Social Drivers Of Health

TIPS TO CREATE YOUR "WHY" WITH YOUR TEAM

One of the biggest challenges when starting an SDOH screening program is defining the **"why"** statement for your patients and your team. Clinicians and staff members may feel *frustrated* that they do not have resources available to meet patients' needs. In turn, patients may feel *confused* that they are being asked about these areas of need if they are not offered support.

With a clear understanding of the purpose and potential of your SDOH work everyone involved—from patients to clinicians—will feel more at ease having these conversations and creating solutions. This tip sheet includes ideas on how to craft messages for your team to explain the purpose of SDOH screening. It also includes ideas for how to build a trusting environment to have these conversations. See the companion document for similar guidance on how to talk with patients about the purpose of SDOH screening.

This tip sheet is based on conversations with patient and family caregiver partners (PFPs) and hospital leaders across the country. We express our deep thanks to everyone who shared their insight, recommendations, and experiences to help craft this document. If you wish to learn more about how to collaborate with the Convergence Patient Family Partner Council, community please contact:
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TIPS FOR **TALKING WITH YOUR HOSPITAL TEAM ABOUT SDOH SCREENING**

1 DEMONSTRATE THE RELATIONSHIP BETWEEN SOCIAL DRIVERS OF HEALTH AND MEDICAL CARE

Requirements for SDOH screening are rooted in evidence that shows the impact of **non-medical factors (including social, economic, and environmental) on health outcomes**. The logic goes: health and health care systems will not be able to improve health outcomes without addressing these underlying factors. If health care organizations are aware of patients' individual SDOH needs, however, they may be able to adjust care plans to mitigate any barriers or connect patients to resources in the community.

Additionally, as health care organizations collect SDOH data over time, they can more readily i*dentify patterns of need in their communities*. Hospitals and health systems, in partnership with others, can then work to build new resources or solutions to these challenges.

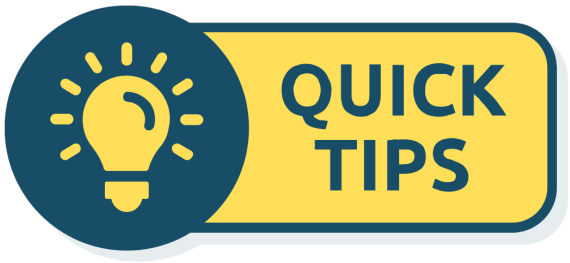
HOW CAN SDOH SCREENING INFLUENCE CARE PLANS?

Your community might not have resources to meet every patient's needs. However, clinicians may be able to adjust care plans based on a patient's SDOH needs, even without making a specific referral. For example, knowing that a person has food insecurity might help a physician or dietitian provide more specific advice on available and affordable foods that could help a patient reach a healthy blood sugar level.

You can find additional detail about the relationship between SDOH and health outcomes from these sources:

- Office of Disease Prevention and Health Promotion: https://health.gov/healthypeople/priority-areas/social-determinants-health
- World Health Organization: https://www.who.int/health-topics/social-determinants-of-health
- Rural Health Information Hub: https://www.ruralhealthinfo.org/topics/social-determinants-of-health

1 DEMONSTRATE THE RELATIONSHIP BETWEEN SOCIAL DRIVERS OF HEALTH AND MEDICAL CARE



1 REASSURE YOUR TEAM THAT IT IS NOT SOLELY THE HOSPITAL'S JOB TO MEET SDOH NEEDS

Rather, having a greater awareness of needs will help care teams and the hospital explore how they can be part of a solution, in partnership with others in the community.

2 ANTICIPATE DIFFERENT LEVELS OF FAMILIARITY WITH SDOH

Some of your team members may have learned about SDOH as part of their educational training. Others may be aware of the challenges people face but will not be used to considering those circumstances in a health care setting. Some of your team may not yet have heard about the relationship between non-medical factors and health care outcomes. Consider how you can explain the goals of the screening to people with different educational or experiential backgrounds.

3 USE STORIES TO CLEARLY ILLUSTRATE THE RELATIONSHIP BETWEEN THE HEALTH SYSTEM'S PRIORITIES AND SDOH NEEDS

You can provide examples from your own experience of times when considering a patient's SDOH needs led to a change in the care plan or an instance where you were able to connect someone to a new resource. Stories show that SDOH screening is more than a data collection exercise but rather an opportunity to provide better care for patients by taking their full life circumstances into account .

"I'm a nurse...we all know that people in our community are struggling, but we've never really focused on these issues as nurses. We've focused on the physical part and assisting patients to get better. But we have patients who are readmitted because they couldn't afford their medication or they are living in a trailer and that impacted their health. SDOH screening is just looking at a whole new aspect of the care we provide, and that's what we have to teach."

2 SHOW HOW SDOH SCREENING RELATES TO THE HEALTH CARE TEAM'S DAY-TO-DAY PRIORITIES.

Nurses, physicians, and other clinicians may not see how a patient's SDOH needs relate to the care they provide in the hospital. This information about the patient's circumstances, however, adds new detail that can inform how we prepare to send patients home and arrange follow up care. Collaborate with your team to explore ideas for how to use SDOH information throughout the patient's stay and beyond. Also consider **whether, when, and how** various team members are accessing the SDOH information.

For example:

> **Is it something that we could be discussing during rounds or in a daily huddle?**

FROM THE FIELD

"Right now, addressing SDOH is not really articulated in the nurses' or physicians' care. They're not really understanding the link between if the patient doesn't have transportation they won't be going to appointments post-discharge, so they will come back and be readmitted. Talking about [SDOH] on a daily basis, with the patients' support people and with the provider as well, kind of gels it all."

"When you're bedside you're thinking about tasks. You're not thinking about what happens when the patient leaves. We need to be thinking about the whole picture as a circle of health and how once they leave there are things that affect them. We're not just treating what the patient is here for but also other SDOH or medical conditions that affect the current diagnosis."

3 SUPPORT DOCUMENTATION IN ADDITION TO MEETING PATIENT NEEDS

Many hospitals already have social workers or care management teams who are asking patients about SDOH and are working to meet those needs. In this case, the new attention to screening tools and documentation may present a different challenge – figuring out how to reconcile those screening requirements with processes already in place. Before implementing a new screening or documentation process, find out if anyone in your organization is already collecting this information and if you can adapt that existing process to meet the new screening requirements.

It may be difficult to for those team members (such as social workers or case managers) to understand why they must adjust their process and documentation to meet new requirements. It might feel like the documentation takes precedence over the ability to connect patients to resources, or that using a more formalized tool impacts their ability to have more free flowing conversations with patients. Take time to explain to your team the value of consistent documentation.

For example:

1. **How will you analyze your screening data?**
2. **What patterns or trends might you discover?**
3. **Demonstrate how this information source will allow the organization to invest in new resources or solutions in the community.**

4 SET A VISION AND DESCRIBE YOUR NEXT STEPS

You team members and patients alike may wonder, "why are we asking these questions if we don't have solutions?" You will never have solutions to all patient needs but over time you will gain a better understanding of the resources that DO exist in your community and you also will likely build or identify some new resources. In the meantime, you can always explain what you are doing and how you are using the information to bring change.

For example, you can:

- Compile a community resource guide to share with your team and patients.
- Demonstrate how you might adjust a patient's care plan based on their circumstances, even if you can't fully address the need.
- Meet with community partners to talk about the information you are collecting and what you are learning. Brainstorm ways to work together to better meet patients' needs.
- Share the data with your hospital leadership team and board of directors.
- Share the data with local government to advocate for community changes that are needed.

We asked hospital leaders to share how the explain the goals of SDOH screening to their teams and to patients:

- "To better meet needs after discharge and to offer assistance while you are here"
- " To help improve outcomes after discharge"
- " To identify where people are struggling, considering the person as a whole being: physically, emotionally, financially, mentally, and socially"
- "When you leave here we want to make sure you stay healthy and that you can stay out of the hospital."

"We're asking these questions not to be invasive but to find out if there is an issue where we can connect patients with resources that we have available in the community, because we have a lot of resources that patients don't realize we have."

For a fun way to talk about your SDOH work with your team, check out the Convergence SDOH Mad Libs . This fill-in-the-blank exercise will help you take stock of your screening process, identify any gaps, and help your team think creatively about how to spread the word about the work.