Evaluating the Implementation of Social Determinants of Health Screening across Los Angeles County Department of Health Services

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Objective

The DHS SDOH Integration Project Steering Committee's overall objective is to integrate social care across the health system with a focus on housing, food security and transportation. As part of a formative evaluation of the current state of social care integration in DHS clinical settings— the specific objective of this study is to describe current workflows, barriers, and facilitators for SDOH screening.

Background

- The World Health Organization (WHO) defines SDOH as the **"conditions in which people are born, grow, live, work and age"** and attributes SDOH as **"mostly responsible for health inequities."**[1]
- LA County's Board of Supervisors challenged the Department of Health Services (DHS) to develop and implement SDOH screening across DHS.

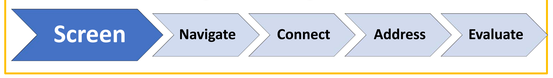
Methods

Study Design: Semi-structured, recorded interviews using an original pre-prepared interview guide with transcripts generated afterwards.

Subjects: DHS providers, in any role, leading social care integration; identified by SDOH steering committee or by subsequent snowball sampling.

Setting: LA County DHS is the 2nd largest municipal health system in the nation, containing 4 hospitals and 19 health centers.[2]

Coding and analysis: The interview guide's questions were modified utilizing a constant comparative analysis method. Themes were coded with Atlas.ti. Data analyses focused on factors influencing screening.



Results: Preliminary Analysis of Screening Process

Initiation

- 18 clinical site leaders from 8 DHS sites were interviewed regarding SDOH screenings.
- In **making the decision to initiate SDOH screenings**, clinical site directors considered:
  - Patients' needs
  - Resources for needs
  - Existing directives
- A few sites initiated SDOH screening workflows prior to systemic guidance and those sites helped create protocols to share across DHS.
- **Current large-scale directives include:**
  - DHS's Behavioral Health initiative (BHI)
  - California ACEs Learning and Quality Collaborative (CALQIC)
  - Senate Bill No. 1152

Development

- Clinical directors who report **developing successful screening workflows** consistently work to:
  - Build a clinical climate around SDOH
  - Delineate staff's scope of work
  - Train staff to practice trauma-informed care
  - Involve frontline workers in the process
  - Focus on screening for actionable SDOH
- Clinical directors report that SDOH screening workflows are **often paired with behavioral health screens** or other intake questions.
- Screening questions are also prioritized if there is funding to address the social need.
- **Validated screening questions** are built into the Electronic Health Record (EHR).

Workflow

Who Screens?

- In **clinical settings where screening workflows are still being developed**:
  - SDOH questions are only asked if the topic arises during the visit
- In **primary care settings** with advanced SDOH integration:
  - Certified Medical Assistants (CMAs) or nurses usually conduct universal SDOH screening
- In **pediatric settings** that address Adverse Childhood Experiences (ACEs):
  - Physicians utilize the Pediatric ACEs Screening and Related Life Events Screener (PEARLS) for targeted screening
- In the **Emergency Department (ED)**:
  - Responsibility for screening is spread across all staff

Outcomes

Clinic specific reports:
- Track data to identify SDOH screening rates and prevalence rates
- Reveal SDOH needs are high but rates may be lower due to patient trust

Barriers:
- Patient trust
- Overtasking current staff
- Lack of staffing
- Lack of training
- Competing screening priorities
- Limited resources to address SDOH uncovered during the screening

Positive impacts:
- Staff fulfillment of meeting patients' needs
- Stronger relationships with patients
- Meaningful integration of social work teams for referrals

Facilitators for success:
- Project champions
- Clinic climate centered around SDOH importance
- Team support
- Staff buy-in
- Expanding partnerships with community orgs to address needs

> *I think what we find with any county facility is that things are implemented first and then questions are asked later.*

> *The most successful kind of practices start with having everybody's voice heard.*

> *There's no point in screening if you can't help people when you identify a positive screen. Making sure the referral— the intervention— is realistic, effective, and useful for the patients, is the most important thing.*

> *[SDOH screening] has made us stop thinking linearly and instead thinking more comprehensively for integration.*

Limitations

- Not all DHS clinical settings with screening implementation were interviewed.
- Small-scale targeted screening initiatives were not thoroughly discussed.
- COVID-19 changed the way clinics are currently operating and complicated their ability to gather screening data.

Conclusions/ Next Steps

- There is **varying SDOH screening implementation** across DHS— ranging from established workflows to strain on current staff.
- Although mandates attempt to unify the screening process, **additional support in training, dissemination, and funding is needed** for smooth screening integration.
- Clinical sites reporting success have directors and team members who **champion addressing SDOH** to meet the root cause of patients' health needs.
- **The findings of this study will help design interventions** that can be used to facilitate successful SDOH implementation.
- **Next steps** for our analyses will include refinement of our emergent themes and mapping those themes to the Behavior Change Wheel model.

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