

## AAEM Clinical Practice Committee Statement

### Addressing Social Risks and Needs in the Emergency Department

#### *Do emergency physicians, and their departments, need to screen for and address social risks to health?*

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#### **Summary Recommendations:**

- 1) Emergency Departments should develop and implement policies to screen for social risks, and when appropriate address social needs of individual patients.
- 2) *Individual* emergency physicians, along with other emergency professionals, including nurses, social workers, pharmacists, and case managers, can contribute in a variety of ways:
  - a. At the level of *individual* patient care - physicians can
    - i. screen for social risks to health
    - ii. address barriers related to these risks in planned treatment, and attempt to connect patients to available resources
  - b. At the *department* level, physicians should advocate for policies and resources to help address negative social determinants, including
    - i. offloading provision of social services from individual physicians at the point of care
    - ii. providing services proven to be beneficial, such as 24-hour social work and substance abuse treatment programs
    - iii. providing free or low-cost medications to patients at the time of ED discharge
    - iv. partnering with community-based organizations that provide outpatient support services, and working with them on community based participatory research
  - c. At the *hospital* level, physicians can advocate for
    - i. an increased budget for social services
    - ii. integrated care and case management
    - iii. development and incorporation of community partnerships
  - d. At the *community* level, physicians can
    - i. engage with, support and advocate for non-hospital based community organizations that address social needs
    - ii. provide education for the community as requested
  - e. At the *national* level, physicians can
    - i. advocate for universal healthcare as a human right
    - ii. advocate for the transformation of health systems to prioritize screening and intervention regarding social needs as a fundamental part of the care process

- iii. advocate for research and funding to develop and maintain ED-based and community-based programs that address social risks
- iv. participate in the development of best practices to be shared across emergency departments

**Introduction:** Contrary to popular beliefs, health outcomes are driven only to a small degree by healthcare, and driven far more by what are called the “social determinants of health” (SDOH). Emergency physicians (EPs) are perfectly situated to provide both local and national leadership to recognize and address such social factors. There are many ways in which we can do this – both individually and collaboratively – and while no individual can be expected to contribute in every relevant area, every one of us can (and should) work on at least one of them.

**Executive Summary:** We performed a structured review of the literature using PubMed, as well as searching the Social Interventions Research & Evaluation Network (SIREN) Evidence and Resource Library. The evidence for social needs screening in the emergency department has been summarized in recent systematic and scoping reviews (1-2). In addition, a recent comprehensive literature search was conducted for a 2021 consensus conference on social needs screening (3-5). We used the results of these literature searches to inform this policy statement. We limited inclusion to reports written in English, and the keywords: Social Determinants of Health, Social Risks, Social Needs, Social Screening, Emergency Department, Hunger, Food Insecurity, Housing, Homeless. References of selected articles were also reviewed for additional supporting studies. Given the relatively limited evidence on the topic, we reviewed recommendations from the National Academies of Science, Engineering, and Medicine publications, as well consensus conference proceedings.

The Social Determinants of Health (SDOH) are conditions in which individuals are born and live, and which have been shown to have a primary effect on health outcomes that is even greater than the impact of clinical care.(6-7) In 2008, the World Health Organization Commission on Social Determinants of Health set an ambitious goal of closing the health gap in society to achieve health equity in a generation (8-9). Negative SDOH reflect larger societal issues related to poverty, inequality, and racism. They are manifested as inadequate access to quality education, economic opportunities, job opportunities, and health care, as well as insufficient resources to meet daily needs (housing stability and food security), exposure to both interpersonal and structural violence, among many others. The failure to address disparities and inequities in the United States helps explain why other nations which spend dramatically less on healthcare, but more on social services, outperform the US on most population health measures (10-12). Improving social conditions is critical to reducing health disparities and improving overall health in the USA, and thus integrating social care into health care delivery is needed to achieve these goals (6-7). The disproportionate harm of the COVID-19 pandemic to communities of color provides a striking example of the relationship between failure to address social needs and negative health outcomes (13-17).

Emergency physicians justifiably take pride in utilizing cutting edge, life-saving interventions. But we also take pride in the ED’s role as safety net for our society. It is evident that we see disproportionately the most vulnerable patients, including those who have nowhere else to go for care (1, 18-20) which makes us uniquely positioned to screen for and begin the process of addressing critical social needs. When we speak of screening, we are specifically referring to social risk factors, i.e. those social determinants that negatively impact health outcomes and for which emergency medicine clinicians could provide assistance. Screening for social risks in and of itself may not be sufficient, as some patients who have such risk factors do not request or accept assistance. At the same time, there are people who deny having social risk factors, but who will nevertheless accept help when offered (i.e. do have social needs) (21-23). Doing this, on a population level, is likely to be the most effective. Although the literature on ED-based screening and programs is an emerging field for which more research is needed regarding the best approach (2-5, 24-26), there is sufficient evidence to make it clear that we should not stand by and do nothing when needs are so pressing. Instead, that evidence suggests that emergency clinicians should actively implement screening at present, while we continue to investigate both how best to screen, and which interventions are most efficacious and cost-effective. Until there is robust evidence to identify the optimal approach there are several available screeners that can be implemented (27-31); the Social Interventions Research & Evaluation Network (SIREN) website maintains up to date reference tables on social needs screeners for adults and children (32-33).

Addressing social risks and needs is not “extra” to the job of the emergency physician; it is a key element in maximizing our chance of truly helping our patients. It is something we have always done, although not formally codified.

When we provide “medical” solutions without considering whether patients can adhere to the treatment plan (because they cannot afford the medication, cannot obtain necessary nutrition, or have no home at which to achieve bedrest or extremity elevation), even the most well-intentioned and evidence-based treatment plans are susceptible to failure. Furthermore, physicians who repeatedly encounter such treatment failures suffer the moral injury that results from a sense of helplessness – what is commonly called burnout. On the other hand, when we improve the chance of a good health outcome by addressing our patients’ social needs, advocates indicate can regain our sense of agency, and feel an even greater sense of fulfillment from doing our critically important work (34-35).

It is important to recognize that there are many challenges to addressing complex societal issues in a fast-paced ED environment. While individual emergency physicians should feel empowered to do more, as they see fit, the goal should ultimately be to create sustainable programs that unburden the individual clinician.

**Conclusion:** Screening for social risks and addressing social needs is an essential part of ensuring high quality, cost-effective care to improve patient outcomes. Attention to structural causes of societal inequities that strongly contribute to bad health outcomes is critical to improved population health, and emergency physicians and emergency departments are well positioned to be leaders in creating positive change. Emergency physicians have a powerful voice, which we can use to drive change and demand better care and services for our patients. Along with our ED colleagues, we can act on an individual, hospital, community or national level. We can start with every individual whom we treat by simply asking about their social risks and needs, as well as possible barriers to their care; we can also work to improve ED care at a systems level. While recognizing that we cannot by ourselves directly change the structural forces that drive social inequality, we can become passionate advocates for such change. At the same time, there is evidence which suggests that we can also do something meaningful on every ED shift we work and at every hospital meeting we attend, as well as by creating bridges with the community. Our specialty can and must lead our health systems and medicine as a whole in re-envisioning the provision of healthcare in this country.

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<b>Literature Grading</b>				
	<b>Publication</b>	<b>Grade</b>	<b>Quality</b>	<b>Comment</b>
1	Hood CM, Gennuso KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. Am J Prev Med. 2016 Feb;50(2):129-35.	D	Outstanding	Cross-sectional observational study examining the 2015 County Health Rankings (CHR). CHR provides data for nearly every county in the USA on four modifiable groups of health factors (healthy behaviors, clinical care, physical environment, socioeconomic conditions) and on health outcomes (e.g. length and quality of life). Results: The relative contributions of socioeconomic factors, health behaviors, clinical care, and the physical environment to the health outcomes composite score were 47%, 34%, 16%, and 3%, respectively. Supporting the fact that the greatest improvements in population health require addressing the social and economic determinants of health.
2	Bradley EH, Elkins BR, Herrin J, Elbel B. Health and social services expenditures: associations with health outcomes. BMJ Qual Saf.2011;20:826-831.	D	Good	Pooled cross-sectional analysis of health and social expenditures from the Organisation for Economic Co-operation and Development (OECD) data (N=30 countries) from 1995-2005. Selected 5 health outcome measures that spanned the most commonly used and fundamental measures of population health (life expectancy, infant mortality, low birth weight, maternal mortality and potential life years lost), and measured health care expenditures, and social services expenditures as a percentage of the country's GDP in the relevant year. Results: Most countries spent between 20-35% of GDP (mean 26.3%) on health and social services, but the mix of social vs health expenditures varied. In the USA the majority of spending was on healthcare. The average ratio of social to health service expenditures for OECD countries was 2.00, but for the USA it was 0.91. The ratio of social to health expenditures was significantly associated with greater life expectancy, lower infant mortality and fewer potential years of life lost, although it was also significantly associated with increases in low birth weight.

3	Papanicolas I, Woskie LR, Jha AK. Health Care Spending in the United States and Other High-Income Countries. JAMA. 2018 Mar 13;319(10):1024-1039. Erratum in: JAMA. 2018 May 1;319(17):1824.	D	Outstanding	Cross-sectional analysis of Organisation for Economic Co-operation and Development (OECD) data 1980-2015. 3 Objectives - (1) How does the US compare to other countries in social spending; (2) Do countries with less on social spending have higher health care spending; (3) Is increased social spending over time associated with decreases in health care spending? Methods: Examined health care and social spending as relative percentage of GDP and absolute spending (dollars per capita adjusted for purchasing power parity (PPP)). Results: Average social spending was 17% of GDP, mostly public spending and 2.1% private, US just below the average at 16.1% and 5.7% private, 10.4% public spending. If including education in social spending, US social spending increases to 19.7% of GDP (greater than the OECD average of 17.7%). Average health care spending across the OECD was 8.8% of GDP in 2015: US notable outlier at 16.8% of GDP. Social spending increased over time, and countries that spend more on social services also spend more on health care.
4	Price-Haygood EG, Burton J, Fort D, Seoane L. Hospitalization and Mortality among Black Patients and White Patients with Covid-19. N Engl J Med 2020. 2020 Jun 25;382(26):2534-2543. doi: 10.1056/NEJMsa2011686. Epub 2020 May 27	D	Good	Retrospective observational cohort study at an integrated health system in Louisiana (population served is 31% Black, 65% White non-Hispanic) from March 1-April 11, 2020. Patients who tested positive for SARS-COV-2, followed to assess hospitalization and in-hospital death. Analyzed 3481 COVID-19 positive patients, 50% female, 70.4% were Black. Black patients had higher prevalence of comorbidities (obesity, diabetes, hypertension, CKD) than White patients. 39.7% of the patients were hospitalized, 76.9% of the hospitalized were Black. In multivariable analysis Black race, increased age, public insurance, higher Charlson Comorbidity index, obesity, and residence in low-income area associated with admission. Of the 326 patients who died, 76.9% were Black. On multivariable analysis increasing age, clinical variables and SES were associated with higher mortality, but not race in adjusted analysis.



5	Lundberg DJ, Wrigley-Field E, Cho A, Raquib R, Nsoesie EO, Paglino E, Chen R, Kiang MV, Riley AR, Chen YH, Charpignon ML, Hempstead K, Preston SH, Elo IT, Glymour MM, Stokes AC. COVID-19 Mortality by Race and Ethnicity in US Metropolitan and Nonmetropolitan Areas, March 2020 to February 2022. JAMA Netw Open. 2023 May 1;6(5):e2311098. doi: 10.1001/jamanetworkopen.2023.11098.	D	Outstanding	Cross-sectional study using data from the Centers for Disease Control and Prevention (CDC). Examined US adult COVID-19 deaths by race and ethnicity across metropolitan and nonmetropolitan areas from March 1, 2020, to February 28, 2022. Results: Death rates were higher for non-Hispanic Black adults, and Hispanic adults than non-Hispanic White adults during the initial (alpha) wave of the pandemic, and the disparity decreased over time but death rates among non-Hispanic Black adults was still higher compared to non-Hispanic White during the Delta and Omicron wave. The national decrease in racial and ethnic disparities in COVID-19 mortality between the initial and Omicron waves was explained by increase deaths in non-Hispanic Whites and changing geography (increases in non-metropolitan areas).
6	Glance LG, Thirukumaran CP, Dick AW. The Unequal Burden of COVID-19 Deaths in Counties With High Proportions of Black and Hispanic Residents. Med Care. 2021 Jun 1;59(6):470-476. doi: 10.1097/MLR.0000000000001522.	D	Good	Retrospective analysis of the pandemic March 2020-November 2020, using multiple national databases including COVID-19 mortality data from USA Facts linked to data from the US Census Bureau, the Health Resources & Services Administration Area Health Resources file. Estimates association estimate the association between total county COVID-19 deaths and the proportion of non-Hispanic Blacks and Hispanic residents adjusting for resident demographics, comorbidity burden, rurality, social determinants of health, and health care resources. Initially in the pandemic counties with >40% Blacks had 6-fold higher death rates than counties with <2% Blacks, but the same was not observed for Hispanics. Counties with high concentrations of non-Hispanic Blacks were disproportionately affected by COVID-19, but other social determinants of health such as health insurance were playing a more prominent role than race and ethnicity in later November.

7	Millett GA, Jones AT, Benkeser D, Baral S, Mercer L, Beyrer C, Honermann B, Lankiewicz E, Mena L, Crowley JS, Sherwood J, Sullivan P. Assessing Differential Impacts of COVID-19 on Black Communities. <i>Ann Epidemiol.</i> 2020 May 14;47:37–44.	D	Good	Analysis of county-level data to examine if COVID-19 at the start of pandemic through April 13, 2020. County-level data from the U.S. Census Bureau American Community Survey 5-Year, COVID-19 cases and deaths at the county from USAFacts, comorbidity data from various CDC databases. Multivariable regression analysis adjusting for confounding with comorbidities and social and environmental factors. Counties with higher proportions of Black residents had more COVID-19 diagnoses and deaths after adjusting for county-level characteristics such as age, poverty, comorbidities, and epidemic duration. Deaths were higher in disproportionately Black rural and small metro counties. Nearly 20% of U.S. counties are disproportionately black, and they accounted for 52% of COVID-19 diagnoses and 58% of COVID-19 deaths nationally.
8	Frisina Doetter L, Frisina PG, Preuß B. Pandemic Meets Endemic: The Role of Social Inequalities and Failing Public Health Policies as Drivers of Disparities in COVID-19 Mortality among White, Black, and Hispanic Communities in the United States of America. <i>Int J Environ Res Public Health.</i> 2022 Nov 14;19(22):14961. doi: 10.3390/ijerph192214961.	D	Adequate	Study to examine which distinct factors relating to policy stringency and community vulnerability influenced COVID-19 mortality among Whites, Blacks, and Hispanics during the first year of the pandemic. Databases used include: Oxford COVID-19 Government Response Tracker (OxCGRT) for policy stringency, the COVID-19 Community Vulnerability Index (CCVI) that encompasses data on seven themes (socioeconomic status, minority status and language, housing and transportation factors, epidemiologic factors of comorbidities, healthcare system factors, high risk environments, population density), and CDC data for COVID 19 deaths. During the first year of the pandemic, the mortality of Whites benefited from state-led policies to reduce COVID-19 exposure and transmission; Blacks and Hispanics suffered disproportionately high mortality relative to their population sizes and failed to see the benefits of the same public policies.
9	Malecha PW, Williams JH, Kunzler NM, Goldfrank LR, Alter HJ, Doran KM. Material Needs of Emergency Department Patients: A Systematic Review. <i>Acad Emerg Med.</i> 2018 Mar;25(3):330-359.	A	Good	Systemic review of observational studies of material needs. Included 43 articles (limited- heterogeneous, cross-sectional, single center examining a variety of social needs: homelessness, poverty, housing insecurity, housing quality, food insecurity, unemployment, difficulty paying for health care, and difficulty affording basic expenses. ED population is vulnerable with high prevalence and number of social needs.

10	Gordon JA, Chudnofsky CR, Hayward RA. Where health and welfare meet: social deprivation among patients in the emergency department. <i>J Urban Health</i> . 2001 Mar;78(1):104-11	C	Good	Cross-sectional study over 24 hours at three EDs (an urban public teaching hospital, suburban university hospital, and semi-rural community hospital in 1997. Consecutive sampling of all patients, response rate 91%; enrolled 300 patients. High prevalence of social needs (31% social deprivation), 40% had no consistent health care outside the ED,
11	Molina MF, Li CN, Manchanda EC, White B, Faridi MK, Espinola JA, Ashworth H, Ciccolo G, Camargo CA, Samuels-Kalow M. Prevalence of Emergency Department Social Risk and Social Needs. <i>West J Emerg Med</i> 2020;21(6)152-161.	C	Adequate	Cross-sectional survey of social risks and social needs at a single urban ED, with 48 hours of time shift sampling over a 7-month period (2018-19). Assessed demographics, education, health literacy, and social domains - housing insecurity, food insecurity, transportation needs, utility needs, interpersonal safety concerns. 269 participants, 100 reported social risk (37%), 83 (31%) reported social need, and 169 (63%) reported no social risk or need. Incomplete overlap (some with risks did not have needs and vice versa). More than 50% of those who reported either social risk or social need screening positive in more than one domain. In multivariable analyses, higher education level and private insurance was associated with lower odds of social risks.
12	Miner JR, Westgard B, Olives TD, Patel R, Biro M. Hunger and food insecurity among patients in an urban emergency department. <i>West J Emerg Med</i> . 2013; 14(3): 253-262.	C	Adequate	Cross-sectional study at a single large urban ED over 3 years (2008-2009), consecutive screening during randomly selected 8-hour time periods. Assessed prevalence of hunger and food insecurity. Among the 7,852 patients analyzed hunger was common and increased over time (20.3% in 2007, 27.8% in 2008, and 38.3% in 2009), and approximately 20% of patients reported having to choose between food or medicine.
13	Courtin E, Kim S, Song S, Yu W, Muennig P. Can Social Policies Improve Health? A systematic Review and Meta-Analysis of 38 Randomized Trials. <i>Milbank Q</i> . 2020 Jun;98(2):29-371. Doi: 10.1111/1468-0009.12451. Epub 2020 Mar 19.	A	Good	Systematic review and meta-analysis of randomized social experiments with health outcomes conducted in the US. Included 61 publications from 38 randomized social experiments. Early life and education, income, and health insurance interventions have the potential to improve health. Some welfare-to-work interventions had a negative impact on self-rated health. Housing and neighborhood trials had no effect on the outcomes included in the meta-analyses. Many of the included studies were underpowered to detect health effects and were at high or moderate risk of bias. There was evidence of publication bias for studies of null effect.

14	Taylor LA, Tan AX, Coyle CE, Ndumele C, Rogan E, Canavan M, Curry LA, Bradley EH. Leveraging the Social Determinants of Health: What Works? PLoS One. 2016 Aug 17;11(8):e0160217.	A	Adequate	Summary of peer-reviewed literature (2004-2014) examining the impact of investments in social services or investments in integrated models of health care and social services on health outcomes and health care spending. 39 articles met criteria for inclusion, 32 (82%) reported some significant positive effects on either health outcomes (N = 20), health care costs (N = 5), or both (N = 7). Several interventions in the areas of housing, income support, nutrition support, and care coordination and community outreach had positive impact in terms of health improvements or health care spending reductions. 7 (18%) studies, 3 had non-significant results, 2 had mixed results, and 2 had negative results in which the interventions were associated with poorer health outcomes.
15	Walter LA, Schoenfeld EM, Smith CH, Shufflebarger E, Khoury C, Baldwin K, Hess J, Heimann M, Crosby C, Sontheimer SY, Gragg S, Hand D, McIlain J, Greene C, Skains RM, Hess EP. Emergency Department-based Interventions Affecting Social Determinants of Health in the United States: a Scoping Review. Acad Emerg Med 2020 Dec 24 doi: 10.1111/acem.14201.	C	Adequate	Scoping review of ED-based interventions aimed at mitigating negative SDoH Identified 135 articles for inclusion; subdivided into three intervention types: a) provider educational intervention (18%), b) disease modification with SDoH focus (26%), and c) direct SDoH intervention (60%), with 4% including two "types." Further grouped into seven SDoH domains: 1) access to care (33%), 2) discrimination/ group disparities (7%), 3) exposure to violence/crime (34%), 4) food insecurity (2%), 5) housing issues/homelessness (3%), 6) language/literacy/health literacy (12%), 7) socioeconomic disparities/poverty (10%). The majority of articles (78%) reported the studied intervention was effective for the primary outcome.