Current Practices in ED Social Determinants Screening and Care Connection: A Literature Review

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Background:
Social determinants of health (SDOH) screening in emergency departments (ED) is a promising method to capture and address the individualized social needs of a broad patient population, ideally lowering emergency department readmissions while reducing health disparities. Studies have shown that individual-level income, housing, employment, and education can contribute to predictions of 30-day readmissions into EDs and housing stability. With new Joint Commission guidelines requiring social determinants to be addressed and the integration of SDOH-related Z-codes into ICD-10 coding, we must implement robust screening and referral programs. This narrative literature review strived to identify best practices prior to the implementation of social determinants screening in the ED of University Medical Center (UMC), New Orleans. Currently at UMC, patients in the ER are screened for SDOH using the Epic Wheel. This built-in feature helps document social, behavioral, and economic information that is pertinent to the patient's health. The wheel includes 10 domains- financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress, and food insecurity. Members of a patient's care team can access the wheel and see patient responses and changes over time to their answers. While this wheel is comprehensive, it is not being used consistently in the ED; there is resistance from ED staff due to increased workload and reduced efficiency stemming from a current lack of a standardized, logistically sound implementation plan. Furthermore, screening for SDOH without connection to care resources renders the process ineffective as there is no resolution of the root problems identified.

Methods:
In this review, we investigated current best practice screening tools and their integration with electronic health records in similar hospital settings across the country. This was done by conducting a descriptive literature review to identify a representative number of works relating to current SDOH screening practices in EDs. We explored past and current practices by pulling relevant journal articles related to ED SDOH screening and interventions. We divided the journals into the following representative categories: current tested screening tools, integration with electronic health records, a discussion of survey formats, referrals and resource navigation, and a final section describing care connection models from screening to referral. Based on our findings, we planned to propose a SDOH screening program that could be implemented in the ED of UMC.

Results:
Key conclusions include the identification of the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) as the ideal screening tool, and that electronic screening tools led to higher levels of social needs reporting compared to paper counterparts. Similar success of written resource referrals and referrals given by a navigator in reducing social risk factors was also identified, highlighting the importance of high-quality, written resource referrals. Lastly, challenges to the formation of a successful, integrated

screening and referral pathway such as loss to follow-up, even in a transition care coordination model that assists patients throughout levels and types of care, are identified.

Conclusions:
These best practices uncovered by the review will be utilized to inform the implementation of a SDOH screening program in the Emergency Department of University Medical Center, New Orleans. Our proposal includes the integration of a program called FindHelp into Epic. FindHelp uses a unique platform to connect patients to local resources and programs aimed at addressing specific social needs found through screening. A MyChart SDOH survey will be completed upon ED check-in and completed by the patient autonomously either before or after triage, with confirmation by a trained staff member. Once the patient has been treated and is ready to be discharged, a FindHelp curated list of community organizations and referrals will be sent home with the patient based on the SDOH FindHelp identified from the survey, with case manager assistance available. This screening and referral program is currently being rolled out at UMC, and while connecting individual patients to services is the main goal, metrics gathered from the screening survey will be used to not only inform ED staff of community members' needs, but to serve New Orleanians by lowering emergency department readmissions and reducing health disparities.