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Next Steps in Social Determinants of Health

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ABOUT THE COURSE AUTHOR

Neely Tolbert Sullivan MPT, CLT-LANA, CDT, has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences have allowed her to treat and develop effective client care programs. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that all clients have the opportunity to attain their highest level of function and quality of life. She has most recently been responsible for the identification, implementation and evaluation of clinical programs in long-term care settings.

Neely currently provides educational support to 16,000+ therapists nationwide as the Director of Wellness and Education Specialist for Select Rehabilitation. Neely has lectured nationally and at the state level on a variety of clinical and regulatory topics. She has authored publications focusing on evidence-based practice and clinical care. Neely conducts audits, quality improvement planning, and clinical training to Select Rehabilitation employees and customers monthly. She is a member of the APTA including the Clinical Electrophysiology and Wound Management section and Geriatric section.

POST-TEST

1. Which of the following is a key CMS-recognized domain of Social Determinants of Health (SDOH)?
 - a) Cultural Beliefs
 - b) Economic Stability
 - c) Genetic Predisposition
 - d) Personal Interests

2. What is one key impact of the 2025 MDS updates on residents in long-term care facilities?
 - a) Reduced need for healthcare assessments
 - b) Elimination of demographic screening
 - c) Enhanced identification of unmet social needs
 - d) Decreased focus on care planning
3. Which factor contributed to Mr. Lee's increased health risks in his long-term care facility in the case study?
 - a) High staff turnover and limited bilingual providers
 - b) Availability of personalized meal options
 - c) Strong family and social support
 - d) Frequent access to transportation for medical visits
4. The PRAPARE screening tool is designed to:
 - a) Diagnose chronic diseases
 - b) Assess social risk factors affecting health
 - c) Monitor staff performance in long-term care
 - d) Identify genetic health risks
5. What is a recommended strategy for addressing transportation barriers in long-term care discharge planning?
 - a) Ignoring transportation needs to simplify care planning
 - b) Encouraging family involvement and coordinating non-emergency medical transport
 - c) Requiring residents to arrange their own transportation
 - d) Limiting medical appointments to avoid travel issues

The post-test and corresponding course evaluation can be accessed at:
https://www.surveymonkey.com/r/Next_Steps_SDoH_On_Demand

Or by using the following QR Code:



If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com

If accessibility of learning is required, please contact Kathleen Weissberg at kweissberg@selectrehab.com for appropriate accommodations.

Next Steps in Social Determinants of Health (SDOH)

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Objectives

- Upon completion of this course, learners will be able to:
 - Define SDOH and recognize multiple dimensions of health outcomes related to specific SDOH in the United States.
 - Identify evidence-based CMS metrics and health screening tools for SDOH and strategies for use in the clinical setting.
 - Describe strategies for mitigating the impact of SDOH through program development and appropriate referrals to care partners.



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Reviewing SDOH



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Definition

“Conditions in the environments in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality of life outcomes and risks.”

Social Determinants of Health



Social Determinants of Health
Healthy People 2030

(ODHP, 2021)



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SDOH Factors

- Health behaviors
- Clinical care issues
- Social and economic
- Physical environmental

(Magnan, 2017)



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CMS Primary Domains of SDOH

- Economic Stability
- Education Access and Quality
- Healthcare Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

(CMS, 2023)



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SDOH in MDS Prior to 2025

- Demographic Information (Section A: Identification Information)
- Communication and Sensory Abilities (Section B: Hearing, Speech, and Vision)
- Cognitive Patterns (Section C: Cognitive Function and Decision-Making Capacity)
- Mood and Mental Health (Section D: Mood)
- Social Engagement and Preferences (Section F: Preferences for Customary Routine and Activities)
- Resident Involvement in Care Decisions (Section Q: Participation in Assessment and Goal Setting)

(CMS, 2024)



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Original/Proposed MDS Updates

- The MDS updates from the FY 2025 Final Rule included questions on:
 - Living Situation: Assessment of housing stability and safety.
 - Food Insecurity: Two questions addressing access to sufficient and nutritious food.
 - Utilities: Evaluation of residents' ability to afford and maintain essential utilities.
 - Transportation: Revised items examining access to reliable transportation for medical appointments and daily activities.



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FY 2026 CMS Final Rule SDOH Changes

- Proposed Section R will NOT be added to the 10/1/25 MDS
- CMS removed specific SDOH items:
 - 1 Living Situation
 - 2 Food
 - 1 Utilities
- CMS cites reducing provider burden and data collection duplication as reasons.



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A1255: Transportation

A1255. Transportation

Complete only if A0310B = 01 and A2300 minus A1900 is less than 366 days.

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Enter Code

☐ 1. No

☐ 2. Yes

☐ 3. Resident declines to respond

☐ 4. Resident unable to respond

Transportation item has been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organizations (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.nachc.org.

Complete only if A0310B = 01 and A2300 minus A1900 is less than 366 days.



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MDS Updates Impact on Staff

- Workflow Adjustments
 - Incorporating SDOH assessments may require modifications to existing workflows.
- Enhanced Care Planning
 - Staff can develop more personalized care plans that address both medical and social needs.



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MDS Updates Impact on Residents

- Holistic Care
 - The inclusion of SDOH in assessments acknowledges the importance of social and environmental factors in health.
- Identification of Needs
 - Systematic evaluation of SDOH can help identify unmet needs related to housing, nutrition, utilities, and transportation, facilitating timely interventions.
- Improved Outcomes
 - Addressing SDOH has the potential to reduce health disparities and promote equity among residents.



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Case Study: Meet Mr. James Lee

Age: 85
Ethnicity: Asian-American
Primary Language: Mandarin
Health Conditions: Type 2 diabetes, hypertension, mild cognitive impairment
Length of Stay in LTC: 2 years
Facility Type: Urban



Photo by Chevanon Photography from Pexels:
<https://www.pexels.com/photo/old-man-smiling-2421934/>

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Case Study: SDOH Challenges

- **Access & Communication:** Limited bilingual staff → difficulty expressing needs
- **Chronic Disease Management:** Uncontrolled diabetes, higher complications
- **Economic Stability:** Medicaid-funded facility with fewer resources
- **Nutrition:** Meals don't align with cultural preferences → requests inconsistently accommodated
- **Social Context:** Severe isolation, limited activity participation, distant family
- **Health Literacy:** Few translated materials → reduced self-management



Photo by fotovegraf from Pexels:
<https://www.pexels.com/photo/back-view-of-elderly-man-standing-near-railing-26892366/>



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Case Study: Outcomes



- Increased hospitalizations due to mismanaged diabetes, worsening mental health due to social isolation, and lack of personalized care.

Photo by Vlad Chetjan from Pexels:
<https://www.pexels.com/photo/monochrome-photo-of-an-old-man-2586537/>



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CMS Metrics and Health Screening Tools



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Screening

- SDOH are part of our clients' stories and holistic care means we know the whole story.
- Data related to SDOH improve predictive models and provide more thorough understanding of a client's life situation.

(Cantor & Thorpe, 2018)



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Screening Tools

- A key first element to addressing SDOH is high quality screening.
- For the screening to be more relationship driven, and less data-driven, the practitioner may need to develop skills to navigate sensitive questions.



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CMS Metrics and Screening Tools

- **Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool**
 - This tool assesses five core domains: housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety.
 - It aids providers in identifying unmet social needs that may impact health outcomes

(CMS, n.d.)



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SAMPLE AHC HRSN Screening Tool Core Questions

- **Living Situation**
 - What is your living situation today?
 - I have a steady place to live
 - I have a place to live today, but I am worried about losing it in the future
 - I do not have a steady place to live (I am temporarily 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)
 - Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY
 - Pests such as bugs, ants, or mice
 - Mold
 - Lead paint or pipes
 - Lack of heat
 - Oven or stove not working
 - Smoke detectors missing or not working
 - Water leaks
 - None of the above

(US, 2017)



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SDOH-1 and SDOH-2 Measures

- CMS introduced these process measures to standardize SDOH data collection (CMS, 2024).
 - **SDOH-1:** Screens for social drivers of health.
 - **SDOH-2:** Reports the screen-positive rate for social drivers of health.



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Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

- National standardized patient risk assessment tool designed to engage patients in evaluating and addressing social drivers of health.
- Featuring 21 SDOH domains
- Scores range from 0 to 22, with 0 indicating no reported risks and 22 indicating all measured risks.
- Translated into over 25 languages



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Key Domains of PRAPARE

- **Demographics:** Race, ethnicity, language, veteran status
- **Social and Economic Factors:** Education, employment, financial strain
- **Housing and Living Conditions:** Homelessness, housing instability
- **Food Security:** Access to adequate nutrition
- **Transportation Needs:** Availability of reliable transportation for medical visits
- **Social Support and Safety:** Personal safety, social isolation, stress levels



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Sample PRAPARE Questions

- **Housing and Living Conditions**
 - What is your current living situation?
 - Are you worried about losing your housing?
 - Does your living environment have any issues such as mold, pests, or lack of heating/cooling?
- **Food Security**
 - In the last 12 months, have you ever run out of food and didn't have money to buy more?
 - Do you worry about having enough food to eat?

(Gold et al., 2018)



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Health Begins Upstream Risks Screening Tool

- Designed to assess and address social determinants of health (SDOH) by identifying upstream factors that influence health outcomes.
- Tool helps healthcare providers screen for social risks such as housing instability, food insecurity, transportation barriers, and financial strain.
- Integrating this screening tool into LTC settings, nursing and staff can better support residents' holistic well-being and connect them with necessary resources.



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Key Components

- **Financial Strain**
 - Does the resident have difficulty affording basic needs like medications, healthcare, or utilities?
 - Are they enrolled in financial assistance programs such as Medicaid or Supplemental Security Income (SSI)?
- **Social Support and Isolation**
 - Does the resident frequently feel lonely or disconnected from family and friends?
 - Do they have access to community programs that encourage social engagement?
- **Access to Healthcare and Medications**
 - Has the resident missed medications or medical treatments due to cost or availability?
 - Do they need assistance managing their healthcare appointments or prescriptions?



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Screening Tools

- Validated Options:
 - AHC HRSN Tool
 - PRAPARE
 - Health Begins Upstream
 - EveryONE Project Short Form
 - Well Rx Questionnaire
- *Note: Some tools ask about race/ethnicity—use per CMS/state guidance*



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Barriers to Screening

- Screening for health-related social needs is not routine
- Data are frequently not collected in a standardized and interoperable format



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Barriers to Screening

- More than 2/3 of providers do not screen for social risk factors
- Barriers include:
 - Staff discomfort/uncertainty in asking sensitive questions
 - Lack of confidence in addressing needs
 - Lack of time and resources
 - Unavailability of standardized screening tools
 - Integrating into workflow
 - Language and health literacy

(Berry et al., 2020)



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Best Practices for Screening and Referral

- Even if they could not address every social determinant of health need, this data could help identify unmet community needs, thus supporting advocacy
- Although possibly burdensome, patients received more holistic care, lessening workloads, and improving care quality
- Resource lists need to be developed and maintained



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Best Practices for Screening and Referral

- Identify community-based resources available to help clinicians connect patients to needed resources at the point of care
- Some patients may refuse follow up care and referrals – this does not mean we don't screen
- Staff need to be aware of implicit bias in circumstances where screening was not completed based on appearance

(Hsu et al., 2019; Wallace et al., 2020)



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Implications for Practice

- Who screens?
- How to respond to a positive screen?
- Who is responsible for referrals?
- How do you document to close the loop?
- How to track data?
- Customize tools to local needs
- Integrate community resource information



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Strategies for Implementing SDOH Screenings

- Develop standardized screening protocols
- Train staff on SDOH measures
- Create referral pathways
- Monitor and evaluate interventions



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Impact on Staff and Residents

- Enhanced Resident Care
- Empowered Staff
- Operational Efficiency



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Mitigating the Impact of Social Determinants of Health in Long-Term Care Facilities



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Influencing Social Determinants

- Take action at the patient, practice and community levels
- Failure to identify hidden social challenges can lead to “misdiagnosis and a path of inappropriate investigations” or inappropriate care plans



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Strategies for Program Development

- Implementing Comprehensive SDOH Screening Programs
 - Routine Assessments
 - Data-Driven Decision Making
 - Collaboration with Care Teams

(Billieux et al., 2019)



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Strategies for Program Development

- Social Engagement & Mental Well-Being Programs
 - Resident Councils & Peer Support Groups
 - Intergenerational Programs
 - Technology-Assisted Socialization

(Billieux et al., 2019)



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Strategies for Program Development

- Food Insecurity
 - Meal Customization & Dietary Preferences
 - Partnerships with Local Food Assistance Programs
 - Nutrition Education & Cooking Classes

(Billieux et al., 2019)



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Strategies for Program Development

- Transportation Assistance & Mobility Support Programs
 - On-Demand Medical Transportation Partnerships
 - Facility-Based Shuttle Services
 - Physical and Occupational Therapy & Fall Prevention Programs

(Billieux et al., 2019)



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Strategies for Program Development

- Healthcare & Specialty Care Coordination Programs
 - Designated Case Managers & Care Coordinators
 - Telemedicine & Remote Monitoring Services
 - Specialized Dementia & Behavioral Health Programs

(Billieux et al., 2019)



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Appropriate Referrals to Care Partners

- Ensuring residents receive comprehensive care requires effective referrals to care partners.
- Referrals help bridge gaps in care, ensuring that residents receive necessary interventions beyond what the LTC facility can provide.
- Requires a strong network of care partners to address residents' complex needs.

(Billieux et al., 2019)



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Key Aspects of Appropriate Referrals

- Identifying Resident Needs
- Building a Strong Network of Care Partners
- Coordinating Behavioral and Mental Health Support
- Enhancing Access to Community-Based Resources.
- Ensuring Follow-Up and Monitoring

(Billieux et al., 2019)



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Appropriate Referrals to Care Partners

- **Healthcare and Social Services Coordination**
 - Developing partnerships ensures comprehensive care for residents.
 - Engaging social workers can alleviate financial and social stressors.
- **Behavioral Health Support**
 - Collaborating with mental health professionals and telehealth counseling services allows residents to receive therapy.
 - Providing caregiver support programs educates staff and family members.

(Billieux et al., 2019)



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Appropriate Referrals to Care Partners

- **Community-Based Partnerships**
 - Partnering with organizations can create additional layers of support.
 - Coordinating with community health workers ensures residents remain connected to resources.

(Billieux et al., 2019)



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Why do Appropriate Referrals Matter?

- Improving Resident Outcomes
- Reducing Hospitalizations & Emergency Room Visits
- Enhancing Resident & Family Satisfaction
- Strengthening Community Collaboration

(Billieux et al., 2019)



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Discharge (DC) Planning

- Effective discharge planning is essential in LTC facilities to ensure that residents transition from facility-based care to home or other supportive settings.
- SDOH can negatively impact health outcomes if not adequately addressed before discharge.
- A comprehensive discharge plan can reduce hospital readmissions, improve quality of life, and promote long-term wellness (Silverstein et al., 2020).



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DC Planning- Conduct Comprehensive SDOH Assessments

- Screen residents for SDOH-related barriers that may affect their health outside the facility.
- By addressing these factors, staff can develop personalized strategies to support residents post-discharge (Billieux et al., 2019).



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DC Planning- Coordinate Housing and Supportive Living Arrangements

- Assess home safety
- Coordinate with social workers
- Collaborate with community organizations



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DC Planning- Ensure Access to Medical Care and Medications

- Scheduling follow-up appointments
- Providing a clear medication plan
- Referring residents to telehealth services
- Ensuring insurance coverage



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DC Planning- Establish Nutrition and Food Assistance Plans

- Connect residents with local food programs
- Provide meal planning guidance
- Enroll residents in food programs



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DC Planning- Address Transportation Barriers

- Identify reliable transportation options
- Coordinate non-emergency medical transportation (NEMT)
- Encourage family involvement



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DC Planning- Strengthen Family and Caregiver Support

- Providing education and training
- Offering respite care options
- Referring families to caregiver support groups



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DC Planning- Implement Post-DC Follow-Up and Monitoring

- Schedule follow-up calls or home visits
- Monitor health status and address concerns
- Adjust the care plan as needed



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Case Study: Meet Mrs. Garcia

- **Name:** Mrs. Rosalyn Garcia
- **Age:** 82
- **Background:** Latina, retired seamstress, low-income background
- **Condition:** Type 2 diabetes, hypertension, early-stage dementia
- **Residence:** Long-term care facility in an urban setting



(Photo credit: istock, [adamkaz](#))



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Case Study: Challenges

- **Finances:** Limited resources for specialized care, transport, personal needs
- **Preventive Care:** Poorly managed conditions before admission → hospitalizations
- **Family & Social Engagement:** Fewer visits, lack of structured programs
- **Nutrition:** Meals don't meet cultural or diabetic needs → poor outcomes
- **Staffing:** Limited activity opportunities → reduced stimulation
- **Cultural Competency:** Few bilingual/competent providers → gaps in care
- **Mental Health:** Anxiety, depression not consistently addressed



(Photo credit: istock, [adamkaz](#))



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Case Study: Intervention Strategies

- **Culturally Appropriate Nutrition Programs:** Collaborate with local organizations to provide meals that meet both dietary and cultural preferences.
- **Enhanced Chronic Disease Management:** Partner with healthcare providers to develop a care plan.
- **Staff Training in Cultural Competency:** Implement regular training programs to educate staff on addressing the unique health challenges and social needs of minority residents.
- **Increased Social Engagement Opportunities:** Establish structured social programs, culturally relevant activities, and virtual family visits.



(Photo credit: istock, [manassanant pamai](#))



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Case Study: Intervention Strategies

- **Mental Health Support Expansion:** Introduce on-site counseling services and mental health professionals.
- **Technology Integration for Healthcare Access:** Provide digital literacy programs and telehealth services.
- **Community-Based Support Networks:** Develop partnerships with community organizations, religious institutions, and volunteers to provide additional companionship and support.



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Case Study: Outcome

- **Improved Health Management:** Mrs. Garcia's diabetes and hypertension became more controlled.
- **Enhanced Social Well-Being:** Increased participation in culturally relevant activities and peer support programs improved emotional resilience.
- **Greater Family Engagement:** Virtual visitations and facilitated in-person family meetings strengthened connections with loved ones.



(Photo credit: istock, [adamkaz](#))



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Case Study: Outcome

- **Better Access to Healthcare:** Telehealth services and staff training resulted in better communication.
- **Improved Mental Health:** Access to mental health professionals significantly reduced symptoms.
- **Higher Resident Satisfaction:** Personalized care approaches led to increased trust in the facility.



(Photo credit: istock, [adamkaz](#))



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Wrap-Up

- **Educate** staff on SDOH's impact on outcomes
- **Screen routinely** with validated or adapted tools
- **Identify supports** within your community for residents
- **Integrate findings** into care planning and discharge planning



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Thank You!

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