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Social Determinants of Health in Care Planning: Asking the Right Questions

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View the entire course including any applicable handouts/resources. Complete a post-test assessment. You must score 80% or better on the post-test and complete the course evaluation to earn a certificate of completion for this activity. If required, Select Rehabilitation will report attendance to CE Broker.

ABOUT THE COURSE AUTHOR

Dr. Kathleen Weissberg, (MS in OT, 1993; Doctoral 2014) in her 30 years of practice, has worked in rehabilitation and long-term care as an executive, researcher and educator. She has established numerous programs in nursing facilities; authored peer-reviewed publications on topics such as low vision, dementia quality care, and wellness; has spoken at numerous conferences both nationally and internationally, for 20+ State Health Care Associations, and for 25+ state LeadingAge affiliates. She provides continuing education support to over 30,000 therapists, nurses, and administrators nationwide as National Director of Education for Select Rehabilitation. She is a Certified Dementia Care Practitioner, Certified Montessori Dementia Care Practitioner, Certified Fall Prevention Specialist, and a Certified Geriatric Care Practitioner. She serves as the Region 1 Director for the American Occupational Therapy Association Political Action Committee and is an adjunct professor at Gannon University in Erie, PA.

POST-TEST

1. According to CMS, which of these is not a primary domain of Social Determinant of Health?
 - a) Housing instability
 - b) Substance use
 - c) Food insecurity
 - d) Transportation difficulties

2. Disparities disproportionately impact which of the following?
 - a) Persons with disabilities and the elderly
 - b) Persons in rural areas and with justice concerns
 - c) Those living in persistent poverty
 - d) All of the above
3. Which of the following would be an appropriate screening question related to food insecurity?
 - a) Do you have enough food?
 - b) Have you worried whether your food would run out before you got money to buy more?
 - c) Are there days that you go hungry?
 - d) Is there a grocery store that you can walk to?
4. Which of the following statements is true related to transportation security?
 - a) Transportation is the main reason people do not obtain medical care
 - b) Transportation may be unaffordable to vulnerable populations
 - c) Almost 1/3 of people with chronic conditions reported they did not have enough resources for transportation
 - d) All of the above
5. Barriers to screening include which of the following?
 - a) Lack of confidence in addressing needs
 - b) Lack of time and resources
 - c) Language and health literacy
 - d) All of the above

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

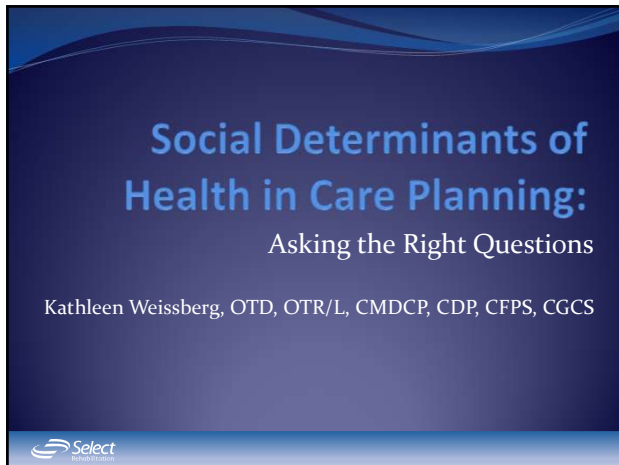
Or by using the following QR Code:



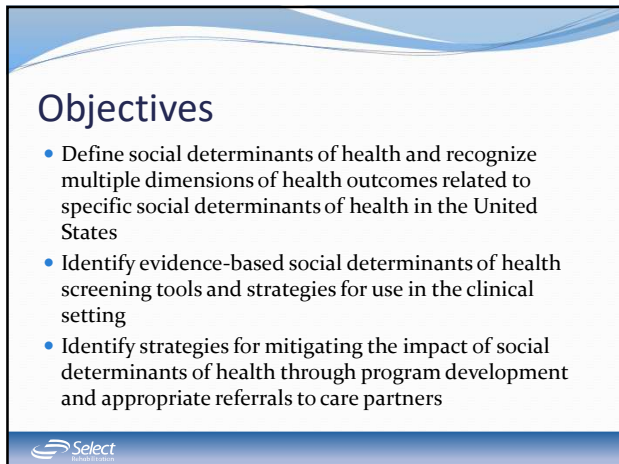
If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

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

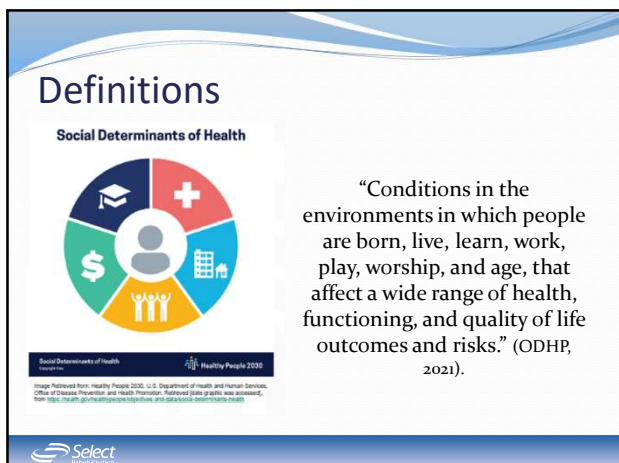
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Domains of SDOH

- Economic stability
- Education access and quality including health literacy
- Healthcare access and quality
- Neighborhood and built environment
- Social and community context




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CMS Primary Domains of SDOH

- Housing instability
- Food insecurity
- Transportation difficulties
- Utility assistance needs
- Interpersonal safety concerns

(CMS, 2016)



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Social Needs vs. Determinants

- Social needs are experienced at the individual level
 - Social needs may exacerbate current health conditions
- Social determinants exist at the community or population level
 - Reflect policies and environments that support or create barriers to health
 - Things essential to health are more or less accessible due to availability, cost, quality, or pre-existing policies

(Hacker & Houry, 2022)



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Disparities

- Life expectancy, chronic & infectious disease influenced by SDoH
- Access to health care alone is not sufficient
- Disparities disproportionately impact:
 - Blacks, Latinos, members of tribal nations, Asian Americans and Pacific Islanders and other persons of color;
 - Members of religious minorities;
 - LGBTQ;
 - Persons with disabilities and older persons
 - Persons in rural areas and with justice concerns;
 - Women and girls;
 - Persistent poverty



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Health Related Social Need

- A specific need that impacts individuals directly is often referred to as a health-related social need or HRSN
- These include income instability, housing instability, and household food insecurity
- While social determinants of health and health related social needs often coincide and overlap, the relationship between them can be complex



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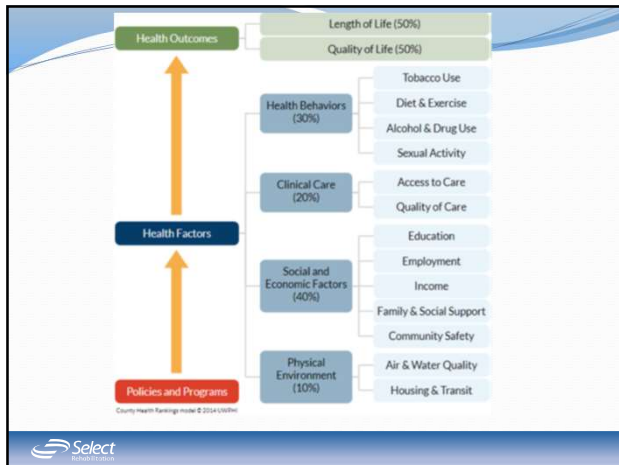
SDoH Factors

- Health behaviors (such as tobacco, diet and exercise, alcohol and drug use, and sexual activity)
- Clinical care issues (access to care and quality of care)
- Social and economic factors (education, employment, income, family and social support, and community safety)
- Physical environmental factors (air and water quality and housing and transportation)

(Magnan, 2017)



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Five Major Domains

- Economic stability
 - Reflects on the connection between a person's financial resources and their health
- Education access and quality
 - Reflects on the connection between a person's education and their health or well-being
- Health care access and quality
 - Reflects on the connection between a person's access to and understanding of health services and their health

Select Health Solutions

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Five Major Domains

- Neighborhood and the built environment
 - Reflects on the connection between where a person lives and their health or well-being
- Social and community context
 - Reflects on the connection between a person's social environment and their health or well-being

Select Health Solutions

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Social and Economic Factors

- Impact 40% of health outcomes
- Screening in this area is to identify and acknowledge the need, make possible referrals, and most importantly, initiate the patients plan of care with these needs in mind

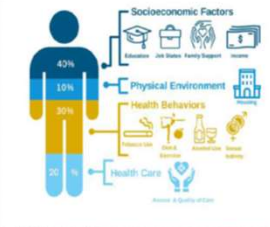


Image retrieved from: <https://www.ahrq.gov/patient-safety/care-coordination/social-determinants-health/>

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Education

Better health outcomes and life expectancy are associated with people who have higher levels of education.

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Employment/Income

- Nearly one in 10 people live in poverty in the United States
- Poverty affects risk factors for disease and ability and opportunity for disease prevention and management
- Screening questions seek to answer the level of financial strain on the patient's ability to pay for basic needs

(Sherrell, 2021; Semega et al., 2018)

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Employment/Income

Unintentional shame may be placed by the care team on the patient with low income when behaviors such as missed or late to appointments and lack of medical treatment adherence are perceived as “noncompliance”

(AAFP, 2021).



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Social Support

- Social support system factors heavily into discharge planning
- Screening questions may ask how often they talk on the phone or get together with family, friends, or neighbors; attendance at activities; marital status (although this does not remove risk)
- Loneliness is a predictor of functional decline and death

(Wallace et al., 2017; Flowers et al., 2017)



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Community Safety

- Effects of violence impact incidence of cardiovascular disease, premature mortality, depression, anxiety, PTSD, suicide May be less likely to engage in physical activity
- Perception of unsafe environment may lead to higher levels of obesity and BMI
- Questions related to community safety include visibility of law enforcement, gang activity, drug traffic, gun violence, public fighting

(Rivera et al., 2019; Meyer et al., 2014; Brown et al., 2014)



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Health Behaviors

The infographic depicts a human figure divided into four colored sections representing different determinants of health. From top to bottom, the sections are: Socioeconomic Factors (blue, 40%), Physical Environment (light blue, 10%), Health Behaviors (yellow, 30%), and Health Care (light green, 20%). Each section is accompanied by icons representing its domain: Socioeconomic Factors includes education, income, and housing; Physical Environment includes air quality, safety, and community; Health Behaviors includes diet, exercise, and stress; Health Care includes medical services and insurance.

- Health behaviors account for 30% of the factors that contribute to health outcomes
- County health rankings model does not include intimate partner violence, depression, or stress as factors of health

Image retrieved from: <https://www.cdc.gov/healthcommunication/materials/publications/2016/04/20160401-determinants-health.html>

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Tobacco Use

- Smoking is the most common cause of preventable disease, disability, and death
- Risk factors are influenced by social environments more often encountered in the landscape of poverty
- Screening questions aim to answer start date, quit date, packs per day, years smoked, and readiness to quit

(Rigotti, 2021; CDC, 2020; Diaz, 2019)

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Food Insecurity

- Nutrition security is defined as consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being
- Food security is when all people, always, have access to enough food to have an active and healthy life


(Coleman-Jensen et al., 2020).

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Food Insecurity

- 33.8 million Americans live in food insecure households
- Food insecurity associated with 15% increased risk of having a chronic illness
- 2X odds of having mental health issues
- 58% increased risk of death from any cause




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Food Insecurity

- Five characteristics associated with food insecurity: education, social networks, social capital, income, and employment
- Screening:
 - Within the past 12 months, we worried whether our food would run out before we got money to buy more and
 - Within the past 12 months, the food we bought just didn't last and we didn't have money to get more

(Hager et al., 2010; Cafiero et al., 2018)




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Food Insecurity

- Increased likelihood of chronic disease
- Greatest risk among single mother households, African Americans, and Hispanics
- Environmental and social factors impacting food security:
 - Geographic proximity to stores
 - Financial constraints
 - Inadequate transportation

(Gregory & Coleman-Jensen, 2017; Heflin et al., 2019; Decker & Flynn, 2018)



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Food Insecurity Among Elderly

- Food insecurity among families with older adults increased from 12.5% in 1999-2003 up to 23.1% in 2015-2019
- Recurring food insecurity increased from 5.6% to 12.6%; chronic insecurity increased from 2% to 6.3%
- Those with low education recurring food insecurity increase from 7.9% to 18.3%, and chronic food insecurity increase from 2.7% to 8.8%
- Low-income families recurring food insecurity increased from 17.4% to 34.5%, and chronic food insecurity went from 7.7% up to 18.8%
- Deaths from malnutrition increased from 2013 to 2020



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Food Insecurity

- Government initiatives to increase access to healthy foods have been associated with lower health care costs and reduced hospitalization and ED visits
- Home delivery meal programs are effective in meeting goals of food security, nutritional intake, and socialization
 - However, they found that these meal programs do not reach everyone who is eligible or who needs services
- Theory-based nutrition education can help with nutritional intake in older adults
- Costs of medication and utilities can be a barrier to purchasing nutritious food
- Home delivery meals can reduce falls, reduce hospitalizations and ED visits, improve QOL, and decrease social isolation.



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Physical Activity

- Incorporating regular physical activity can improve health
 - Decrease risk of mortality, heart disease, HTN, etc.
- Screening questions include days and minutes per week involved in strenuous exercise

(Healthy People 2030, 2021; Piercy et al., 2018; Coleman, 2012)




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Alcohol/Drugs/Substance Abuse

- Screening has the individual answer a single question of alcohol use, with expansion into daily and weekly limit to screen for excess
- Positive screen should use the AUDIT Tool

(CDC, 2014)




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Sexual Activity

- Sexual risk behaviors can result in unintended health consequences such as HIV infection, sexually transmitted infections
- Sexual health is influenced by health care access, health literacy, insurance level, income, cultural and social norms, sexual behavior, education, sex, gender identity, and sexual orientation

(Stumbar et al., 2018; CDC, 2021)




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Intimate Partner Violence

- IPV affects 1 in 4 women and 1 in 10 men
- Survivors experience depression, PTSD, possibility of unhealthy behaviors like drinking, smoking
- Screening questions allow the individual to answer yes, no, or refuse and ask whether they have experienced humiliation or fear from their partner and abuse in the three areas (emotional, physical and sexual)

(Sohal et al., 2007; CDC, 2020)



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Interpersonal Safety Concerns

- Themes: abuse and neglect of older adults AND safety of caregivers
- Most cases due to self-neglect or abuse by adult children
- Abuse of elders occurs most times when spouse is caregiver and care needs are high
- Abuser more likely to be a female child who is the primary caregiver and financially dependent on the victim
- Caregiver education and services have been found to positively influence outcomes



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Depression

- Disability, morbidity, and mortality are significantly impacted by major depression
- PHQ-2 useful tool because of its brevity and ease of use
 1. Interest or pleasure in doing things
 2. Feeling down, depressed, or hopeless



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Stress

- Patient's self-report on their feelings then thoughts on if and how often they feel worried, tense, nervous, and anxious, or if they are having difficulty sleeping because their mind is distressed
- Chronic stress affects an individual's well-being, physically and mentally, leading to muscle pain, insomnia, anxiety, high blood pressure, weakened immune system, cognitive function, behavioral health

(McEwen, 2017; Franke, 2014)



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Stress

- Screening tools include Generalized Anxiety Disorder or the PHQ-2
- “Over the last several months, have you been continually worried or anxious about a number of events or activities in your daily life?”

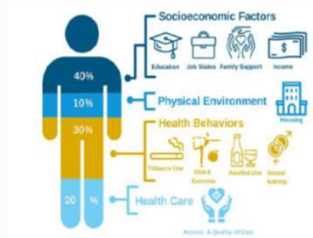
(Biegler et al., 2016)



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Clinical Care

Clinical care factors account for 20% of the factors that contribute to our health outcomes.



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Access to Care

- Approximately 1 in 10 people do not have insurance
- Access to preventative care is less likely for people experiencing SDOH
- Screening questions: do they have a primary care provider, insurance, or a medical card
- Having insurance increases access to care and improves health outcomes. Yet, access to care is different depending on where you live.

(Berchick et al., 2018; Heath, 2020; Sommers et al., 2017; Kirby & Yabroff, 2019)



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Quality of Care

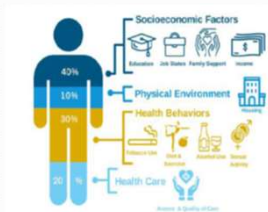
- Essential services to promote health equity: primary care, mental health and substance use care, emergent care, prenatal care, transportation, diagnostic services, home health, dental care, and a community referral structure

(Bhatt & Bathija, 2018; AHA, 2016).



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Physical Environment



The physical environment contributes to 10% of health outcomes.



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Transportation Insecurity

- Transportation is the main reason 3.6 million people do not obtain medical care in the United States each year
- Transportation may be unaffordable to vulnerable populations
- Almost 1/3 of people with chronic conditions reported they did not have enough resources for transportation
 - Lack of accessible transportation, awareness and limited information on available services, scheduling complications, high costs of transportation, limited availability of transportation for non-medical purposes, and lack of funding


(AHA, 2017; Wolfe et al., 2020)



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Transportation Insecurity


- Telehealth systems were identified as a way to overcome barriers to transportation
- Although use of technology may be a solution to overcoming transportation barriers, lower rates of internet use among adults may be a barrier
 - Low use due to lack of financial resources, lack of exposure to technology, or issues related to accessibility



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Transportation Insecurity

Screening questions address if the lack of transportation has kept the patient from missing appointments or from getting needed medications and if it has kept them from work, meetings, or school or from getting things necessary for daily living




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Housing

- Housing stability, quality, safety, and affordability are the four pathways connecting housing and health outcomes
- Over 8.53 million households were either living in severely inadequate rental conditions, paying more than 1/2 of their income toward rent, or both
- Inadequate housing can increase the risk of exposure to unsanitary conditions

(Taylor, 2018; Artiga & Hinton, 2018)



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Housing

- Housing stability has many facets, which include homelessness, unsafe housing, weatherization, housing quality, rent and mortgage affordability, and utilities
- Over 500K people experience homelessness
- Providing stable housing and case management to chronically ill, homeless adults reduced hospitalizations by 29%
- Screening questions should address if the patient has a steady place to sleep, use of shelters, the ability to pay rent or mortgage and utilities in a timely manner, or any concern of losing housing



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Housing

- Evaluating neighborhoods for rates of violence and injuries, unsafe air or water, poor or no lighting, sporadic garbage pickup, and other health and safety risks is needed to assess and address these social determinants of health
- Access to stable housing can reduce health care cost and improve health

(Taylor, 2018)



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Air and Water Quality


- Air pollution has a variety of health effects and is associated with cellular inflammation and oxidative stress
- Although most Americans likely take water quality for granted, there are vulnerable communities experiencing inadequate infrastructure providing clean water and sanitation
- Asking if the air and water are safe should be considered

(Manisalidis et al., 2020; NIH, 2021; Roller et al., 2019)




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How Can You Make a Difference?



System

- Advocacy
- Collaboration



Person

- Screening
- Intervention
- Interprofessional Collaboration

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Screening

- Social determinants of health are part of our patients' stories and holistic care means we know the whole patient story.
- Data related to social determinants of health improve predictive models and provide more thorough understanding of a patient's life situation

(Cantor & Thorpe, 2018)

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Screening Tools

- A key first element to addressing social determinants of health 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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MDS SDOH Elements

- Ethnicity
- Race
- Transportation
- Health literacy
- Preferred language
- Isolation

How are you currently using this information to drive the discharge planning and care planning process?



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Screening Tools

Core 5 screening tool

1. Do you or your family worry about whether your food will run out and you won't be able to get more?
2. Are you worried about losing your housing, or are you homeless?
3. Are you currently having issues at home with your utilities such as your heat, electric, natural gas, or water?
4. Has a lack of transportation kept you from attending medical appointments, from work, or from getting things you need for daily living?
5. Are you worried that someone may hurt you or your family?



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Screening Tools

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PREPARE)
- The EveryONE Project – Short form
- Health Begins
- Health-related Social Needs Screening Tools
- SINCERE
- Well Rx Questionnaire
- OCHIN



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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:
 - Lack of comfort in asking patients about social needs
 - 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)



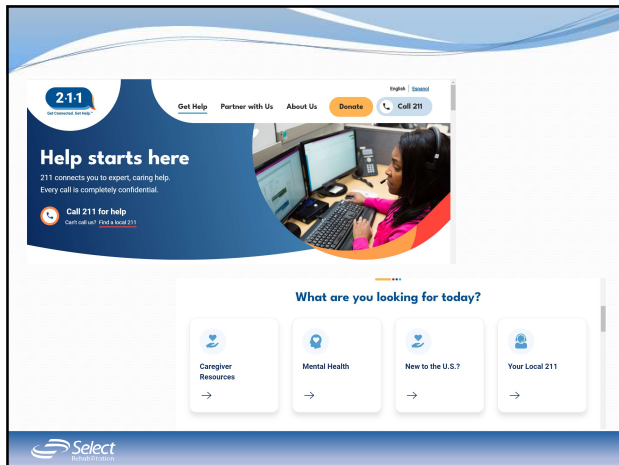
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Best Practices for Screening and Referral

- 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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Best Practices for Screening and Referral

- Screening tools appropriate in terms of literacy, culture and language
- Integrate screening into existing workflows
- Universal screening
- Referral base for internal and community resources
- Technology integration into HER
- Data tracking system for referral and receipt of services
- Optimal staffing for referral program sustainability

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Best Practices for Screening and Referral

- When adopting screening, assess duration of status to better inform services
- Ensure some type of scoring or interpretation
- Screening should be applied universally in clinical settings



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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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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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The “Patient” Level

- Asking patients about social challenges in a sensitive and caring way
- Referring patients and helping them access benefits and support services
- Advocate for individual patients and help patients to access benefits or programs to which patients are entitled



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The “Practice” Level

- Improving access and quality of care for hard-to-reach patient groups
- Patient experience surveys may provide useful input toward redesigning practices to be more accessible and responsive to patient needs
- Integrating patient social support navigators into the primary care team



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The “Community” Level

- Partnerships with community groups, public health and local leaders
- Using clinical experience and research evidence to advocate for social change
- Community engagement, empowerment and changing social norms




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Health Literacy

- Health literacy and social determinants of health are closely intertwined
- This connection is even more pronounced in rural and underserved urban areas where low health literacy prevalent


(AHRQ, 2020).



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Health Literacy


- Only 12% of adults in the United states have proficiency or a high degree of competency in health literacy
- Approximately 9 out of 10 Americans lack the knowledge to navigate health systems
- Low health literacy is one of the inequities that individuals face on a daily basis that leads to unequal health care opportunities and poor health outcomes



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Health Literacy

- Rural residents have a lower health literacy proficiency level compared to those in urban areas 7.7% versus 12.7%
- Rural residents have 33% higher odds of low health literacy
- Most health information is disseminated digitally or virtually, and individuals without Internet services, such as those living in rural areas, may not be able to access this information.
- Unfortunately, 80% of older adults have a combination of 1 chronic condition and low health literacy levels, increasing their risk for poor health outcomes



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Health Literacy

- Assess the availability of resources for all patients as part of the initial screening phase
- Offer resources that will address disparities and inequities
- Create health education at low literacy levels and train clinicians about the evidence-based practice of teach back and show back



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Takeaways

- Home delivery meal programs, especially those that deliver daily meals to older adults, provide substantial benefits in several domains and are opportunities for delivering bundled services
- Telehealth shows promise for delivering interventions remotely and is relatively well accepted by older adults
- Formalized training may better prepare caregivers and positively affect mood
- Look at economic resources that are available



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White House Playbook on SDOH

- Supporting flexible funding
- Increase payment for assessing and addressing social determinants of health
- Reduce barriers to using grants to address health related social needs
- Support expanded Nutrition Assistance



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Congressional Action

- Support Medicare coverage of screening for social determinants of health and linkage to social supports
- Support Medicare coverage for evidence-based support services delivered by a community health worker, including screening for social determinants of health and linkage to social supports



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Bottom Line

- We need to be educated regarding SDOH and their effect on health and health outcomes.
- We need to screen. Pick a tool, develop your own. Make it a routine with every patient, every time.
- We need to look within our own communities to determine what, if any, supports are available for our patients



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Social determinants of health are part of our patients' stories. Our patients want us to know their story, and WE are uniquely qualified to assess and intervene in support of our clients meeting their needs.



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