Facilitators and Barriers to Implementing a Screening Program for Social Determinants of Health with Practices Enrolled in the Innovation Support Project

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BACKGROUND

- Social determinants of health (SDOH) refer to the conditions in which people live, work, and play that may impact their health and quality of life.
- Ambulatory care practices are increasingly adopting “social prescribing” programs where patients are screened for social barriers to health and referred to community organizations based on need.
- As part of the Innovation Support Project (CU Anschutz) participating practices can receive support with planning, implementing, and sustaining a social needs screening and referral program.

WHY STUDY FACILITATORS AND BARRIERS WITHIN A SOCIAL NEEDS SCREENING PROGRAM?

- Nationwide, there continues to be large variation in processes, workflows, and resources used with social needs screening programs.
- Little-to-no evidence-based guidance on how to implement a social needs screening program.
- There is a large diversity of practices enrolled within ISP and working on social needs screening – are there any universal best-practices?

PURPOSE

- Better understand the facilitators and barriers to planning and implementation of a social needs screening program among ambulatory care practices opting into the social needs building block of the Innovation Support Project.
- Findings will be applied by ISP personnel to inform the creation of resources and support structures for participating practices.

WHAT IS PRISMS?

- Tool used to investigate how program design, external environment, the implementation and sustainability infrastructure, and the recipients influence adoption, implementation, and maintenance of a new program.

WHAT IS PRAPARE?

- A national standardized patient risk assessment protocol designed to engage patients in assessing and addressing social determinants of health.
- Toolkit built from best practices found during pilots.

METHODS

- Of the 81 practices enrolled in the ISP, 43 focusing on the optimal social needs milestones
- Field notes submitted monthly from Practice Facilitators
- 314 field notes ranging from April – November (2020)
- Deductive coding: Codes added throughout analysis
- Codes derived from the PRISM program evaluation framework and the PRAPARE toolkit
- 60-minute focus groups using question guide derived from initial analysis from field notes
- Interview topics: overall successes and challenges, specifics of the workflow (screener type, who screens, where screening takes place, how referrals are placed), attitudes and mindsets of key stakeholders, relationships with community organizations, and experiences as a result of COVID-19.
- Rural vs Urban categorization done using HRSA Rural Grant Eligibility Analyzer
- IRB approval not required

RESULTS

Summary of facilitators and barriers to implementation of a social needs screening program aligned to PRISM domains (** denotes rural specific themes)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Patient</th>
<th>Organizational</th>
<th>Patient</th>
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<tbody>
<tr>
<td>Perspective</td>
<td>Perspective</td>
<td>Characteristics</td>
<td>Characteristics</td>
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<td>Intervention</td>
<td>Staff and leadership engagement</td>
<td>Staff training</td>
<td>Staff turnover and training</td>
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<tr>
<td>Recipients</td>
<td>Shared understanding</td>
<td>Training on processes, best practices on screening delivery</td>
<td>Within practice, community</td>
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<tr>
<td>Implementation and sustainability infrastructure</td>
<td>Relationships and communication</td>
<td>Patient and care team**</td>
<td>Time to train</td>
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<td>Technology</td>
<td>EHR integration</td>
<td>Automated communication</td>
<td>Patient complexity and engagement</td>
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<td>Online tools to connect patients to community resources</td>
<td>Full-time care coordinator</td>
<td>Only new patients screened</td>
<td>Workflow</td>
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<tr>
<td>Workload</td>
<td>Full-time care coordinator</td>
<td>Paper handouts to connect patients to resources</td>
<td>Community Resources</td>
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<td>Environment</td>
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<td>Low number**</td>
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<td></td>
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<td>Large distance**</td>
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<td>Stigma</td>
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<td>COVID-19</td>
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CONCLUSIONS

- Many findings consistent with those found in literature: staff and leadership engagement, staff turnover and training, relationships and communication, patient engagement, and presence of care coordinators (patient navigator).
- Implementation of a social needs screening program is not “plug-and-play”: Community-specific contextual factors lead to large diversity in workflows.
- The cost of screening is a large barrier for many practices – there’s a need for statewide grants to assist with staffing, technology, and training.
- COVID-19 caused many practices to stop screening at a time when patients had the highest need.
- Rural communities need more community resources – there’s an opportunity to create region-wide resources available to many smaller communities.
- Patient perspective is missing from the data – no practices engaged patients when determining screening workflow.

FUTURE DIRECTIONS

- Larger data set, more focus group participants
- Patient interviews
- Stratify data by practice type (IM, FM, Peds, etc)

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