

The Survey Clarified...

1. ...the likeliest healthcare system partners to engage in patient social needs projects within EHRs.
2. ...the demographics most likely to be available to healthcare system partners to help focus patient social needs work.
3. ...the barriers that grant support can most effectively focus on to alleviate to further this work.

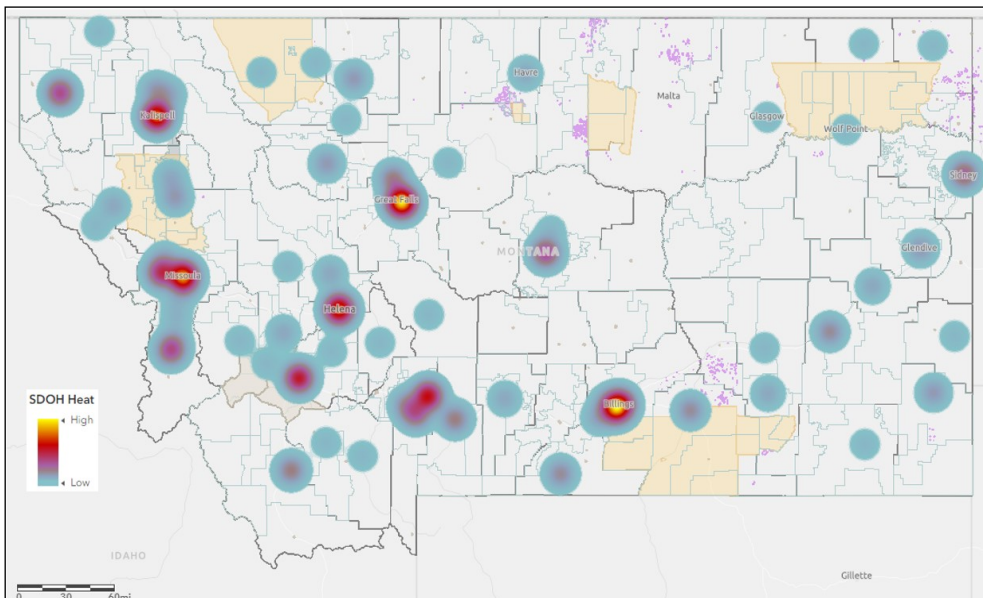
Patient Social Needs Screening & Referral Practices in Montana Healthcare Systems

Globally and especially in light of the COVID-19 public health emergency, increasing emphasis is being placed on the importance of measuring and addressing patient social needs, such as food insecurity and transportation access, and including the social determinants of health (SDOH) for improving patient health outcomes¹. In May 2022, the Montana Cardiovascular Health Program (CVH) and the Montana Diabetes Program (MDP) at the Montana Department of Public Health and Human Services (DPHHS) sent a survey to healthcare providers across the state asking how they and the healthcare systems they work with address patient social needs. Questions focused on screening, documentation, and referral practices, as well as barriers to screening and referral. The purpose of this survey was to help the Chronic Disease Prevention and Health Promotion Bureau identify potential projects that will support Montana health systems as they are called to help address patient social needs in the future.

The survey was sent to 3,000 potential respondents. Recipients included 2,400 physicians, psychologists associated with a healthcare system, physician assistants (PAs), and advance practice registered nurses (APRNs) listed as being licensed in Montana in the WIM tracking database². Six hundred licensed practice nurses, registered nurses, and skilled nursing facility administrators also were randomly selected from a Montana Department of Labor and Industry licensure database.

The survey was available in paper and electronic formats; one reminder postcard was sent. After subtracting the return-to-sender surveys (93), our potential respondent pool was 2,907. We had 323 respondents; after removing incomplete and duplicate surveys, our sample size was 305 (10.5%). Data were analyzed using SPSS 23 to derive descriptive statistics. Responses were returned from across Montana, although primarily from more urbanized areas (Figure 1). Results and next steps for the CVH and MDP are provided in this report.

Figure 1. Concentration of Survey Respondents across Montana.



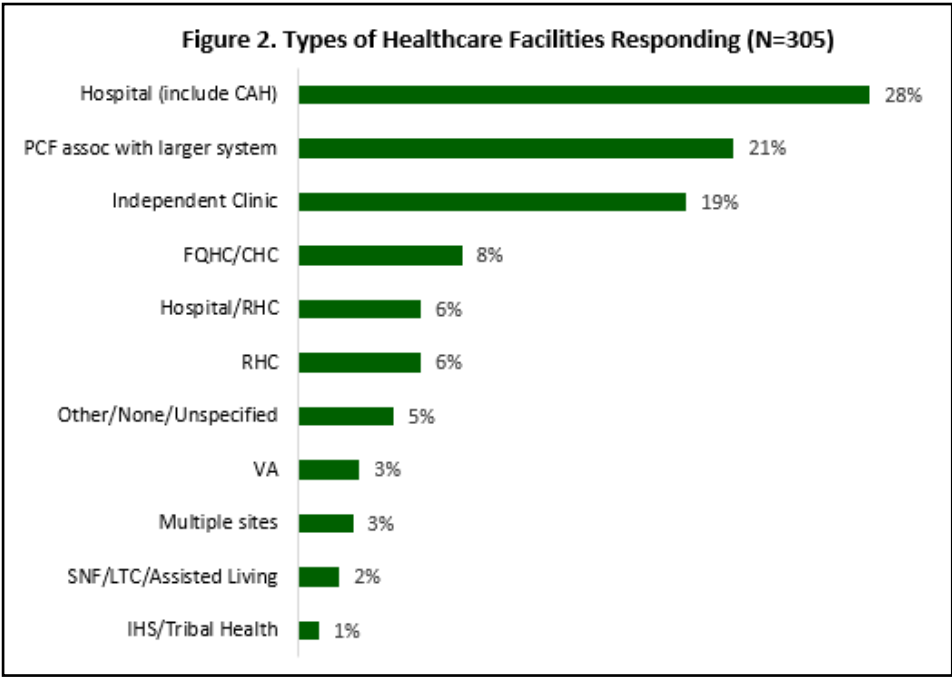
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Respondent Characteristics

The types of healthcare systems responding to the survey are shown in Figure 2. The top three types of facilities represented in the data are hospitals, including critical access hospitals (CAH); primary care facilities (PCF) associated with larger healthcare systems; and independent clinics. A smattering of other site types also responded. We intend to analyze responses by healthcare facility type at a later date to assist internal focus on existing facility-based practices and potential needs.

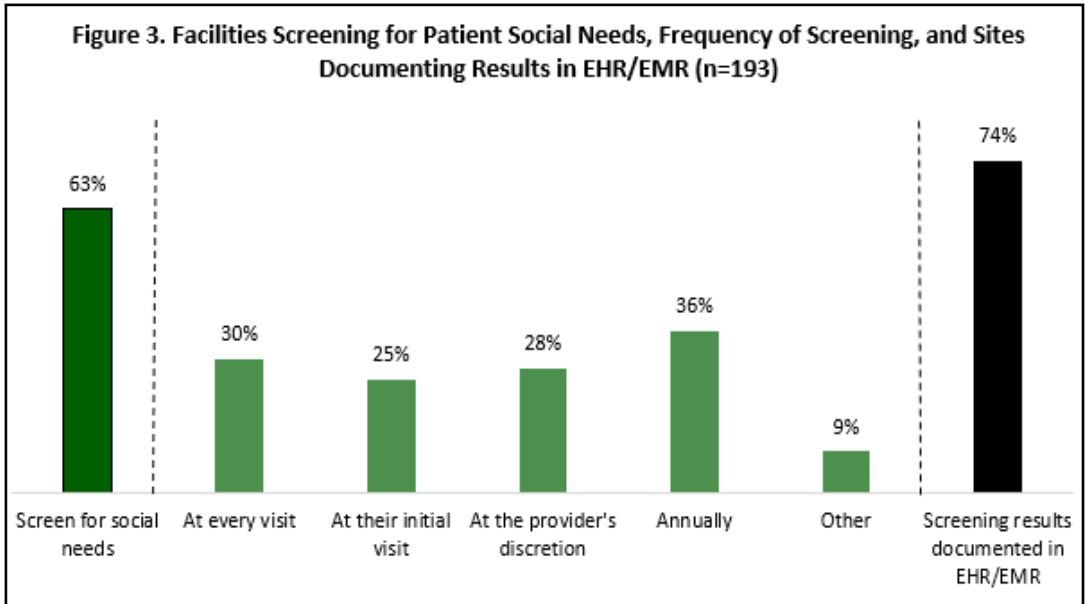


Respondents primarily identified as physicians of various specialties (n=104) and nurses of all licensures and specialties (n=82), followed by a diverse array of administrators (n=26), physician assistants (n=24), and a smaller selection of other titles.

Among respondents, 56.7% (n=173) indicated they have a staff position to focus on patient social needs. The most common titles for these staff positions include social worker (n=49), care manager (n=25), case manager (n=21), and care coordinator (n=20). Thirty-three respondents indicated they have more than one staff position dedicated to addressing patient social needs. Two indicated they have different staff for inpatient and outpatient social needs.

Screening

To assess the extent of patient social needs-focused practices, respondents were asked whether their facilities screen for these needs; if so, how frequently; and whether they document the results in their electronic health/medical records (EHR). Those who were unsure or whose facilities do not screen were asked to skip several questions. Sixty-three percent of respondents screen for patient social needs (Figure 3). These screenings happen at



a variety of frequencies with sometimes multiple timings within a facility (respondents could choose more than one option). Of those facilities that screen, 74% document results in their EHRs/EMRs.

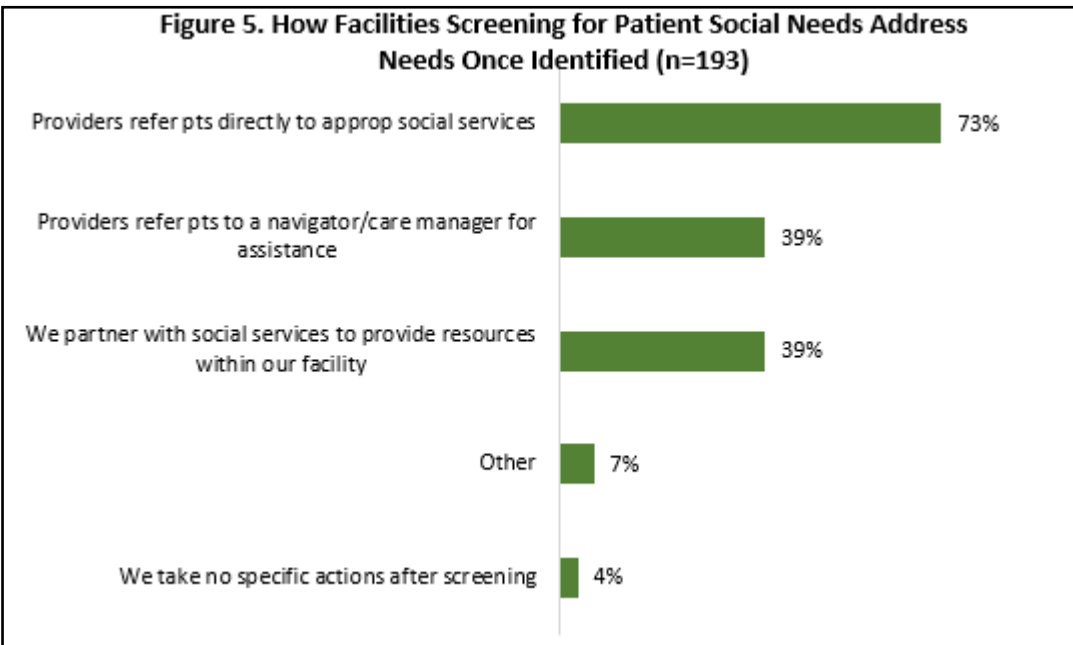
More than half of respondents (57%) indicated that they screen all of their patients for social needs, while 34% screen 50% or more of their patients, and 8% screen less than 50% of their patients (Figure 4).

There is no uniformity in the type of patient social needs screener used across respondents. Types include add-ins to facility EHRs, unspecified social determinants of health screeners, validated instruments such as PRAPARE³, depression and mental health assessments, and questionnaires about specific needs, such as food security, housing, and personal safety.

Addressing Patient Social Needs

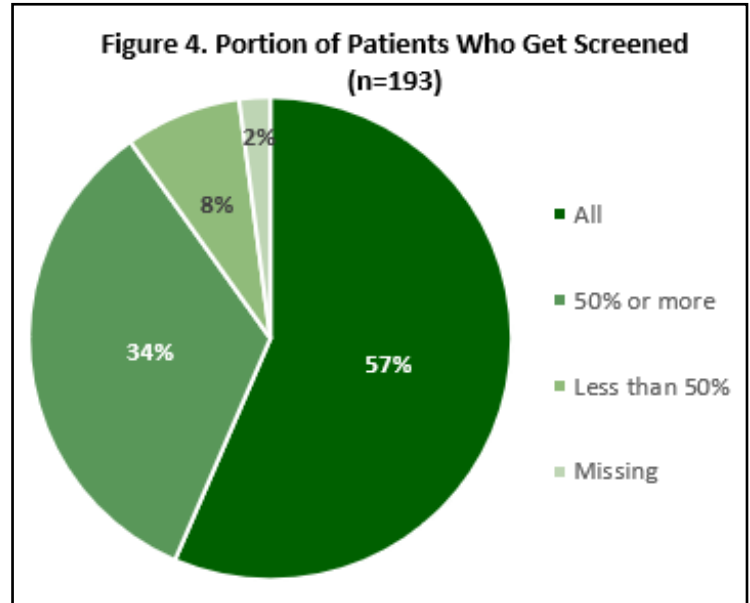
In Facilities that Screen

Respondents who indicated they do screen for social needs were also asked how they address those needs once identified and, if they do make referrals to supportive services, how those referrals are made. Respondents could choose more than one option for both of these questions. Providers primarily refer patients directly to social services



(Figure 5), although about two in five also refer patients to another staff member to facilitate service connection and partner with social services to provide resources within the facility (e.g., partnering with public transit to offer medical transportation or with a food bank to help alleviate food insecurity). About 4% of respondents take no specific action after screening, an avenue of possible support and improvement for future DPHHS grant cycles (see discussion at end of section).

Facilities that screen make referrals most frequently within their EHR (73%), followed by phone (53%), giving information to patients to follow up on (51%) and via warm hand-off (direct introduction of the patient to the social service provider, 47%). See Figure 6 for further information.



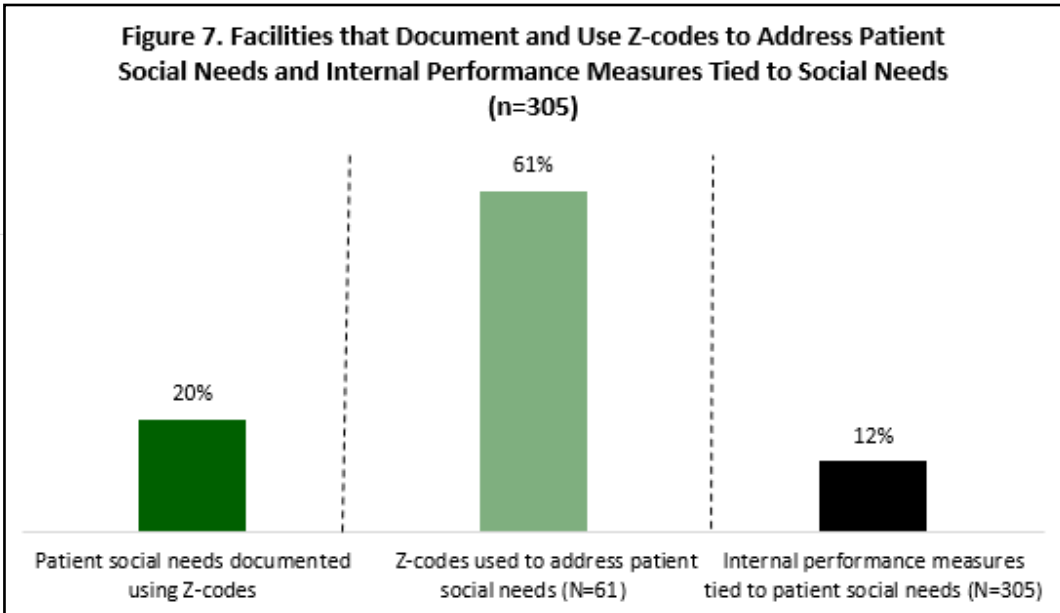
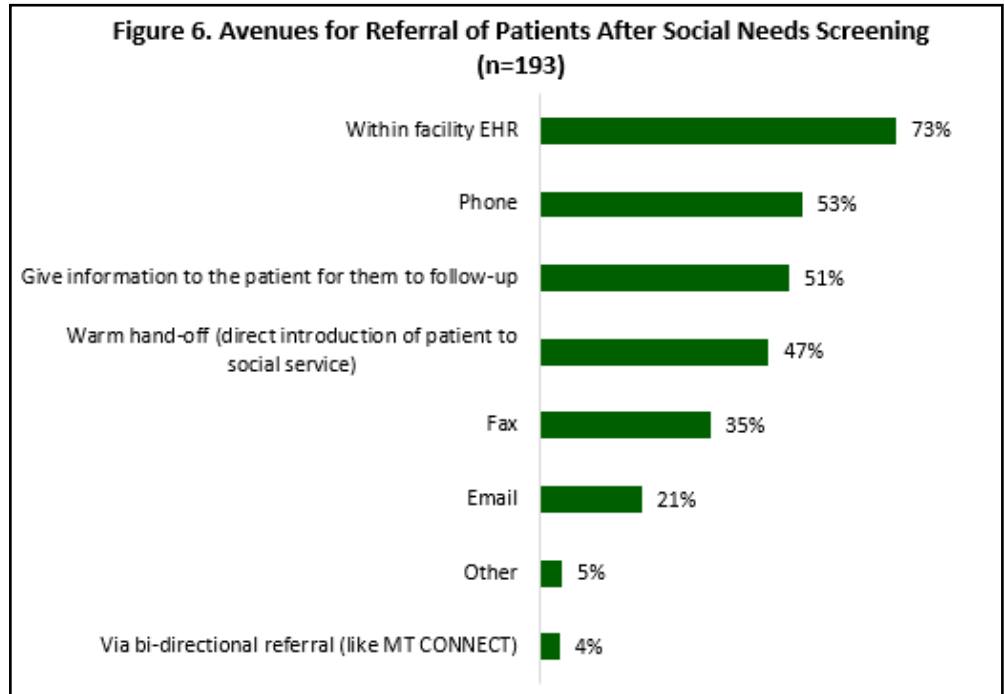
In Facilities that Do Not Screen

There were 109 respondents who said their facility does not screen for patient social needs (n=70) or who were unsure about the answer to this question (n=39). These respondents were asked how their facilities address patient social needs when they present themselves. Of the 109 respondents, 49% provide contact information to the patient to follow up, while 42% directly refer patients. About one in five (18%) do not address patient social needs, again highlighting a potential avenue for improvement and support for DPHHS.

Another important note for both facilities that do and do not screen: patients who are given information to follow up on are less likely than patients who receive a referral or warm hand-off to connect to supportive services⁴. For both facilities that do and do not screen for social needs, altering referral methods to include more direct referrals, thereby removing the necessity from the patient, can lead to better health outcomes.

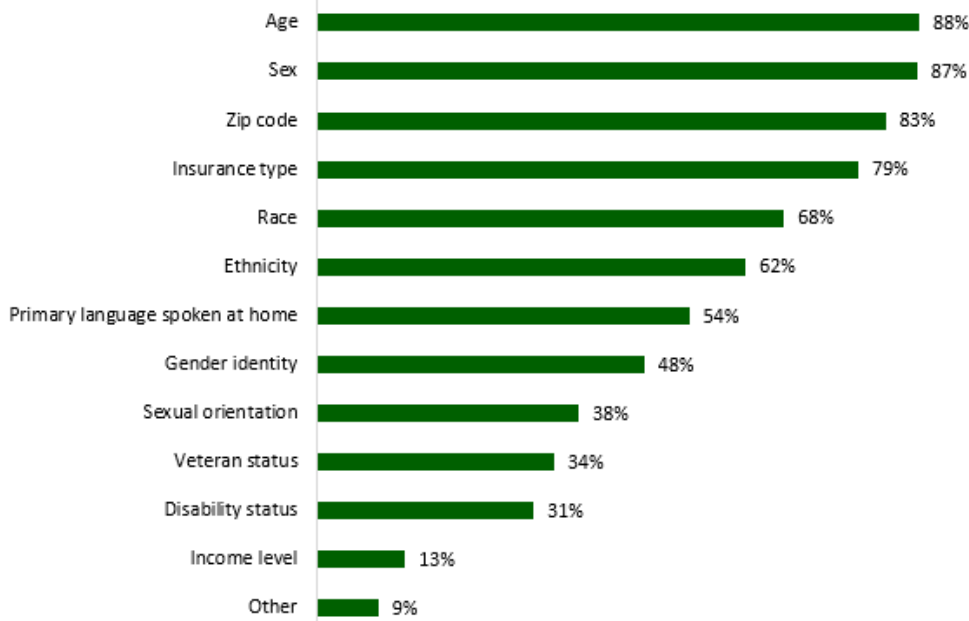
Z-Codes and Internal Performance Measures

Respondents were asked whether they document and use Z-codes to address patient social needs. Z-codes are ICD-10 codes that give deeper information about the circumstances of a patient whose symptoms make their conditions hard to diagnose. Some of these codes pertain to SDOH and might be of use in understanding and addressing patients' complex needs, although they are not billable codes. Respondents also were asked whether they have internal performance measures tied to patient social needs. The responses to these questions also may guide future DPHHS grant-making.



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Figure 8. Demographic Data that Can Be Pulled from Respondents' EHRs (N=305)



While only 20% of respondent facilities use Z-codes (Figure 7), 61% of those facilities use them to address patient social needs. Only 12% of facilities have internal performance measures tied to patient social needs, another potential avenue of support and quality improvement for DPHHS programs.

Demographics

Figure 8 shows the patient demographic data responding facilities can pull from their EHRs. The most commonly available demographic data are age (88%), sex (87%), zip code (83%), and insurance type (79%). “Other”

categories cited by respondents include marital status and religion. Demographic data is crucial to understanding the risks, needs, and health burdens of the populations served by healthcare systems. Disparate health outcomes can be attributed to demographic differences. Focused outreach to high-risk and high-burden populations through demographic data analysis and thoughtful partnership with community social supports can improve patient and population health, reduce healthcare costs, and increase community interconnectedness, highlighting the intersection of health within and outside of a healthcare facility.

Barriers

Although screening and referring patients to community social supports is shown to improve health outcomes, the process can be challenging, and unexpected barriers can hinder the most well-intentioned efforts. Respondents were asked to select the barriers that make it difficult for their facilities to address patient social needs. They had the option of selecting as many barriers as were pertinent. The top three challenges identified (Figure 9, following page) are lack of internal or community resources (60%), lack of time (52%), and not having a screening and referral process built into daily workflows (39%).

Although this option was not included among the choices in this question, many healthcare providers cite lack of reimbursement as a reason for not addressing either patient social needs or prevention measures in general. Healthcare is slowly moving toward a value-based payment model in which team-based care, clinical-community linkages, and partnering to alleviate upstream determinants of health are monetarily rewarded, but this change from fee-for-service with a focus on disease has not taken hold in every healthcare system or facility.

Furthermore, although community supports do exist to assist patients with their socioeconomic, behavioral health, mental health, and preventive needs and goals, the organizations that provide these services often are understaffed, underfunded, and under-capacitized in ways that would make it difficult to address the needs of every referred patient. Many locations do not have the types of supports their patients require, from behavioral health providers to adequate quantities of affordable, safe, accessible housing.



These issues should be taken into account as public health moves toward encouraging healthcare systems to assist with patient social needs to avoid overburdening the partners who would make this process possible. A potential solution is fostering collaborations among departments and programs throughout state government as well as with non-profit and community-serving organizations with a statewide

profile to address the most effective SDOH interventions⁵. These collaborations might leverage state-scaled resources while allowing locally driven solutions to emerge in a more enriched and supportive environment. Another potential solution, using Medicaid dollars to reimburse social welfare agencies to provide health-improving services, is being modeled in North Carolina⁶.

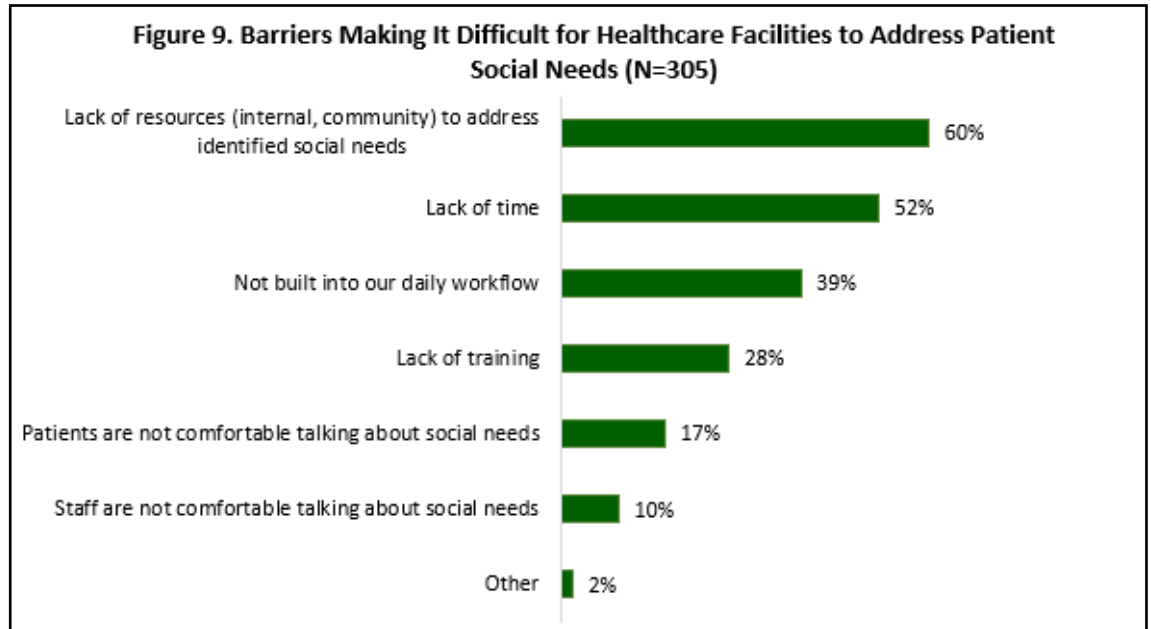
Next Steps

About one in three (n=98) respondents expressed interest in receiving technical assistance and resources to improve their patient social needs-oriented work or to receive information about future funding opportunities from the CVH and MDP on social determinants of health projects. This information will be distributed soon after completion of this report.

Results from this survey will be presented to the Chronic Disease Bureau’s Epidemiologist Work Group, as well as to the Chronic Disease Bureau Management Team to inform future work with local healthcare system and community supportive service partners as public health moves nationally to address patient social needs through building and sustaining clinical-community linkages for the benefit of patients and the systems they rely on.

End Notes

1. Nash, D. (2022) Social Determinants of Health: Measuring What Matters. MedPage Today April 29, 2022. <https://www.medpagetoday.com/opinion/focusonpolicy/98491>
2. WIM Tracking Database (2022) Health Workforce Information System for Wyoming, Idaho, and Montana. <https://wimtracking.com/>
3. PRAPARE. (2022) Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences. Accessed July 29, 2022 <https://prapare.org/>
4. Sanderson D et al. (2021) Increasing Warm Handoffs: Optimizing Community Based Referrals in Primary Care Using QI Methodology. J Prim Care Community Health Jan-Dec;12:21501327211023883.
5. Patient Engagement HIT (2022) Top Effective Social Determinants of Health Interventions. March 9, 2022 <https://patientengagementhit.com/features/top-effective-social-determinants-of-health-interventions>
6. Donnelly-DeRoven, C. (2022) “It’s never been done before”: How NC plans to use Medicaid dollars to improve social determinants of health. NC Health News , March 9, 2022. <https://www.northcarolinahealthnews.org/2022/03/09/its-never-been-done-before-how-nc-plans-to-use-medicaid-dollars-to-improve-social-determinants-of-health/>



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