FAQ

SDoH Screening

1. What are Social Determinants of Health (SDoH)?

Social determinants of health (SDoH) are the conditions we are born, grow, live, work, play, and age.

These nonmedical conditions greatly impact our health.

After all, health is not created in a doctor's office.

Health is created in equitable, prosperous communities.

These communities have equitable distribution of power and resources. These communities have quality childcare and education, affordable housing, employment opportunities, livable wages, healthy food, safe parks, and safe streets and transportation options connecting people to destinations.

Globally, improvements in SDoH conditions over the past 100 years have contributed to improvements in health. The drastic differences we see in health outcomes and life expectancy across nations today can be largely explained by inequities in SDoH. Learn more here.

However, the United States has struggled to identify and address SDoH issues.

2. How Do SDoH Issues Manifest?

SDoH are often grouped in five domains:

1. Economic stability
2. Education access and quality
3. Neighborhood and built environment

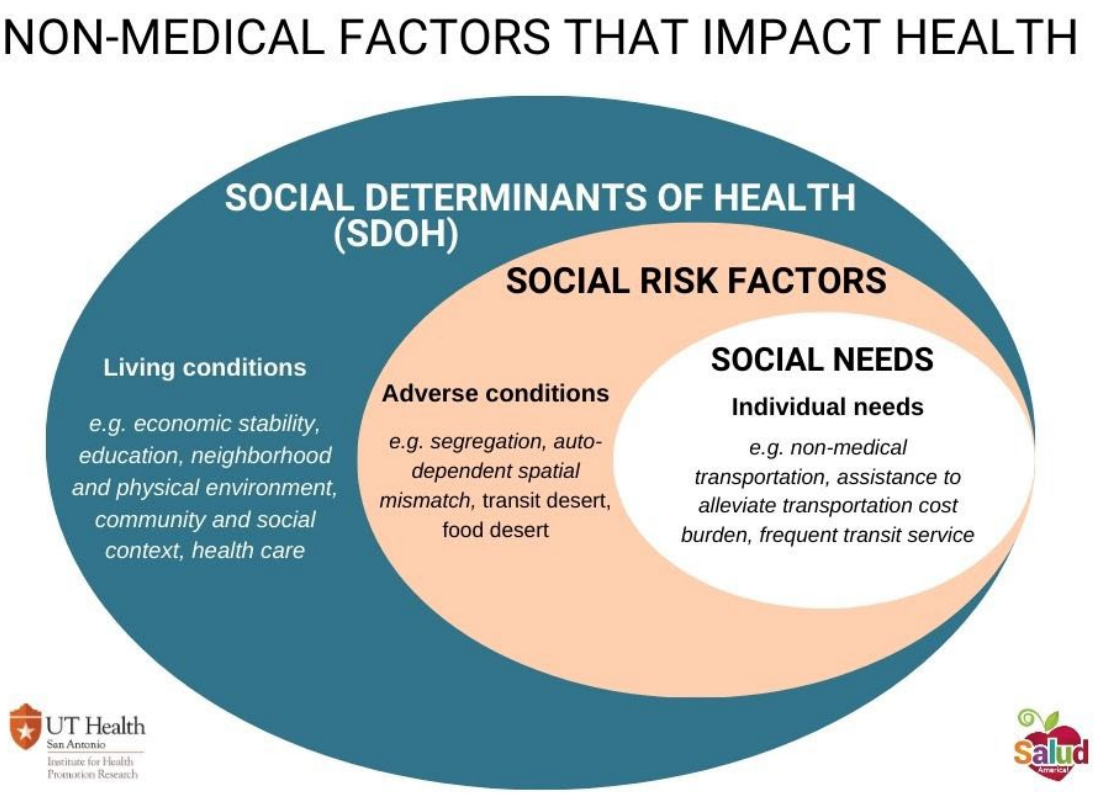
Salud America!
Institute for Health Promotion Research (IHPR) at UT Health San Antonio
7411 John Smith Drive, Suite 1000 | San Antonio, TX 78229
210.562.6500 | Fax 210.562.6545 | www.salud-america.org

4. Social and community context
5. Health care access and quality

Within each of these SDoH domains are various social risks and social needs.

Think of it this way: SDoH and social risk factors are structural, systemic, and/or community-level issues. Social needs are individual-level issues.

SDoH are broad living conditions, and social risk factors being inequitable or bad living conditions. Social needs are the immediate needs that arise due to those living conditions.



Social needs may or may not arise from social risk factors, and different social needs may arise from the same social risk factors.

Inadequate transportation, for example, is a social risk factor that may contribute to various individual social needs, such as being unable to get to the doctor, being unable to get healthy food, or being late to or missing work.

Thus, while entire communities may be exposed to the same social risk factor, social needs will vary from individual to individual.

As an example, see how transportation is a critical SDoH issue and how it plays out in social risk and social needs.

3. Should SDoH Issues Be Addressed Individually or Systemically?

Because health outcomes are influenced by factors outside of the exam room, addressing patient health outcomes must also take place outside of the exam room.

Thus, SDoH issues deserve a systemic focus.

Individual-level interventions are not bad in and of themselves.

On one hand, we need a variety of local, state, and federal assistance programs to help these individuals meet their immediate social needs.

But many health advocates caution against claiming that individual-level interventions are addressing community-level social determinants and social risk, because it conveys a false sense of progress and makes it harder to focus on the systemic changes necessary to address root causes of poor health outcomes, also known as upstream causes.

"If we, even inadvertently, imply that the social determinants of health can be solved by offering Uber rides to individual patients or by deploying community health navigators, it will be challenging, if not impossible, for public health advocates to make the case for proven policies like alcohol sales control, complete streets, and healthy food procurement," writes Brian C. Castrucci and John Auerbach in Health Affairs.

Thus, on the other hand, we need to change policymaking and investment decision-making at the local, state, and federal level to improve the affordability, safety, and availability of transportation options so that everyone can meet their daily needs without burdensome tradeoffs.

Learn more about why the distinction between social determinants and social needs matters in Castrucci and Auerbach's article.

"Social needs are the downstream manifestations of the impact of the social determinants of health on the community," they write.

As an example, see how transportation is a critical SDoH issue that needs a systemic focus.

4. Should SDoH Issues Be Addressed Downstream, Midstream, or Upstream?

SDoH issues deserve an upstream focus.

Using the metaphor of a flowing stream or river, addressing upstream conditions will address the root causes of poor health outcomes that produce downstream effects.

Take, for example, pollution.

Say there is an oil refinery located upstream. This can discharge harmful pollutants into the stream, exposing individuals living downstream to pollutants. Pollution, in this example, is the community-level social risk factor for which various individual-level social needs may arise, such as the need for medical care and clean drinking water.

A downstream strategy to reduce the harmful impact of pollutants would provide individual-level medical care to those exposed. In public health, this is a known as a tertiary prevention strategy. Notice, this strategy does nothing to address the root cause of the problem. Thus, demand for medical care would remain constant year after year, generation after generation. You can see why this is not cost-efficient.

A midstream strategy to reduce the harmful impact of pollutants would provide water filters to those concerned about exposure. In public health, this is known as a secondary prevention strategy. Although midstream strategies will reduce some demand for medical care, again, these strategies do nothing to address the root cause of the problem, and demand for water filters would remain constant year after year, generation after generation. You can see why this is not cost-efficient.

An upstream strategy to reduce the harmful impact of pollutants would eliminate pollution at the source. This eliminates unnecessary demand for both water filters and medical care. In public health, this is known as a primary prevention strategy, and it has the greatest long-term population impact. Through laws, policies, and regulations, strategies improve the conditions upstream to reduce the effects downstream, thereby reducing public and private costs.

Downstream and midstream strategies address individual-level social needs rather than reduce the prevalence of social needs; upstream strategies address social determinants, thereby reducing the prevalence of social needs.

"This isn't about picking one approach over another – we need social and economic interventions at both the community and individual levels," writes Castrucci and Auerbach. "The demand for social needs interventions won't stop until the true root causes are addressed. This should ring especially true as the movement to Accountable Health Communities and value-based care gains momentum. Any success these new payment structures enjoy will be short-lived if the underlying social conditions in the communities where they work remain unchanged."

As an example, see how transportation is a critical SDoH issue that needs an upstream focus.

5. How Should We Begin to Address SDoH?

Before we create midstream strategies to reduce social needs and upstream strategies to reduce the underlying social risk factors, we need to better understand the prevalence of social needs and the scope and extent to which social conditions contribute to or safeguard against health problems.

This means we need to screen Americans for social needs and the underlying social risk factors that contribute to social needs.

While diagnosing and treating social needs should not be the sole responsibility of the health care system, healthcare organizations share responsibility in identifying patients' social needs and the social risk factors from which they arise.

Thus, we need SDoH screening in healthcare.

6. What is SDoH Screening?

SDoH screening is a questionnaire given to patients in a healthcare setting that can help identify non-medical barriers to health, such as those relating to financial hardship, transportation, housing, food, employment, and safety.

Patients can then be referred to helpful community resources.

The SDoH screening can be completed electronically, in writing, or verbally.

A systematic review of 21 SDoH screening tools in 2018 found that the majority were administered by paper (n=11, 52.4%), followed by verbally (n=9, 42.9%) and electronically (n=7, 33.3%).

However, since this review, the electronic health record system, EPIC, has embedded a SDoH screening tool, thus much more screenings are being done electronically.

Learn more about the rise of SDoH screening!

7. What SDoH Screening Tools Exist?

Several nationally recognized SDoH screening tools exist, although most technically only screen for social needs and do not screen for SDoH or the underlying social conditions.

The most widely accepted and used SDoH screening tool is PRAPARE® (Protocol for Responding to and Assessing Patient's Assets, Risks and Experiences).

From 2013 to 2016, the National Association of Community Health Centers (NACHC) helped create the PRAPARE® SDoH screening tool to enable community health centers (also known as federally qualified health centers) to identify social needs among patients and refer them to local resources for aid.

Today, PRAPARE® is available in over 25 different languages and has been implemented onto a plethora of digital platforms, including electronic health record systems.

The PRAPARE® Implementation and Action Toolkit – available in English and Spanish – includes resources on how to implement PRAPARE®, how to use PRAPARE® data, and best practices and lessons learned from community health centers who piloted PRAPARE®.

See how PRAPARE® was created!

Other SDoH screening tools exist, too.

Go here to learn more about:

- American Academy of Family Physicians (AAFP) Social Needs Screening Tool
- Kaiser Permanente's Your Current Life Situation (YCLS) Survey

Go here to learn more about:

- The Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool
- WellRx SDoH screening tool
- HealthBegins SDoH screening tool

8. Why Should a Healthcare System, Hospital, or Clinic Choose to Implement SDoH Screening?

Here are seven key reasons why a health system, hospital, and/or clinic should screen for SDoH:

- Helps Patients Speak Up
- Helps Clinicians Better Understand Patients
- Helps Clinicians Address Patients' Needs
- Helps Foster Community Collaboration
- Helps Healthcare Assessment, Management
- Can Increase Advocacy for Addressing 'Root Causes'
- Can Improve Health Equity in the Healthcare System

Find out more about these several reasons.

However, an inadequate screening tool can limit quality improvement and research on social risk screening and intervention programs.

So, it's important to find the right SDoH screening tool.

9. How Do You Know Which SDoH Screening Tool Is Best?

Due to a lack of evaluative studies on SDoH screening tools, there is no single recommended tool.

There is not yet firm scientific evidence of validity (consistency) and reliability (accuracy) in SDoH screening tools. There is also little evidence the tools can differentially identify social risk between population groups, or measure the impact of screening on health outcomes, according to a systematic review of the pragmatic and psychometric properties of social risk screening tools.

Additionally, there is not yet a standardized and interoperable format to collect data on health-related social needs.

Still, you have the potential to gather all the information you need to compare, modify, adapt, or create a tool in the guide provided in Step 3 of this Action Pack. And you can advocate for the scientific testing of the tools to ensure they are measuring what they are supposed to measure with accuracy and consistency and without imposing time or cost burdens on the staff administering or the patients completing the tool. Additionally, you can advocate for the collection of standardized and interoperable data.

As a reminder, screening tools are a type of measurement instrument. All measurement instruments are subject to error and uncertainty, particularly those in the social sciences wherein the objective is to measure intangible and theoretical concepts across different contexts and populations.

10. What Should Be Considered in Measuring SDoH / Social Needs?

To give you the information you need to compare and modify SDoH screening tools, we must first explain four key questions to ask when attempting to measure intangible and theoretical concepts, like social needs.

In doing this, we take a critical approach to explore strengths and weaknesses from an upstream, non-medical social risk perspective—as opposed to a downstream, medical social needs perspective.

Before asking the four questions, you must identify a sub-domain within the social needs content domain.

Sub-domains could be unmet transportation needs, financial hardship, unmet housing needs, unmet healthcare needs, or unmet nutrition needs.

Then, think through these four key questions:

1. What concepts make up this sub-domain? In other words, what are key aspects of how people experience the sub-domain.
2. How are those concepts organized into constructs? In other words, how are the distinct aspects of the sub-domain organized into a combination of indicators that can be directly measured?
3. How are those constructs operationalized? In other words, how are each of the unique aspects of the sub-domain measured?
4. Do the measurement instruments created to measure those constructs do so with accuracy and consistency across various contexts and populations?

As an example, see how transportation can be measured through a social risk lens and these four questions.

Also, see our guide for selecting or adapting an SDoH Screening Tool in Step 3 of this Action Pack.

11. Who Will Conduct SDoH Screening?

Healthcare systems, hospitals, and clinics must identify their SDoH screening workflow and staff most suited to complete each step.

Establishing an SDoH screening program will be more successful in places that have adopted a medical home model, known for patient-centered, comprehensive, and coordinated care.

The SDoH screening workflow includes:
1. Administering the SDoH screening tool;
2. Charting the results and communication them to the rest of the care team;
3. Providing the patient with a referral to relevant community resources.

Some practices and health systems embed both their screening tools and their referral resources within their EHR system, such as Children's Health, the largest pediatric health system in North Texas.

Regarding community referrals, check out this guide that explores the unique capabilities of community resource referral platforms and the experiences of healthcare organizations that have used these tools. The guide was developed by the Social Interventions Research & Evaluation Network (SIREN) at the University of San Francisco California to help safety-net healthcare providers make decisions on implementing a community resource referral platform.

While there is no evidence-based gold standard for how screening programs should be conducted or who should conduct the screening, lived experiences from clinics that have

successfully implemented a SDoH screening program can help healthcare facilities make critical decisions in designing their own screening program.

Go here to see how Nemours Children's Hospital and Hope Clinic in Houston chose a screener.

12. How Often Should Patients Be Screened?

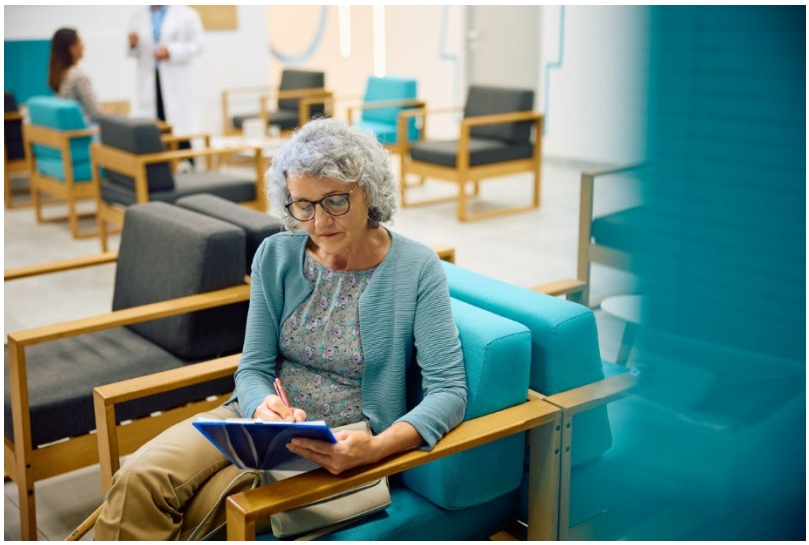
There is not yet national consensus on how often patient's should be screened, ranging from annually to each visit.

Children's Health System of Texas in Dallas, for example, screens patients every six months.

In 2022, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that requires Medicare Advantage Special Needs Plans (SNPs) to include social needs questions in the initial and annual health risk assessment of each SNP beneficiary.

As part of the CMS Inpatient Prospective Payment System (IPPS), hospitals conduct SDoH screening for inpatient stays.

According to the Accountable Health Communities Model, "screening could take place before, during, or after a clinical visit."



In 2024, CMS finalized a new stand-alone code to pay for SDoH assessment not more often than every 6 months.

Thile there is a distinction between SDoH assessment and SDoH screening, with a screening often being conducted on all patients prior to their visit and an assessment being conducted based on the practitioner's diagnosis or treatment of the patient, the same screening tools are used.

13. How Can You Show Compassion and Sensitivity While Screening for Social Needs?

Many healthcare facilities require healthcare staff to complete regular sensitivity trainings on cultural competency, bedside manner, and similar topics.

These trainings can help providers deliver compassionate care for diverse patients.

But, as more healthcare systems go the extra mile to create an SDoH screening program to care for patients' non-medical social needs, staff may need additional resources to guide conversations that are often deeply personal for some patients.

Go here to learn how healthcare staff can build rapport with patients and gain confidence in discussing potentially sensitive topics on social needs, from housing to income.

Go here to see modules on Training Primary Care Residents on SDoH.