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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinical Teams Integrate Findings From Social Needs Screenings Into Children's Care Plans?

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Abstract

Unmet social and structural needs negatively influence children's health outcomes. Even in pediatric health systems in the United States that have implemented social needs screening programs, little guidance exists about best practices for how clinical teams should respond to children's unmet needs. This commentary on a case discusses ethical principles and caregivers' perspectives that can be used to guide best practices for screening and resource referral.

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Case

Dr K is a pediatric hospitalist caring for DD, a child insured by Medicaid who is admitted to an inpatient general pediatrics service with an acute asthma exacerbation. DD's mother completes a validated tablet-based social needs screening questionnaire during her child's admission. Questions on the screening form include "Do you always have enough food for your family?" and "Do you think you are at risk of becoming homeless?" DD's mother expresses concerns about food and housing. Dr K reaches out to a social work colleague, SW, who meets with DD's family to discuss food and housing resources. As part of their follow-up assessment, SW learns that DD's family is concerned that they may need to leave their current home due to environmental triggers contributing to DD's asthma symptoms, including mold exposure. SW and Dr K document key findings in DD's health record, noting that these concerns will require follow-up.[1,2]

SW asks Dr K, "How should our team follow up with DD's family regarding their concerns?" Dr K considers how to respond and how to document progress toward short- and long-term goals of DD's care plan.

Commentary

Health-related social or structural needs (HRSN) are household-level social and economic factors that affect health, such as food insecurity, unsafe or unstable housing conditions, and difficulty paying utility bills. HRSNs can negatively influence children's health and well-being.[1] For this reason, HRSN screening and resource referral programs

are used to help identify and address these needs, thereby increasing access to resources and improving health outcomes for children like DD.[3]

Although evidence on the health benefits of social needs screening is still evolving, the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and several state Medicaid managed care organizations have all recently issued mandates or incentives encouraging screening, resulting in its widespread implementation within health systems across the country.[4,5,6] In particular, CMS has incentivized social needs screening through coverage of some HRSN interventions.[7] However, these organizations have provided limited guidance on how health systems should address families' needs and tailor patient care based on screening results.[6]

In determining whether (if not required), when, and how to ethically screen for and address HRSNs in clinical settings, health systems should consider how to maximize potential benefits and mitigate potential harms to patients, families, and members of health care teams.

Best Practices for Responding to Screening Results

In qualitative studies, caregivers of pediatric patients have expressed concerns about the sensitivity of questions asked during HRSN screening, the potential for bias and discrimination, and the risk of child protective services (CPS) involvement as a result of disclosing needs.[8,9,10] Parents requested that health systems explain that HRSN screening is the standard of care for all families, provide transparency about documentation of social needs in the electronic health record (EHR), and allay their concerns about CPS referrals by emphasizing that the primary purpose of screening is to provide families with resources and tailor their care based on their needs.[8,9,10]

Health systems implementing screening might first consider whether to screen universally (as mandated by CMS for adults in inpatient settings[11]) or target screening to individuals believed to be at highest risk of experiencing HRSN. While the Joint Commission allows hospitals to select a representative sample of patients to screen,[5,12] we believe that universal screening is the most ethical and equitable approach, in line with recommendations from CMS and the American Academy of Pediatrics.[7,13] Targeting HRSN screening based on patients' demographic or clinical characteristics could increase stigma associated with screening and inadvertently exclude some families who could benefit from support.[14]

As they implement screening, health systems should also recognize that not all families that express needs desire assistance. One commonly used screening tool, WE CARE, aims to prioritize autonomy by asking caregivers whether they want help with each of their identified needs, allowing them the agency to opt-in to support.[15,16]

Some parents experiencing social needs have expressed concerns about "double loss," described as disclosing HRSNs and expressing a desire for assistance without receiving meaningful support.[17] Health systems implementing HRSN screening should therefore work to ensure they have the capacity to connect families with resources targeted to their needs.[18] Providing this support requires the knowledge and experience of an interdisciplinary team, including physicians, nurses, social workers, community health workers, and community-based organizations, to develop a strategy for connecting families with resources and tailoring care plans to their needs. For example, if a family has trouble paying utility bills, their community health worker could refer them to the

Low-Income Home Energy Assistance Program, their social worker could write a letter to their utility company advocating for a medical exemption to utility shutoff, and their physician could modify their care plan to minimize reliance on medical equipment, particularly if they are at risk of having their utilities shut off. Importantly, when clinical teams make referrals, they cannot predict the support families will receive. Community-based organizations may determine that a family is not eligible for support, or the support provided may not meet a family's needs. Therefore, health systems implementing HRSN screening should be transparent about the limitations of these resources and avoid over-promising support. For example, instructions for HRSN screening, which are typically either read to patients' guardians or given to them to read, should explicitly state that health systems might not be able to provide support for families' needs.

Regardless of what concrete resources are provided, clinical teams can also work with families to tailor their care plans based on their social needs.[3,19] In DD's case, SW conducted a thorough assessment following their positive HRSN screen and identified mold exposure as a potential contributor to DD's uncontrolled asthma. In response, Dr K could consider the addition of nasal corticosteroids or antihistamines to DD's asthma care plan, which could ameliorate some of the risks associated with this environmental exposure. Dr K and their team could also share information about community-based asthma education and home remediation resources that might benefit DD, some of which have been shown to improve asthma morbidity and reduce rates of rehospitalization.[20,21,22,23]

As another example, if DD's family members shared that they had difficulty paying for transportation to appointments, Dr K's team could arrange to have DD's primary care and pulmonology appointments scheduled on a single afternoon, thereby minimizing the need for repeated travel. Providing care tailored to families' needs could improve patient-clinician relationships, destigmatize conversations about social needs, and ultimately enhance access to care and improve health outcomes.

Providing Short-Term and Long-Term Support

Many social needs, like DD's family's housing concerns, cannot realistically be resolved with a single conversation or referral; these needs are complex and multifaceted and may therefore require longitudinal follow-up.[24] We can consider the response to social needs, particularly those identified in the hospital, in terms of short- and long-term strategies that maximize benefits for patients and families.

In the short-term, hospitalists should use information about patients' HRSNs to partner with families and develop safe discharge plans. Screening tools like WE CARE can be particularly helpful for discharge planning because they include questions about the urgency of families' needs.[15,16] If urgent needs are identified during an inpatient admission, members of the care team should prioritize connecting families to resources while their child is in the hospital to ensure a safe discharge and reduce the risk of readmission related to HRSNs. For non-urgent needs, families could be connected with resources either prior to or soon after patient discharge.

In the longer-term, hospitalists' ongoing partnership with families, community-based organizations, and primary care practitioners (PCPs) may be necessary to address social needs. In our health system, families who indicate social needs during an inpatient admission receive a follow-up phone call from a community health worker 2 to 4 weeks

after discharge to provide ongoing support and troubleshoot challenges that families may have experienced with resource connection.

As longer-term follow-up of unmet social needs may not be feasible for inpatient care teams, hospitalists should also talk to families about whether they would like ongoing support for their HRSNs from their outpatient care team. If families request this additional support, inpatient care teams could reach out to the patient's PCP prior to discharge and provide them with information about social needs identified, resources provided, and any potential obstacles families have faced in connecting with resources.

It is important to recognize that primary care clinics can vary significantly in their ability to support families with social needs, as these offices have varying levels of support from social workers, community health workers, and other staff members who might assist in responding to these needs. Inpatient teams should strive for open communication with PCPs about ongoing needs but also be cognizant of these limitations. Inpatient teams should aim to begin addressing any acute needs during hospitalizations and set realistic expectations for families regarding resource availability in the outpatient setting.

An EHR can be a useful tool for transmitting information about families' HRSNs across care settings and thereby facilitating longitudinal support. However, studies have found that families value autonomy and transparency in determining how this sensitive information is shared.[8,9] Health systems engaged in EHR-integrated social needs screening should therefore inform families whether and how information about their social needs will be documented and shared in the EHR. Families should be given the option to opt-out of screening if they would prefer not to have their needs documented or shared with other providers, and families who do opt-out should still have the option of requesting confidential resources and support.

Who Should Be Responsible for Addressing Social Needs?

It is important to note that implementation of HRSN screening has the potential to exacerbate feelings of burnout and moral injury among physicians, social workers, and other members of the care team, particularly if they feel they do not have the time or resources needed to appropriately respond to families' needs while balancing their many other competing priorities. Payers and policymakers incentivizing HRSN screening should ideally also provide sustainable financial support for the interdisciplinary workforce needed to respond to positive screens, including social workers, community health workers, and hospital-community-based organization partnerships.[6] Incentivizing or mandating HRSN screening without providing support for health systems to respond to positive screens may be unethical, as it could lead to more harms than benefits for patients, families, and health care teams.

Health systems should consider investing in tiered models of HRSN support in which social workers are responsible for responding to the highest acuity needs, such as acute homelessness; other staff members, like community health workers, are responsible for responding to lower acuity needs, such as food insecurity; and physicians are responsible for tailoring patients' medical care based on their families' social needs. Working as part of a well-resourced interdisciplinary team to effectively address families' HRSNs could help mitigate burnout and moral injury if physicians and social workers feel they are equipped with the resources needed to ensure their patients' and families' needs are adequately addressed.

In addition, the responsibility for addressing HRSNs should not fall on health systems and clinicians alone. While health systems may be able to support individual patients and families experiencing food insecurity or housing instability, communities and local, state, and federal governments should collectively be responsible for addressing these needs at the population level. Health systems could contribute to this work by investing their community benefit spending in local organizations focused on addressing HRSNs and by using their position as anchor institutions to advocate for government programs and policies that mitigate inequities in access to resources and provide economic support for children and families living in poverty.

Conclusion

HRSN screening and resource referral programs have the potential to enhance family-centered care delivery, strengthen relationships, build trust between families and clinicians, and improve health outcomes for pediatric patients. However, these benefits are contingent on performing screenings and providing support via an ethical, team-based approach that maximizes benefits and minimizes harm to families, prioritizes autonomy, and preserves trust in the health care system. Physicians can achieve these goals by partnering with an interdisciplinary team to provide families with support, thoughtfully incorporating information about social needs into medical care plans, and upholding principles of family-centered care throughout the social needs screening and support process.

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Editor's Note

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