Creating a Social Needs Screening and Referral Experiential Learning Opportunity
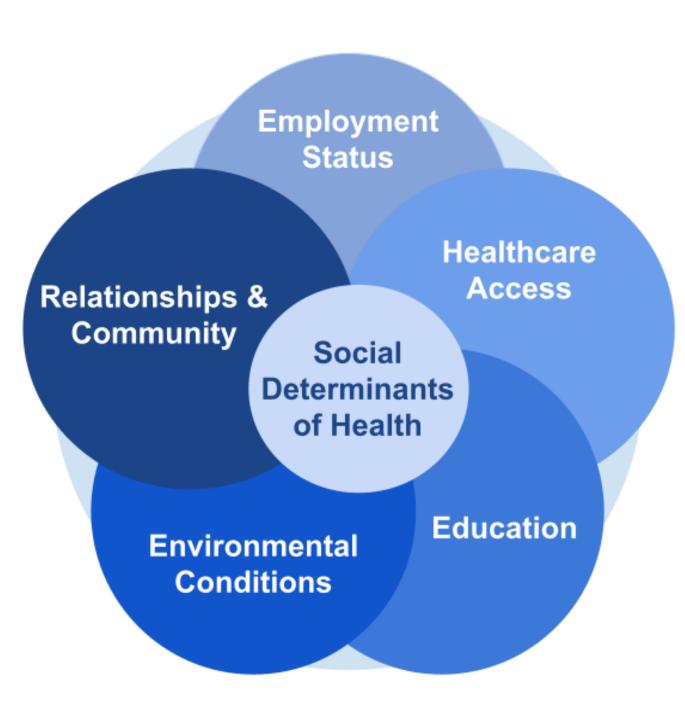
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BACKGROUND

Social Determinants of Health:

The Social Determinants of Health (SDOH) characterize the environmental, social, and political forces that shape our health, including employment status, healthcare access, education, housing conditions, and more[1]. Research has shown SDOHs play a predictive role in health outcomes so additional research is needed to support targeted interventions addressing SDOHs[1].

Social Determinants of Health: Employment Status, Healthcare Access, Education, Environmental Conditions, Relationships & Community

CMS Requirements[2]:

Performance Measure	Title	Description
SDOH-1	Screening for Social Drivers of Health	Report if screening for the five SDOH domains
SDOH-2	Screen Positive Rate for Social Drivers of Health	Report positive screening rates for five SDOH domains

Starting in 2023, the Centers for Medicare & Medicaid Services (CMS) required hospitals reporting to the Inpatient Quality Reporting (IQR) program to both screen patients for SDOHs and record positive screening rates[2]. This includes University of Kentucky (UK) Healthcare. The five domains requiring screening by CMS include: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety[2].

PROBLEM AND PROPOSAL

Problem: Hospitals with healthcare worker shortages and limited resources to grow staff may have a reduced capacity to implement and maintain screening[3].

Proposal: Creating a student experiential opportunity to support social needs screening and referral is a potential solution to meet the personnel gap[3].

ACKNOWLEDGEMENTS

TEAM UP — A Public Health Academic Practice Collaborative

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METHODS

A literature review was conducted in UK Libraries' search engine, InfoKat, using the queries: "Social Determinants of Health Screening," ["Social Determinants of Health Screening" AND "implementation"], ["Social Determinants of Health Screening" AND "referral"], and ["Social Determinants of Health Screening" AND ("student volunteer" OR "student" OR "volunteer")]. Results were screened for relevancy to topic by discussion of specific screening, referral, and implementation methods, especially when utilizing students in volunteer- or credit-based experiences. Post-screening, a total of 15 articles were reviewed for strengths and weaknesses regarding social needs and referral screenings, with 5 directly informing models, seen in the model tables.

IMPLICATIONS

Per the CMS mandate, hospitals reporting to the IQR program are required to both report a screening mechanism for SDOHs and positive screening rates[2]. While screening and referral (S&R) programs are important in decreasing barriers to healthcare access and improving overall health outcomes, limited resources and staff may create difficulty in expanding current employee roles to encompass S&R programs[3]. In exploring the strengths and weakness of both employee-based and student-based S&R programs, there are benefits and drawbacks to both; however, student-based S&R programs create a unique opportunity to decrease burden on staff and provide hands-on clinical experience for students interested in healthcare[3-5]. Both models are not mutually exclusive and could be combined for an effective S&R program, especially when utilizing students in screening and follow-up and community health workers in referrals[3,5,7]. This necessitates further research into the character and quality of referral networks and its impact on the effectiveness of S&R programs.

MODEL COMPARISONS

Student Experience Models

Student Role	Program	Setting	Screening Format	Referral Format	Strengths	Weaknesses
Volunteer as Staff[4]	Volunteer staff, including undergraduate and graduate nursing students, performed screenings and referrals[4]	Nurse-Led Mobile Clinic[4]	Paper[4]	Information Provided by Patient Request[4]	Nursing education included background in SDOHs, so volunteers had prior familiarity[4]	Literacy issues may have prevented patients from filling out forms[4] Patient responses must be reported manually and could have resulted in reporting errors[4] Patients may haven chosen or forgotten to reach out, reducing the likelihood a patient is followed up with[4]
Service-Learning Program, More Conservative Model[3]	Undergraduate-led program where trained students performed ONLY follow-up[3]	Academic Emergency Department[3]	Electronic Medical Records (EMR) Integration[3]	Automatic[3]	Supported the behavioral health team performing the screening and referral process by increasing follow-up by calling patients[3]	Data was entered twice because students were not able to have access to the EMRs in maintaining system security[3]
Service-Learning Program, Less Conservative Model[5]	Undergraduate-led program where trained students performed both screening, referral, AND follow-up[5]	Academic Emergency Department[5]	Digital tablet[5]	Automatic[5]	Provided additional capacity for follow-up with patients and reduced burden on hospital staff by passing the task to students[5] Undergraduates were required to maintain their position for nine months, decreasing turnover[5]	

Expanding Employee Role Models

Employee Role	Program	Setting	Screening Format	Referral Format	Strengths	Weaknesses
Hospital Staff[6]	Staff who checked patients in and collected insurance information were trained in both administering a screening survey and referring patients[6]	Academic Emergency Department[6]	Digital tablet[6]	Information Provided by Patient Request[6]	Shared referrals in real-time to community partners, who then reached out to patients, reducing the likelihood a patient would not be followed up with[6] Staff felt given their experience and training, they were well-equipped to determine if patients would benefit from screening and referral services[6]	Staff felt initially uncomfortable asking questions about unmet social needs[6] Despite minimal evidence of logistical barriers or barriers related to time required to screen, only a third of patients who screened positive for a social need requested a referral[6]
Medical Assistants & Community Health Workers[7]	Medical Assistants and Community Health Workers worked in tandem to complete both screenings and referrals[7]	Outpatient Family Medicine Clinic[7]	Paper or orally, then EMR Entry[7]	Information Provided by Patient Request[7]	Decreased barriers for people with low literacy and people who were visually- or hearing- impaired by offering multiple formats[7] Medical Assistants provided an initial screening then referral with resource fliers. Then Community Health Workers assisted patients with accessing services by filling out forms, accompanying patients, arranging meetings, and more[7]	

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