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Perspectives on standardized screening for social needs in primary care: a qualitative study

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Abstract

Aim: This study aimed to explore patient perspectives on standardized screening for social needs within the context of primary care in Canada. *Background:* Social determinants of health significantly influence patient health outcomes. While standardized screening for patient social needs has gained momentum, patient perspectives on the utility of said screening, particularly within the Canadian context, remains underexplored. *Methods:* Semi-structured interviews were conducted with participants aged 18 and older (n = 195), recruited from a larger multi-site study, using purposive maximum-variation sampling across four Canadian provinces (Ontario, Manitoba, Saskatchewan, and Newfoundland and Labrador). Questions asked during the interviews focused on financial well-being (ability to afford basic needs), housing status, social well-being, transportation, ability to afford utilities, and employment status. These interviews followed another study component where participants were asked to complete a short social needs questionnaire (the SPARK tool). Data was analysed using a thematic content analysis. Five themes were generated, including (1) openness to screening for social needs, (2) value in healthcare providers knowing patients' social needs, (3) overall scepticism and trust/distrust in the healthcare system and professionals; (4) potential for harm; (5) meaningful engagement and provider training on social needs. *Findings:* Participants were generally comfortable being asked about their social needs but stressed the importance of privacy, especially regarding financial well-being (ability to afford basic needs and extended health-care related expenses), as well as clear usefulness of the data and building physician-patient trust. Participants were generally open to social needs screening, though discomfort emerged when discussing race, employment, housing, and financial well-being, largely driven by concerns about privacy, trust, and data use. These findings highlight the importance of transparent communication, robust data governance, and explicit informed consent to support acceptable and effective implementation of social needs data collection.

Introduction

Social determinants of health (SDOH) are the social, political, and economic conditions in which people are born, grow, work, live, and age spanning macro to individual levels that impact health and well-being (Commission on Social Determinants of Health, 2008). Examples include employment, financial well-being (i.e., ability to afford basic needs), social well-being, and housing. These conditions influence access to resources and opportunities, contributing to unequal patterns and health inequities across populations.

Healthcare settings often lack social needs data at the individual patient level (Andermann, 2011). Many medical organizations, including the College of Family Physicians of Canada (2015), recommend social needs screening to better understand patient context, enhance care delivery, improve health outcomes, and reduce inequities. This has led to increased use of SDOH screening tools in primary care not only across Canada, but internationally in the United States

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and the UK (British Medical Association, 2011; Rane *et al.*, 2025). Although, administrative burden and limited resources are barriers that persist (Byhoff *et al.*, 2019; Chang *et al.*, 2022; Collins *et al.*, 2014; Davis *et al.*, 2025; Waldren and Billings, 2023).

Alongside these challenges, there is growing recognition that the effectiveness of social needs screening should be informed by patient perspectives (Davis *et al.*, 2023). Most research has focused on clinician perspectives (Byhoff *et al.*, 2019; Waldren and Billings, 2023) and while some studies have examined patients' willingness to discuss social needs (Bender *et al.*, 2025; Collins et al., 2014), less is known about patient preferences and experiences related to collecting and using this information in clinical settings (Herrera *et al.*, 2019; Lofters *et al.*, 2011; Rudisill *et al.*, 2023; Spain *et al.*, 2021; Wilkerson *et al.*, 2023).

Given the personal nature of social needs data and the role of trust and communication in disclosure (Adekoya *et al.*, 2023; Spain *et al.*, 2021), centring patient perspectives is essential when developing social needs data collection processes, particularly among diverse populations. The objective of this study was to understand patient perspectives on social needs screening in primary care.

Methods

This qualitative study was part of a larger mixed-methods study aimed at developing and implementing an existing tool to capture demographic and social needs data (the SPARK Tool) (Adekoya *et al.*, 2023; Davis *et al.*, 2025).

Study design

In-depth interviews were conducted to explore how participants perceived social needs screening in primary care. We utilized a maximum variation sampling approach to include diversity in ages, racial and ethnic backgrounds, geographic settings, languages, and gender identities (Adekoya *et al.*, 2023). One-on-one semi-structured interviews via videoconference software occurred across four Canadian provinces, Ontario (1), Newfoundland and Labrador (5), Saskatchewan (3), and Manitoba (4).

Adults aged >18 were recruited for the larger study from August to December 2021 via community outreach methods such as study advertisements (Appendix 1) in waiting rooms of health and community centres, Facebook, Twitter, and Kijiji, and community collaborator distribution lists (Adekoya *et al.*, 2023). The advertisements were available in English, French, and translated to the three most common languages spoken in the study's participating provinces per the Canadian census (Arabic, Farsi, Punjabi, simplified Chinese, and Tagalog) (Statistics Canada, 2017, 2021).

Data collection

All interviews were conducted by female research staff (AD-P, DH, LK, IA, AZS) with training or prior experience in qualitative interviewing. The research team included individuals from diverse professional backgrounds, consisting of research coordinators, assistants, analysts, and the professional backgrounds and credentials of all involved community partners, PhD, MD, and master's degree researchers. The study was informed through regular consultation with a national advisory group composed of patient partners, scientists, and collaborators.

Data collection occurred between April 2021 and January 2022. Interviews lasted approximately 60–90 minutes and followed a semi-structured interview guide of fourteen questions focused on social needs data collection and data privacy (Appendix 2). The guide was iteratively refined through research team meetings (Graneheim and Lundman, 2004), and participant feedback. Interview topics included financial well-being, housing, social support, transportation, utilities, and employment.

All interviews were audio-recorded and transcribed verbatim. Interviewers received training to identify issues in question wording, redundancy, and interview length. Written informed consent was obtained for in-person interviews and verbal consent for remote interviews. No prior relationships existed between interviewers and participants. Interviews were conducted in English, and data collection continued until thematic saturation was reached.

Data analysis

A qualitative descriptive approach guided a thematic content analysis (Sandelowski, 2000). Interviews were audio recorded, transcribed by To The Letter Transcription and de-identified. The interviewers and analysis team (VHD, JRQ, IAM, DH, AZS, LK, AD-P, ADP), led by VHD and JQR, collaboratively developed the codebook. ADP and IAM created the initial outline after reviewing two transcripts, refined through team discussion, and used to inform the preliminary codebook. Reflexive journaling and memos were written for each participant to document early findings. The team then used the outline to review 10 additional transcripts and iteratively edited the codebook. VHD and JRQ made final updates based on review of two additional transcripts before sharing the final version with the study team. VHD and JRQ independently coded the remaining interviews, randomly divided by province.

Transcripts were coded using a combined inductive and deductive approach. For the inductive approach, segments of text (meaning units) conveying distinct ideas relevant to the study aim (Graneheim and Lundman, 2004; Lindgren *et al.*, 2020) were identified, coded, and organized into themes. For the deductive approach, predefined codes based on the research and interview questions were applied. Themes were finalized through team consensus that they adequately addressed the research questions and aligned with the dataset. Data were analysed using NVivo 12 software. All analytic decisions were documented to support transparency and consistency.

Ethical considerations

Research ethics approval was obtained from Unity Health Toronto (#20-241), the University of Manitoba Health Board (#HS24204), the Newfoundland and Labrador Health Research Ethics Board (#2020.259), and the Saskatchewan Behavioural Research Ethics Board (#2373).

Results

One hundred ninety-five participants were interviewed across the four study provinces. Participant characteristics are described in Table 1.

The following sections present the five themes and their respective findings generated from participant interviews, with corresponding quotes noted in brackets and available in Tables 2–6.

Theme 1: Openness to being screened for social needs

Openness to social needs screening was common among participants but contingent on clarity for and trust in their physicians to clarify their concerns and ease any discomfort.

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Table 1. Demographic characteristics table (n = 195, source Adekoya *et al.* (2023).

Characteristics	No. of participants, n (%)[a]
Province of residence	
• Ontario	125 (64)
• Saskatchewan	25 (13)
• Manitoba	24 (12)
• Newfoundland and Labrador	21 (11)
Race and ethnicity	
• Asian	71 (36)
• Black	17 (9)
• Indigenous	8 (4)
• White	47 (24)
• Other	10 (5)
• Multiracial	16 (8)
• Data not collected (Manitoba) or no response[b]	26 (12)
Gender	
• Man	58 (30)
• Woman	126 (65)
• Transgender, gender fluid, or nonbinary	9 (5)
• No response	≤5
Sex at birth	
• Male	58 (30)
• Female	133 (68)
• Intersex	≤5
• No response	≤5
One or more unmet social needs[c]	
• Yes	75 (38)
• No	120 (62)
Difficulty making ends meet	
• Yes	43 (22)
• No	151 (77)
• No response	≤5
Highest level of education attainment	
• Less than a high school diploma	≤5
• High school diploma or some postsecondary education	48 (25)
• Trades certificate or diploma	14 (7)
• College or university degree	94 (48)
• Postgraduate degree	34 (17)
• No response	≤5

[a]Percentage values are not provided for values that are ≤5.
[b]Race and ethnicity data were not collected in Manitoba.
[c]Unmet social needs were based on the following categories: precarious employment (presence of all of the following: short term, casual, or temporary employment; fear of being fired if raised employment concerns; and varying pay); living in social housing; missed rent or utility bill payments; missed appointment due to transportation cost; avoided filling prescription or made it last longer due to cost; difficulty making ends meet; and lack of social support.

Some participants reported discomfort when revisiting past hardships. Reflecting on these experiences, one participant shared that it was unpleasant to recall times when they had to stretch their medications or miss appointments due to financial constraints (Participant 4_96), highlighting the emotional difficulty of discussing experiences tied to vulnerability.

Most participants described feeling comfortable when responding to questions about social needs. Participants perceived that questions about their social needs were asked with their best interest in mind and viewed them as useful for helping providers tailor treatment plans to their circumstances (Participant 5_12).

Others described feeling comfortable discussing their social needs in the moment but later reflecting on how these disclosures might shape their providers' perceptions of them (Participant: 1_41).

Participants expressed the importance of understanding why they are being asked to provide information about their social needs. For many, openness to sharing personal information depended on having this clarity, as it influenced their comfort and the level of detail they were willing to disclose (Participant: 1_89).

Participants noted that transparency in collecting, using and maintaining privacy and security of the data were important. Some suggested that their healthcare practitioners obtain their informed consent to collect the data (Participant: 1_106).

Theme 2: Value of healthcare providers knowing patient's social needs

Participants generally recognized that providing information about their social needs or personal characteristics could help healthcare providers deliver more tailored and appropriate care. However, there was uncertainty about how their disclosures might be used. They noted that understanding patients' social circumstances (housing, employment, and racial and cultural background) could guide clinical decision-making, highlight potential health risks, and support more holistic care.

While participants valued this knowledge, they also emphasized that the benefits depended on the information being used appropriately and discussed meaningfully within the clinical encounter. One participant explained how sharing their race could inform preventive care and risk assessment (Participant: 1_72).

As some participants appreciated that social needs information could help providers tailor care, one other participant raised concerns about potential inequities in how the information might be used (Participant: 1_27).

Some participants also noted that social needs data could help providers identify when additional time or attention was needed during appointments, underscoring how such information might inform patient-centred care planning (Participant: 1_68).

Together, these perspectives highlight that while participants recognized the value of providers having insight into their social needs, they also emphasized the importance of using this information equitably, transparently, and to meaningfully improve care experiences.

Theme 3: Overall scepticism and trust/distrust in the healthcare system and professionals

Participants' discussions revealed underlying scepticism about the healthcare system's capacity to use social needs data responsibly. Some highlighted that their willingness to share social needs information depended not only on trust in their primary care provider but also on understanding who would have access to the data.

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Table 2. Selected quotes for analysis: openness to being screened for social needs

Participant #	Quote
Participant: 5_12	*"When my health provider realizes that I don't have stable housing as an example, well, they may want to, you know, go a different path for me with the medical plan, the care plan, so I understand the value of collecting it."*
Participant: 4_96	*"It wasn't so nice to have to think of times when I've had to stretch medication. It wasn't exactly the best of times [Pause] so that wasn't so nice. [Laugh] But [Pause] other than that it was [Pause] yeah . . . in the past 12 months yeah, I avoided attending appointments cause of money. That was brutal."*
Participant: 1_41	*"I didn't think of it as strange for them to ask but [Pause] yeah, thinking back now it is a little bit strange like I wonder again like how would I be treated"*
Participant: 1_89	*"Participant: I just wondering why they need this information . . . The housing part also my housing condition is a little bit weird . . . this employment things . . . I don't know how doctors or healthcare workers use this information so I don't know how much detailed information they need too.* *Interviewer: So, you would really like if they could clarify what they're using it for?* *Participant: Because it depends on the purpose. My answer would be a little bit different. If it's important for the medical service [that is provided, from that] perspective then definitely I have to mention some specific condition about myself, but if it's statistics and just vaguely or widely then I don't have to."*
Participant: 1_106	*"I'd like to know who they would share it with. That's the first thing I would want to know. I'd like to know what sort of security, any databases they have, they use, would have and why they need it. How would that impact my life? Like what is it, why is it important that they need this information as opposed to just automatically giving it over like you know how when you normally sign up for almost anything there's a huge, long page of stuff. And you never read the 20 pages of fine print. I don't want that happening with health information. I don't want it to be where someone has 40 pages of print and then you say I agree and they could have all your health information. No, no, no, no. That has to be done more specifically."*

Table 3. Selected quotes for analysis: value of healthcare providers knowing patient's social needs

Participant #	Quote
Participant: 1_72	*"I was born in China . . . Southeast Asia in general like a ton of people have diabetes on a per capita basis just cause of their diet. It's like a lot of fried foods and things like that so if I, for example, if I were to check Southeast Asian or something then my doctor might be like oh, this person is probably at an increased risk of diabetes like so, yeah . . . I personally think its good"*
Participant: 1_27	*"It makes me feel a little worried. To be honest, it means that, you know, as minorities they know or whoever is you know designing this tool or the research going into it, they know that there is a little bit of you know segregation when it comes to race and the treatment that we might be getting"*
Participant: 1_68	*"I hope that it's used appropriately to [Pause] sort of say okay, 'you know what we need to spend a lot more time in this appointment with this person' and sadly I feel like that just doesn't happen; right, you get a quick ten-minute appointment and that's it."*

Table 4. Selected quotes for analysis: overall scepticism and trust/distrust in the healthcare system and professionals

Participant #	Quote
Participant: 1_123	*"Personally, from my regular healthcare providers I don't think there would be a change. I've known them for some time. There may be a change if I had to go into a hospital for something but I also know that doctors are so overwhelmed and have so much to look at on charts and things like that I do have to question if they would take the time to read through the SPARK tool, and how many of them would find it useful or not."*
Participant: 3_9	*"I just don't trust those companies so like insurance companies and stuff like that maybe family services. I don't, I'm not sure exactly what they do but they might be able to like help some people but the other ones I don't trust, I don't trust insurance companies or law enforcement so I wouldn't want them to have all of my information."*
Participant: 1_49	*"I'd be comfortable sharing it with like my family doctor just because I have . . . the most communication with them. I guess it'd be good to, not good but at least it would be in someone's hands that I speak to more often and trust. That would probably be the only real place like I wouldn't really want it anywhere else."*
Participant: 1_30	*"If you can get the buy-in from healthcare providers and different groups speaking . . . it'll take some time to build it up . . . talking about why it's important that this information is being collected, getting peoples' thoughts and maybe their fears and concerns. So it's kind of like you know with the vaccination; like people are scared and hesitant and then they switch, it doesn't have to be mandatory, but they can be asked again at a later point if they're willing to share this information. Be accountable and sharing back with people, this is what we learned. Maybe there's some small briefs that are shared back out to the community to show that like we're not just collecting this just for the sake of collecting information"*

A small number of participants were doubtful that social needs data can be successfully integrated into the delivery of healthcare services due to providers' time and resource limitations (Participant: 1_123).

Some participants' distrust extended beyond primary care, encompassing related institutions, such as insurance companies and social services, that they viewed as interconnected in how social needs data might be used or shared (Participant: 3_9).

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Table 5. Selected quotes for analysis: potential for harm

Participant #	Quote
Participant: 3_5	*"I definitely don't think it should negatively impact the care you know? I definitely don't think that they should be judgmental like let's say there's a financial barrier. I hope that they would not look down on the person or just to maybe kind of like have a tone about them that is condescending cause I truly believe that some people, some human beings are like that and just because somebody's in healthcare doesn't mean that they're not like that, I think that that would be a concern."*
Participant: 1_27	*"For example, if there's someone that's an extremist and Caucasian, they get a South Asian patient like I in colour I am not that dark. They might not be able to tell that by looking at me if it's not on my record but if they see it on my record and they have these you know preconceived notions on you know this is how this type of person is or their community is then yeah, then I feel that the quality of treatment I might get might be you know not as good."*

Table 6. Selected quotes for analysis: meaningful engagement and provider training on social needs

Participant #	Quote
Participant: 4_5	*"Sometimes you hear about where the doctor talked down to the patient sort of in a blaming way. You know I guess in a rushed world putting the blame on the patient whereas if you saw all these other factors, you might, you know have a little more [Pause] compassion for them."*
Participant: 5_3	*"Otherwise it sounds like . . . I'm being mined for more data . . . I'm sick of that. I want the data; I want to see how it's going to actually transform or change the way health providers are addressing . . . these things."*

Participants expressed that this access should be kept to one professional, primarily the patient's family doctor, and the data should not be accessed by other professionals who are not involved in the patient's care (Participant: 1_49).

Some participants suggested that transparent communication about the purpose of data collection, addressing patients' concerns, and providing feedback could help foster trust and encourage sharing, particularly in settings where patients do not have long-standing relationships with the care team (Participant: 1_30).

Theme 4: Potential for harm

Across study participants was the concern that there is potential for harm among those experiencing social disadvantages (i.e., financial difficulties at home). For example, patients may experience perceived judgement related to their income level (Participant: 3_5).

Some participants expressed concern that providing personal information such as race, gender, or financial well-being (ability to afford basic needs and extended health-care related expenses) could expose a patient to bias or differential treatment from healthcare providers (Participant: 1_27).

Theme 5: Meaningful engagement and provider training on social needs

Participants communicated that providing their social needs information alone is not enough to ensure positive change in healthcare delivery and health outcomes. They emphasized that healthcare providers needed the skills and understanding to respond appropriately and engage with social needs in compassionate, non-judgmental conversations (Participant: 4_5).

Several participants also expressed that social needs conversations should feel meaningful rather than purely data driven. More importantly, as one participant (5_3) noted, they wanted assurance that the information they provide would be acted upon. Specifically, that it would lead to tangible support addressing their social needs.

They wanted to understand how sharing information would influence their care, and that it will guide their healthcare providers' responses to addressing their patient's social needs.

Discussion

This study assessed patient perspectives of social needs data collection in primary care settings. Our findings identified that participants are generally comfortable answering questions about their social needs, although there were concerns and occasional discomfort around sharing some types of information. Racial or cultural background, employment, housing, or financial strain were the most common sensitive touch points. To address these concerns, participants emphasized appropriate data management guidelines, transparency, privacy, and trust as essential for advancing equity-focused data collection in primary care. This is consistent with other research in this area, which also recommends additional qualitative research to better understand these issues, improved patient education, and collecting data through family physicians' offices (Lofters *et al.*, 2011; The College of Family Physicians of Canada, 2015).

Participants perceived social needs data to be largely helpful, with disclosure seen as vital to holistic patient care. Many participants also echoed prior findings on patients' preference for sharing sensitive information with trusted providers (family physicians or certified social or community workers) (Pfeiffer *et al.*, 2022; Spain *et al.*, 2021; Waldren and Billings, 2023; Wilkerson *et al.*, 2023). At the same time, participants acknowledged possible harms that could occur by sharing sensitive SDoH, highlighting the need to clarify why social needs screening is important to patients (Bender *et al.*, 2025; Lofters *et al.*, 2011; Pfeiffer *et al.*, 2022; Rudisill *et al.*, 2023). Moreover, participants indicated wanting their physicians to directly address their social needs if they are going to collect this information. This aligns with previous research suggesting that while patients may agree with the idea of collecting social needs data, their willingness to disclose depends heavily on trust in individual providers and in the broader healthcare system (Spain *et al.*, 2021; O'Loughlin *et al.*, 2022; Pfeiffer *et al.*, 2022; Wilkerson *et al.*, 2023). Patients often prefer to share personal information with familiar and trusted providers, such as family physicians or community-based professionals (Spain *et al.*, 2021; O'Loughlin *et al.*, 2022; Pfeiffer *et al.*, 2022; Wilkerson *et al.*, 2023).

Efforts to screen for social needs data in healthcare settings are increasingly common (Davis *et al.*, 2023). These efforts can

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improve care and inform policy only with thoughtful integration of patient perspectives (Davis *et al.*, 2023; Hosseinpoor *et al.*, 2015; Kirst *et al.*, 2017; Pinto *et al.*, 2016). When patients are asked to share social needs information, some bring the weight of past experiences, particularly those from racialized communities who have endured discrimination within healthcare and other institutions of authority, such as law enforcement (Williams *et al.*, 2022). These histories shape perceptions of risk, privacy, and trust Comas-Díaz *et al.*, 2019). Without addressing these unmet needs and the legacies of systemic inequity, social needs screening may unintentionally reinforce distrust (Sue *et al.*, 2007; Williams, 2020).

Practice implications

These issues were mirrored in our participants' own accounts. Throughout our interviews, scepticism about social needs screening and distrust of healthcare institutions was more common among participants from socially disadvantaged groups. Participants highlighted that simply collecting social needs information is insufficient. It requires healthcare professionals to be trained on how to ask specific questions and respond appropriately. These findings underscore the importance of combining provider training with meaningful action to ensure that the information collected leads to positive changes in care (Byhoff *et al.*, 2019; Collins *et al.*, 2014; Pfeiffer *et al.*, 2022; Wilkerson *et al.*, 2023).

Policy implications

Our findings show that health systems implementing social needs screening should prioritize (1) robust data governance frameworks that clearly communicate to patients how their information will be stored, accessed, and acted upon. (2) Transparency about data utility, specifically how patients' social needs data will lead to changes in their care, is essential for sustaining patient willingness to disclose. Policymakers should consider embedding explicitly informed consent processes into screening workflows, ensuring patients retain their agency over their data. Together, these measures would help ensure that social needs data screening fulfills its intended purpose of advancing health equity, rather than becoming an administrative exercise that erodes the patient – provider relationship.

While this study was conducted in Canada, the findings carry relevance for primary care systems internationally. Social needs screening initiatives have expanded considerably in the United Kingdom, where social prescribing has been integrated into their National Health Service primary care system (British Medical Association, 2011; National Health Service, 2019), and in the United States, where policies increasingly encourage SDOH screening (Rane *et al.*, 2025; Rj *et al.*, 2023).Despite different healthcare structures, common themes emerge across Canadian and international contexts: patient trust, privacy concerns, and the expectation that social needs data collection leads into meaningful action in patient care, particularly among those from racialized and socially disadvantaged communities.

Strengths and weaknesses

This study's strengths include robust qualitative methodological approaches with large, demographically varied sample of one hundred and ninety-five participants across four Canadian provinces, which significantly enhanced the generalizability of the findings. However, the study also has some limitations. We may have preferentially recruited people who may have existing levels of trust in the healthcare system, potentially biasing who and how participants responded to questions. We mitigated this potential bias with our approach to recruitment participants outside of healthcare settings. Another limitation is that our findings are from English-speaking participants only, potentially excluding unique perspectives of non-English speakers, or those who participant in English but were not native speakers and perhaps unable to accurately express themselves despite indicating themselves that no translation services would be needed. The findings may not fully represent all of Canada due to the fact there were seven provinces and territories not included in the sample. Lastly, the interviews were conducted remotely via video, which, while practical, prevented the nuances often gained from in-person interactions.

Conclusion

Collecting social needs data is crucial, but effective implementation depends on addressing patient perspectives and concerns. Participants expressed being generally open to social needs screening but had concerns and occasional discomfort when asked about their racial or cultural background, employment, housing situation, and financial well-being. Our participants consistently raised questions relating to privacy, the patient – provider relationship, access, and security. This underscores the need for transparent communication, robust data governance, and explicit informed consent to build trust. Overall, patients expressed an expectation for social needs data to translate into actionable interventions to address social needs. Future research should focus on patient-informed implementation strategies for social needs screening in primary care, including strengthening data security to build trust and supporting clinicians and administrators in integrating patient perspectives into care planning.

Data availability statement. The data underlying this study are available upon reasonable request from the corresponding author, ADP.

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References

Adekoya I, Delahunty-Pike A, Howse D, Kosowan L, Seshie Z, Abaga E, Cooney J, Robinson M, Senior D, Zsager A, Aubrey-Bassler K, Irwin M, Jackson L, Katz A, Marshall E, Muhajarine N, Neudorf C and Pinto AD (2023) Screening for poverty and related social determinants to improve knowledge of and links to resources (SPARK): Development and cognitive testing of a tool for primary care. *BMC Primary Care* **24**(1), 247. https://doi.org/10.1186/s12875-023-02173-8

Andermann A (2011) Addressing the social causes of poor health is integral to practising good medicine. *CMAJ : Canadian Medical Association Journal* **183**(18), 2196. https://doi.org/10.1503/cmaj.111096

Bender JL, Tong E, An E, Liu ZA, Shapiro GK, Avery J, Chu A, Schulz-Quach C, Hales S, Maybee A, Sayani A, Pinto A and Lofters A (2025) Collecting data on the social determinants of health to advance health equity in cancer care in Canada: Patient and community perspectives. *Current Oncology* **32**(7), 406. https://doi.org/10.3390/curroncol32070406

British Medical Association (2011) *Social Determinants of Health What Doctors Can Do*. Available at https://www.paho.org/en/documents/social-determinants-health-what-doctors-can-do (accessed: November 10, 2025).

Byhoff E, De Marchis EH, Hessler D, Fichtenberg C, Adler N, Cohen AJ, Doran KM, Ettinger de Cuba S, Fleegler EW, Gavin N, Huebschmann AG, Lindau ST, Tung EL, Raven M, Jepson S, Johnson W, Olson AL, Sandel M, Sheward RS and Gottlieb LM (2019) Part II: A qualitative study of social risk screening acceptability in patients and caregivers. *American Journal of Preventive Medicine* **57**(6 Suppl 1), S38–S46. https://doi.org/10.1016/j.amepre.2019.07.016

Chang C, Ceci C, Uberoi M, Waselewski M and Chang T (2022) Youth perspectives on their medical team's role in screening for and addressing social determinants of health. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine* **70**(6), 928–933. https://doi.org/10.1016/j.jadohealth.2021.12.016

Collins PA, Resendes SJ and Dunn JR (2014) The untold story: Examining Ontario's community health centres' initiatives to address upstream determinants of health. *Healthcare Policy = Politiques De Sante* **10**(1), 14–29.

Comas-Díaz L, Hall GN and Neville HA (2019) Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist* **74**(1), 1–5. https://doi.org/10.1037/amp0000442

Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health*. Available at https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1(accessed: March 27, 2026).

Davis VH, Dainty KN, Dhalla IA, Sheehan KA, Wong BM, Pinto AD and Aé R (2023) Addressing the bigger picture: A qualitative study of internal medicine patients' perspectives on social needs data collection and use. *PLos One* **18**(6), e0285795. https://doi.org/10.1371/journal.pone.0285795

Davis VH, Qiang JR, Adekoya MacCarthy I, Howse D, Seshie AZ, Kosowan L, Delahunty-Pike A, Abaga E, Cooney J, Robinson M, Senior D, Zsager A, Aubrey-Bassler K, Irwin M, Jackson LA, Katz A, Marshall EG, Muhajarine N, Neudorf C, Garies S and Pinto AD (2025) Perspectives on using artificial intelligence to derive social determinants of health data from medical records in Canada: large multijurisdictional qualitative study. *Journal of Medical Internet Research* **27**, e52244. https://doi.org/10.2196/52244

Graneheim U and Lundman B (2004) Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* **24**, 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Herrera C-N, Brochier A, Pellicer M, Garg A and Drainoni M-L (2019) Implementing social determinants of health screening at community health centers: clinician and staff perspectives. *Journal of Primary Care & Community Health* **10**, 2150132719887260. https://doi.org/10.1177/2150132719887260

Hosseinpoor AR, Bergen N and Schlotheuber A (2015) Promoting health equity: WHO health inequality monitoring at global and national levels. *Global Health Action* **8**(1), 29034. https://doi.org/10.3402/gha.v8.29034

Kirst M, Shankardass K, Singhal S, Lofters A, Muntaner C and Quiñonez C (2017) Addressing health inequities in Ontario, Canada: What solutions do the public support? *BMC Public Health* **17**(1), 7. https://doi.org/10.1186/s12889-016-3932-x

Lindgren B-M, Lundman B and Graneheim UH (2020) Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies* **108**, 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Lofters AK, Shankardass K, Kirst M and Quiñonez C (2011) Sociodemographic data collection in healthcare settings: An examination of public opinions. *Medical Care* **49**(2), 193–199. https://doi.org/10.1097/MLR.0b013e3181f81edb

National Health Service (2019) NHS England » Social prescribing. Available at https://www.england.nhs.uk/personalisedcare/social-prescribing/ (accessed: March 22, 2026).

O'Loughlin K, Shadowen HM, Haley AD, Gilbert J, Lail Kashiri P, Webel B, Huebschmann AG and Krist AH (2022) Patient preferences for discussing and acting on health-related needs in primary care. *Journal of Primary Care & Community Health* **13**, 21501319221115946. https://doi.org/10.1177/21501319221115946

Pfeiffer EJ, De Paula CL, Flores WO and Lavallee AJ (2022) Barriers to patients' acceptance of social care interventions in clinic settings. *American Journal of Preventive Medicine* **63**(3 Suppl 2), S116–S121. https://doi.org/10.1016/j.amepre.2022.03.035

Pinto AD, Glattstein-Young G, Mohamed A, Bloch G, Leung F-H and Glazier RH (2016) Building a foundation to reduce health inequities: Routine collection of sociodemographic data in primary care. *Journal of the American Board of Family Medicine: JABFM* **29**(3), 348–355355. https://doi.org/10.3122/jabfm.2016.03.150280

Rane P, Weimer MB and Baus A (2025) Clinician attitudes and experiences in screening patients for social determinants of health using PRAPARE. *Journal of Appalachian Health* **6**(4), 28–40. https://doi.org/10.13023/jah.0604.04

Mazurenko O, Hirsh AT, Harle CA, Shen J, McNamee C and Vest JR (2023) Screening Health-Related Social Needs in Hospitals: A Systematic Review of Health Care Professional and Patient Perspectives, PubMed [Preprint]. Available at https://pubmed.ncbi.nlm.nih.gov/37092962/ (accessed: March 27, 2026).

Rudisill AC, Eicken M.G. A, Gupta D, Macauda M, Self S, Kennedy AB, Thomas D, Kao E, Jeanty M and Hartley J (2023) Patient and care team perspectives on social determinants of health screening in primary care: A qualitative study. *JAMA Network Open* **6**(11), e2345444. https://doi.org/10.1001/jamanetworkopen.2023.45444

Sandelowski M (2000) Whatever happened to qualitative description? *Research in Nursing & Health* **23**(4), 334–340. https://doi.org/10.1002/1098-240x(200008)23

Spain AK, Monahan EK, Alvarez K and Finno-Velasquez M (2021) Latinx family perspectives on social needs screening and referral during well-child visits. *MCN: The American Journal of Maternal Child Nursing* **46**(3), 143–149. https://doi.org/10.1097/NMC.0000000000000710

Statistics Canada (2017) Release and Concepts Overview, 2016 Census of Population: Immigration and ethnocultural diversity release. Available at https://www12.statcan.gc.ca/census-recensement/2016/ref/98-501/98-501-x2016008-eng.cfm (accessed: November 10, 2025).

Statistics Canada (2021) 2016 Census of Population. Available at https://www12.statcan.gc.ca/census-recensement/2016/index-eng.cfm (accessed: November 10, 2025).

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Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder A.M. B, Nadal KL and Esquilin M (2007) Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist* **62**(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

The College of Family Physicians of Canada (2015) *Best Advice Guide: Social Determinants of Health*. Available at https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-social-determinants-health/ (accessed: November 10, 2025).

Waldren S and Billings E (2023) A guide to relieving administrative burden: Essential innovations for documentation burden. *Family Practice Management* **30**(4), 17–22.

Wilkerson K, De Marchis E, Rudd N, Williams JC, Pantell M, Ackerman SL, Amerson EH and Chang AY (2023) Patient perspectives on social risk screening and documentation in a dermatology clinic. *JAMA Dermatology* **159**(12), 1346–1358. https://doi.org/10.1001/jamadermatol.2023.3887

Williams MT (2020) Microaggressions: Clarification, evidence, and impact. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science* **15**(1), 3–26https://doi.org/10.1177/1745691619827499

Williams MT, Khanna Roy A, MacIntyre M-P and Faber S (2022) The traumatizing impact of racism in Canadians of colour. *Current Trauma Reports* **8**(2), 17–34. https://doi.org/10.1007/s40719-022-00225-5

APPENDICES

Appendix 1. Study recruitment advertisement



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Appendix 2. Semi-structured interview guide: social needs data collection question portion

10. Do you have difficulty making ends meet at the end of the month?
- Yes
- No

11. In the last 12 months, did you avoid filling a prescription or do anything to make a prescription last longer *because of the cost*?
- Yes
- No
- Not Applicable

12. a) What is your current housing?
- Own home
- Rent
- Staying with friends or relatives because you have no alternative [couch surfing]
- Shelter
- On the street
- Other (Specify)_____

b) If you rent → Is your current housing social housing, subsidized housing, or rent-geared-to-income?
- Yes
- No
- Not Applicable

c) If own home/rent → During the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
- Yes
- No
- Not Applicable

13. a) Do you feel you have family or close friends who you can open up to?
- Yes
- No

b) Are you able to rely on them if you need help (e.g., transportation, emotional or financial assistance)?
- Yes
- No
- Not Applicable

14. In the past 12 months, did you avoid attending an important appointment because of the cost of transportation?
- Yes
- No
- Not Applicable

15. In the past 12 months, did you miss making a payment on your electric, gas or other utilities bills *because of cost*?
- Yes
- No
- Not Applicable

16. a) Are you employed in a casual, short-term or temporary position?
- Yes
- No
- Not Applicable

b) Do you feel fearful that you could be fired if you raise employment concerns?
- Yes
- No
- Not Applicable

c) Does your pay vary a lot from month to month?
- Yes
- No
- Not Applicable

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