Screening for Social Determinants of Health

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Disclosures

- Nothing to Disclose

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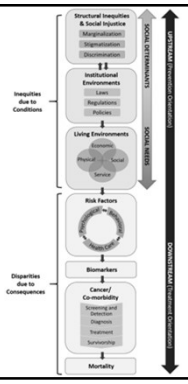
Social Determinants of Health

- Non-medical factors that influence health outcomes
  - Income and social protection
  - Education
  - Unemployment and job insecurity
  - Working life conditions
  - Food insecurity
  - Housing, basic amenities and the environment
  - Early childhood development
  - Social inclusion and non-discrimination
  - Structural conflict
  - Access to health services



Alcaraz et al. CA A Cancer J Cln, 70: 31-46; 2020.

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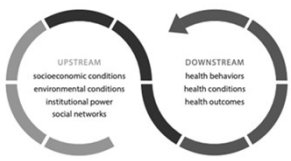
Why do SDOH matter?

- Social factors can drive as much as 80% of health outcomes.



Robert Wood Johnson Foundation; PRAPARE Toolkit.

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SDOH & Cancer Care


Persistent Disparity: Socioeconomic Deprivation and Cancer Outcomes in Patients Treated in Clinical Trials

JAMA Network Open

Association of Cumulative Social Risk and Social Support With Receipt of Chemotherapy Among Patients With Advanced Colorectal Cancer

JAMA Oncology | Original Investigation

Association of Social Determinants and Tumor Biology With Racial Disparity in Survival From Early-Stage, Hormone-Dependent Breast Cancer


HOUSING

Housing Status Changes Are Associated With Cancer Outcomes Among US Veterans

RESEARCH ARTICLE

WILEY

Differences in receipt of multimodality therapy by race, insurance status, and socioeconomic disadvantage in patients with resected pancreatic cancer

Scarlett Hao MD[1] | Anastasios Mitsakos MD[1] | William Irish PhD[1,2] | Janet Elizabeth Tuttle-Newhall MD, FACS[1] | Alexander A. Parikh MD, MPH, FACS[1] | Rebecca A. Snyder MD, MPH, FACS[1,2]

SPECIAL SERIES: DISPARITIES IN CANCER CARE FOR BLACK PEOPLE IN THE UNITED STATES

Social Determinants of Health and Disparities in Cancer Care for Black People in the United States

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Integrating Social Care into Delivery of Health Care

TABLE S-1 Definitions of Health Care System Activities That Strengthen Social Care Integration

Activity	Definition	Transportation-Related Example
Awareness	Activities that identify the social risks and assets of defined patients and populations.	Ask people about their access to transportation.
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers.	Reduce the need for in-person health care appointments by using other options such as telehealth appointments.
Assistance	Activities that reduce social risk by providing assistance in connecting patients with relevant social care resources.	Provide transportation vouchers so that patients can travel to health care appointments. Vouchers can be used for ride-sharing services or public transit.
Alignment	Activities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergies, and invest in and deploy them to positively affect health outcomes.	Invest in community ride-sharing or time-bank programs.
Advocacy	Activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs.	Work to promote policies that fundamentally change the transportation infrastructure within the community.

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CMS Framework for Health Equity: 2022-2032

ICD-10-CM	Description
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

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CMS Mandate

- Hospitals reporting to the Inpatient Quality Reporting Program must submit 2 new measures of SDOH screening in 2024
  - Of all patients admitted to the hospital, how many were screened for SDOH?
  - Of all patients who received screening, how many were identified as having one or more social risk factor?
- Five screening domains:

https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

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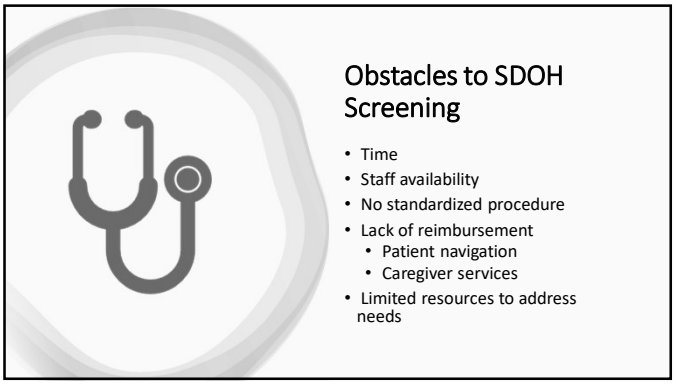

Obstacles to SDOH Screening

- Time
- Staff availability
- No standardized procedure
- Lack of reimbursement
  - Patient navigation
  - Caregiver services
- Limited resources to address needs

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SDOH Screening Tools

- Epic Healthy Planet
- PRAPARE
- The EveryONE Project Social Needs Screening Tool
- Accountable Health Communities Health Related Social Needs Screening Tool
- HealthBegins SDOH Screening Tool

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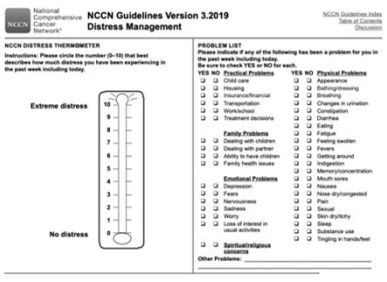
NCCN Distress Thermometer



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Potential Challenges

1. How do we fit into existing workflow without increasing visit time?
2. How do we add another initiative to already busy schedules?
3. What if we do not have the resources to address identified SDOH needs?

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Feasibility of Screening

Objective: To assess feasibility and acceptability of implementation of an electronic health record (EHR) instrument designed to measure SDOH into routine clinical practice at East Carolina University Cancer Center.

Methods:
- Prospective pilot study 11/2020-7/2021
- All patients in new evaluation visit for biopsy-proven gastrointestinal cancer
- EHR-based screening tool administered by nurse navigator, social worker, or trained medical student

PRIMARY OUTCOMES
- Percent screened
- Median clinic visit time
- Acceptability

Hao S, Snyder RA et al. Ann Surg Oncol. 30(12):7299-7308. 2023.

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Results

- Of 118 eligible patients, 113 (95.8%) successfully completed screening.
- Resources offered to 20 patients (17.6%) to address SDOH needs.

Most Common Severe Needs
- Physical activity (n=62)
- Stress (n=55)
- Tobacco use (n=23)
- Food insecurity (n=9)

Most Common Moderate Needs
- Social connection (n=76)
- Tobacco use (n=44)
- Physical activity (n=21)
- Financial strain (n=12)

Hao S, Snyder RA et al. Ann Surg Oncol. 30(12):7299-7308. 2023.

Unpublished data; under revision

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Results

	Pre-implementation	Post-implementation	P-value
Median Clinic Visit Time	97 minutes [70-107]	99 minutes [73-118]	0.95

- Team members found SDOH screening acceptable and did not report clinic workflow disruptions.
- Staff and physicians were supportive of ongoing use based on interview and quantitative survey-based findings.

Most Common Reasons For Lack of Screening (n=5)

- Screener unavailable
- Patient needing direct admission
- Patient continuing care elsewhere

Hao S, Snyder RA et al. Ann Surg Oncol. 30(12):7299-7308. 2023.

Unpublished data; under revisions

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Ecological Fallacy

Census Tract Measure	SDOH Domain	Coefficient	p-value
Median Household Income	Financial Strain	0.20	<0.05
	Food Insecurity	0.01	0.90
% Below Poverty	Financial Strain	0.12	0.22
	Food Insecurity	0.10	0.32
% Unemployed	Financial Strain	0.13	0.18
	Food Insecurity	0.09	0.37
% Households Without a Vehicle	Lack of Transportation	0.27	0.01
	Food Insecurity	0.06	0.57
% No High School Diploma	Financial Strain	0.21	0.04
% Low Access to Healthy Foods	Lack of Transportation	0.18	0.04

Hao S, Snyder RA, *In Press.*

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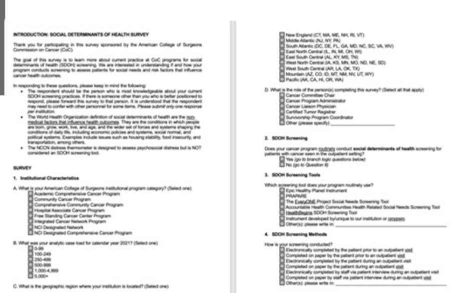
Upcoming Survey: SDOH Screening



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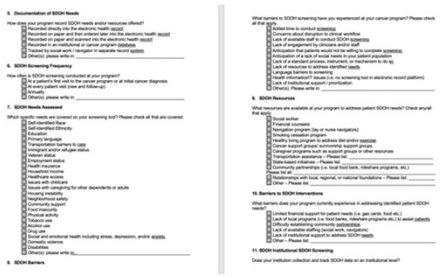
Upcoming Survey: SDOH Screening



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Key Takeaways

- Social risk factors and needs influence receipt of cancer care and long-term cancer outcomes.
- Screening for social determinants of health allows us to identify patient barriers to care and address them proactively.
- Addressing social needs may improve adherence to recommended treatment and improve health equity.

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Thank you!

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