Social Determinants of Health

Strategy Worksheet

Social Needs Screening

Screening is a great first step when building a strategy to address Social Determinants of Health (SDoH). The following questions are a few questions you may want to consider in planning your SDoH screening strategy.

Where in your current clinical workflows would a SDoH screening tool fit best?
Obtaining this information at first contact might fit best for some practices, while others may find more value introducing the tool and addressing results later in the therapeutic process.

What screening tool will you use?
We recommend that you use a standardized, nationally recognized tool. You can find a great comparison of tools here: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison. Two tools commonly used in Colorado are the Accountable Health Communities Model tool and PRAPARE.

Who do you want to screen?
Some practices screen only at certain visit types (new visits). Some practices are only screening patients who are on Medicare or Medicaid. It is important to pick a population and screen the entire population so that patients don't feel stigmatized.

How often will you screen?
The nationally recognized best practice is to screen annually. Some practices screen more frequently as a way to assess changing needs.

Will you administer the screening tool verbally or hand out a form for the patient to fill out? Do you have a front-desk application that enables you to do the screening on a tablet or device?

Who will hand out or administer the screening tool?

Where will screening occur (lobby, clinical room, other)?

Who reviews the screening results and provide the patient with information on resources?
We believe that it is the best practice to review the screening results and provide the patient with resources in the same visit that you screen. We know that if you try to follow-up by phone or in a later visit, a certain percentage of patients will be lost to follow-up. Providing an immediate resource lists ensures that all people with needs receive some information.

How will you develop a list of resources to hand patients?
There are many resources available so you should be able to leverage resources in the community. Some family resource centers have resource lists. 2-1-1 in your region may be able to provide a list.

Where and how will your document screening results? Will your documentation methodology enable clinicians to see the results?

If your screener asks about interpersonal violence or safety of children at home, how will you handle positive results including assessing for Mandatory Reporting?

How will you train staff on social determinants of health?
We recommend ensuring that all staff involved in the workflow have some level of training about poverty and resources available to address social needs. There are many free and virtual trainings on topics like SNAP. Bridges out of Poverty is also a common training course that many staff have found helpful.

How will you monitor your screening success? What data can you track? How often will you track the data and do you have pre-existing meetings or quality improvement processes that you can leverage?

Social Needs Programs

There are many ways that you can address the SDoH needs of your population, in addition to or instead of social needs screening. Some ways that clinical organizations are addressing SDoH are in-house food banks, having staff with Peak Pro access who can complete SNAP applications with patients, and rent relief programs (funded by grants, non-profits or private citizens).

What are the priority social needs in your patient population? If you don't know, how could you find out (do you have a Patient Advisory Council or another mechanism to gain input)?
The most common social need is food insecurity. Housing is a need that is less common but has a very significant impact on health.

Are any of your staff particularly passionate about a particular topic?
Sometimes having a staff champion for a particular project can make a big difference in creating a successful program.

What resources do you have (space, staff time)?

What partners in the community could you reach out to and seek assistance from?