

Screening for Social Determinants of Health

Children's Hospitals Respond



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As the health care industry evolves, there's greater awareness of what factors contribute to health. Social determinants impact 20 percent of health, and children's hospitals are working to identify and address them to improve patient health outcomes. Responding to member inquiry, the Children's Hospital Association (CHA) set out to define tactics implementing social determinants screening, the community linkages needed and the inherent challenges they present. A representative sample of children's hospitals contributed to this snapshot of where screening for social needs stands, and what questions must be answered to bring the practice to scale throughout children's hospitals.

Screenings: Finding a Tool to Understand the Whole Patient

It's been well over a decade since literature on the importance of addressing social determinants of health (SDoH) began to rise in prevalence. Defined by the CDC as "conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes," SDoH can include things like food scarcity/insecurity, homelessness or unsafe housing conditions, unemployment, and lack of access to care. Recognizing the profound impact of these factors, health care providers realize that they can no longer solely focus on the medical needs of their patients. While some children's hospitals work within their community to address these issues on a population level, others are working to address the social needs of individual patients and families.

Children's hospitals have an added level of complexity when trying to address social determinants of health, as the needs and context extend beyond the patient to include the family. Children with unmet social needs are familiar to those in the hospital, presenting as non-compliant, with frequent visits to the emergency department for inability to control chronic conditions or issues like failure to thrive. Additional signs often seen are stressed parents and/or children, an apparent lack of engagement in care or prolonged illness from persistent minor health problems. The consequences of these issues limits the impact of the medical care being provided, affecting the family's engagement and the child's overall health.²

CASE STUDY

The following example shows how unmet social needs play out within clinical settings:

Lucy is an 8-year-old patient with insulin dependent diabetes mellitus. She was admitted to Children's Hospital of Wisconsin multiple times in Diabetic Ketoacidosis, a potentially life threatening condition of uncontrolled elevated blood sugar. Lucy had sporadic attendance at primary care and diabetes clinic visits, and her pediatrician – concerned that Lucy's mother may have low health literacy – engaged the community health navigator who serves Lucy's neighborhood. Once the navigator met Lucy and her mother, she learned they were homeless, moving between willing friends or family members, and squatting in abandoned buildings. Insulin must be refrigerated to maintain its effectiveness, and Lucy often was without electricity, making it impossible to manage her diabetes well.

Without the community health navigator, clinical staff would not have the complete picture of the challenges Lucy and her mom faced, and Lucy's health would have continued to decline. By identifying this family's problems, hospital staff was able to connect them with community resources, bringing more stability to their lives and predictability to Lucy's medical care.

A Starting Point: Building Community Connections

One reason many hospitals don't currently screen for social needs is the uncertainty of how to address them when they are found. To overcome this, respondents suggest a good starting point for building a successful screening process inside the hospital is to establish community relationships outside the hospital. These relationships need to go beyond typical coalition building. It's important to understand, and assess, the depth and breadth of resources provided by community and social service organizations in their catchment area, as well as their capacity for referrals.

Strategies for connecting to social service resources vary from community to community. Many areas have active 2-1-1 programs, call centers supported by United Way Worldwide and staffed by local resource specialists who connect callers to a variety of social services and community resource providers. If this is

available, the 2-1-1 programs can serve as the bridge between the hospital and the resource providers. For communities without a 2-1-1 program, or if those resources aren't comprehensive to the needs of the patient population, hospitals have to find another option. One possibility is to build their own networks of resources, sometimes in creative ways, like the one shared by Dayton Children's. (right)

While learning who the community resource providers are is a start, establishing relationships with them is key as well. Children's Hospital and Medical Center in Omaha reports their social work team conducted site visits to the community resources they refer families to. This allowed

staff to learn more about the services to better answer questions from families. Additionally, it demonstrates the hospital's commitment to addressing social needs to the community.

Children's Mercy Kansas City has taken a similar approach. During the Resident Advocacy Rotation, the residents visit WIC sites and food pantries to better understand the experience of their families. The hospital also provides food prescriptions which can be claimed at a local market. To better assess needs, hospital staff follow up to see where the prescriptions are redeemed to determine if it was close to the patient's home, close to the clinic or in another area of the community.

Identifying Community Supports

A robust set of community supports are critical to the success of any social needs screening and connection program. Building an effective database to support that program, however, requires significant additional staffing.

Dayton Children's Hospital partnered with the University of Dayton pre-medicine program to build the initial database for the hospital's Family Resource Connection social needs screening program. Staff from Dayton Children's and university faculty created a 1-credit hour "mini-course" for ten pre-medicine students.

The service-learning based mini-course covered the SDoH and their impact on children, along with relevant policies impacting each social determinant. Students then learned the basics of social needs screening programs through review of applicable literature. A Skype session with a Health Leads consultant taught the students how to use the Health Leads REACH™ database software. Key training points were the identification of eligibility, desirability and accessibility for each resource. The students then called or visited community resources, obtained necessary information, and entered them into the database.

By the end of the semester nearly 150 resources had been identified and served as an excellent foundation for the program.

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In communities where the network of resources is not currently connected or well established, sometimes the children's hospital becomes the anchor, bringing the necessary parties together. This is the case in Los Angeles, where Children's Hospital Los Angeles worked within a collaborative to create a "Healthy City for LA" website with a resource directory. The hospital now funds the ongoing maintenance of the site while another collaborator oversees the content.

Another option, which has added expense, but added benefits as well, is for hospitals to co-locate medical services with social services. St. Christopher's Hospital for Children in Philadelphia used a co-location model when they opened their Center for the Urban Child in 2015. In addition to housing primary care services, the Center is home to a dozen other services including food resources, free legal advice, injury prevention specialists, literacy resources, the WIC program and more.

Tools: Selecting the Right Questions

For many, the issue of what comes first – the screener or the resource - is a tough one. While hospitals have taken different approaches, most report they don't want to ask social needs questions until they have a way to do something with that information. That's why the topic of building community connections appeared first in this paper. Once those are in place, hospitals can then move to determining which screening tool to use.

Through the information gathering process for this paper, which involved collecting data from both acute and specialty hospitals, independent and those within systems, from all regions of the country, one thing nearly all had in common was the question "What social needs screener are you using?" did not have a simple answer.

Most hospitals report using hybrid tools – combinations of questions from validated screeners, and those developed by their in-house experts. This allows them to create a tool best suited to gather information from their patients and be implemented most effectively by their providers. This has the benefit of being customizable to meet the specific needs of patient populations served and the hospital's capacities, but can be a challenge as the questions often aren't validated and their efficacy can be uncertain.

The challenge most hospitals report is finding a tool that:

- encompasses the social needs questions they are prepared to ask (i.e. the ones they have resources available to address);
- is pediatric appropriate; and
- either incorporates, or at least doesn't duplicate, other screening tools being used. An audit of surveys and data already collected may influence what is needed in the screener tool.

Questions to Consider

- Does your hospital have the network of resources needed in place, or will that need to be built before screening can begin?
- What role does the hospital have capacity to take in identifying that network?
- Do you want to approach screening as one way (just providing a referral/warm hand-off) or two way to track the referral outcome?
- Do the community resources have capacity for additional referrals?
- Is co-locating community services of interest, and is it an option for your organization to consider now or in the future?

Frequently Cited Tools and Platforms

The following list provides a sampling of the screeners and referral platforms member hospitals are referencing. Screeners typically just refer to the set of questions being asked, while referral platforms help identify community resources and may involve care management.

Name:	Type of Resource:	Description
ACES	Screener	Adverse Childhood Experiences Screener. Originally developed for adults, a validated pediatric version is also available.
Accountable Health Communities Health-Related Social Needs	Screener	Developed by the Center for Medicare and Medicaid Services (CMS) for use by their Accountable Health Communities and made publicly available.
Hunger Vital Sign	Screener	2-question screening tool to identify households with food insecurity. Developed by Child Watch and endorsed by AAP and CMS.
iHELP	Screener	Pediatric-focused screening tool developed by clinicians, which includes both household needs and child-specific questions.
Medical Legal Partnership	Screener	A customizable screener that identifies legal needs
RAAPS - PH	Screener	Rapid Assessment for Adolescent Preventive Services (RAAPS) is a tailored social needs screener for adolescents to young adults (9-24). The "PH" version of the tool aims to further identify youth most at risk for access to tangible needs (food, water, electricity).
PRAPARE	Screener	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) is a comprehensive screening tool that includes 16 core measures as well as four optional measures.
SEEK PQ	Screener	Safe Environment for Every Kid Parent Questionnaire (SEEK PQ) screens parents for psychosocial issues and topics that impact safety for the child.
SWYC	Screener	Survey of Well Being for Young Children (SWYC) screens children five and younger, and focuses on developmental milestones and family risk factors.
WE-CARE	Screener	Validated tool that asks parents questions about child care, food security, housing, parent education and employment.
Health Leads	Screener/Referral Platform	Both a screening tool and a platform for referral. Clients opt-in to this student-based, help-desk model for assistance. Hospitals elect which feature to use.
Healthify/Purple Binder	Screener/Referral Platform	Platform with software tools to identify resources, screen for social needs, and track and coordinate referrals. Currently has contracts in 30 states.
HelpSteps	Screener/Referral Platform	Developed by Boston Children's Hospital based on a library of known screener tools. Offered in partnership with Boston Health Department. Looking to expand beyond Massachusetts.
Aunt Bertha	Referral Platform	Uses zip code to identify resources for patient families, not a screening tool.
NowPow	Referral Platform	Uses zip code as well as patient- specific data to identify resources for patient families, not a screening tool.
Unite Us	Referral Platform	A referral platform with closed-loop capabilities. Initially focused on veterans, working on expansion to pediatrics.

Implementation: Starting Small to Make Big Changes

Building community connections takes time, effort and strategy. Selecting the best tool for your environment requires the same approach, followed by implementation of the new process. Questions quickly arise when the discussion shifts to implementation:

- How do we institute another process without disrupting clinic flow?
- How does social needs screening interact with the other screenings already taking place?
- Do we automate the process on tablets or computers? Use pen and paper? Have it done person-to-person?
- Who talks to the family about resources for a positive screen?
- Do we institute a process that is referral only, or do we want to “close the loop” and know services were received?

These are only a sample of the logistical concerns hospital teams face when trying to implement a new process. For this reason, many children's hospitals are starting small with their social needs screening. Children's Hospital of Greenville Health System in Greenville, South Carolina began screening for social needs in their resident primary care clinics. However, this screening has caught the attention of a few specialty providers who have seen success with interventions from the Medical Legal Partnership, and were interested in implementing routine screening for their patients as well. While that step-by-step expansion is a slow process for bringing something to scale, it helps to have clinical champions interested in the work to ensure success.

Gaining physician buy-in for social needs screenings is often cited as a challenge, yet an RWJ survey of pediatricians and primary care physicians nationwide found many wished they could write prescriptions to help patients with social needs (e.g., 75% wish they could prescribe fitness programs, 52% wish they could prescribe employment assistance for their low-income patients)³.

Arkansas Children's Hospital sought advance input from providers throughout the hospital when identifying their screener as a way to secure support for the project. Staff created a committee of clinicians to determine the tool they would use for the screening. They quickly decided a hybrid approach would work best, and used champions from these program areas to identify screening questions. This ended up being a powerful method for screener implementation, getting support from different areas of the hospital.

Jumping past “analysis paralysis” was a big step for Phoenix Children's. Their clinically integrated network began screening each patient referred for care management for social needs, which led to a culture change. It changed the notion of non-compliance of families by suspending judgment and focusing on the social factors impacting compliance. To implement this change they flipped their ratio in the clinic, decreasing the number of nurses and increasing the number of social workers to better serve the patient and family needs.

Preparing to Screen

As part of its transition to value-based payment, Nemours Children's Health System is exploring ways in which it can more seamlessly connect the patients and families it serves with social services available in the community. Nemours is conducting an environmental scan that consists of scripted phone interviews and a follow-up survey of key primary care pediatricians, specialists, social workers, psychologists and others in the Delaware Valley and Florida.

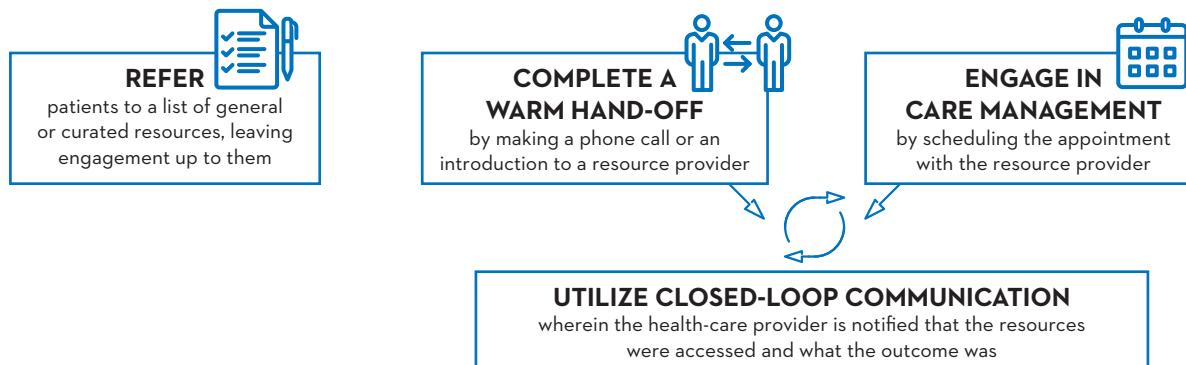
Questions cover these topics:

- whether a standardized social needs screener or other process is currently in use and if so, what it entails;
- current methods for inventorying community resources that address social needs;
- the staffing and workflows involved in connecting patients and families to those community resources;
- whether and how Nemours tracks what social services are actually provided to the patients/families; and
- what a recommended protocol for each of these domains would entail.

Results from the environmental scan of current practice will inform Nemours' future strategy.

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Upon screening for social determinants, clinicians can



Implementation Requires Process Improvement

Quality improvement techniques, and their unique vocabulary of terms, have expanded beyond traditional clinical settings and can be found in all areas of hospitals. Many hospitals have found these strategies helpful when addressing social needs. Examples of program improvement include:

Presuming Need: as safety net providers, children's hospitals are familiar with the socioeconomic status of the families they serve, but can often be surprised at how much need there truly is. A Children's Hospital of Wisconsin pilot program screens at nine clinics across their service area. Providers were surprised to find a significant number of patients in the suburban clinics also had a high prevalence of positive screens.

Normalizing the Process: To be transparent and demonstrate that screening questions are given to all patient families visiting Dayton Children's Hospital's primary care clinic, the screener is distributed on neon green paper. This makes it highly visible and clear that screening for social needs is standard protocol for everyone.

Training is Key: Children's Hospital of Philadelphia ran into an execution problem when they began conducting mental health screenings. Their primary care physicians didn't get adequate information about the resources available, and instead referred positively screened patients to the hospital's emergency department.

Patient/Family Pushback: Seattle Children's found the responses they got depended on who was asking the question, with a high prevalence of needs identified if the question was asked by a medical assistant rather than a physician.

Validating Data: Having researchers look at the data from the screenings can help improve the process. A hospital reports high food insecurity among their patient population shows up in the community health needs assessment (CHNA), but was not coming up on the tool utilized for screening patients. The staff suspected this was because families weren't thinking about that issue when they were at the hospital and focused on medical needs. More patient education can help families make the connection between health and social needs.

Questions to Consider

- What questions are currently being asked and who is asking them?
- Often issues like transportation, food security and social supports come up through regular clinic visits. When they do, what happens to that information? Is it being received and not utilized? Is there capacity to do more?
- Are there champions in your hospital who would like to engage more on addressing these issues?
- Are your providers aware of the resources already in place from a case management or social work team?
- Is your community benefit team who is likely plugged into the resources available in the community communicating with those inside the hospital about those resources?
- What are the financial policies in place to assist individuals?

Moving Past the Why to Improve Health Outcomes

Collaboration between clinicians and community to improve care for children can be found in the origin story of children's hospitals. That collaboration remains active today, and in many instances, is growing as evidence demonstrates the importance of addressing social needs to achieve positive medical outcomes. Children's hospitals are large, complex institutions focused on providing high quality medical care. But without addressing the other risk factors impacting a patient's life, medical care can only go so far. Initially, the conversations were focused on why changing the care delivery model from sick care to holistic health was important.

With this paper, the decision was made to no longer discuss the why. It's been clearly established that addressing social determinants of health is crucial when addressing children's health. The big question for children's hospitals is now the how. The steps outlined in this paper - identifying the resources, determining the screening tool and implementing a new process - present challenges, but are also great opportunity to better serve the unique needs of the patients and families our hospitals serve.

The questions throughout the paper can support your organization's efforts to develop strategies that effectively address the needs of your patients. The hospital examples can connect you with colleagues who found ways to integrate screening tools and uncover factors contributing to poor health outcomes. And because of their critical role in population health, children's hospitals can benefit from being part of the learning community offered by CHA. This focus on openly sharing best practices will ultimately improve children's health.

References

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