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Social Risk Screening Is Increasing, but Is Screening Enough?

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To achieve optimal health, individuals must navigate across not just medical domains, but also social, behavioral, economic, neighborhood, and educational domains. In addition to health and health care disparities, there are well-known social, economic, neighborhood-based, and education-based disparities that together amplify health disparities when not addressed. Therefore, in recognition of the limitations of focusing solely on biomedical conditions, systematic approaches to addressing social drivers of health have recently begun to be addressed.[1]

Social drivers of health are nonbiomedical factors that influence the health of an individual or community.[2,3] These drivers can provide either assets or risks for individuals with health needs.[4] Those with social risk factors have been found to have a higher burden of chronic disease, more advanced disease at diagnosis, and an accelerated trajectory toward advanced complications.[4,5] Due to the growing recognition of the association of social risk factors with individuals' health and health care access and societies' health and health care disparities, systematic methods of screening for social risk factors have begun to be implemented across health systems, often leveraged via electronic health records. Screening interventions tend to be heterogeneous, as there is little consensus regarding which specific risk factors should be queried, which screening tools are best, and how screening interventions should be implemented.[4]

In a 2019 study, Fraze et al[5] used self-reported survey data from the National Survey of Healthcare Organizations and Systems (NSHOS) from 2017 to 2018 to measure screening of 5 social risks (interpersonal violence, transportation needs, food insecurity, housing instability, and utility needs) and found that few US physician practices and hospitals screen patients for all 5 of these measured social risks (15% across all sites reporting data; 47% response rate). Importantly, the authors note that health practices that reported serving underresourced patients were more likely to report higher rates of social risk screening and that direct or indirect efforts to screen that were tied to reimbursements were associated with higher rates of screening.

Since the study by Fraze et al[5] half a decade ago, several policy and cultural factors could be associated with an increase in social risk screening. For instance, the proliferation of literature on the negative association of unmet social risks and social needs with individuals' health,[4] the increased advocacy by medical societies on the need for social risk screening,[6] the growth of accountable care organizations and other value-based care programs,[7] and the potential health care worker cultural change in light of increased medical education surrounding health care disparities and social drivers of health[8,9] may have galvanized screening efforts.

Therefore, Brewster and colleagues[10] evaluated whether social risk screening has increased over the half decade since the study by Fraze et al.[5] Brewster et al[10] used a repeated cross-sectional study design for NSHOS surveys completed by a nationally representative survey of physician practices in both 2017 and 2022 to determine if nearly 3500 practices screened for the same 5 common social risks. They found that the number of physician practices reporting screening for all 5 measured social risks nearly doubled from 15% in 2017 to 27% in 2022. Furthermore, the number of social risks screened per practice increased from 1.71 to 2.34. Although the practice characteristics associated with screening for a larger number of social risks remained consistent over time (federally qualified health center status and having higher scores for innovation culture, advanced information systems, and payment reform), the increases in screening were seen across a wide variety of practices.

This study has several key strengths, including use of a nationally representative survey, NSHOS, which was the same survey used by Fraze et al[5] to compare 2022 data with the previously reported 2017 data. To our knowledge, no other similar studies have been conducted since the prior study by Fraze et al.[5] In addition, the study by Brewster et al[10] incorporated several sensitivity analyses that added additional rigor to the study methods and results. These sensitivity analyses included limiting the sample to the practices that had results from both study years, testing interactions between study year and independent variables, and examining potential heterogeneity by social risk factor. For the most part, results from these sensitivity analyses remained unchanged from the primary analysis. Given the changing landscape of reimbursement and the cultural shifts in health care and medical education, this study is important in highlighting that social risk screening is still suboptimal at less than one-third of practices across the US.

Despite the strong methodological approach to this study, there are some additional opportunities to elucidate data on social risk screening not addressed in this study. For instance, given the cross-sectional nature of the study, longitudinal trends were not identified. To address this limitation, the authors conducted a sensitivity analysis using fixed effects for practices that were represented in both the 2017 and 2022 data. However, evaluation of NSHOS data if available across all years between 2017 and 2022 could shed light on the rate of increases in screening and whether the COVID-19 pandemic affected implementation of screening. Furthermore, the social risk factors screened for do not always match a patient's own goals and priorities related to social needs; hence, more work is needed to understand how to effectively screen for and address patient priorities and identified needs regarding their health. Moreover, the survey does not, as the authors note, identify whether screening led to actual interventions to address these unmet social needs. Given that the lack of screening uptake is in part due to concerns about not having sufficient resources to address identified risks, it will be important for future studies to evaluate the effectiveness of screening on health outcomes.

Other considerations regarding the results of this study that warrant discussion include the relatively low response rate. Only about one-third (38%) of practices reported data, down from nearly half (47%) in the study by Fraze at al.[5] The relatively low response rate in the study by Brewster et al[10] could introduce bias into the results, leading to either overestimates or underestimates of overall social risk screening among practices. Also, surveys were usually completed by a single practice leader reporting on the practice's social risk screening, which may have led to misclassification if they were not aware of all aspects of screening at their practice. Hence, the results of the study need to be considered in light of these factors. Finally, the characteristics of the practices responding need to be kept in mind when considering the generalizability of these results. For instance, most practices (>80%) comprised 12 or fewer physicians. Furthermore, about one-third (28%) of responses were from practices that received 20% or more of their practice revenue from Medicaid. Whether social risk screening rates vary at larger practices or practices with different payer mixes warrants future evaluation.

Despite additional unanswered questions regarding when, who, and how to screen for social risk and whether screening is associated with actionable outcomes, this study highlights that screening is still vastly underperformed. Although screening for social drivers of health has nearly doubled over a half-decade, less than one-third of physician practices report screening for all 5 common social risk factors. Critically, though, data on whether social risk screening is associated with improved health outcomes are still needed and are likely paramount to increasing further health system and payer investment in screening. Simultaneously, we must acknowledge that the degree of investment we make in addressing identified social risks will also affect the likelihood of finding a positive association. In the meantime, as we await further data on how to improve all aspects of achieving optimal health, including effectively addressing social risk factors, we must continue to educate our health care students and fellow professionals on the full scope of our professional roles in caring for patients and advocate for the resources necessary to do so.

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