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From Screening To Intervention: Healthcare Team Perspectives On Integrating Social Needs Assessment Into Clinical Workflows

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Abstract

This study examines healthcare team perspectives on integrating social determinants of health (SDoH) screening and intervention into clinical workflows. Despite growing recognition that social factors significantly impact health outcomes, healthcare organizations face substantial challenges implementing systematic approaches to identify and address patients' social needs. Drawing on recent research and implementation experiences, we explore the evolution of SDoH screening from pilot programs to more comprehensive initiatives, analyzing the perspectives of diverse healthcare team members including clinicians, clinical assistants, care managers, and community health workers. Key implementation considerations include selection of appropriate screening tools, workflow integration strategies, role delineation, response protocols, and partnerships with community-based organizations. The article highlights successful approaches to balancing screening depth with clinical efficiency, addressing privacy and ethical concerns, and developing sustainable models for intervention. Recent policy developments, including changes to Medicare payment systems that recognize the impact of social factors on healthcare resource utilization, create new opportunities for sustainable implementation. By understanding healthcare team perspectives and incorporating their insights into program design, organizations can develop more effective approaches to addressing social determinants, ultimately improving patient outcomes and advancing health equity.

Introduction

The recognition that social determinants of health (SDoH) significantly influence health outcomes has grown substantially over the past decade. Defined by the World Health

Organization (WHO) as "the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness," SDoH are the non-medical social, economic, and environmental factors that can profoundly impact an individual's health status (WHO Commission on Social Determinants of Health, 2008). Research has consistently demonstrated that SDoH contribute to approximately 60% of health outcomes, far outweighing the influence of medical care alone (Care Process Model, 2020).

In response to this growing recognition, healthcare organizations have begun implementing screening programs to identify patients with social needs. The Centers for Medicare and Medicaid Services (CMS) has identified five primary social determinants that significantly affect health outcomes: food insecurity, housing instability, unmet utility needs, transportation challenges, and exposure to interpersonal violence (A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, 2023). Secondary determinants include education level, employment opportunities, family and social support, and health behaviors. Together, these factors create a complex web of influences that shape individuals' health trajectories and healthcare utilization patterns.

Healthcare systems across the United States have been developing and implementing strategies to integrate SDoH screening and intervention into clinical workflows. This integration represents a paradigm shift in healthcare delivery—moving from a predominantly medical model to a more holistic approach that acknowledges the interconnectedness of social needs and health outcomes. However, implementing such programs requires navigating numerous challenges, including workflow integration, staff training, resource allocation, and coordination with community-based organizations (CBOs) (De Marchis et al., 2023).

This study examines the perspectives of healthcare teams as they work to integrate social needs assessment and intervention into clinical workflows. Drawing on recent research and real-world implementation experiences, we explore the barriers and facilitators to successful integration, the impact on healthcare providers and patients, and emerging best practices for sustainable programs. By understanding these perspectives, healthcare organizations can better design and implement SDoH initiatives that effectively address patients' social needs while maintaining clinical efficiency.

The Evolution of SDoH Screening in Healthcare Settings

Transition from Pilot Programs to Systematic Implementation

The journey of SDoH screening in healthcare settings has evolved significantly over the past decade. What began as small-scale pilot programs in select clinical settings has gradually transformed into more systematic approaches across healthcare systems (De Marchis et al., 2022). This evolution reflects a broader recognition of the importance of addressing social needs as an integral component of healthcare delivery.

Early SDoH screening initiatives were often limited to specific patient populations, such as pediatric patients or individuals with chronic conditions. These targeted approaches allowed healthcare organizations to test screening methodologies and intervention pathways on a smaller scale before expanding to broader populations. For example, the Safe Environment for Every Kid (SEEK) model was developed specifically for pediatric patients to screen for problems in the family environment that might affect a child's health and well-being (Care Process Model, 2020).

As evidence of the impact of social needs on health outcomes accumulated, healthcare organizations began developing more comprehensive screening programs. Tools such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool were developed to standardize the assessment of social needs across diverse healthcare settings (A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, 2023).

The CMS Accountable Health Communities Model, launched in 2017, represented a significant milestone in this evolution. This model provided a framework for healthcare organizations to systematically screen Medicare and Medicaid beneficiaries for social needs and connect them with appropriate community resources (A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, 2023). The model's emphasis on bridging clinical care and community services helped establish a blueprint for more integrated approaches to addressing social determinants of health.

Current State of SDoH Screening Implementation

Despite growing interest in SDoH screening, implementation remains inconsistent across healthcare settings. A systematic scoping review by De Marchis et al. (2023) found considerable variability in screening practices, including the tools used, populations targeted, workflow integration approaches, and follow-up protocols. This variability reflects both the evolving nature of SDoH initiatives and the need for adaptability to different healthcare contexts.

The prevalence of SDoH screening has increased substantially in recent years. Meyer et al. (2020) reported on the implementation of universal SDoH screening at a large U.S. academic medical center, demonstrating the feasibility of integrating screening into routine care processes. Similarly, Gold et al. (2018) documented the adoption of SDoH electronic health record (EHR) tools by community health centers, highlighting the growing technological infrastructure supporting these initiatives.

However, implementation challenges persist. Healthcare organizations continue to grapple with questions about optimal screening frequency, appropriate screening tools, and effective workflow integration. The trade-offs between comprehensive screening and clinical efficiency remain a significant consideration, with many organizations opting for brief screening tools that can be easily incorporated into existing workflows (LaForge et al., 2018).

Regulatory and Policy Landscape

Recent policy developments have accelerated the adoption of SDoH screening in healthcare settings. The CMS has increasingly recognized the importance of addressing social determinants through various policy initiatives. Most notably, the FY 2024 Hospital Inpatient Prospective Payment System (IPPS) final rule included provisions related to social determinants of health, including changing the severity designation of ICD-10-CM diagnosis codes for homelessness to reflect the higher resource costs associated with treating patients experiencing homelessness (FY 2024 Hospital Inpatient Prospective Payment System, 2023).

Additionally, CMS has incorporated SDoH measures into quality reporting programs. The PPS-Exempt Cancer Hospital Quality Reporting Program now includes measures for "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health," reflecting the growing emphasis on social needs assessment as a component of quality care (FY 2024 Hospital Inpatient Prospective Payment System, 2023).

These policy developments signal a shift toward greater institutional support for SDoH screening and intervention. As healthcare payment models continue to evolve toward value-based care, addressing social determinants becomes increasingly aligned with financial incentives for healthcare organizations. This alignment creates a more supportive environment for healthcare teams working to integrate social needs assessment into clinical practice.

Healthcare Team Perspectives on SDoH Screening Implementation

Clinician Perspectives and Concerns

Healthcare providers' perspectives on SDoH screening vary widely, influenced by their roles, practice settings, and prior experiences with addressing social needs. Research has identified several common themes in clinician perspectives that can significantly impact implementation success.

Many clinicians acknowledge the importance of addressing social determinants but express concerns about the additional workload that screening may entail. Byhoff et al. (2018) noted that time constraints and competing priorities in clinical practice can create resistance to implementing new screening protocols. Clinicians often worry about workflow disruptions, especially in high-volume settings where appointment times are already limited.

Another significant concern relates to the responsibility for addressing identified social needs. Garg et al. (2016) highlighted the ethical dilemma clinicians face when they identify social needs but lack clear pathways to address them. This "screen and report" approach without adequate intervention capacity can lead to clinician frustration and moral distress. As one physician quoted in a study by LaForge et al. (2018) stated, "Why would I want to ask about something I can't help with?"

Despite these concerns, many clinicians recognize the value of SDoH screening in providing more comprehensive patient care. Payne et al. (2021) found that primary care providers serving Medicare Advantage patients acknowledged the importance of social determinants in achieving optimal health outcomes, particularly for complex patients. This recognition often motivates clinicians to support screening initiatives, even amid implementation challenges.

Staff Roles and Responsibilities in SDoH Screening

The distribution of roles and responsibilities for SDoH screening within healthcare teams significantly influences implementation success. Research suggests that a team-based approach with clear role delineation is most effective for sustainable screening programs.

Care Process Model (2020) outlines a comprehensive team-based approach to SDoH screening, detailing specific roles for various team members:

- **Patient Service Representatives (PSRs)** may administer screening questionnaires during check-in.
- **Clinical Assistants** input screening data into electronic health records and sometimes provide resource information to patients.
- **Providers (physicians, advanced practice providers)** review screening results, acknowledge findings with patients, and make appropriate referrals.
- **Care Managers** assist with connecting patients to resources and providing follow-up support.
- **Community Health Workers (CHWs)** serve as liaisons between healthcare teams and community resources, often providing more intensive navigation support for patients with complex needs.

This distributed approach helps prevent any single team member from becoming overwhelmed with screening responsibilities. It also leverages the unique skills and relationships of different team members to create a more comprehensive response to identified social needs.

Workflow Integration Challenges and Solutions

Integrating SDoH screening into clinical workflows represents one of the most significant implementation challenges. Healthcare teams must balance screening thoroughness with clinical efficiency, avoiding disruptions to existing care processes.

LaForge et al. (2018) studied how six healthcare organizations developed tools and processes for SDoH screening in primary care. They identified several common workflow integration approaches, including:

1. **Pre-visit screening**: Patients complete screening questionnaires before their appointments, either through patient portals, mailed forms, or in waiting rooms.

2. **Integrated EHR screening**: Screening questions are incorporated into existing EHR templates and clinical documentation workflows.
3. **Dedicated screening staff**: Specific team members (e.g., medical assistants, community health workers) are designated to administer and document screening.
4. **Phased implementation**: Organizations gradually expand screening to different populations or clinical settings, allowing for workflow refinement.

Successful workflow integration often requires iterative refinement based on real-world implementation experience. Gold et al. (2018) described how community health centers adapted their SDoH screening workflows over time, making adjustments based on staff feedback and practical constraints. This iterative approach acknowledges that optimal workflow integration may vary across different clinical settings and patient populations.

EHR integration represents a particularly important aspect of workflow design. De Marchis et al. (2022) noted that effective EHR integration can streamline documentation, facilitate referrals, and enable population-level data analysis. However, EHR customization often requires significant technical resources and organizational support, creating potential barriers for smaller healthcare organizations with limited IT capacity.

Screening Tools and Approaches

Comparison of Commonly Used Screening Tools

Healthcare organizations employ a variety of screening tools to assess social needs, each with distinct advantages and limitations. Understanding these differences is essential for healthcare teams implementing SDoH screening programs.

The **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)** tool was developed by the National Association of Community Health Centers and partners. This comprehensive tool includes 21 core measures covering various social determinants, including housing, food security, transportation, social support, and financial strain. PRAPARE emphasizes actionable measures and has been widely adopted by community health centers (Care Process Model, 2020).

The **Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool** was developed by CMS for use in the Accountable Health Communities Model. This 10-item tool focuses on five core domains: housing instability, food insecurity, transportation difficulties, utility needs, and interpersonal safety. Its brevity and focus on high-priority domains make it suitable for integration into busy clinical workflows (A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, 2023).

The **Social Check** tool, used by Intermountain Healthcare and SelectHealth, represents a shortened screening approach focusing on immediate social needs. This tool asks patients if they or someone in their household has gone without essential needs in the past year, including food, housing, utilities, safety, transportation, and healthcare services. Its simplicity facilitates rapid administration and interpretation (Care Process Model, 2020).

The **Safe Environment for Every Kid (SEEK)** questionnaire specifically targets pediatric patients (birth to age 5) and screens for factors affecting a child's home environment. It covers topics such as food insecurity, housing instability, parental stress, intimate partner violence, and substance abuse, providing a developmentally appropriate screening approach for young children (Care Process Model, 2020).

Each tool offers different trade-offs between comprehensiveness and practicality. De Marchis et al. (2022) note that while more comprehensive tools provide a more thorough assessment of social needs, shorter tools may be more feasible in time-constrained clinical settings. Healthcare

teams must consider their specific contexts and resources when selecting appropriate screening instruments.

Screening Frequency and Target Populations

Determining optimal screening frequency and identifying appropriate target populations represent key implementation decisions for healthcare teams. These decisions significantly influence the resource requirements and potential impact of screening programs.

Regarding frequency, the Care Process Model (2020) recommends annual screening for all patients, with additional screening as needed based on clinical judgment. This approach balances the need for regular assessment with practical constraints on healthcare team capacity. However, practices vary widely, with some organizations implementing universal screening at every visit and others employing more selective approaches based on risk factors or visit types.

Target population selection also varies across healthcare settings. Some organizations implement universal screening for all patients, while others focus on specific high-risk populations. Meyer et al. (2020) described the implementation of universal SDoH screening at a large academic medical center, demonstrating the feasibility of this approach. In contrast, other organizations prioritize screening for patients with specific characteristics, such as those with chronic conditions, high healthcare utilization, or insurance through public programs like Medicaid.

The decision to implement targeted versus universal screening involves trade-offs between resource efficiency and comprehensive identification of social needs. Universal screening may identify patients whose social needs might otherwise go unrecognized but requires more substantial infrastructure and staff capacity. Targeted screening allows for more efficient resource allocation but may miss patients with social needs who do not fit predefined risk categories.

Documentation and Data Management Considerations

Effective documentation and data management are crucial components of SDoH screening programs. Healthcare teams must navigate issues related to EHR integration, privacy concerns, and data utilization for population health management.

EHR integration of SDoH screening data facilitates clinical decision-making and care coordination. Gold et al. (2018) described how community health centers incorporated SDoH tools into their EHR systems, enabling better documentation and tracking of identified needs. However, this integration often requires significant customization, as many EHR systems were not originally designed to capture social needs data comprehensively.

Privacy considerations also influence documentation practices. The Care Process Model (2020) highlights specific documentation guidelines for sensitive information, such as intimate partner violence. These guidelines caution against placing certain diagnoses on problem lists visible to patients through patient portals, as this visibility could potentially compromise patient safety in some circumstances.

Coding practices for SDoH represent another important consideration. The Care Process Model (2020) notes that ICD-10-CM includes Z codes (Z55-Z65) specifically for social determinants of health. However, reimbursement for these codes varies across payers, creating financial considerations for healthcare organizations. The recent CMS decision to change the severity designation of homelessness diagnosis codes reflects growing recognition of the impact of social determinants on healthcare resource utilization (FY 2024 Hospital Inpatient Prospective Payment System, 2023).

Beyond clinical documentation, healthcare organizations increasingly use SDoH data for population health management and quality improvement. Aggregated data can identify patterns of social needs across patient populations, inform resource allocation, and guide partnership

development with community-based organizations. However, realizing these benefits requires robust data infrastructure and analytical capacity that may exceed the resources of smaller healthcare organizations.

From Screening to Intervention: Building Effective Response Systems

Developing Response Protocols for Identified Social Needs

Effective SDoH screening programs extend beyond identification to include thoughtful response protocols for addressing identified social needs. Healthcare teams must develop systematic approaches for responding to screening results, ensuring that patients receive appropriate support and resources.

The SBIRT (Screening, Brief Intervention, Referral to Treatment) model, originally developed for substance use disorders, has been adapted for addressing social determinants of health. As described in the Care Process Model (2020), this approach involves:

1. **Screening**: Systematic assessment for unmet social needs at the point of care.
2. **Brief Intervention**: Interpreting results, acknowledging findings with patients, and determining the need for services.
3. **Referral to Treatment**: Connecting patients to appropriate resources and services to address identified needs.

Response protocols often incorporate a tiered approach based on the intensity of identified needs. The Care Process Model (2020) outlines three levels of response:

- **Low-intensity needs**: Providing resource information (e.g., 2-1-1 handout) and encouraging future discussion if needed.
- **Medium-intensity needs**: Providing resource information and involving care team members for additional support.
- **High-intensity needs**: Providing resource information, engaging the care team, and potentially initiating more intensive case management.

This tiered approach helps match the level of intervention to the severity of need, optimizing resource utilization while ensuring that patients with more significant needs receive appropriate support.

Care Management and Navigation Services

For patients with complex social needs, care management and navigation services play a crucial role in facilitating connections to appropriate resources. These services help bridge the gap between identification of needs and successful resource utilization.

Care managers serve as critical liaisons between clinical teams and community resources. As described by Schickedanz et al. (2019), care managers with specific training in social needs navigation can significantly impact healthcare utilization among high-need patients. Their study of social needs navigation in a large integrated health system demonstrated reductions in emergency department visits and inpatient admissions among patients receiving navigation services.

Community Health Workers (CHWs) represent another valuable resource for supporting patients with social needs. The Care Process Model (2020) describes how CHWs can provide outreach services to high-risk members, make connections to social services and healthcare providers, and maintain ongoing communication about patient progress. Their knowledge of community resources and ability to build trusting relationships with patients make them particularly effective in navigating complex social service systems.

The Intermountain Community Care Team (ICCT) provides an example of a more intensive care management approach for high-risk patients. This team provides in-home case management for patients with significant medical and social needs, using the Social Check tool to identify specific needs and connecting patients to appropriate resources (Care Process Model, 2020).

Partnerships with Community-Based Organizations (CBOs)

Addressing social determinants effectively requires strong partnerships between healthcare organizations and community-based organizations that provide social services. These partnerships create pathways for patients to access resources beyond the scope of healthcare systems.

The Care Process Model (2020) offers guidance for healthcare teams working with CBOs, emphasizing the importance of:

1. **Understanding capacity limitations**: Recognizing that many CBOs have limited staff and financial resources.
2. **Knowing eligibility requirements**: Ensuring that referred patients meet program qualifications to avoid frustration and wasted time.
3. **Building personal connections**: Establishing relationships with frontline staff at CBOs to facilitate warm handoffs and improve referral success.
4. **Verifying resource availability**: Confirming that resources remain available, as CBO programming often depends on grant funding that may expire.

Some healthcare organizations have developed more structured partnerships with CBOs through formal agreements or shared technology platforms. The Care Process Model (2020) describes the "Unite Us" platform, which digitally connects patients with healthcare and social service providers. This platform facilitates electronic referrals, tracks referral status, and reports outcomes, creating a more coordinated system for addressing social needs.

Initiatives like Intermountain Healthcare's Alliance represent more comprehensive approaches to CBO partnerships. This demonstration project, based on the Accountable Health Communities model, aims to improve well-being and reduce healthcare costs by addressing social determinants through partnerships with community organizations (Care Process Model, 2020).

Evaluation and Outcomes of SDoH Screening Programs

Measuring Implementation Success

Evaluating the success of SDoH screening and intervention programs requires attention to multiple dimensions of implementation outcomes. Proctor et al. (2011) proposed a framework for implementation research that distinguishes between implementation outcomes, service outcomes, and client outcomes. This framework provides a valuable structure for assessing SDoH initiatives.

Key implementation outcomes for SDoH screening programs include:

1. **Adoption**: The uptake of screening by healthcare teams and organizations. Meyer et al. (2020) reported on the adoption of universal screening at a large academic medical center, achieving screening rates of 25.5% within the first year of implementation.
2. **Fidelity**: The degree to which screening is implemented as intended. De Marchis et al. (2023) noted significant variability in screening implementation across healthcare settings, highlighting the importance of measuring fidelity to understand program effectiveness.

3. **Acceptability**: The perception among stakeholders that screening is agreeable or satisfactory. De Marchis et al. (2019) found generally high acceptability of social risk screening among patients and caregivers, with 79% of participants reporting comfort with screening.
4. **Feasibility**: The extent to which screening can be successfully carried out in a particular setting. LaForge et al. (2018) identified various workflow adaptations that enhanced the feasibility of screening implementation in primary care settings.
5. **Sustainability**: The extent to which screening becomes institutionalized or routinized within an organization. Gold et al. (2018) described factors that supported the sustained adoption of SDoH EHR tools in community health centers, including leadership support and alignment with organizational priorities.

The Consolidated Framework for Implementation Research (CFIR) provides another valuable approach for evaluating implementation success. Keith et al. (2017) described how this framework can produce actionable findings for improving implementation by examining the interaction between intervention characteristics, inner setting, outer setting, individuals involved, and implementation process.

Impact on Patient Outcomes and Healthcare Utilization

The ultimate goal of SDoH screening and intervention is to improve patient outcomes and optimize healthcare utilization. Emerging research suggests promising impacts in these areas, though evidence remains limited.

Schickedanz et al. (2019) conducted a quasi-experimental study examining the impact of social needs navigation on healthcare utilization among high utilizers in a large integrated health system. They found that patients who received navigation services experienced significant reductions in emergency department visits (16% reduction) and hospitalizations (17% reduction) compared to matched controls. These findings suggest that addressing social needs can reduce unnecessary acute care utilization.

Shier et al. (2013) demonstrated that strong social support services, such as transportation assistance and caregiver support, can lead to lower healthcare use and costs. Their research highlighted the potential return on investment from addressing social determinants, particularly for vulnerable populations with complex needs.

Beyond healthcare utilization, some studies have examined the impact of SDoH interventions on clinical outcomes. However, establishing direct causal relationships between social interventions and clinical outcomes remains challenging due to the complex interplay of factors influencing health. More robust research designs with longer follow-up periods are needed to fully elucidate these relationships.

Sustainability and Scaling Considerations

As healthcare organizations move beyond pilot programs to more systematic implementation of SDoH screening, questions of sustainability and scalability become increasingly important. Several factors influence the long-term viability of these initiatives.

Financial sustainability represents a significant consideration. Horwitz et al. (2020) analyzed health systems' investments in social determinants of health, finding that these investments varied widely across sectors and often relied on temporary funding sources. Sustainable screening programs typically require alignment with organizational financial incentives, whether through value-based payment models, quality incentive programs, or dedicated funding streams.

Workforce capacity also influences sustainability. The Care Process Model (2020) emphasizes the importance of distributing screening responsibilities across team members to prevent

burnout and ensure program continuity. Organizations that incorporate SDoH screening into existing roles and workflows, rather than creating separate processes, may achieve greater long-term sustainability.

Technology infrastructure plays a crucial role in scaling SDoH initiatives. Gold et al. (2018) noted that effective EHR integration facilitated broader adoption of screening across community health centers. Similarly, platforms that connect healthcare systems with community-based organizations can enhance the scalability of intervention efforts by streamlining referral processes and communication.

Institutional policies and procedures that formalize SDoH screening expectations contribute to sustainability. Imran et al. (2022) described how incorporating SDoH initiatives into organizational strategic plans and performance metrics helped institutionalize these efforts at a system level.

Ethical and Practical Considerations

Privacy, Consent, and Data Sharing Concerns

SDoH screening raises important ethical considerations related to privacy, consent, and data sharing. Healthcare teams must navigate these considerations while striving to address patients' social needs effectively.

Privacy concerns are particularly salient when screening for sensitive social needs, such as intimate partner violence or housing instability. The Care Process Model (2020) provides specific guidance for documenting intimate partner violence, cautioning against placing such information on problem lists visible through patient portals to prevent potential safety risks if perpetrators gain access to this information. This guidance highlights the need for thoughtful approaches to documentation that balance transparency with patient safety.

Consent processes for SDoH screening vary across healthcare settings. Brown et al. (2023) reviewed the literature on patient and caregiver perspectives on social screening, finding that patients generally expect to be informed about the purpose of screening and how their information will be used. Clear communication about how screening data will be utilized and shared is essential for maintaining patient trust and engagement.

Data sharing between healthcare organizations and community-based organizations presents additional complexities. Apathy and Holmgren (2020) noted that opt-in consent policies can create barriers to health information exchange, potentially limiting the effectiveness of referral systems. Healthcare teams must develop clear protocols for obtaining appropriate consent for information sharing while minimizing unnecessary barriers to care coordination.

Health Equity Implications

SDoH screening has significant implications for health equity, with the potential to either reduce or exacerbate existing disparities depending on implementation approaches. Healthcare teams must consider these implications throughout program development and implementation.

Universal screening approaches can help identify social needs among patients who might not otherwise be recognized as at-risk based on demographic characteristics or clinical presentations. Meyer et al. (2020) found that universal screening at an academic medical center identified social needs across diverse patient populations, including those not traditionally considered high-risk.

However, screening without adequate resources for intervention can potentially exacerbate disparities. Garg et al. (2016) cautioned against the "unintended consequences of screening for social determinants of health," noting that identification without intervention could lead to stigmatization and frustration, particularly for marginalized populations. This concern

underscores the ethical imperative to develop robust response systems alongside screening initiatives.

The digital divide represents another potential source of disparity in SDoH screening implementation. Screening approaches that rely heavily on patient portals, mobile applications, or other digital technologies may disadvantage patients with limited digital access or literacy. Healthcare teams must ensure that screening methodologies accommodate diverse patient needs and capabilities.

Language and cultural considerations also influence the equity implications of SDoH screening. The Care Process Model (2020) notes that screening tools should be available in multiple languages, with the Social Check assessment specifically available in both English and Spanish. Additionally, screening questions must be culturally appropriate and sensitive to diverse perspectives on social needs.

Balancing Screening Depth with Clinical Efficiency

Healthcare teams face practical challenges in balancing comprehensive screening with clinical efficiency. This balance requires thoughtful consideration of screening scope, timing, and workflow integration.

The depth versus brevity trade-off represents a fundamental consideration in screening tool selection. Comprehensive tools like PRAPARE provide more detailed information about patients' social contexts but require more time to administer and interpret. Shorter tools like Social Check may be more feasible in time-constrained settings but provide less nuanced information about specific needs.

LaForge et al. (2018) found that healthcare organizations often adapted screening approaches based on practical constraints and workflow considerations. Some organizations implemented staged screening, beginning with brief assessments and conducting more comprehensive screening only for patients with identified concerns. Others rotated through different screening domains at different visits to distribute the screening burden over time.

The role of technology in enhancing efficiency has become increasingly important. Gold et al. (2018) described how EHR integration of SDoH tools streamlined documentation and follow-up processes. Similarly, patient-facing technologies, such as tablet-based screening in waiting rooms or pre-visit screening through patient portals, can reduce the burden on clinical staff during time-constrained appointments.

Staff training and role clarification contribute significantly to screening efficiency. Boyce et al. (2014) reviewed healthcare professionals' experiences with patient-reported outcome measures and found that clear guidance on administration, interpretation, and response protocols enhanced implementation success. Similarly, the Care Process Model (2020) emphasizes the importance of delineating specific roles for various team members in the screening and response process.

Future Directions and Recommendations

Emerging Trends in SDoH Screening and Intervention

Several emerging trends are shaping the future landscape of SDoH screening and intervention in healthcare settings:

1. **Integration with value-based care models**: As healthcare payment continues to shift toward value-based models, addressing social determinants becomes increasingly aligned with financial incentives. The FY 2024 Hospital Inpatient Prospective Payment System (2023) highlights CMS's growing recognition of social factors in payment determinations, including the reclassification of homelessness diagnosis codes to reflect their impact on resource utilization.

2. **Advanced analytics and predictive modeling**: Healthcare organizations are increasingly utilizing advanced analytics to identify patients at high risk for social needs, target interventions more effectively, and evaluate program impacts. These approaches can enhance the efficiency and effectiveness of screening and intervention efforts.

3. **Bi-directional communication platforms**: Technological solutions that facilitate communication between healthcare organizations and community-based organizations are expanding. Platforms like Unite Us, described in the Care Process Model (2020), enable seamless referrals, status tracking, and outcome reporting across sectors.

4. **Policy support for addressing social needs**: Federal and state policies increasingly support addressing social determinants through healthcare initiatives. The incorporation of SDoH measures into quality reporting programs, as described in the FY 2024 Hospital Inpatient Prospective Payment System (2023), exemplifies this trend.

5. **Standardization of screening approaches**: Efforts to standardize SDoH screening tools and protocols are gaining momentum. The Accountable Health Communities Health-Related Social Needs Screening Tool represents a step toward standardization, potentially facilitating more consistent data collection and cross-site comparisons.

Recommendations for Healthcare Organizations

Based on the evidence and experiences reviewed, several recommendations emerge for healthcare organizations implementing SDoH screening and intervention programs:

1. **Adopt a team-based approach**: Distribute screening and response responsibilities across team members to prevent burnout and leverage diverse skills. The Care Process Model (2020) provides a comprehensive framework for role delineation in SDoH screening and response.

2. **Integrate screening into existing workflows**: Avoid creating parallel processes that add burden without integration into routine care. LaForge et al. (2018) described successful approaches to workflow integration in primary care settings.

3. **Develop clear response protocols**: Establish systematic approaches for addressing identified social needs, with tiered responses based on need intensity. The SBIRT model adapted for SDoH, as described in the Care Process Model (2020), offers a useful framework.

4. **Build robust community partnerships**: Develop relationships with community-based organizations to create effective referral pathways. The Care Process Model (2020) provides guidance for working effectively with CBOs, emphasizing the importance of understanding capacity limitations and eligibility requirements.

5. **Invest in supportive technology**: Implement technological solutions that facilitate screening, documentation, referral, and follow-up processes. Gold et al. (2018) highlighted the value of EHR integration for SDoH screening and intervention.

6. **Monitor implementation outcomes**: Regularly assess adoption, fidelity, acceptability, feasibility, and sustainability of screening initiatives. The framework proposed by Proctor et al. (2011) provides a useful structure for this assessment.

7. **Engage leadership support**: Secure organizational leadership commitment to addressing social determinants as a strategic priority. Imran et al. (2022) emphasized the importance of leadership engagement for system-level improvements in addressing social determinants.

8. **Provide ongoing staff education**: Ensure that all team members understand the importance of social determinants and their roles in addressing them. Boyce et al. (2014) noted that staff education was a key factor in successful implementation of patient-reported outcome measures.

Conclusion

The integration of social needs assessment into clinical workflows represents a significant paradigm shift in healthcare delivery. As healthcare organizations move from fragmented screening initiatives toward more systematic approaches, understanding the perspectives of healthcare teams becomes increasingly important for successful implementation.

The evidence reviewed highlights both the promise and challenges of SDoH screening and intervention. Healthcare teams recognize the importance of addressing social determinants but face substantial implementation barriers, including workflow disruptions, resource limitations, and coordination challenges with community-based organizations. Successful programs navigate these challenges through team-based approaches, clear role delineation, thoughtful workflow integration, and robust community partnerships.

The evolving policy landscape, with growing recognition of social determinants in payment and quality reporting systems, creates new opportunities for sustainable implementation. However, healthcare organizations must continue to balance screening comprehensiveness with clinical efficiency, develop effective response protocols for identified needs, and address ethical considerations related to privacy, consent, and health equity.

As SDoH screening becomes more standardized and integrated into routine care, healthcare teams will play a crucial role in translating this approach from concept to practice. Their experiences and insights provide valuable guidance for developing screening programs that effectively identify and address social needs while maintaining clinical efficiency and patient-centeredness.

By listening to healthcare team perspectives and incorporating their insights into program design, healthcare organizations can create more effective, sustainable approaches to addressing social determinants of health—ultimately improving patient outcomes and advancing health equity.

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