

# IDENTIFYING SOCIAL RISK AND NEEDS IN HEALTH CARE

PROMISING APPROACHES TO SCREENING  
FOR SOCIAL DETERMINANTS OF HEALTH  
& RECOMMENDATIONS FOR  
CONTINUED EXPLORATION



# INTRODUCTION

Health and wellbeing are foundational to economic vitality, business competitiveness, personal achievement, and prosperity, and an increased level of health for all Americans is key to the promotion of thriving lives, economies, and communities. Health outcomes strongly relate to social determinants of health, which include a variety of non-medical factors like food access and nutrition, transportation, housing, incarceration and recidivism, jobs/wages, safety, education, and other community-based and environmental conditions. Healthy People 2020 defines the social determinants of health (SDOH) as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”<sup>1</sup>

This is the first in a series of issue briefs from the National Alliance to impact the Social Determinants of Health (NASDOH) designed to address key issues and advance our national efforts to address social determinants of health. Addressing social determinants of health requires a complex and coordinated cross-sector effort that begins in communities, but spans the entire nation. Foundational to any such effort is the identification of social risk through screening tools, which is the subject of this first brief. Future briefs will discuss how to act upon social risk data (e.g., what capacities must be developed with the health care system, within the social care system, and at a more holistic community level), and how to integrate the systems and processes for addressing social determinants across care settings. Please visit our website (<http://www.nasdoh.org/>) as we continue to publish additional briefs on topics such as addressing social needs; developing a framework for measuring and evaluation of social risk; aligning, sharing, and utilizing SDOH data; and sustainable financing models to address SDOH.

## IDENTIFYING SOCIAL RISK AND NEEDS

Systematic assessment of the social determinant risk status of individuals is an area of active development. Better understanding a person’s needs at a broad level is integral to identifying the presence of important social factors or conditions, such as food insecurity, that can have a significant impact on health outcomes. Identification, within the clinical environment, of social factors that relate to health risk is an essential first step toward fulfilling unmet social needs and improving health by linking people with the social care and public health systems. Yet, as future briefs will address, much more must be done to instill trust and build the capacity for data and resource sharing to empower the social care system to be an effective partner for the health care system.

Though there are many promising practices for identifying social risk, there is not yet a best practice or standard. However, initial efforts have led to key learnings that can inform future development of social risk assessments and integration of social needs screening into the clinical environment in a way that does not place additional burden on providers or patients.

Innovation in the field has also led organizations to leverage big data across a wide range of sources and sectors to paint a detailed picture of social needs at both the individual and the population level. These “secondary” social risk assessment approaches may help to alleviate the burden of primary screening and can inform population-level interventions within the public and private sectors.

While significant progress has been made to better assess social and environmental risk factors as a means of predicting and improving health outcomes, there remain many challenges with both primary and secondary screening mechanisms and the utility and reliability of the data they produce. This brief provides a set of principles to guide future screening efforts and identifies key challenges and considerations for ongoing exploration as social determinants of health screening for unmet needs become more commonplace.

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“Conditions in the environments in which people are born, live, learn, work, play, worship, and age... affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

– Healthy People 2020

<sup>1</sup>Healthy People 2020 – “Social Determinants of Health”, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>, accessed 03 January 2019.

# PRINCIPLES FOR PRIMARY SCREENING

A primary screening approach identifies social risk and needs through individual assessments. Many of these approaches are being deployed in the health care environment and serve to augment a more traditional medical model of care by providing additional context for the health of individuals and populations. As health care organizations look to integrate SDOH screening into their system of care, the following principles should be considered:

**1. Screening that occurs in the clinical environment should be incorporated into the workflow to minimize additional burden to clinicians and patients.**

Perhaps the most critical factor in achieving broad-scale adoption and consistency of primary screening models is securing and assuring buy-in from providers and patients. While data on health-related social risks has potential to improve clinical care, this potential must be balanced with the burden that screening assessments may place on clinicians and the clinical environment. To the extent possible, screening for social determinants of health should not add time to clinical visits, detract from the interactions between the patient and care team, or create discomfort for patients. Considerations could include tool administration (e.g., self-administered tools versus a survey administered by a clinician or assistant), or alternative modes (e.g., telephonic) or settings (e.g., during home visits) of screening.

**2. Screening tools should be seamlessly integrated into the existing systems of records such as electronic health records (EHR) or other digital platforms used for documenting or coordinating the health care and social care sectors.**

Part of building screening capabilities into the clinical workflow includes the integration of data on health-related social risks into the EHR, which already houses important medical information. Currently, no uniform, accepted data model exists for representing social determinants in an EHR.<sup>2</sup> A standard for non-medical data is integral to translation of social determinants information into meaningful outcomes or conditions (akin to ICD-10 codes for medical diagnoses) that lend themselves to clinical response. Integration of standardized data into EHRs can enable additional functionalities such as automatic referral systems, however, this type of integration with entities outside the health care system (e.g., community/social services) also requires standardized data and data connections. Therefore, while the benefits to EHR integration are numerous, the investment required to successfully achieve functional integration can be significant.<sup>3</sup>

**3. The health sector should agree on a core set of screening questions.**

If a health care system stakeholder chooses to assess social need in the health care environment, they should use a screening tool from either a unified screening instrument agreed to by the sector, or at a minimum, a bank of screening questions. This would allow data to be more readily aggregated across providers and payers in a geographic area, enable comparisons of efforts in different communities, and ease the process of integrating SDOH data into EHR and other digital systems of record. In addition, it will also be important to develop standards for where screening should be done, and how patient-specific information is shared across care providers.

**4. Screening questions should be actionable.**

Though there is value in understanding health-related social needs, the lack of available resources and infrastructure to address the identified needs may be a source of frustration for the clinical and/or social care team, as well as the individuals being served. Therefore, health care systems may consider pairing screening with a social service linkage or integration plan that leverages internal capacities, enables referrals to community-based resources where necessary, and ensures that patients make the appropriate resource connections.<sup>4</sup> Additionally, screening for social needs should promote appropriate clinical intervention for current needs and anticipate future social and health-related needs to allow providers and communities to better plan for and prioritize resources. Therefore, health systems should find ways to facilitate ongoing collaboration with social service and public health agencies, including advocating for necessary resources and services.

**5. Individual privacy and preferences should be respected when collecting information about social risk and need.**

Integral to respecting privacy rights is the incorporation of meaningful consent when collecting social risk factor data. Every health system that undergoes screening and identification of the social risk of individuals and populations should ensure that they protect patient data by following privacy laws and obtaining patient consent. Further, it is common that those with identified social determinant of health needs do not desire assistance for those needs. It is important

<sup>2</sup>Cantor MN, Thorpe L, “Integrating Data On Social Determinants Of Health Into Electronic Health Records.” *Health Affairs* 37(4), 2018.

<sup>3</sup>Gold R, Bunce A, Cowburn S, Dambrun K, Dearing M, et al., “Adoption of Social Determinants of Health EHR Tools by Community Health Centers.” *Ann Fam Med* 16(399-407), 2018.

<sup>4</sup>Garg A, Boynton-Jarrett R, Dworkin PH. “Avoiding the Unintended Consequences of Screening for Social Determinants of Health.” *JAMA* 316(8):813-814, 2016.

that providers take a patient-centered approach to providing additional social supports and work with a patient to determine which types of referrals and resources are appropriate. It is also essential that providers inform patients of, and obtain consent for, the potential uses of their screening data. This includes allowing individuals to decline to answer screening questions without that decision impacting access to the care they are seeking.

**6. Screening tools should reduce stigma and bias and protect against discrimination.**

Although the burdens of the social risk may be felt more heavily in communities impacted by poverty, social determinants of health are not exclusive to persons impacted by economic poverty. The terminology, screening tools, and solutions developed to address the social determinants of health should be sensitive to the full spectrum of social risk (e.g., loss of employment, social isolation, family conflict, social displacement) in all communities and all persons regardless of socioeconomic status, race, gender identity, sexual orientation, religion, ethnicity, etc. Further, appropriate consents and protections should be built into the screening process to ensure that the social risk data acquired through screening is utilized to promote clinical excellence and not to discriminate (e.g., via insurance coverage, access, or services) on the basis of any social risk factors.

**7. Screening tools should enable the use of social risk factor information to provide insights to drive upstream community health improvement.**

With appropriate consent, data acquired via social needs screening should be available for use at a level beyond the individual patient to support community-wide efforts directed at mitigating negative social determinants of health. There may also be data sources or frameworks within a given community that can inform screening question development. Systems and processes for sharing, de-identifying, and aggregating data on social risk factors should be established within the health care system, public health organizations, and social service organizations to bolster clinical-community linkages and give social service agencies access to information that will better enable them to provide appropriate individual and community-level services.



# PRIMARY SCREENING TOOLS IN THE FIELD

A number of tools and approaches for assessing social risk have been developed and deployed in the field.<sup>5</sup> The emerging set of screening tools and approaches deployed within the health care system will continue to inform ongoing development and implementation of screening protocols.

The National Association of Community Health Centers (NACHC) developed one of the earliest comprehensive screening tools for social needs known as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). The tool includes questions across sixteen domains with additional optional measures to be used according to community-specific priorities.<sup>6</sup> The PRAPARE tool is free to the public and comes with templates for use in select, existing electronic health record systems. Additional tools like the Your Current Life Situation (YCLS), released in 2017, incorporate indications for positive screenings that might require referral, advice, or an alteration of how care is provided.<sup>7</sup>

Drawing on the questions and learnings from some of existing assessment tools including PRAPARE, the National Academy of Medicine (NAM) and the Centers for Medicare and Medicaid Services (CMS) then proposed a screening tool for use by the Accountable Health Communities (AHC)<sup>8</sup> to address the critical gap between clinical care and community services. The AHC Screening Tool was designed to test whether systematically identifying and addressing the health-related social needs (HRSN) of Medicare and Medicaid beneficiaries impacts total health care costs and utilization, increases quality of care, and improves health.

## THE ACCOUNTABLE HEALTH COMMUNITIES (AHC) SCREENING TOOL

The Centers for Medicare and Medicaid Services (CMS) developed a 10-question screening tool to identify patient needs in five different domains:

- Housing stability
- Food insecurity
- Transportation difficulties
- Utility assistance needs
- Interpersonal safety

In developing the AHC screening tool, CMS followed three guiding principles:

- The tool needed to consistently identify the broadest set of health-related social needs that could be addressed by community service providers.
- The tool needed to be simple and streamlined to ensure that its questions were readily understandable to the broadest audience across a variety of settings, as well as to allow for inclusion of routine screening in busy clinical workflows.
- The tool needed to be evidence-based and informed by practical experience.

The tool was designed to be short, accessible, consistent, and inclusive. Importantly, all of the questions in this screening tool align with existing standards in the electronic medical record, which makes data collection and extraction more seamless.

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<sup>5</sup> Social Interventions Research & Evaluations Network (SIREN) Social Need Screening Tools Comparison Table, at <https://sirennetwork.ucsf.edu/node/17826>, accessed 03 January 2019.

<sup>6</sup> National Association of Community Health Centers (NACHC) PRAPARE, at <http://www.nachc.org/research-and-data/prapare/>, accessed 03 January 2019.

<sup>7</sup> Social Interventions Research & Evaluations Network (SIREN) Kaiser Permanente's Your Current Life Situation Survey, at <http://sirennetwork.ucsf.edu/tools-resources/mmi/kaiser-permanentes-your-current-life-situation-survey>, accessed 03 January 2019.

<sup>8</sup> Centers for Medicare & Medicaid Services (CMS) The Accountable Health Communities Health-Related Social Needs Screening Tool, at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>, accessed 03 January 2019.

# LEVERAGING SECONDARY DATA FOR RISK ASSESSMENT

An evolving adjunct to primary assessment of social risk is secondary screening that leverages existing, publicly-available data sources that can provide information on social factors, conditions, and behaviors at the community-level, rather than relying upon survey instruments to query individuals. These publicly available sources of information (e.g., claims, clinical, retail data) can be used to develop population profiles, and in some cases, provide a geocoded overview of the social determinant characteristics of populations and communities. This information can then be used to provide broad risk profiles for populations within certain communities, the results of which could be used to categorize individuals based on risk scores, or extrapolated in a clinical setting with a more individualized focus. At the state level, both Massachusetts and Minnesota have utilized secondary data on social determinants to improve risk adjustment for Medicaid providers.<sup>9</sup> There are also organizations that are exploring the utility of big data on social determinants across payers, providers, and geographies.<sup>10</sup>

There continue to be many considerations for the use of non-health care data in a clinical setting, particularly as methods and restrictions for sharing and utilizing health data are still being considered. Clinicians or others utilizing secondary screening data must weigh the risks and benefits of disclosing their awareness of patient- or community-level social determinant of health data to individual patients. Without appropriate awareness of the data being used in clinical decision-making, the underlying trust within the doctor-patient relationship may be at stake. It is also important to consider controls around how clinicians and others in the health care industry (e.g., insurers) utilize social risk information acquired from secondary sources. As discussed earlier, social risk factor data should be used to improve clinical patient care and not to discriminate against patients.



*Solutions developed to address the social determinants of health should be sensitive to the full spectrum of social risk...in all communities and all persons regardless of socioeconomic status, race, gender identity, sexual orientation, religion, ethnicity, etc.*

## ONGOING CHALLENGES WITH SCREENING IMPLEMENTATION

Implementation of screening protocols across a variety of settings comes with many challenges. As screening tools are further refined and implementation of SDOH screening proliferates, health care and community providers, as well as the developers of social needs assessments, will need to consider and address challenges such as the following:

- **Scalability** – The risk and needs of populations varies drastically across settings and geographies. While data standards and screening tool consistency are valuable to making accurate and appropriate assessments of both needs and their corresponding interventions, extreme variability across populations complicates the scalability of any standard screening approach.
- **Screening Goals** – Populations do not just vary across geographies, but also over time. The true clinical and organizational benefits of identification of social determinants of health may often come not just from the ability to screen for existing needs, but the ability to identify risk factors that will with high likelihood lead to future needs. The

<sup>9</sup>Breslin E and Lambertino A. “Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes.” Health Management Associates, July 2017.

<sup>10</sup>National Association to impact the Social Determinants of Health (NASDOH) Predicting Social Risk, at <http://www.nasdo.org/resources/#predicting-social-risk>, accessed 03 January 2019.

creation and use of screening tools and their corresponding interventions will vary depending on whether the goal is to identify existing or future needs.

- **Social Care System Referrals** – The ability to respond to identified needs relies on the ability of health care organizations to link patients to the appropriate services. Integral to this process is the willingness of health care, public health, and social service providers to share data with one another to facilitate effective handoffs. This can only be achieved by fostering the underlying relationships that promote trust among all providers. Further, responding to identified needs requires a process for assessing internal capacity of a health care provider to address certain needs, understanding the resources available in a given community, and determining the appropriate path forward whether that involves augmenting internal capacity, referring patients outside of the health care system, or a combination of the two.<sup>12</sup>
- **Utility & Reliability of Screening Data** – SDOH data acquired from primary or secondary screening can be incredibly informative. However, considerations for the utility of such data include the reliability of patient-reported data, the availability of appropriate resources and interventions to respond to needs, and the willingness and ability of providers to have conversations about non-clinical needs. Additional considerations for the use of secondary data include the source of information (e.g., credit card purchases, which may be more applicable to certain populations). The reliability of screening data will be particularly important as public and private payers move toward SDOH risk-adjustment and risk-based payments for providers.<sup>13</sup>
- **The Scientific Grounding of Screening Instruments** – Screening tools used in the field should be assessed for their psychometric properties such as validity and reliability.<sup>14</sup>

## RECOMMENDATIONS FOR CONTINUED EXPLORATION

Moving forward, we encourage those implementing screening tools with their patient populations to share promising practices or challenges of operationalizing these programs. These may include clinical benefits, financial return on investment, or the influence of factors such as when and where screening takes place, how often screening takes place, which screening tools/questions are used, and who conducts the screening. In addition, we encourage further research around the development and refinement of screening tools. Specifically, we recommend:

1. **Tool Refinement** – Further development and refinement of screening tools to narrow the list of relevant, actionable survey questions that can lead to meaningful results.
2. **Systematic Evaluation** – Evaluation of existing and newly developed screening tools and mechanisms to help determine broadly applicable best practices for screening.
3. **Shared Learnings** – Development of a communications network/infrastructure for sharing promising practices and challenges across organizations, communities, and geographies to enable improvements and refinements to screening practices across the country.
4. **Informed Consent** – Additional work to determine what meaningful informed consent looks like in a clinical setting with the goal of balancing patient privacy needs with the utility of social risk data within and beyond the clinical environment.
5. **Social Service Networks** – Additional exploration of how to best facilitate collaboration across a broad network of clinical and social service providers to promote timely action through a shared understanding of a given need and the resources necessary to meet that need.
6. **Social Determinants of Health Data Standards** – Increased adoption and maturity of common data standards to promote sharable, comparable screening data within the health care system, and between the health care system and other community/social service entities.

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<sup>11</sup> Health Care Transformation Task Force (HCTTF) Integrating Social Services into Care for the High-Need, High-Cost Population, at [http://hcttf.org/wp-content/uploads/2018/01/HCTTFWebinar\\_IntegratingSocialServices\\_5.23.17002.pdf](http://hcttf.org/wp-content/uploads/2018/01/HCTTFWebinar_IntegratingSocialServices_5.23.17002.pdf), accessed 03 January 2019.

<sup>12</sup> Freeman GA. "Health Plan Addresses Social Issues With Data." *HealthLeaders*, May 30, 2018.

<sup>13</sup> Andermann A. "Screening for social determinants of health in clinical care: moving from the margins to the mainstream." *BMC* 39(19), 2018.

- 7. Community Data Commons** – Development of a non-proprietary data commons that can lead to meaningful innovation at the community level by helping organizations identify risk in their community without needing to fully implement their own screening tools and infrastructure.
- 8. Patient Trust** – Exploration of the best ways to obtain the non-clinical information that will enable health systems, social service, and public health agencies to develop social service integration plans that are actionable and relevant (e.g., patients may be more comfortable sharing information on social risk with community health workers/peer navigators and peer support personnel rather than clinicians or their staff).
- 9. Screening Integration** – Exploration of community-based screening (versus screening in the clinical environment) and methods to integrate upstream findings into the clinical environment to enable early interventions.

# ABOUT NASDOH

The National Alliance to impact the Social Determinants of Health (NASDOH) is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts. For more information, please visit:

**[www.nasdoh.org](http://www.nasdoh.org)**

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