Beyond the Surface: A Proactive Guide Series on Screening for Social Determinants of Health

This series of guides is a resource to equip primary care physicians with useful strategies and tools to effectively screen for social determinants of health in their practice.

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Guide 1: Social Needs Screening Overview

"When you trace back to the causes of the causes of illness, in so many cases you see how our social fabric itself is in need of mending."[1]— Dave A. Chokshi

Social and structural forces are imperative drivers of health and health outcomes.[2] In the United States, 37.9 million people live in poverty, 34 million experience food insecurity and more than 10 million experience domestic abuse.[3-5] It has become increasingly evident that "**the strongest predictor of health outcomes in the [United States] is not medical care but rather the broader social context in which people live and work**."[6]

Currently, medical practices operate under a risk factor paradigm that focuses on behavioral changes as the main strategy to prevent disease, but this has not proven to be an effective approach.[7] In many cases, people are not in control of the factors that make them sick, and a person's environment can influence their health before they are even born. Therefore, primary care physicians must recognize the impact of social determinants of health, or SDOH, on their patients and adopt a comprehensive approach that addresses broader factors influencing patients' well-being.

The American Academy of Family Physicians defines SDOH as "the conditions under which people are born, grow, live, work, and age."[8]

Factors that strongly influence a person's health outcomes include the following:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating and cooling)
- Early childhood social and physical environment, including child care
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities

- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs. isolation)
- Socioeconomic status
- Spiritual/religious values

For the medical community to make a substantial, lasting difference in the health of patients and communities, it is essential to address patients' needs beyond the boundaries of the office. To effectively identify and address the social factors influencing patients' health, clinicians must deeply understand the needs of their patient population, the practice's capacity to assess those needs and the availability of community resources.

Primary care physicians play an especially important role in identifying patients' needs, connecting them to essential services and serving as a natural integration point for clinical care, public health, behavioral health and community-based services.[9,10]

According to estimates, 50% of people who have health-related social needs may not be identified due to a lack of routine screening.[11] Understanding a patient's social needs gives their physician a foundation for getting to know them, yet both physicians and patients have limited time. Interventions proven to improve patient health and well-being should be prioritized.[12] You and your team may find social needs surfacing when you are obtaining a patient history, or specific signs and symptoms may indicate a social need.

Familiarity with the community you are serving will help your practice team identify populations at greater risk and potential resources. When social needs are identified, tools such as the AAFP's Neighborhood Navigator (aafp.org/neighborhood-navigator) can help practices identify local resources to help their patients. Establishing collaborative partnerships with community organizations can also help health care teams address recurring social needs in the community.[13]

Key Definitions & Terms

In 2021, the AAFP worked with members to develop a shared understanding of what we mean when we use the term "DEI."[14]

Diversity

Differences of people with respect to, but not limited by, race, ethnicity, color, religion, background, national or geographic origin, age, gender identity or expression, sexual orientation, ability, education, thoughts, preferences and skills, among others.

Equity

The absence of avoidable and unfair differences among individuals or groups of people. The playing field has been leveled so that everyone has a fair opportunity to attain their full potential, and no one is disadvantaged from achieving this potential for any reason.

Inclusion

Equitable opportunities are provided for participation and sharing that demonstrate everyone is equally valued and feels welcome.

In 2023, the AAFP adopted *Advancing Health Equity: A Guide to Language, Narrative and Concepts* as the primary resource for any terms or definitions not defined elsewhere in our policies.

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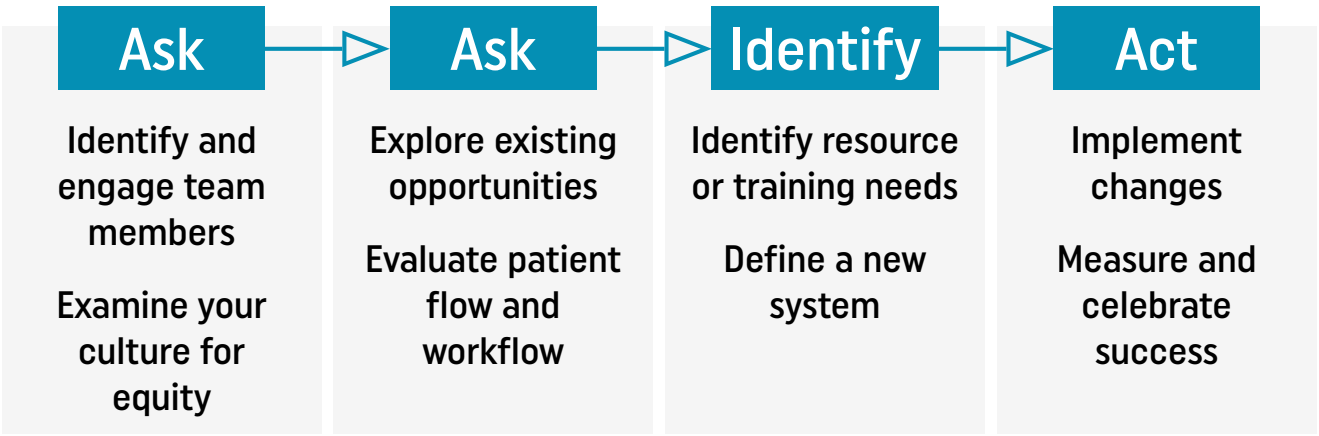
Guide 2: Preparing Your Practice

The first step in addressing social determinants of health, or SDOH, in a primary care setting is to conduct a brief, informal assessment that gauges your practice's readiness to begin this work. Once a practice is ready to identify, plan and implement changes to address SDOH, the American Academy of Family Physicians recommends a three-phased practice change framework that encourages primary care physicians and their health care teams to do the following[1]:

1. **Ask** patients about their SDOH.
2. **Identify** resources in patients' communities that can help address SDOH.
3. **Act** to help connect patients with resources to address their SDOH.

This guide walks through a process that will prepare your practice to implement each step in the practice change framework. Clinical teams can prepare to address SDOH and engage in the work in many different ways, but we think using a version of the ASK-IDENTIFY-ACT framework in your practice is the easiest approach.

Practice Change Framework



It is important to note that this process is most successful when physicians and their health care teams are prepared to carry out all three steps in a culturally sensitive and patient-centered way. Creating a culture of health equity in a primary care practice does not happen by accident. It takes intentional, ongoing work by the practice leader and all members of the team. Ultimately, the goal is to create an atmosphere of trust and safety in which patients feel comfortable being vulnerable and talking about sensitive issues.

ASK — Identify and Engage Team Members

The AAFP's policy on team-based care states that patients are best served when their primary care needs are met by a multidisciplinary, integrated team delivering comprehensive care.[2] A central goal of team-based care is providing evidence-based patient care that is effective, efficient and accessible. We recommend leveraging a team-based philosophy as you address SDOH in your practice. Recognition of the unique skills of each health care team member is key to providing comprehensive care and identifying how everyone on the team can contribute to addressing SDOH.[3] While you may need to identify champions to move this work forward, be intentional about including your full team in the process. Each person's contributions will be necessary to ensure your patients receive effective care.

Numerous resources and tools are available to help you organize and engage your practice team. The *FPM* article *Taking Team-Based Care to the Next Level* (aafp.org/pubs/fpm/issues/2022/0500/p25.html) includes an excellent summary of team-based care resources from a wide range of organizations.

Examine Your Culture for Equity

Developing a practice culture that values health equity is not something that happens overnight. The good news is that even seemingly small steps can go a long way to helping patients feel comfortable and included.

Create an Inclusive Space

Inclusivity in health care is essential to the success of an equitable practice culture. Just like the built environment can support a healthy community, the design of an office space can set the stage for a healthy patient experience. Patient-centered health care requires an understanding of patients' beliefs, culture and lived experiences in the space of care. Ensuring that your practice is inclusive for a diverse range of patients helps reduce their fears and frustrations when they access care, and it also helps you avoid contributing to health disparities in your community.[4]

An office visit's tone is set even before the patient enters an examination room. For example, patients spend an average of 18 minutes per visit in the waiting area.[5] Offering private check-in locations and/or digital check-in options can eliminate the need to have private conversations in a public area. Providing access to inclusive bathrooms and family bathrooms is another way to show that you understand the wide range of needs a person or family may have while they are in your office space.

Use Inclusive Signage and Imagery

Inclusive signage and imagery foster a comfortable health care environment. When choosing images for your practice's walls, use a variety of different people and family types to help patients see themselves in your space. Choose easy-to-read signage that features the languages spoken by your patient population. In addition, consider providing a variety of magazines and other reading materials in the waiting area and examination rooms so all patients have access to patient education and/or entertainment.

Ensure Accessibility

Accessibility is the cornerstone of an inclusive practice. Ensuring that entrances are mobility conscious and compliant with the Americans With Disabilities Act is a bare minimum expectation. Practices need to consider not only whether they are accessible for people who use wheelchairs or motorized scooters but also whether bariatric mobility aids can easily pass through hallways and doorways, including in bathrooms. Motorized entrance doors and lightweight restroom doors also make it easier for patients to move through your practice space independently.

Providing easy access to various gown sizes and equipment that makes care accessible for all patients (e.g., bariatric specula for pelvic examinations) creates a more inclusive patient experience. Consider having motorized examination tables, lifts and wheelchair-accessible scales in examination rooms. Other possible ways to improve accessibility in your practice include offering maps to show patients where access is easily available, providing overhead signage for those with hearing loss, ensuring availability of handouts at an appropriate reading level and utilizing an accessibility analyzer tool for your practice website.

Limit Stressors and Overstimulation

Health care settings can be anxiety-inducing places for many patients. Mistrust, disability and trauma are among the reasons that patients may experience stress and anxiety when receiving care, which can result in poor health outcomes. Patients are not the only ones who are affected by stressors during an office visit. Clinicians need to be self-aware so they can identify how the practice environment is impacting their ability to be mentally and emotionally present for their patients.

Another cause of anxiety in health care settings is overstimulation, which occurs when one or more of the five senses receives more input than a person can comfortably tolerate. This is more common in people who have a condition such as attention-deficit/hyperactivity disorder or autism spectrum disorder.[6] Techniques to help patients avoid overstimulation during an office visit include having a designated space without bright colors or signage, limiting how much you switch between personnel and regularly reassuring the patient.[7] Extra measures that could be beneficial for patients include offering headphones or earplugs to limit noise exposure and providing tactile objects as an outlet for energy release. Continue to reassess each patient's comfort level throughout their visit and make adjustments as necessary.

Foster Inclusive Conversations

Screening for SDOH can be stressful for clinicians and patients, especially if no system is in place to address the challenges that are uncovered. Leveraging inclusive conversation principles can help your practice reduce the risk of unintended consequences.

Prepare Your Team

Some health care teams will require training to acquire different knowledge, skills and attitudes so they are prepared to create the environment necessary for addressing patients' social needs. Training models that emphasize relationship development among team members through frequent, timely and accurate communication of shared goals and knowledge, mutual respect, and problem-solving have been associated with high-quality interprofessional team functioning, better health outcomes, improved care quality and efficiency, and patient and team satisfaction.[8]

Long-term, established relationships rooted in patient-centered care help health care teams build rapport with people who may experience hardships outside of their health. This rapport makes it easier to have open conversations about difficult topics. In addition, patients' willingness to respond to questions about SDOH is impacted by how clinicians ask such questions.[9] Team members may benefit from educational opportunities to help them understand their role in conversations about SDOH and explore basics such as how to phrase and ask sensitive questions and how to manage unexpected responses.[10] Innovative training tools (e.g., simulated role-playing with real-time feedback) can be used for behavioral rehearsal to increase confidence and skills for physicians and their teams.

Obtain the Patient's Consent to Discuss SDOH

Questions about SDOH may seem intrusive or make a patient feel vulnerable to adverse consequences (e.g., fear that admitting to food insecurity may cause a report to child protective services and result in losing custody of a child). This can make screening for social needs more challenging than screening for other medical concerns. Conversations about SDOH may be especially stressful for people from underrepresented and marginalized populations with a history of medical mistrust.

To develop patient-clinician trust over time, you need to identify and reinforce shared values.[11] You can also build trust by reassuring your patients that they have the authority to decide what to disclose during their office visit. Ask for their permission to ask sensitive questions, be transparent about what you intend to do with their responses and let them know that they can decline to answer. You can demonstrate commitment to your patients' autonomy by being willing to listen and intentionally sharing decision-making with them.

Determine and Use The Patient's Preferred Method of Communication

Communication is central to collaboration between a patient and their health care team. Social needs can be a sensitive topic, so it is critically important for clinicians to communicate context and meaning effectively and engage patients and their families in meaningful dialogue and problem-solving. The language used in patient encounters — including both the actual language/dialect and the choice of words and phrasing — can play a large role in achieving the level of open communication needed for true shared decision-making.

In health care settings, limited English proficiency has been shown to negatively impact patients' health care outcomes, resource utilization, satisfaction and perception of shared decision-making.[12] The AAFP's position paper on cultural sensitivity highlights the importance of ensuring that people with limited English proficiency have equitable access to health services, can understand their care and can participate in health-related decisions.[13] It also notes that organizations must comply with relevant federal, state and local requirements. For example, Title VI of the 1964 Civil Rights Act mandates that federally funded programs provide equal treatment to all people, regardless of their level of English proficiency.[14] The AAFP endorses the 2013 *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice,* which outlines 15 actions people and organizations can take to implement culturally and linguistically appropriate health care services.[13]

Additional information about the National CLAS Standards, including implementation tools, education and resources, is available at https://thinkculturalhealth.hhs.gov/clas/standards.

For each patient in your practice, identify what language to use to communicate with them, their preferred communication format (e.g., verbal, print, audio) and even who should be invited to participate in conversations with them, if applicable. Also, keep in mind that not all methods of communication are useful for providing optimal patient care in all situations. For example, after the COVID-19 pandemic, many practices transitioned to using telemedicine services as part of routine primary care. While this option is beneficial for some patients, people who live in areas where broadband is not available may not have access to video capability. People experiencing housing insecurity may have a difficult time finding a private place to conduct a telemedicine visit.

Specific medical conditions can add a layer of complexity to patient communication. For example, some people who have autism spectrum disorder may have difficulty interpreting body language, tone and conversational nuances, and this can cause misunderstandings between the clinician and patient. Using visual diagrams, images and other shared decision-making tools may help some patients understand health-related conversations better. Providing large-print options for patients with vision loss and closed captioning for patients with hearing loss are other ways your practice can meet communication needs.

Be aware that some patients have a combination of communication needs that impact their ability to collaborate with the clinical team. For example, a patient could have limited English proficiency, low numeracy skills and hearing loss. It would be important for you to take into account each of these potential challenges and identify how to address them to communicate effectively with the patient.

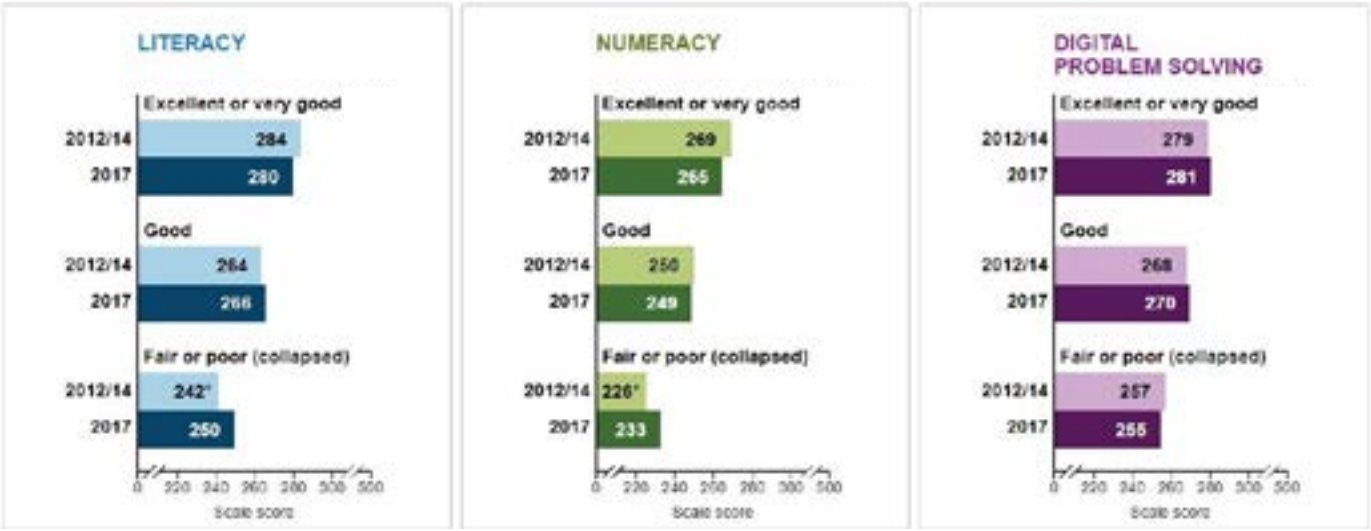
Consider the Impact of Literacy and Numeracy

The U.S. Department of Education defines adult literacy and numeracy as follows[15]:

- "Literacy is understanding, evaluating, using, and engaging with written text to participate in the society, to achieve one's goals and to develop one's knowledge and potential.
- Numeracy is the ability to access, use, interpret, and communicate mathematical information and ideas, to engage in and manage mathematical demands of a range of situations in adult life."

In 2017, the Program for the International Assessment of Adult Competencies conducted an assessment of adult literacy in the United States for the National Center for Education Statistics. On average, U.S. adults who reported higher levels of health scored higher on literacy and numeracy than adults who reported lower levels of health (*Figure 1*).[16]

Figure 1. Average scores on PIAAC literacy, numeracy and digital problem solving for U.S. adults ages 16 to 65, by self-reported health status: 2012/14 and 2017



PIAAC = Program for the International Assessment of Adult Competencies.
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Failing to account for low literacy and numeracy can make screening for SDOH more challenging. For example, patients with low literacy may be less likely to feel confident completing medical forms and more likely to decline participation. Having a clinical team that is able to identify and address patient needs related to literacy and numeracy will support the success of social needs screening in your practice.

You must also consider your patients' health literacy, which is defined as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."[17] More than one-third of U.S. adults have limited health literacy.[18,19] Limitations are more common among older adults, people from racial and ethnic minority groups, people experiencing poverty and people with less than a high school education.[18] People in these populations may also be disproportionately affected by SDOH. A variety of tools are available to help health care teams screen for health literacy in the office setting *(Table 1)*.

Table 1. Commonly Used Health Literacy Assessment Tools

Tool	Measurement	Administration time (minutes)	Number of items
Newest Vital Sign	Reading and applying information	2 to 6	6 questions based on information from a nutritional label
Rapid Estimate of Adult Literacy in Medicine	Word recognition and pronunciation; provides an approximate grade level for reading ability	3	66 medical terms to be read out loud
Short Test of Functional Health Literacy in Adults	Reading comprehension and numeracy skills	7 to 12	2 prose passages and 4 items assessing numerical ability
Single Item Literacy Screener	Identification of patients who need help with reading health-related information	1 to 2	1 question: How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Test of Functional Health Literacy in Adults	Reading comprehension and numeracy skills	22	3 prose passages followed by a 50-item reading comprehension section

Information from references 20 through 23.

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Demonstrate Respect Through Words and Tone

While it may take time for trust to develop over the course of the clinician-patient relationship, respect is something that can and should be demonstrated with each interaction. Some basic ways to demonstrate respect include being thoughtful about the words we use and the tone of our interactions. For example, people-first/person-first language, or PFL, refers to emphasizing the person before a disability, illness or condition. It uses phrases like "person with a disability" rather than phrases that identify people based solely on their disability, such as "a disabled person." Other examples of PFL include saying "a patient with diabetes" rather than "a diabetic" and saying "people experiencing homelessness" rather than "the homeless."

While the shift to PFL is common in academic medicine and in policies, research indicates that many clinicians in practice are still referring to patients in an outdated way.[24] Other language and tone challenges can result when clinicians use terms they were taught to refer to certain clinical situations or conditions. For example, labeling patients as "noncompliant" or "difficult" is stigmatizing and supports a culture of blame. Similarly, labeling a patient who has substance use disorder as an "addict" and describing periods of abstinence as "being clean" feed into a stigmatizing narrative of the patient's life and experience.

In 2023, the AAFP adopted *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf) as the primary resource for any terms or definitions not defined elsewhere in our policies. Developed by the American Medical Association and the Association of American Medical Colleges, this guide provides examples and practical suggestions for people and organizations to consider when creating more inclusive content and environments.

ASK — Explore Existing Opportunities

Before deciding what practice changes to implement, spend some time thinking about whether any existing work in your practice is aligned with your team's desired approach to screening for SDOH. As a team, identify areas in which you excel and areas in which you have opportunities for improvement. Then, conduct a brief, informal assessment of your practice to identify additional opportunities to address SDOH and create a more inclusive experience for patients and their families. This will help you determine specific actions you want to take.

Answer the following questions to assess your practice[1]:

1. How does your practice currently identify and document SDOH, if at all? Whose responsibility is this?
2. In what ways does your practice currently help address your patients' SDOH? (Select all that apply.)
    - Screen for SDOH
    - Maintain up-to-date records of community-based resources
    - Refer patients to community-based resources
    - Engage patients to discuss how to address their SDOH
    - Other: _____
3. What systems do you have in place to ensure SDOH are addressed at patient visits?
    - Reviewing prompts in the electronic health record system
    - Identifying SDOH as part of a patient's vital signs
    - Maintaining a registry of patients by categories of SDOH
    - Using flags or stickers on paper charts
    - Other: _____
4. What resources are available in your patients' communities that they could use to address SDOH?

5. What initiatives are occurring in your patients' communities to address the drivers of SDOH? How could your practice engage in these?
6. Imagine that your practice is successfully doing everything possible to help address SDOH. What would that look like?
7. With your health care team's unique strengths and needs in mind, what can your practice do differently to address SDOH?

Evaluate Patient Flow and Work Flow

You and your practice team can identify opportunities to address your patients' SDOH by using the following questions to consider how patients flow through your office[1]:

1. Where do patients go when they enter the office?
2. What do patients see and do before they are called back for their visit?
3. Who do patients see before meeting the clinician?
4. What questions are asked when vital signs are measured?
5. What information is exchanged with patients before the patient-clinician encounter?
6. What path do patients take as they exit the office?

If your practice has already taken steps to address your patients' SDOH, answer the following questions[1]:

1. How do clinicians address SDOH during the encounter?
2. How are counseling or other interventions for SDOH documented?
3. What reminder systems and prompts are in place to alert clinicians of opportunities to discuss SDOH?
4. As patients exit the office, do they make any stops to speak with nonclinical staff (e.g., social workers, navigators, reception)?

Based on your observations, create a flowchart that shows how patients advance through your system from the time they enter until the time they leave. In addition, document what actions are currently taken and/or will be taken to address patients' SDOH and at which steps. *Figure 2* provides an example of how one family medicine practice incorporates SDOH into their practice's patient flow.

Figure 2. Sample Patient Visit Flowchart

Step	Actions and Considerations
Patient checks in ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient sits in waiting room ↓	Social determinants of health screening tool is distributed to patients at check-in to be completed in the waiting room.
Height and weight checked in hallway ↓	Nurse or medical assistant confirms social needs with patient and provides information to office clerk to cross-reference social needs with available community resources.
Remaining vital signs checked in exam room ↓	Posters are available in the exam room that prompt patients to discuss their social needs.
Patient meets with clinician ↓	Clinician discusses social needs with patient and available resources.
Patient meets with counselor ↓	Nurse or medical assistant finalizes plan to address patient's social determinants of health and referrals to community resources.
Patient stops at billing/scheduling station ↓	Office staff schedules follow-up appointment.
Patient leaves	

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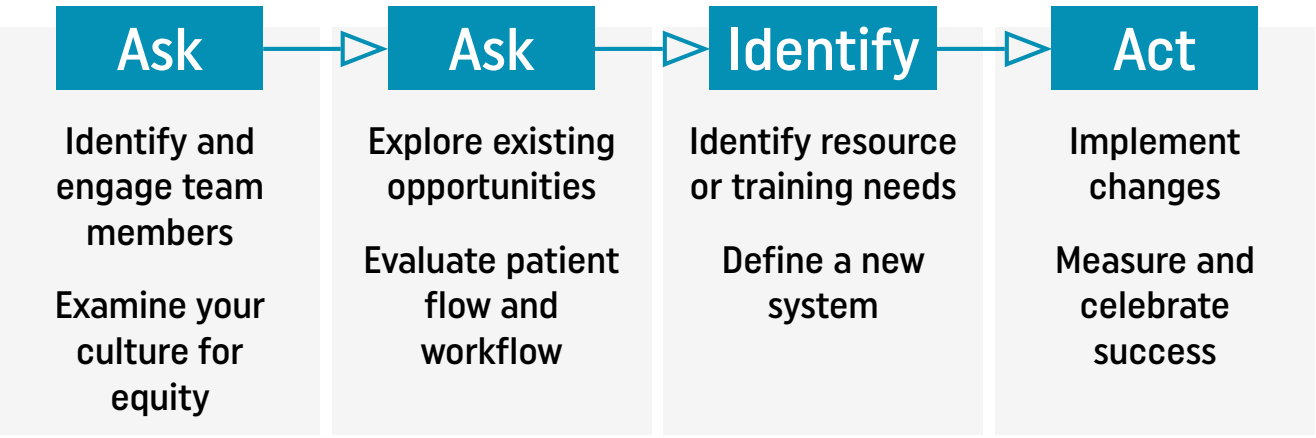
Guide 3: Implementing Change

The American Academy of Family Physicians recommends that primary care physicians and their health care teams use the ASK-IDENTIFY-ACT practice change framework to engage in the important work of addressing patients' social determinants of health, or SDOH. Guide 2 covered the ASK steps of the framework to help you prepare your practice for change. This guide focuses on the IDENTIFY and ACT steps to help you and your team implement practice changes.

Practice Change Framework



IDENTIFY — Identify Resource or Training Needs

The ASK steps in the ASK-IDENTIFY-ACT practice change framework often uncover the need for resources and/or training to help the practice team successfully implement SDOH screening in a culturally sensitive and patient-centered way. Although each practice is unique, practices that are developing and implementing a social needs screening process commonly need to address the following:

- Building team capacity
- Identifying resources and tools

Building Team Capacity

Implementing change can be a difficult process. Some members of the practice team may be more ready to take on the work than others. Some may be willing but lack the self-efficacy or skill set to do all of the new tasks that are required. Team members may be hesitant for a wide variety of reasons, and some may need support to help them be willing to engage in the practice change.

A 2017 AAFP member survey identified the following common barriers to addressing SDOH in a family medicine practice[1]:

- Perceived lack of payment for SDOH
- Lack of staff expertise and capacity
- Implicit bias and lack of cultural proficiency
- Lack of resources in patients' communities
- Difficulty ensuring that patients know what to do and how to follow up with their health care team
- Difficulty engaging the health care team and building momentum

Other common areas for practice team development include the following:

- Equity
- Team-based care
- Patient-centered communication and shared decision-making
- Foundational concepts about social needs and screening principles
- Community awareness (e.g., community needs and health experiences, resources)
- Change management

The AAFP offers a number of resources to support practice teams as they seek to learn more together (*Table 1*). Organizations including the American Medical Association, the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality also provide useful resources for health care teams.

Table 1. Selected AAFP Resources for Building Team Capacity

Topic	Training/Education Resource
Equity	• *It's Time: Six Steps to Creating an Anti-Racist Clinic*
Team-based care	• Team-based Care: Do What You Do Best • How to Use Advanced Team-based Care in Family Medicine • *Making a Business Case for Team-Based Care* • *Taking Team-Based Care to the Next Level* • *A Team-Building Model for Team-Based Care*

Patient-centered communication and shared decision-making	• Key Functions of a Medical Home: Patient and Caregiver Engagement • *Shared Decision-Making: Guidelines From the National Institute for Health and Care Excellence* • *Patient-Centered Communication: Basic Skills* • *Practical Patient-Centered Goal Setting* • *Involving Patients in Medical Decisions: What Happens in Real-World Practice?*
Foundational concepts about social needs and screening principles	• *Screening for Social Determinants of Health in Daily Practice* • *The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned* • *A Practical Approach to Screening for Social Determinants of Health*
Community awareness	• HealthLandscape Community Vital Signs Data Library
Change management	• Basics of Quality Improvement • *When Everyone Leads: Addressing Your Practice's Toughest Challenges* • *A Prescription for Project Management Success* • *Change Is Hard: What Really Happens When You Try to Implement a New Care Model* • *Implementing Change: From Ideas to Reality* • *A Team Approach to Quality Improvement*

Identifying Resources and Tools

Every patient, practice and community is different, and there is not a one-size-fits-all approach to addressing social needs. Integration of a social worker or community health worker in a primary care practice is an efficient way to provide help and resources to patients. However, a practice does not need to have these resources available in order to start screening patients for SDOH. *Table 2* lists community-based resources and tools that practice teams can use to identify social services available within their area to help address specific social needs.

Table 2. Community-Based Resources and Tools

Neighborhood Navigator aafp.org/neighborhood-navigator	Free online social services search engine built off of the FindHelp.org platform. It connects people in need to programs in their community. The site lists available social services, including food, housing, transportation, health care, finances, education, employment, legal aid and goods/supplies (e.g., baby supplies, clothing). The services are based on ZIP code and allow for electronic referrals.
211 Helpline Center helplinecenter.org/2-1-1	The 211 dialing code provides callers with information about and referral to available social services in their location. It is currently available in portions of all 50 states and Puerto Rico.
County Health Rankings & Roadmaps countyhealthrankings.org	Gives a snapshot of a community's health by providing county-specific data about factors that influence health, including the following: • Health outcomes (length of life, quality of life) • Health behaviors (tobacco use, obesity, food environment index, physical inactivity, access to exercise opportunities, excessive drinking, alcohol-impaired driving deaths, sexually transmitted diseases, teen births) • Clinical care (uninsured, primary care physicians, dentists, mental health professionals, preventable hospital stays, mammography screening, flu vaccinations) • Social and economic factors (high school completion, some college, unemployment, children in poverty, income equality, children in single-parent households, social associations, injury deaths) • Physical environment (air pollution-particulate matter, drinking water violations, severe housing problems, driving alone to work)
HealthLandscape Service Area PoPulation Health ImpRovEment (SAPPHIRE) maps.healthlandscape.org/sapphire	Geospatial mapping program that allows a practice to upload ZIP code-level data, explore service areas and link clinical data to dozens of community SDOH
Health Department Directories cdc.gov/publichealthgateway/healthdirectories/index.html	The CDC offers information about public health resources to help you connect with your state and local agencies and find useful community resources.
The Community Guide thecommunityguide.org	Collection of evidence-based recommendations and findings from the Community Preventive Services Task Force regarding the effectiveness and economic impact of public health programs, services and other interventions in the community
Community Tool Box ctb.ku.edu/en	Free online resource with tools for identifying and assessing community needs and resources, addressing SDOH, engaging stakeholders, planning steps, building leadership, improving cultural competency, planning an evaluation and sustaining efforts over time

CDC = Centers for Disease Control and Prevention; SDOH = social determinants of health.

Define a New System

Once the practice team feels confident and ready to implement a change, it is time to define your new system for addressing SDOH, taking into account all the information you have gathered. While there may be nuances to your practice's workflow that add complexity, the most basic framework for addressing social needs follows the ASK-IDENTIFY-ACT approach.

Framework for Addressing Social Determinants of Health

Ask
patients about their SDOH

Identify
community resources

Act
to connect patients with resources

Tips for Defining a New System

- **Do not make these changes alone.** You have been working and learning together as a practice team to identify opportunities to address your patients' SDOH. The physician leader may create the first draft of a system from which the rest of the team can work, but you should lean into the group's collective wisdom to decide which changes to make first.
- **Intentionally explore new roles.** This is a great opportunity for team members to explore new or different roles. Some examples of role changes to consider are listed on the AAFP's Social Needs Screening: Practice Self-Assessment Worksheet.
- **Consider making small, stacking changes.** Some teams will want to change their whole process at once. However, for many teams, a disruption that large would create additional stress and make it harder to gain support for the new system. Choosing smaller changes that stack over a series of weeks or months may be a better option to keep the practice moving forward without overwhelming team members.

The Social Needs Screening: Practice Self-Assessment Worksheet includes a section you can use to document your new system. Many teams find it helpful to create two visions of their new system. One is the perfect system in which everything has been implemented successfully (i.e., the dream state), while the other is a more realistic, short-term system that may not be perfect but would support the majority of your patients well.

ACT — Implement Changes

Implementation is one of the hardest stages of the process. For those closest to the work, it will be an exciting time to see their hard work come to life. However, they may become frustrated if team members farther away from the work forget the new steps or are less supportive of the disruption.

Tips for Implementing Changes

- **Choose an official start date** when the new process will go into effect, and make it a big deal. Communicate early and often about exactly what will happen on the start date.
- **Identify a support team** that will be available during the transition. Encourage them to talk about both what is going well and what is creating challenges.
- **Communicate early and often** about successes and challenges. Early in the transition, you may find it helpful to have team huddle meetings so unforeseen challenges can be addressed promptly with adjustments.
- **Embrace challenges as they arise.** No change goes perfectly the first time. Giving anticipatory guidance and helping the team feel safe even if the transition does not go perfectly will reduce their anxiety and help them be more transparent about the true impact of the change.

Measure and Celebrate Success

Teams that set goals and measure their progress are more likely to stay committed to improving even if there are challenges. Being transparent about both wins and challenges and highlighting identified solutions will help the whole team feel engaged and supported during the change process. Plan to celebrate milestones throughout the implementation stage to keep momentum, reward adopters (based on effort and success) and ensure that the change is sustainable once it has become more routine.

References

American Academy of Family Physicians. 2017 Social Determinants of Health Survey.

Guide 4: Social Needs Screening Tools

Choosing the social needs screening tool your practice will use may be as simple as adopting the preferred tool selected by your health system, electronic health record or prominent insurers. If you have the option to choose a screening instrument, you can consider the pros and cons of a number of validated tools based on the needs of your practice and community (*Table 1*).

The American Academy of Family Physicians offers a brief screening tool and supporting materials (aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html) that physicians and their practice teams can use to screen patients for social determinants of health, identify community-based resources to help them and work with patients to develop an action plan that encompasses social needs.

Table 1. Overview of Selected Social Needs Screening Tools

Tool	Description	Strengths	Limitations
Upstream Risks Screening Tool — HealthBegins	28-question screening tool that covers a wide range of SDOH including socioeconomic status, food security, housing stability, education, employment, transportation access and social support	Comprehensive screen that is widely used and validated Assesses physical activity, immigration matters, exposure to violence, diet, civic engagement and stress	Does not adequately cover racial discrimination or cultural factors Relatively long and time-consuming Potential for language and cultural barriers
PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences) — NACHC and partners	Widely used screening tool developed by the NACHC 21 questions are divided into 4 domains: personal characteristics, family and home factors, money and resources, and social and emotional health Assesses factors including child care, clothing, employment, food insecurity, housing, incarceration history, income, language preference and medical needs (e.g., insurance coverage)	Comprehensive, validated assessment that covers a broad range of SDOH Allows for flexibility and customization Standardized reporting and coding analysis Can be integrated into EHR or patient portal or administered using a paper-based survey Has been standardized across ICD-10, LOINC and SNOMED Available in English and more than 30 additional languages	Relatively long and time-consuming Requires a certain level of literacy and comprehension and might be challenging for some patients

Tool	Description	Strengths	Limitations
SVAT (Structural Vulnerability Assessment Tool)	43-item questionnaire that assesses needs across 6 domains: economic stability, education, social and community context, health and clinical care, neighborhood and physical environment, and food security Also asks users about experiences with discrimination, which is a useful metric to assess how discrimination impacts health outcomes	Comprehensive, validated assessment that covers a broad range of SDOH Assesses legal status, social network and risk environments Can be tailored to specific populations, communities and contexts to assess specific vulnerabilities and challenges Helps identify root causes and systemic barriers	Lengthy and time-intensive
WellRx Toolkit	11-item questionnaire that assesses key SDOH domains including drug use, access to child care, employment, food insecurity, economic stability, neighborhood and physical environment, and housing security	Relatively quick and simple screen Designed to be at a third-grade reading level Utilizes yes-or-no questions Can be integrated within the EHR or administered on paper Includes user access to community resources to address any identified social needs Has been translated into Spanish	Not as comprehensive as other screens May suggest interventions that are not readily available to the patient Focuses on individual-level social factors and does not capture broader systemic or structural factors
Your Current Life Situation survey — Kaiser Permanente	32-question survey that examines 6 domains of SDOH: economic stability, education, social and community context, health and clinical care, neighborhood and physical environment, and food security	Assesses access to child care and dental care, activities of daily living, and legal or public benefits needs Available via EHR or patient portal or on paper	Relatively long and time-consuming Requires a certain level of literacy and comprehension and might be challenging for some patients

Tool	Description	Strengths	Limitations
Social Needs Screening Tool — AAFP	15-item questionnaire that assesses housing, food, transportation, utilities and personal safety Also examines factors including employment, education, child care and financial strain	Short-form 11-item questionnaire also available Available in English and Spanish	May not be fully integrated with the EHR

AAFP = American Academy of Family Physicians; EHR = electronic health record; ICD-10 = International Classification of Diseases, 10th Revision; LOINC = Logical Observation Identifier Names and Codes; NACHC = National Association of Community Health Centers; SDOH = social determinants of health; SNOMED = Systemized Nomenclature of Medicine.

Information from Heath S. What are the top social determinants of health screening tools? May 10, 2023. Accessed November 21, 2023. https://patientengagementhit.com/features/what-are-the-top-social-determinants-of-health-screening-tools

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