



Social Determinants of Health

GUIDE TO SOCIAL NEEDS SCREENING TOOL AND RESOURCES

“Why treat people and send them back to the conditions that made them sick in the first place?”¹

– Sir Michael Marmot

INTRODUCTION

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual’s health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

[SDOH](#), as defined by the American Academy of Family Physicians (AAFP), are the conditions under which people are born, grow, live, work, and age. Factors that strongly influence health outcomes include a person’s:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling)
- Early childhood social and physical environment, including child care
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs. isolation)
- Socioeconomic status
- Spiritual/religious values

Family physicians understand that it is important to identify and address SDOH for individuals and families to achieve optimal health outcomes and whole-person care. The challenge is operationalizing and implementing a large task with many factors into a busy practice environment in a manner that is actionable and practical.

The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

The AAFP is committed to helping you and your patients with a series of tools to use at the point of care by the practice team to quickly and efficiently screen your patients, act when needed, and link to community resources. All SDOH do not need to be addressed at one time, nor should this all be done by the family physician alone.

To help get you started, the AAFP is providing resources that you can customize to your individual practice, population, and community needs. These tools are intended to be useful to you and your practice team. However, we acknowledge that not all practices have access to the same level of community resources and support.

Additional tools and resources will be developed to engage your care team and address SDOH factors that influence your patients’ health outcomes.

TEAM-BASED CARE AND SDOH

As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team. This requires clear guidelines on roles and responsibilities. Team members and their responsibilities will depend on your practice size and structure, but may include:



Receptionists/medical assistants

- Distribute the SDOH screening tool to patient upon arrival
- Make educational materials and resources available in waiting areas and exam rooms

Nurses, physician assistants, and/or health educators

- Review the completed SDOH screening tool and determine patient needs
- Determine resources available in your community and complete action plan prior to the visit
- Counsel patient during the visit and assist with documentation and follow up

Family physician

- Review the completed SDOH screening tool and action plan prior to the visit, and incorporate into the plan of care for the patient
- Consider action at each visit with information available
- Refer patients to additional team members for education, as needed

Administrators

- Ensure adequate resources and staffing to screen and provide action plan
- Communicate to each staff member his or her responsibilities
- Provide training and education about responsibilities to staff, assuring new staff are also trained

Social workers and/or community health workers (if available)

- Determine resources available in your community and complete action plan prior to the visit
- Facilitate referrals to community resources based on patient needs
- Case management and follow up between patient visits

SCREENING FOR SOCIAL DETERMINANTS OF HEALTH

Screening for SDOH can help identify specific needs of an individual. This toolkit includes a short- and long-form screening tool that can be adapted for your practice. The short-form version screens for five core health-related social needs, which include housing, food, transportation, utilities, and personal safety, using validated screening questions. While there are many social determinants that affect health, these social needs were chosen based on the following criteria: 1) quality evidence that links poor health and increased health utilization to cost; 2) the social need can often be addressed by community services; and 3) the need is not routinely addressed by health care workers.

Social determinants of health are interrelated. A positive screen could indicate the need for an in-depth conversation about needs and challenges outside of a specific social need. Increased stress due to multiple social determinants further impacts health.

The long-form version of the screening tool is intended for practices that choose to screen for additional needs. It includes the five core health-related needs in the short-form version, as well as screening for the additional needs of employment, education, child care, and financial strain.

Screening for SDOH does not need to be administered by a physician, and it can be performed upon check in or while rooming so that it does not disrupt the flow of the visit while promoting more comprehensive care.² The screening tool can be self-administered or given via an in-person interview. However, individuals may be more likely to disclose sensitive information, such as interpersonal violence, when self-administered.³

The following SDOH screening tools and patient action plan provides a starting point to make it easy and efficient to integrate into your busy clinic.

- SDOH Short-form Screening Tool
- SDOH Long-form Screening Tool
- SDOH Patient Action Plan

CORE SOCIAL NEEDS

Underlined answer options indicate a positive response for a social need for the housing, food, transportation, utilities, child care, employment, education, and finances categories.

Housing



Housing instability is defined by several factors, including frequent moving, homelessness, overcrowding in the home, unsafe housing conditions, difficulty paying rent, or rent accounting for more than 50% of household income. Individuals with insecure housing are more likely to put off accessing health care due to cost and have a poor or fair self-reported health status.⁴

Health outcomes associated with housing difficulties include respiratory and cardiovascular diseases from indoor air pollution, illness and death from temperature extremes, accelerated spread of communicable diseases, and risk of at-home injury.⁴



What is your housing situation today?⁵

- I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- I have housing today, but I am worried about losing housing in the future
- I have housing

Think about the place you live. Do you have problems with any of the following? (check all that apply)⁵

- Bug infestation
- Mold
- Lead paint or pipes
- Inadequate heat
- Oven or stove not working
- No or not working smoke detectors
- Water leaks
- None of the above

Food



Food insecurity refers to unreliable, inconsistent access to nutritious and affordable food. Food insecurity impacts both short- and long-term health outcomes, including a greater risk of diabetes and hypertension in adults, higher risk of hospitalization in children, and excess weight gain in women who are pregnant.⁶ Food insecurity can be related to challenges with transportation, low-income levels, low-educational attainment, and limited access to healthy food options.⁶

Within the past 12 months, you worried that your food would run out before you got money to buy more.⁵

- Often true
- Sometimes true
- Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.⁵

- Often true
- Sometimes true
- Never true

Transportation



Inconsistent access to reliable transportation can have a significant impact on health and the ability to make healthy lifestyle decisions. Lack of transportation can prevent individuals from accessing goods and services, including healthy foods, medication, education, employment, and health care visits.⁷

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply)⁵

- Yes, it has kept me from medical appointments or getting medications
- Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- No

Utilities (water, gas, electricity, oil)



Difficulty paying utility bills and receiving shut-off notices are indicators of utility needs. Utility shut offs can lead to dangerous living environments, including unsanitary conditions and temperature extremes.⁸

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?⁵

- Yes
- No
- Already shut off

Child Care



Child care can impact the health of the child and the caregiver. Access to adequate child care and early childhood education are associated with improved cognitive and emotional development, academic achievement, as well as a reduction in teen birth and crime rates.⁹ Lack of consistent access to child care impacts parents as they may forgo health needs, such as scheduled medical appointments to care for their children. Further, lack of child care is a barrier to educational and employment opportunities for parents.¹⁰

Do problems getting child care make it difficult for you to work or study?

- Yes
- No

Employment



Stable employment is the key to many social determinants of health. It can enable individuals to live in safer neighborhoods, afford better health care, provide education or child care for their children, and buy nutritious food.¹¹ Unemployment, or under-employment leads to a strain on financial resources and is a barrier to obtaining basic needs.¹¹ Unemployed individuals are likely to self-report worse health status, may experience more depressive symptoms, and are at a higher risk for mortality.¹²

Do you have a job?

- Yes
- No



Education



Lower education levels are correlated with lower income, higher likelihood of smoking, and shorter life expectancy.¹³ Individuals with lower levels of education are less likely to engage with their physicians, tend to have poorer medical compliance, and have higher rates of hospitalization.¹³

Do you have a high school diploma?

- Yes
 No

Finances



Financial strain is composed of cognitive, emotional, and behavioral responses to financial hardship where an individual cannot meet

their financial obligations.¹⁴ It is more than just income and encompasses other core needs, such as housing instability and food insecurity. Individuals experiencing financial strain may forgo medical care and prescriptions in order to meet their essential needs, such as housing and food, and may make more affordable, but less healthy food choices.¹⁴ Additionally, financial strain has been linked to depression in both parents and children, and to marital stress.¹⁴

I don't have enough money to pay my bills:

- Never
 Rarely
 Sometimes
 Often
 Always

Personal Safety



Exposure to violence, whether interpersonal or community violence, has lasting effects on an individual's physical and emotional health.¹⁵ The

AAFP recommends screening all women of childbearing age for intimate partner violence.¹⁶ This screening tool incorporates the HITS (Hurt, Insult, Threaten, Scream) instrument, but it has been modified, referring to "anyone, including family" instead of only "your partner." This change broadens the scope beyond intimate partner violence.

A value greater than 10 when the numerical values for answers to the following questions are summed indicates a positive screen for personal safety.

How often does anyone, including family, physically hurt you?⁵

- Never (1)
 Rarely (2)
 Sometimes (3)
 Fairly often (4)
 Frequently (5)

How often does anyone, including family, insult or talk down to you?⁵

- Never (1)
 Rarely (2)
 Sometimes (3)
 Fairly often (4)
 Frequently (5)

How often does anyone, including family, threaten you with harm?⁵

- Never (1)
 Rarely (2)
 Sometimes (3)
 Fairly often (4)
 Frequently (5)

How often does anyone, including family, scream or curse at you?⁵

- Never (1)
 Rarely (2)
 Sometimes (3)
 Fairly often (4)
 Frequently (5)

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RESOURCES AND TOOLS

When screening for SDOH, it is important to have a plan for what to do when needs are identified. While acknowledging and documenting the needs may help a clinician better understand their patient's stressors, having a mechanism to assist with a need will provide more benefit to the patient, the clinician, and the community. Ensuring that the patient wants assistance and engaging the patient to determine what will be most helpful to them is essential.

Every patient, practice, and community is different. There is not a one-size-fits-all approach to addressing social needs. Inclusion of a social worker or community health worker in the practice is an efficient way to provide help and resources to patients. However, it is not essential to have these resources before screening for social needs. This toolkit provides some basic resources to help you set up a process in your practice to efficiently screen for social needs and provide appropriate community referrals.

The following are tools to use at the practice level to identify social services available within a demographic area to help address specific social needs.

Aunt Bertha

Aunt Bertha (www.auntbertha.com) is a free online social services search engine. It connects people in need to programs in their community. The site lists available social services, including food, housing, transportation, health care, finances, education, employment, legal aid, and goods/supplies (e.g., baby supplies, clothing). The services are based on ZIP code and allow for electronic referrals.

211 Helpline Center

The 211-dialing code provides a caller with information about and referral to available social services in their location. It is currently available in portions of all 50 states and Puerto Rico.

Patient Action Plan

The sample action plan provided can be given to staff to indicate what types of referrals are needed.

– SDOH Patient Action Plan

Community Health Needs

Family medicine serves as the cornerstone for building a strong health care system that ensures positive health outcomes and health equity for everyone. Ideally, a patient's diabetes or high blood pressure are routinely assessed. Other factors that may compromise a patient's health, such as inconsistent access to food, experiencing poverty, or exposure to air pollution, may be more difficult to measure.

Place of residence can contribute to health outcomes. For example, pollution in communities, and access to healthy food options and places to exercise can affect your patients' overall health. These resources show your state and community health rankings and solutions to help advance health equity.

County Health Rankings & Roadmaps

(www.countyhealthrankings.org) provides a snapshot of a community's health. Broaden your view and explore factors that drive health in your county including:

- Health Outcomes (length of life, quality of life)
- Health Behaviors (smoking, obesity, food environment index, physical inactivity, access to exercise opportunities, excessive drinking, alcohol-impaired driving deaths, sexually transmitted diseases, teen births)
- Clinical Care (uninsured, primary care physicians, dentists, mental health providers, preventable hospital stays, diabetes monitoring, mammography screening)
- Social and Economic Factors (high school graduation, unemployment, children in poverty, income equality, children in single-parent households, violent crime, injury deaths, social associations)
- Physical Environment (air pollution-particle matter, drinking water violations, severe housing problems)

State Public Health Departments and Resources

The Centers for Disease Control and Prevention offers public health resources (www.cdc.gov/mmwr/international/relres.html) to connect with your state and local agencies and find useful community resources.

U.S. Department of Health and Human Service Community Guide

The Community Guide (www.thecommunityguide.org) offers community stakeholders tools and resources vetted by experts that aim to improve population and community health.

Community Tool Box

The Community Tool Box (www.ctb.ku.edu/en) is a free, online resource with tools for learning and assessing community needs and resources, addressing social determinants of health, engaging stakeholders, action planning, building leadership, improving cultural competency, planning an evaluation, and sustaining efforts over time.

Questions in the housing, food, transportation, utilities, and personal safety categories are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.



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