Please see the Q&A from "*To screen or not to screen, that is (an important) question*" below.

Does the 24 resource list include qualifying criteria for all of the resources in order to avoid sending people to places where they cannot be served?

- Some information - like languages and fees - are included that might be used as criteria. Earlier iterations of CommunityRx did more "matching" on gender, location, insurance, etc, but this one did not.

Did I understand Dr. Makelarski correctly that the intervention group had a higher rate of ED visits? (52% compared to 30% of control group)

- 30% of children in the control group and 52% in the intervention group had an ED visit in the 12 months post-discharge.

Did you see differences in impacts between the COVID period and afterwards?

- We've struggled with how to analyze the data in reference to COVID timelines - any ideas are welcome. Follow-up was 12 months. And some outcomes measured over shorter time would have flucations by season too (HRSRs). It's really hard to tease out.

[for Jennifer Makelarski] Great presentation! What platform was used to text and how did monolingual English speakers navigate texting in multiple languages, receiving responses in multiple languages, etc. Thank you so much!

- We use Mosio to text - the platform allows "storylines" that can be automatically sent based on a start date. We did not have language eligibility criteria, but everyone enrolled was English or Spanish speaking and we had navigators that spoke both languages. If we had enrolled someone that spoke another language, we would have use the medical center's translators.

Is anyone relying on census track vulnerability/risk data as a proxy for screening?

- It might be helpful to peek at the linked papers here, which consider the use of neighborhood level data as proxies: a) "Assessing area-level deprivation as a proxy for individual-level social risks"; b) "Comparison of community-level and patient-level social risk data in a network of community health centers"; and c) "Uses and misuses of patient- and neighborhood-level social determinants of health data".

Hi! This was amazing, thank you all! I am wondering if anyone of you are familiar with efforts that exist to coordinate HRSN screening & interventions across a state, between payers/health systems/etc.? Thanks!!

- the statewide waivers and ILOS initiatives are excellent examples here (NC, MI, MA, NY)
- The ACL CCH hub work is a good path as well via the Partnership to Align Social Care
- Gravity also has presentations on these efforts in our implementation library. Our last session was all about similar efforts
    - NY Waiver
    - On payer Highmark: PA, WV, NY

I would love any best practices/research about equity and pt centered documentation practices?

- AAP Food Insecurity Screening Toolkit
- Consensus-driven Standards on Social Determinants of Health
- Considerations for Documenting and Sharing Health-related Social Needs Information in Pediatric Care Settings
- Barriers and facilitators to caregiver comfort with health-related social needs data collection in the pediatric clinical setting
- Parent Perspectives on Documentation and Sharing of Health-Related Social Needs Data

I understand that your research shows that offering a menu instead of a needs-based screening is better for various reasons, but do you have recommendations for higher-cost resources, like medically tailored meals?

- Given understandable resource limitations, intervention programs will necessarily have to grapple with "triage." My recommendations would still be assessing desire for assistance as a first step in order to maximize the denominator, so to speak. Then apply appropriate eligibility criteria based on the program (medically tailored meals generally are linked to specific disease conditions), and potentially additionally triaging based on urgency of need and/or complexity of needs (desire for assistance in multiple domains, comorbidities, ineligibility for other programs, etc). I would flag that as with all interventions, care should be taken to provide resource information, at a minimum, to those who are not selected for higher-cost and/or limited programs.

I find the barrier of information going into EHRs important in judgements we make about others and that information lasting a lifetime. Thoughts on what we do about that to help people get what we need to ameliorate the EHR problem?

- EHR and documentation. Here are some good resources:

  - Considerations for Documenting and Sharing Health-related Social Needs Information in Pediatric Care Settings
  - Barriers and facilitators to caregiver comfort with health-related social needs data collection in the pediatric clinical setting
  - Parent Perspectives on Documentation and Sharing of Health-Related Social Needs Data

Given the CMS PFS 2026 focusing more on physical activity and nutrition (vs broad HRSN), how does it affect the use of standardized SDOH screening tools? Also, the codes are paying more for navigation vs screening. Curious to hear how you all are interpreting the impact of these on how healthcare providers / payers are implementing HRSN screening + social interventions.

- As far as we can see the physical activity and nutrition requirements are in addition to the continuity of HRSN screening. So the use of standardized tools remains. And in the ASM model need for specialists and PCPs to collaborate on addressing HRSN is called out specifically.

Given all of these (valid!) concerns from respondents about the appropriateness of screening questions, have you also considered whether there might be significant data quality concerns about the outputs from social risk screening processes?

If we have reasons to doubt the reliability of data that comes from these tools, that seems like another reason that they should not be deployed.

- This risk could be addressed by verification of risk after screening, as we should do with all screening (depression, substance use, etc.) as opposed to stopping screening.
- The SIREN team guest also supported a special issue of the *American Journal of Preventive Medicine* that included research from multiple studies exploring strategies to improve screening-related activities, including Nederveld et al's study IMAGINE: A trial of Messaging Strategies for Social Needs Screening and Referral.

I have a question for Dr. Cullen: she mentioned having electronic resources for all, and im curious to know what that means. Is there a resource repository on a hospital's website or something else? Thank you!

- We used an electronic resource map with find help (findhelp.org) through our institution-based relationship (communityresourceconnects.org)

Interesting findings, Danielle. Have they been published yet? (If so, could you please share the citation or link?)

- Full results are in press in Pediatrics— hopefully have a pub date soon! otherwise, our multilingual methods are published in Jama Peds, and qual results published in HSR
    - **Multilingual Research Strategies to Enhance Equity**
    - **Barriers and facilitators to caregiver comfort with health-related social needs data collection in the pediatric clinical setting**

For Danielle - How different is the patient's experience of screening vs. selection of resources on a resource menu (Arm 1 vs Arm 2)? How different is that as an experience, concerns about stigma, etc.

- Based on our qualitative work, resource menu reduced concerns regarding stigma as caregivers don't have to "own" material hardship, and have less concerns about risks of this documentation. we believe that this is what contributed to the increased ability to identify families in the resource menu arm

Do you find any benefits for screening aside from identifying resources, such as a useful way to initiate conversations with providers, etc?

- There's so much face validity to Danielle's suggested tiered model that gets us both - universally delivered resources, support for those who want it, the ability for clinician's to adjust.

Can we get a summary of the difference between the ACH screener and the UChicago intervention? It sounded like the latter (CommunityRX) was not actually using a screening tool, but rather extending an invitation to self-identify needs and request assistance with finding resources… but maybe I missed something.

- That's right - the intervention itself didn't screen (so the navigator never administered a screening tool or needs assessment). Everyone - whether or not they had a need or risk - could enroll in the trial and everyone got all the resources at the initial delivery. After that initial delivery, the navigator's automated texts sometimes asked things like "Are there any resources I can help you find?" Or might ask about more specific questions, like "I have some places where you get free fruits and vegetables, do you want me to send you information about these place?"

What hypothesis do you have for why your screener was more accurate in identifying needs and the sensitivity for AHC was so low? Is it how the questions are phrased?

- I think people have resources for a lot of different reasons and the risks-based questions on the AHC screening tend to focus on only some of those. For example, the screener uses the 2-item Hunger Vital Sign which is great in so many ways, but focuses more so on food needs resulting from financial reasons. People could have food needs for other reasons - like no transportation or no place to cook food.

- It may also be helpful to review SIREN’s report on The State of the Science on Social Screening in Healthcare Settings for more information on screening tool validity. Overall, very few of the multi-domain tools have been tested for psychometric validity. In the section on tool validity, the authors note: “The very limited testing of the psychometric and pragmatic validity of different social screening tools has left important gaps in evidence to guide screening tool selection. Only one study provided information regarding how validity constructs varied by race and ethnicity (no differences were reported). None of the studies explored differences by language.”

Can you say again how many of those who were more engaged had screened positive for any needs using the AHC screening tool?

- The rates of engagement were very similar among those with and without food insecurity (based on the USDA 18-item tool, not AHC). We actually haven’t looked at engagement by other HRSRs.
- Also see this AJPM article by De Marchis, et al. Do Patients Want Help Addressing Social Risks?