Identifying and Addressing Social Determinants of Health: A Health-System Specialty Pharmacy Approach

HPR148

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BACKGROUND

- Social determinants of health (SDOH) are the conditions in which people are born, live, work, and play, which contribute to approximately 50% of health outcomes.[1]
- Health-related social needs (HRSNs) are social and economic experiences that directly impact an individual's health and well-being and may include access to healthy food, employment, reliable transportation, secure housing, education, personal safety, and family support.[2]
- Among people with type 2 diabetes mellitus (T2DM) and HIV, several SDOH-related disparities exist, including socioeconomic status (e.g., poverty and homelessness), healthcare access, and neighborhood.[3,4]
- Screening for and addressing unmet HRSNs among people living with T2DM and HIV can help close the health inequality gap, and health-system specialty pharmacy (HSSP) teams provide a unique opportunity to expand and operationalize this process.

OBJECTIVES

To describe the findings of a HSSP-led SDOH screening and referral initiative

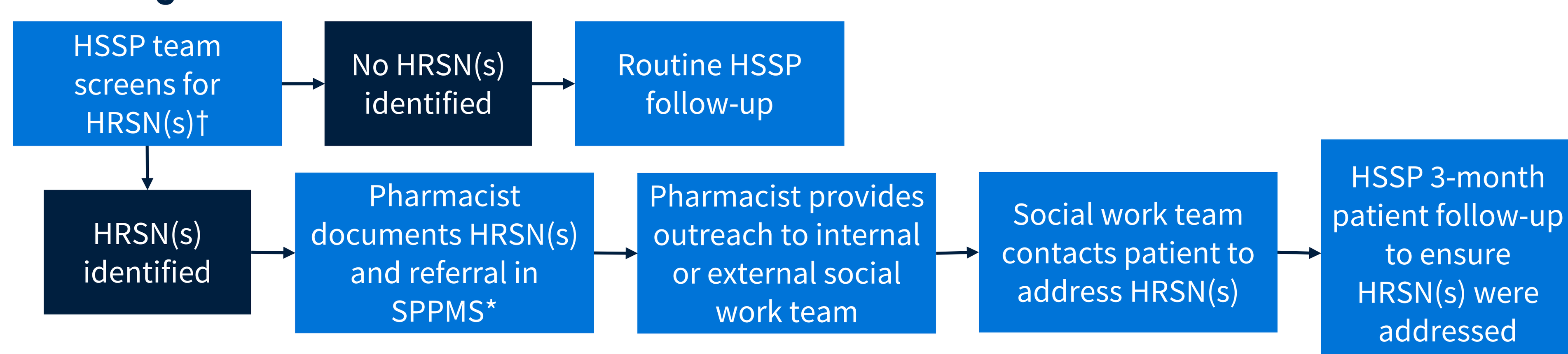
METHODS

In August 2023, SDOH screening pilot programs were implemented at two client-managed HSSPs. The target population was adult patients living with HIV (site 1) and T2DM (site 2) who were dispensing with the HSSP and enrolled in specialty pharmacy clinical services.

Pre-Implementation Steps

- Selection of HRSN screening tool (adapted from the Health Leads Screening Toolkit)[4]
- Collaboration with health system and/or local health department social work teams to identify resources and support services available for addressing identified HRSNs
- Integration of a community resource guide, developed by the county health department, for pharmacists' use

Screening & Referral Process



†Completed by pharmacist or liaison
*Specialty Pharmacy Patient Management System

Data Collection & Endpoints

Data included patients' responses from the screening tool and were recorded in data collection sheets via Microsoft Excel.

1. Number of Patients Screened
2. Screen Positive Rate
3. Identified HRSNs
4. Referral for Assistance

METHODS

TABLE 1: HRSN Screening Tool

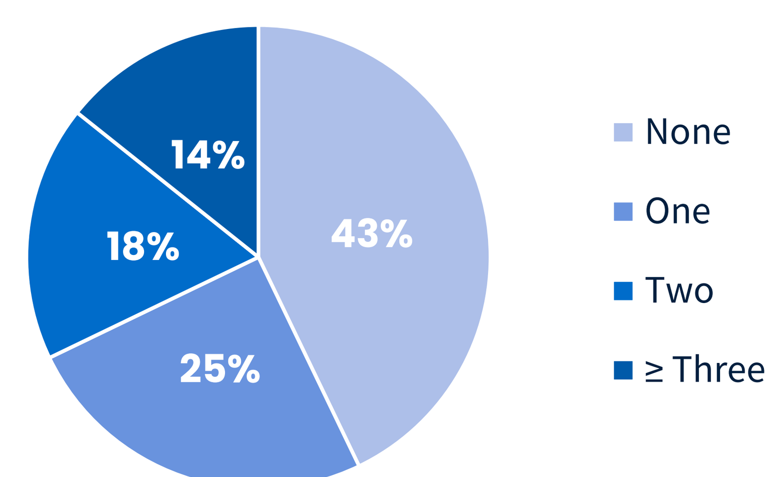
Question (Y/N)	Associated HRSN
In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Food insecurity
Is it difficult to get enough healthy food to eat?	Food insecurity
In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Utility help needs
Are you worried that in the next 2 months, you may not have stable housing?	Housing instability
Do problems getting childcare, or family care make it difficult for you to work or study?	Family and community support
In the last 12 months, have you needed to see a doctor, but could not because of cost?	Financial strain
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Transportation problems
Do you ever need help reading or understanding hospital materials?	Health literacy
Do you feel unsafe in your daily life?	Interpersonal safety
Do you often feel that you lack companionship?	Family and community support
If you answered YES to any questions above, would you like to receive assistance with any of these needs?	

RESULTS

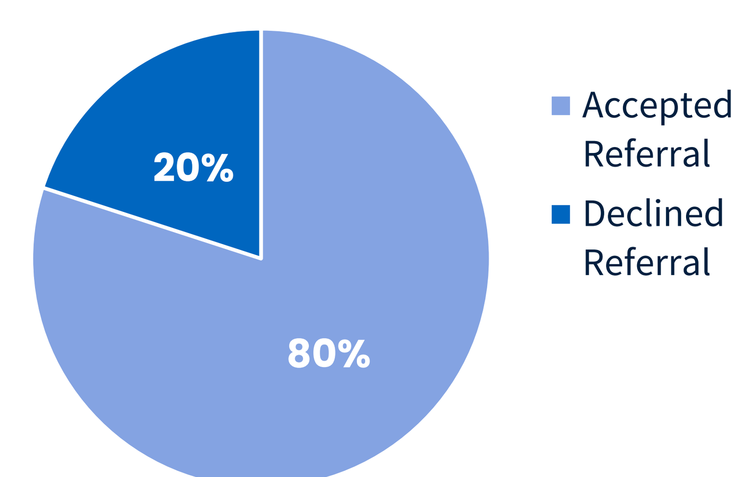
FIGURE 1: Pilot Program SDOH Outcomes

HRSNs screening was completed for 59 patients (44 HIV, 15 T2DM) and revealed a screen positive rate of 59%

Number of HRSN(s) Identified

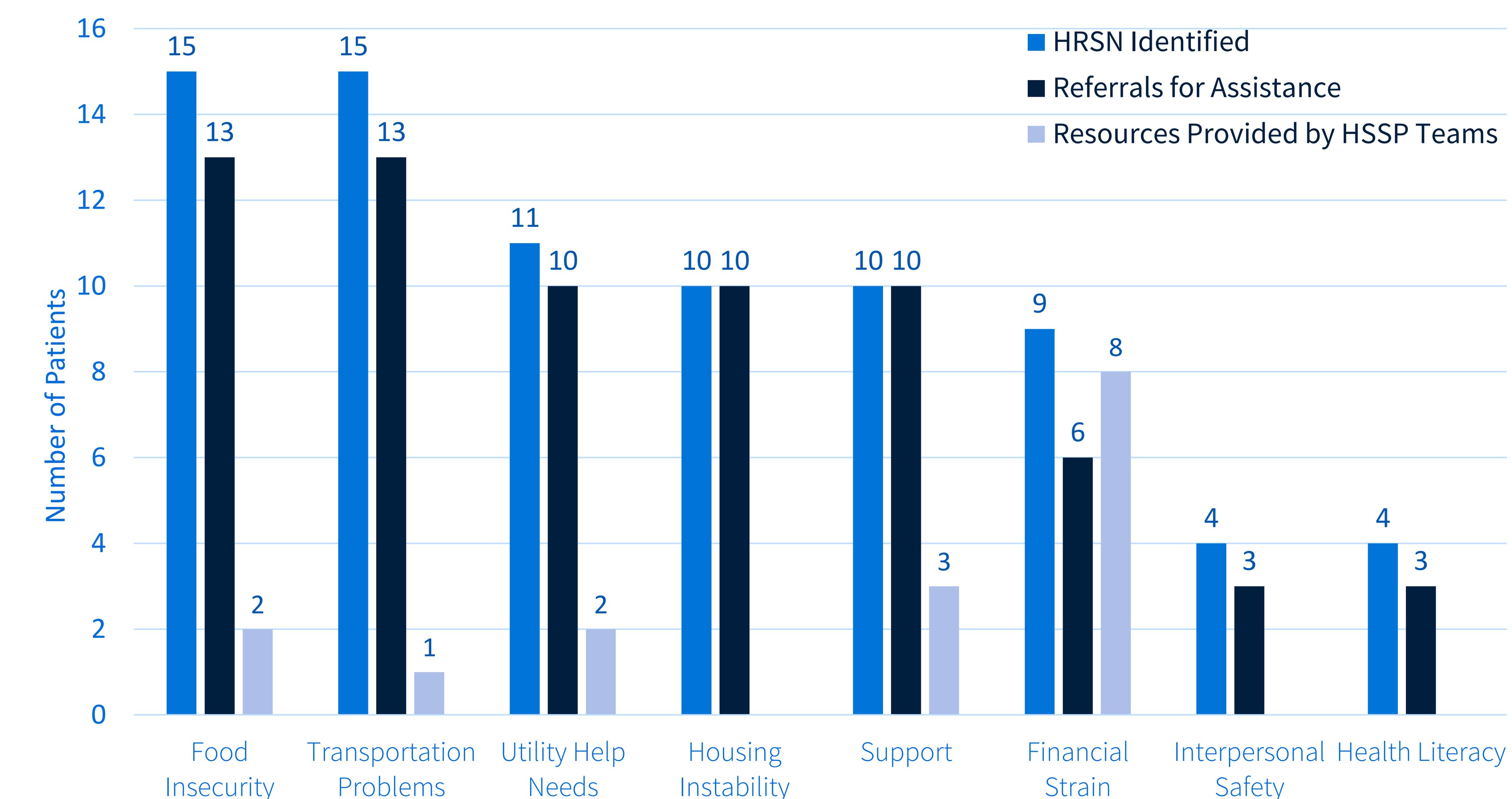


Referral for Assistance (n=35)



RESULTS

FIGURE 2: Screening Identified HRSNs & Associated Actions



DISCUSSION AND CONCLUSION

Key Findings

- HSSP teams can effectively screen for HRSNs and refer patients to resources within the health system or community when social needs are identified.
- HRSNs remain prevalent among people living with HIV and T2DM.
- When HRSNs were identified, most patients accepted assistance to address needs.

Future Directions

- Continue to follow patients with identified HRSNs over the next year to explore the impact of the screening and referral process on clinical outcomes (e.g., medication adherence and healthcare utilization)
- Repeat screening annually, at a minimum, to continually assess for HRSNs
- Integrate screening and referral process across all client-managed HSSPs to ensure that HRSNs are considered when developing treatment plans

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