Utilizing a Tailored Approach to Standardized Screening of Health-Related Social Needs

Qaashuntae Wright, MSN, AGACNP-BC, CCRN

DNP Project Presentation

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Practice Mentor: Danielle Wentworth, MSN, FNP

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Introduction

- **Medical care**
  - 20% of health outcomes (Jacobs, 2021)
- **Social Determinants of Health**
  - 80% of health outcomes (Jacobs, 2021)
  - The conditions in which people are born, grow, live, work, and age (CDC, 2022)

  Social Needs
    - Lack of essentials that impede one's health, well-being, and safety (Glasheen, 2019)

Background

- 68% of Americans have at least one unmet social need (MacDonald, 2019)

- **Unmet social needs are linked to:**
  - Highest health expenditures
  - Higher rates of admissions, readmissions, and ER utilization
  - Greater difficulty in managing chronic diseases
  - Premature death (Artiga & Hinton, 2018)

Background

- **Screening Practices**
  - 24% US hospitals & 16% private practices (Fraze et al., 2019)
- **Provider Perception**
  - 85% HCPs- advocate for social needs
  - 80% HCPs- lack confidence in addressing social needs (Sufrin et al., 2018)
- **Barriers**
  - Time constraints
  - Insufficient staffing
  - Lack of referral resources
  - Lack of reimbursement and health policies
  - Lack of education and training

(Schickedanz et al., 2019; American Academy of Family Physicians, 2022)

Literature Review

- **Body of Evidence**
  - Utilized different screening tools, screening methods, & referral interventions
  - Successful implementation
- **Essential Components of the social needs screening process**:
  - Universal screening
  - Established referral process
  - Screening integrated as a normative process
  - Interdisciplinary teamwork
  - Social needs education & training

(Bechtel, 2021; Berry et al. 2021; Boch et al., 2020; Bradywood et al. 2021; Buitron de la Vega et al., 2019; Escobar et al., 2021; Gold et al., 2018; Meyers et al., 2018; Quinones-Rivera et al., 2021; Wallace et al., 2020)

Purpose Statement

The purpose of this quality improvement project was to implement a social needs screening tool and referral process tailored to clinical workflow in an outpatient clinic in order to increase social needs identification and referrals to community resources.

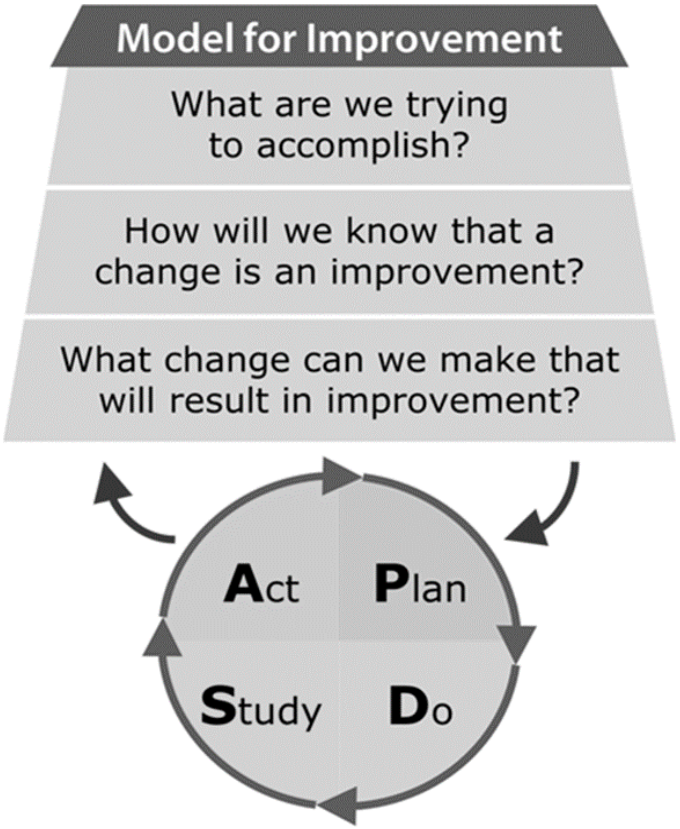
Setting

Outpatient dialysis clinic

- 75 patients, 8 nurses, 5 dialysis technicians, 1 social worker, & 1 nurse practitioner
- High staff turnover
- Higher patient acuity & co-morbidities than other local dialysis clinics
- No formal social needs training currently
- No standardized social needs screening tool
- Annual social needs screening
- No standard method of communication to the social worker

(Y. Jarvis, personal communication, June 15, 2022)

Method: Model for Improvement



The Institute for Healthcare Improvement

Aim

- Increase the identification of social needs and referrals to community resources

Measures

- Number of social needs identified
- Number of referrals by the social worker
- Usability survey of screening tool and process

Change

- The tailored process includes:
  -Increase staff's awareness of social needs
  -Nursing staff involvement in the screening process
  -Standardized screening tool

PLAN Phase

Develop a test of change

- **Form a team:** Doctoral student, nursing staff & social worker
- **Set the Aim:** Increase social needs identification and referrals
- **Establish measures:** Screening rates & patient demographics
  Number & types of social needs
  Number of referrals by social worker
  Usability of the tool and process
- **Test of Change:** Implement screening tool and referral process

Core 5 Screening Tool

Core Determinants of Health Screening Tool (the "Core 5")

	Yes	No
1. Has a lack of transportation kept you from work, attending medical appointments, or from getting things you need for your daily living?		
2. Are you currently having concerns at home with your utilities such as your heat, electric, natural gas, or water?		
3. Are you worried about losing our housing or are you homeless?		
4. Do you or your family worry about whether your food will run out and you won't be able to get more?		
5. Are you worried that someone may hurt you or your family?		

(Ohio Action Coalition, 2017)

DO Phase

Testing of the change, observe, and learn

Stage 1: September

- Staff education

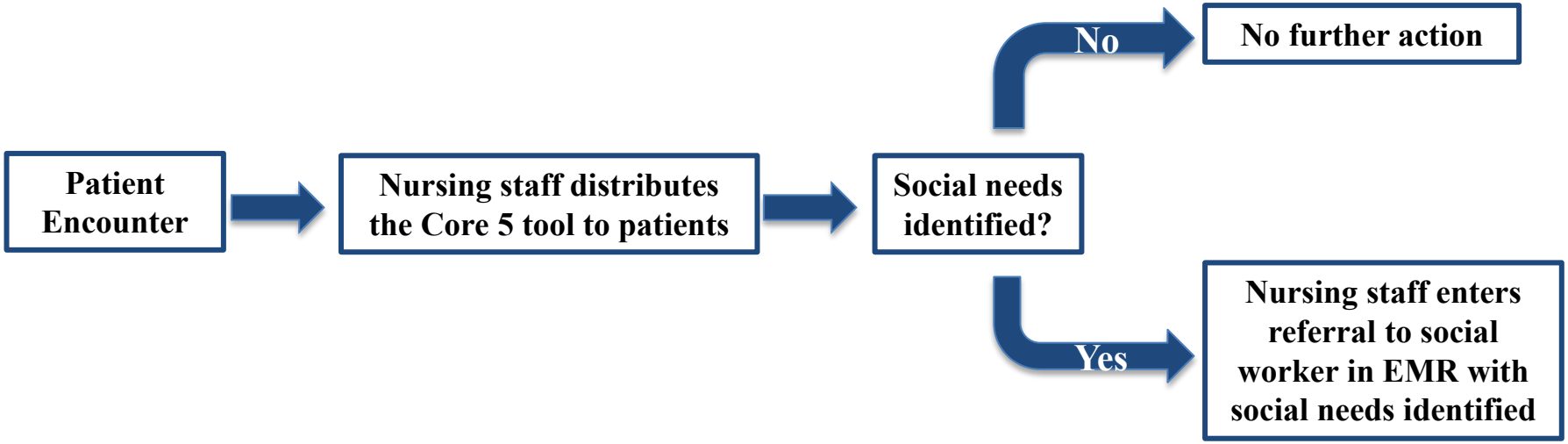
Stage 2: October

- Core 5 tool complete on all patients
  - Paper form - translated forms & translation services available
  - Brief rationale by nurses & dialysis technicians
  - Nurses document social needs identified in EMR clinical note
- Social worker referrals
  - Assess and connect patients to community resources

Data collection: Collected & stored on a secured drive

Data source: EMR & Core 5 tool

Screening Algorithm



STUDY Phase

Analysis of the findings

- Descriptive statistics
  - Screening rates & patient demographics
  - Number & types of social needs
  - Number of referrals by social worker
  - Usability of the Core 5 tool and referral process

- Pre-implementation: Between September 2021- September 2022
- Post-implementation: October 2022

ACT Phase

Determine modifications & recommendations

- No modifications were required
- Results presented to the clinic's leadership
- Recommendation - to embed the Core 5 tool within the clinic's practice

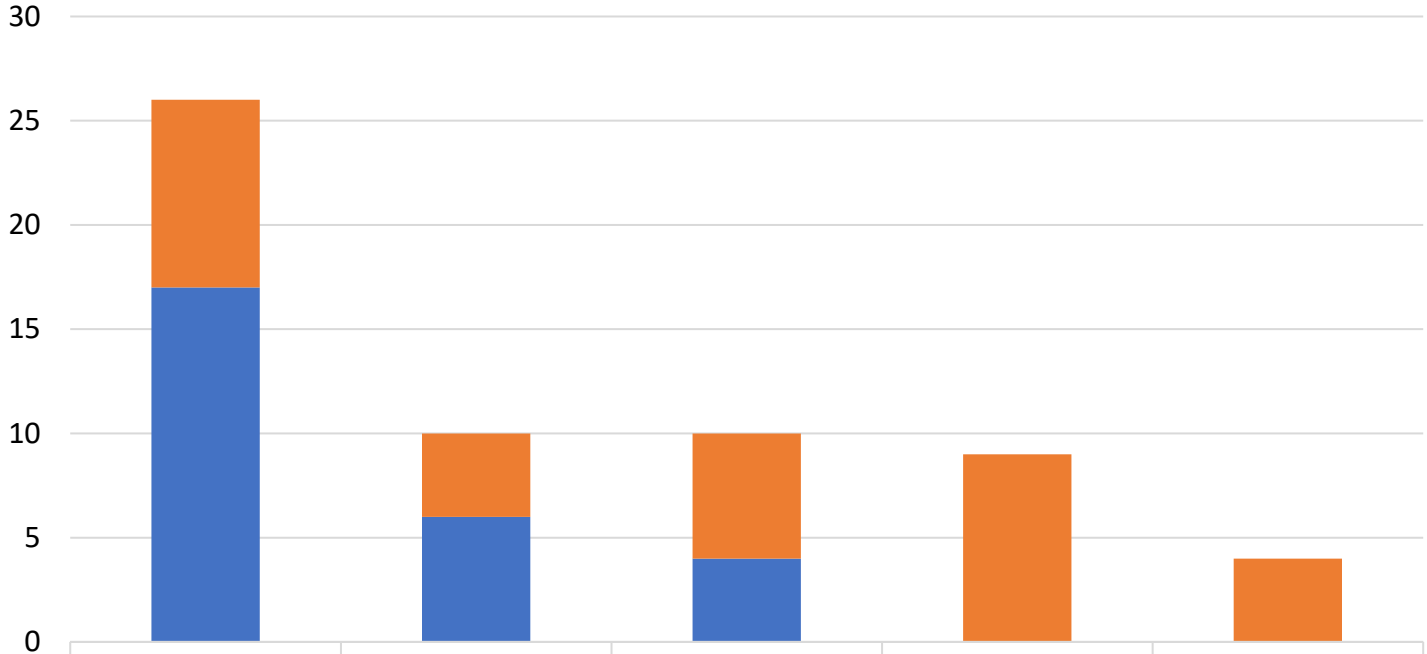
Screening & Demographics

Characteristics	*n*	%	*M (SD)*	Range
Age (years)	73		62.34 (12.63)	22-84
Gender				
Male	44	60.3		
Female	29	39.7		
Race				
White	23	31.5		
Black	44	60.3		
Hispanic	4	5.5		
Asian	3	2.7		

Social Needs Per Patient (N = 73)

Characteristics	*n*	%
No needs	52	71.2
One need	14	19.2
Two needs	5	6.8
Three needs	1	1.4
Four needs	0	0
Five needs	1	1.4

Type of Social Needs



	Transportation	Food	Housing	Utilities	Safety
POST- Intervientionn	9	4	6	9	4
PRE- Intervention	17	6	4	0	0

PRE- Intervention POST- Intervientionn

Results: Core 5 Tool & Process Usability

Score	Survey Questions
4.8	The tool and referral process were clear and easy to use.
4.8	The tool was completed in a reasonable amount of time (< 5 minutes).
4.8	The process easily incorporated into the dialysis visit.
4.7	Patients seem comfortable answering the questions.
4.8	The process completed during the patient visit.
4.8	The tool and referral process should be continued.

Average Score = 4.8

Discussion

- **Core 5 tool**
  - Easy to integrate
  - Identifying 32 previously unmet social needs (118.5% increase)
- **Referral Process**
  - Social needs addressed by the social worker
  - Increased nursing staff's awareness of patients' needs
  - Minimal interruption to workflow
- **Usability of Core 5 tool and process**
  - Positive feedback - integrated well within clinic workflow
  - Responses validate the Core 5 tool selection

Limitations

- Specific population
- Short time frame
- Designed within the scope of the clinic's needs
- Risk of social desirability & non-response bias

Conclusion

- The Core 5 tool and referral process increased:
  - Social needs identification
  - Interdisciplinary involvement
  - Referrals to required resources
- Recommendation accepted
- Project complements existing studies
- Tailored approach - Sustainable integration
- Future work – Use in other ambulatory and tertiary settings

Nursing Practice Implications

- Increased use of a standardized screening tool and referral process
- Improved social needs awareness & plan of care to address patients' needs.
- Become standard practice to identify unmet social needs for patients at the current institution.

- **Ethical Aspects**
  - Beneficence - universal screening
  - Justice - connection to community resources

Financial Analysis

Expenses	Description	Salaries (average)	Projected Cost
Materials			
Tools & Resources	Public use/permission		$0
Photocopies	Paper screening tool		$10
Supplies	Clipboards & pens		$30
Time			
Nurses	Referral clinical note = 1 minutes * 21 patients	$50/hour / 60 minutes *21	$17.50
Social worker	21 referrals = 90 minutes	$30/hour	$45
IT personnel	EMR clinical note = < 1 hour	$27/hour	$27
Training			
RN & Technicians	On the job training = 10 minutes	$50 (8) + $20 (5) = $500 / 60 minutes * 10	$83.33
Total			**$212.83**

(Indeed, 2023)

Dissemination

- Submission to the UVA's School of Nursing and Libra database
- Journal of Nursing Care Quality (JNCQ)
- Sigma Theta Tau Poster Presentation 2023

Questions?

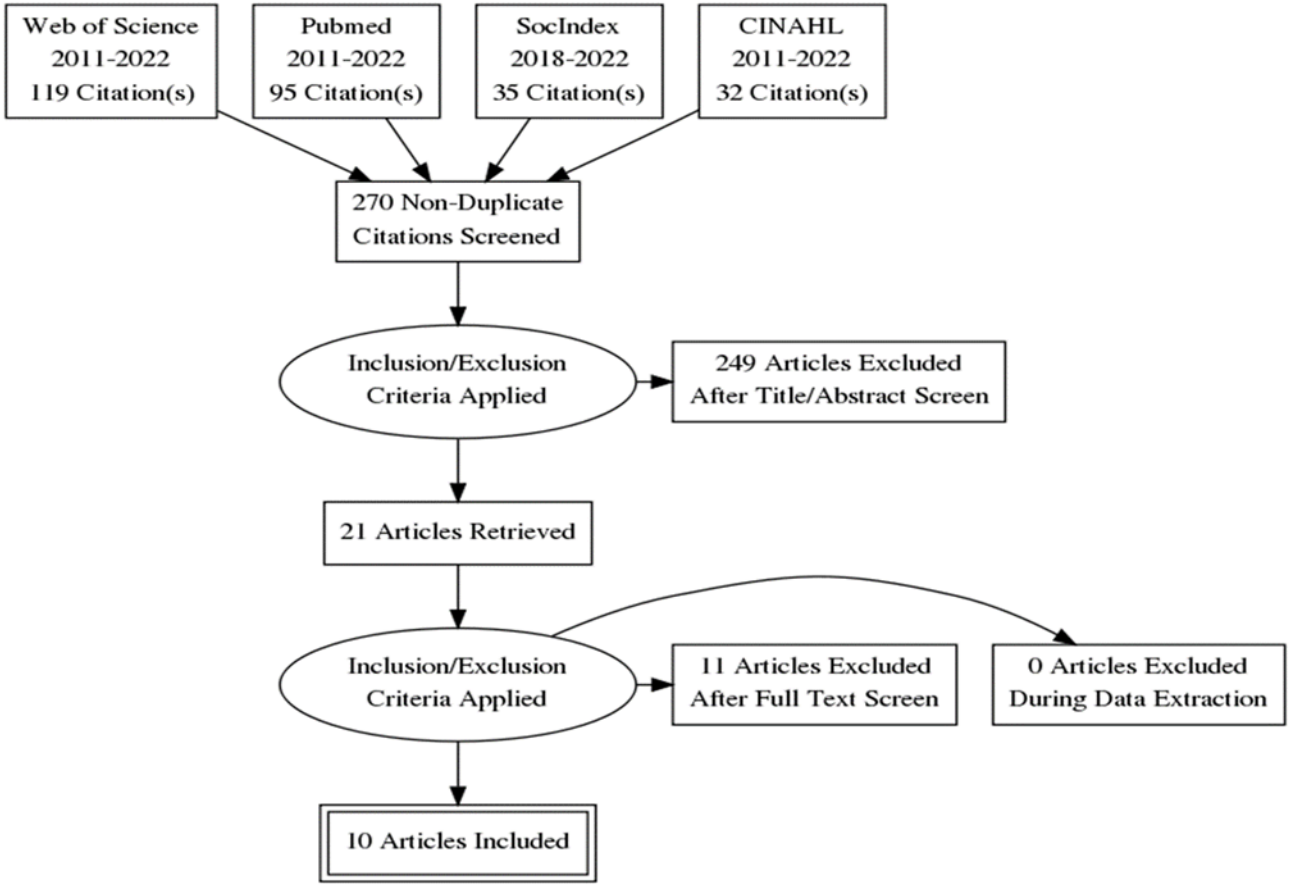
Thank You!

Dr. Clareen Wiencek
Dr. Ishan Willams
Mrs. Danielle Wentworth, FNP
Dialysis Clinic Staff
Dr. Ivora Hinton
Mr. Dan Wilson

PICO Question

For clinicians working in an outpatient clinic that includes underserved populations, what is the best practice to enhance social needs screening resulting in increased social needs referrals?

Review of Literature: Prisma Flow Diagram



Review of Literature

- **Bechtel et al. (2021) - Quasi-experimental – Primary care clinic**
  - 135 of 311 patients had one or more social needs
  - 125 patients received social needs referrals
  - The Core 5 screening tool

- **Gold et al. (2018) - Mixed Method Analysis – Community health center**
  - 1,096 of 1,130 patients had at least one social need
  - 211 patients had documented social needs referrals
  - PRAPARE screening tool

Review of Literature

- **Meyer et al. (2018): Quality Improvement – Primary care clinic**
  - 1,939 of 13,273 patients had previously undetected social needs
  - 944 patients were referred to social need services
  - CMS's Accountable Health Communities HRSN screening tool

- **Escobar et al. (2021): Systematic Review – Various outpatient clinics**
  - 35 sources
  - 6 different social needs screening tools
  - Social needs screening was feasible and can increase referral rates
  - The screening and referral process had positive impacts on patient satisfaction, healthcare utilization, and healthcare cost.

Review of Literature

- Essential Components of social needs screening process:
  - **Universal screening & Established referral process** (Bechtel, 2021; Berry et al. 2021; Boch et al., 2020; Bradywood et al. 2021; Buitron de la Vega et al., 2019; Escobar et al., 2021; Gold et al., 2018; Meyers et al., 2018; Quinoes-Rivera et al., 2021; Wallace et al., 2020)
  - **Screening integrated as normative process** (Bradywood et al., 2021; Buitron de la Vegas et al., 2019; Wallace et al., 2020).
  - **Interdisciplinary teamwork** (Bechtel et al., 2021; Berry et al., 2020; Boch et al. 2020; Escobar et al. 2021; Gold et al., 2018; Meyer et al., 2018; Quinones-Rivera et al., 2021).
  - **Social needs education & training** (Boch et al. ,2020; Bradywood et al., 2021; Buitron de la Vegas et al., 2019; Gold et al., 2018; Meyer et al., 2018; Quinones-Rivera et al., 2021).

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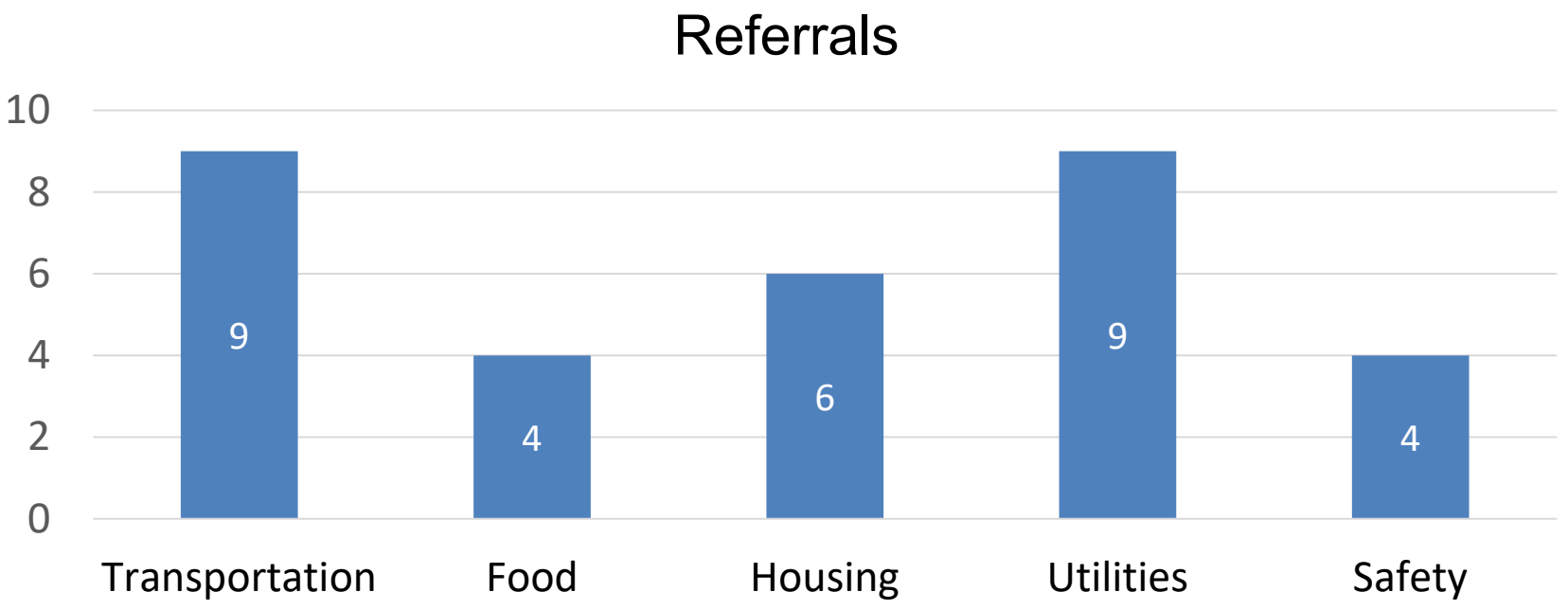
Screening Tools	Authors	Domains Assessed	# Questions
The Accountable Health Communities Health-Related Social Needs Screening Tool	The Centers for Medicare & Medicaid Services (CMS)	• 5 core domains • 8 supplemental domains	• 10 questions • 17 supplemental questions
PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences)	The National Association of Community Health Centers (NACHC)	• 8 domains	• 21 questions
Health Leads social need screening tool	Health Leads	• 7 domains	• 10 questions
The American Academy of Family Physicians (AAFP) social needs screening tool	The American Academy of Family Physicians (AAFP)	• 9 domains	• 14 questions
The Core Determinants of Health screening tool	The Columbus Ohio Public Health Department	• 5 domains	• 5 questions

Results


Referrals
10
8
6
4
2
0
9
4
6
9
4
Transportation
Food
Housing
Utilities
Safety

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