Social Care in the Pediatric Emergency Department

INTRODUCTION

Social care, the practice of raising awareness and delivering assistance around key social determinants of health (SDoH), has been embraced across medical specialties and regulatory bodies as critical to improving the health of populations. In both adult emergency departments and pediatric clinics, there has been growing literature documenting the impact of social care and laying out best practices. Social care in the pediatric emergency department (PED), while not as robustly developed, has the potential to bring needed interventions to an at-risk population who may not otherwise have ready access to social services via primary or hospital-based care. However, the PED can also present unique challenges for appropriate and sustainable screening, intervention, and follow-up processes that are distinct from the clinic or inpatient setting.

THE TOOLKIT

Given the paucity of PED-specific literature around social care, this toolkit was assembled by a national group of experts - a collaborative effort between adult and pediatric emergency medicine faculty and trainees, including fellows and residents, as well as social workers. The toolkit is intended to serve as a brief and easily accessible introduction to social care in the academic and community PED setting, a supplement to program directors' efforts to create a more effective learning climate, a reference to reinforce skill sets, and a guide to implementation of interventions with workflow integration. We review best practices of screening for social needs, offer quick access to useful resources, provide examples of successful programs across the country, and help facilitate education for trainees and faculty. We hope this is a useful starting point for those interested in learning more about this important component of pediatric emergency medicine, or those considering launching their own program.

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Social Needs Screening Tools

Section assembled by: Kristol Das, MD; Natalie Tedford, MD; Eric Fleegler, MD MPH

All social care starts with screening, and there are several existing screening tools for both pediatric and adult populations, although none are specific to pediatric emergency medicine (PEM). Consider the following best practices when choosing to screen.

Before you select a screening tool, consider these questions and best practices:

1. **To guide appropriate screening tool selection; assess your institution, department, and population served; and establish goals of social care screening.**
    - Why do you want to conduct social care screening?
        - *Ex: Centers for Medicare & Medicaid Services (CMS) updates or other billing/insurance-related reasons, integration of referral networks into the health system, internal health system screening reasons.*
    - What specific factors would you like to assess?
        - *Ex: Food insecurity, housing insecurity, homelessness, transportation, intimate partner violence, medical home or other access to care needs.*
    - Who do you want to screen?
        - *Ex: All patients, lower emergency severity index (ESI) triage levels, public insured or uninsured patients, based on child opportunity index (COI)/area deprivation index (ADI) of patient's reported address.*
    - How many patients will you target?
        - *Ex: Universal screening, % of total ED census, only when social work/care management is present if there is not 24/7 coverage.*
    - What are the literacy and language needs of the population?
        - *Ex: Language requirements of patient population being targeted with screening, ability to perform electronic screeners vs paper.*
    - What screening already exists within your institution?
        - *Ex: Is there a screener already in use? Is there a workflow with care management/social work? Is there a referral network?*
    - What will you do with the results? This relates back to why you want to conduct screening.
        - *Ex: CMS updates or other billing/insurance-related reasons, integration of referral networks into health system, internal health system screening reasons.*

2. **Can you integrate tool administration and responses into the electronic health record (EHR) and existing resource network?**
    - Patient-completed, computer-based tools have been shown to lead to more reporting of social needs, likely due to a more private modality that reduces

stigmatization around discussing one's social context. Balance this with the literacy level of your population; electronic screens may not be the ideal screening for low literacy groups.
        - *Audio-enhanced, computer-assisted self-interviewing (CASI) systems can read out loud questions and answers and overcome literacy issues in multiple languages.*
    - If EHR integration is not possible, regular audits of screen administration and follow-up by a designated individual are even more critical to maximizing information gathering and intervention.
    - In all forms of screening, patients/families should understand why health providers are conducting the screen and should provide consent to services.
    - Consider the time needed and any costs associated with screening implementation in order to ensure sustainability.
        - Costs include: Time (social worker, triage/intake, response review), training input, and referral organization costs.

3. **Do note that screening is a 'starting point' for a conversation on social risk and assistance. A need may still exist if the screen is negative. Conversely, a patient/family may not desire assistance after positively screening for social risk.**
    - Think of social risk at the *population health* level: underlying it are complex and historical social, economic, and political structures and policies that contribute to marginalization, unequal opportunity, and health disparity. In contrast, social need is at the *individual* level: it encompasses areas where a patient or family desires assistance.
    - Given the difference between risk and need as well as factors in the screening environment that may prevent a family from endorsing needs, available resources should be offered to all.[1] Screening tools can differentiate between social risk and need simply by asking if the patient/family desires help.

4. **Pilot the screening tool you select before scaling it to the whole emergency department (and healthcare organization). This will allow you to gather feedback from families and staff, adjust questions, and tailor the screening process to improve effectiveness.**
    - Key elements of the pilot will include gaining buy-in from all stakeholders (providers responsible for reacting and responding to screens, staff responsible for screen administration, social workers tasked with urgent referrals), identifying when and where screening will happen during the ED visit process, as well as what patients/families will be screened, including ESI level.
    - The Social Interventions Research & Evaluation Network (SIREN) guide linked below includes a step-by-step guide to conducting the pilot.

[1] Cullen D, Wilson-Hall L, McPeak K, Fein J. Pediatric Social Risk Screening: Leveraging Research to Ensure Equity. Acad Pediatr. 2022 Mar;22(2):190-192. doi: 10.1016/j.acap.2021.09.013. Epub 2021 Sep 24. PMID: 34571253; PMCID: PMC8479442.

What tool is best for my institution, or what published questions can I pull from to create the right tool for us? Here is a table examining potentially useful screeners and important PEM considerations.

For more in-depth information about the process of implementing a new social risk screening program, SIREN has a step-by-step guide targeted to social risk screening and referral-making in the clinic setting

The **Gravity Project** offers consensus-driven data standards to support the collection, use, and exchange of data to address SDOH.

For more information about SDOH and appropriate screening considerations specific to the pediatric setting, check out this guide from Texas Children's Hospital

How to identify & document local existing resources

Section assembled by: Mia Kanak, MD, MPH, Tajah Tubbs, MD, MPH, Brit Anderson MD, Dennis Hsieh MD

This section reviews, step-by-step, how to identify and document local existing resources when establishing a new social care program. It is crucial to have relevant and reliable referral resources when trying to link families with social needs.

Step 1: Identify local resource options

Start by asking known contacts about existing local resources or partnerships. Within your institution, contacts may include colleagues from departments such as General Pediatrics, Emergency Medicine, Social Work, Office of Community Affairs, or Government Relations. Outside your institution, consider contacting your local professional organizations such as the AAP (American Academy of Pediatrics), ACEP (American College of Emergency Physicians), or SAEM (Society for Academic Emergency Medicine) to gather information on local resources. You can also reach out to government organizations (e.g., Department of Health Services or the Department of Public Health) other healthcare organizations (e.g., community health centers), or even other community resources (e.g., local school system or parent information networks), as they may be able to provide valuable information and links to local resources.

Consider searching publicly accessible social care resource databases. Try exploring your local 2-1-1, which is available in all 50 states and provides access to databases of private and public resources. Another option is Findhelp, formerly known as Aunt Bertha, which is one of the largest free databases with over 500,000 organizations. In certain areas (California, Florida, New Mexico), consider using One Degree, which offers more specialized functions such as guided search and filters. These public accessible free social care resource databases differ from community resource referral platforms, such as United Us, Healthify, or NowPow, which require paid institutional accounts or logins. Further reading and a comparison of different platforms are available on SIREN.

Step 2: Contact resources to learn more

Once you curate a list of organizations of interest, we recommend contacting potential referral sites to gather more information regarding their services. Specifically, consider inquiring about the scope of services they provide, as well as clarifying the communities they serve by asking about any age, gender, insurance, or citizenship requirements for eligibility. Obtain operational details including languages offered, operating hours, and current capacity to take new referrals (e.g., are they currently accepting new clients, and if so, what is the typical wait time or intake process). If you

plan to maintain your own database of referrals, rather than use already curated systems like 211.org, then it is important to regularly update the resources (recommended annually) to ensure that patients are referred to operational organizations.

Step 3: Select a few "go to" resources

Narrow your list to select a few key resources to share with families. Consider referral sources that align with the social needs reflected in your own screening results: if many patients have food insecurity, select food resources; if many patients have multiple needs falling under an umbrella category like immigration, select larger agencies that offer full scope wrap-around assistance. Next, consider the proximity of the resource to the household, as choosing resources that are conveniently located can make it easier for families to access the support they need. Last but not least, factor in patient-specific characteristics such as language requirements, gender-specific services, and operating hours of the resources. This ensures that the selected resources are compatible with the unique characteristics and preferences of the families you are supporting.

Step 4: Share resources with families

Share a brief description of resources provided, language, hours, address, phone number, and/or a website, that the family can refer back to after the ED visit. See HelpSteps for examples. There are three main options to consider in how to share resource information. First, you can provide resources in paper format, such as a printed handout or including a dot phrase in the discharge paperwork. Secondly, you can share information via phone by sending text messages or by providing a QR code that links to a PDF document or website with the resources. Lastly, you can utilize online resources, such as an email list or a dedicated website, to make the information easily accessible to families.

Step 5: Get feedback from resource agencies

In addition to scheduling periodic check-in meetings with any agencies you are often referring families to, consider creating a formal data tracking system to share more information about referrals with the partnered agency. This can be as simple as a shared spreadsheet to track the number of ED referrals made to that agency in a month and a column for the agency to fill in how many people showed up with an ED referral. This allows the data to be de-identified and easily track numbers over time. If partners already use some sort of referral tracking system, ask them what they use and if the de-identified data can be given back to your hospital on a regular basis. Community Information Exchange (CIE) provides examples of equitable information sharing and coordinated care. Meet with community partners to troubleshoot unique issues (i.e., client retention) and to obtain feedback (i.e., sharing updated service information with families).

Step 6: Get feedback from families

When referrals are initially made, collect family contact information so that you can call and follow up on how the referral went (including if the service was accessible). These follow up calls can be made by a discharge coordinator or clerk, a social worker, a patient liaison or navigator, a research team member, or a volunteer. An alternative is to text families a survey a few (2-4) weeks after you have made the referral to gather data on the referred service, if it was accessed, any barriers to using the service, and feedback on the service's utility and adequacy. Direct feedback from families can also be collected using paper surveys or online using a QR code linked to a survey or another website. Direct feedback from families can be collected using paper surveys or online using a QR code or another link to a website. Additionally, consider flagging referrals made in patient charts so other providers can follow up on this with patients at their next visit.

Ready to get started?

Use this link to our quick guide, which references the steps above. You can post this up as a visual for your working group or use it as a premade checklist to keep your team on track as you identify and document existing resources in your community!

Integration of Social Care into Clinical Workflow: how do we make it work?

Section assembled by: Natalie Tedford, MD; Aakriti Bhargava, MD; Susan Duffy, MD

Norton Children's Hospital Emergency Department-
ED Food Pantry, expanding social care program

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What does the social care program in your emergency department look like? How did you integrate the process into the ED flow?

The social care program in our ED consists primarily of more traditional activities but has recently expanded. We have dedicated ED social work (with the exception of some late nights) which provide consultations for abuse and neglect concerns as well as our patient's immediate social needs (a ride home, referral for shelter, etc). ED providers are given education about local resources that families can be referred to and this information is available electronically on a platform created by our primary care colleagues and in a paper notebook. We opened a food pantry and compiled food specific resources for distribution with food. We try to offer a bag of groceries to all families in the fast track area of the ER, and have signs posted in every room about food availability. This has been both a

challenging and exciting process and the pantry served over 6,000 people in the first year of being open. Select safety equipment is available in our ED free of charge, including gun locks and bike helmets.

What do you like most about this model?

Our ED team has been incredibly receptive to the needs of our patients and expressed interest in supporting the families that come to the ED. An iterative approach has been a necessity as the ED is a busy place to work and staffing shortages have been a challenge. New programs have been well received by patients and providers in general. Our current system allows provider autonomy in using resources to help patients.

What has been challenging in this model?

In the chaotic ED environment, it is a significant challenge to identify and appropriately support families with social needs. Our current model relies heavily on staff and provider effort which is really difficult during the time constraints of an ED visit.

What local organizations did you work with, and how did you partner with them?

In setting up our food pantry program, we worked closely with the local food bank, the prevention and wellness department at our hospital, and the hospital foundation.

What advice would you offer to a department looking to launch a new social care program?

If an ED was interested in setting up a food pantry I would say “do it!” It has been an extremely rewarding experience for many involved. I would recommend establishing a multidisciplinary team.

Boston Children's Hospital - Starting Small

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What does social care in your emergency department look like?

We have social workers 24/7, so they can help with many issues. In a study conducted 4 years ago, we did extensive social needs screening in the ED (using the Center for Medicare & Medicaid Innovation Accountable Health Communities 10 question screener + additional questions) and used HelpSteps to make referrals for families. But today we have no specific screening protocol. In each ED room we have a big laminated poster (11x17") that has all sorts of social resources listed with many QR codes that families can use. While on the one hand, that is better than nothing, in truth I'm not sure how much better- it looks good, we care, but do families even really see it (they aren't oriented to it), and do they ever use it or find it useful? We don't know.

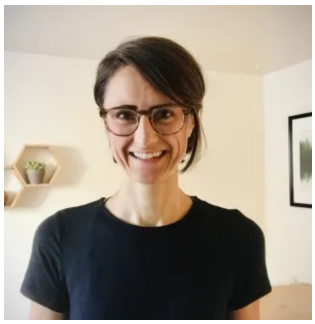
What local organizations did you work with, and how did you partner with them?

We use HelpSteps, which I developed and is now run by Mass2-1-1 to help connect families. We do have some small relations with food pantries that are local but nothing formal. Our hospital has opened a food pantry that is offsite near a community health center owned by Boston Children's Hospital.

What advice would you offer to a department looking to launch a new social care program?

Identify what you want to help with, develop not only a good questionnaire but really figure out how to administer it (paper, tablet, cell phone). Does the info need to go into the EMR or is it outside of this? Do you need to screen for a problem, or just offer help (i.e. Hunger Vital signs vs. ask directly if the family would you like help with SNAP, WIC, food pantry, etc).

University of Utah / Primary Children's Hospital - Understanding Patient Population & Utilizing Community Partnership



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What does social care in your emergency department look like?

We have social workers 24/7, so they can help with many issues though have less focus on connecting families to resources with the current burden of other responsibilities. Thus, as my fellowship project, I integrated social need screening in our ED utilizing our undergraduate research program. The research assistants have a structured workflow to approach English- and Spanish-speaking caregivers of patients <18 years old. Caregivers are provided a tablet to self-enroll and complete a social needs screening tool (p-SINCERE) with the option to request a community referral via United Way Utah 211 (UWU 211). Referral to UWU 211 occurred within 48 hours of PED discharge. The screening that takes place in our ED serves as the general intake with our community partners as well as part of a current National Institutes of Health (NIH) study to understand what enables and helps families to have needs addressed through this community resource referral. See "Intensifying Community Referrals for Health: The SINCERE Intervention to Address COVID-

19 Health Disparities" [#1R01NR019944-01 (PI –Andrea Schneider Wallace, Ph.D., RN, FAAN)].

How did you integrate the process into the ED flow, and (if relevant) into your larger hospital system?

We are currently in conversations with our hospital and health system regarding the integration. This process has been slow but essential to involve the various stakeholders and ensure that a more robust screening goal has the appropriate and sustainable referral mechanisms in place.

What do you like most about this model?

Our team from the research assistants to the information navigators at 211 have been incredibly receptive to the needs of our patients and expressed interest in supporting the families that come to the ED. The use of our undergraduate research program has enhanced social needs screening and referral practices during ED visits from 0% to 30% of total ED census. Although there are challenges and issues in depending on an undergraduate research program, this has helped initiate upstream efforts to address social determinants of health within our ED patient population. Our current process with research assistants and community partnerships demonstrate how this can aid in offloading hospital teams.

What has been challenging in this model?

The current model has times with semester breaks result in no or little screening efforts and thus community partner referrals. The ED is a busy place to work and staffing shortages have been a challenge as we try to plan for universal screening and wider implementation efforts.

What local organizations did you work with, and how did you partner with them?

We partner with United Way of Utah 211. Our collaboration was built on other research efforts. We connected with others in our university system early on as well as our healthcare system to establish the best means of support. Through these conversations, we subsequently were able to serve as a site on the NIH-funded project to continue screening and referrals while working with the hospital system to plan for sustainable efforts.

What advice would you offer to a department looking to launch a new social care program?

Nothing worthwhile is easy. Build connections with many and communicate visions and goals throughout these conversations. Ask questions and know that no one has it all figured out.

Communication Tips and Best Practices

Section assembled by: Jordan Blaine SW, Kristol Das, MD, Danielle Graff, MD MSc

Here we have summarized key communication points that are applicable to all clinical practice but extend to screening for SDOH. You will find links to additional resources as well as staff training tools under the Resources header at the end of this section. As noted in the Screening Tools section of this toolkit, a strengths-based approach to screening involves families in screener development and selection, acknowledges that screening can identify both social needs and problems; and that the ideal screening has established clear linkages to resources for identified needs.

Emphasize Empathy

- Empathy is key in conversations, no matter the duration or outcome. As Halpern describes in *From Detached Concern to Empathy:*
  "As long as practitioners continue to view empathy as an extra step, distinct from the core aspects of medical care, we see it as something we have no time for… Clinical empathy is not an additional task, but rather an adverb describing how healthcare practitioners might do many things that we are already doing." - Jodi Halpern
- Every person brings a unique perspective and lived experience to the screening process. Recognize that "[it] is not about seeing oneself as being in the same boat as one's patients, but about being genuinely interested in understanding each person's distinct problems."

Explain the what, why and how long

- Introduce yourself and your role, what you are screening for and how/if the screening process impacts management and evaluation of the family's chief complaint.
- Acknowledge that questions may be sensitive and explain why you might need to ask about them.

Ask for permission, establish family driven priorities

- Respect a family's wishes to decline screening.
- Use active and open listening.

- *Phrases like 'Tell me if I have this right…' establish that you are listening and interested in their input.*
- *'Which of these things feels like a priority for your child's and family's well being?'*
- *'Is this an area where you'd be interested in getting additional support?'*
- *'Even if you don't have time to talk about this today, I'd like to ask one of my teammates to give you a call in the next few days to follow-up. How does that sound?*

Body language

- Respect personal space.
- Use open body language - hands visible, arms not folded.
- Sit if possible and establish eye contact.

Additional Resources

- Brief video highlighting Empathic Inquiry for social determinants of health screening.
- Watch as Dr. Jodi Halpern, author of From Detached Concern to Empathy, summarizes some of the key concepts in a talk from 2014.
- Curriculum on simulation exercises and best practices on trauma informed care.

Further reading:

Boynton-Jarrett, R. & Flacks, J. (2018). Strengths-based Approaches to Screening Families for Health-Related Social Needs in the Healthcare Setting. Washington, DC.

Dowd, M. D., Kennedy, C., Knapp, J. F., & Stallbaumer-Rouyer, J. (2002). Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. Archives of Pediatrics & Adolescent Medicine, 156(8), 794-799.

Schwartz R, Dubey M, Blanch-Hartigan D, Sanders JJ, Hall JA. Physician empathy according to physicians: A multi-specialty qualitative analysis. Patient Educ Couns. 2021 Oct;104(10):2425-2431. doi: 10.1016/j.pec.2021.07.024. Epub 2021 Jul 15. PMID: 34330597.

Social Care Education: Recommendations on Curriculum Building for Faculty & Trainees

Section assembled by: Rammy Assaf, MD, MPH; Jerri A. Rose MD, FAAP

The 2021 National Social Care Practices Survey of PEM fellows and their Program Directors (PDs) demonstrated that while the majority highly valued social care training and delivery, few felt prepared to practice social care. Only 21% of fellows reported receiving SDOH education and 8% reported receiving training in social needs screening during fellowship. Improving the sustainable delivery of social care in the PED also includes enhancing awareness, education, and advocacy, and there are a growing number of resources to help you build a curriculum for your trainees and/or faculty group.

Accreditation Council for Graduate Medical Education (ACGME) Program Requirements

In its Educational Program requirements for PEM fellowships, the ACGME requires that curriculum for PEM fellowship must contain "a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates" (IV.A.1). In the area of Systems-based Practice, the ACGME requires that "Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care." (IV.B.1.f). As PEM fellows are uniquely positioned in healthcare leadership and child advocacy, effective social care training during fellowship begins with more clearly defining curricular objectives and methods.

- Revised American Board of Pediatrics (ABP) entrustable professional activity (EPA) entitled “Use Population Health Strategies and Quality Improvement Methods to Promote Health and Address Racism, Discrimination, and Other Contributors to Inequities Among Populations” (2022)

Building a curriculum

Include SDOH topics in regular didactic conferences and other educational experiences, directed to both trainees and faculty. Consider useful educational collaborations, such as with your institution’s social workers and diversity, equity, and inclusion (DEI) officer. Some of the content of didactic material may be uniquely geared towards the sociocultural

context of your local patient population, but should be standardized and *integrated longitudinally* in trainee educational activities and existing conference schedule. Define learning objectives of the social emergency medicine curriculum. The sections below feature examples of curricular components from specific institutions, along with implementation guides.

- Specific sessions or format suggestions:
    - Incorporate routine discussion and analysis of health and racial inequities in morbidity and mortality reports, and grand rounds:
        - Framework for building an M&M conference format that incorporates principles of health equity
    - Implement health equity journal clubs
    - Invite an anti-racism facilitator/educator to a didactic session on racism in emergency medicine and trauma-informed-care:
        - The D-E-F framework (distress, emotional support, family) for traumatic stress in ill and injured children
    - Incorporate health disparity-focused simulation exercises
    - Consider running a poverty simulation. Access a poverty simulation kit through the Missouri Community Action Network.
    - **Community Engagement Partnerships:** Organize an in-person or virtual tour with representatives from community organizations in order to build partnerships and practical experience in referral network operations and procurement of needed resources. Designate time - during an elective or longitudinally - for trainees to shadow ED social workers, community health workers, and/or local medical-legal partnership. These activities target trainee comfort and knowledge of social determinants of health and community resources. Examples of other activities:
        - Medical liaison with shelter outreach
        - Create an in-house food pantry program
        - Design educational interventions around specific social determinants of health (Table 1)
- General resources:
    - The AAMC MedEdPortal has a growing library of content focused on educating around social care topics, including specific collections focused on Diversity, Equity and Inclusion, and Anti-racism. Many of these can be easily adapted to the appropriate training level of your learners.
    - Utilize virtual asynchronous learning with modules, podcasts, and video vignettes:

- The National Health Equity Grand Rounds
- American Medical Association Center for Health Equity Modules
- Academic Pediatric Association Child Poverty Modules
- Social Interventions Research and Evaluations Network Educational Podcast Series
- SDoH-based social history taking vignettes