SCREENING & REFERRAL FOR SOCIAL NEEDS

North Carolina Institute of Medicine
Task Force on
Accountable Care Communities

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Poll Question

What percent of your patients are regularly screened for social determinants of health in North Carolina?

1. 0%
2. 1-25%
3. 26-50%
4. 51-75%
5. 76-100%

1 | Just one more statistic...

2 | **Who** should be addressed?

3 | **How** do you engage?

4 | **When** are you successful?

Non-Medical Needs Drive Outcomes and Cost

Patients' lives outside the clinic drive vast majority of health outcomes and cost

Housing, transit, air and water quality

Tobacco use, diet, exercise, AAOD, sexual activity

Education, employment, income, community safety, etc

Source: Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness. 2015. Data from NEHI 2013. http://www.tbf.org/tbf/56/hphe/Health-Crisis.

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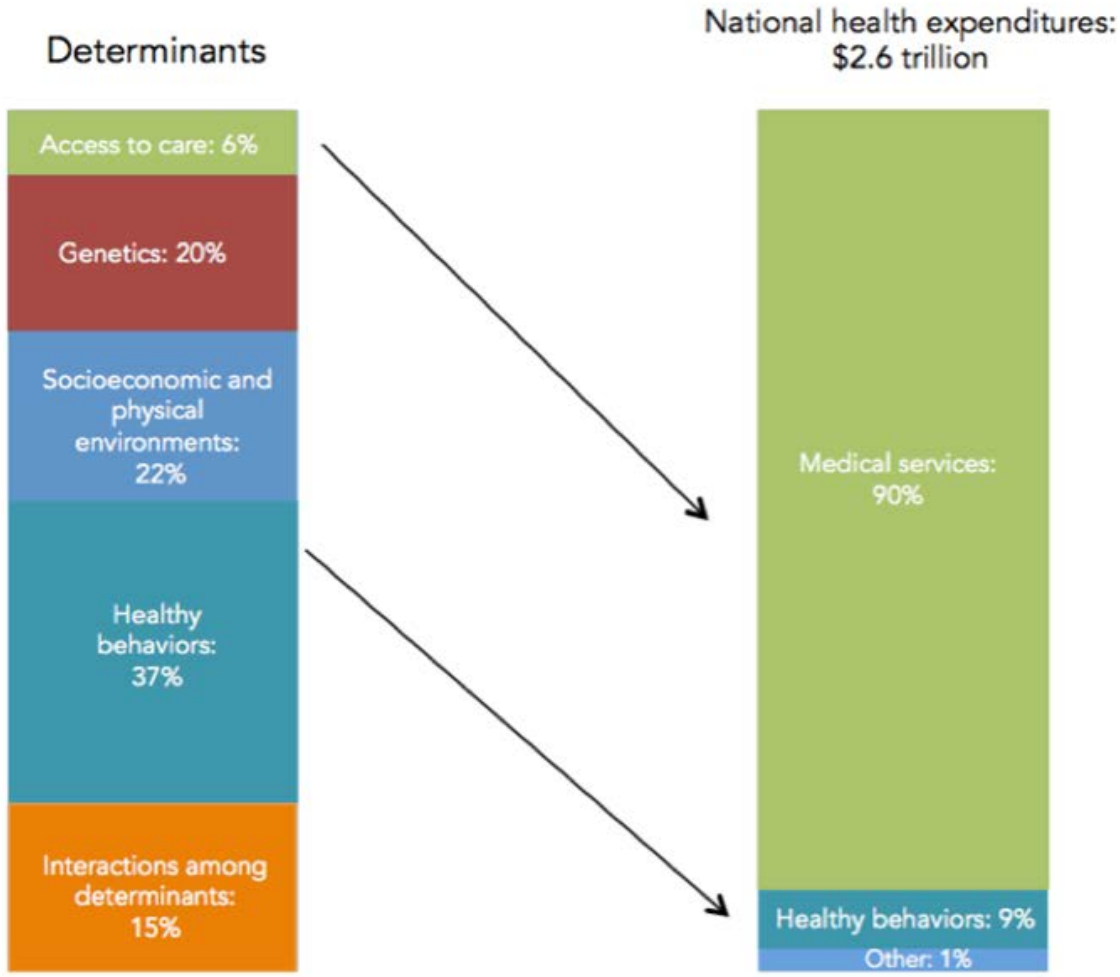

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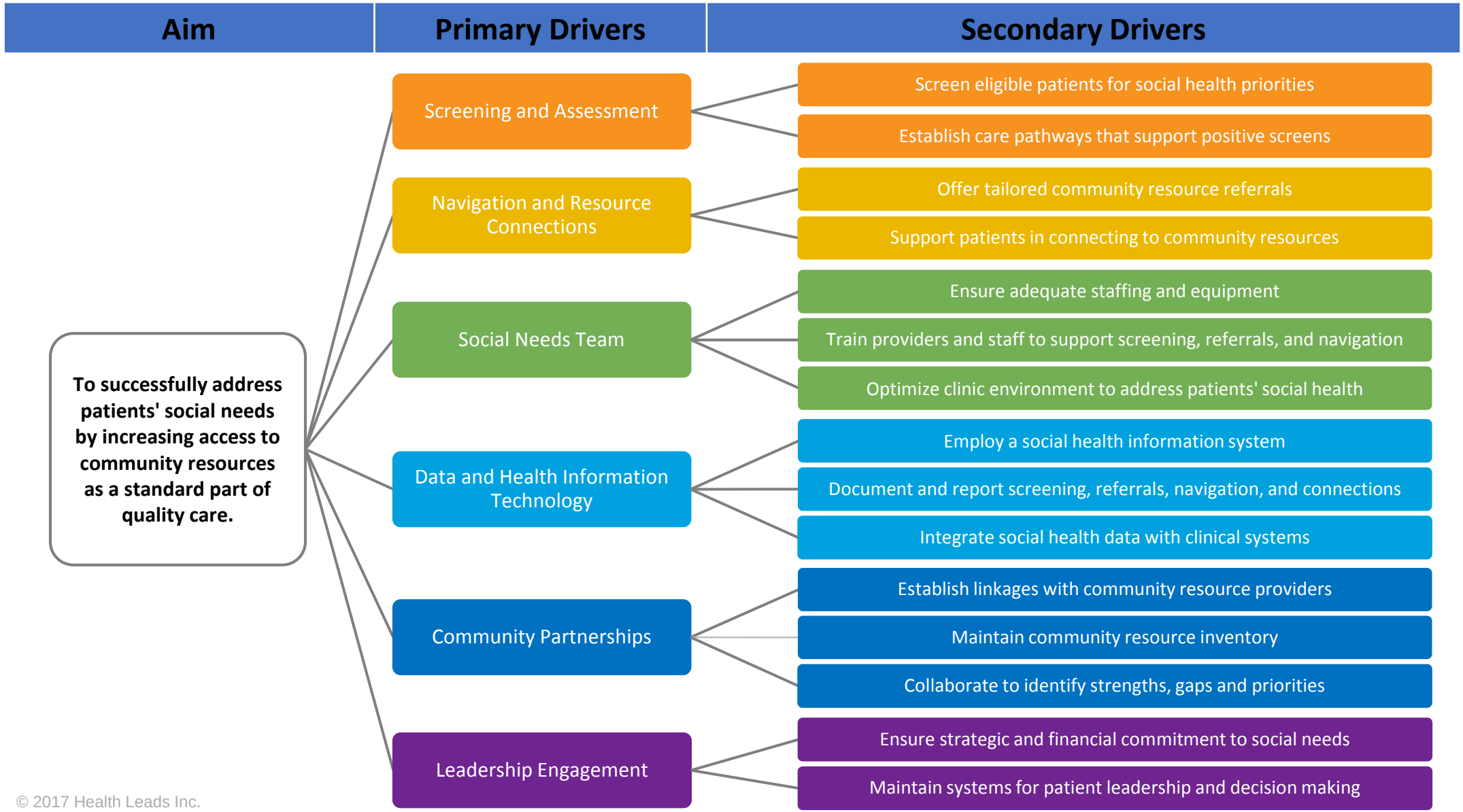
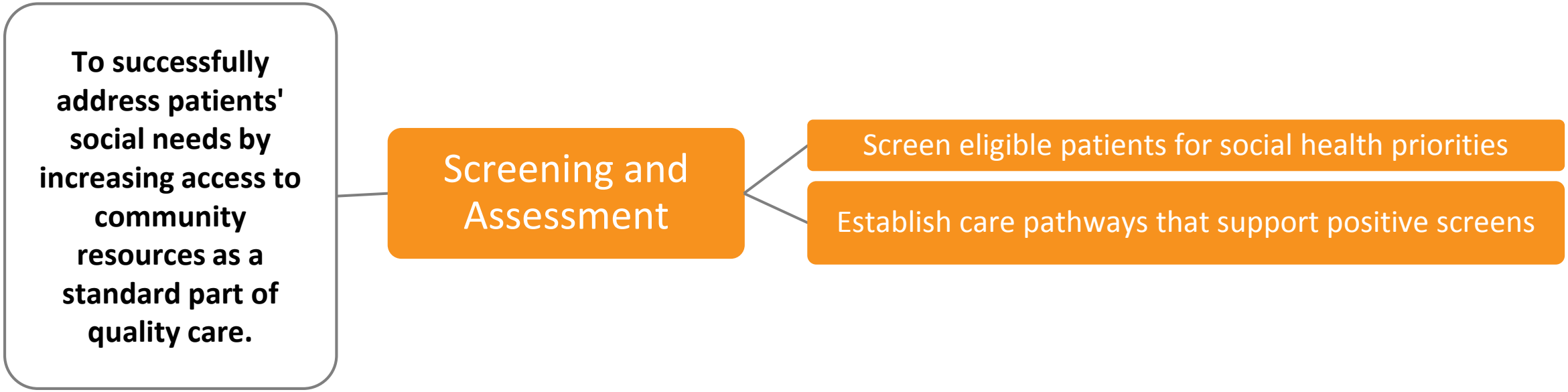
Driver Diagram



Driver Diagram

Aim	Primary Drivers	Secondary Drivers



North Carolina's SDOH Screening Tool

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?	Yes	No
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	Yes	No

Housing/utilities

Do you have housing?	No	Yes
Are you worried about losing your housing?	Yes	No
Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	Yes	No

Transportation

Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	Yes	No

Interpersonal Safety

Do you feel physically and emotionally safe where you currently live?	No	Yes
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	Yes	No
Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	Yes	No

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As you’re starting

Who to Screen: Removing Assumptions

Not just a Medicaid/Medicare problem

- Academic Medical Center
- 80% Private Pay Insurance
- 20% Medicare or Medicaid
- College student volunteers working with patients
- % screening positive for basic needs

40%

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To screen or not to screen?

Reasons to screen

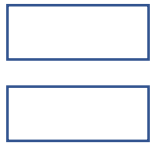
- Minimize bias
- Understanding the communities needs
- Equity, everyone is screened

Reasons not to screen

- Developing the relationship is goal
- Capacity restraints
- Equity, can’t screen ALL (not just sub-population)

Screening vs. Intake

Screening Process



Standard questions that uncover ***presence*** of need

"In the last 12-months has your Utility company ever turned off your service for not paying your bill?"

Intake Process

Eligibility
Frequency
Severity

" Do you have any children under the age of 2, over the age of 65 or with a medical disability living in your home?"

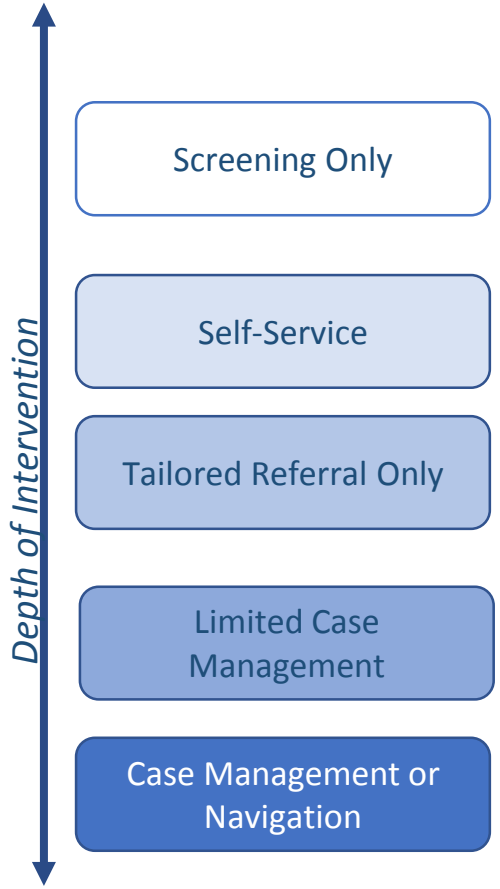
Poll Question

What level intervention (if any) should patients receive when screening positive?

1. Screening for prevalence
2. Patients receive resource guide
3. Patients receive resource guide + 1:1 overview
4. Patients receive resource guide + 1:1 overview + follow-up

Defining your Intervention

Will you provide referral and navigation after screening?



Description

Survey/screen for prevalence. No Intervention

Patient facing app, Kiosk, or printout

Screen and customized referral.
No follow-up

Follow-up once or twice

Weekly or bi-weekly follow-up

Consider:

1) Staff Capacity for Navigation

1) Patient population need for navigation

Intake and Assessment

Goal of Intake Process:

More in depth understanding of client's goals, needs & eligibility than can occur during screening process

Screening

Intake & Assessment

During intake:

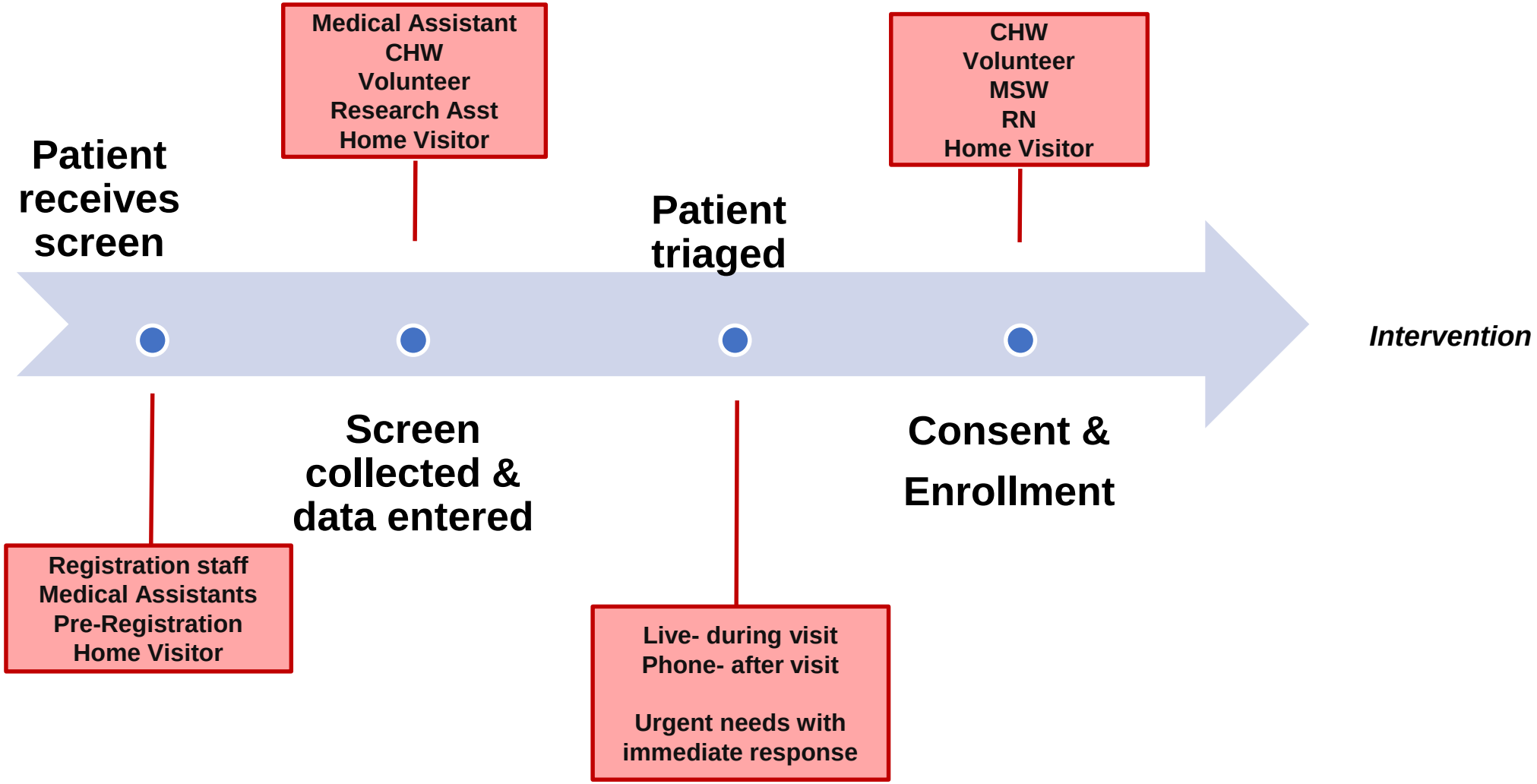
- Understand patient's goals, assets and eligibility
- Benefits screening (SNAP, WIC, Medicaid, etc.)
- Develop coordinated care plan & provide referrals

Consider:

- Integrate rather than duplicate!
- Who is best suited to perform intake?
  - SW? RN? CHW? Volunteers?

Referral

Implementing into your workflow



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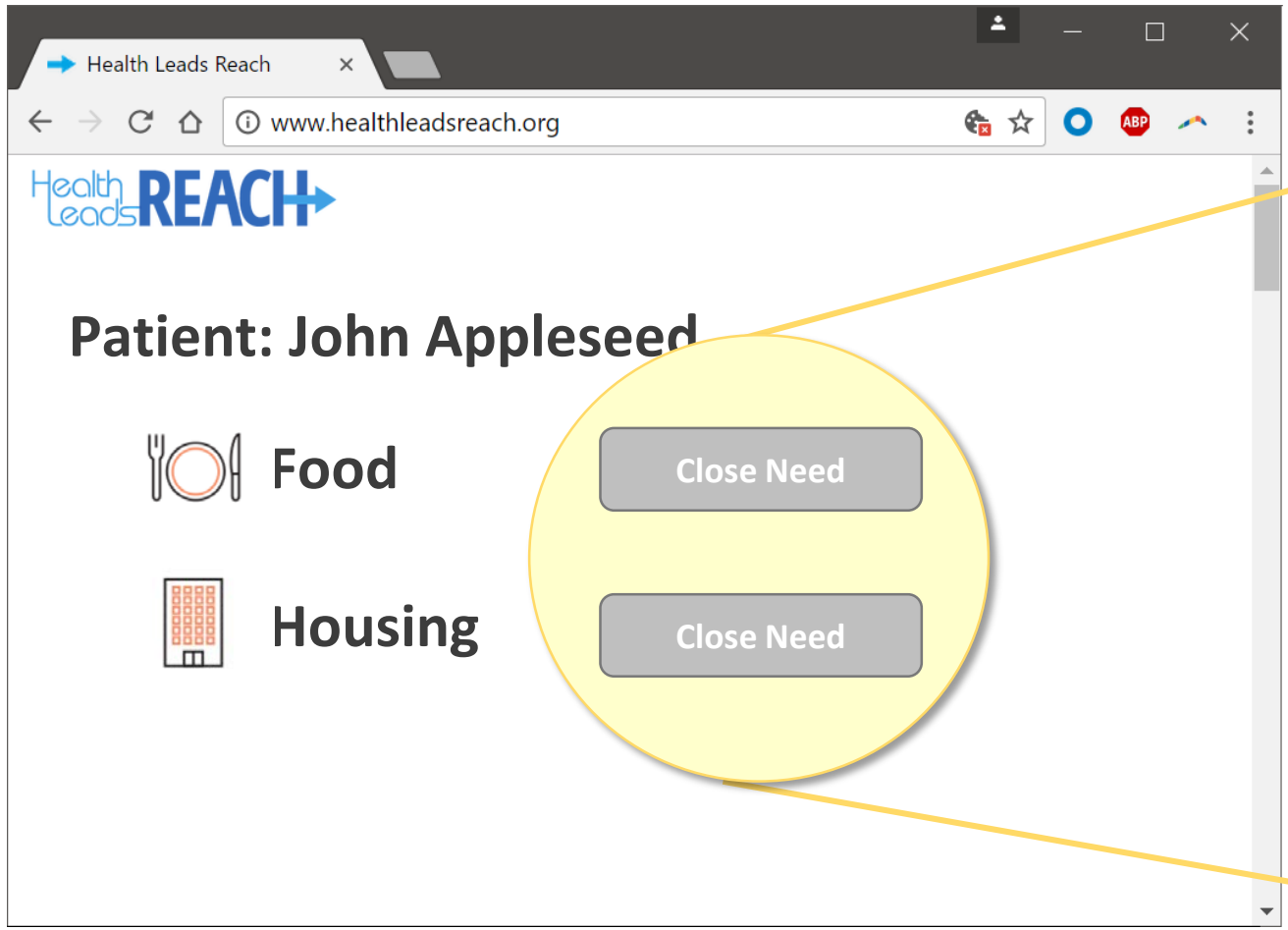
Questions

For the organization, when is an intervention successful?

For the client/patient, when is an intervention successful?

Measuring Success

http://healthaffairs.org/blog/2017/01/26/defining-success-in-resolving-health-related-social-needs/



Clear definition of success for each social need

Track success by resource

When positive, doesn't always mean action for provider

When parent screened positive, % declined assistance with finding resources

- Would you like help to get **GED**? **No- 52%**
- Would you like help finding **employment**? **No- 45%**
- Would you like help finding **childcare**? **No- 20%**
- Would you like help with accessing enough **food** for your family? **No- 14%**
- You are at risk of becoming **homeless**, would you like help? **No- 12%**

unintended consequences

Thank you

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