Social Determinants of Health

• Before developing and implementing a protocol or procedure for screening for needs related to the social determinants of health, assure you have the resources and/or referrals to address identified needs. Work with community partners to develop referral resources.

• *The SPOT @ Jennings High School*
  
  o Screeners used:
    ▪ PHQ-9 (Depression)
    ▪ CRAFT (Substance use in adolescents)
    ▪ Two-question screener on trauma symptoms
    ▪ Two-question Hunger Vital Sign for food insecurity
    ▪ Questions about income, housing insecurity, and access to oral health services
  
  o Screeners completed upon first visit to clinic, yearly following that
  
  o Depressions/anxiety and substance use are included in every psychosocial history completed with adolescents (verbally screened during visit)
  
  o Full-time case manager addressed identified needs from screening as well as Medicaid insurance
  
  o SBHC has adopted trauma-informed practices to be intentional about how to respond to students with positive trauma screenings

• *KCPS*
  
  o Clinician works in two schools, collaborating with school counselors, nurses, educators, etc. to provide short-term clinical interventions based on student needs
  
  o SDOH needs are addressed by case managers
  
  o Participate in Problem Solving Teams to stay in touch & understand what resources are available; used Google Classroom to organize & update resources
  
  o Collaborate with as many people as possible to meet student needs since home visits were impacted by COVID-19
  
  o During COVID-19, exhausting every form of communication with students—email, phone, text, Google Form, etc.—and leveraging emergency or parent contacts
• KCPS Security put door hangars on doors of families that they had been unable to contact with contact information for clinicians
• Leveraged Facebook to outreach to parents about how to contact clinicians
• Built trust with parents by explaining the resources that could be provided and by addressing the needs of the whole family

**KC CARE Health Center**
• Used the Arizona Self Sufficiency Matrix to screen from SDOH
  ▪ Can create screener online, adoptable to patient needs
  ▪ Scores domains from 1 to 5 and helps determine how to provide support
  ▪ Client-centered approach has clients choose the domains they want to work on
  ▪ Domains include: child care, children’s education, parenting/coping skills, dental/vision, family/partner/social relations, health insurance, medical needs, child’s mental health, income, housing transportation, food and household items, language, medication costs, medication adherence, ED utilization
• Critical to assess needs that impact the entire family and then also isolate needs that impact the child, as we know we cannot impact a child without helping the entire family system
• Long conversations over the phone are difficult with families, outreach during COVID-19 has shifted to outreaching to clients based on existing known needs
• Client-focus also helps to keep phone outreach more supportive
• If still doing virtual learning in the Fall, will work with teachers (who will be seeing students via virtual learning) to receive referrals

**Additional Resources**

• [Mental Health Alliance](https://mha.org/) in St. Louis is a great need-based referral partner.
• Information on telehealth policy changes available here: [https://dss.mo.gov/mhd/providers/pages/provtips.htm#200320telehealth](https://dss.mo.gov/mhd/providers/pages/provtips.htm#200320telehealth)

Please find recordings and summaries of previous Listening & Learning Sessions available here.

**Show-Me School-Based Health Alliance of Missouri**

[info@moschoolhealth.org](mailto:info@moschoolhealth.org) | (800) 807-8494 | moschoolhealth.org