**Background & Significance**

- Social determinants of health (SDOH) are the places and conditions in which people are born, live, learn, work, and play, affecting a wide range of health risks and health outcomes (WHO, 2008).
- Striking differences in health status are evident in poorer communities; poorest of the poor demonstrate higher levels of illness and mortality.
- Direct impact of SDOH on health outcomes:
  - Blood Glucose
    - Those who are continuously insured tend to have lower baseline HgbA1C (Li et al, 2016)
    - Glycemic control demonstrated to have an inverse relationship with education and social support (Walker, Smalls, & Egge, 2015)
    - Glycemic control demonstrated to have a positive correlation with employment status and neighborhood (Li et al, 2016)
  - Blood Pressure
    - Strong positive association between hypertension and poverty (Kolat et al 2019)
  - Interventions aimed at SDOH in combination with better BP control (McClincht & Bogner, 2017)

Despite growing emphasis of the impact of social determinants on health and health outcomes, currently, there is no routine approach to the assessment and management of SDOH.

**Aims & Objectives**

- To address SDOH and improve screening in the primary care setting
- To assess current SDOH screening, if any
- To develop a toolkit to help providers in ambulatory care integrate best evidence for screening SDOH into routine practices
- To create a guide for available community resources.

**Methodology**

- **Design** Quality improvement project
- **Theoretical Framework** Plan-Do-Study-Act cycles
- **Sample** Convenience sample -- 10 providers (8 MD/DOs, 2 nurse practitioners) employed in ambulatory care services
- **Setting** An integrated health system providing services to military veterans in NJ
- **Intervention** De novo survey (12 question, Likert style) administered over 4-week period with gap analysis comparing current practice with evidence to create practice recommendations and develop SDOH toolkit

**Clinical Question**

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**Are there differences between evidence-based and current practice of screening for SDOH in a primary care setting?**

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**Results**

**Frequency of Screening**

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>Housing (N, %)</th>
<th>Employment (N, %)</th>
<th>Food Insecurity (N, %)</th>
<th>Social Support (N, %)</th>
<th>Exposure to Crime and Violence (N, %)</th>
<th>Transportation (N, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never ask</td>
<td>0, 0%</td>
<td>1, 10%</td>
<td>0, 0%</td>
<td>1, 10%</td>
<td>1, 10%</td>
<td>1, 10%</td>
</tr>
<tr>
<td>I ask only new patients at an initial visit</td>
<td>1, 10%</td>
<td>1, 10%</td>
<td>0, 0%</td>
<td>1, 10%</td>
<td>1, 10%</td>
<td>0, 0%</td>
</tr>
<tr>
<td>I ask all patients once a year (at a health maintenance visit)</td>
<td>1, 10%</td>
<td>2, 20%</td>
<td>2, 20%</td>
<td>2, 20%</td>
<td>3, 30%</td>
<td>2, 20%</td>
</tr>
<tr>
<td>I ask all patients once a year (at a health maintenance visit) and periodically as needed.</td>
<td>5, 50%</td>
<td>5, 50%</td>
<td>6, 60%</td>
<td>5, 50%</td>
<td>1, 10%</td>
<td>3, 30%</td>
</tr>
<tr>
<td>I ask only patients at risk or as needed basis.</td>
<td>3, 30%</td>
<td>1, 10%</td>
<td>2, 20%</td>
<td>2, 20%</td>
<td>4, 40%</td>
<td>4, 40%</td>
</tr>
</tbody>
</table>

**SDOH Toolkit**

- **What are we doing?** Social Determinants of Health Screening Implementation
  - **How?** Select a standardized Social Determinants of Health Screening tool (e.g., PRAPARE tool, ECHO/ONE Project screening tool)
  - **Who?** Will administer the screening tool?
    - Non-clinical staff
    - Medical assistant
    - Nurse
    - Provider
  - **Where?** Where will be the screening tool distributed?
    - In the waiting room
    - In the provider’s office
  - **When?** When will an individual receive the screening tool?
    - Next visit
    - During the visit
  - **Who will you refer?** How frequently do you refer?
    - New patients
    - New patients annually
    - Quarterly
    - Bi-annually

- **What do we need?**
  - **Available Standardized Social Determinant of Health Screening Tools:**
    - Centers for Medicare and Medicaid Services’ Accountable Health Communities Health-Related Social Needs Screening tool (AHC-PRAPARE) to guide assessment addressing housing instability, food insecurity, transportation needs, utility needs, and interpersonal safety.
    - National Association of Community Health Centers Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) tool: 5 demographic questions + 15 core questions assessing housing, employment, education, security, transportation, social integration and stress, which can be administered by staff (clinical or non-clinical) or can be self-administered.

- **Available Resources:**
  - American Academy of Family Physicians EveryONE Project screening tool: 1 question assessment tool addressing housing, food, transportation, utilities, personal safety, and the need for assistance, which can be administered by staff (clinical or non-clinical) or can be self-administered.

(NOT SHOWN: EXISTING LOCAL RESOURCES TO ADDRESS IDENTIFIED SOCIAL NEEDS)

**Discussion**

- Prior to this project, the facility had no standardized, routine practice for the screening and referral of SDOH.
- Frequency of screening proved to be sporadic with rates for routine screening varying from 10 to 60%.
- The select domain(s) screened also varied by provider.
- Screening primarily was done without the use of standardized screening tools.
- Most providers were unaware of local community resources to which screened patients can be immediately referred.
- Based on the identified gaps in practice, a toolkit was developed that included workflow considerations, recommended standardized SDOH screening tools, and a list of local public services that address specific SDOH.

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**References**


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