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Concordance between Social Needs Screening and Availability of Associated Programs in US Hospitals

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Purpose

The purpose of this study is to assess the extent to which rural hospitals screen for social needs, a previous quality measure in Medicare hospital payment, as well as to evaluate the level of alignment (hereafter referred to as concordance) between hospitals that perform these screenings and the availability of corresponding programs in their community to address these needs. It also examines this concordance by ownership type, region, and Accountable Care Organization (ACO) participation.

Key Findings

- The analysis found that CAHs had significantly lower concordance between social needs screening and the presence of programs to meet those needs when compared to both urban and rural PPS hospitals. This trend was observed across various types of social needs such as employment/income support, utility assistance, housing services, and programs addressing interpersonal violence.
- Non-profit hospitals demonstrated the highest prevalence of social needs screening across all ownership types. Urban PPS non-profit hospitals reported the highest levels of screening, followed closely by rural PPS hospitals and CAHs.
- Hospitals that were part of ACOs showed notably higher availability of programs to address social needs compared to non-participants. This was especially evident for services addressing employment/income, housing, education, and social isolation, indicating that participation in ACOs by hospitals may be linked to greater support for social needs.

Background

CMS previously required to screen for social drivers of health and report the screen positive rate.[3,4,5] CAHs could voluntarily participate in the inpatient quality reporting system and, if so, also report these measures.

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Hospitals need to actively engage in partnerships with a diverse array of organizations both within and beyond their communities to effectively address upstream drivers—policies, systems, environments, and cultural factors affecting health. If social needs screening is conducted, programs must be in place to ensure that those patient needs are being addressed either through direct service provision via internal programming or referrals to outside organizations providing needed services. Previous RUPRI Center work examined partnerships to address social needs among rural hospitals.[7]

However, limited research has assessed the concordance between social needs being screened and programs/partnerships in place to address those needs. To address this research gap, our study aimed to a) analyze whether hospitals are screening for social needs; and b) evaluate the concordance between the types of social needs being screened and the availability of corresponding programs or strategies.

Methods

We analyzed the data from the 2022 American Hospital Association (AHA) survey (the most recent data available at the time of this analysis) to assess hospitals' efforts to screen for social needs and whether they have any programs or strategies in place to address those needs. Our analysis was restricted to only general medical and surgery, non-federal hospitals in the 50 U.S. states operating for the full fiscal year that completed the supplemental survey (n=2,896). The survey assessed whether a hospital/health system screened for social needs and, if yes, what type of social needs they screened: housing (instability, quality, financing); food insecurity or hunger; utility needs; interpersonal violence; transportation; employment and income; education; social isolation (lack of family and social support); and health behaviors. The survey also assessed whether the hospital or health system had established programs/strategies to address each of these distinct needs.

The AHA survey also captures information on hospital characteristics. We constructed three categories of hospitals: metropolitan/urban PPS hospitals, rural/non-metropolitan PPS hospitals, and CAHs located in non-metropolitan counties. Non-metropolitan hospitals are those that are part of a micropolitan core-based statistical area (CBSA) or labeled as neither micropolitan nor metropolitan by the 2003 Office of Management and Budget definition. Based upon the state location of the hospital, we categorized the hospitals by the U.S. Census Region: Northeast, South, Midwest, and West. We also used other characteristics: hospital ownership types including government, non-federal, non-profit, and for-profit, and if the hospital has ever participated in an ACO.

To analyze whether hospitals are screening for social needs, we computed the percentages of hospitals that did not screen for social needs, screened for social needs in all patients, and screened in some patients. This analysis was stratified by hospital location/type (urban PPS, rural PPS, and CAHs), regions, ownership type, and participation in an ACO. We used Chi Square tests to evaluate whether these differences between the groups were statistically significant. To assess

concordance between social needs screened and corresponding programs, we calculated the percentage of hospitals that a) screened for eight specific social needs and b) had programs/strategies that addressed the associated social need. We compared these percentages across urban PPS, rural PPS, and CAHs. Additionally, we calculated percentages of hospitals that have associated programs or strategies in place to address the social needs for which they conduct screenings. We compared these percentages across hospital location, ownership types, regions, and ACO participation. We used Chi Square tests to evaluate whether these differences between the groups were statistically significant.

Findings

The 2,896 hospitals in our analysis include 1,795 urban PPS hospitals (62.0 percent), 446 rural PPS hospitals (15.4 percent), and 665 CAHs (22.6 percent). Distribution across location, region, type and ACO participation is provided in Appendix Table 1. Among all hospitals evaluated, 49.7 percent conducted social needs screening for all patients, 41.8 percent conducted for some patients, and 8.5 percent did not conduct social needs screening (Figure 1). Among different types of hospitals based on location, urban hospitals had the highest percentage (95.8 percent) for social needs screening for all or some patients combined, followed by rural PPS hospitals (89.9 percent), and CAHs (80.6 percent). Rural PPS hospitals showed the highest percentage (52.9 percent) of screening for all patients, followed by urban PPS hospitals (51.8 percent) and CAHs (41.8 percent).

Figure 1: Percentage of Hospitals Screening for Social Needs Stratified by Location

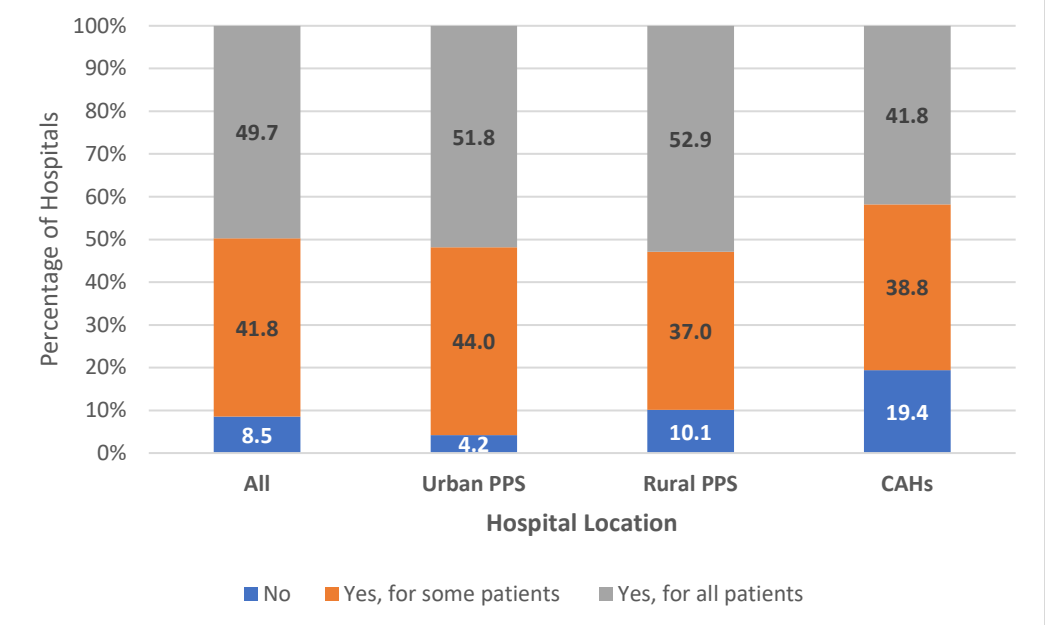

Figure 2 presents percentages of hospitals screening for social needs stratified by ownership type, location, and hospital type. Among all ownership types, non-profit hospitals showed the highest percentage of hospitals that screened for social needs, with urban PPS being the highest (97.6 percent), followed by rural PPS (95.5 percent), and CAHs (87.5 percent). Conversely, non-federal government ownership showed the lowest

percentage of hospitals that screened for social needs, with CAHs being the lowest (68.3 percent), followed by rural PPS (76.1 percent), and urban PPS (94.8 percent).

Figure 2: Percentage of Hospitals Screening for Social Needs Stratified by Hospital Ownership and Hospital Location

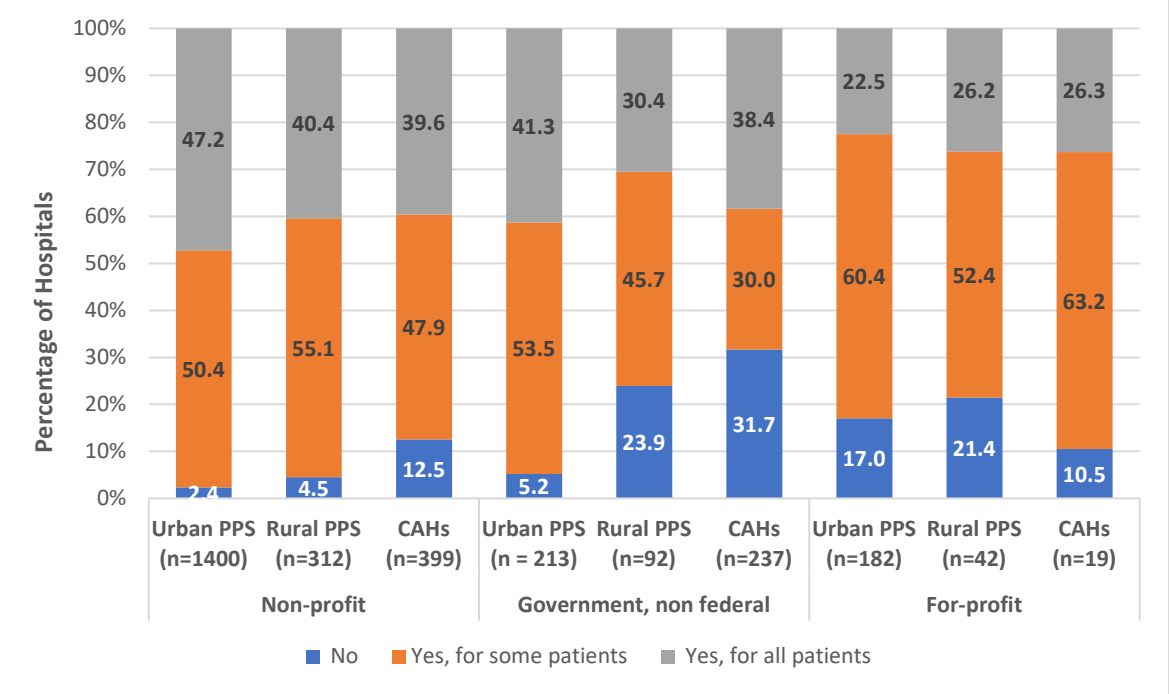

Figure 3 shows percentages of hospitals screening for social needs by region, location, and hospital type. Among all regions, the South showed the lowest percentage of hospitals that screened for social needs, with CAHs being the lowest (74.3 percent), followed by rural PPS (83.2 percent), and urban PPS (93.0 percent), compared to their counterparts in other regions. Conversely, Northeast showed the highest percentage of hospitals that screened for social needs, with urban PPS being the highest (99.3 percent), followed by CAHs (97.2 percent), and rural PPS (96.2 percent). Except for those in the Northeast, CAHs hospitals had the lowest percentage of hospitals that screened for social needs, with the lowest in South (74.3 percent), followed by Midwest (80.9 percent), and West (83.8 percent), compared to other hospital types.

Figure 3: Percentage of Hospitals Screening for Social Needs Stratified by Region and Hospital Location

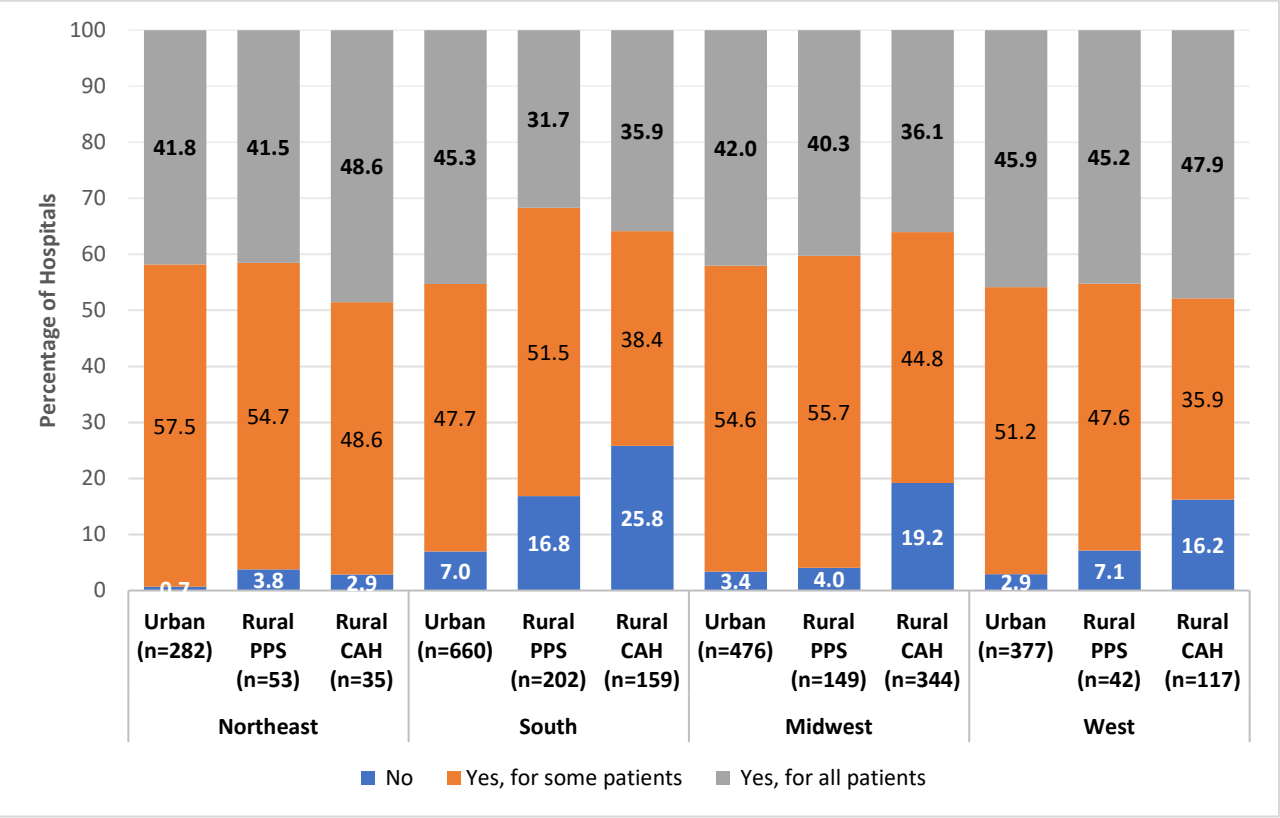

Figure 4 shows the percentages of hospitals screening for social needs by ACO participation, location, and hospital type. Hospitals that never participated in an ACO showed lower percentages of social needs screening in all three categories of hospitals: CAHs (72.9 percent), rural PPS (84.6 percent), and urban PPS (90.5 percent) compared to those that participated in ACOs. Hospitals participating in ACOs consistently report higher screening percentages for all categories of social needs compared to non-ACO participating hospitals (appendix table 1). This trend is evident across Urban PPS, Rural PPS, and CAH settings, with ACO hospitals showing significant improvements in screening areas such as food insecurity, transportation, and housing. For example, in Rural PPS hospitals, the screening for food insecurity is notably higher in ACO participants (83.5%) compared to non-ACO participants (65.9%). This highlights the positive impact of ACO participation on social needs screening efforts in hospitals.

Figure 4: Percentage of Hospitals Screening for Social Needs Stratified by ACO Participation and Hospital Location

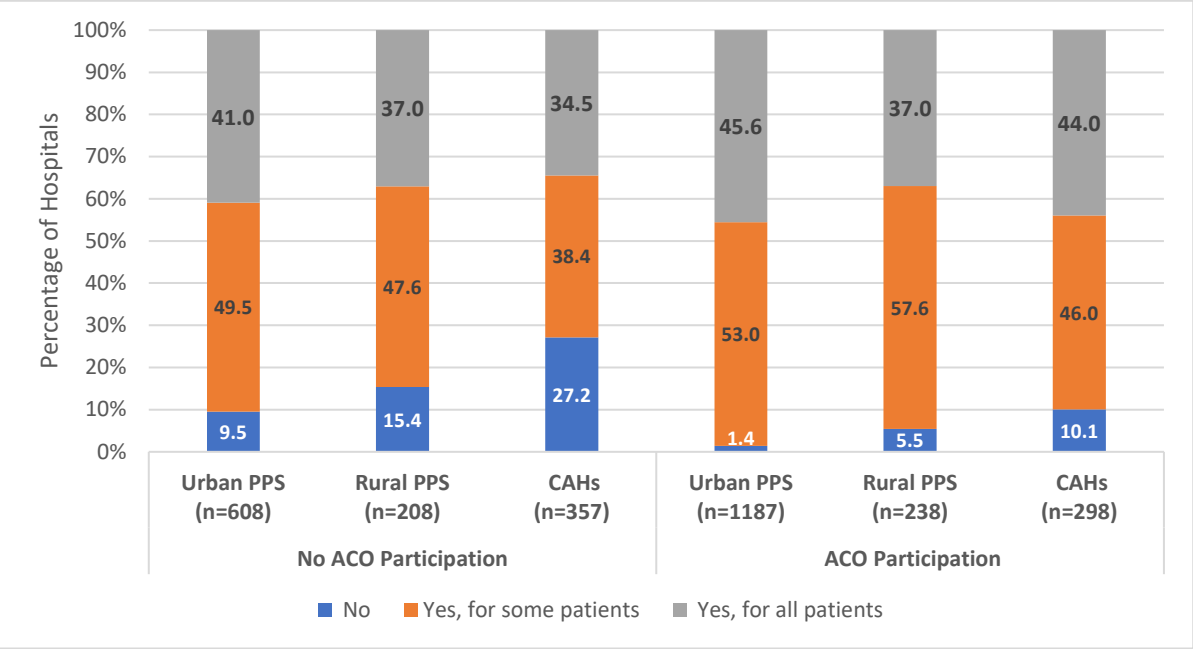

Table 1 shows the concordance between the types of social needs screened and the availability of corresponding programs or strategies. Specifically, these results examined whether hospitals that screen for particular social needs also have programs or strategies in place to address those needs. More than 70 percent of the hospitals had programs to address their associated social needs with health behavior programs being the highest (92.7 percent), followed by food insecurity (90.7 percent), transportation (90.6 percent), interpersonal violence (80.4 percent), education (79.6 percent), social isolation (79.2 percent), utility needs (78.7 percent), housing (77.9 percent), and employment/ income (71.7 percent). Across different locations, concordance between social needs screening and the availability of corresponding programs was significantly lower in CAHs compared to rural and urban PPS hospitals, specifically for employment/ income programs (55.0 percent vs 68.7 percent and 76.5 percent), utility needs (62.3 percent vs 78.3. percent and 82.6 percent), housing (63.5 percent vs 73.1 percent and 82.7 percent), and interpersonal violence (63.5 percent vs 79.1 percent and 85.4 percent). Differences for health behavior programs were not significant.

Table 1: Percentages of hospitals that screen for HSRNs and have programs or strategies to address identified social needs

Social need Program/strategy	All Hospitals (n=2896)
Education	79.6
Employment/Income	71.7
Food Insecurity	90.7
Health Behavior	92.7
Housing	77.9
Interpersonal Violence	80.4
Social Isolation	79.2
Transportation	90.6
Utility Needs	78.7

By Hospital Location

Social need Program/strategy	Urban PPS (n= 1,795)	Rural PPS (n=446)	CAH (n=655)
Education**	82.3	76.6	72.1
Employment/Income***	76.5	68.7	55.0
Food Insecurity***	93.3	89.4	82.0
Health Behavior	93.4	93.3	90.1
Housing***	82.7	73.1	63.5
Interpersonal Violence***	85.4	79.1	63.5
Social Isolation***	82.4	76.5	69.7
Transportation***	92.8	87.0	85.1
Utility Needs***	82.6	78.3	62.3

By Ownership Type

Social need Program/strategy	Government, Non-federal (n=542)	Non-profit (n=2111)	For-profit (n=243)
Education**	72.5	81.7	69.7
Employment/Income***	63.9	73.6	65.4
Food Insecurity***	83.5	93.1	77.5
Health Behavior	90.7	94.1	82.0
Housing***	71.0	79.8	71.3
Interpersonal Violence***	77.6	81.5	74.6
Social Isolation***	74.0	81.1	68.6
Transportation***	88.4	91.5	85.3
Utility Needs***	75.4	79.6	74.7

By Census Region

Social need Program/strategy	Northeast (n=370)	South (n=1021)	Mid-west (n=969)	West (n=536)
Education	82.1	78.9	79.5	78.6
Employment/Income	71.7	69.1	71.7	76.2
Food Insecurity***	96.7	89.8	88.6	90.9
Health Behavior*	95.0	92.2	90.8	95.0
Housing**	83.5	75.2	75.9	81.1
Interpersonal Violence*	86.0	80.2	77.2	81.5
Social Isolation	82.4	78.0	78.2	80.8
Transportation	94.0	89.3	90.1	91.3
Utility Needs**	80.9	76.5	75.8	85.9

By ACO Participation

Social need Program/strategy	No ACO Participation (n=1173)	ACO Participation (n=1723)
Education	71.8	83.1
Employment/Income	65.3	74.4
Food Insecurity***	86.7	92.6
Health Behavior*	90.0	94.1
Housing**	70.8	81.3
Interpersonal Violence*	75.8	82.7
Social Isolation	72.9	82.2
Transportation	88.0	91.9
Utility Needs**	76.6	79.7

* Indicates statistical significance across categories at $p < 0.05$, ** at $p < 0.01$, and *** at $p < 0.001$. ns refers to non-significant; n/a refers to not applicable; values in the cells are in percentages

[a]Chi Square significance testing was conducted for all the comparisons within different categories of hospitals

±The availability of programs based on ACO participation sub-classified by hospital location added in the appendix table 1

Discussion

We examined concordance between screening for upstream drivers and having strategies or programs to address identified opportunities. CAHs showed lower rates (80.6 percent) of social needs screening compared to rural and urban PPS hospitals. These findings corroborate previous research that suggested rural hospitals and CAHs are engaging in fewer strategies to address social needs, likely due to limited financial resources, workforce shortages, and lower availability of community resources in rural settings.[8–10] Additionally, we found that the concordance between the percentage of hospitals screening for specific social needs and the presence of associated programs/strategies was significantly lower in CAHs, specifically for employment/income programs, utility needs, housing, and

interpersonal violence. We observed a similar trend in rural PPS hospitals, with an even lower percentage of concordance.

CAHs and rural PPS hospitals with non-federal government ownerships were less likely to screen for social needs compared to nonprofit hospitals. A previous study also suggested that rural hospitals and those with government ownership (specifically CAHs) may have fewer resources and receive lower governmental support compared to other hospitals.[11] Notably, compared to other hospital types, for-profit hospitals had highest screening percentages but showed the lowest availability of service programs to addressed identified needs.
Hospitals in the Northeast region of the United States showed higher percentages of screening social needs, and the South showed the lowest percentages, indicating regional variations that could reflect differences in state-level policy environments, hospital infrastructure and resources, or community social needs. Additionally, we observed significantly lower percentages of Midwest hospitals having concordance between hospitals screening for specific social needs and the presence of associated programs/strategies, specifically for food insecurity, utility needs, interpersonal violence, and health behavior programs, compared to Northeast, South, and West. These results resonate with a study that reported the lowest screening rates for food insecurity, housing instability, utility needs, transportation needs, and experience with interpersonal violence in Midwest physician practices and hospitals for 2017 to 2018.[10]

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Appendix

Table 1: Percentage of programs available based on ACO participation and hospital location

	Urban PPS (n= 1,795)		**Rural PPS** (n=446)		**CAH** (n=655)	
	No ACO	ACO	No ACO	ACO	No ACO	ACO
Education	46.9	63.6	44.3	57.4	45.8	47.0
Employment/Income	42.4	62.6	34.7	50.4	31.6	39.2
Food Insecurity	77.9	90.9	65.9	83.5	62.9	71.0
Health Behavior	81.0	89.0	81.8	87.0	73.8	82.3
Housing	64.3	78.0	47.2	65.2	44.0	54.8
Interpersonal Violence	69.2	77.4	56.3	75.2	42.2	54.1
Social Isolation	61.2	76.0	53.4	68.7	48.7	59.7
Transportation	81.4	89.8	71.6	83.5	66.2	71.7
Utility Needs	51.4	65.6	43.2	58.7	33.8	36.8