
SOCIAL DETERMINANTS OF HEALTH

GUIDE



I. INTRODUCTION

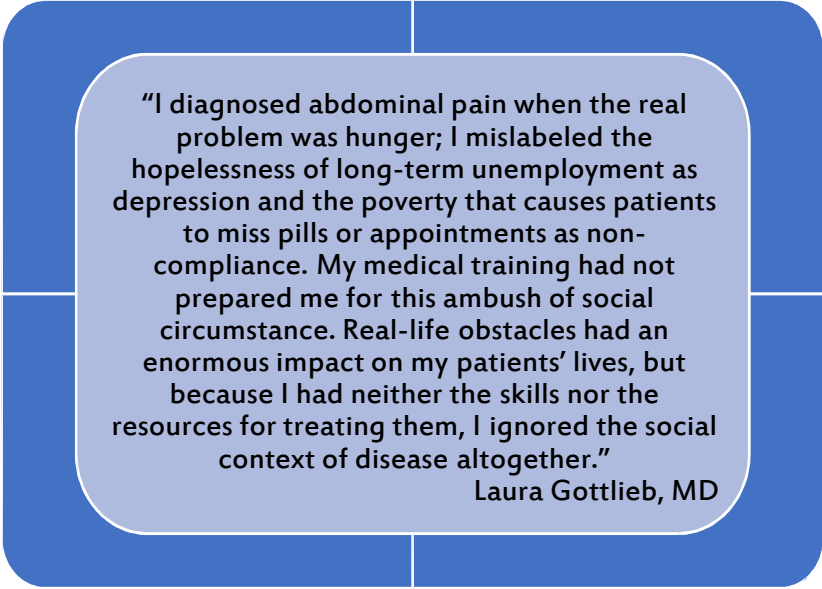
“90 percent of health care spending in the United States is on medical care. While access to high-quality medical services is crucial to health, research shows that up to 80 percent of a person’s overall health is driven by other social and environmental factors and the behavior influenced by them—known as “social determinants of health” or SDOH.” ⁽¹⁾

Addressing SDOH involves ⁽²⁾,

- Reviewing this guide thoroughly;
- Implementing the SDOH assessment tool (Appendix A);
- Collecting patient-level information related to SDOH;
- Creating workflows to track and address patient needs; and
- Identifying social service resources and tracking linkages.

NC Department of Health and Human Services (DHHS) developed a tool that could be used to screen for SDOH. This tool carefully pulls together evidence based questions to guide those providing care to not only identify SDOH needs but seek out solutions for those needs.^{(3) (4)}

Partners has expanded on that SDOH tool so that long-term risks are identified, enhancing the overall analysis. (Appendix A)



“I diagnosed abdominal pain when the real problem was hunger; I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as non-compliance. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.”

Laura Gottlieb, MD

Partners welcomes network providers to join us to take the next, important step recognizing that health is determined not merely by behavioral, biological and genetic factors but also by environmental and social issues which significantly contribute to better health and well-being.

II. THE FACTS

Nearly a quarter of North Carolina children have experienced adverse childhood experiences (ACEs), including physical, sexual or emotional abuse or household dysfunction, like living with someone struggling with a substance use disorder.

Conditions such as food insecurity, housing instability, unmet transportation needs and interpersonal violence not only have a deep impact on a person's health, safety and well-being, but also on healthcare utilization and costs.

Strategic interventions and investments in these initial core domains of food, housing, transportation and interpersonal safety, in partnership with local community groups and healthcare providers, will help us meet our mission of improving health, safety and well-being for all North Carolinians. It will also provide short and long-term cost savings and make our healthcare system more efficient.⁽²⁾

Partners has sufficient data to posit that the focus on SDOH is critical to consider if a whole person perspective is to be targeted and accomplished. Behavioral health has to consider the influence of SDOH

deficits when considering treatment planning and interventions, both as the focus of intervention and as possible influences to the member's ability to engage and benefit from services.⁽³⁾

In North Carolina, people grapple with the impact of unmet health-related social needs every day.⁽¹⁾

More than 1.2 million North Carolinians cannot find affordable housing and one in 28 of our state's children under age 6 is homeless.

North Carolina has the 8th highest rate of food insecurity in the United States, with more than one in five children living in food insecure households.

In some North Carolina counties, one in three children live in food insecure households.

Forty-seven percent of North Carolina women have experienced intimate partner violence.

Of 1,904 SDOH assessments conducted by Partners' providers in 2018 and 2019, 35.6% of members indicated employment is a current need or concern and 17.6% members answered "no" when asked if they had housing.⁽³⁾

III. JOIN PARTNERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

A. Agency name:		Click or tap here to enter text.	
B. Where will tool be used?		List programs that will use tool:	
☐ Organization wide - All programs ☐ One or more programs Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.		Click or tap here to enter text. Click or tap here to enter text.	
C. Where are programs located?	☐ Burke ☐ Catawba ☐ Cleveland	☐ Gaston ☐ Iredell ☐ Lincoln	☐ Rutherford ☐ Surry ☐ Yadkin
D. The tool is designed to be completed every six months after the initial screening. How will you begin implementation?			
☐ With new members ☐ With re-authorizations ☐ With follow-up visits Other: Click or tap here to enter text.			
E. How will the SDOH tool will be completed?			
☐ Partners Electronic Version ☐ Partners Data Entry Template			
F. Who will be implementing the tool?		☐ Member or responsible person ☐ Peer support specialists ☐ Intake staff ☐ Therapists or enhanced services staff Others: Click or tap here to enter text.	
G. Who will be the organization points of contact for this implementation process? Those listed will be responsible for oversight of the project.		1. Name: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text. 2. Name: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text. 3. Name: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text.	
H. When will implementation begin?		Date: Click here to enter a date.	

I. How will you utilize results to improve member health, population health and community engagement?

Describe the plan: [Click here to enter text.](#)

NOTE: The critical question of measurement-based care and using data to inform outcomes is central to this question.

Providers should be ready to take the SDOH data, assess it against the wellness of the member, use data to address resource shortages, and document efforts to address SDOH deficits for members as part of an overall plan.

J. Partners thanks you for joining us to address SDOH. The risk level for SDOH impact is three or more SDOH's. As such, best practice indicates a plan to address SDOH when three or more elements are affirmative. Identified current needs should be prioritized. Providers/clinicians will be asked to confirm that a plan that documents the deficits are being or will be addressed is included in the member's SDOH Tool upon submission.

Entries into Partner's electronic format may be completed on an on-going basis. For providers who send data in the Data Entry Template, please send that to SDOH@partnersbhm.org by the 5th of each month for the prior month.

PLEASE COMPLETE SECTION III AND SEND TO SDOH@PARTNERSBHM.ORG TO BEGIN THE PROCESS.

IV. INSTRUCTIONS

A. Data analysis results provided by Partners will include analysis at the following levels:

County	Agency
Zip code	Analysis using descriptive/comparison statistics

Individual level analysis will not be provided.

*As noted in section II, agencies will be expected to address SDOH deficits and develop a plan for those with three or more indicators, ameliorating critical SDOH disparities as part of overall health and wellness.

NOTE: Partners employs Complex Systems Innovations to analyze SDOH data.

B. Assessment Tool Completion Instructions - *To ensure we preserve the quality of the data, please ensure ALL questions are answered.*

DATE	Date the form is completed
MEDICAID #	Member's Medicaid Number
ALPHA ID:	Partners' Alpha ID Number
LAST NAME:	Member's last name
FIRST NAME:	Member's first name
AGENCY:	Name of agency where member is completing the tool
COUNTY:	Member's county of residence
ZIP CODE:	Member's residence zip code

C. Electronic SDOH Tool

The SDOH tool would be completed by designated staff in your organization. After the application portion in section III is completed and submitted in its entirety to SDOH@partnersbhm.org, credentials will be sent by Partners with log-in instructions. Each staff member completing the tool in the portal will be required to create an account.

The data available will be limited to your organization. However, to support identification of resource needs, provider reports will include county data to compare against provider responses.

D. Contact Information

Questions about the implementation process and requests for technical assistance may be sent to SDOH@partnersbhm.org.

V. REFERENCES

1. <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/about-healthy-opportunities>
2. <https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/>
3. Walby, Dr. Gary; Partners Whole Person Integrated Care (WPIC) Model. Social Determinants of Health Summary Report (Aug. 2019)
4. <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions>
5. <https://duckduckgo.com/l/?kh=-1&uddg=https%3A%2F%2Ffiles.nc.gov%2Fncdhhs%2Fdocuments%2FSDOH-Screening-Tool-Paper-FINAL-20180405.pdf>

Appendix A

Social Determinants of Health Assessment

Medicaid # _____ Alpha ID # _____

Date _____ Agency _____

First Name _____ Last Name _____

County _____ Zip Code _____

*There are local programs to help you with needs that can affect your health.
Are there things you need help with?*

	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	☐	☐
1.a. Is having enough food a current need or concern?*	☐	☐
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	☐	☐
2.a. Is food not lasting a current need or concern?	☐	☐
3. Do you have housing?*	☐	☐
4. Are you worried about losing your housing?	☐	☐
5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	☐	☐
5.a. Are having utilities a current need or concern?	☐	☐
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	☐	☐
6.a. Is this a current need or concern?	☐	☐
7. Do you feel physically and emotionally safe where you currently live?	☐	☐
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐	☐
8.a. Is this a current concern?*	☐	☐
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	☐	☐
9.a. Is this a current need or concern?	☐	☐
10. In the past 12 months, have you had trouble affording health insurance (such as deductibles, co-payments, etc.)	☐	☐
10.a. Is health insurance a current need or concern?	☐	☐
11. In the past 12 months, have you had trouble paying for or accessing medications?	☐	☐
11.a. Is this a current need or concern?	☐	☐
12. In the past 12 months, have you had concerns over obtaining or maintaining employment?	☐	☐
12.a. Is employment a current need or concern?	☐	☐

CRITICAL: For completion by therapist/staff: ☐ Check and initial _____, confirming that if three (in bold) or

more of items **1.a, 2.a, 3 (if no), 5.a, 6.a, 7 (if no), 8.a, 9.a, 10.a, 11.a, 12.a.** are checked that a plan will be developed to address the deficits. *Essential; needs to be addressed immediately. 091919