“Health inequalities and the social determinants of health are not a footnote to the determinants of health. They are the main issue.”

– Sir Michael Marmot
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**DISCLAIMER**

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**ACKNOWLEDGMENT**

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Margot Savoy, MD, MPH, FAAFP  |  Venis T. Wilder, MD  |  David O’Gurek, MD, FAAFP
The American Academy of Family Physicians (AAFP) define social determinants of health (SDOH) as the conditions under which people are born, grow, live, work, and age. Prominent factors of SDOH include socioeconomic status; racism and discrimination; poverty and income inequality; and lack of community resources. One study suggests that social and economic factors account for as much as 55% of health outcomes. Other studies have shown that a substantial proportion of all deaths are attributable to poverty (2-6%), income inequality (9-25%), and lower socioeconomic status (18-25%).

Primary care physicians provide the majority of health care in the United States. Specialists in primary care are a natural point of integration among clinical care, public health, behavioral health, and community-based services. In addition, family medicine was developed as a medical specialty, in part, due to the recognition of the role social factors have on health. This makes primary care, especially family medicine, a critical component of the nation’s health system for addressing patients’ SDOH. In their patient-centered practices, family physicians and their staff identify and address the SDOH for individuals and families, incorporating this information in the bio-psychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care.

This implementation guide provides suggested changes family physicians and their practices can make to address their patients’ SDOH as a means for advancing health equity. 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 instructions on roles and responsibilities.

Team-based Primary Care

Addressing your patients’ social determinants of health (SDOH) requires a team-based approach and are not intended to be implemented by the physician alone. The procedures outlined within this implementation guide are intended to support team-based care and recognizes the unique skills of different types of health care workers, and how they can contribute to addressing SDOH in primary care.

Definitions of Key Terms

Social determinants of health (SDOH): SDOH include the conditions under which people are born, grow, live, work, and age. For the purposes of this implementation guide, the term refers to patient’s individual level and immediate social needs.

Health equity: Health equity is the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” For the purposes of this implementation guide, the term refers to population-level factors.

Community-based resources: Community-based resources refer to organizations that provide programs and services that assist individuals with their social and economic needs. For the purposes of this implementation guide, the term is broad in scope and entails organizations that provide financial assistance, supplementary food assistance, and job placement and training, among a variety of other services.

Develop a Culture That Values Health Equity

Primary care practices are becoming increasingly patient centered. Patient-centered models offer you and your practice team an opportunity to improve how you help address your patients’ SDOH. It is based on a continuous relationship between the patient, the physician, and the health care team, and requires the team to take collective responsibility for the patient’s ongoing care.

Practices can be successful by creating a culture that values health equity, identifying patients’ SDOH, and connecting your patients with community-based resources to address their social needs.

Establishing a culture that values health equity should include:

- Learning more about your patients’ communities. Start by asking a few basic questions, such as: What barriers do your patients face to good health? What resources are in their communities that can enhance their health?
- Learning about the impact social factors have on health outcomes and the processes through which they influence health status.
- Uncovering implicit biases possibly held by your health care team, and working to understand how these biases impact patient care and a means for improving care.
• Empowering all staff to think about how they can address your patients’ SDOH and improve health equity.

• Incorporating health literacy and medical interpretation.

### Addressing Implicit Bias

Implicit bias refers to the underlying attitudes and stereotypes that people hold toward members of other groups. As opposed to explicit bias or prejudice, implicit bias is unconscious and can affect people’s behavior towards members of other groups. Research has shown that levels of implicit bias are the same among health care providers as they are among the general public and that this can impact the quality of health care provided.

Acknowledging and responding to implicit bias can be difficult, but it needs attention to best address your patients’ SDOH and to advance health equity. Addressing implicit bias is a conscious decision, and there are proven ways to approach this in your practice. Implicit bias cannot be measured through self-reporting. Instruments have been created to measure implicit bias, with the most common being the Implicit Association Test (www.implicit.harvard.edu/implicit).

Consider incorporating the following strategies for identifying and addressing implicit bias in your practice:

• Remember that everyone has implicit biases. By working to reveal your practice team’s implicit biases, you have made a positive acknowledgement that should be commended.

• Develop an understanding of health disparities and bias in medicine to help lay a foundation of the effect of implicit bias.

• Avoid categorizing specific groups of patients and treating them differently based on their social group.

• Take stock of your practice team’s implicit biases. Implicit Association Tests are available online (www.implicit.harvard.edu/implicit) to help assess biases.

• Address implicit biases to practice better medicine. For example, “physicians can address their biases by paying attention to their gut reactions to different patients and pausing, when possible, to ask themselves if the reaction may be stemming from an implicit bias. If it is, the physician can consider how they might react to the same situation if it involved a different patient.” It is also important for you and your practice staff to understand how their implicit biases may affect patient care.

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### Social Determinants of Health Quick Facts

• Numerous studies suggest that social determinants of health account for between 30-55% of health outcomes.

• There are vast differences in the health status of individuals based on socioeconomic status, income, race and ethnicity, educational status, and geographic location, among a variety of other factors.

• There is up to a 20-year gap in life expectancy between the counties with the lowest and highest life expectancy in the U.S.

• Health risk factors, such as poor diet, inadequate exercise, and smoking, are more common in groups with lower socioeconomic status and are reflective of health disparities.

• Social determinants of health limit opportunities to participate in healthy activities and behaviors. SDOH, such as reduced access to health care, poorer educational opportunities, and increased exposure to environmental toxins, help create conditions that lead to chronic stress.

• Social determinants of health lead to health inequities through social stratification and reduced political and social influence, which ultimately results in an imbalance of power between groups based on socioeconomic situation, race, ethnicity, and other characteristics.
Building Cultural Competence and Proficiency

The AAFP defines cultural proficiency as “the knowledge, skills, attitudes, and beliefs that enable people to work well, respond effectively to, and be supportive of people in cross-cultural settings. Family physicians care for a wide variety of patients and need these skills to offer better patient care.”

Today’s health care environment is increasingly diverse, and physicians interact with patients from a wide range of ethnic and sociocultural backgrounds. Family physicians and their teams strive to provide the best patient experience possible for everyone we serve in our practice. The following resources can help you and your practice team better understand the issues that surround providing culturally proficient and linguistically appropriate care:

- Cultural Proficiency: The Importance of Cultural Proficiency in Providing Effective Care for Diverse Populations (Position Paper) (www.aafp.org/about/policies/all/cultural-diverse-populations.html)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf)

Learn More about the Communities You Serve

Some SDOH do not occur at an individual level (e.g., environmental hazards, community deprivation, social capital, prejudice, etc.). Patients may be unaware of these issues and will not be able to tell you and your practice team that they are being impacted by them. There are many databases that allow you and your practice team to examine contextual factors in your patients’ communities and how they impact health. These resources include:

- HealthLandscape: HealthLandscape is an interactive, web-based mapping tool that allows you and your practice team to combine, analyze, and display information in ways that promote better understanding of health and the forces that affect it. (www.healthlandscape.org)
- County Health Rankings & Roadmaps: The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in the U.S. The annual rankings reveal a snapshot of how health is influenced by where we live, learn, work, and play. They provide a starting point for change in communities. (www.countyhealthrankings.org)

- County and City Health Department’s Community Health Assessment: A community health assessment is the process that systematically collects and analyzes data to understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, SDOH, health inequity, and information on how well the public health system provides essential services. Community health assessment data inform community decision making, the prioritization of health problems, along with the development, implementation, and evaluation of community health improvement plans. Find your local health department’s webpage at the National Association of County and City Health Officials’ (NACCHO) directory. (www.naccho.org/membership/lhd-directory)

- Nonprofit Hospital’s Community Health Needs Assessments: Community health needs assessments are conducted by hospitals as part of their community benefit program and as a requirement for nonprofit status. They are similar to the community health assessment and community health improvement plans that county and city health departments create with many hospitals and health departments coming together to conduct them. Hospitals are required to present their assessments and implementation plans publicly, usually on their websites.

Health Literacy and Interpretation Services

Health literacy can be defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Nearly nine out of 10 adults may not possess the skills they need to assist them in managing their health and preventing disease. It might be helpful to assume that some of your patients have limited health literacy. Patients with low health literacy may not comprehend drug labeling or medical instructions, with the result that they appear unwilling to follow recommendations. Patients may have difficulty with understanding health publications, giving adequate history or comprehending content, and completing medical and insurance forms. To assist your patients, consider the following recommendations:

- Use plain language instead of medical jargon or technical language.
- Sit down to achieve eye-level communication.
- Use visual models to illustrate a procedure or condition.
- Have patients explain back to you the care instructions you gave them or demonstrate procedures you explained.
As the U.S. population becomes more diverse, family physicians are more likely to encounter patients with limited English proficiency. This can be challenging. Other disabilities, such as hearing or visual impairments should also be considered. These can lead to communication challenges. Steps practices can take to develop a strategy to overcome language barriers and improve the quality of care include:28

- Determine the need for services in your practice.
- Develop a policy.
- Determine the method of communication to be used during the patient encounter.
- Seek financial support for medical interpretation.
- Provide language-appropriate patient forms and educational resources.28

For more information about health literacy and medical interpretation, please see:
- Health Literacy in Primary Care Practice (www.aafp.org/afp/2015/0715/p118.html)
- Incorporating Medical Interpretation into Your Practice (www.aafp.org/fpm/2014/0300/p16.pdf)

**EVALUATE YOUR CURRENT SYSTEM**

This section will help identify small changes you and your practice team can make to integrate SDOH into your practice.

**Assess Your Practice Environment and Workflow**

Your practice can demonstrate a commitment to addressing SDOH and facilitate patient-centered conversations with a physical environment that supports these efforts.

Conduct a brief, informal assessment of your practice by answering the following questions.

1. How does your practice currently identify and document patient’s social determinants of health (SDOH)? Whose responsibility is this?
2. How does your practice currently help address patient’s SDOH? (Select all that apply.)
   - [ ] Screen for SDOH
   - [ ] Maintain up-to-date records of community-based resources
   - [ ] Refer patients to community-based resources
   - [ ] Engage patients about how to overcome their SDOH
   - [ ] Other ________________________________

3. What systems do you have in place to make sure SDOH are addressed at patient visits?
   - [ ] Prompts in electronic health record (EHR) system
   - [ ] SDOH as part of vital signs
   - [ ] Registry of patients by categories of SDOH
   - [ ] Flags or stickers on paper charts
   - [ ] Assessing implicit bias
   - [ ] Cultural proficiency training
   - [ ] Other ________________________________

4. Imagine that your practice is successfully doing everything possible to help address patients’ SDOH. How would that look?

5. What are some of the challenges you and your practice team face in identifying and addressing patients’ SDOH?

6. What has worked in the past to help identify and address patients’ SDOH?

7. Whose responsibility is it to work with patients to address SDOH?

8. What resources are available in your community that your patients could access to help address their SDOH?

**Evaluate Patient Flow**

Take a moment to examine how patients flow through your office. This will help you and your practice team identify opportunities for addressing your patients’ SDOH. Create a simple document that shows how patients advance through your system, from the time they enter until the time they leave.

Think about the following questions, relative to SDOH, as you and your practice team document your current patient flow.

- Where do patients go when they enter the office? What do they see and do before they are called back for their visit?
- Who do patients see before meeting the clinician?
- What questions are asked when vital signs are measured?
- What information is exchanged with patients before the patient-clinician encounter?

If SDOH are currently being addressed in your practice:

- How do clinicians address SDOH during the encounter?
- How are counseling or other interventions for SDOH documented?
- What reminder systems and prompts are in place to alert clinicians of opportunities to discuss SDOH?
- What path do patients take as they exit the office? Do they make any stops to speak with non-clinical staff (social workers, navigators, reception, etc.)?
Integrating SDOH into Your Workflow

Based on your observations, create a new flowchart that shows what actions will be taken to address patients’ SDOH and at which step. The following flowchart provides an example of how one family medicine practice incorporates SDOH into their practice’s workflow.

### Sample Patient Visit Flowchart

<table>
<thead>
<tr>
<th>Step</th>
<th>Actions and Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient checks in</td>
<td>Posters are available in the waiting room that prompt patients to discuss their social needs.</td>
</tr>
<tr>
<td>Patient sits in waiting room</td>
<td>Social determinants of health screening tool is distributed to patients at check-in to be completed in the waiting room.</td>
</tr>
<tr>
<td>Height and weight checked in hallway</td>
<td>Nurse or medical assistant confirm social needs with patient and provides information to office clerk to cross reference social needs with available community resources.</td>
</tr>
<tr>
<td>Remaining vital signs checked in exam room</td>
<td>Posters are available in the waiting room that prompt patients to discuss their social needs.</td>
</tr>
<tr>
<td>Patient meets with clinician</td>
<td>Clinician discusses social needs with patient and available resources.</td>
</tr>
<tr>
<td>Patient meets with counselor</td>
<td>Nurse or medical assistant finalizes plan to address patient’s social determinants of health and referrals to community resources.</td>
</tr>
<tr>
<td>Patient stops at billing/scheduling station</td>
<td>Office staff schedules follow-up appointment.</td>
</tr>
<tr>
<td>Patient leaves</td>
<td></td>
</tr>
</tbody>
</table>

### Identify Barriers

What challenges do you expect to experience as you and your practice team make these changes to address patients’ SDOH? This implementation guide provides solutions to those challenges.

A team meeting to identify potential barriers is a great place to begin your process. Start by making a list. For many clinicians, common barriers to addressing patients’ SDOH include: a system for addressing SDOH; staying up-to-date on resources available in patients’ communities; perceived lack of payment for interventions; proper staffing; and a lack of experience/training. Additionally, practices may find confronting implicit biases to be uncomfortable and challenging.

Many family medicine practices lack systems that:
- Maintain up-to-date records for resources in patients’ communities.
- Identify changes in patients’ SDOH.
- Identify factors in patients’ communities that influence their health.
- Refer patients to resources in patients’ communities that can help address their social needs.
- Allow for follow up after referring patients to community-based resources.
- Confirm that patients understand what they need to do.
Another potential barrier is having inappropriate expectations about addressing the SDOH in the practice setting. By their nature, SDOH are complicated and commonly require changes in social, environmental, and economic systems which are outside of the patients’ and practices’ control. Family physicians and their health care teams may not be able to address each of their patient’s social needs, and should be encouraged by the help you and your practice team can provide.

**DEFINE A NEW SYSTEM**

Now that you and your practice team have evaluated your current system, it is time to take steps to define and implement a system to address SDOH. The AAFP suggests a modified “Ask and Act” process called “Identify, Ask, and Act.” This approach encourages family physicians to IDENTIFY what resources are in their patients’ communities, ASK their patients about their SDOH, and ACT to help connect patients with resources that can help address their patients’ social needs.

This easy-to-remember approach provides the opportunity for every member of the practice team to intervene at every visit. Interventions can be tailored to a specific patient based on his or her needs, as well as to the structure of the practice and each team member’s knowledge and skill level.

As you think about how to systemize your interventions, consider the Identify, Ask, and Act recommended framework.

### IDENTIFY

- Identify and maintain a directory of community-based resources in your patients’ communities. There are organizations that maintain up-to-date databases of community-based resources for most areas throughout the U.S., such as Aunt Bertha (www.aunbertha.com) and 2-1-1 (www.211.org).

### ASK


### ACT

- Identify patients with social needs.
- Match community-based resources with the patient’s social needs.
- Refer patients to appropriate community-based resources.
- Follow up with patients about use of the community-based resource.
- To assist with this step, use the AAFP’s Social Determinants of Health Patient Action Plan (www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/provider-long-print.pdf).

**Identify**

As with any screening program, it is essential to be able to address problems as they are identified. The AAFP suggests family medicine practices first identify what community-based resources exist in their patients’ communities. Historically, this has been a major undertaking because of the number of resources and how frequently they change. In more recent years, organizations now maintain up-to-date information on these resources, as well as help with referral.

- **Aunt Bertha** is a free, web-based tool that helps people and organizations navigate social needs. Aunt Bertha provides instant access to comprehensive, localized listings of community-based resources in every ZIP code in the U.S. These resources are maintained and kept up to date. Aunt Bertha includes tools to make and manage referrals, tag favorite programs, and receive information about how your patients are using Aunt Bertha (www.aunbertha.com).*

- **2-1-1** is a free and confidential service that helps people across the U.S. and in many parts of Canada find the local resources they need. For 24 hours a day, seven days a week access to this service by phone, text, and web, visit the 2-1-1 website (www.211.org).*

- **County and city health departments** often have strong relationships with community-based resources and may be able to provide you and your practice team with an up-to-date list of these resources. You can find your county or city health department at the National Association of County and City Health Officials’ (NACCHO) directory (www.naccho.org/membership/lhd-directory). *

*Aunt Bertha and/or 2-1-1 include information about: supplemental food and nutrition program; shelter and housing options and utilities assistance; emergency information and disaster relief; employment and education opportunities; services for veterans; health care, vaccinations, and health epidemic information; addiction prevention and rehabilitation programs; re-entry help for ex-offenders; support groups for individuals with mental illnesses or special needs; and a safe, confidential path out of physical and/or emotional domestic abuse.

**Ask**

After you and your practice team have developed an understanding of the resources available in your patients’ communities, the next step is to ensure that SDOH are assessed and documented for every patient at every office visit. The National Academy of Medicine (formerly called the Institute of Medicine) identified 11 SDOH domains. These can be used to develop a systematic approach for inquiring about patients’ SDOH. This is important because:

- Patients may not know to discuss non-medical issues with their physician—this will prompt them to discuss their needs.
• Patients’ SDOH status can change. For example, opportunities for good health can be constrained after a job loss.
• Validated questions exist for inquiring about SDOH.

If you are using paper records, expand the vital signs to include SDOH. Electronic health records (EHRs) may allow for integration of the SDOH into the practice workflow, facilitating system-level changes. Prompts on face sheets or summary screens can help you easily identify patients with SDOH, similar to a chart sticker or flag. After the initial identification of the patient’s social needs, the EHR should then be programmed to remind the clinician to ask the patient about their social needs at subsequent visits.

The AAFP has produced a guide to social needs screening tool that incorporates validated questions on common SDOH (www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-guide.pdf). The questionnaire is provided in figure 1.

Figure 1: Social Needs Screening Tool

<table>
<thead>
<tr>
<th>PROVIDER FORM (short version)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Needs Screening Tool</td>
</tr>
</tbody>
</table>

1. What is your housing situation today?
2. Think about the place you live. Do you have problems with any of the following? (Check all that apply)
3. Inside the past 12 months, you worried that your food would run out before you got money to buy more.
4. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.
5. In the past 12 months have the electric, gas, oil, or water utilities ever been turned off for non-payment?
6. In the past 12 months has the company threatened to shut off services in your home?
7. How often does anyone, including family, physically hurt you?
8. How often does anyone, including family, insult or talk down to you?

<table>
<thead>
<tr>
<th>PASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When the past 12 months, you worried that your food would run out before you got money to buy more.</td>
</tr>
<tr>
<td>2. Inside the past 12 months, you worried that your food would run out before you got money to buy more.</td>
</tr>
<tr>
<td>3. Inside the past 12 months, you worried that your food would run out before you got money to buy more.</td>
</tr>
</tbody>
</table>

STANDARDIZE THE SYSTEM

Now that you and your practice team have a broad understanding of how to address SDOH in your practice, it is time to standardize your office systems to ensure that every patient’s social needs are identified and provided assistance.

Electronic Health Records

Electronic health records (EHRs) can be used to help systemize the process for addressing SDOH by tracking patient’s information and providing clinicians with reminders. To incorporate EHRs in your SDOH process, you and your practice team should:

• Integrate SDOH screening questions into the EHR.
• Document arrangements made for patients to visit appropriate community-based resources.
• At follow-up, document in the EHR the results of the referral.

Referral of Community-based Resources

Providing support and follow-up to patients with social needs is the challenging part of integrating SDOH into your practice. Strategies for referring patients to community-based resources include:

• Provide a brief description of what services are available and address common misconceptions. For example, a list of community-based services that are available in the patient’s community could be printed from Aunt Bertha and discussed with and/or provided to the patient (Figure 3).

Figure 3: List of Community-based Resources in Aunt Bertha

Multiple community-based resources are listed
This list can be printed and provided to patients.

Act

Once you and your practice team have determined that a patient has social needs, it is important to connect patients with resources in their communities that can help address their specific needs. Identify resources for the patient based on their identified social needs and arrange for the patient to access community-based resources. The websites, 2-1-1 (www.211.org) and Aunt Bertha (www.auntbertha.com) are intended to be used by patients.
• Recommend services and personalize them. For example, if you have identified preferred community-based resources, you could say, “I have referred many of my patients to this service, and they have found it helpful.”

• Assess the patient’s interest in getting help.
  – If the patient is unsure, explore his or her ambivalence.
  – If the patient is not interested, offer a printout of the resources available, and provide information about Aunt Bertha or 2-1-1.
  – If the patient is interested, provide a referral. This can be accomplished through:
    o Aunt Bertha’s “connect” feature, which allows you to send a message to the community-based resource, informing them that your patient will be seeking their services (Figure 4).

Figure 4: Aunt Bertha Detailed Information and Referral Option for Specific Community-based Resource

Aunt Bertha’s “connect” feature allows you to easily inform community-based resources that your patient will be seeking their services.

• Develop a tracking method to capture referrals to community-based organizations.

• Formulating a patient action plan.

A tool like the AAFP’s Social Determinants of Health Patient Action Plan are available to assist with this step (www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/provider-long-print.pdf) (Figure 5).

Figure 5: The AAFP’s Social Determinants of Health Patient Action Plan

Make Assignments/Team Approach

As you implement your practice’s process of change, bring together your practice team. Discuss how best to incorporate SDOH into your practice setting. The team should do the following:

• Select resources to be used in the office and determine how they will be stored, distributed, and accessed.

• Choose who will discuss SDOH issues with the patient, how and when this will happen, and where the responses should be documented on the chart.

• Choose who will work with patients to develop a plan for their SDOH.

• Discuss how the team will provide follow-up care for patients and create mechanisms to ensure that this care is provided.

Roles of Multidisciplinary Team Members

Systematizing processes requires very clear guidelines on roles and responsibilities. Assignments may vary based on practice size and structure. As you and your practice team define who will assume various roles in your practice’s process, consider the following options:

Physicians

• Discuss with your patients their SDOH and available community-based resources.

• Deliver strong, personalized messages about preferred community-based resources.

• Refer your patients to other team members for supplemental counseling and referral.
Follow up with your patients about their use of community-based resources and the quality of their experience.

Keep current on research.

**Nurses, physician assistants, and/or health educators**
- Assess your patients’ SDOH and their readiness to find help.
- Provide counseling, with a focus on identifying strategies to overcome obstacles and reduce stress.
- Perform follow-up counseling.

**Receptionists/medical assistants**
- Distribute SDOH questionnaire to your patients.
- Ensure that information about commonly preferred community-based resources is available in waiting areas.
- Schedule or arrange for appointments with community-based resources.
- Follow up with your patients to remind them of their appointments with community-based resources.

**Administrators**
- Ensure adequate human resource support for staff addressing patients’ SDOH.
- Support integration of SDOH tools into the EHR.
- Arrange for training on SDOH and health equity, implicit bias, and cultural proficiency.
- Implement quality audits and monitor key implementation activities.
- Ensure data are tracked for program evaluation.
- Communicate outcomes to other members of the health care team.

Be sure to communicate to each staff member about his or her responsibilities for addressing SDOH. Incorporate a discussion of these staff responsibilities into training of new staff.

**Physician and Staff Feedback**

To improve the process, data is necessary and feedback is essential to system improvement. Formal, regular communication about how the SDOH process is working should be integrated into the system. Several elements can be measured and reported, such as the following:
- The number and percent of your patients with specific SDOH.
- The number and percent of your patients who have been referred to community-based resources to address their SDOH.
- The number and percent of your patients who have visited community-based resources and have received assistance.
- The number and percent of your patients who received meaningful assistance with their SDOH.

Identify the administrator who can provide feedback to clinicians and staff about their performance, drawing on data from chart audits, electronic medical records, and computerized patient databases. Evaluate the degree to which your practice is identifying, documenting, and assisting patients with their SDOH.

Set benchmarks or target goals. Use a few minutes in regular staff meetings to share information about the SDOH process. Include unblinded data in internal practice communications. Reinforcing the importance of SDOH efforts and continuously creating ways to improve the system are crucial to success.

**PREVENT AND OVERCOME STAFF RESISTANCE TO CHANGE**

In any organization or group, including a medical office, change can be threatening, even if new ideas or processes lead to improvement. No matter how well changes are communicated prior to their implementation, some people will resist.

It is very important to anticipate resistance and plan strategies for dealing with it. This applies not only when the change is introduced, but also over the long term. Clear communication is imperative. For example, spell out how changes will affect the office, how patient care will be improved, and how roles and responsibilities are defined.

Office leadership should present changes in a unified, positive way, creating opportunities for communication, staff input, feedback, and improvement in the new system. Share goals for both operations and improved patient care outcomes.

You and your practice team will be more willing to accept change if everyone:
- Likes the way the change is communicated and feels included in the process.
- Likes and respects the source of the change.
- Understands the motivation and goals for the change.
- Feels a sense of challenge and satisfaction.
- Helps put the new plan in place, as opposed to having it forced upon them.
- Sees that the change will improve patient care, processes, and health outcomes.
CELEBRATE SUCCESSES
Remember to call out the early wins and major breakthroughs as your practice works to incorporate SDOH into your work. It is important for the practice team to see that their effort is having an impact.\textsuperscript{31} Suggestions for how to celebrate successes in a way that reinforces change include:

- Developing a system for recognizing people so opportunities are not missed.
- Celebrating success and recognizing people publicly.
- Using regular meetings to celebrate and recognize people.
- Making sure stakeholders are aware of these achievements.

Celebrating success builds team morale and helps create support among skeptics.

YOUR IMPLEMENTATION PLAN
Put your new ideas into action. Use this worksheet to develop a plan for systems change. This is a basic checklist and should not limit the development of system modifications for your practice.

<table>
<thead>
<tr>
<th>TASK</th>
<th>PERSON RESPONSIBLE</th>
<th>DATE TO BE COMPLETED</th>
<th>CHECK WHEN COMPLETED</th>
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</thead>
<tbody>
<tr>
<td>Conduct initial meeting with staff</td>
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<tr>
<td>Cultivate a culture of health equity</td>
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<tr>
<td>• Provide training on social determinants of health and health equity</td>
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<tr>
<td>• Assess implicit biases among the health care team</td>
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<td>• Provide training for cultural proficiency</td>
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<td>• Other ________________</td>
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<tr>
<td>Track the patient experience and highlight opportunities for addressing social determinants of health</td>
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<td>Update vital signs (if needed)</td>
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<td>Create flags, prompts, and templates for electronic health records or paper charts</td>
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<td>Formalize protocol for addressing social determinants of health</td>
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<td>Provide staff training on new protocols</td>
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<td>Update billing process to ensure payment</td>
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<tr>
<td>Create a list of community-based resources, or incorporate use of outside services (Aunt Bertha, 2-1-1, etc.)</td>
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<tr>
<td>Create a patient registry</td>
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<tr>
<td>Create and implement a system to track and communicate success</td>
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<tr>
<td>Make staff assignments</td>
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<tr>
<td>Define roles of:</td>
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<tr>
<td>• Physician(s)</td>
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<tr>
<td>• Nurse(s)</td>
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<td>• Health educator(s)</td>
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<tr>
<td>• Medical assistant(s)</td>
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<tr>
<td>• Administrator(s)</td>
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<tr>
<td>• Receptionist(s)</td>
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REFERENCES


