

Suggestions for Partners Engaged in Social Determinants of Health Assessment & Referral to Resources

Purpose: This document strives to provide direction and suggestions to Diabetes Prevention Program and Diabetes Self-Management Education and Support partners who are considering collecting participant information on social determinants of health. Organizations can use this as a guidance tool as they explore what might work best for their organization. Please work with a Diabetes Prevention and Control Program Consultant on CDC 1815/1817 specific activities.

The **social determinants of health (SDOH)** are "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." Examples of social determinants include access to educational, economic and job opportunities; public safety; access to fresh food; social support; transportation options; residential segregation; and others (Healthy People 2030 | health.gov).

Stakeholder Support

SDOH efforts, including assessing clients' SDOH, should be vetted and approved by your organizations' leadership to gain stakeholder support. Before asking staff, leadership, and patients to collect and provide personal and sensitive information, it is important to educate all stakeholders on the importance of collecting data on SDOH and how that information will inform care and services (PRAPARE Toolkit, pg. 12).

Examples:

- When speaking to staff about collecting SDOH information, do not use the word *"project."* It is better to frame as a way to achieve your mission of improving health. Some examples include: *"these efforts will add value to existing work/goals"* or *"collecting SDOH information is a way to better understand patients'/participants' needs."*
- Have conversations with executive leadership to highlight the ways that collecting SDOH information aligns with existing organizational priorities and how data on SDOH will add value to other organizational initiatives.
- Actively listen to community members' questions and work with them to address any concerns. Consider collecting feedback through community events or paper form.

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Environmental Scan

Conduct an environmental scan to create or enhance a list of resources or a "Community Resource Guide" that maps out assets, risks, and experiences. Engage a wide variety of staff, especially enabling services staff, patients, and community members in developing this list as they may be knowledgeable about resources available in the community. If local resources do not exist for a particular need, provide alternative suggestions in the next closest city and/or national resources or online links (PRAPARE Toolkit, pg. 18).

Examples of websites to evaluate current environment and resources: Find Help OR 211.

- Check in with local partners to become familiar with their services/resources. Ask community partners about initiatives they may be involved in that you can share (Good Food Box, Double Up Food Bucks, Meet Up and Eat Up, Cooking Matters, etc.).
- Consider exploring how Medicaid and managed care organizations can support clients such as providing transportation.
- A client should be aware of why the assessment is being provided and information should be shared in advance with the client on what support can be offered.
- When collecting SDOH data from clients, take note of the needs that could be better supported by your organization or a community partner. If you find that there is a gap, connect with community organizations to determine what potential solutions may be.

Leverage Partner Effort

Leverage partner efforts by checking in to see if they are already collecting SDOH information to ensure that efforts are not duplicative, but complementary. If sharing this type of information, please note the privacy and security aspects. Proper steps should be taken, which may include establishing Memorandum of Understandings (MOUs), Business Associate Agreements (BAAs), privacy agreements, etc.

- Check with partners to see if a current environmental scan already exists (see 'Environmental Scan').
- Connect with organizations that employ community health workers (CHWs) such as Federally Qualified Health Centers (FQHCs). CHWs can more easily relate to patients, understand their needs, and build trusting relationships. Contact info@michwa.org to find a CHW connection near you.

Timing of SDOH Assessment

It is helpful to determine the timing of an SDOH Assessment so that it does not burden the client but ensures that the client feels comfortable, and that the information is collected. Start by asking clients a general question about their interest in being connected to SDOH assistance in the very beginning. For example: *"Would you like to be connected to support services, such as transportation or childcare and someone who will help you navigate services?"*

Examples:

Diabetes Prevention Program (DPP)

- Have clients complete the SDOH assessment during the initial registration, session 0, sessions 1-2, or align assessment with content during sessions.
- If having clients complete SDOH assessment early on, suggest that they do so at home, before DPP classes start.

Diabetes Self-Management Education and Support (DSMES)

- Consider having client complete the SDOH assessment prior to the DSMES initial assessment form.

Assessment Questions

It is okay to start small with assessment questions. In the beginning start simple with two to three questions addressing SDOH areas that have a high level of impact. Your organization can also pilot a screening approach such as holding an open forum or community dialogue to learn and engage with community members.

- To address literacy, ensure adequate staffing to assist participant in completing assessment. There may also be opportunities to showcase questions in alternative ways e.g., picture based or verbally asking questions. CDC, Health Literacy
- Ensure SDOH assessment is available in the preferred languages of the population(s) served. A diverse workforce assists in serving clients in their preferred language if other than English.
- The following are commonly used SDOH tools and can be used to gather potential SDOH assessment questions:
  - The AHC Health-Related Social Needs Screening Tool (cms.gov)
  - PRAPARE Screening Tool
  - HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status | ASPE
- During registration/intake, it may be helpful to gather disability information from the participant to see what populations may have disparities in SDOH challenges.
- Prior to implementation it is important to solicit review of SDOH assessment questions from various staff, patients, and the community. Organizations may consider piloting the SDOH assessment questions on a small scale before incorporating into everyday workflow.

Consider this!

The Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true':

1. *"Within the past 12 months we worried whether our food would run out before we got money to buy more."*
2. *"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."*

FEEDBACK/EVALUATION OF EFFORTS OF SDOH

It is important to regularly collect feedback from both participants and team members involved in the implementation of SDOH assessment to determine how the process is working for them. This feedback can be used to implement changes to improve the process for optimal workflow and efficiency. Questions can be directed to both participants and staff to help identify issues and opportunities. Overall, the questions should explore three main themes:

- The process of SDOH collection.
- An understanding of how data is used to foster change at the patient, organizational, community and systems-levels.
- The effectiveness, replicability, and sustainability of the collection model.
- More information can be found at PRAPARE Screening Tool, pg. 70.

GUIDING PRINCIPLES FOR SOCIAL NEEDS SCREENINGS

Consider incorporating "Guiding Principles for Social Screening" into both staff training/education as well as designing/conducting assessment. Empathy, trust, autonomy, and support are some of the key principles (Screening for Social Needs: Guiding Care Teams to Engage Patients, pg. 6).

Consider using the method of Empathic Inquiry: an approach to social needs screening that promotes partnership, affirmation, and patient engagement through synthesis and application of the concepts and methods of motivational interviewing and trauma-informed care, as well as input from patients and professionals (PRAPARE Toolkit, pg. 21). Other suggestions for trainings include: motivational interviewing, cultural competency, implicit bias, etc.

Messaging should be used to address common questions from clients as to why they are being asked questions about their socioeconomic situation. For examples, see PRAPARE Toolkit, pg. 12.

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