Recognizing and Addressing Social Determinants of Health (SDOH) in Comprehensive Obesity Management

Importance of Recognizing SDOH[1]

- SDOH—the conditions in which people live, work, and play—can drive weight gain and create barriers to care
- Adults with obesity are more likely to have high SDOH burden (eg, low income, food insecurity, lack of health insurance)
- The combination of obesity and high SDOH burden is linked to increased risk of early death

SDOH Screening Tools

- SDOH risk assessment is included in the Healthcare Common Procedure Coding System[2,3]
- Screening tool examples are included here, but other standardized, evidence-based, validated tools may be used[3]
- Use principles of respectful communication when speaking with patients about obesity-related healthcare needs; see the resource on language choices for more information
- Confirm that results are recorded in patients' charts

10-Item Centers for Medicare and Medicaid Services Accountable Health Communities Health-Related Social Need (CMS AHC-HRSN) Screening Tool[4]

Core CMS AHC-HRSN Screening Tool Domains		
Domain	**What it Covers**	**Why it Matters for Weight**
Food insecurity	Worry that food will run out; food not lasting	Low-cost foods are typically high calorie and low nutrient
Housing instability	Unstable, unsafe, or substandard housing	Limits cooking and refrigerated storage for food and injectable medications
Transportation	Cannot reliably get to appointments	Missed follow-up, labs, and medication titration
Utilities	Shut-off notices; no heat, electricity, or running water	Disrupts daily routines and self-management
Interpersonal safety	Physical, verbal, or emotional harm at home	Chronic stress contributes to weight gain; unsafe conditions limit change
Additional domains include financial strain, employment, family and community support, education, physical activity, substance use, mental health, disabilities.		

Quick Food Insecurity Screen[5]

The Hunger Vital Sign	
1.	"Within the past 12 months, you worried that your food would run out before you got money to buy more." (Often/ Sometimes/Never true)
2.	"Within the past 12 months, the food you bought just didn't last and you didn't have money to get more." (Often/ Sometimes/Never true)
→ "*Often true*" or "*Sometimes true*" to either = food insecure.	

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SDOH and Obesity: What to Do Next

Hospitalization, Discharge, Follow-up, and Documentation

- Put obesity on the problem list when it contributes to the admission
- Include obesity-specific discharge instructions with a named follow-up plan
- Consider starting or continuing obesity medication at discharge with primary care follow-up
- Hand off identified social needs to the outpatient team in the discharge summary
- Rescreen at every inpatient admission and after any major live change
- Close the loop on referrals and document whether the need was met[6]
- Track BMI, A1C, blood pressure, and lipids on a planned schedule to avoid unnecessary visit burden
- Revisit care plans when social needs change
- Document SDOH findings with appropriate International Classification of Diseases, 10th revision (ICD-10) Z-codes (Z55-Z60, Z62-Z65)[7]

Match the Action to the Need

Social need	Action
Food insecurity	Refer to food assistance program (eg, Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) or food bank.
Housing/utilities	Refer to housing assistance and Low Income Home Energy Assistance Program (LIHEAP). If refrigerated injectable storage is impractical, work with pharmacy on alternatives or storage solutions.
Transportation	Offer telehealth or phone follow-up. Arrange Medicaid non-emergency medical transport (NEMT) or use a healthcare rideshare service.
Activity environment	Recommend indoor or home-based activity. Refer to local recreation centers or community programs.
Cost of medications	Use manufacturer savings cards or patient assistance programs. Verify formulary coverage. Document medical necessity for prior authorization.
Mental health	Screen with Patient Health Questionnaire (PHQ) - 2. If positive, complete PHQ-9 and refer directly to behavioral health.

Referral Pathways

Resource	What it Does	How to Access
211	24/7 hotline for food, housing, utilities, transportation, and crisis support	Dial 2-1-1 or visit 211.org
Findhelp	ZIP code directory of local community programs; integrates with many electronic health records	findhelp.org
SNAP/WIC	Federal food assistance programs	fns.usda.gov/snap
Registered dietitian	Nutrition therapy tailored to budget, food access, and culture	Medicare covers for diabetes and kidney disease; verify commercial coverage
Community health worker	Navigates referrals and confirms the patient is connected	Available through Federally Qualified Health Centers (FQHCs) and many Medicaid plans

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