Developing a Senior-Specific Screener: Identifying and Addressing Social Determinants of Health for Seniors

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BACKGROUND

Social determinants of health (SDOH) significantly impact seniors’ health outcomes and costs, as well as influence their ability to age in place. However, SDOH are infrequently identified and addressed in clinical settings (i.e., social prescribing).

As part of a multi-year project to provide comprehensive care to senior patients, an approach to systematically identify and respond to unmet SDOH-related needs was developed and tested at the University of California, Irvine Senior Health Center (SHC).

METHODS

Formative evaluation was conducted at the SHC to understand staff perspectives and current processes. Findings showed a lack of standardized processes to identify SDOH and a need for a senior-specific needs screener.

This led to the development of the screener:

1) Compiled 6 existing social needs screeners
2) Held working sessions with experts
   • E.g., geriatricians, social workers, researchers
3) Selected/modified questions from 7 domains
4) Rapid cycle testing of 11-item screener with subset of patients (3-month)
   • 6 iterations based on feedback
5) Reached final 12-item version of screener

RESULTS

Changes before testing included:
- Reduced to 7 SDOH domains
- Modified wording of existing questions
  - E.g., physicians were concerned with emphasis on finances for food insecurity

Changes during testing included:
- Changed the order of questions
- Developed and added a nutrition quality question
- Edited wording for clarity
- Changed title (“social needs”)
- Reformatted for ease of use

Rapid cycle testing of 11-item specific social needs screener

344 approached
276 screened
22 screened +

12-item Senior-Specific Social Needs Screener

<table>
<thead>
<tr>
<th>Domain (Source)</th>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness/Social Isolation (PRAPARE)</td>
<td>1. How often do you see or talk to people that you care about and feel close to? For example, talking to friends on the phone, visiting friend or family, going to church.</td>
<td>&lt;1 time a week (1)</td>
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<tr>
<td>Loneliness/Social Isolation (N/A)</td>
<td>2. Are you satisfied with the amount of social interactions you have every week?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Mobility/Daily Living (HRA LTSS*)</td>
<td>3. Do you need help from another person or service animal with any daily activities, such as bathing, dressing, eating or doing household chores?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Mobility/Daily Living (HRA LTSS)</td>
<td>4. Can you easily and safely move around in your home?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Caregiving (HRA LTSS)</td>
<td>5. Do you have family members or other people willing and able to help you when you need it?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Food/Nutrition (N/A**)</td>
<td>6. In the last 6 months, were you able to afford to eat healthy meals?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Food/Nutrition (Health Leads*)</td>
<td>7. In the last 6 months, did you ever eat less than you felt you should?</td>
<td>Yes(1) No(1)</td>
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<tr>
<td>Housing (PRAPARE)</td>
<td>8. Are you worried about losing your housing?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Transportation (PRAPARE)</td>
<td>9. In the past 6 months, has lack of transportation kept you from medical appointments?</td>
<td>Yes(1) No(1)</td>
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<tr>
<td>Transportation (PRAPARE)</td>
<td>10. In the past 6 months, has a lack of transportation kept you from attending social events (e.g., church, senior center) or getting things needed for daily living (e.g., groceries, clothes)?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Finances (HealthBegins)</td>
<td>11. Do you ever have problems making ends meet or being able to afford everything you need?</td>
<td>Yes(1) No(1)</td>
</tr>
<tr>
<td>Finances (Health Leads*)</td>
<td>12. In the last 6 months, has your utility company (e.g., electric, gas, or water) shut off or threatened to shut off your service for not paying your bills?</td>
<td>Yes(1) No(1)</td>
</tr>
</tbody>
</table>

SOURCES:
- PRAPARE: Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences
- HRA LTSS: Health Leads Social Needs Assessment
- HealthBegins: Upstream Risk Screening Tool

NEXT STEPS

The senior-specific social needs screener and associated workflows are currently being implemented across the SHC. This includes:
- Process and outcome evaluation
- Assessing utility of screener items
- Modifying implementation strategies to address barriers identified during rapid cycle testing
- Developing patient-facing materials
- Engaging broader stakeholders

Developing and formalizing a process to address the full range of social needs of senior patients at the SHC is a critical step in building a culture that promotes health equity within the SHC. Ultimately, this process may help seniors stay healthy in their homes.

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