Guidance on Completion of Social Determinants of Health Screening Questions: AIDS Institute Reporting System (AIRS)

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PURPOSE OF THIS DOCUMENT

This document was developed to provide guidance regarding the implementation of screening for social determinants of health within the AIDS Institute Reporting System (AIRS). It offers practical guidance and answers frequently asked questions. In addition to this guidance, a training titled ***Affirming Screening for Social Determinants of Health*** is available at https://www.hivtrainingny.org/.

IMPORTANT DEFINITIONS

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the overarching factors in society that impact health. These include:

- Secure employment, safe, bias-free working conditions and equitable living wages;
- Healthy environment, including clean water and air;
- Safe neighborhoods and housing;
- Food security and access to healthy food;
- Access to comprehensive, quality health care services;
- Access to transportation;
- Quality education;
- Access to a social support network.

Inequities in access to SDOH are a result of structural racism, sexism, homophobia, transphobia, poverty, stigma, and other forms of oppression that are perpetuated by current social structures and institutions.

HEALTH DISPARITIES: The statistical difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.

HEALTH INEQUITIES: Disparities in health that result from social or policy conditions that are unfair or unjust.

HEALTH EQUITY: Health equity is achieved when no one is limited in achieving good health because of their social position or any other social determinant of health. The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes.

How can screening for social determinants of health improve health outcomes and promote health equity?

Screening for social determinants of health (SDOH) is a central element of health equity programming. Experts estimate that genetics and individual choices contribute about 20% to our likelihood of positive health outcomes, while SDOH - where we live, how much money we have, our access to healthy food, etc. - account for about 80% of our likelihood of well-being and positive health outcomes. Health Policy in Brief: RWJF The purpose of screening for SDOH is to help health and human services providers identify clients whose health is vulnerable because of a lack of access to essential needs. Screening will enable providers to identify those clients with one or more SDOH vulnerabilities for intensive support, especially during critical periods such as throughout the duration of HCV treatment, initial HIV diagnosis, PrEP initiation, etc. At the agency manager level, screening for SDOH will allow an agency to more closely monitor health outcomes for the most vulnerable clients, become aware of, and advocate for, needed services and resources in the community, plan local referral networks to meet needed essential services, and better evaluate the impact of the program on individuals and the community.

Screening Tool	
SDOH Domain	**Question**
Housing Status	What is your living situation today? 1. I have a steady place to live 2. I have a place to live today, but I am worried about losing it in the future 3. I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) 4. Chose not to respond
Food/Nutrition	Do you need assistance accessing enough healthy food for yourself and your family on a regular basis? 1. Yes 2. No 3. Chose not to respond How often do you or your family not have enough to eat? 1. Often 2. Occasionally 3. Never 4. Chose not to respond
Transportation	Do you regularly have trouble accessing reliable transportation to medical appointments, work or getting things needed for daily living? 1. Yes 2. No 3. Chose not to respond
Financial	How hard is it for you to pay your bills? 1. Very hard 2. Somewhat hard 3. Not hard at all 4. Chose not to respond
Employment	Are you interested in assistance with finding employment or job training? 1. Yes 2. No 3. Chose not to respond
Health Literacy	Do you need help reading or understanding medical information and materials? 1. Yes 2. No 3. Chose not to respond
Social Isolation and Support	How often do you feel lonely or isolated from those around you? 1. Never 2. Sometimes 3. Always 4. Chose not to respond

Stigma	Do you avoid getting healthcare (doctor) because you feel stigmatized, discriminated against or uncomfortable there? 1. Yes - If yes, which of the following do you experience: (check all that apply) Racism Homophobia Transphobia Sexism Other 2. No 3. Chose not to respond
Disabilities	Do you have any disabilities that make it hard for you to do errands alone, such as visiting a doctor's office or shopping? 1. Yes 2. No

Script for Beginning the Conversation

This script below reviews points that help set a positive tone when conducting screening for social determinants of health. Health and human services providers are most effective when they internalize the key points from the script and make it their own, rather than reading it verbatim.

Hi, my name is ____, (state your title and pronouns). What would you like to be called? I would like to ask you a series of questions about some of the things that are important for supporting your health. The questions will be about access to food, transportation, and more. At our agency, we ask these questions of all of our clients who participate in this program. We do this because we want to support your health and connect you to any resources you need. Our agency has strict confidentiality protections. The information is available to other people in this agency who need it in order to provide care to you and designated staff who are responsible for maintaining and protecting the data. It is not given to others without your consent. It usually takes about 10 minutes to go through this, and at the end, if there is anything you need help with, we will connect you with a service to the best of our ability, if that is what you'd like.

Is it ok for us to proceed?

Good Practices for Conducting Social Determinants of Health Screening in an Affirming Manner

1. Post signs and symbols in public spaces to affirm that all are welcome.
2. Be genuine and present. Try to avoid having the client feel that you are just reading a set of questions.
3. Allow the conversation to flow as naturally as possible, not necessarily in the order of the screening questions.
4. Follow the client's lead about eye contact.
5. Make it clear you are listening attentively to their responses, not looking at your computer or the next question.
6. Consider health literacy and use plain language.
7. Clarify that this information is important for the care or service you will be providing.
8. Create space to allow the person to ask questions or seek clarification.
9. Check in with the client periodically to see if they are feeling comfortable.
10. Provide a peaceful and confidential environment without distractions or fear of someone overhearing their responses.
11. Demonstrate a sense of caring and compassion.
12. Explain next steps, including the process of connecting the person to services if any needs are identified.

Addressing Unmet Needs Regarding Social Determinants of Health

After completing the screening process, it is important to thank the person for sharing and acknowledging that some of their answers may have been deeply personal. Explain that the intent of this screening was to identify any services they need to support their health and well-being. Review any areas of unmet needs and ask the person their priorities and how they would like to proceed. Explain the resources/ referrals options available to meet their needs and who would be providing follow-up, if it's not you. Explore their preference for how to get connected to any new services: 1) would they like the contact information so they can call on their own, 2) would they like you to set up the appointment and possibly accompany them, or 3) any other available options. To avoid unrealistic expectations and disappointments, identify a realistic timeframe for getting them connected to the service. Explain that you will follow-up to make sure they truly have a successful referral and get what they need. Arrange needed follow-up appointments at a convenient time for the person. Identify their preferred method of contact and also gather several alternative ways of contacting the person. This is important in case they are not able to attend the follow-up appointment.

FREQUENTLY ASKED QUESTIONS

1. **Do I have to fill out each of these fields for every client?** All questions included in the screening should be asked of each individual. In some cases, a person may not want to answer a question. They may have many different reasons for this. It can be helpful to review the purpose for asking the questions or to offer to come back to the question later. See question 2 below for more information. It is important to note that each question includes a "Chose not to answer" option. This should be used only in instances where an individual truly does not want to answer the question.

2. **How can I respond if a client says they don't have time or don't want to answer the questions?** It is important to acknowledge and respect a client's feelings if they say they don't have time or don't want to participate in the screening. It is appropriate to gently ask for clarification: Is the issue not having the time because they have some other pressing needs to address or, do they simply not want to participate for some other reason? It might be helpful to reassure the person that you will make time to address the specific concern(s) that brought them in for the appointment today. As noted above, it can be helpful to revisit the purpose of the screening, so they understand why you are asking the questions. SDOH screening should not be imposed or continued against a client's expressed desires or wishes. If a person truly does not want to participate in the SDOH screening at this time, the focus should be on respecting their wishes and keeping the door open for future engagement.

3. **What can I do if someone has a strong emotional reaction when they are answering the questions?** Individuals who have a history of adversity or trauma may become emotionally dysregulated or upset when responding to sensitive questions like those in the screening. If you notice a strong emotional reaction to a question, it is important to acknowledge the reaction by saying something like: "I see this is upsetting", or "This is difficult." Serve as a witness to their experience by validating the emotions but recognize that it is not appropriate in this context to ask for more details that will take the person further into their upset. In some cases, it might be helpful to simply say that you can come back to that question later. Trauma-informed strategies for working through emotional upset might include: encouraging the person to take a moment; getting them some water; encouraging them to breathe; leading the person

through a self-care grounding activity, such as notice your feet on the floor, notice five things that you see in the room, or some other self-care practice that your agency approves and you are comfortable sharing. Alternatively, you can shift the focus to how they are managing or offer concrete support in the form a referral or connection to a useful resource. It is important for agencies to have a policy for how to proceed if a person's reaction is beyond your skill set. This might involve calling in your supervisor, a mental health professional, or some other internal or external resource.

4. **What can I say if a client wants more information about who has access to the answers to these questions?** If a client asks about who will have access to this information or indicates concern about confidentiality, explain that only individuals at the agency who are included in the "need to know" circle will have access to personally identifiable AIRS data. The "need to know" circle includes people who need the information in order to provide services to you and designated staff who are responsible for maintaining and protecting the data. Reassure the person that all agency staff are trained in confidentiality and that confidential information will not be shared without your consent. Staff at the NYS Department of Health who are responsible for overseeing the NYS HIV Surveillance system and the AIRS system have access to some of the data and follow strict confidentiality guidelines and protocols which have successfully safeguarded all HIV-related information since the beginning of the epidemic.

5. **Many individuals served at my agency participate in more than one program and each program has its own requirements regarding client assessments. Having to ask the client the same questions multiple times can feel like a burden to the client and staff and even retraumatize the client when they have to repeatedly report difficult life circumstances or events. How can I address this concern?** Agencies are encouraged to explore options for minimizing repetition of screening questions that inquire about the same issues. For example, the questions outlined in this SDOH screening might overlap with information required for the electronic medical record, a case management assessment, or other service. To the extent possible and permitted by different funding sources, it is beneficial to: a) make efforts to align screening questions conducted under different initiatives so that the same question/answer can suffice for multiple programs; and b) streamline screening processes such that data collected during one interview might be used to populate different data systems with the patient's responses, for example, AIRS fields and fields in the electronic medical record. Final decisions regarding these practices should be made by agency managers who fully understand the fiscal and programmatic implications.

6. **In my agency, I provide client services and we have other staff who are responsible for actually entering the data into AIRS or other data systems. Will the AIDS Institute make available a printable form with these screening questions that can completed by direct service staff and provided to the data entry person for entering into AIRS?** This form is available on AIRSNY.org under the "Assessment Forms" section.

7. **How often should this screening be repeated?** It is important to repeat screening for SDOH in accordance with agency policy and requirements or guidance of the funder. Repeating screening every six months or annually allows for identification of changes that may occur in the client's life circumstances. Ideally, the rapport built with a client through the initial screening will result in them returning for assistance as any new need arises. However, conducting routine, periodic screening is a critical component of a care plan and promotes early identification of changes in client circumstances which may impact their health and wellness.

8. **How can I best document the details of housing status for clients who indicate that they do not have a steady place to live?** The third option for answering the Housing question is: *I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).* There is a great difference between staying in a hotel versus living in a park. It is important to ask follow-up questions to fully understand the person's housing status. In addition, a client's housing status is recorded during the initial intake. The AIRS intake form allows you to indicate the person's housing status from a detailed list of thirteen different options. After the intake, updates to a client's housing status should be made in the Housing Information History Section. This is a separate screen from the intake and allows for periodic updates to housing information. The history is maintained so you can track the client's housing status information over time. Given that housing is such an important social determinant of health, follow-up for every client who is unstably housed is critical.

9. **Will my agency be penalized if many clients choose to not respond to these questions?** Agencies will not be penalized if clients choose not to respond to the SDOH screening questions. If an agency has consistent difficulty eliciting responses, this may be a reflection of the staff's discomfort and should be addressed through supervision and training. The AIDS Institute is also available to provide technical assistance if needed. Contact HIV Education and Training Programs at 518-474-3045 or email hivet@health.ny.gov.

10. **What is the role of supervisors or program managers in promoting culturally sensitive discussion of these questions and high-quality data collection?** Supervisors and program managers are responsible for creating an environment in which staff and clients can dialogue about access to SDOH in a safe and supportive manner. Steps should be taken to ensure quality data collection by reviewing records and discussing with staff any data entry and data quality issues. If issues arise, the supervisor or program manager should address them during staff meetings, offer training and consider using quality improvement practices to address them.

Resources:

Health Equity Resources: A comprehensive list of health equity resources compiled by the AIDS Institute. This document provides links to websites for health equity resources from government organizations, national organizations and community organizations, and includes health equity training resources. **https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/health_equity.pdf**

Health Equity 101 On-Line Training: A comprehensive online training that reviews important health equity terms and concepts. Visit www.hivtrainingny.org and search for Health Equity.

Health Equity Competencies for Health Care Providers: The Health Equity Competencies found in this document will be useful to all health care providers who seek to promote health equity in any health care setting. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/health_equity_providers.pdf

Health Care Organization Considerations in Support of Health Equity: This document outlines elements that health care organizations should consider to promote health equity in their practice and community. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/organization_considerations.pdf