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When There Is Value in Asking: An Argument for Social Risk Screening in Clinical Practice

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Assessing patients' social context is increasingly considered an essential step on the road toward health equity. Yet, health care clinicians have not wholly embraced social-screening practices (1). Clinicians cite several reasons for their reluctance to collect social needs information, chief among which is the inability to “cure” social adversity (2). Garg and colleagues argue that screening for social risks without a solution for the many consequences of poverty and structural racism can result in unintended harms for patient trust and clinician empowerment (3). This framing undermines the benefits of social screening, which are distinct from the screen and referral pathway.

We describe 4 benefits of social-screening initiatives supported by recent research, unrelated to the resolution of social adversity. Together, they might help clinicians think differently about the promise of social-screening initiatives in health care settings. We conclude by highlighting why these potential benefits may go unrealized even in settings where screening is undertaken and recommend ways to increase the likelihood that social screening contributes to improvements in patient, provider, and population health.

Tailoring Care

High-quality medical care should be grounded in high-quality effectiveness evidence. Health professionals appreciate that high-quality care is tailored to individual patients: it is not just what works, but what works and for whom. Precision medicine began as a field to understand how our genetic code predicts risks and informs treatments and, more recently, has been adopted to inform ways in which we tailor care to social context too. Examples of tailoring based on social context abound in clinical practice, including instances where clinicians prescribe alternative medications based on pharmacy copays or cluster medical

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appointments on a single day for patients without transportation. These practices have also been called whole-person care, shared decision making, and biopsychosocial-informed care. In all iterations, clinicians recognize that patients' social contexts provide treatment-relevant data beyond the basic "social history" of medical training. Socially tailored care is a "readily available treatment" that can improve the uptake—and therefore effectiveness—of other medical interventions.

Strengthening Patient–Provider Relationships

Still setting aside the idea of "curing poverty," it might be persuasive enough that incorporating social data into care decisions impacts medical decision making, which, in turn, influences care quality and outcomes. But there are additional arguments to support social screening in health care settings. Confining the value of social data to informing referrals and decision making undervalues how discussions about social context themselves might affect patient–provider relationships in the absence of other interventions. In qualitative research, patients have reported that they do not expect clinical teams to help them resolve social barriers but instead want their clinicians to understand their life experiences (4). Patients' perceptions of equity-oriented care—including care that is trauma-, culture-, and context-informed—are associated with comfort and confidence in care, which, in turn, is associated with improved self-efficacy to manage health problems (5). In a trial of social service patient navigation, improvements in health occurred regardless of whether social risks were addressed. Subsequent qualitative work found that patients not only felt emotionally supported by these conversations but they also learned about new services. Including social context in clinical conversations helped to validate patients' lived experiences and thereby strengthened patient–provider relationships.

Destigmatizing Social Services

Incorporating social screening routinely into clinical conversations may help to destigmatize both discussing social needs and seeking social services. When discussions about social context are the default, patients are less likely to feel singled out. Routine social risk conversations may normalize the experience of social screening and provide opportunities to frame social needs as related to health, thereby potentially destigmatizing the receipt of social services (6). In contrast, current efforts to address patients' social needs commonly involve referrals to religious or community-based organizations that provide social services where perceptions of both "deservingness" and "charity" are barriers for receipt of social services. Although evidence suggests that patients do not universally expect clinicians to resolve their social barriers (4), normalizing the health relevance of social adversity may instead improve both micro social services referral efforts and macro public health investments.

Increasing Social Investment

Conceptually, discussing social needs as foundational to health also serves as an opportunity to shift the national dialogue about social adversity away from perceptions of individual-level failure, which can perpetuate individuals' feelings of shame and stigma, and toward

universal principles of public health (7). This public health approach views health-promoting social circumstances as fundamental building blocks of good health. If the data from clinical conversations are aggregated and disseminated, routinely including conversations about social context in clinical interactions can surface the pervasiveness of unmet social needs and elevate our communal understanding of the real societal costs of continuing to ignore social context (8). Social needs conversations will have the added benefit of drawing attention to the widespread and complex intersections of social and health conditions; ideally, these data would help to move the responsibility for addressing needs away from individual clinicians or health systems and toward broader social investments (9).

Current Screening Practices and Improvement Strategies

Of course clinicians feel a responsibility to do something about their patients' housing instability or food insecurity (2). Screening for social needs *is* doing something. We acknowledge concerns about adding more checkboxes to already brief clinical encounters. To minimize clinician burden, screening often is separated from clinician encounters. Non-clinician-dependent approaches, for example, tablet-based previsit questionnaires, have emerged as efficient screening models. These approaches increase feasibility, may increase social service referrals, and perhaps drive community investment initiatives. However, these efficient approaches can mean that clinicians are left out of the loop and fail to incorporate social data into clinical conversations, inadvertently reducing the benefits of social screening. Providers do not need to collect social needs data but, to achieve benefits of screening beyond referrals, they should be on the hook for meaningfully incorporating social context into patient-centered care. This requires more attention to empathic inquiry and conversations about the constraints of lived experiences on choices and opportunities (10). High-quality social care is not solely about social services referrals. Armed with awareness of the range of possible benefits, we can do better.

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