Implementation Considerations for Social Determinants of Health Screening and Referral Interventions

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From pediatrics to geriatrics, addressing patients’ social determinants of health is becoming an integral component of health care delivery. The National Academy of Sciences has endorsed screening for unmet social needs, while payers, including Medicaid, have incentivized it in states such as Massachusetts and Oregon. In Congress, a bill was recently introduced with bipartisan support that would provide planning grants for public sector social determinants of health accelerator programs and establish an interagency technical advisory board. Social determinants of health research conducted within the medical setting has increased exponentially in the past 5 years. With greater recognition of the influence of social risk on health and emphasis on providing value-based care, addressing patients’ unmet social needs is clearly having its day in the sun. Yet, despite attention from politicians and the clinical, policy, and research realms, 2 fundamental questions remain: what should social determinants of health screening and referral interventions look like, and do they ultimately improve patients’ health and well-being?

The study by Gottlieb et al1 adds to the scant evidence base. The authors conducted a randomized clinical trial (RCT) in a pediatric urgent care clinic at an urban safety-net hospital to compare the efficacy of 2 interventions on reducing social risks and improving child and caregiver health 6 months after enrollment.1 Caregiver-child dyads were screened for 18 social risk factors (eg, housing stability, food, employment) and randomized to receive either written information about available social services or written information plus in-person social services navigation assistance for their identified risks. Navigators assisted with scheduling appointments and completing forms and were in contact with caregivers via telephone, text message, or email every 2 weeks for up to 3 months. Caregivers met with the navigator a mean (SD) of 4.34 (2.76) times during the study. Unexpectedly, the study found no statistically significant differences between the 2 groups at follow-up in any of the primary outcomes. With both interventions, families had fewer social risks, caregivers had better general health and less stress and depression symptom severity, and children had better general and emotional health as reported by their caregiver.

Gottlieb et al1 are to be commended for conducting this large social risk-intervention efficacy trial and for presenting their null findings, bucking the known publication bias in academic research. The results differ from a 2016 RCT from Gottlieb et al,2 which found significantly fewer social risks and better parent-reported child health 4 months after enrollment for only dyads in the in-person navigation assistance group. The authors speculate that this difference was likely owing to the improved quality of the written resource sheets, which for this new study1 contained regularly updated information on local community-based social services, plus contact information for specific individuals within social services organizations. Their findings are in line with a 2015 cluster RCT that 1 of us (A.G.) conducted3 demonstrating the effect of the WE CARE screening and referral intervention on significantly increasing family enrollment in new community resources compared with usual care. The WE CARE screening consisted primarily of a self-reported 6-item social risk screener that triggered parental receipt of written resource sheets and social service applications only when parents indicated wanting help. The findings of the study by Gottlieb et al,1 along with results from the 2015 trial,3 suggest that pediatric practices, regardless of size and support staff, can address patients’ unmet social needs by handing out high-quality written information. As Gottlieb
et al conclude, this relatively low-dose and low-cost intervention "could be effective for pediatric populations." 1

Unfortunately, the study by Gottlieb et al1 is not designed to address critical implementation factors necessary to transform clinical practice. Although testing the efficacy of the authors' interventions under controlled conditions is important, it is unclear how these results would translate in real-world pediatric primary care practice conditions. For example, study staff, not clinic staff, administered the screener, distributed the written information sheets, and served as patient navigators. If pediatricians conducted the screening in alignment with their professional guidelines and current standard practice, the results may have included larger effect sizes, as a 2004 study4 demonstrated higher adherence to recommendations if they were coupled with physician guidance. Study designs that simultaneously test the effectiveness and implementation of social needs screening and referral interventions are urgently needed to address these critical efficacy vs effectiveness and implementation science research gaps. Such hybrid studies, along with in-depth qualitative interviewing with stakeholders (ie, parents, patients, physicians, staff, and community partners) would advance the field and accelerate the adoption of screening into pediatric practice. Until then, the effectiveness and unintended consequences of screening and referring for unmet social needs remains unknown.

Despite the results reported by Gottlieb et al,1 the potential capacity of personalized social services navigation to mitigate patients' social risks requires additional investigation. The background, training, relatability, communication, and empathy skills of navigators are likely key factors for success. Some families may be hesitant to engage with a patient navigator owing to the stigma of having unmet social needs, while others may be grateful to have guidance on traversing the labyrinth of social services. Learning how best to create meaningful relationships between caregivers and navigators that respect parents' autonomy while also guiding them in real time is crucial. While Gottlieb et al1 found no difference in social risk outcomes between the 2 study groups, the results, paradoxically, may still be very different. For example, a study by Bergman et al5 conducted with 420 housing voucher recipients compared the receipt of housing voucher information alone with housing voucher receipt and navigation assistance and found no difference in moving rates. However, many more families in the navigation assistance group moved to high upward-mobility areas compared with the control group (54% vs 14%). Context matters, and designing future studies that can detect these types of differences is essential for understanding how social need interventions can improve the adverse social conditions that children grow up in.

Overall, the study by Gottlieb et al1 is an important contribution to our understanding of the effects of addressing social risks in the clinical environment. It also raises key questions that require further study. Additional short- and long-term measures of child health and well-being need to be examined; nontraditional health outcome measures, such as school readiness, high school graduation, and life satisfaction, should also be explored.

However, future social determinants of health interventions will be inherently limited in their capacity to advance equity by the current state of the social safety net in the United States. The United States lags behind comparable countries in social expenditures despite studies demonstrating that higher social service spending relative to health care spending is significantly associated with improved population health.6 Social programs, such as the Supplemental Nutrition Assistance Program (also known as food stamps), are chronically underfunded and face further eligibility restrictions. The proposed expansion of the public charge rule to include receipt of a broader range of social benefits has had the chilling effect of deterring immigrant families from enrolling in social programs, such as Medicaid—likely contributing to the recent increase in uninsured children in the United States after almost a decade of steady decline.7 Thus, without sufficient social services, public benefits, and community-based resources, the downstream patient-level social determinants of health screening and referral interventions that are rapidly being implemented across health care delivery systems are likely to fail at improving children's overall health and well-being in the United States.
REFERENCES


