Social Needs Screenings Programs: Factors for Success

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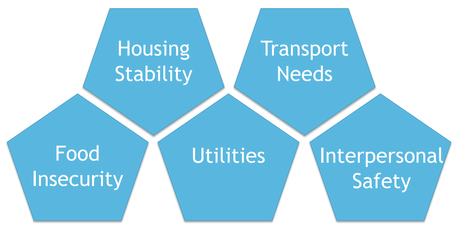
Abstract

- **Introduction**: In January 2024, the Centers for Medicare and Medicaid Services (CMS) implemented Health Quality Measure (HQM) 487, which required participating hospitals to annually screen admitted patients for the 5 domains of the Social Determinants of Health (SDOH). These requirements allowed hospitals to develop individualized, but compliant, screening programs. Previous SDOH screening research has focused on measurement tools, but not the mechanisms of screening present in various hospitals.
- **Research Objectives:** This study will investigate the mechanism(s) for a social needs screening program (which is reflective of underlying SDOH disparity) in a large, multi-hospital academic health system in the Northeastern United States. A secondary objective will be to determine factors that positively and negatively affect the ability of a program to accurately capture underlying SDOH disparities and improve health outcomes.
- **Methods:** Directors from 17 hospitals within the health system will be interviewed using a standardized survey and structured interview. Questions about topics such as the screening setting, screening administrators, and which SDOH domains are screened for will be asked.
- **Preliminary Results**: Not available.
- **Expected Outcomes and Significance**: This investigation aims to holistically characterize SDOH screening programs in a hospital setting and highlight their distinguishing attributes. This may allow for better contextualization of SDOH data collected across different institutions, leading to a better understanding of disparities across larger populations. Well contextualized data will also strengthen disparity-influenced decision making and allow providers to better leverage public sector and industry social services to address health inequities.

Introduction

- Collection of SDOH data during inpatient hospital stays may allow care decisions to consider disparities and ensure optimal outcomes for patients.
- In fact, social needs screening has been found to decrease healthcare costs and screening is regarded by some patients as a form of greater communication with their health system[1,2] .
- In January 2024, the Centers for Medicare and Medicaid Services (CMS) began requiring hospitals to screen all their inpatient populations for the 5 domains of the Social Determinants of Health (SDOH).



- However, because of flexible CMS guidance, hospitals can create their own tool or choose from the more than 30 screening tools documented in the literature.
- They must consider factors such as data generalizability and the needs of the local population served[3].
- Individual implementation of these tools further increases the variability in hospital-collected SDOH data.
- Additionally, there is a need for validated and psychometrically sound social needs screening tools as well as investigation into a screening program's success or failure at improve health outcomes[3,4].
- Existing research on SDOH screening focuses on characterizing SDOH screening tools in the abstract--absent a hospital setting or real-world implementation.
- Thorough characterization of SDOH screening tools in their associated screening programs in a hospital setting will clarify the landscape of SDOH screening tools and facilitate further research that uses SDOH screening data.

Implementation Plan

- A survey will be given with questions that can easily be quantified gathering basic facts about the hospital screening program including the screening tool used and the general screening environment created by the screening program.
- Interview questions will be asked in a semi-structured format with the below questions as a template.
- These questions will cover topics such as diversity and inequity considerations, data usage, and future directions.

Screening Setting:

1. When in patient the encounter is the interview conducted?
    1. At admission, before discharge, not specified
2. Where is the screen performed?
    1. Emergency room, patient room
3. Who performs the screening?
    1. Doctor, nurse, CNA, social worker
4. How often is the screen performed on a given patient?
    1. If the patient is readmitted, would they be screened again?
5. In which clinical settings are screenings currently performed in?
    1. Do the screeners follow a different program in different settings?

Screening Tool Characterization:

1. How many questions are on the screening tool currently in use?
2. How many risk factors are assessed by the current screening program?
    1. Which domains are beyond the 5 CMS required domains?
3. Is the questionnaire given orally or through paper?
    1. Is the questionnaire able to be translated into different language
    2. If so which languages?
4. Was the questionnaire designed from scratch or based off an existing tool?
    1. If based off an existing tool was the tool statistically validated and peer reviewed?
5. Does the screening tool have open or closed ended answers?
    1. If so, which domains are assessed with opened vs closed ended questions?
6. Does the screening tool assess eligibility for resource programs such as Medicaid, Medicaid, Supplemental Nutritional Assistance Program etc.?
7. Was the screening tool developed in partnership with community members or leaders from other hospitals?
8. When was the social needs screening program started at this hospital?

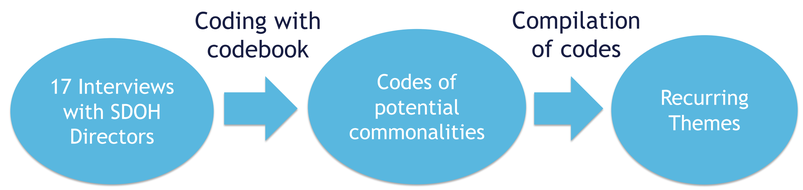
Current State of SDOH Screening:

1. Who provides information on how screening programs should be laid out? Are the directives the same enterprise wide or do they vary hospital by hospital?
2. What was the goal of the screening program when it was first established?
3. What changes have been made since the program was first established?
4. What limitations were considered when designing the screening program?
5. What unexpected problems have arisen since the implementation of the program?
6. What does the hospital do with the information collected?
    1. If a patient screens positively, are they automatically connected with resources?
    2. Is the information collected displayed in the EMR so providers can view it?
    3. Who else has access to a patient's social needs screening data?
7. How is the information collected from screening surveys used to inform care?
8. How is the hospital's social needs screening program tailored to serve the health and social needs of the hospital's specific patient population?
9. How is the hospitals social needs screening program working towards directly benefiting underserved populations and addressing health disparities?

Future Improvements:

1. What changes have been made to the program to comply with the 2024 CMS mandate?
2. Do you foresee any problems complying with the 2024 CMS mandate?
3. Have there been enterprise level changes and initiatives centered around CMS compliance?
    1. Have these initiatives been accompanied with additional funding?
    2. Do you see any room for improvement in the CMS mandate to improve social needs screening more?
4. What innovations do you see in the field of SDOH screening?

Data Analysis and Evaluation



- Each of the qualitative interviews will be individually coded.
- A thematic analysis will be conducted compiling these codes into themes that reoccur across multiple interviews, until no new themes emerge.
- The survey style questions are quantitative in nature and the results from each hospital will be counted and any trends in response type and associated factors will be presented.
- Information gathered from the interviews will be presented by calculating what percent of experts endorsed a given factor/theme.

Linkage to Healthcare Disparities

- Through structured interviews with hospital leaders, we will characterize similarities and differences between the SDOH screening programs of hospitals in a single urban academic health system.
- Compiled data about perceived needs and future directions of hospital leaders will inform screening programs creation and allow for the creation of a standard questionnaire tailored to community need.
- Quantification and characterization of the SDOH data collection process will allow for better contextualization of social needs data, allowing for better inter-hospital comparison.
- This will create a more accurate picture of the social need of a community based on multiple well integrated viewpoints, giving providers better information with which to leverage social services to address health inequities.

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