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## Screening for Social Determinants of Health in Ohio Physical and Occupational Therapists

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# Screening for Social Determinants of Health in Ohio Physical and Occupational Therapists

## Abstract

**Purpose:** The purpose of this study was to investigate if and how frequently Ohio occupational and physical therapists are screening for social determinants of health within their patient population. **Method:** A cross sectional electronic survey was sent out to all occupational and physical therapists in the state of Ohio who have an active license with the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board (There is a single board in Ohio that represents all three of these disciplines.). Frequencies and cross tabulations were analyzed to determine relationships between asking about social determinants of health and various demographic factors. **Results:** Of the 18,416 surveys sent out, 1,639 surveys were returned and eligible for analysis. Sixty six percent of respondents indicated they were screening for social determinants of health at least half of the time. While patient discomfort was indicated as the greatest barrier to screening for social determinants of health, 20% of respondents stated they experience no barriers. Additionally, demographic factors such as clinical affiliations, years practiced, membership in the American Occupational Therapy Association or American Physical Therapy Association, and profession did not impact the frequency of screening for social determinants of health. On the other hand, factors such as working in the home health setting, having a Doctor of Science, Education, or Philosophy degree, having a post-graduate certification and specialization, and having participated in a fellowship program showed slightly higher rates of screening. **Conclusions:** The majority of occupational and physical therapists in the state of Ohio report they are screening for social determinants of health at least half of the time, and few differences were noted between demographic factors. While some barriers to screening have been identified, further research should be done to gain a better understanding of these barriers and how to address them. Additionally, further research may be needed to identify if therapists are truly addressing social needs or addressing contextual factors.

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### **ABSTRACT**

**Purpose:** The purpose of this study was to investigate if and how frequently Ohio occupational and physical therapists are screening for social determinants of health within their patient population. **Method:** A cross sectional electronic survey was sent out to all occupational and physical therapists in the state of Ohio who have an active license with the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board (There is a single board in Ohio that represents all three of these disciplines.). Frequencies and cross tabulations were analyzed to determine relationships between asking about social determinants of health and various demographic factors. **Results:** Of the 18,416 surveys sent out, 1,639 surveys were returned and eligible for analysis. Sixty six percent of respondents indicated they were screening for social determinants of health at least half of the time. While patient discomfort was indicated as the greatest barrier to screening for social determinants of health, 20% of respondents stated they experience no barriers. Additionally, demographic factors such as clinical affiliations, years practiced, membership in the American Occupational Therapy Association or American Physical Therapy Association, and profession did not impact the frequency of screening for social determinants of health. On the other hand, factors such as working in the home health setting, having a Doctor of Science, Education, or Philosophy degree, having a post-graduate certification and specialization, and having participated in a fellowship program showed slightly higher rates of screening. **Conclusions:** The majority of occupational and physical therapists in the state of Ohio report they are screening for social determinants of health at least half of the time, and few differences were noted between demographic factors. While some barriers to screening have been identified, further research should be done to gain a better understanding of these barriers and how to address them. Additionally, further research may be needed to identify if therapists are truly addressing social needs or addressing contextual factors.

**Keywords:** social determinants of health

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## INTRODUCTION

Social determinants of health (SDOH) are defined as the economic and social conditions in which individuals live, work, play, or learn that affect a wide range of health, functioning, and quality of life outcomes.<sup>1</sup> This may include access to nutritious food, safe housing, transportation, and job opportunities as well as level of income, presence of discrimination or violence, education level, and literacy skills. SDOH can contribute to healthcare disparities and inequities in many populations. If an individual does not have access to reliable transportation, it may be unrealistic for a provider to expect them to show up to three appointments per week consistently. Additionally, if an individual does not have access to nutritious foods or does not have enough food, this can slow down healing processes in the body which can lead to a poorer prognosis.<sup>2</sup> Being aware of a patient's SDOH can help clinicians create more individualized, effective, and meaningful prognoses and plans of care.

Studies have shown how large an impact SDOH have on recovery from injury. Evidence has shown that musculoskeletal recovery is only influenced 20% by the medical care an individual receives, with the rest being made up of influences of SDOH.<sup>3</sup> SDOH can also be associated with higher incidences of chronic diseases such as arthritis, diabetes, and heart disease.<sup>4</sup> It has been shown that SDOH can affect a patient's motivation and compliance with care and therefore prognosis.<sup>5,6</sup> However, there are gaps in the research exploring how often SDOH are screened for as well as how they are screened for. While literature justifies the importance of screening for SDOH, it is not known with what frequency SDOH are screened for by specific providers, if at all.

The American Occupational Therapy Association (AOTA) and American Physical Therapy Association (APTA) both have published articles stating the importance of identifying SDOH in individuals seen by these professions.<sup>7,8</sup> The US Department of Health and Human Services created Healthy People 2030, a list of core objectives and initiatives to improve health and wellbeing over the decade.<sup>9</sup> SDOH are listed as a priority area, stressing the importance of screening for and addressing SDOH in all areas of healthcare in order to decrease inequities and health disparities. The Commission on Social Determinants of Health was established by the World Health Organization in March 2005 to support countries and global health partners in addressing the social factors leading to ill health and health inequities. A report was released stressing the importance of screening for SDOH and urged governments to recognize and address these issues.<sup>4</sup>

The purpose of this study was to investigate if and how frequently Ohio occupational and physical therapists are screening for SDOH within their patient population. This data can be used to provide insight to the awareness and utilization of SDOH in these professions as well as information on possible barriers to screening for these important factors.

## METHOD

### Design

This study involved a cross sectional; electronic survey distributed in May and June of 2022. To complete the survey, respondents were required to provide electronic informed consent. The study was considered exempt by the Walsh University Institutional Review Board.

### Survey Development

Content Validity- The survey was sent to both occupational therapy and physical therapy educators to ensure content validity and clarity.

### Respondents

Convenience sampling was used to recruit respondents. Ohio occupational and physical therapists were targeted due to availability of a database. To be eligible for the study, the therapists had to have an active license and email address on file with the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board. Respondents were recruited via email.

### Procedure

The survey was distributed through SurveyMonkey, Inc. (US). The Survey was open for five weeks; reminder emails were sent an average of once per week during that period requesting participation. Survey responses were confidential and could not be traced back to the participant. Repeat submissions were not permitted. To further reduce the risk of bias during the coding process, each variable was coded in an isolated fashion.

### Data Analysis

Frequencies and cross tabulations were analyzed using SPSS version 28.

Frequency data was analyzed for each quantitative survey question. In addition, cross tabulations were run to determine relationships between asking about SDOH and various demographic factors such as practice setting, clinical affiliation, years of practice, highest degree earned, post graduate certification/specialization, and AOTA/APTA membership.

## RESULTS

A total of 18,416 surveys were sent out via email to actively licensed occupational and physical therapists in the state of Ohio on file with the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board. Of these, there were a total of 1,641 physical and occupational therapy responses received. Two of the respondents did not consent to their data being used, therefore they were not included in the results and analytics reported below, leaving 1,639 responses and a response rate of 8.9%. Within the survey questions (excluding question 1 on consent and question 5 on barriers due to multiple responses), a median number of 10 responses were missing per question (min = 1, max = 222).

Demographics for all survey participants are displayed in Table 1. While the majority demonstrate a good distribution within categories, there were a few characteristics with specific standout areas. Nearly two-thirds of the respondents were practicing physical therapists as compared to occupational therapists, with a majority not being members of the national association of their profession. Over two-thirds did not have a specialization beyond their initial degree with the majority having either a Master's or Doctorate level degree. More respondents practice in the outpatient setting than any of the other settings, and over half of the respondents worked in clinics associated with a hospital or healthcare system.

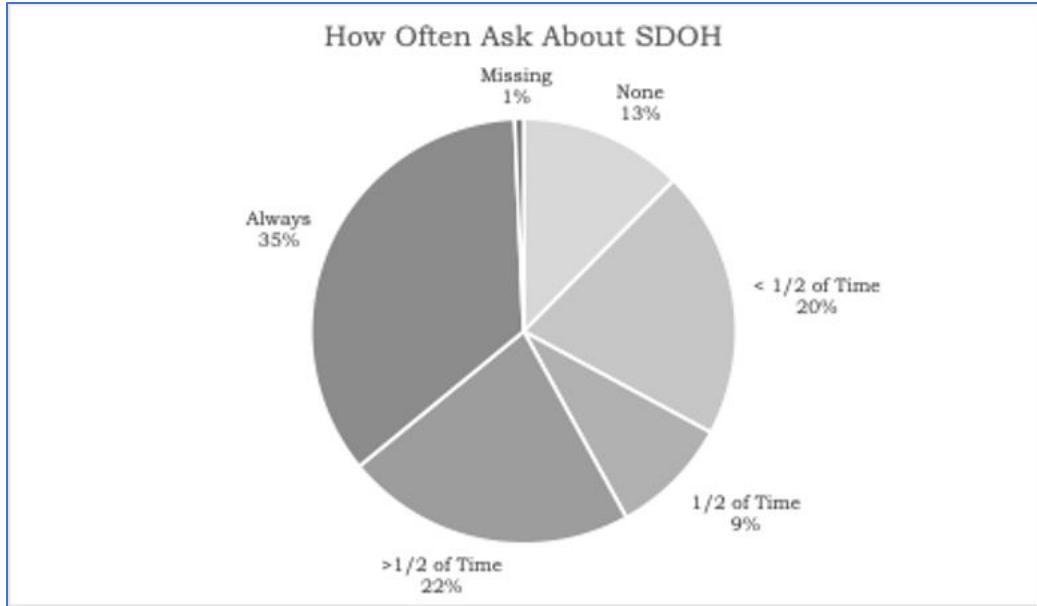
**Table 1.** Demographics

Variable	Number (n=1639)	Frequency
<u>Practice Setting</u>		
Acute Care/Hospital	238	14.5%
Skilled Nursing Facility	199	12.1%
Inpatient Rehab	83	5.1%
Outpatient	617	37.6%
Home Health	203	12.4%
Schools	144	8.8%
Military	5	0.3%
Other	141	8.6%
Missing	9	0.5%
<u>Clinic Affiliations</u>		
Hospital/Healthcare System	914	55.8%
Privately Owned	473	28.9%
Other	126	7.7%
Missing	126	7.7%
<u>How Long Practicing Clinician</u>		
0-5 years	329	20.1%
5-10 years	310	18.9%
11-15 years	198	12.1%
16-20 years	147	9.0%
21-25 years	230	14.0%
26-30 years	144	8.8%
>30 years	280	17.1%
Missing	1	0.1%
<u>Highest Degree Earned</u>		
Bachelor's	346	21.1%
Master's	579	35.3%
Transitional Doctorate (tDPT or t-OTD)	104	6.3%
Doctorate (DPT or OTD)	571	34.8%
Doctor of Science (DSc), Education (EdD), or Philosophy (PhD)	36	2.2%
Missing	3	0.2%

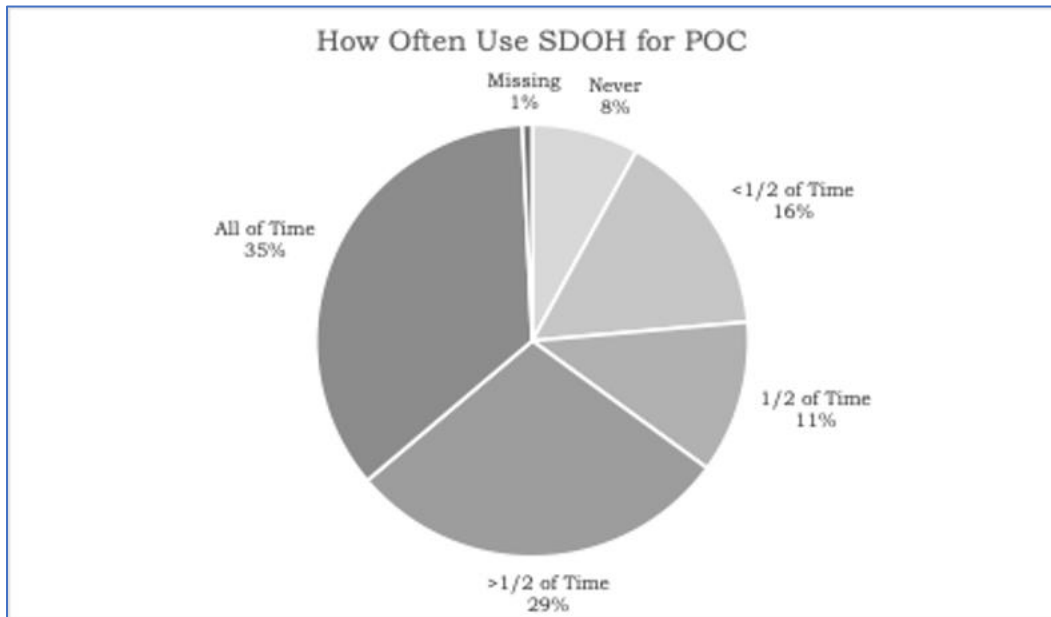
Variable	Number (n=1639)	Frequency
<u>Post-Graduate Specializations/Certifications</u>		
None	976	59.5%
ABPTS Certification	137	8.4%
Residency	29	1.8%
Fellowship	12	0.7%
Other	263	16.0%
Missing	222	13.5%
<u>APTA or AOTA Membership</u>		
Yes	658	40.1%
No	972	59.3%
Missing	9	0.5%
<u>Profession</u>		
Physical Therapy	1076	65.6%
Occupational Therapy	558	34.0%
Missing	5	0.3%
tDPT = transitional Doctor of Physical Therapy; t-OTD = transitional Doctor of Occupational Therapy; DPT = Doctor of Physical Therapy; OTD = Doctor of Occupational Therapy; DSc = Doctor of Science; EdD = Doctor of Education; PhD = Doctor of Philosophy; ABPTS = American Board of Physical Therapy Specialties; APTA = American Physical Therapy Association; AOTA = American Occupational Therapy Association		

The results of all survey questions related directly to the screening and usage of SDOH are represented in the figures below (Figures 1-5). Of all the participants, 98.8% answered yes to performing the initial examination in their practice at this time. The majority of respondents are completing a SDOH screening at least half of the time and are also using SDOH to alter their plan of care (Figures 1 & 2). Nearly half of the respondents are performing the screening themselves through verbal conversation with their patient or client, and a similar percentage are addressing these areas of concern directly with their patient or client (Figures 4 & 5).

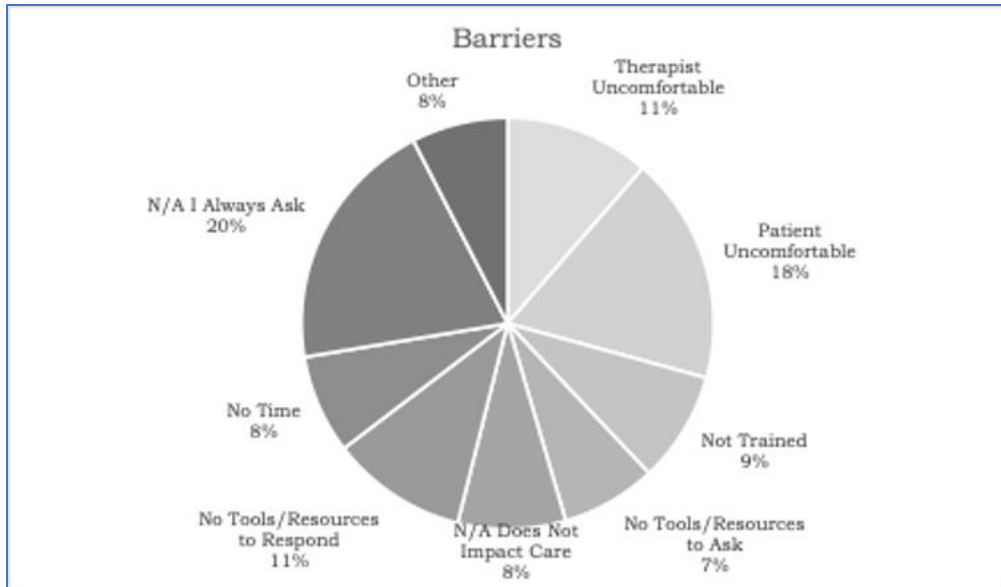
Regarding barriers to screening, there was no one area that appeared to be limiting the therapist's screening potential over another. The results of this question are represented as a percentage of responses rather than percentage of respondents due to the ability for participants to select multiple responses. Respondents were not limited to the barriers listed and could provide their own barrier if they selected other. One-fifth of respondents reported that they always asked about SDOH regardless of the potential barriers listed (Figure 3).



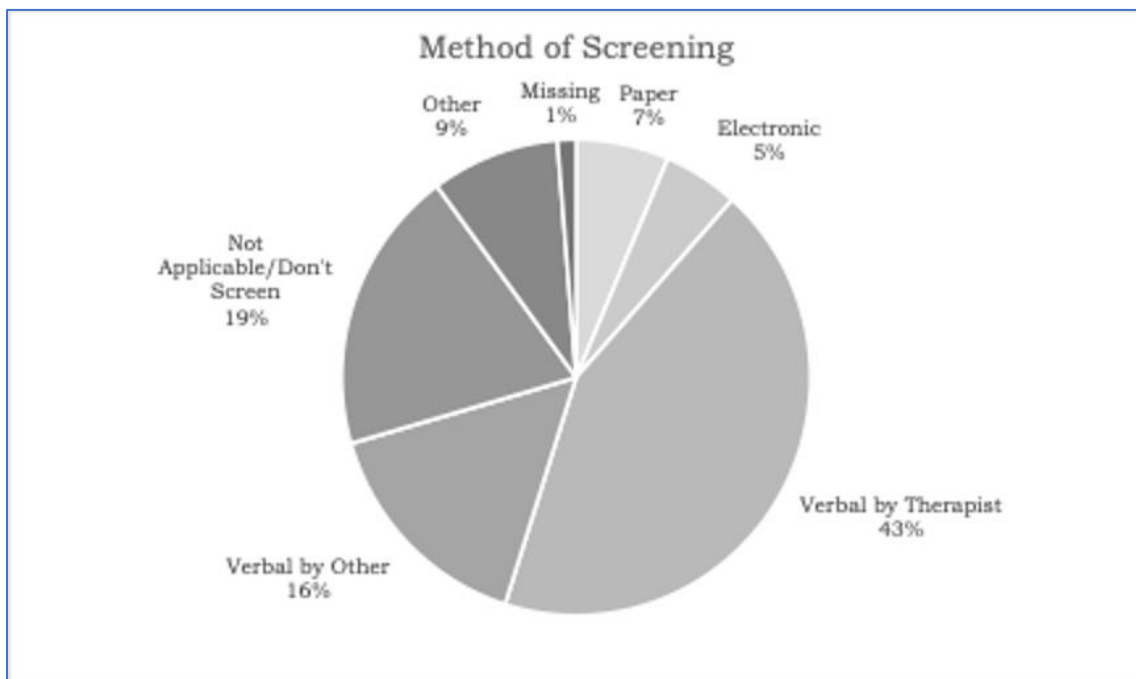
**Figure 1.** Select the statement that most accurately reflects how often you ask your patients/clients (or families about their social determinants of health.



**Figure 2.** Select the following statement that most accurately reflects how often you use information about social determinants of health when making a plan of care.

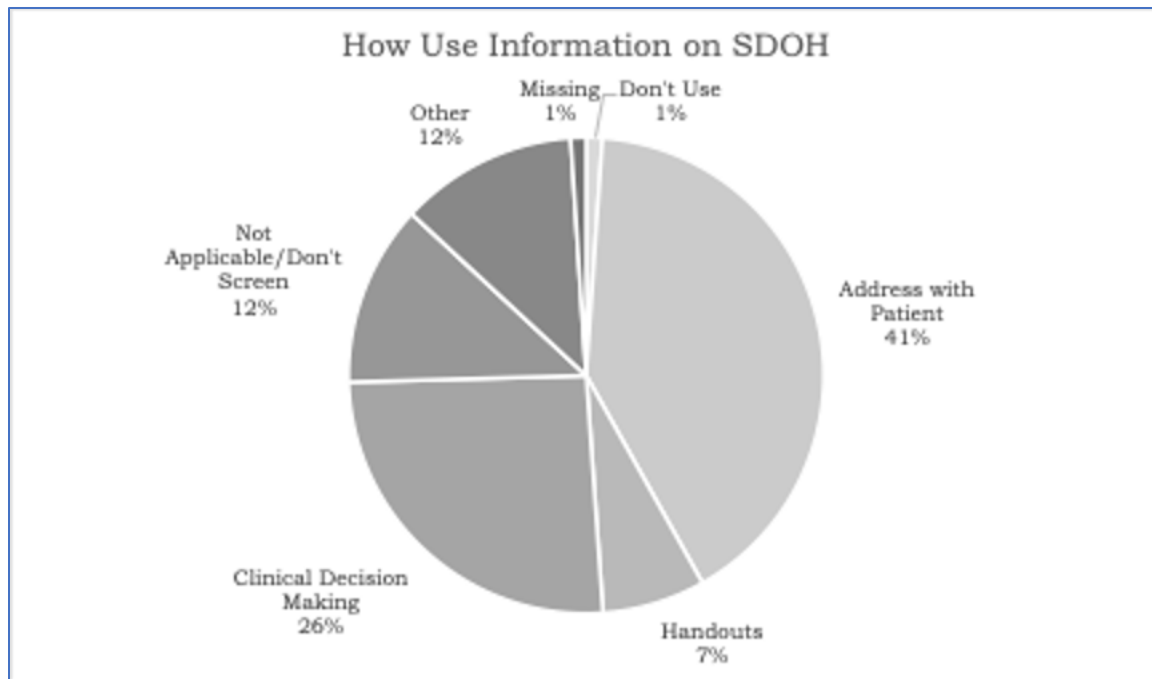


**Figure 3.** Select all of the following barriers that prevent you from screening for social determinants of health.



**Figure 4.** If your facility screens for social determinants of health, what method do you use?





**Figure 5.** When identifying patients’ social determinants of health, what do you typically do with this information?

Demographic data was analyzed to determine the relationship between the respondents' frequency to screen for SDOH of health and various demographic factors. The relationships found in these cross tabulations are listed below in Tables 2-8. Clinical affiliations, years practiced, membership in the AOTA or APTA, and profession did not impact screening for SDOH and nearly all these categories demonstrated approximately two-thirds of respondents screening at least half of the time (Table 3, 4, 7, & 8).

Across practice settings, home health respondents reported screening at least half of the time approximately ten to fifteen percent more than other settings (Table 2). In contrast to this, respondents working in schools and in the military were the only areas demonstrating a greater percentage of respondents screening less than half of the time. While the majority of all degree levels are screening at least half of the time, those with Doctor of Science, Education, or Philosophy degrees demonstrated fifteen to twenty percent more respondents screening at least half of the time (Table 5).

Post-graduate certification and specialization respondents demonstrated an overall small increase in percentage asking about SDOH at least half of the time (Table 6). With this, of those who underwent a residency program, zero respondents reported that they never screened for SDOH. Over half (58.3%) of those who participated in a fellowship program reported that they screened for SDOH all of the time.

**Table 2.** Relationship Between Practice Setting and Asking About SDOH

Practice Setting	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Acute Care	34.6%	65.4%
Skilled Nursing Facility	30.1%	69.8%
Inpatient Rehab	32%	68.7%
Outpatient	34.3%	65.7%
Home Health	18.3%	81.6%
Schools	58.1%	42%

Practice Setting	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Military	75%	25%
Other	23.9%	76%

**Table 3.** Relationship Between Clinical Affiliations and Asking About SDOH

Clinical Affiliation	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Hospital	31%	69.1%
Private	32.1%	67.9%
Other	31.8%	68.2%

**Table 4.** Relationship Between Years of Practice and Asking About SDOH

Years of Practice	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
0-5	33.1%	66.9%
6-10	30.5%	69.5%
11-15	33.5%	66.5%
16-20	34%	66%
21-25	33.9%	66.1%
26-30	34.5%	65.5%
>30	33.5%	66.4%

**Table 5.** Relationship Between Highest Degree Earned and Asking About SDOH

Highest Degree Earned	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Bachelors	34.2%	65.8%
Masters	35.8%	64.2%
Transitional DPT/OTD	28.4%	71.6%
Entry-Level Doctorate (DPT/OTD)	31.7%	68.4%
Doctor of Science (DSc), Education (EdD), or Philosophy (PhD)	11.8%	88.2%

DPT = Doctor of Physical Therapy; OTD = Doctor of Occupational Therapy; DSc = Doctor of Science; EdD = Doctor of Education; PhD = Doctor of Philosophy

**Table 6.** Relationship Between Post-Graduate Certification/Specialization and Asking About SDOH

Certification/Specialization	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
None	35%	65.1%
ABPTS	29.4%	70.7%
Residency	27.6%	72.3%
Fellowship	25%	74.9%
Other	28%	72%
ABPTS = American Board of Physical Therapy Specialties		

**Table 7.** Relationship Between Membership in APTA/AOTA and Asking About SDOH

Membership	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Yes	29.7%	70.4%
No	35.3%	64.7%

**Table 8.** Relationship Between Profession and Asking About SDOH

Profession	<1/2 Ask About SDOH	≥1/2 Ask About SDOH
Physical Therapy	32.9%	67.2%
Occupational Therapy	33.1%	66.8%

## DISCUSSION

The purpose of this study was to investigate if and how frequently Ohio occupational and physical therapists are screening for SDOH within their patient population. This study aims to assess two things: first, the frequency with which therapists are screening for SDOH; second, the potential barriers preventing therapists from screening for SDOH. The current findings suggest that approximately two-thirds of all practicing and licensed occupational and physical therapists in Ohio that responded to this survey are screening for SDOH at least half of the time. There is minimal discrepancy noted in the likelihood of asking about SDOH regardless of all demographic data analyzed, and there was minimal difference noted between the two professions. Subsequently, the vast majority of those who are screening, are then addressing these concerns with patients either directly or indirectly through referrals and/or resources. Lastly, while there were barriers identified that prevent therapists from potentially screening for SDOH, there was no one area that was more limiting than another.

A strength of this study is the investigation of SDOH across both disciplines of occupational and physical therapy as multidisciplinary approaches help to enhance a professional's scope of practice and depth of learning. Occupational and physical therapists often work closely together, so the sharing of knowledge and practices between the two professions can enhance patient outcomes. Another strength of this study is that, to the authors' knowledge, this is the first study to analyze whether or not occupational and physical therapists are screening their patient's for and addressing their SDOH. It is also the only study conducted specifically in Ohio.

The current study provides a glimpse at the frequency and consistency that occupational and physical therapists are asking their patients about disparities in health that they face. A few aspects to note from this study include that the majority of participants who identified their practice setting in schools and in the military, reported that they screened for SDOH less than half of the time. One potential reason for this is that in both settings, the patients are often followed by multiple members of the interdisciplinary team. Due to this fact, occupational and physical therapists may feel there is not as great of a need to directly ask

about their patients' social needs. Another interesting point is that 11.8% more therapists in the home health setting reported screening for SDOH greater than half of the time, more than any other setting. One possible explanation of this could be that therapists in the home health setting are able to directly view a patient's living and social conditions and have a better idea of what questions to ask and what needs need met.

Previously, studies have looked at healthcare provider and patient attitudes towards SDOH and what barriers prevent providers from screening for social needs, in an attempt to better understand the perceived and very real barriers providers face in meeting those needs.<sup>10,11</sup> Our findings support the current research showing that healthcare providers do believe that looking at social needs is an important aspect of holistic care, however it also echoes that while some providers routinely ask about social needs no matter the circumstances, there are barriers that do limit most provider's ability to screen. In this study, one-fifth of respondents said that they always screen for SDOH, while four-fifths of respondents noted that they experience barriers that prevent them from screening 100% of the time. These barriers included the therapists having a lack of time, training, and/or tools and resources, either the therapist or patient being uncomfortable, and the inability for patients to accurately provide information due to either being children or having impaired cognitive status. Studies show that the assessment of social needs is necessary and important in the development of the care plan for a patient to ensure optimal medical decisions are made to meet each unique need.<sup>10,11</sup>

Hamity et al looked at how clinicians and patients view and experience a social needs assessment.<sup>10</sup> Despite the consensus that completing this screening would provide valuable information and promote a holistic treatment perspective, on average, clinicians were not consistently assessing social needs. The primary reason for this was due to lack of time and resources, a response consistent with the results of this study. In addition, skepticism from patients about the privacy of their shared responses, deterred patients from disclosing their social needs. Berkowitz et al further elaborated on barriers in a study where half of the medical staff reported they were not aware of available resources to refer patients to and were not confident in their ability to help patients address their social needs.<sup>12</sup> In regard to implementing the survey, the staff identified several barriers including, lack of time for patients to complete the survey and for staff to respond to social needs, lack of training on administering the survey and on responding to social needs identified from the survey, and lack of resources to adequately address social needs.

Sokol et al discussed the barrier of a patients' ability to understand and accurately provide information about SDOH based on age or cognitive status.<sup>13</sup> In their study parents and/or caregivers provided information regarding SDOH; however, it was recognized informants may be uncomfortable providing accurate information due to social desirability or fear of child protective services intervening. In order to address this fear, they were able to identify tools, including the Safe Environment for Every Kid Parent Screening Questionnaire, that were developed with information from experts that prioritized risk factors, as well as began with an empathetic statement towards parents and caregivers, stating the practice's understanding and ability to help address identified issues.<sup>13,14</sup> Information each of these barriers identified were consistent with the results of this study. It is clear that healthcare providers routinely recognize and support screening for SDOH, however they also recognize the barriers that get in the way.<sup>11</sup> When healthcare providers feel at ease through sufficient training in social history taking and in addressing these issues in clinical practice, as well as through sufficient education of local referral sources, they are more likely to broach these sensitive issues and refer their vulnerable patients to the appropriate sources.<sup>15</sup>

To provide patient care that is holistic, SDOH must be considered. Screening for SDOH aids in identifying individuals who may be in an inequitable situation or are predisposed to one due to a lack of sufficient resources available to them. Unmet social needs can lead to poor health outcomes, contribute to decreased access to healthcare, health inequities, as well as higher healthcare costs.<sup>16</sup> By screening for SDOH, practitioners can uncover patients' apprehensions and obstacles to care, and then help to coordinate care and resources appropriately. Through a literature search, the authors were able to identify several tools that screen for SDOH including The Health Begins Upstream Risks Screening Tool and Guide, The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), and the American Academy of Family Physicians (AAFP) Social Needs Screening Tool; The EveryONE Project. The Health Begins Upstream Risks Screening Tool and Guide is a 15-29 question guide that addresses SDOH domains including, economic stability, education, food, neighborhood and physical environment, and social and community context.<sup>17</sup> The PRAPARE is a 17-21 question guide that addresses SDOH domains including food insecurity, utilities, medicine/health care, clothing, child care, incarceration, intimate partner violence, work, and household income.<sup>18</sup> The AAFP's EveryONE Project is a 14 question form tool that addresses SDOH domains including housing, food insecurities, transportation, utilities, child care, employment, education, finances, and personal safety.<sup>19</sup>

With all of this in mind, emphasizing the importance of addressing SDOH should begin within both physical and occupational educational institutions. As the awareness of SDOH is on the rise, most doctoral and master programs introduce their students to SDOH throughout their curriculum. It is the authors' opinion that not only should SDOH, and its impact be introduced at the start of students' postgraduate education, but it should also be incorporated into their coursework where appropriate. In addition,

students should be made aware of specific tools that are available to screen for social needs. This should carry over into orientation and training once starting in the workforce. Health systems and private clinics should make it a priority to provide sufficient training to their new hires so that they feel at ease in asking the tough and sensitive questions needed in screening for social needs in their patient population. Morrison et al showed that residents were more comfortable with discussing SDOH in the clinical setting after having completed a simulation based SDOH training activity.<sup>20</sup> The greatest gain from this simulation was found in the most recent graduates. Moreover, there should also be sufficient education on local referral sources that therapists can utilize to address any disparities revealed by their patient. A therapist cannot treat a patient well without knowing and addressing the stressors in a patient's life, so having the appropriate referral sources is crucial for patient health outcomes.

Moving forward, additional studies should be conducted to investigate the thoughts, perceptions, beliefs, and training that therapists nationwide have in regard to SDOH and if those then influence the therapists screening habits or ability to address identified needs within a patient population. In addition, research is needed in investigating if therapists or healthcare providers are getting a true measure of social needs or if they are additionally assessing contextual factors. Moreover, future research should spend time delving into the specific barriers that therapists and patients perceive when SDOH are involved, due to the sensitivity and stigma associated with it, as well patient ability to provide accurate information. Finally, a systematic review of specific screening tools used in practice would be beneficial for increased implementation of SDOH screening within the healthcare field.

### **Limitations**

There are several limitations of this study that must be considered. First, by sending out a survey labeled "Social Determinants of Health" to all therapists, it is possible that the therapists that interact and respond to the survey are more likely to have a strong opinion on the topic. This means that there is the potential for the respondents of this survey to either feel strongly that SDOH should be screened for and addressed or feel strongly that screening for and addressing SDOH does not need to be a priority. Due to this, bias could be present, and the results of this study may not actually match the opinion of the population. Second, despite defining the categories of SDOH at the start of the survey, it seemed apparent from the qualitative data that respondents interpreted SDOH to include contextual factors beyond what was listed. This included mental health factors like depression and anxiety, and patient medical conditions. Third, we had low response rates from respondents that were a part of the military, participated in a post-graduate residency or fellowship, or received their Doctor of Science (DSc), Education (EdD), or Philosophy (PhD). While there are not as many practicing clinicians with these advanced degrees, these low response rates may be expected, or they may not represent the greater population. Additionally, despite defining the categories of SDOH in the survey, it seemed apparent from the qualitative data that respondents interpreted SDOH to include contextual factors beyond what we listed, including: mental health/depression. This may have resulted in an inaccurate representation of the number of respondents that are truly screening for SDOH. Regarding data collected about barriers to screening for SDOH, respondents were able to identify their own barriers if they selected other. Some responses listed were not barriers, but rather reasons why clinicians were not performing the screening themselves, such as information being available in the patient chart, or delegating this task to other members of the care team including the social worker or case manager. Because of this, the results may not show a true reflection of actual barriers. Finally, the Likert scale was utilized to show the differences of categories, however, due to this being an ordinal level of measurement, p-values were unable to be attained. This prevented the authors from saying whether any patterns identified and measured had any statistical significance.

### **CONCLUSIONS**

The majority of occupational and physical therapists in the state of Ohio report they are screening for social determinants of health at least half of the time, and few differences were noted between demographic factors. While some barriers to screening have been identified, further research should be done to gain a better understanding of these barriers and how to address them. Additionally, further research may be needed to identify if therapists are truly addressing social needs or addressing contextual factors.

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### **Ethics Approval**

The study was approved by the Walsh University Human Subject Review Committee (13-43).

### **Funding**

There are no funding sources to report.

### **Disclosures**

There are no disclosures to report.

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