Section III

Understanding, Screening and Responding to Social Determinants of Health

CENTER FOR
COMMUNITY HEALTH
ALIGNMENT

Contents

Understanding, Screening and Responding to Social Determinants of Health 3

Understanding Social Determinants of Health 3

Tips for Selecting and Implementing Social Determinants of Health Screening Tools 4

Determine the Best SDOH Screening Tool for you and your Organization 6

Responding to Social Determinants of Health Data 6

Community Health Workers in Action: Resources that Highlight Why CHWs are Vital in Understanding, Screening and Responding to SDOH 8

Technical Assistance Support 8

Acknowledgments 9

Understanding, Screening and Responding to Social Determinants of Health

Understanding Social Determinants of Health

Social determinants (or social influences) of health (SDOH) are conditions in the environments in which 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. Material conditions (e.g., social, economic, and physical) in these various environments and settings affect health outcomes, as well as patterns of social engagement, sense of security, and perception of well-being. These conditions impact an estimated 80% of health outcomes, compared to 20% impacted by clinical/medical care, as shown in Figure 1 below.

Resources that enhance social factors can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local parks and green spaces, and clean air and water. Additional information on Social Determinants of Health and how they impact health can be found ***here***.

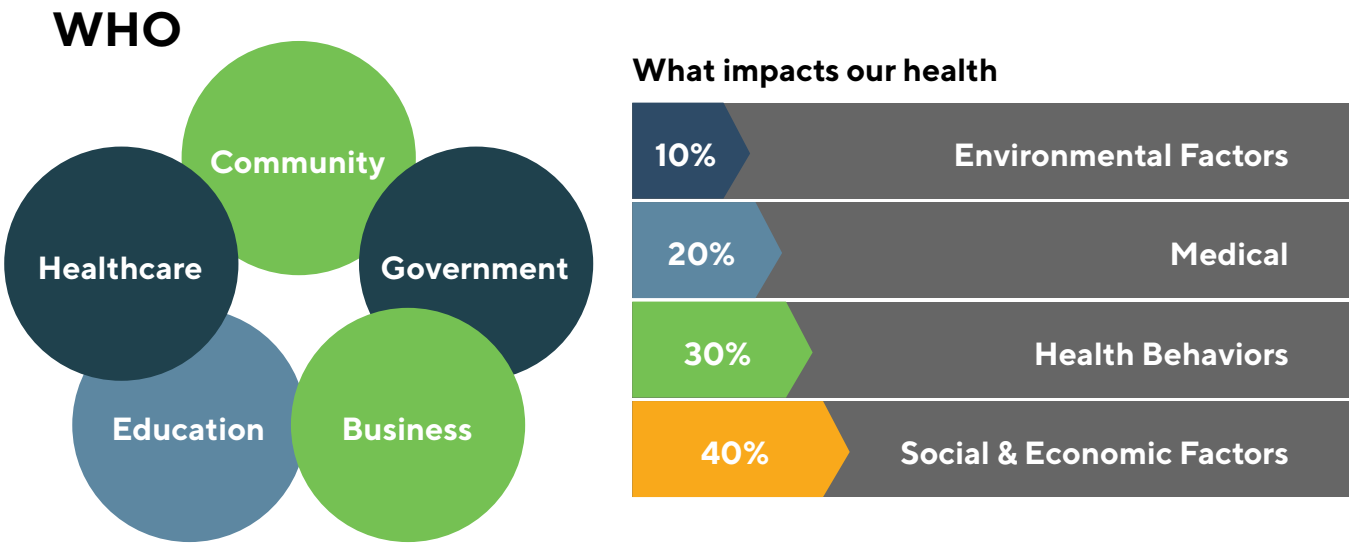

Figure 1.

Source: 2019 Annual Report of Live Healthy South Carolina

Collecting information on both personal and community assets, as well as social needs and risks, is a key component of developing effective strategies to address SDOH. We can use these strengths to develop patient-level interventions or population level strategies. To find more information about SDOH, agencies and providers can use existing data from secondary sources or collect the information directly from your patients.

Questions to consider before starting a new CHW program or intervention?	
Q1. Does your organization have an infrastructure for data collection and reporting, such as personnel with expertise in this area, systems in place to collect and store data, or partnerships with evaluators?	Y / N Not Sure
Q2: Does your organization currently have the capacity to respond to Social Determinant of Health needs of patients/clients?	Y / N Not Sure
Q3. Has your organization determined what Social Determinants of Health domains would you like to assess (such as interpersonal violence; health care/medicine access and affordability; social support; housing insecurity, instability and homelessness; transportation, education, employment, stress, utilities, neighborhood safety)?	Y / N Not Sure

Tips for Selecting and Implementing Social Determinants of Health Screening Tools

How Can Your Organization Select a Screening Tool that Best Fits You?

Effectively screening, assessing and responding to social determinant data can help your organization to transform care to meet the needs of patients, improve health and reduce costs. There are many SDOH screening tools that could fit with your organization's capacity to assess and follow-up on specific unmet needs of patients/clients. Many of these are in the form of validated questionnaires, surveys, or interview guides.

A few notes of caution to consider when you are considering how to screen individuals for SDOH:

- Do not let a questionnaire take the place of conversation and building trust. Many patients may not feel comfortable revealing needs and vulnerabilities on a survey, but they may disclose them when talking with a trusted healthcare team member. Also, considering how much paperwork is involved in appointments or organizational intake, they may not pay close attention to the survey they are completing.
- What will happen once patients are screened, and unmet needs are discovered?" It can be dissatisfying to patients if you collect information and are unable or unwilling to address it. Before you ask a patient about their needs, have a plan in place for your next steps if the answer is yes. It is a waste of your time and your patients' energy to collect data that you do not plan to act on. A screening tool should be considered the start of a deeper exploration of what the individual wants and needs in order to improve their health, or the basis of a larger strategy to address SDOH at the community-level.

Questions to consider before starting a new CHW program or intervention?	
Q1. Has your organization determined at what point after meeting a patient/client that SDOH questions will be asked?	Y / N Not Sure
Q2. Has your organization determined what SDOH screening tools be completed?	Y / N Not Sure
Q3. Has your organization identified who will be asking SDOH questions?	Y / N Not Sure
Q4. Has your organization considered if the staff person(s) or team member(s) asking SDOH questions has a trusted relationship with individuals screened?	Y / N Not Sure
Q5. Has your organization identified in what settings SDOH questions be asked (e.g., clinic, home, private office, community setting, etc.)?	Y / N Not Sure
Q6. If a location has been identified, has your organization confirmed the safety and confidentiality of the location?	Y / N Not Sure
Q7. Has your organization determined how often will you screen for specific unmet needs (e.g., at intake, at each appointment, bi-annually, annually, or at program completion)?	Y / N Not Sure

What is Your Organization's Capacity to Integrate a Screening Tool into Your Overall Workflow?

Organizations administering SDOH assessments often establish workflows to track individual needs and referrals. Establishing a consistent approach to measurement ensures that Individuals are assessed at appropriate intervals to track changes in health conditions, social needs, goals, and referrals. In establishing workflows, organizations must consider the following additional questions:

○ What will be the duration of the assessment?
○ What is the appropriate time and mode for administration?
○ Which team members will be responsible for conducting the assessment and making any necessary referrals?
○ Do team members have the necessary tools and training?
○ What protocols for tracking SDOH information and follow-up of referrals may also be developed? These may include: who asks the question, how the questions are asked, in what space they're asked, and how sensitive info is handled?

As next steps, your organization should

Determine the Best SDOH Screening Tool for you and your Organization

SDOH tools are based on organizational needs and capacity identified by the assessment for fit. Here are just a few examples of clinic-based and community-based tools:

Clinic-based Examples

- ***PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences***
- ***The Accountable Health Communities Health-Related Social Needs Screening Tool***
- ***Social Needs Screening Tool from the American Academy of Family Physicians***

Community-Based Example

- ***National Healthy Start Tool***
- **Please note that many community-based organizations use their own proprietary, culturally specific screening tools. You can reach out to organizations directly for tools that they utilize or to the Center for Community Health Alignment for other examples.**

- Integration of Screening Tools into Workflows: To effectively facilitate Social Determinants of Health Screenings with individuals/communities the following questions informed by best practices for cultural competency and discussing sensitive information should be considered:
  - *Who is asking SDOH questions?*
  - *Does this staff person have a trusted relationship with the individuals screened?*
  - *In what settings will SDOH questions be asked?*
  - *Is the location safe and confidential?*

Responding to Social Determinants of Health Data

Collecting data is only important if it leads to community action. The data you collect will allow community leaders to prioritize different SDOH projects and build a network of resource providers. Once you have collected your data, organizations can follow these steps to address the needs that have been identified.

Questions to consider before starting a new CHW program or intervention?	
Q1. Does your organization currently have the capacity to respond to SDOH needs?	Y / N Not Sure
Q2. Does your organization have a plan for follow-up on referrals to ensure that the loop is closed (e.g., the client went to the referred appointment and received the resources needed)?	Y / N Not Sure

As next steps, your organization should:

- Establish Referrals: Organizations may use SDOH data to identify assets and gaps related to community social services, help individuals understand and access certain benefits, or establish relationships with partner organizations to address SDOH. Technology-based applications, such as 1degree, Aunt Bertha, NowPow, Thrive Hub or Healthify, are often used to ensure individuals are connected to relevant social service agencies or community-based organizations to receive needed services. Organizations may also directly implement clinical or non-clinical interventions to address social risk factors.

  However, these tools and strategies do not ensure that the unmet need was addressed or that organizations have the capacity to close the referral loop. Closed loop referrals are key to ensure that the client's needs are being met and that this information is being communicated back to the appropriate team member(s) for any necessary next steps and/or additional follow-up. This process should also include workflow steps to ensure that the team understands the outcome and can make any required next steps beyond the referral.
- Respond to Challenges: Organizations face several challenges in addressing SDOH related to communicating appropriately with individuals about SDOH, building an adequate referral network, integrating electronic assessment tools and resource inventories, and breaking down silos between health and social service organizations.
- Develop Long-Term Strategies: Organizations need to think through and develop a longer-term plan to respond to SDOH needs. Consider some of the following questions:
  - *What is your organization's intention/ability to do closed-loop referrals and follow-up on the outcomes?* For example, if an individual needs stable housing, how far will you go? How far can your partner organizations go? Will you share information back and forth on outcomes?
  - *Does your organization have a team that can respond to structural determinants that arise for multiple patients, or a group you can approach about them?* Structural determinants include governing process, economic and social policies that affect pay, working conditions, housing, and education. Structural determinants are the root cause of health inequities because they shape whether resources needed in a community are distributed equally. Racism, redlining, and socioeconomic status (classism) are examples of structural determinants. It is suggested that organizations consider engaging in ***racial equity trainings*** to be able to fully understand and respond to racial inequities.
  - Is your staff allowed time to address SDOH that may be time consuming?

Effectively addressing SDOH can greatly impact the health and well-being of an individual and the organization. It is important that your organization has a process in place that can identify the gaps in care so that the organization can work to address those needs and ultimately achieve better outcomes for the individuals and communities served.

Community Health Workers in Action: Resources that Highlight Why CHWs are Vital in Understanding, Screening and Responding to SDOH

- ***Why Community Health Workers are Vital to Addressing SDOH*** is an article that discusses how CHWs make a difference in helping to address SDOH and how this helps improve patient outcomes.
- ***Community Health Workers and Covid-19 — Addressing Social Determinants of Health in Times of Crisis and Beyond*** shares a perspective of the integral work of CHWs in supporting patients and communities and the critical role CHWs have played as frontline workers during the pandemic.
- ***Addressing social determinants of health through community health workers: A call to action*** is a grantee publication on policy recommendations that would promote support for community based CHW services with sufficient resources to address SDOH.

Technical Assistance Support

We are here to assist. Check out how CCHA can ***support your organization***.

Acknowledgments

The Center for Community Health Alignment strongly believes that when attempting to co-create strategies and solutions with our community, formal education is not enough. In addition to subject matter expertise, we must have folks with extensive lived experience at the table to provide much needed context to the topics being discussed. This toolkit has been developed in collaboration with Community Health Workers (CHWs) and CHW allies with extensive expertise in planning, implementing, and showing the impact of the CHW model. Thank you to all the CHWs and CHW Allies that contributed to the creation of this best practice toolkit section!

Marek Calhoun, CHW, MAC, MSAJS*
CareSouth Carolina
Sarah Covington-Kolb, MSW, MSPH
Center for Community Health Alignment
Bonita Clemons, CHW, MPH
SC Community Health Worker Association
Whitney Davis, CHW, BS, FPHW*
Darlington County Frist Steps
Barb Dendy, CHW, M.Th.*
Prisma Health
Vanessa Earle, CHW*
Prisma Health
Ashley Ford, CCHW, BSBA*
CareSouth Carolina
Lorene Godbold, LMSW
McCleod Regional Medical Center
Andrea Heyward, CHW, MHS, MCHES®
Center for Community Health Alignment
Cartia Higgins, CHW*
Community Volunteer
Terri Jowers, CHW
The Aiken Center
Renee Linyard-Gary, CHW, MBA
Trident United Way
Donna Mack, CHW, PMP®, IHC, PT
SC Community Health Worker Association
Maria Martin, CHW, MSW
PASOs
Reeshemah McKelvey, CHW, MSW*
AccessHealth Tri-County
Chief Michelle Mitchum, CHW, MSCJ/Law, MA, CPT, LC/CDC*
Pine Hill Indian Community Development Initiative
Kimberly Rawlinson, CHW, MPH
Center for Community Health Alignment
Suzanne Sanders, MPH, MCHES®
SC Department of Health and Environmental Control
Rebekah Shilling, CHW, CEIM, CLC, FPHW, CPST*
Prisma Heath Midlands Healthy Start
Julie Smithwick, CHW, MSW
Center for Community Health Alignment
Darin Thomas, LMSW, MBA
Prisma Heath
Yajaira Beet Uzcategui, CHW, BA* PASOs/ Beaufort Jasper Hampton Comprehensive Health Services
Virginia Berry-White, CCHW, LMSW
SC Office of Rural Health Family Solutions (Retired)
Barbara Wright
CareSouth Carolina

**SC Community Health Worker Ambassador*