FOUNDATION FOR
Health Care Quality

Improving health outcomes through collaboration, data, and finding common ground

Social Need Screening

June 2023

Background

Only about 20% of health outcomes are determined by clinical care. The other 80% are influenced by health behaviors, the physical environment, and social and economic factors.[i] Some of the social determinants, or social influencers, include housing, food security, and transportation needs. In 2019, the National Academies of Science released a report on integrating social care into the delivery of healthcare to better address upstream factors that influence patient health outcomes.[ii] Many healthcare organizations now recommend assessing patient's for social need as a routine part of care, including the AAFP's EveryOne Project, the NACHC's PRAPARE Toolkit, and Kaiser Permanente's Social Risk Playbook.[iii, iv, v] While many organizations recommend screening for social need, more work is needed to implement screening workflows in healthcare settings and to get all patients and providers on the same page.

The Foundation's Social Need and Health Equity Steering Committee convened a Social Needs Screening workgroup to specifically review existing tools and workflows for social need screening. Screening focus areas are highlighted in **Table 1.**

Table 1: Assessment Focus Areas

Focus Area	Goals
Planning	• Ensure adequate buy-in from leadership, staff, and patients. • Prepare for any anticipated barriers and avoid duplicative efforts.
Screening Tool and Domains	• Choose an appropriate screening tool for local needs. • Determine which social need domains to screen for, ensure the screening tool will integrate with existing resources and technology.
Administration	• Plan minimally disruptive workflows for social need screening. • Determine staffing needs and resource needs for screening. • Develop an iterative process for evaluation and quality improvement.
Recording and Communicating Responses	• Ensure responses to screening assessments are recorded and linked to interoperable data standards. • Communicate assessment results with all internal parties, including providers and care coordinators.

Recommendations

Planning

- Review the organization's internal programs and policies to determine if other departments or staff members are already screening for social need. Avoid duplicating efforts.
- Assess current capacity for screening and follow-up interventions for social need. Develop a long-term plan to build capacity for social need interventions, but begin screening workflows in the meantime. Refer to social need interventions recommendations for more information.
- Engage with leadership and staff to develop buy-in and identify champions.
- Determine available resources (staff, technology, funding) to implement new screening workflows and make a plan to obtain additional required resources.
- Engage with patients/people who will be screened.
    - Involve them in the planning process and invite feedback on screening workflows, including the screening domains important to them, where the tool should be administered, who should administer the screening, and who should communicate follow-up information.
    - Build buy-in around the rationale for screening and answer questions about how the screening information will be used.
- Develop a communication plan to share upcoming workflow changes and describe the rationale behind social need screening. Work to build trust with patients/people being screened.
- Plan screening workflows in advance to reduce administrative burden.
    - Determine which staff member will be responsible for administering screening and ensure the appropriate human resources are available.
    - Determine the technology needs for collecting screening information and ensure appropriate resources are available.
- Consider a vanguard phase or a pilot area to test screening.
- Ensure there is an iterative process for feedback and engagement to test current workflows and make updates as needed. Test key elements of the screening workflow – including pre-screening questions, paper vs. electronic screening, and self-report vs. staff-mediated screening.

Screening Tools and Domains

- Work collaboratively with leadership, staff, and patients/community members to choose a validated screening tool to screen for social need. Screening tools can be found through SIREN Screening Tool Comparison Tables or Kaiser Permanente's Systematic Review of Social Need Screening Tools.
    - Recommended screening tools with existing implementation resources include the AHC HRSN Screening Tool, the PRAPARE Toolkit, and the AAFP's EveryOne Toolkit.
- Ensure the screening tool will meet the needs of the population being served as well as current and anticipated regulatory needs:
    - Ensure the screening tool chosen is compatible with the organization's electronic health record or data system if one exists.

- Ensure the screening tool includes social need domains that are relevant to the local community. Screen for at least three domains - housing security, food security, and transportation need – as well as other high-priority needs identified by community members.
    - In the 2023 IPPS Final Rule, CMS mandated that hospitals submit measures on SDOH (Social Drivers of Health) screening rates and the prevalence of SDOH need among admitted patients. CMS' five SDOH domains are Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, and Interpersonal Safety.
    - In the 2023 HEDIS Quality Measures Update, NCQA added a measure called "Social Need Screening and Interventions" (SNS-E) that assesses whether health plan members were screened for food, housing, and transportation needs and received a corresponding intervention if they screened positive.

Administration and Workflows

- Develop an assessment workflow that works for the population being served. Sample workflows can be found from the Kaiser Permanente Social Risk Playbook, the Boston Medical Center, and the PRAPARE toolkit. Some key decisions to make include:
    - Choose a pilot population to begin screening:
        - Examples include starting with a specific setting like outpatient care or a specific program like diabetes management.
    - Determine method and timing for administering screening:
        - Choose if the screening tool will include a brief pre-screening question to target resources and follow-up efforts.
        - Choose whether responses will be self-reported or collected via staff-mediated interviews.
        - Choose whether self-reported assessments will be conducted using paper or electronic forms.
        - Choose whether staff-mediated interviews will be conducted in-person or virtually.
    - Determine staffing needs for the screening workflow, and ensure staff are adequately trained and supported.
        - Choose the staff members responsible for monitoring or administering screening.
        - If conducting screening via staff-mediated interviews, train staff on collaborative screening or motivational interviewing.
- Ensure that the assessment process builds trust between staff and people being screened. Ensure all people who complete the screening form receive information about how screening results will be used and those who screen positive receive a follow-up interview or conversation with staff.
- Ensure social need assessments are available in accessible formats (i.e. large text for the visually impaired, forms in alternative languages based on local needs).
- Leverage peer-learning settings (learning collaboratives, implementation round tables, discussion groups) to develop and support workflows.

- Use decision aids to help with workflow planning when possible. Consider developing new decision aids to help other organizations build screening workflows.

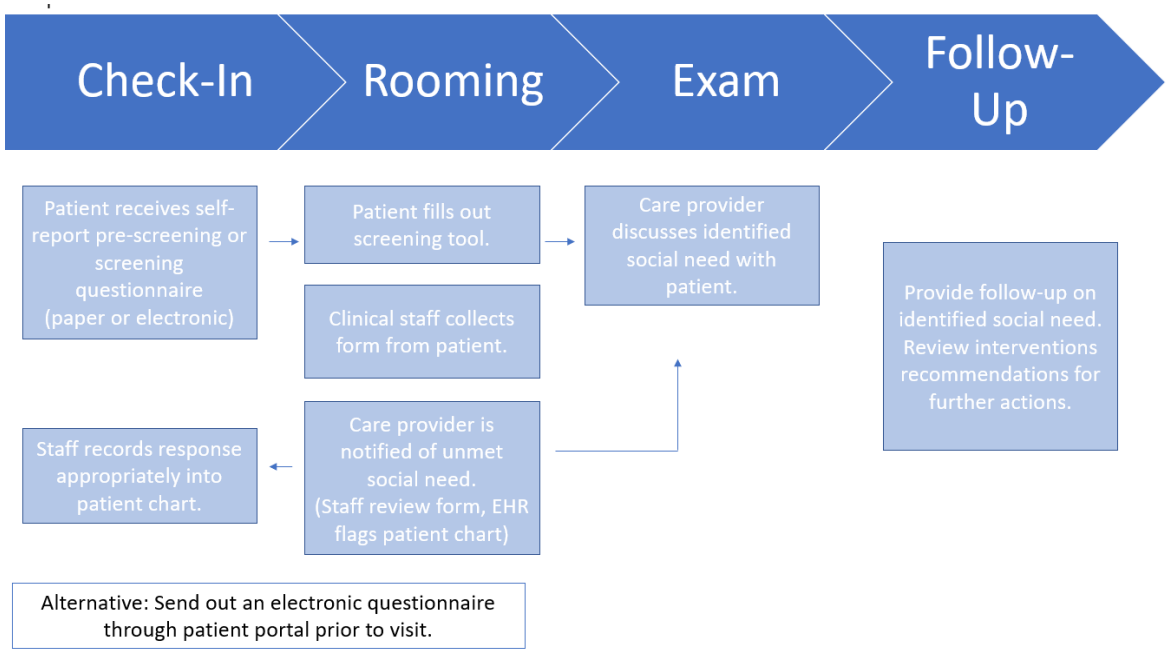
Recording and Communicating Responses

- Ensure that data collection, whether on paper or digital, is standardized. Move toward interoperable collection and storage of social need data in health data systems (such as electronic health records) using existing standards.
    - Follow the Gravity Project's terminology workstream for content code standards (z-codes, SNOMED, LOINC, etc.) and refer to the FHIR Implementation Guide for exchange standards.
    - Develop educational programming to help staff implement standard codes. Develop written procedures for documenting z-codes related to social need screening.
- Ensure screening results are recorded in the electronic health record, if applicable.
    - Start the process early to work with your EHR vendor to develop social need modules for the chosen screening tool.
- Assign staff to monitor and review social need assessment results. Develop written procedures for reviewing and flagging social need screening responses.
- Ensure assessment results are communicated to all internal relevant partners.
    - Ensure providers are aware of patient responses and are able to incorporate information into the care plan.
    - Develop a communication plan with relevant staff members to avoid duplication of assessments at different sites/specialties.
    - Ensure other members of the care team (social workers, community health workers, patient navigators, etc) are aware of identified social need and able to follow-up.
    - Ensure patients are aware of how their social need information will be used and how the organization will connect patients to resources.
    - Ensure screening results are shared for analytics and referrals.
- Develop an ethical statement about how the organization will use social need data.
- Develop a plan to follow-up on identified social need. Review the Social Need Interventions recommendations for more information.

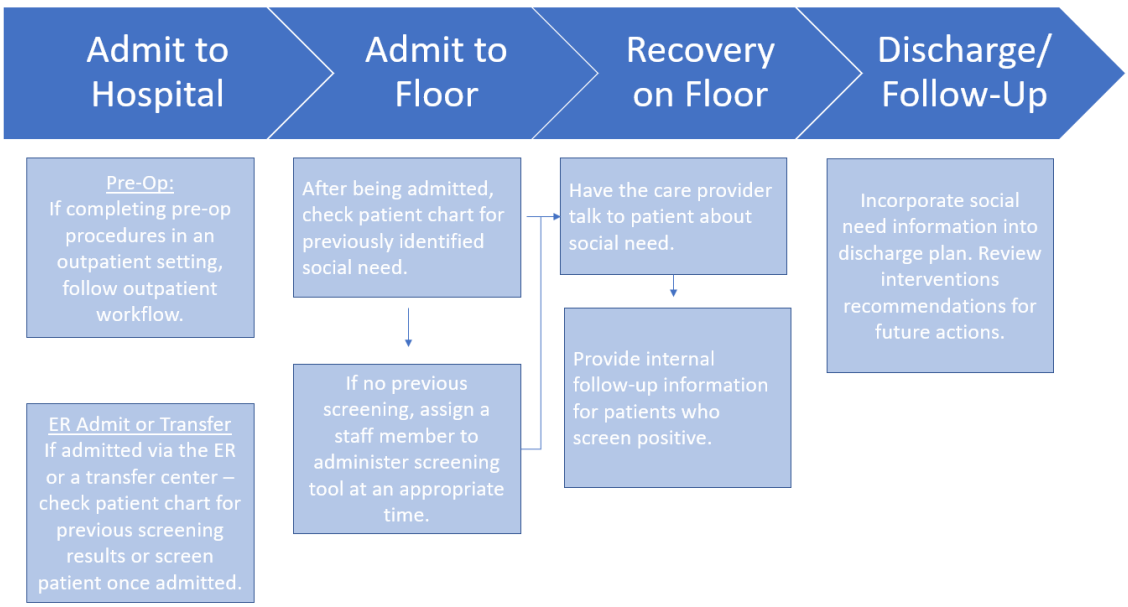
Sample Workflows

The samples below are intended to start a conversation about how to administer social need screening in a clinical setting. This workflow is not meant to be prescriptive. Additional workflows from specific organizations that have already implemented screening include Kaiser Permanente and Boston Medical Center.

Outpatient Screening Workflow



Inpatient Screening Workflow



Stakeholder Roles and Responsibilities

Each stakeholder plays several roles in the health and social care ecosystem. This list (adapted from the Robert Wood Johnson Foundation Raising the Bar Report) provides several suggested actions for specific stakeholders to take depending on their role. The actions suggested are not in chronological order. Stakeholders are invited to develop an action plan to achieve the objectives relevant to their organization.

Leaders: C-suite executives, directors, and managers in charge of setting priorities and allocating resources.

Goal: Commit necessary resources to social need screening workflows and develop leadership/staff buy-in.

- 1.1: Orchestrate planning for social need screening workflows, including developing staff buy-in and engaging with patients being screened.
- 1.2: Pilot screening workflows and evaluate the workflow for quality improvement.
- 1.3: Commit the necessary resources for long-term sustainability of screening workflows.

Health Care Providers: Physicians, other clinicians, and other providers responsible for treating and managing patients.

Goal: Incorporate social need screening into the practice and normalize asking patients about social need.

- 2.1: Actively promote and facilitate social need screening workflows in your practice setting.
- 2.2: Establish and sustain a trusting environment with patients and staff that prioritizes whole-person care.
- 2.3: Provide holistic, high-quality care to patients that incorporates social need concerns into the treatment plan.

Employers: Any organizations that support and manage staff, human resource departments.

Goal: Understand and support the workforce's social needs.

- 3.1: Develop a voluntary social need screening process for employees to better understand how to support staff through the employee life cycle.
- 3.2: Leverage purchasing and benefits to support the workforce's social need.

Partners: Organizations that facilitate relationships across multiple sectors to achieve equity.

Goal: Engage with community organizations and residents to build trust and better understand community social needs.

- 4.1: Engage with community organizations and residents (or patients) to prioritize the community's identified social need.
- 4.2: Build trusting relationships with individuals and organizations in the communicate.
- 4.3: Include transparency around social need screening practices and the use of data.

Advocates: People and organizations who advocate for greater change.

Goal: Advocate for greater awareness of social need and social drivers

- 5.1 Actively push for and adopt payment reforms that emphasize social need screening and interventions in alignment with the mission of improving holistic health and well-being.
- 5.2: Use healthcare's voice to shape public understanding about the influence of social need on health outcomes.

Purchasers: Organizations in charge of purchasing benefits for their employees, staff, or other clients.

Goal: Leverage purchasing strategies to advance social need screening.

- 6.1: Leverage purchasing strategies to advance social care integration. Pursue plans and payment mechanisms that reimburse sites for social need screening.

Insurers: Organizations that manage health plans for enrollees.

Goal: Leverage contracts, policy, and internal initiatives to advance social need screening of enrollees.

- 7.1: Leverage reimbursement strategies to incentivize social need screening in clinics.
- 7.2: Develop screening workflows for enrollees at least upon enrollment in the plan.

Regulators and Policy: Organizations and people in charge of developing policy that governs healthcare organizations and regulating/enforcing these policies.

Goal: Advance policies for social need screening and incorporate social need screening metrics into quality improvement programs.

- 8.1: Develop quality metrics to monitor plans and providers for social need screening.
- 8.2: Aid organizations that are adopting new quality metrics to advance social care integration.
- 8.3: Leverage public policy to address social need integration.
- 8.4: Direct sustainable funding toward social care integration activities.

Population Health: Organizations that collect population-level data and focus on multi-sector partnerships to advance health.

Goal: Coordinate social need screening activities and report on population health data for quality improvement and evaluation purposes.

- 9.1: Facilitate partnerships and alignment around social need identification activities.
- 9.2: Aggregate social need information from hospitals and plans for population health reporting purposes.

Tools and Resources

- Gravity Project
  - Terminology Workstream (for data standards, especially related to social need)
  - FHIR Implementation Guide (for using exchange standards)
- Assessment Tools:
  - Kaiser Permanente's Systematic Review of Social Needs Screening Tools
  - SIREN Screening Tools Comparison Tables
- Evidence Reviews
  - AHRQ Evidence on Social Need Screening
  - SIREN State of the Science on Social Need Screening
- Workflow Examples/Toolkits
  - PRAPARE Implementation and Action Toolkit
  - KP Social Health Playbook
  - AAFP EveryOne Project Toolkit
  - Boston Medical Center THRIVE Model

Glossary of Terms[vi]

- **Social Determinants of Health**: The Office of Disease Prevention and Health Promotion defines social determinants of health as "conditions in which people are born, live, learn, work, play, worship, and age that affect health [physical and mental], functioning, and quality of life." Social determinants can impact health positively or negatively and are shaped by policies, systems, and social norms that determine the distribution of money, power, and resources. Thus, social determinants are upstream factors such as policies and systems that play a role in health and health inequities.
- **Social Risk**: Social determinants affect everyone, not just the socially and economically disadvantaged. On the other hand, social risk factors are specific adverse conditions at the individual or family level that are associated with poor health and can exacerbate health inequities.
- **Social Need:** Social needs (also sometimes referred to as health-related social needs, non-medical factors, material need insecurities, or unmet needs) are the social risks an individual seeks assistance with immediately. Although a person may indicate the presence of several social risk factors, they may only need help with one of those at the time of screening. In other words, social needs take into account the individual and/or family's preferences and priorities, and thus requires a person-centered approach when intervening.
- **Health Related Social Needs:** Another term for social need, often abbreviated as HRSNs.

- **Social Need Domain:** Broad categories of social need or social risk factors. Common social need domains include housing security, food security, transportation need, social isolation, and more.
- **Social Need Screening Tool:** A reliable and/or validated tool for assessing individual's current social need. Often a screening tool consists of multiple questions that ask about one or more social need domains.
- **Z-Codes, SNOMED, LOINC:** These are three examples of clinical content codes used for recording diagnoses, procedures, or other clinical interactions in an interoperable format. All three of these types of codes include codes for social need. Additional codes for these systems are being developed by the Gravity Project.
- **FHIR:** Fast healthcare interoperability resources (FHIR) are the commonly accepted data exchange standards for healthcare settings.

References

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