Lessons Learned from Social Needs Screenings in Various Healthcare Delivery Settings

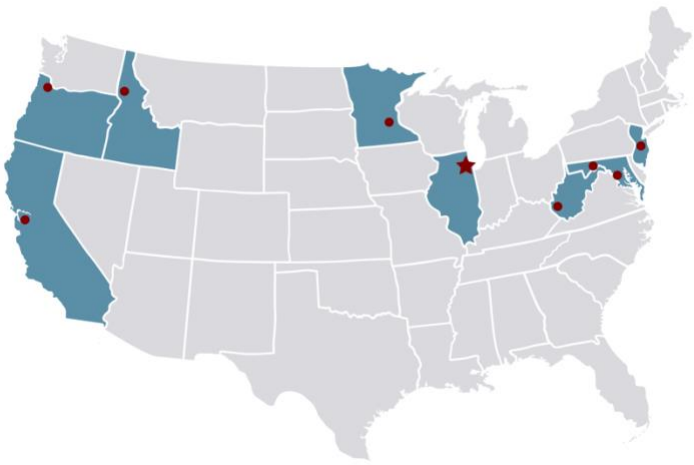
Photos from left to right: Roots' health navigator, Mountain Comprehensive Health Center's CHW, Providence's CHW collaborating with patients

Monica E. Peek, MD, MPH, MSc
Yolanda O'Neal, MPA
Jacob Tanumihardjo, MPH
Marshall Chin, MD, MPH

BACKGROUND

Social needs screening is a growing practice within healthcare, because identifying and addressing patients' unmet social needs can potentially improve health outcomes and reduce healthcare costs.[1,2] Social needs screening within healthcare is a potential mechanism to improve health outcomes, particularly for marginalized patients, by addressing underlying drivers of disease.[1,3] Little is known about how screening is conducted across different healthcare organizational types.[4] The *Bridging the Gap: Reducing Disparities in Diabetes Care* initiative surveyed its eight grantees to examine workflows for social needs screening. In this report, we provide a brief overview of how these heterogeneous grantee organizations conduct social needs screening that best meets the needs of their patients and their organizations.

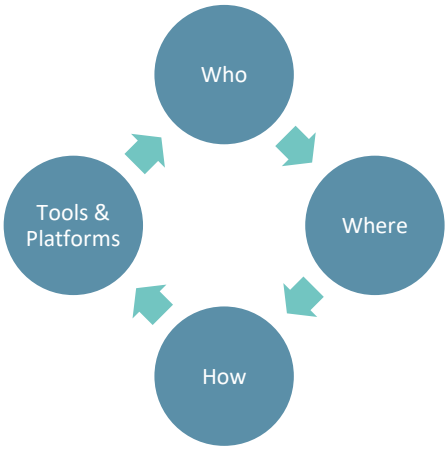
METHODS



The National Program Office at the University of Chicago conducted a survey on social needs screening workflows among grantee sites in the *Bridging the Gap: Reducing Disparities in Diabetes Care* initiative. As previously described, sites had significant heterogeneity in geographic location, payor mix, size, organization type, patient demographics, and other characteristics.[5,6] Surveys were distributed among care transformation teams within each organization to query screening workflows: who, where, and how screening was conducted, and the tools used. Open-ended questions were developed based on literature review and content expertise of the team. Themes were extracted from the data and synthesized by the research team. Responses were also close-coded for descriptive characteristics.

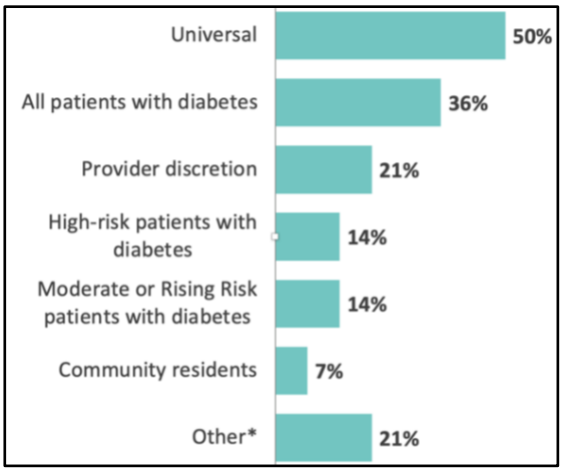
RESULTS

All eight Bridging the Gap: Reducing Disparities in Diabetes Care grantees participated and a total of 14 organizational surveys were completed and returned. An overview of population screened (WHO), the locations that patients are screened (WHERE), the processes utilized to screen patients (HOW), and the structures and systems needed to support screening (TOOLS & PLATFORMS) is described below.



WHO is screened?

Half of respondents reported universal screening for at least one social need (e.g., food insecurity). However, given the limited infrastructure and available staff, some organizations noted that universal screening with comprehensive tools is not feasible. Consequently, some healthcare organizations pre-identified high-risk patients (e.g., high utilizers of healthcare services, poorly controlled diabetes) to comprehensively screen for social needs, while low-risk patients received limited to no screening.

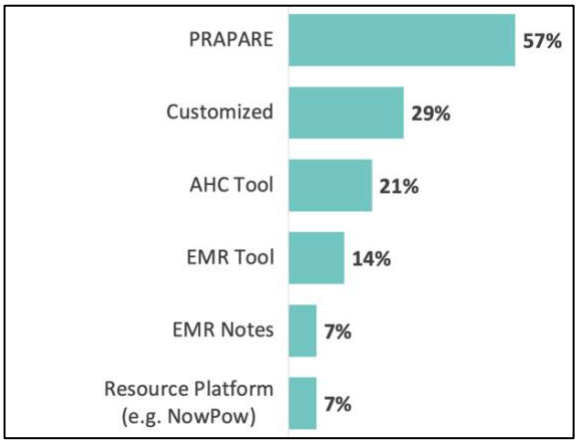


WHERE are patients screened?

While organizations screen at various locations, there was a general consensus that in-person home screening worked best. Home-based screening provided a familiar environment with assured privacy, that facilitated open and honest conversations. Regardless of location, in-person screening was the preferred screening method (e.g., clinic waiting rooms, examination rooms). To maximize time management, some organizations recommended social needs screening outside of routine diabetes visits necessary. Challenges were noted with screening methods that were not in-person, although often. Concerns were noted about remote screening because patients may feel less comfortable disclosing verbally than on paper. However, 71% of respondents reported using telephonic communication as one screening method due to efficiency. Online screening had increased anonymity but challenges of reaching patients with limited digital access and digital literacy.

HOW are patients screened?

Community health workers (CHWs) and lay health workers (LHWs) conducted the majority of screening, due to embedded screening in LHW-tailored interventions. Some staff received training in trauma-informed practice, which can provide a non-judgmental environment that encourages open dialogue with empathic inquiry.[7] This person-centered approach has been successfully integrated into a variety of clinical and non-clinical settings.[8] Others used self-complete paper instruments to facilitate self-disclosure of sensitive material. The most critical element of social needs screening was seen as identifying the right people to conduct screening; CHWs are effective because they are racially, ethnically and/or culturally concordant with the populations they serve and share a lived experience to facilitate social connections and trust.



What screening TOOLS and PLATFORMS are being used?

The most commonly used social needs screening tool was the Protocol for Responding to Assessing Patient Assets, Risks and Experiences (PRAPARE).[9] Over time, several sites customized this instrument, or created a new survey altogether, to better fit the needs of their patient population. Some organizations used PRAPARE for the initial intake and at set intervals (e.g., annually), but used shorter interim surveys to assess highly prevalent social needs (e.g. housing, income, food). Ease of use and fit for the population determined decisions about screening tools.

Half of respondents used paper forms to document screening that, to be clinically meaningful to other team members, needed to be re-documented in electronic formats (e.g., electronic medical record [EMR]), placing additional work burden on staff and increasing risk for burnout.

Yet documentation was seen as key to reorganizing work and identifying and strengthening needed partnerships. Bidirectional social needs software platforms (e.g., NowPow), can directly integrate with the EMR and reduce double-documentation.[10] The use of immediate referrals and patient nudges was a strength, but organizations noted delays in engaging patients who lacked smart phones or email access. EPIC introduced Healthy Planet to allow healthcare organizations to directly screen and document social needs in the EMR, but several organizations had to adjust the module (e.g., customize housing and utilities domains) to meet their needs.

DISCUSSION

In this heterogenous group of healthcare organizations, social needs screening was conducted in a variety of ways. Yet there was a general consensus that using CHWs or LHWs to screen in home settings using standardized instruments tailored for the population could yield the most accurate and comprehensive results. Identifying optimal workflows is critical within each health system.[11]

FUNDING
The research team at the University of Chicago acknowledges funding from the Merck Foundation's initiative *Bridging the Gap: Reducing Disparities in Diabetes Care*.

REFERENCES

1. Schickedanz A, Hamity C, Rogers A, Sharp AL, Jackson A. Clinician experiences and attitudes regarding screening for social determinants of health in a large integrated health system. Medical care. 2019;57(Suppl 6 2):S197.
2. Wang GX, Gauthier R, Gunter KE, Johnson L, Zhu M, Wan W, Tanumihardjo JP, Chin MH. Improving diabetes care through population health innovations and payments: Lessons from Western Maryland. Journal of General Internal Medicine. 2023 Mar 2:1-8.
3. Roth SE, Gronowski B, Jones KG, Smith RA, Smith SK, Vartanian KB, Wright BJ. Evaluation of an Integrated Intervention to Address Clinical Care and Social Needs Among Patients with Type 2 Diabetes. Journal of General Internal Medicine. 2023 Mar 2:1-7.
4. Murray GF, Colla CH. Prevalence of screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals. JAMA network open. 2019;2(9):e1911514-.
5. Gunter KE, Peek ME, Tanumihardjo JP, Carbrey E, Crespo RD, Johnson TW, Rueda-Yamashita BR, Schwartz EI, Sol C, Wilkinson CM, Wilson JO. Population Health Innovations and Payment to Address Social Needs Among Patients and Communities With Diabetes. The Milbank Quarterly. 2021; 99(4):928-73
6. Gunter KE, Tanumihardjo JP, O'Neal Y, Czadzeck G, Peek ME, Chin MH. Reforming Care to Address Medical and Social Needs: COVID-19 Lessons to Improve Diabetes Care and Reduce Disparities. 2022. White Paper
7. Tanumihardjo JP, Eversole C, Zhu M, Gunter KE, Peek ME. Glycemic Control and Patient-Reported Outcomes Among Patients with Diabetes Engaged with Community Health Workers in Rural Settings. Journal of General Internal Medicine. 2023 Mar 2:1-3.
8. Naz A, Rosenberg E, Andersson N, Labonté R, Andermann A. Health workers who ask about social determinants of health are more likely to report helping patients: mixed-methods study. Canadian Family Physician. 2016;62(11):e684-93.
9. National Association of Community Health Centers. https://www.nachc.org/research-and-data/prapare/. 2019. Accessed April 1 2022.
10. Tanumihardjo JP, Morganstern E, Gunter KE, Martinez A, Altschuler S, Towns C, Schwartz E, Hopkins K, Burnett J, Ricks-Stephen C. Community health collaborative facilitates health system and community change to address unmet medical and social needs in New Jersey. Journal of General Internal Medicine. 2023 Mar 2:1-5.
11. Berry C, Paul M, Massar R, Marcello RK, Krauskopf M. Social needs screening and referral program at a large US public hospital system, 2017. American journal of public health. 2020;110(S2):S211-4.