

Tackling Social Drivers of Health

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Disclosures

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Have documented no financial relationships to disclose or Conflicts of Interest (COIs) to resolve.



Learning Objectives

To describe the benefits of utilizing a public health model to address social drivers of health

To discuss multi-disciplinary strategies to identify and address social drivers of health across a large healthcare system



Setting

Texas Children's Hospital

More than 900 beds at 4 Texas campuses: Texas Medical Center, West Campus, The Woodlands, and North Austin

4.9 million patient encounters and nearly 7,000 births annually

More than 15,000 faculty and staff across its hospitals and community locations



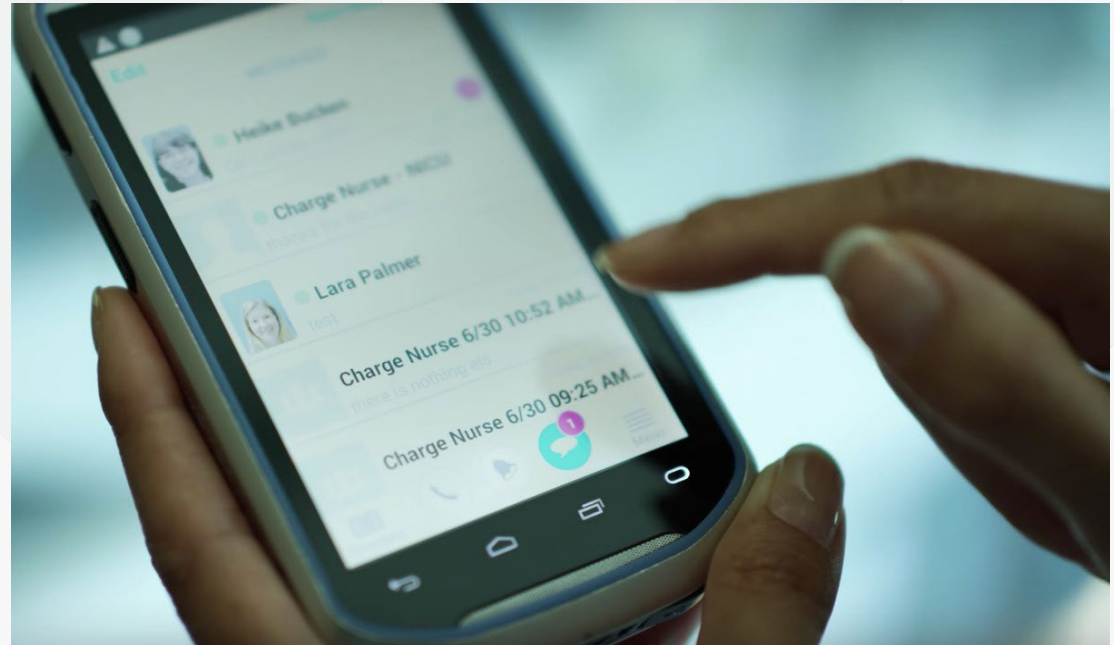
Baylor College of Medicine

Private medical school in Houston

Training for medical students, residents, fellows, physician assistants



"Mom wants to leave AMA."



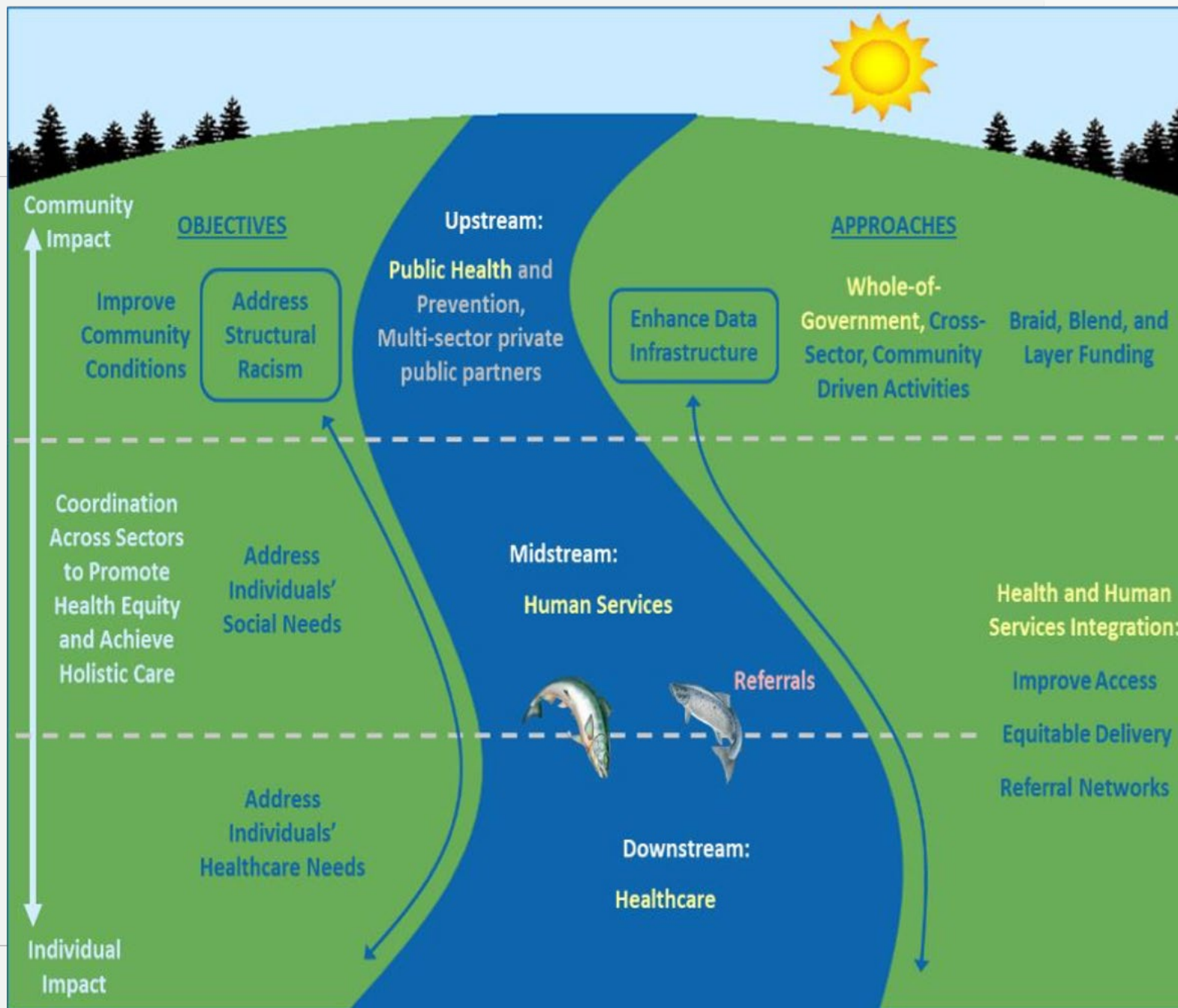
Social Drivers of Health

Social Determinants of Health, Health Related Social Needs, Non-Medical Drivers of Health

Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

5 primary domains- economics, education, healthcare, neighborhoods, and social context





SDOH in Health Systems

Screening and Response

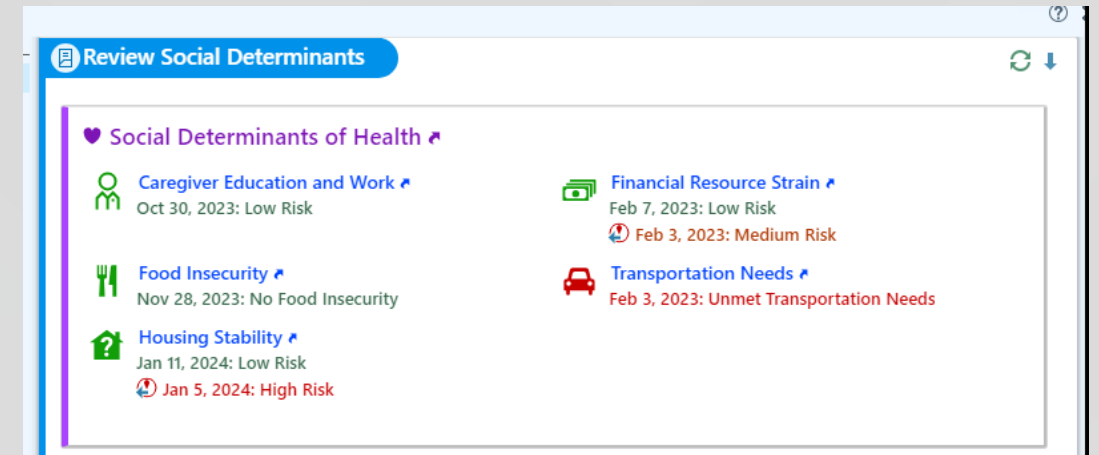


Increased recognition on the importance and role of healthcare institutions to identify and respond to social drivers of health

Requirements to screen for and respond to social drivers of health are increasing



Tools for documenting social drivers of health are improving



SDOH Research at TCH

38-48%
Household
Food
Insecurity

43-46%
Caregiver
Inpatient Food
Insecurity

58% Rent and
Utility
Assistance

25%
Transportation
Assistance

21% Education
Assistance

Passive referrals to community resources did not result in increased enrollment in the inpatient setting in a randomized controlled trial but families liked being screened. Subsequent research with active referral to a community based organization connected most families with resources and was rated highly by families.

The background of the image shows a blurred hospital room with blue padded railings and medical monitors. In the foreground, two bright yellow plastic cups are hanging from a white, crumpled cloth or bag. The cups are slightly tilted and have thin, light-colored straps attached to their rims. The lighting is soft, highlighting the texture of the cloth and the smooth surface of the cups.

“It’s like when you’re on an airplane and they explain to you that you have to put on your own breathing mask before you can put on your child’s breathing mask. The patient is under a lot of stress and a lot of things are going on with them and they really need the support system.”

What frustrations or challenges have you faced when thinking about addressing social drivers of health in your setting?



Assessment and Strategy Development

- Met with 80+ key stakeholders across 35+ departments at TCH and BCM
- Shadowed 10 team members including social workers, care coordinators, provider, and interpreter
- Surveyed 64 TCH social workers and TCHP Field Relations Coordinators
- Reviewed literature, regulatory requirements, and local data
- Joined local and national collaboratives focused on social determinants of health and health equity
- Meeting with key community partners

"I have noticed limited resources for housing and financial assistance in the community. I have no resources that can assist families due to lack of availability or waitlist."

"Although a lot of these organizations can provide various types of assistance some are limited to only providing assistance once a year and have a waitlist. For some families they are evicted or lose electricity before they are able to obtain assistance."

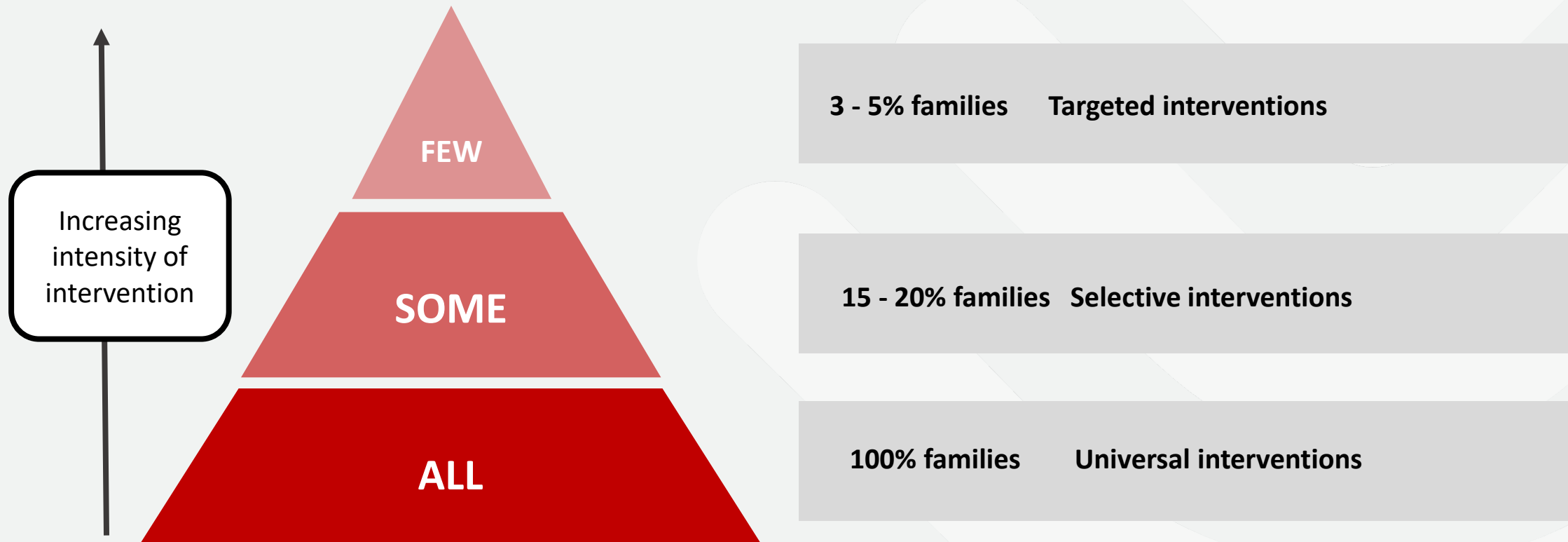
"Families with [undocumented] immigration status are afraid to ask for assistance."



A Multi-Tiered System of Supports Framework (MTSSF)

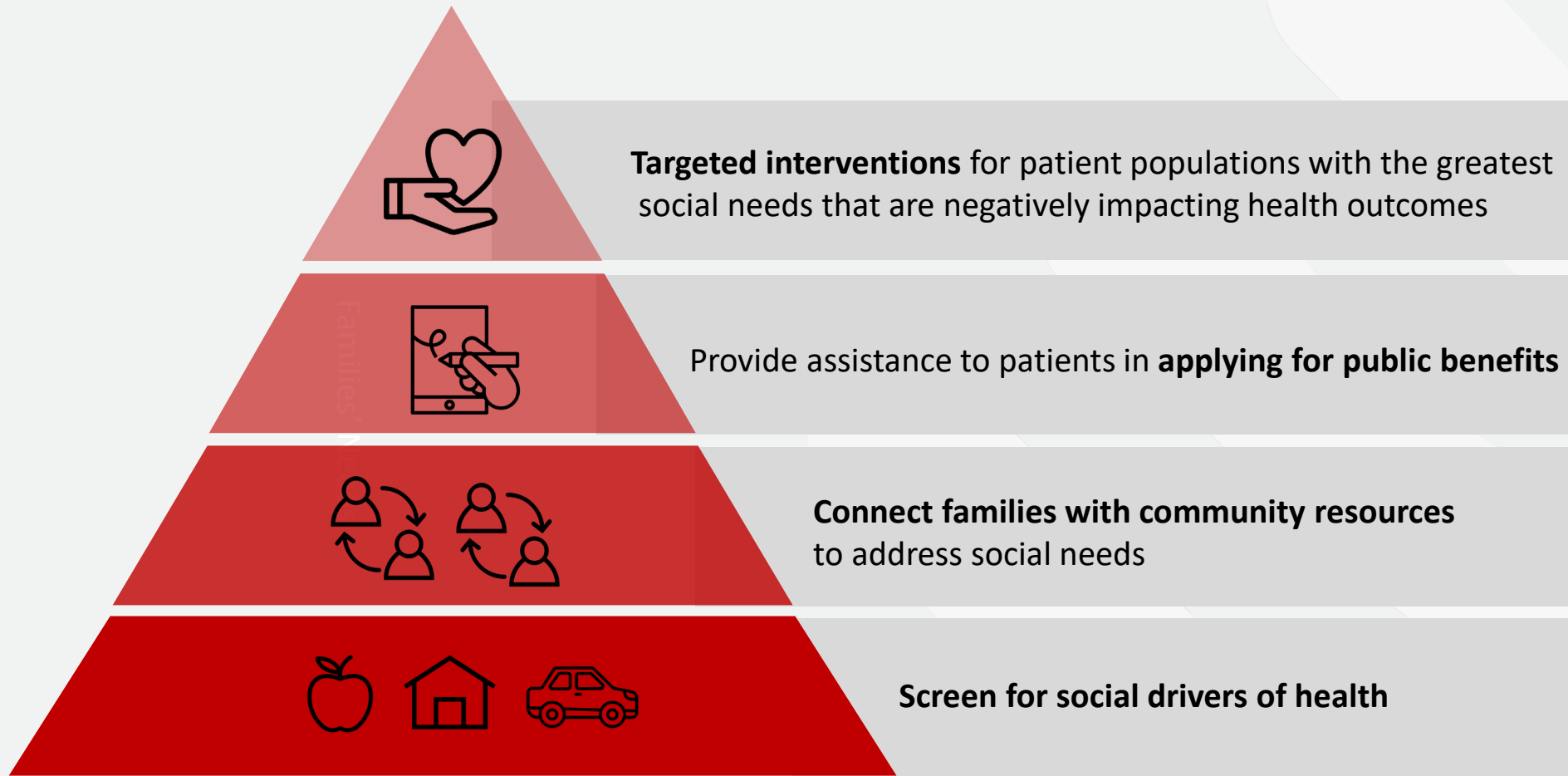
Strategic Framework

- A Multi-Tiered System of Supports Framework provides a structured approach to addressing health needs by varying levels of support from universal interventions to intensive, individualized interventions



A Tiered Model To Address SDOH

Strategic Framework



Screening for Social Drivers of Health

- Beginning in June 2024, Texas Children's Hospital started screening admitted patients for 5 social drivers of health.
 - Food insecurity
 - Housing
 - Transportation
 - Financial assistance
 - Caregiver education and health literacy
- In some units, care coordinators screen for social drivers of health; in other units social workers screen for social drivers of health.
- After patients are screened, they are asked if they would like assistance. If they respond, "yes," a consult is placed for social work.
- Patients should only be screened once every 6 months.
- Screening modality
 - Verbally, paper, online

Family Needs Survey

Many families experience challenges with items such as food, finances, housing, and transportation. At Texas Children's Hospital, we care about supporting our patients and their families, and we ask all families these questions. If you are experiencing challenges and are interested in assistance, we will work together to connect you with resources.

Within the past 12 months, you worried your food would run out before you got the money to buy more.

☐ Never true ☐ Sometimes true ☐ Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Never true ☐ Sometimes true ☐ Often true

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard ☐ Not hard at all

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

☐ Yes ☐ No

In the past 12 months, how many times have you moved where you were living?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Other: ____

At any time in the past 12 months, were you homeless or living in a shelter (including now)?

☐ Yes ☐ No

In the past 12 months, has lack of transportation kept you from medical appointments or getting medications?

☐ Yes ☐ No

In the past 12 months, has lack of transportation kept you from meetings, work or from getting things needed for daily living?

☐ Yes ☐ No

Do you have a high school degree?

☐ Yes ☐ No

Do you ever need help reading hospital materials?

☐ Yes ☐ No

Would you like help with any of the above items?

☐ Yes ☐ No

If yes, what do you want help with?

☐ Food ☐ Housing ☐ Transportation ☐ Finances

☐ Understanding medical condition or illness

☐ I don't want help with these items

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PC PRIMARY CARE PRACT (All Providers)									
Filter by Status Total: 1									
Status	SDOH	L...	Time	Dur	Time since check in	Current Event	Time in Event	Patient Locat...	Patient
Scheduled			5:00 PM	15					 Test, Gryffin 4 y.o. / M

Snapshot Chart Re... Order In... Specimen... Review F... Results Allergies History Problems Implants Demograp... ?

PCP Snapshot

PCP Snapshot Active Orders Labs Longitudinal Plan of Care More

Patient

Gryffin Test
4 year old male
6/9/2020
Comm Pref: 

Recent Visits with You
01/23/2025 Orders Only
[More...](#)

Preferred Pharmacies

None

Future Appointments (All Departments)

Social Drivers of Health

-  **Food Insecurity**
Feb 19, 2025: Food Insecurity Present
-  **Transportation Needs**
Feb 13, 2025: No Transportation Needs
 Feb 12, 2025: Unmet Transportation Needs
-  **Financial Resource Strain**
Feb 13, 2025: High Risk
-  **Caregiver Education and Work**
Feb 13, 2025: Medium Risk
-  **Housing Stability**
Feb 13, 2025: High Risk

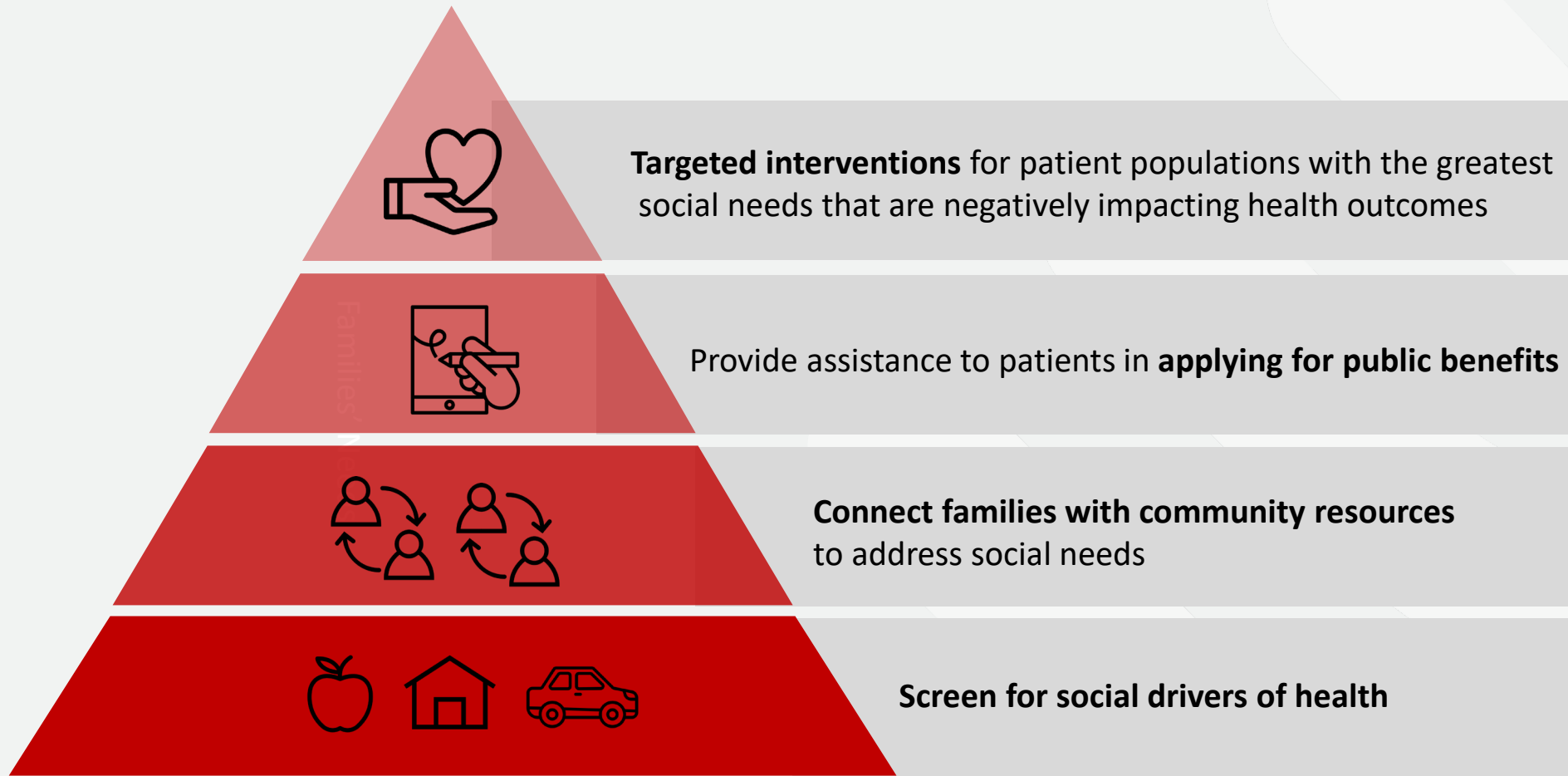
SDOH Screening... by the numbers

- Screened **27,000+** admitted patients for SDOH since June 2024 and **48%** of patients and families are screening positive for one or more SDOH
 - **39%** Unmet financial needs
 - **22%** Food insecure
 - **20%** Unstable housing
 - **16%** Health literacy concerns
 - **7%** Unmet transportation need
- Areas of highest need include: oncology, renal, cardiology, and pulmonary
- Of the families that are screened, **40%** of families want our assistance in addressing the unmet health related social need
- Screening rate is **72%** of admitted patients



A Tiered Model To Address SDOH

Strategic Framework



Connect Families to Community Resources

- 130+ Social workers
- TCH Family Resources | Find Help
- Social work survey → prioritize community partnerships
- Funding for community partnerships
- Strengthening referral pathways to community partners

The screenshot shows the Texas Children's Family Resources website. The top navigation bar includes links for Support, Sign Up, and Log In, and a search bar with a dropdown menu for language selection. The main content area displays search results for 'food' in Houston, TX. The results are sorted by relevance and show 1 - 25 of 288 results. The first result is 'Food Locator' by Houston Food Bank (HFB), reviewed on 01/12/2024. The second result is 'Food Pantry' by Mission Bells Food Pantry, reviewed on 01/11/2024. The page also includes a map of Houston with red location pins and filters for personal and program filters.

The screenshot shows the Texas Children's Family Resources website. The top navigation bar includes links for Support, Sign Up, and Log In, and a search bar with a dropdown menu for language selection. The main content area displays a search bar with the text 'Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here:'. Below the search bar is a button labeled 'Search'.



Houston Food Bank and Texas Children's Pediatric Clinics

Provider identifies a patient is food insecure

Provider asks if family would like to be connected with Houston Food Bank and obtains consent

Provider submits an order set to Front Desk / Referral Coordinator

Front Desk / Referral Coordinator submits referral to Houston Food Bank's First Link program

Houston Food Bank navigator calls patient and assists with SNAP applications and identification of community resources

October 2024 – March 2025

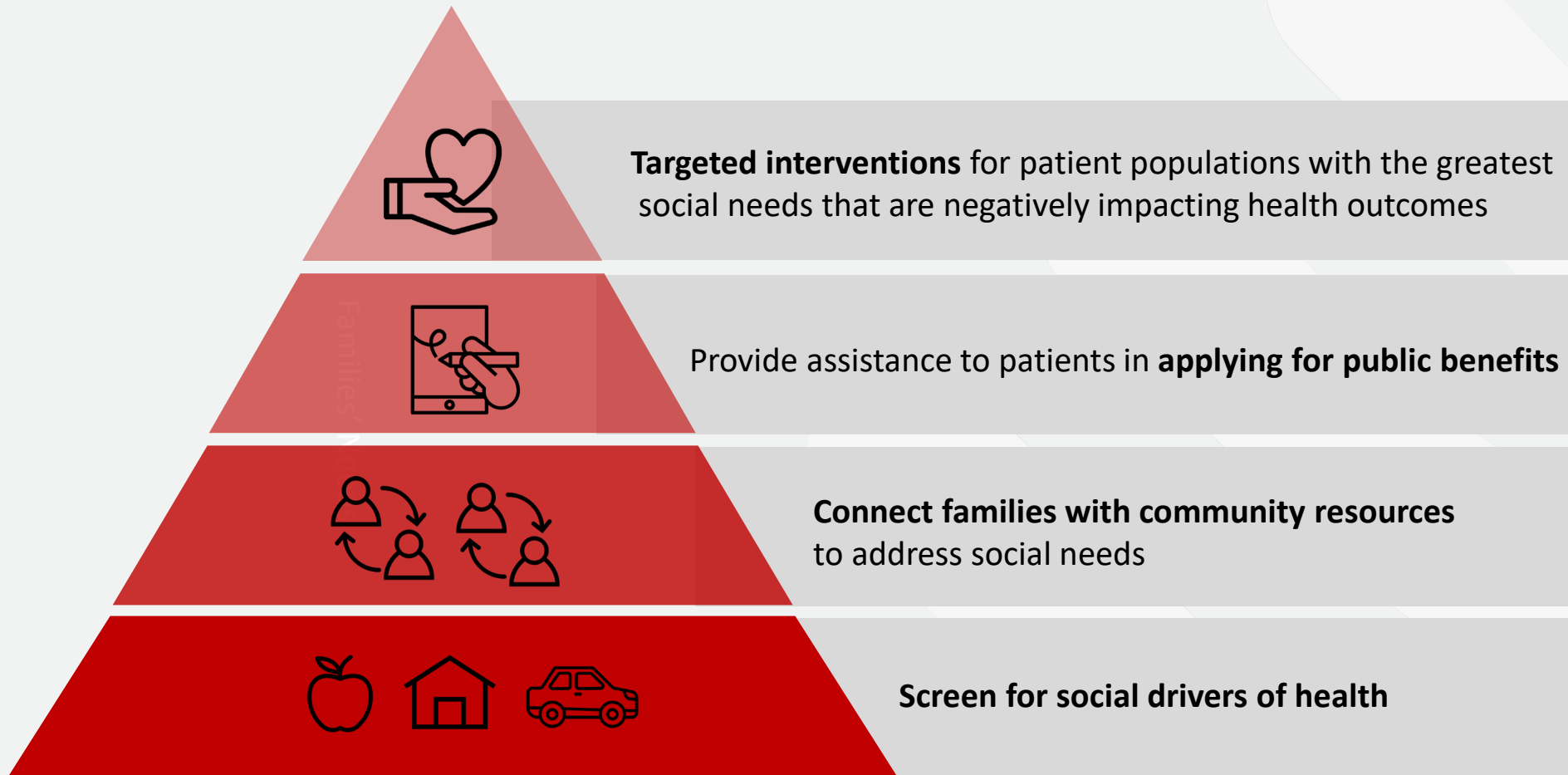
Submitted 2,207 referrals from 11 clinics

- 54% requested assistance with food
- 28% requested assistance with public benefit applications
- 1,628 families received help
 - 458 public benefit applications were submitted
- 104 requests in progress
- 475 requests closed unsuccessfully



A Tiered Model To Address SDOH

Strategic Framework



Public Benefits

15% of admitted patients at TCH are SNAP eligible, but not enrolled

\$973 monthly SNAP allowance for a family of four

19 number of pages of a SNAP application (in Texas)

1 Community Health Worker can complete 5 – 8 applications day

Admissions

Inpatient

**Pediatric
Clinics**



Investing in Public Benefits: The Business Case

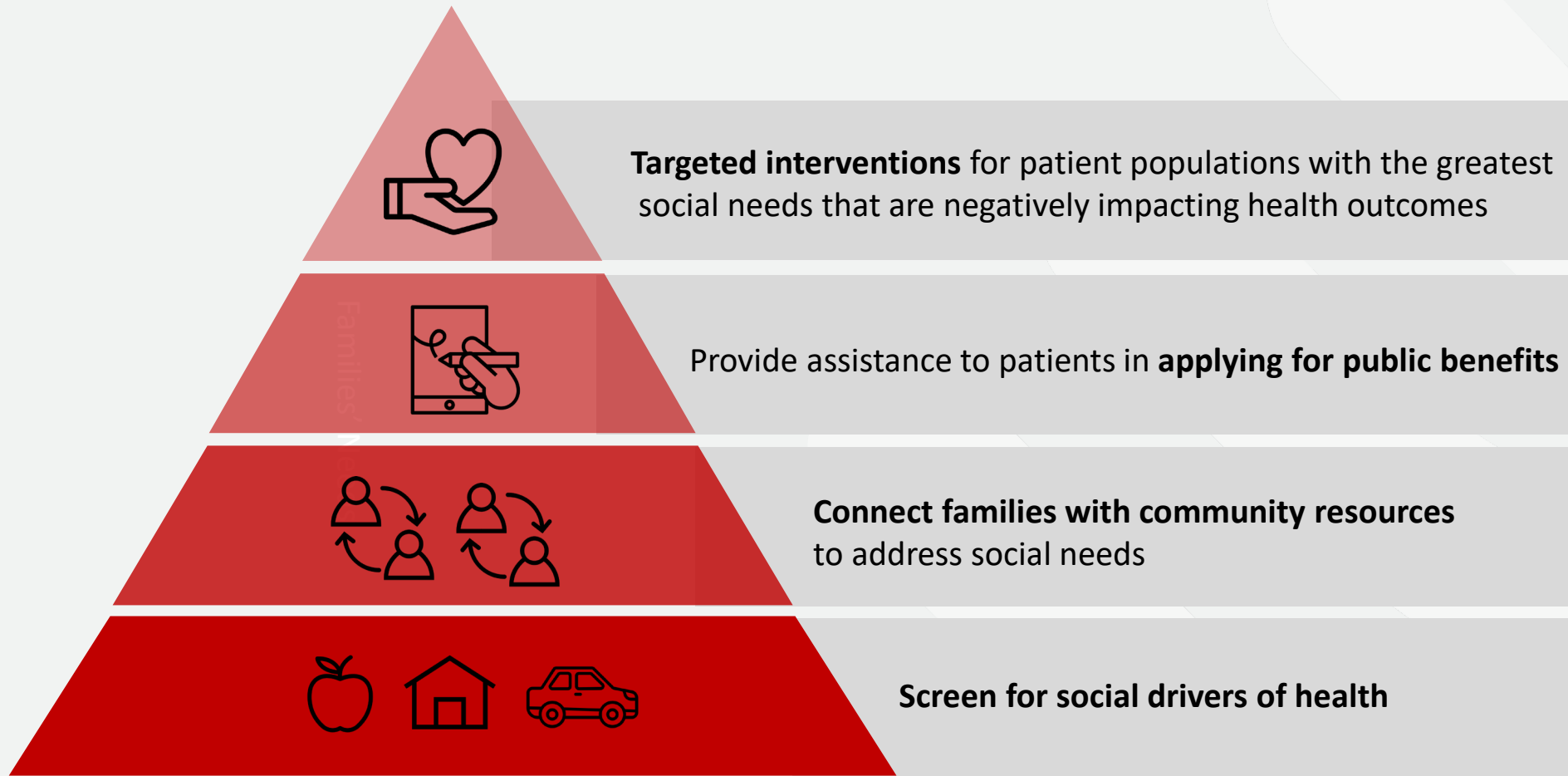
1 Community Health Worker * 5 applications daily * 230 working days per year * 75% applications approved * up to \$973 per month * 6 months of SNAP benefits = up to \$5 million in SNAP funding

A \$70k investment in a community health worker may result in \$5 million in federal funding to provide food to our low income patient population every year



A Tiered Model To Address SDOH

Strategic Framework



Targeted Interventions



Review SDOH screening data to identify areas with greatest needs

Partner with clinical and community partners to identify and implement targeted interventions

Evaluate interventions on impact on health outcomes



Targeted Interventions

Caregiver Trays and Direct Assistance

- In 2024, provided **58,000 meals** to caregivers that could not afford food

Medical Legal Partnership

- Life Threatening Asthma Clinic

On-site Navigators from local Food Banks

Transportation Partnerships

- In 2024, TCPs provided **5,619 rides** to families that would have missed their appointments

“Yesterday I had a mom that needed to come in for feeding issues with her newborn. Mom called and was upset because she needed to have her baby seen but was worried about having to catch 2 buses to get to the appointment.... I scheduled her Lyft. When she got here, she said how grateful she was that we provided our patients with this because her car had been stolen and she needed her newborn to be seen. She was worried about the heat and having to take 2 buses to get here. The Lyft program has become very beneficial to our patients, and they are very grateful.”



Lessons Learned

- Perfection is the enemy of progress
- Importance of utilizing a patient-centered approach
- Value of patient stories and perspectives
- Quality improvement mindset- sustain efforts through regular check-ins, flexibility, resourcefulness, and continuing to improve
- Power of engaging with interprofessional team members across the organization and across the community
- Strength in building the case – generating data to support process changes and adapting research to clinical operations
- Significance of education, training, selling the story, and listening to team members



"Thank you. We have many patients who tell stories that indicate difficult circumstances that impact health.

From no air conditioning in the summer to many children sharing beds due to only having one room... there is a great need in our city. I appreciate the presentation, information and TCH trying to be a helper to our patients and their families."

"This module is so insightful and important in today's health care environment.... People are so focused on things that don't greatly affect health and ignore these important factors, leading to poor public health outcomes as a whole....I wish I could download this presentation and keep it to show friends and family!"



"It's so encouraging to know that this hospital cares about the families and barriers that affect care. And we are striving to help in the efforts to alleviate those barriers."



Future Directions

- Expanding SDOH screening to outpatient and Emergency Centers
- Hiring Community Health Workers to assist with connection to community resources and public benefit application assistance (supplemental security income)
- Strengthening and funding community partnerships and referral pathways
- Developing, implementing, and evaluating targeted interventions



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Thank you! and Questions?

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