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Improving Social Determinants of Health Screening Implementation Through Collaboration: Leveraging a Clinical-Academic Partnership.

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Problem Addressed

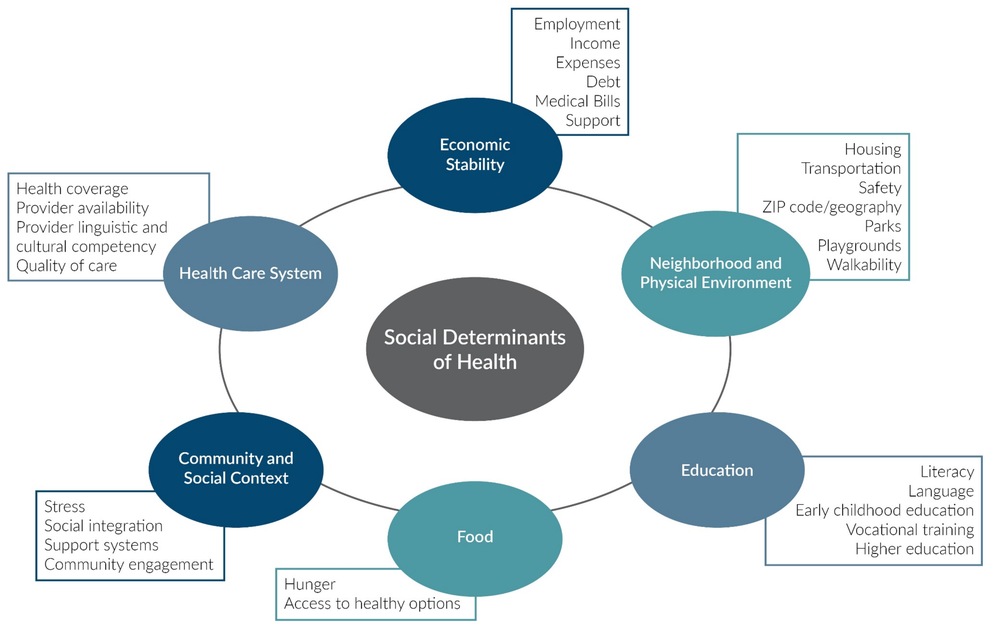
•There are growing efforts to capture information about patients' social determinants of health (SDOH) in healthcare and provide services targeted at health-related social risk factors.

•SDOH data create opportunities for healthcare providers to make referrals to social service agencies to address individual patients' needs and to tailor treatment plans to individuals' specific needs, working towards the goal of achieving better health outcomes for disadvantaged patients.

•No standard screening tools exist, and screening policies tailored to the needs of specific patient populations may be necessary.

•There is limited evidence on how SDOH data collection is currently carried out both formally and informally across clinical settings, prompting research questions such as:
- •What types of screening are offered?
- •Which SDOH data are of highest priority to collect?
- •What barriers to screening exist?
- •How frequently are patients screened for SDOH?
- •Which SDOH are most frequently disclosed?

Figure 1: Types of SDOH



Methods

•Parkview Health (PH) is a non-profit health system featuring 9 hospitals in Indiana and Ohio. To identify existing formal and informal SDOH screening tools and practices at PH, we conducted interviews with 36 PH providers, staff, and administrators. We conducted a thematic analysis of interview transcripts. We also analyzed electronic health record (EHR) data from Population Health Department, which addresses patients' social needs.

Results

Table 1: Demographic Characteristics	
Age	Mean=44, range=33-61
Gender	30 female, 6 male
Example roles	RN, social worker, MD, educator, practice manager, administrator
Clinical practice duration	Mean=16 years

•SDOH screening at PH primarily takes 2 forms:
- •Clinical assessments, which varied both in level of structure and in scope of narrow to broad ranges of social needs
  - •Narrow: handful of questions routinely asked by providers
  - •Broad: comprehensive assessment using SDOH screening tool
- •Patient self-report using surveys

•SDOH data were generally thought to be helpful, and providers found data about transportation, access to medication, social support, access to enough food, and financial strain to be most useful.

Table 2: Barriers to SDOH Screening
Time burden for providers & patients
Limited accessibility of collected data in some clinics and for some roles
Variability in usefulness of data

Table 3: SDOH Screening and Disclosure Frequency				
Frequency of SDOH Screening and Positive Screenings				
	Visit-level		Patient-level	
	Frequency	%	Frequency	%
Screening occurred	13185/84660	15.6	7784/16782	46.4
Positive screen	6029/13185	45.7	4516/7784	58.0
Frequency of Disclosures of Each Type of SDOH				
Financial Insecurity	3593/11175	32.2	2824/6858	41.2
Transportation	1517/10714	14.2	1429/7256	19.7
Social Support	910/10473	8.7	824/7270	11.3
Food Insecurity	376/ 6471	5.8	318/4257	7.5
Health Literacy	127/3214	4.0	127/2638	4.8
Housing/Utilities	291/10330	2.8	244/7099	3.4
Domestic Violence	98/4894	2.0	85/2833	3.0

Conclusion

•Evaluating existing SDOH screening in a variety of clinical settings, made possible by our partnership, allows us to learn how screening impacts patients and providers and identify opportunities to inform a shared definition of SDOH, improve SDOH data quality, and evaluate the impact of screening standardization.

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