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Nurses' role in addressing social determinants of health

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Abstract: Nurses have a vital role in addressing social and health inequities to promote quality healthcare for all. This article discusses the tools to screen for social determinants of health (SDOH) and key considerations for nurses and nurse leaders to advance the integration of SDOH information into their workflows.

Keywords: SDOH, social determinants of health, health disparities, health equity

Up to 80% of a person's health is determined by socioeconomic factors, health-related behaviors, and environmental conditions.[1] Identifying and helping patients manage these social determinants of health (SDOH) should be key parts of proactive patient care. In the past, data about SDOH were either unknown or had fallen outside of the traditional purview of hospitals and clinics.[2] To collect and exchange SDOH information, methods were developed to screen and collect data electronically. In 2014, the National Academy of Medicine created standard social and behavioral domains for primary care settings highlighting the importance of capturing these domains electronically.[2] This involves implementing tools to support SDOH assessment by healthcare teams and standardizing the process for conducting SDOH assessments within roles and responsibilities.

Multiple national medical professional associations recommend social risk screening and documentation in healthcare settings because of the compelling evidence that social risks are associated with poorer adherence to treatment plans, worse health outcomes, and increased costs of care.[3] Despite these recommendations and growing national attention for the

health impacts of SDOH, the uptake and prevalence of healthcare-based screening for service delivery are highly variable, and existing efforts to assess patients' SDOH have typically been ad hoc.[4]

The Centers for Medicare and Medicaid Services developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to address the critical gap between clinical care and community services.[5] This unique 10-question tool assesses five key domains of health-related social needs, collecting a breadth of information that increases the likelihood of identifying significant needs.[5,6] The tool can also be integrated into multiple clinical workflows and accessible across diverse patient populations.[6]

In a study evaluating the acceptability of the AHC HRSN Screening Tool among adult patients and adult caregivers of pediatric patients, a sizable majority of participants found the tool appropriate across diverse healthcare settings.[7] They also reported being comfortable with having the results integrated into electronic health record (EHR) systems.[7] Screening acceptability varied among subgroups based on prior exposure to social screening and assistance, trust in clinicians, experience with healthcare discrimination, and recruitment from a primary care setting or healthcare facility with more patients who are uninsured or have public health insurance. These variations were small to moderate, and both screening appropriateness and comfort with EHR documentation were high for all subgroups. These findings suggest that patient acceptability is not likely a major barrier to SDOH screening implementation.[7] Given these findings, barriers could be more closely associated with technical and logistical factors such as workflow, data collection, review and response, screening tool implementation, and referral mechanisms. Additionally, the United States is in the midst of a deeply problematic nursing shortage that is expected to continue through 2030.[8] This has created a major imbalance in workloads for those remaining in the job and resulted in less time, incomplete communication, and thus, lapses in continuity of care.[9]

This article reviews the SDOH assessment process and screening tools used in the context of nursing workflows and discusses key considerations for nurses and nurse leaders to advance the integration of SDOH information into clinical care.

Screening tools

SDOH assessment tools are used to identify social risks that reflect a person's unmet social needs. Although differing in methodology, content, and follow-up procedures, these tools often focus on key SDOH domains.[10] These commonly include housing, food, transportation, employment, education, financial strain, and personal safety.[11]

Although an organization could develop and validate its own questions, organizations often find it most expedient to implement existing and validated assessment questions or tools. Many SDOH screening tools are available.[11-14] However, there is a lack of national guidance on the use and effectiveness of these tools (see *Common SDOH screening tools*).[15] According to the National Committee for Quality Assurance (NCQA) Social Determinants of Health Resource Guide, organizations must make addressing SDOH a strategic priority then design an SDOH assessment program involving these four main workstreams:[16]

- ***Whom to assess***: Determining whom to assess might depend on an organization's resources, budget, and current workflows. Some organizations begin with universal assessments, while others start with high-risk individuals and expand to a broader scope once workflows are optimized.
- ***What to assess***: There are three different approaches to SDOH assessment. Strengths-based assessment is often used in behavioral health and focuses on measuring a person's protective factors (such as social support system, access to resources) that help them thrive in adversity. Risk-based assessment and needs-based assessment are commonly used in medical environments. They focus on capturing individual characteristics that put a person at risk for poorer physical health (such as poverty, sexual orientation) or an individual's immediate unmet social needs.
- ***What questions to ask***: Although most readily available SDOH assessment tools include screening questions on food, housing, transportation, and finances, limited evidence supports screening for specific SDOH factors. When choosing specific questions, consider the social risks in the population served and available local resources.
- ***How to implement the assessment***: A variety of individuals may have responsibility for SDOH assessment including social workers, community health workers, physicians, care managers, nurses, transportation providers, clergy, housing assistance providers, and other service providers. Methods used for collecting information have included verbal in-person, verbal remote, written assessment, and through a kiosk, computer workstation, smartphone, or tablet.

Research on the effectiveness of screening in improving patient outcomes has been divided into two categories: (1) screening for single domains of social risk and (2) simultaneously screening for multiple domains of social risk.[17] Given that social risks tend to aggregate, screening for multiple SDOH domains would seem to make more

Common SDOH screening tools

Screening Tool	Developed By	Features
Protocol for Responding to and Assessing Patient's Assets, Risks and Experiences (PRAPARE)	National Association of Community Health Centers (NACHC)	Consists of a set of national core measures and a set of optional measures for community priorities Informed by research, the experience of existing social risk assessments, and stakeholder engagement Aligns with national initiatives prioritizing social determinants (such as Healthy People 2030), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System[11]
Health-Related Social Needs (HRSN)	Centers for Medicare and Medicaid Services (CMS)	Developed as part of the Accountable Health Communities Model to determine if systematic screening for health-related social needs affects total healthcare costs and health outcomes Helps providers find patients' needs in five core domains including housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety[4]
The Health Leads Social Needs Screening Toolkit	Health Leads	Provides a comprehensive blueprint for organizations seeking to identify and screen individuals for adverse social determinants of health Includes updates based on the latest social needs research, lessons learned from long-standing screening programs, and feedback from clinicians and healthcare providers[12]
HealthBegins	HealthBegins	Contains 28 questions assessing five domains: economic stability, education, social and community context, neighborhood and physical environment, and food[13]

sense; however, there is a much larger body of research related to screening for single domains of social risk, particularly intimate partner violence, suicide, and child and elder abuse.[18] A 2017-18 National Survey of Healthcare Organizations and Systems that estimated the prevalence of screening for five social risks (food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence) concluded that screening across multiple domains is not yet common in clinical settings.[19]

Once an organization has decided to screen, the fourth workstream becomes critical: How to implement the assessment. Although many community-based organizations may initiate assessments or the patients themselves may choose to complete a digital screening tool, this article focuses on healthcare organizations as the point of origin of assessments.

Working in the most trusted profession, as reported in the most recent Gallup Honesty and Ethics poll, nurses are in a unique position to screen for SDOH.[20] One study found that nurses feel knowledgeable and confident in discussing certain determinants of health, particularly issues related to access to healthcare.[21] With an integrated screening tool accessible from the EHR, nurses can collect SDOH data within their current documentation workflows. Having this information can be valuable to support patient care and discharge processes. All aspects—including confidence in discussing SDOH, knowledge about the importance of collecting this information, and proficiency in using an integrated screen tool—must be addressed with nursing workflows in mind to increase adoption and use.

The SDOH screening expectations and frequency should be outlined in the organization's standard processes (for example, during triage or intake,

prior or after the initial appointment, at discharge, and on every home visit) and part of nursing orientation processes. The frequency of SDOH screening must be clearly outlined, noting that it may be adjusted according to the patient's risk level and ongoing needs. As SDOH data are modified over time, the creation of an electronic notification within the EHR would be beneficial to alert care team members when new data are present. Procedures for successful screening should consider patient education on the reasons for collecting data, how it will be used, and who will have access to the data.

Access to and integration of SDOH data

Using collected SDOH data, nurses will have the ability to identify patients at risk for negative health outcomes and connect patients with needed services. Based on the socioeconomic and environmental needs and risks of the patient, SDOH data can be reviewed regularly alongside the plan of care to address the patient's needs. Easy access to and visibility of SDOH data facilitates referrals to community services and supports a greater understanding of the factors that affect health.

Information overload has been a critical issue for clinicians, who often have limited time to review the vast amount of data that has not been translated into relevant information when they are needed.[22] The collection and documentation of the information itself also increases responsibility and workload of nurses, who are often tasked with administrative burdens that would otherwise be outside of their job descriptions.[23,24] Accessing information at the proper point in the clinical decision-making process is critical.[25] To optimize its use, SDOH data must be integrated into clinical workflows in a way that supports the efficient use of the information without creating an undue burden on nurses.

Common approaches to implementing clinical decision support tools, such as identifying the needs of the users and what the system is expected to do, may be useful in integrating SDOH data into workflows.[26] This includes the use of the EHR in presenting the right data in the right place to the right clinician at the correct point of the clinical workflow.[27] A thorough understanding of SDOH information needs in settings and situations may also contribute to its optimal integration into workflows.

To decrease the cognitive burden of nurses, machine learning algorithms can be used to build SDOH data models. These types of predictive and prescriptive analytics can provide new insights into the interaction between social conditions and health outcomes in specific patient populations. A recent study in the *American Journal of Managed Care* found that applied machine learning can be used to predict patient utilization of inpatient and EDs based on their SDOH.[28] These findings can be applied on a wider scale and could positively impact patients, the community, and the health systems.[28]

Interoperability

Nurses must also explore the level of interoperability or the amount of SDOH data exchange between healthcare organizations and external stakeholders, particularly its impact on nursing workflows. It is important that SDOH data can be shared and exchanged with community partners and other healthcare systems to develop a system of holistic and longitudinal care for patients, primary care providers, case managers, and other healthcare workers who may require access to SDOH data. Data flows should be examined, and where possible, SDOH data should be reused and shared for optimal use (see *SDOH screening in clinical practice: Use cases*).[29]

SDOH screening in clinical practice: Use cases

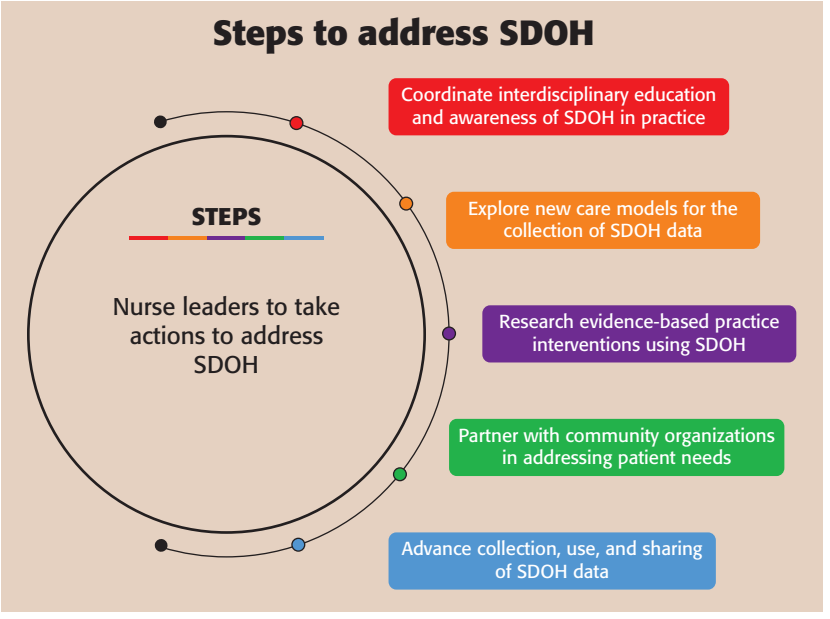
Use case #1: Primary care clinic care setting

Prisma Health in Greenville, S.C., implemented SDOH screening tools in a phased approach for their value-based contract patients and uninsured patients in the primary care clinics. During the intake process, nurse care managers conduct a basic needs SDOH screening in the EHR. Next, the nurse care manager generates a list of personalized referrals via a referral platform embedded in the EHR. The referral list is attached to the After Visit Summary and shared with the patient in their preferred modality (text, email, or print). Prisma Health plans to roll out this process within all ambulatory clinics across their enterprise to screen all patients in support of their health for SDOH impact.

Use case #2: Primary care and inpatient care settings

Allina Health, based in Minneapolis, Minn., utilizes the Accountable Health Communities (AHC) Model. During the intake process in the primary care clinics, all patients with Medicare and Medicaid are screened using the AHC screening tool. With the standardization of this process, Allina Health has been able to reach 90% of its target population screening goal along with community referrals. Patients with identified established needs receive a consult for nurse navigation. Allina Health has found that patients with existing primary care are most interested in accepting navigation services, highlighting the importance of establishing a primary care relationship that enables trust for the provision of services such as care navigation.

Allina Health also utilizes the AHC screening tool in the inpatient units, focusing on the behavioral health and population of mothers and babies. Incorporating the tool into their workflow, nurses screen, identify, and "e-prescribe" personalized referrals based on SDOH needs and available community services.



Recommendations for nurses

Although nurses routinely consider the elements of SDOH in clinical practice, the systematic collection and established procedures for use are not commonplace in healthcare organizations.[30] Nurses can take the lead in education, research, and practice by partnering with community organizations. Nurse leaders should participate in organizations, task forces, and committees at the local, state, or national level to advance standards, policies, and incentives supporting the collection, use, and sharing of SDOH data.[31] Nurses can cultivate a culture that promotes the importance of SDOH among healthcare professionals and the integration of screening tools and visualization of SDOH data into existing workflows. Finally, nurses must collaborate with community agencies and healthcare entities to define how SDOH can be fully integrated into patient care (see *Steps to address SDOH*).

For clinical nurses who want to understand how SDOH data can be integrated into their healthcare organization, consider the following actions:

- Learn more about the organizational policies and procedures for SDOH.
- Explore EHR documentation to identify where SDOH data may already be collected and the best locations to review data.
- Encourage colleagues to have discussions with patients to understand their comfort levels with sharing SDOH information.
- Support and advise organizational plans to implement SDOH into nursing workflows.
- Identify opportunities to conduct a nursing inquiry for SDOH interventions.
- Establish ways to triage support based on individual responses to SDOH-related questions by involving interdisciplinary team members such as social services, nutritionists, and mental health professionals.

Conclusion

Integrating SDOH data into nursing workflows has the potential to improve patient care. Nurses are well-positioned to advance operational efforts to incorporate SDOH screening tools and information into new care models that prioritize the efficient use and exchange of such information to adequately meet patient needs. The increased involvement of nurses and nurse leaders in the use of social risk data in clinical decision-making can facilitate progress toward achieving health equity for all. ■

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