SCREENING FOR SOCIAL NEEDS

DECEMBER 2018

CENTER FOR CONSUMER ENGAGEMENT *in health innovation*
A better way to better health. For everyone.

Screening for Social Needs: An Introduction

It is increasingly recognized that social determinants of health—factors such as socioeconomic status, education, housing stability, nutrition and access to health care—have a greater impact on the health of individuals than genetic predispositions or medical care. Researchers attribute 70 to 80 percent of health outcomes to social, behavioral and environmental factors. Addressing social determinants, thus, is essential to improving health, reducing health disparities and decreasing costs.

As states grapple with expanded Medicaid coverage, they are introducing new payment models that hold providers financially accountable for quality outcomes. These payment models provide new incentives for providers to screen for and address unmet social needs—and many Medicaid programs are requiring that they do so. According to a recent survey by Kaiser Family Foundation, in 2017, 19 states required Medicaid plans to screen for and/or provide referrals for social needs.[1] This brief aims to provide consumer health advocates with an overview of social needs screening tools, so they can better advocate for the effective and culturally competent use of these tools in state public programs.

Why Screen for Social Needs?

Social needs screening can be effective in 1) improving the health of individuals who face social, behavioral and environmental barriers to wellness and 2) improving health at the population level. At the patient level, social needs assessments are being used to determine eligibility for services, to make clinical decisions, and to manage care; at the population level, states are using this data to improve care through payment reforms or other interventions targeted to specific communities.

Social needs assessments are usually combined with some type of referral to social services or community-based organizations equipped to assist the patient and/or family. In a survey of 12 states with accountable care models, 10 states required that participating accountable care organizations (ACOs) and managed care organizations (MCOs) develop relationships with community organizations to implement social needs interventions, and two others required individuals to be referred to community services.[2]

Without strong linkages to community-based organizations that can address unmet needs, screening has not been shown to be effective in improving health. As a result, some physicians and public health experts argue that screening for unmet needs in the absence of necessary services or supports is unethical. Screening is not risk-free for vulnerable families—thus, asking patients to reveal those vulnerabilities without offering a credible solution can undermine the doctor-patient relationship.[3]

Screening is not the only approach to addressing social needs and improving health. If health providers have strong partnerships with community services organizations, it may be as effective to provide *all* low-income or high-risk patients information on how to access these services. This approach, however, doesn't allow for collecting data that could be useful in evaluating outcomes.

MICHIGAN

In Michigan's Pathways to Better Health program, community health workers visit the homes of participants and using a tablet-based checklist, screen for unmet employment, education, housing and food security needs. The data is entered into a web-accessible database and is used to develop care coordination strategies and inform program evaluation.

TENNESSEE

TennCare screens participants for unmet needs in housing, social support, food security and employment. MCOs develop customized care needs assessments, which are used to inform care management and coordination, as well as program evaluation. They must report housing and employment data to the state as part of an effort by the state to identify areas where resources should be invested to improve population health.

Source: Spencer, Anna et al. Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. Center for Health Care Strategies, Inc. December 2016.

Choosing a Screening Tool

A social needs screening tool is a set of questions that can be asked by a physician, nurse, social worker, or other health care personnel, to elicit whether a patient has certain unmet social needs. States vary in terms of whether or not they mandate a specific tool be used for social needs screening. The advantage of a single tool is that it allows for uniform data collection, which is useful for developing systems for tracking and sharing data and evaluating outcomes. Where providers are serving very different communities, there may be advantages to asking questions tailored to particular populations.

The first step in choosing a tool is to determine which domains are most relevant to the populations targeted for screening and health-improvement goals. In 2014, the Institute of Medicine (IOM) recommended that health systems screen on a minimum of ten social and behavioral domains and one neighborhood/community domain. Among the domains recommended were several that appear frequently in "off-the-shelf" screening tools: housing and food insecurity, education/literacy, employment/income, intimate partner violence and social connection. IOM also recommended several behavioral domains, including alcohol use, tobacco use, physical activity and depression.

To compare widely available screening tools, the Social Interventions Research and Evaluation Network (SIREN) has put together a useful resource that indicates the domains covered, the number of questions for each domain and populations for which the tools were designed. Below is a chart that shows five of the most popular tools and the primary social domains covered by those tools.

	Accountable Health Communities Tool (Centers for Medicare and Medicaid)	Health Leads	IHELLP (Medical Legal Partnership)	PRAPARE (National Association of Community Health Centers)	Your Current Life Situation (Kaiser Permanente)
Number of Questions	19	10	10	17	19
Education/ Literacy	✓	✓	✓	✓	✓
Housing Insecurity and/or Quality	✓	✓	✓	✓	✓
Employment	✓	✓	✓	✓	
Food Security	✓	✓		✓	✓
Interpersonal Violence	✓		✓	✓	✓
Utilities or Financial strain	✓	✓		✓	✓
Transportation	✓	✓		✓	✓
Family and Social Support	✓	✓		✓	✓
Childcare access		✓		✓	✓
Income			✓	✓	
Neighborhood safety				✓	✓
Health care access		✓		✓	✓

Screening results can be improved through a strengths-based approach in which screeners ask not only about deficits but also what are the resources or supports that make the patient or family resilient. This approach provides a richer picture of the patient's circumstances and potentially creates a more trusting relationship with the health team.[4] Researchers have also found that it is more effective to ask about the desire for assistance than simply identifying unmet needs.[5]

Creating a Customized Screening Tool

Some states are choosing to develop their own tools in order to ensure the screening tool uses valid questions, aligns with program goals and available services, and is compatible with other screening or data collection efforts in the state. For its Support and Services at Home (SASH) program, Vermont collects SDOH data using the "SASH Assessment." The data is used to connect low-income seniors and adults with disabilities to community-based services and to promote care coordination. The tool screens for food insecurity, substance use, tobacco use and social isolation, and is integrated into a care coordination platform.[6]

North Carolina is preparing to launch Prepaid Health Plans (PHPs) for its Medicaid enrollees in 2019. PHPs will be required to conduct social needs screenings using ten standardized questions that cover four domains: food security, housing and utilities, transportation and interpersonal safety.[7]

In deciding whether to use an existing screening tool or to create one tailored to specific needs, Medicaid programs should consider:

- Does the state have unique program needs that would require a customized tool?
- Are resources available to create a tool that collects validated, measurable data?
- How will the data be integrated into care coordination platforms and electronic medical records?
- How will staff be trained to use the tools once they are created?

Existing tools have evolved to respond to these needs. It may be most efficient to adapt an existing tool, where questions have already been tested and validated. Most tools that are commercially available come with templates to ensure integration into electronic health records (EHRs). Additionally, organizations often offer training and coaching to support providers in implementing their social needs screening programs.

How Is Data Shared and Used?

States are taking a wide variety of approaches to collecting, sharing and implementing health-improvement strategies in response to the data collected. CMS and the National Quality Forum recommend using EHRs to collect and manage data.

SCREENING BEST PRACTICES

Social needs screening is most effective when it is:

1) Patient- and family-centered and involves shared decision making
2) Conducted within a comprehensive process and system that supports early detection, referral, and linkage to a wide array of community-based services
3) Engages the entire practice population rather than targeted subgroups; and
4) Acknowledges and builds on strengths of patients, families and communities.

Source: Garg, Arvin et al. "Avoiding the Unintended Consequences of Screening for Social Determinants of Health." JAMA (August 23/30 2016). Vol. 316, No. 8.

NORTH CAROLINA DESIGN PRINCIPLES FOR SOCIAL SCREENING QUESTIONS

- High-quality evidence links the chosen domains to health outcomes and community services are available to address those needs.
- Questions are simple, brief and applicable to most populations.
- Questions are validated, drawn from best practices and are written at accessible reading levels.
- Questions align with existing screening tools being used in the state (to ensure easier implementation and similar data collection).

Source: North Carolina Department of Health and Human Services. Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina. 5 April 2018.

Advocates can play a role in making sure that consumers are engaged in the process to define what data is shared and how privacy will be protected.

By building necessary infrastructure and passing legislation that creates secure data sharing and protects privacy, some states have promoted widespread information sharing. Washington State, for example, has established the Predictive Risk Intelligence System (PRISM), an integrated system with medical, public health, behavioral health, social services and long-term care data, shared among state agencies. The database is used to identify beneficiaries with the most complex needs for care coordination.

Policy Levers

There are a number of policy levers state advocates can look to in thinking about how they might influence the use of social needs screenings in their state. Advocates can try to influence Medicaid policies as the state level, particularly as states are thinking about transforming the Medicaid payment and delivery through demonstration projects or waivers. For example, advocates could try influencing requirements around social needs screening, referral systems and partnerships with community based organizations in Medicaid programs, through section 1115 waivers. The process used by Medicaid programs to contract with managed care organizations, accountable care organizations or provider organizations can present additional opportunities to shape requirements about social needs screening. Advocates can also work directly with specific health plans or systems to implement a patient-centered and culturally competent screening process and referral system, and there are many additional resources geared toward helping providers adopt screening and referral processes.[8]

Challenges and Considerations

While an important step toward addressing social determinants, social needs screening on its own is not sufficient for addressing social determinants of health. Advocates have an important role to play in ensuring that screening is implemented in a way that is helpful and not harmful, and that is part of a more comprehensive strategy to improve the health of vulnerable populations. When developing advocacy strategies around social needs, state advocates can glean some important lessons from the early experiences of states that have implemented accountable care models, managed care, or medical homes to deliver care to Medicaid beneficiaries. These include:

- Make sure that screening is accompanied by a strong referral system. Provider organizations should have the ability to quickly and effectively connect people to the services they need. This could include use of electronic platforms designed to catalogue community resources and help health systems track referrals,[9] as well as explicit partnerships with community-based organizations providing affordable housing, nutritional support, shelter for domestic violence victims, or training and employment services.
- Recognize that screening in and of itself does not address social needs. Advocacy for screening should be accompanied by advocacy for strong investments in community infrastructure and services. This can be done through value-based payments or flexible spending arrangements. In

KANSAS

KanCare incorporates social needs assessment into required behavioral health, home and community-based services, and long-term care performance and pay for performance measures. MCOs are required to conduct health risk assessments to collect data on certain domains and submit data quarterly to the state. The state has implemented a quality strategy that includes rigorous data collection and measurement covering key indicators, measure specifications, target populations, data sources for measuring, frequency for reporting and reporting benchmarks.

OHIO

CareSource, a Medicaid MCO, has a program that connects interested enrollees with employment and educational opportunities. The MCO collects self-reported data every 90 days on key domains: enrollee employment status, educational status and resources, income sources and debts, food security, housing, transportation, social support, and criminal background. This data is shared quarterly with the Ohio Department of Medicaid.

Source: Spencer, Anna et al. Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. Center for Health Care Strategies, Inc. December 2016.

Massachusetts, for example, a "neighborhood stress score" is used for risk-adjusted payments. In distressed areas, programs serving 1000 to 2000 people will have an extra $100,000 to support innovations that address health-related social determinants such as lack of stable housing.

- Ensure there is strong consumer and community engagement in the design and oversight of social needs screening and referral programs. This includes a mechanism for evaluating the effectiveness of referrals in meeting needs.
- Make sure that provider organizations invest in sufficient training and infrastructure, including partnerships with community-based organizations. Many people are fearful of revealing vulnerabilities such as their immigration status, housing insecurity, entanglements with the court system, or domestic violence. Therefore, social needs screening is most effective when there is a high level of trust. Taking a strengths-based approach and using community health workers who share the lived experience of patients has shown to be most effective in eliciting information related to sensitive topics such as discrimination, immigration status, domestic violence and neighborhood safety.[10]

For Further Reading:

- Social needs Screening and Intervention Implementation Resources, Social Intervention Resource and Evaluation Network (SIREN) at University of California, San Francisco
- Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations, Center for Health Care Strategies
- Addressing Social Determinants of Health through Medicaid Accountable Care Organizations, Center for Health Care Strategies
- A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability, National Quality Forum
- Social Determinants of Health Series, American Hospital Association

Endnotes

[1] Kathleen Gifford, et al. Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Kaiser Family Foundation. October 2017. Available at: https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/

[2] Tina Kartika. How States Address Social Determinants of Health in Their Medicaid Contracts and Contract Guidance Documents. National Academy for State Health Policy. August 2018. Available at: https://nashp.org/how-states-address-social-determinants-of-health-in-their-medicaid-contracts-and-contract-guidance-documents/

[3] Arvin Garg, et al. Avoiding the Unintended Consequences of Screening for Social Determinants of Health. Journal of the American Medical Association. No. 8, August 23/30, 2016. Available at: https://jamanetwork.com/journals/jama/article-abstract/2531579

[4] JoHanna Flacks and Renee Boynton-Jarrett. A Strengths-Based Approach to Screening Families for Health-Related Social Needs. MLPB. January 2018. Available at: https://cdn2.hubspot.net/hubfs/235578/pdfs_and_other_documents/2018-A%20strengths-based%20approach%20to%20screening.pdf?t=1538156214677

[5] Arvin Garg, et al. The Inherent Fallibility of Validated Screening Tools for Social Determinants of Health. Academic Pediatrics 2018,18:123-124. Available at: https://www.academicpedsjnl.net/article/S1876-2859(17)30606-X/fulltext. In this study, researchers found a 10-fold increase (70 percent vs. 7 percent) in their ability to identify and address social needs by reformulating questions to ask about the desire for help.

[6] Anna Spencer, et al. Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. Center for Health Care Strategies. December 2016. Available at: https://www.chcs.org/resource/measuring-social-determinants-health-among-medicaid-beneficiaries-early-state-lessons/

[7] North Carolina Department of Health and Human Services. Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource needs in North Carolina. April 2018. Available at: https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf

[8] See the Health Leads Resource Library at: https://healthleadsusa.org/resource-library/health-leads-tools/

[9] Caitlin Thomas-Henkel and Meryl Schulman. Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Center for Health Care Strategies. October 2017. Available at: https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/

[10] JoHanna Flacks and Renee Boynton-Jarrett. A Strengths-Based Approach to Screening Families for Health-Related Social Needs. MLPB. January 2018. Available at: https://cdn2.hubspot.net/hubfs/235578/pdfs_and_other_documents/2018-A%20strengths-based%20approach%20to%20screening.pdf?t=1538156214677

@CCEHI
healthinnovation.org

COMMUNITY CATALYST

ONE FEDERAL STREET, 5TH FLOOR
BOSTON, MA 0211

617.338.6035