Understanding Social Determinants of Health (SDOH)

* SDOH are conditions in which people are born, grow, live, work, and age that affect a wide range of health risks and outcomes. Screening for HRSN is essential as it helps to identify the negative SDOH impacting patients' lives.

Benefits of HRSN Screening

* Improves Patient Health: There is evidence that addressing unmet social needs within a primary care setting can improve patient health outcomes.
* Tailored Treatment Plans: Collecting information about social needs allows clinicians to develop treatment plans better suited to a patient’s unique circumstances.
* Increases Patient and Provider Satisfaction: Efforts to address patients’ social needs have been found to increase satisfaction for both parties and may even mitigate provider burnout.

Implementation of HRSN Screening

* Feasibility: Pilot studies have shown that it is feasible to screen for HRSN without disrupting clinic flow.
* Customizable Approaches: There is no one-size-fits-all approach to screening; tools can be comprehensive or targeted based on the patient population and practice needs.

How to talk to members/patients about HRSN screening

* Begin the conversation with empathy, understanding that discussing social needs can be sensitive.
* Consider the patient's cultural, linguistic, and literacy needs during the conversation.
* Explain the purpose of the screening clearly, emphasizing its importance in providing comprehensive care.
* Assure confidentiality and that the information will be used to better understand and meet their health needs.
* Obtain informed consent before administering the screening using a validated tool such as SCRA or PRAPARE.
* Be prepared to provide resources or referrals from your registry of community-based service providers on CommunityCares based on the screening outcomes to address any identified needs.
* Document the screening results and referral to appropriate service providers in your EHR.
* Train staff thoroughly on how to conduct screenings and handle patients' responses effectively and sensitively.
* Regularly review and update the screening process to align with best practices and emerging evidence.

Research and Resources

* AHRQ EvidenceNOW, Identifying and Addressing Social Care Needs in Primary Care Settings brief: This document provides guidance for primary care practices on integrating social needs screening into clinical services, offering resources and considerations for implementation to improve patient health and healthcare efficiency. Learn more: https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf

Community Services Connection:

* As a requirement of Milestone 3F/G, participants must develop and maintain a registry of community services providers through CommunityCares (or another closed-loop referral system) or any other means if not using a closed-loop referral system.