclusion and Next Steps

A lot of work remains to figure out how to address SDOH consistently and effectively to take advantage of the power of its impact on patient health. WCN and WNAC are committed to screening for and addressing SDOH and elevating the role of nursing in leading this process. Starting where we are, we know there are a variety of tools used to screen for SDOH published

online for use as is or with customizations. Additionally, the health care facilities themselves have designed tools and protocols with attention to the unique needs of their patients—broadly or even within a specific department. For example, a department serving a diabetic population may focus heavily on food insecurity and housing given that diet impacts blood sugar, and one needs a consistent refrigerated unit within which to store insulin.

While customizations will likely be needed, we have combined the most common elements we saw among the 20 tools we analyzed into the Wellington SDOH Screening Tool ([Appendix C](#))—named after Tracy Wellington, MN, RN, who interned with WCN while gaining her Master's in Nursing and is now a collaborative member of WNAC. This tool asks a short series of questions related to housing, food, utilities, safety, employment, social support, and mental health. While we have not included explicit questions on macrolevel factors like income, level of education and racism, they impact health and should be included in future protocols or screening questions to assess social needs. Once we have a more accurate picture of social and SDOH needs, we may be able to gain insight from overlaying the findings with nursing data. For example, we might compare the differences in economic stability and education across Washington alongside a map of nurses practicing per capita. Regardless of the exact route forward, with the continued commitment and passion of nursing leaders like Tracy, the collaboration with health systems and community partners, and the trust of our patients, we will progress in transforming our health care system, better serve our communities and achieve improved health, health equity and thriving for all Washingtonians.

Appendix A: Social Determinants and Social Needs



Source: HealthAffairs.org, Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health (January 2019). Retrieved from: <https://penandthepad.com/cite-graphic-apa-format-8113335.html>

Appendix B: List of Screening Tools

General Use

- [AccessHealth Spartanburg: Social Determinants Screening Tool](#)
- [The Accountable Health Communities Health-Related Social Needs Screening Tool](#)
- [American Academy of Family Physicians Social Needs Screening Tool \(Patient: Long Version\)](#)
- [American Academy of Family Physicians Social Needs Screening Tool \(Patient: Short Version\)](#)
- [American Academy of Family Physicians Social Needs Screening Tool \(Physician: Long Version\)](#)
- [American Academy of Family Physicians Social Needs Screening Tool \(Physician: Short Version\)](#)
- [Core Determinants of Health Screening Tool \(Core 5\)](#)
- [Health Leads Social Needs Screening Toolkit](#)
- [OneCare Vermont: Self-Sufficiency Outcomes Matrix](#)
- [Oregon Primary Care Association Patient Support Questionnaire](#)
- [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE, Full Toolkit\)](#)
- [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE, One-Pager\)](#)
- [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE, Redwood Community Health Coalition\)](#)
- [Roots to Health Survey](#)
- [ThedaCare: Community Paramedicine Pilot Health Assessment](#)
- [Virginia Commonwealth University Health System: Social Needs Assessment](#)

Child-Specific Tools

- [Adverse Childhood Experience \(ACE\) Questionnaire](#)
- [Ages and Stages Questionnaires: Social-Emotional](#)
- [Brief Infant-Toddler Social and Emotional Assessment \(BITSEA, Parent Form\)](#)
- [Brief Infant-Toddler Social and Emotional Assessment \(BITSEA, Physician Form\)](#)
- [SEEK Parent Questionnaire: A Safe Environment for Every Kid](#)
- [Survey of Well-being of Young Children \(Full Set\)](#)
- [Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education \(WE CARE\)](#)

*More tools are available online (resource suggestions: [The Gravity Project](#) through the [SIREN Network](#) and [Health Leads](#)), and several facilities are customizing these tools or creating their own. The question after tool creation remains: Who asks the questions, how, when, and then what? How is the data stored? Who ensures patients get the resources they need?

Appendix C: The Wellington SDOH Screening Tool

Wellington Social Determinant of Health Screening Tool



HOUSING: What is your current living situation?

- I have stable housing and do not fear losing my home in the future
- I have stable housing but am worried about losing my home in the future
- I do not have stable housing and need assistance



FOOD: In the past 12 months, have you worried about running out of food before you had money to buy more?

- Yes No

In the past 12 months, have you run out of food and didn't have money to buy more?

- Yes No



TRANSPORTATION: In the past 12 months, has a lack of reliable transportation made it difficult to get to medical appointments, work, or other important activities?

- Yes No

UTILITIES: In the past 12 months, have you been overdue for any utility bills, such as electric, gas, oil, or water?

- Yes No



In the past 12 months, has any utility company threatened to shut off the services in your home?

- Yes No

In the past 12 months, have any of your utilities been shut off?

- Yes No

SAFETY: Has anyone, including family and friends, recently insulted you or talked down to you?

- Yes No



Has anyone, including family and friends, recently screamed or cursed at you and made you feel unsafe?

- Yes No

Has anyone, including family and friends, ever threatened to harm you?

- Yes No



EMPLOYMENT: Are you currently employed?

Yes No

SOCIAL SUPPORT: Do you need help with any day-to-day activities, such as shopping, preparing meals, managing finances?

Yes No



Do you ever feel lonely or isolated from those around you?

Yes No

MENTAL HEALTH: Over the past 2 weeks, have you felt down, depressed or hopeless?

Yes No



Over the past 2 weeks, have you lost interest in things you used to enjoy?

Yes No

THRIVING: On a scale of 1-10, with 10 being the best possible life and 1 being the worst, please rate where you are today.

1 2 3 4 5 6 7 8 9 10

Where were you five years ago?

1 2 3 4 5 6 7 8 9 10

Where do you believe you will be five years from now?

1 2 3 4 5 6 7 8 9 10

PRIORITY: What do you need most right now?

Note for Organizations:

It will be important for organizations to look at who asks these questions, how and when in order to track the financial impact of screening, the efficiency of data collection and sharing and success in connecting patients to resources identified through screening. These questions may be asked verbally or in writing and multiple languages.

¹ https://www.who.int/social_determinants/en/.

² http://htnys.org/education/community_health/docs/2018-08_addressing_social_determinants_of_health.pdf

³ <https://www.healthaffairs.org/doi/10.1377/hblog20190115.234942/full/>

⁴ <https://www.aha.org/system/files/media/file/2019/09/screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf>

⁵ [https://www.ajpmonline.org/article/S0749-3797\(19\)30321-6/fulltext](https://www.ajpmonline.org/article/S0749-3797(19)30321-6/fulltext)

⁶ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁷ https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1096/RAND_WR1096.pdf

⁸ [ibid.](#)⁷

⁹ [ibid.](#)⁷

¹⁰ <https://journals.sagepub.com/doi/abs/10.1177/1937586715592633>

¹¹ <https://www.healthaffairs.org/doi/10.1377/hblog20190520.243444/full/>

¹² <https://www.aafp.org/fpm/2018/0500/p7.html>

¹³ Pizzitola, Rebecca. 2020, September 23. Interview.

¹⁴ <https://www.sciencedirect.com/science/article/abs/pii/S0277953619305659?via%3Dihub>

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https://cdn.ymaws.com/www.ohioleaguefornursing.org/resource/resmgr/ohio_action_coalition/ph_nurse_leader_project/Attachment_B_CDH_Screening_T.pdf