### INTRODUCTION
- Consult Liaison Psychiatry’s mission
  - Address the complex needs of patients with medical and psychiatric comorbidities
  - Improve healthcare outcomes
  - Promote integrated and collaborative care
- As listed in the curriculum for the Consult-Liaison Psychiatry (CLP) Fellowship in Systems-Based Practice section 2: System Navigation for Patient-Centered Care, the Level-1-Milestone, “Identifies community health needs and disparity issues”[1]
- This is glossing over awareness of Social Determinants of Health (SDoH); however, there is no other mention of them in the Supplemental Guide on CLP from the Accreditation Council for Graduate Medical Education (ACGME)
- There is a mention in ACGME Program Requirements CLP section II.A.4.a. (2) but this lack of emphasis on SDoH highlights fundamental shortcomings in both health care equity and equality
- Conducting standardized screenings of patients to comprehend their social context serves as a pathway toward addressing impediments and enhancing overall health which is a cornerstone of CLP
- SDoHs are vital when formulating a treatment plan known since the Whitehall studies conducted decades ago, showcasing how social context can significantly affect an individual’s health and well-being.[2,3]
- The main issue arises with how to integrate and not take a “just one more thing” approach as piling on physicians has been shown to decrease overall patient outcomes and lead to burnout.[4]

### CURRENT RESOURCES

**Epic**

![EPIC SDoH Wheel](image1)

**Social Determinants of Health**

- Alcohol Use
- Tobacco Use
- Physical Activity
- Housing Stability
- Food Security
- Transportation Needs
- Social Connections
- Income
- Education
- Employment

**NowPow**

*Figure 1: EPIC SDoH Wheel*

*Social Risk Factors vs. Behavioral Risk Factors*

As social factors are documented the SDoH Wheel will update:

- Green...no to low risk
- Yellow...moderate risk
- Red...high risk
- Gray...no data

*Figure 2: NowPow’s PowRx Platform*

NowPow, a digital platform to provide personalized referrals to community resources that will help them continue to improve their health after they leave Hackensack Meridian Health’s care with integration into EPIC EMR.

### METHODS

- Retrospective data collection sourced from EPIC
- Data provided by the HMH Data Analytics Team

**Define Study Population**

**Inclusion Criteria:**
1. Inpatient Consult to Psychiatry
2. Location JSUMC
3. Blank Form in SDoH

**Exclusion Criteria:**
1. < 18 Years Old
2. Hospice care/Terminally ill
3. Blank Form in SDoH

**Total Number of Patients Reviewed:**

- n = 7655

### RESULTS

- Preliminary results of complete utilization of entire fields on the SDoH Wheel yielded 7%. The average utilization completed 8 fields with the most frequent absent field being social connections followed by physical activity. The most completed field included Intimate Partner Violence followed by depression with alcohol use following.
- Preliminary findings are yielding no significant difference in gender, sexual orientation or identity as well as no significant difference in race at rates of recording SDoH.
- Preliminary findings indicate statistically significant findings in time of day SDoH reporting is being completed with rates reporting greatest between between 0900-1000 and the least between the hours 1800-1900.
- Preliminary findings indicate that the lowest rate of completion was for patients 65-75 with the highest being those 25-35 but that these were not statistically significant findings

### CONCLUSIONS

- Our preliminary findings show that there is a need for better integration of SDoH screening so that clinicians can have the ability to utilize this information when making informed decisions about patient care.
- Initial data is suggesting there are not differences amongst cohorts but that on a whole better implementation must be an emphasis going forward.

### FUTURE RESEARCH

- Future research aims at addressing any shortcomings in these results and implementing standardization in the form of the CMS’s Accountable Health Communities project Health-Related Social Needs screening tool (AHC-HRSN) so that treatment teams have baseline assessment tools to utilize SDoH considerations
- Currently, medical care in the United States tends to focus on Healthcare over health, limiting CL-Psychiatrist’s ability to address social context. Nevertheless, they can take practical steps addressing SDH.
- Screening and coordinating services to meet social needs is an opportunity to improve healthcare where social and policy barriers once prevented particularly in those underserved and diverse communities.