Implementation Research on Social Screening

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Background

Screening approaches/implementation strategies can affect patients/caregivers, healthcare team members, and program sustainability.

Without attention to the experience of sub-populations, screening may unintentionally worsen inequities.
Aim of this study

To synthesize peer-reviewed implementation research on social screening initiatives in healthcare settings.
Methods

Original systematic scoping review of peer-reviewed literature on social screening implementation. Article must:

- Involve multi-domain social screening in a clinical setting
- Describe implementation outcomes related to the following RE-AIM constructs: Reach, Adoption, Implementation, and/or Maintenance

Two reviewers abstracted data relevant to key study elements, including study sample, setting, and results on each of the included RE-AIM constructs.
Methods: Applying RE-AIM\(^1\) Implementation Science Framework to Social Screening Practices

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<tr>
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<th>Definition(^2)</th>
<th>Relevant outcomes in implementation studies</th>
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<tr>
<td>Reach</td>
<td>The number or proportion of individuals who participate in an intervention (and who are the target of that intervention).</td>
<td>Comparative screening rates, including pre/post intervention, between clinical sites, or by sociodemographic characteristics.</td>
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<td>Adoption</td>
<td>The number or proportion of individuals that deliver the intervention.</td>
<td>Rates of screening by workforce.</td>
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<td>Implementation</td>
<td>The consistency with which an intervention is delivered, the time and cost of an intervention, and adaptions made to an intervention.</td>
<td>Time required for screening; comparative implementation approaches and program fidelity (e.g. across modality, workforce); and program costs.</td>
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<td>Maintenance</td>
<td>The extent to which an intervention is sustained over time.</td>
<td>Rates of screening over time.</td>
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1,2: See next slide for table notes.
1. In this study, we did not include studies on **Effectiveness** (e.g. studies examining the impact of screening on social risk, health, utilization/cost) because studies that included Effectiveness outcomes did not distinguish between the impacts of screening itself versus screening plus subsequent interventions.

Results

42 articles met inclusion criteria.

Most articles reported implementation outcomes in their results but did not study factors that influenced those outcomes.

Descriptive study designs and variability in implementation approaches across studies limited generalizability of findings.
Different aspects of comparative reach were evaluated, including differences in reach by workforce conducting screening and screening modality.

5 articles reported on differences in screening reach by patient race/ethnicity; there were no consistent differences in reach by specific race/ethnic demographic groups in these studies.

2 articles reported on differences in screening reach by patient language; both found lower rates of screening among Spanish vs. English-speaking patients.

Reach facilitators: Adapting workflow, building trust and improving communication with patients, using motivational interviewing.
Results: **Adoption** (N=14)

Most articles reported on adoption of screening by clinicians, though clinicians were not the team members most commonly conducting screening across studies.

No articles directly evaluated factors influencing healthcare team member adoption of screening.

Facilitators to adoption: Education/training of healthcare team members and use of continuous quality improvement interventions.
**Results: Implementation (N=30)**

**Customization vs. standardization:** Standardization of screening can normalize screening and improve workflow integration, but flexibility in who can screen/when screening can occur may improve adoption and reach. In two studies, staff reported that decisions about whether to screen were based on staff judgements rather than universal or agreed on target populations.

**Time:** Screening time varies depending on tool used/modality of screening/workforce used/integration into workflow (range: 1-9 minutes).

**Workforce and modality:** Few studies compared workforce and/or modality of screening; in a handful of studies, it appeared community health workers or technology-assisted screening improved disclosure rates and reduced the burden of screening on healthcare teams.

**Implementation facilitators:** Regular communication with healthcare teams on screening progress/processes; clear communication with patients/caregivers about screening rationale/processes; training healthcare teams on empathic inquiry and trauma-informed care.

**Implementation barriers:** Lack of time and insufficient staffing
One article reported a significant drop in screening over the 21-month follow up period after an educational intervention to increase social screening by pediatric residents.
Looking Forward

We should leverage the rapidly increasing number of social screening programs to explore implementation approaches that prioritize a) equitable reach and b) patient and provider experience of care.
Download the full SCREEN report and executive summary on the SIREN website.

Questions about this section?
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