Improving Social Determinants of Health Screening Implementation Through Collaboration: Leveraging a Clinical-Academic Partnership

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Problem Addressed and Project Purpose

Motivated by the transition to value-based payment models,[1] there are growing efforts to capture information about patients' social determinants of health (SDOH) in United States (US) healthcare and provide subsequent services targeted at those health-related social risk factors. The collection of data about social risk factors creates opportunities for healthcare providers to make referrals to social service agencies to address individual patients' needs and to tailor treatment plans to individuals' specific needs, a goal of precision health[2,3]. Hence, by accurately and appropriately collecting SDOH data from patients and actionably displaying these data to providers, healthcare systems may provide resources and effective patient-centered treatment, working towards the goal of achieving better health outcomes for patients who are disadvantaged[2]. While healthcare organizations are beginning to screen patients for numerous social needs using a variety of tools, no standard or universally-used screening tools or processes exist. At the same time, varied screening policies tailored to the needs of specific patient populations may be necessary to ensure accurate and appropriate data collection[1]. There is limited evidence on how social risk data collection is currently carried out both formally and informally in different clinical settings, suggesting open research questions such as what types of screening are offered, which types of providers or staff performs screening, when are patients screened, how are patients screened, and what is the impact of standardized screening practices on patients and providers? We have formed a partnership between Parkview Health and the University of Michigan to address these questions.

Methodology Overview

Parkview Health System is non-profit health system featuring nine hospitals in northeast Indiana and northwest Ohio. To identify existing social risk screening practices at Parkview Health, as well as those clinical areas in which formal or informal screening is currently underway, we convened two stakeholder meetings featuring 31 healthcare provider attendees in November 2019. Participants were asked to bring copies of any screening tools currently in use, allowing for a show-and-tell session which they identified a range of unique social risk screening practices. Informed by the findings of the stakeholder meetings, we have begun interviewing providers and staff who participate in social risk data collection and use in 4-5 clinical sites so as to learn about individuals' varied experiences using existing tools. Additionally, we will conduct observations in clinical areas in which screening is occurring to document existing screening processes, including variation by provider type or specialty, and identify opportunities to improve SDOH workflows. Finally, we will conduct patient interviews to characterize patients' experiences of screening.

Evaluation Results

We will characterize existing SDOH screening practices of providers and staff using qualitative data from interviews and observations. We will use interview data to describe the impact of SDOH screening on patients.

Conclusions

Evaluating existing SDOH screening in a variety of clinical settings, made possible by our partnership, will allow us to learn of how screening impacts a diverse range of patients and providers and identify opportunities to inform a shared definition of SDOH, improve SDOH data quality, and evaluate the impact of screening standardization.

References

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