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

**Alec E. Kerins**
**Department of Family Medicine, University of Colorado School of Medicine**

## 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

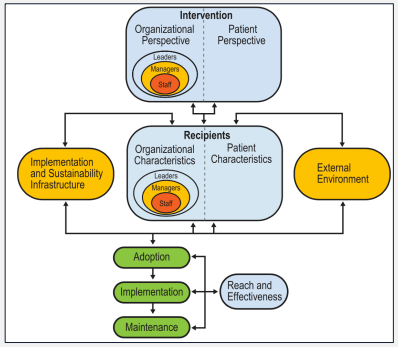
- Better understand the **facilitators and barriers** to **planning and implementation of a social needs screening program** among **ambulatory care practices** opting into the social needs building block of the **Innovation Support Project**.
- Findings will be applied by ISP personnel to inform the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

## METHODS

- Of the **81** practices enrolled in the ISP, **43 focusing on the optional 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**

### WHAT IS PRISM?

- 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

## RESULTS

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

| | Intervention | | Recipients | | Implementation and Sustainability Infrastructure | External Environment |
|---|---|---|---|---|---|---|
| | **Organizational Perspective** | **Patient Perspective** | **Organizational Characteristics** | **Patient Characteristics** | | |
| **Facilitators** | **Staff and leadership engagement**<br>• Shared understanding<br>• Health equity mission | | **Staff training**<br>• Training on processes, best practices on screening delivery<br><br>**Relationships and communication**<br>• Patient and screener**<br>• Feedback for improvement of processes<br>• Communication plan<br>• Frequent communication with comm. partners | | **Technology**<br>• EHR integration<br>• Automated communication<br>• Online tools to connect patients to community resources<br><br>**Workflow**<br>• Full-time care-coordinator<br>• Non-verbal screener<br>• Every patient every visit<br>• Warm handoff | **Community Resources**<br>• Diverse in type<br>• Large number<br>• Frequent referral<br>• Integrated within clinic |
| **Barriers** | **Staff and leadership engagement**<br>• Competing priorities<br>• Providers in "silos"<br><br>**Cost**<br>• Staff time<br>• Technology<br>• Online tools<br>• Travel** | **Screener burden** | **Staff turnover and training**<br>• Within practice, community<br>• Time to train | **Patient complexity and engagement**<br>• Medical issues prioritized over screening | **Workflow**<br>• Part-time care coordinator<br>• Only new patients screened<br>• Paper handouts to connect patients to resources | **Community Resources**<br>• Low number**<br>• Large distance**<br><br>**Stigma**<br><br>**COVID-19**<br>• Less screening<br>• Staff ill<br>• Unable to meet w/ partners |

## 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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