EvidenceNOW
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# IDENTIFYING AND ADDRESSING SOCIAL NEEDS IN PRIMARY CARE SETTINGS

## Should our primary care practice screen for social needs?

**Social determinants of health (SDOH) are widely recognized as having an important impact on health and mortality,[1] and there is now strong evidence of the benefits of addressing people's unmet social needs.** For example, ensuring access to healthy foods and providing supportive housing for people facing homelessness have been found to lower healthcare utilization and costs.[2] In addition, there is emerging evidence that screening for and attempting to address unmet needs within a primary care setting can improve patient health.[3] In response to this growing body of evidence, primary care practices and health systems are increasingly integrating formal screening for social needs into clinical care services.

In addition to helping patients connect with needed services that can improve their health, **collecting information about social needs allows clinicians to develop treatment plans that are better tailored to a patient's unique needs and priorities – resulting in plans that patients may be more likely to follow**. Satisfaction has been found to increase for both patients and providers when providers make efforts to address patients' social needs,[6] and provider burnout can even be mitigated.[7] While many primary care clinicians may have justifiable concerns about adding yet another activity to their already busy practices, pilot studies have demonstrated that it is feasible to screen for patients' social needs without disrupting clinic flow.[8]

### TERMINOLOGY

**Social determinants of health** are defined by the World Health Organization (WHO) as "the conditions in which people are born, grow, live, work and age."[4]

**Social needs** refer to an individual's perception of his or her own needs, based on the negative SDOH they face in their own lives.[5]

**This tool is designed for practices that are thinking about beginning to screen patients for social needs.** For these practices, the tool will help you:

- Find resources and information to get started
- Consider what implementation approaches might work best in your practice
- Understand how you can use collected information to address patients' social needs, tailor care to their circumstances, and maximize reimbursement.

# What social needs information should we collect?

There is no "one-size-fits-all" approach to screening for patients' social needs. You can **choose a tool to conduct comprehensive social needs screening**, **or you may want to start out by screening for only one or two key social needs.**

Whether you decide to take a comprehensive or targeted approach to screening, be sure to consider your patient population – including languages spoken and literacy levels – when selecting which screening tool or questions to use.

## SCREENING TOOLS AND QUESTIONS

**Resources are available to help you find the screening tool or questions that will work best for your practice. Below are examples of resources to help you get started.**

**Health Leads Screening Toolkit**

This free Toolkit includes a brief screening tool in both English and Spanish that is ready for printing and quick implementation. The Toolkit also includes a library of screening questions for developing your own tool or selecting individual questions, and also provides general implementation considerations.

**Kaiser Permanente® Systematic Review of Social Risk Screening Tools**

This website helps providers and other stakeholders select social risk assessment tools for their setting and population. The **Find Tools** feature has filters to select domains and constructs to find tools that meet specific criteria and includes detailed descriptions with related articles and tool ratings.

**American Academy of Pediatrics Screening Tool Finder**

This table allows you to compare tools with a focus on early childhood screening (target population is children aged 0 to 5 years).

# How should we collect social needs information?

There are many ways to implement social needs screening in primary care, and each practice can determine which approach they want to take. **Regardless of your chosen approach, it is important to standardize information collection to reduce the potential stigma associated with screening, and staff should be trained to conduct screening with sensitivity, empathy, and careful attention to privacy.**[9, 10] Pilot testing the process you choose will give your practice a chance to make needed refinements before full implementation.

Below are some pros and cons to consider when selecting an approach.

### Self-administered or staff-administered screening:

- Some research suggests that self-administered tools may enhance self-disclosure of social needs, and that patients prefer this approach.[11, 12] However, patients with limited literacy or who are completing screening forms not in their primary language may need assistance.
- A staff-administered approach eliminates literacy concerns and allows staff to enter results directly into the EHR. However, staff time and private space are needed for this approach. Medical Assistants are often tasked with asking screening questions and entering the data.

**Some electronic health records (EHR) have built-in tools for social needs screening and EHR templates are available for some existing tools, such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**

### On-site or at-home screening:

- Conducting screening when patients come into the office (for example, while they are in the waiting room, or while waiting for the clinician in the exam room) has the advantage of allowing for immediate referrals but could miss patients without frequent visits.
- Patients can be asked to complete a screening tool on their own between visits (or as part of a telehealth visit) by sending the tool via a patient portal (electronic) or mailing it (paper). This approach alleviates the need to integrate the administration of screeners into the clinic visit workflow but may result in a lower proportion of completed screeners. Your practice may want to conduct follow-up calls with non-respondents to administer the screening tool by phone.
- A combined approach of both on-site and at-home screening can be used to reach as many patients as possible.

Once you have determined your preferred approach for conducting screening, you will need to establish workflows to ensure patients are connected with needed services. Often the primary care provider, a social worker, or a patient navigator (if available) conducts this step. Keep in mind that follow-up phone calls will be necessary for patients who identify social needs during at-home screenings.

# How do we connect patients with needed community resources?

**Identify trusted organizations in your community** where you can refer patients for identified social needs. If you are not already aware of local community resources, these resources can help you get started:

- **211 Helpline Center:** Dialing 211 gives callers information and referrals to local social services. Available in all 50 US states and Puerto Rico. The **211 website** (https://www.211.org/ and http://www.211pr.org/) provides information by zip code and is accessible in 180 languages.
- **Aunt Bertha** (findhelp.org) has a free online directory of community resources that is searchable by zip code.
- Several companies offer directories of community resources and referral tracking for a fee. For more information, see *Community Resource Referral Platforms: A Guide for Health Care Organizations*.

**Make sure patients want assistance** before making any referrals. Even when a patient screens positive for a social need, they may not want or need help at that time. If a patient screens positive for multiple issues, ask them to help prioritize which ones are most urgent for them.

**Make referrals.** There are different ways to make referrals, and you may want to consider using different types of referrals for different social needs.

- ***Direct referrals*** are when your practice directly contacts the service agency on behalf of the patient. Be sure to only share information that the patient has given you permission to share. Establishing formal referral or information-sharing agreements with key organizations can facilitate the process.
- Making a ***specific referral*** to a community-based organization is another approach. The Agency for Healthcare and Quality (AHRQ) Community Referral Form is a sample form your practice can use for this type of referral.
- Providing a ***tailored resource*** *list* is a simple, but still effective, way to refer patients to community resources.[13] Confirm that the resource information is accurate before sharing it with patients and update information periodically.

**Consider using a Warm Handoff Intervention when possible – this is when a practice makes a referral while the patient is present. The patient gets to hear what is being discussed and is engaged in the process, allowing them to clarify or correct information as needed.**

**Follow-up** with patients after referring them to a community resource to make sure they received the assistance they needed. If patients report negative experiences, identify alternate agencies for future referrals.

## How can we use the social needs information we collect?

**For patient care:** Documenting social needs and referrals in the patient chart provides useful and actionable information to improve clinical care. For example, if a patient has identified food insecurity, this could impact the nutritional guidance that is provided for heart disease or weight loss.

**For population health:** Systematically documenting social needs information in the EHR provides an opportunity to analyze your patient population's needs over time. This information can be used to identify if new partnerships or approaches are warranted, including co-location of key services or offering direct services within the clinic.

- For example, some practices have set up their own mini food banks or farmer's markets, help eligible patients enroll in Supplemental Nutrition Assistance Program (SNAP) benefits or transportation services, or have set up medical-legal partnerships to assist patients with immigration or housing issues.

**For quality improvement (QI):** Tracking positive screenings and follow-up actions in structured fields within the EHR allows you to understand how consistently you are conducting screening, make needed adjustments to your approach, and identify how efforts are impacting patient care and outcomes. Use AHRQ's Plan-Do-Study-Act (PDSA) worksheet to track your progress.

**For reimbursement:** Social needs information can now be used as part of determining medical complexity for office visits, so documenting social needs may help your practice achieve higher reimbursement rates. Learn more about Social Determinants of Health and 2021 E&M Code Changes.

- Additional payment reforms that help address patients' social needs in primary care may be on the horizon. For example, the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities model is currently testing if screening, referral, and community navigation services for health-related social needs impact the health care utilization and costs for Medicare and Medicaid beneficiaries.

# Where can we find more information?

**Resources are available for more information and to help your practice work through the considerations described in this tool.**

- The **SIREN Evidence & Resource Library**, is a searchable database of articles, reports and other resources about social needs screening and interventions in health care settings.
- **AHRQ Tools and Resources to Help Healthcare Organizations Address SDOH**

## CITATIONS


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