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**Background Research in Social Needs Screening**

**Compiled for the Social Determinants of Health Measurement Workgroup August 2020**

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**Oregon’s State-Designed Transformational Measure Development Process**

The Oregon Health Authority (OHA) State-Designed Transformational Measures process is used when the decision has been made to consider adopting a new quality incentive metric for CCOs, but there are not any relevant Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally standardized measures available. The measure development process and timeline for developing a new measure is described in this brief.

**State-Defined Transformational Measure Development Process**

# Conceptualization

The metrics development process begins when the Oregon Health Policy Board (OHPB), Metrics and Scoring Committee (M&S), or Health Plan Quality Metrics Committee (HPQMC) identifies a focus area for a new metric. If appropriate to the topic, OHA may identify and engage internal subject matter experts to conduct a national environmental scan and literature search. OHA may also convene a public workgroup tasked with conceptualizing the metric and answering key questions (see insert).

# Specification Development

The public workgroup develops precise specifications for the measure, including: mode of collection, characteristics of the measure, inclusion and exclusion rules, codes and identifiers, time periods and reporting lags, national or local benchmarks, technical aspects of collection, feasibility of data collection, and rules for how the final measure will be calculated.

# Testing

# The process of testing depends on the nature of the measure. In some cases, OHA convenes a workgroup of experts in analytics and other related disciplines to provide input on the metric concept and its specifications. The metric concept and draft specifications go through an iterative improvement process where they are presented to the HQMPC, M&S, the Metrics and Scoring Technical Advisory Group (TAG), and other relevant stakeholders. Then feedback is obtained, and the measure specifications refined. The refined specifications are then presented again to each of the above groups.

**Conceptualizing a Metric: Sample Key Questions**

**Define the concept:**

* What are we trying to measure and what do we need to know?
* How are the measure’s related health services organized and delivered, and how do they affect the recipient?

**Identify data sources:**

* What information could be realistically collected to show a change in outcomes (e.g. claims, electronic health records, opinion surveys, financial records)?

**Determine if it all fits together:**

* Does the measure have a direct link to the service delivery and a direct impact on outcomes?
* Do the data source and definitions fit well with the rest of the concept?
* Will the concept work for different types of settings and geographies?

**Typical Metrics Development TimelinePilot Test**

Pilot testing is used to fine-tune the measure. Pilot testing is conducted using existing available data. A pilot testing plan is presented to HPQMC and M&S for input. The test is implemented and then the results of the test are used to refine the specifications.

**Implementation**

The final measure and specifications are presented to HPQMC for a decision on whether to include it in the Aligned Measure Menu, the list of measures which the M&S Committee can choose from when selecting CCO Incentive Measures.

**The HPQMC evaluates the measure against the following criteria:**

1. The measure addresses an HPQMC and/or OHPB health priority topic for which there is a gap in the HPQMC Measures Menu.
2. No measures specific to the topic have been endorsed by HPQMC, by a national metric endorsing body, or the HPQMC has evaluated the nationally endorsed measures as failing to meet other HPQMC measure selection criteria.
3. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health and/or patient experience. Evidence may include community and consumer experience-informed research.
4. Structured pilot testing or local experience operationalizing the measure has confirmed: operational feasibility, including how the metric is collected, scored and reported, and face validity or perceived positive impact of metric use on a care process or outcome. (1)

If selected as a pay-for-performance measure, the measure is then operationalized by OHA. This process involves developing formal tools, such as guidance and specification documents. The OHA Transformation Center works to communicate the measure and its specifications to stakeholders, to answer questions, and to monitor the rollout. The TAG and the Innovator Agents serve as resources during the rollout process.

**Utilization, Evaluation & Maintenance**

The HPQMC and M&S review metrics every year to refine specifications or other aspects of the work that affect collection of the measure, to update benchmarks, targets or attestations, and to consider inclusion and exclusion codes and rules. Measures are also continuously reviewed by OHA staff using population analysis techniques.

**Additional Reading**

1. 2020 CCO Incentive Measures: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-CCO-incentive-measures.pdf> accessed 5/4/20.
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**Equity Considerations for Social Needs Screening in Health Care**

Nearly half of the Oregon Medicaid population has one or more social need, and racial and ethnic minority groups are disproportionately affected (1). While there is increased momentum to understand and address unmet social needs, screening for social needs requires patient- and community-centered strategies. These strategies are especially critical for priority populations that are more likely to experience complex social, cultural, linguistic, and psychosocial barriers. Considerations from the scientific literature and best practices from health equity experts can help inform screening plans.

# Health equity can be defined as the time when all people reach their full health potential (see insert for Oregon Health Authority’s definition of health equity). Unfortunately, not enough research has been done about equitable approaches to social needs screening of diverse populations seeking health care. In fact, screening for social needs is a relatively recent phenomenon in some areas of health care. Even in settings serving low-income populations, where unmet social needs are more prevalent, rates of screening are low (2). That said, the scientific literature and experts point to some activities that could increase health equity in social needs screening.

**Oregon Health Authority**

Definition of Health Equity

Health Equity is where all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

* The equitable distribution or redistributing of resources and power; and
* Recognizing, reconciling and rectifying historical and contemporary injustices.

# Key Factors to Increase Equity in Screening

# Design screening with the most marginalized and underserved communities in mind

# Experts suggest that to increase equity in a process such as screening for social needs it is best to design the entire process around the most marginalized and underserved communities that the effort may reach. Awareness of how these populations experience health care is key to developing an effective screening strategy. There are multiple studies that demonstrate that diverse populations have a poorer experience of health care and of their physicians than non-diverse populations (3,4). These poorer experiences include the physician’s style (thoroughness of examination, listening skills, explanations the patient can understand), and trust (referrals to specialists when needed, unnecessary tests, is influenced by insurance rules)(3). Medicaid or other public health insurance coverage, lack of physician continuity, and fewer visits to physicians are also associated with poorer satisfaction with health care and physicians (3).

# Awareness of cultural roles of the family within these populations is also important to screening design. Some screening tools are intended to capture a nuclear family (i.e. parents and their children) which is not necessarily the unit of measure for diverse families.

# Ideally, to design screening that accounts for the needs of marginalized and underserved communities, members of those communities should be meaningfully engaged in measure research and design. The methods of community-based participatory research (CBPR) can support more equitable research design.(5) CBPR is a partnership of community member and researchers working to understand and address health inequity.

# Engage a diverse screening workforce

# Despite effort on the part of medical schools and other training programs, the health care workforce is rarely representative of the patients they serve. Engaging a diverse workforce for screening should support equity efforts. Many clinics and Coordinated Care Organizations in Oregon employ community health workers to support the work of screening for social needs. Community health worker interventions have been shown to have positive health outcomes for chronically ill, uninsured, or Medicaid-insured populations, and positive returns on investment.(6) Community health workers can be trained to follow interview protocols to understand patients’ social needs, and connect them to appropriate community resources.(6)

# Train providers

# Experts emphasize the importance of cultural responsiveness and cultural sensitivity training for providers in order to promote cultural humility. Cultural responsiveness and sensitivity training can consist of modules on awareness of one’s world view and assumptions, cultures and cultural norms of diverse cultures, language barriers, racism, and cross-cultural interviewing skills. Cultural humility, as described in the literature, includes a commitment to: 1. continued learning about the self and the patient, 2. humbleness about one’s own beliefs and of the patients’ views and beliefs, and actively working to redress imbalances in power between patient and provider, and 3. recognizing the importance of institutional accountability (7).

# Address language barriers

# In monolingual adults and children, there are significant differences in language proficiency across underrepresented populations (8,9). These differences may contribute to difficulty understanding screening questions, regardless of effectiveness of delivery or translation. Unfortunately, many of the available screening tools have been developed by researchers and tested in limited experiments. Even when translated, these tools may not be linguistically or culturally accessible to patients. This is also true for monolingual speakers with low language proficiency and/or health literacy. Translation of screening tools, however, is likely not enough. In a Canadian trial, non-English speakers were reported to be more likely to refuse to participate in social needs screening, despite the availability of translated surveys (7).

# To make social needs screening acceptable and accessible to diverse populations, institutions not only need to ensure that the screening tool is translated effectively into the main languages spoken by community members, but they also should work towards increasing language concordance, where the screener and other providers involved in care are highly proficient in the patient’s preferred language.

# Ensure sensitivity in approach

# Cultural and economic factors such as poverty, immigration, lack of understanding of why questions are being asked, and prior experience of trauma can increase reluctance to be screened. Questions including sensitive information, such as interpersonal violence, may cause patients to experience discomfort and underreport stigmatized conditions. For example, teenagers and young adults living in poverty are a particularly vulnerable population reluctant to discuss sensitive issues (10). Ethnic minority women also are less likely to accept support for interpersonal violence due medical mistrust, traditional gender roles, discrimination, and immigration status (11).

# Provide resources to address needs

# Marginalized and underserved communities face repeated screening for social needs as they attempt to access state and community services. Repeated screening without addressing needs is thought to be traumatic, ineffective, and possibly unethical.(12) Others argue, however, that understanding a patient’s social needs, even when resources are not available, could still be beneficial as social needs can be factored into treatment plans resulting in better health outcomes. (13)

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**Taking a Trauma-Informed Approach**

While there is no agreement on a precise definition of trauma-informed care, the Trauma Informed Care Project describes it as “an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-informed care also emphasizes physical, psychological, and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.”(1) While the literature on trauma-informed screening for social needs is nascent, the evidence on trauma-informed approaches to providing care can be informative to the screening design process.

# Trauma-Informed Health Care Models

Trauma is caused by events or circumstances beyond one’s control, such as: abuse, neglect, violence, racism, accidents, grief and loss, and cultural, intergenerational and historical events (1,2). In the U.S., 61 percent of men and 51 percent of women report exposure to at least one physical or emotional traumatic event during their lifetimes (3).

Research has linked trauma to poorer health outcomes. For example, adverse childhood experiences, such as physical and sexual abuse, neglect, and family dysfunction, among others, have been found to be associated with heart, lung and liver disease, obesity, diabetes, and depression (4).

A trauma-informed approach is “a program, organization, or system that realizes the widespread impact of trauma and...responds by fully integrating knowledge about trauma into policies, procedures, and practices…”(5). Instituting a trauma-informed approach can improve patient perceptions of health care and their ability to self-manage. A 2018 empirical study found that patients receiving a model of equity-oriented health care that included “trauma- and violence-informed, culturally safe, and contextually tailored care” showed improved confidence in the health care services they received, and in their own ability to prevent and manage health problems (6).

**Factors to Address in Screening Design**

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) six guiding principles to a trauma-informed approach to care (6) (see inset) can be helpful when planning for screening implementation. These principles, and the key considerations for trauma-informed screening that they raise, are discussed below (6).

**Six Guiding Principles to a Trauma-Inform**

**SAMHSA, 2014**

**CDC, 2020**

**(**<https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm>)

**Safety:**

The SAMHSA model emphasizes that employees and patients should feel physically and psychologically safe. Questions to ask during the design process include:

* Do the screening questions address safety concerns? If so, are the patients’ physical safety and data privacy assured?
* Are there plans in place to support patients who have adverse reactions to the screening?
* Are there efforts to avoid re-traumatizing patients being screened (e.g. a system to avoid unnecessary re-screening)?
* Do the screening questions focus on strengths and avoid stigma?

**Trustworthiness and Transparency:**

The SAMHSA model emphasizes transparency as a method to build and maintain patient trust. Questions to ask during the design process include:

* Does the screener have an established and trusted relationship with the patient?
* Is there a plan to address the needs of the patient in a timely manner?
* Does the process include an explanation for why questions are asked and how information will be used?

**Peer Support:**

People with lived experience of trauma can be an effective resource for screening for social needs in a patient-centered way. Key questions to ask in the design process include:

* Is there an effort to include persons with lived experience in design and implementation of screening?
* Have the screening process and questions been reviewed by people with lived experience?

**Collaboration and Mutuality:**

The SAMHSA model emphasizes the leveling of power differences among the care team, and encourages all care team members have a role in being trauma-informed. A question to ask in the design process includes:

* Are all of the providers and staff trained in trauma-informed care?

**Empowerment, Voice and Choice:**

The SAMHSA model emphasizes shared decision-making, joint goal setting, and cultivation of self-advocacy skills. Key design questions include:

* Are patients/members given the autonomy to decide what they wish to share about their needs, and whether they want help to address them?
* Are patients given opportunity to decline to answer?
* Do the patients have a voice in their own plans of care?

**Cultural, Historical and Gender Issues:**

The model points to the importance of recognizing stereotypes and biases, and being responsive to the racial, ethnic and cultural needs of patients. Questions to consider include the following:

* Do the screeners and other providers reflect the races and ethnicities of the people they are screening?
* Are the cultural beliefs and needs of the patients understood?
* Are the screening questions and methodologies culturally acceptable?

**Additional Suggested Reading**

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**Screening Domains & Tools**

An array of screening tools have been developed to identify social needs. As with any burgeoning resource, there are many opinions about which tools are best and how to implement them. While many individual social needs screening questions have been scientifically validated, few whole screening tools have been studied for efficacy and patient acceptability. Considerations for selecting a screening tool include: desired domains, available tools, relevant populations, electronic medical record, care management and community information exchange capabilities, staff capacity, and available resources and interventions for positive screens. Also important are the trauma and equity implications of these decisions.

**Questions for Screening Tool Selection (1)**

1. Is there a tool that has been validated for the selected population that includes the desired domains?
2. Does the tool yield actionable info?
3. Can data be aggregated for reporting if multiple tools are selected?
4. Can the tool be integrated with electronic health records?
5. How easy and costly is the tool to administer?

# Domain Considerations

# Domains are the topics included in the screening tool. There are several considerations when selecting domains, including the prevalence of social needs in the population that will be screened, whether evidence exists of improved health and/or reduced cost of interventions for the domain within the identified population, and whether resources exist for those interventions in the selected communities (1). Additional considerations for selecting domains include: the costs and potential benefits of addressing the domain, possible duplication of existing efforts, and aligning with community priorities (1).

# Domains commonly included in available screening tools include: economic stability, food, housing, neighborhood and safety, transportation, utilities, and social isolation (See attached comparison of social needs screening tools by Social Interventions Research and Evaluation Network, SIREN)(2).

# Screening Tools in Use in Oregon

# A recent survey shows that at least 80% of Oregon Coordinated Care Organizations (CCOs) conduct social needs screening at the CCO- level, predominantly with high-need and high-risk populations, and 66% report using a home-grown screening tool (4). These tools can include published evidence-based social needs questions compiled into a tool, or questions developed de novo.

# Oregon health systems and clinics also use home-grown screening tools, and published tools and questions. The two most commonly used published screening tools in Oregon are the Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) and Accountable Health Communities (AHC). PRAPARE is implemented at community health centers throughout Oregon and is used for an alternative-payment model that is administered by the Oregon Primary Care Association and the Oregon Health Authority. AHC is used in clinical sites that are part of a project funded by the Centers for Medicare and Medicaid Services (CMS). Both PRAPARE and AHC have substantial overlap in domains, and even share some of the same questions (2). AHC in Oregon is only using the food, housing, transportation, utilities, and safety questions from the screening tool. State agencies also collect social needs information, much of which is required by federal funders or programs (4).

**Selecting a Screening Tool**

The development of multi-domain social needs screening tools for health care is a relatively new phenomenon. A 2019 study uncovered only 18 non-proprietary evidence-based SDOH screening tools, and over half of these were created in the last five years (3).

There are many key questions to consider whether one is deciding to implement screening in a clinical setting, at a state agency, through payers, or through other partners. These are discussed in greater detail below.

***Is there a tool that has been validated for the selected population that includes the desired domains?***

While it is possible to develop new ones, there are already many questions that have been clinically tested and validated. It may save resources to look into existing questions in the desired domains before determining that new ones need to be developed. Note that not all evidence-based screening tools have been tested in all age groups and populations.

***Does the tool yield actionable information?***

To yield actionable information a tool should provide a specific and timely assessment of the need. Some tools include questions that are high level and require additional clarifying questions. Others provide an historical assessment of need, but do not identify the most current or pressing needs, and do not address whether the patient wants help with identified needs.

***Can data be aggregated?***

Some states allow multiple questions to be used to survey the same needs. Allowing for multiple screening tools and questions could help sustain existing screening efforts. It could also lead to data that cannot be aggregated, and thus has limited use for understanding need across populations and geographies. For this reason, it is important for states to consider the limitations of allowing multiple tools or considering ways to standardize across tools, questions or domains (e.g. through claims-based z-codes.)

***Can the tool be integrated with electronic health records?***

Many Oregon health systems have been working on integrating information on social needs into their electronic health records (4). The ease of incorporation of new screening tools into already developed social needs screening modules will likely be an important factor in screening adoption.

***How easy and costly is the tool to administer?***

Key decisions such as who should screen, how often, and where screening should take place affect both the ease and cost of administering social needs screening. For example, screening during a clinical visit by a provider in an exam room is likely more costly and possibly more challenging to fit into the clinic schedule than patients screening themselves in a clinic waiting room. That said, patient factors, such as where patients feel comfortable being screened, and patient safety, should also be factored into implementation decisions.

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**Social Needs Screening Workflows**

Screening for social needs at the health plan level, clinical level, or both is a fundamental decision that is influenced in part by how the information will be used. Equally important is determining feasible workflows for screening in a health care context. Decisions include: who should conduct the screen, how frequently to screen, whether to screen directly into an electronic health record, whether to have patients screen themselves, and how to follow up on needs identified. Recent research in Oregon provides some insight into the prevalence of social needs, and the challenges of screening in clinical sites. Ultimately, factors such as familiarity with technology, staff availability, length of visit, and patient preferences should be considered when determining a social needs screening workflow.

# Health Plan or Clinic or Both?

# Many clinical sites in Oregon currently screen for social needs during intake appointments, care coordination visits, annual check-ups, and at other times. At least 80% of Oregon Coordinated Care Organizations (CCOs) screen at the CCO-level, however that screening is seldom universal. Additionally, at least 70% of CCOs report receiving social needs data on some of their members from their contracted providers (1).

# Whether to collect social needs information at the health plan level, the clinical level, or both depends in part on what the data will be used for. Reasons to collect this information at the health plan level include that the data from multiple contracted clinics need to be aggregated for population health, for risk stratification, or for community needs assessments. It may also be advantageous to screen at the plan level to include people who have not engaged in clinical services. Social needs data collection at the clinical level may be preferable if one plans to use the data for prevention and disease management at the point of care. For example, there are health conditions, such as diabetes, for which having social needs information available at the point of care could affect the care plan. Of course, social needs information could be collected at both the health plan and clinic levels, and with data agreements and systems in place data could be shared. This methodology may be advantageous if the goal is to avoid re-screening patients.

# Patient Acceptability

# Although limited, the available literature points to high patient acceptability of social needs screening in a number of settings:

# A 2020 study found that 84% of patients felt screening in a primary care setting for food insecurity was valuable (2).

# Another 2020 study found that 83% of patients feel that it is appropriate to screen for social needs in primary care, and 75% feel that it’s appropriate in the Emergency Department (3).

# A 2019 qualitative study of patient opinions of social needs screening in primary care and emergency settings found that screening for social risk was acceptable, important, and increased the patient’s sense of whole-person care. Patients also expressed the importance of empathetic and compassionate screening, and confidentiality (4).

# Considerations in Selecting Workflows

# The workflows selected need to be able to accommodate the volume of work involved in screening, documentation, and interventions. For example, research in Oregon has consistently demonstrated that food insecurity and housing questions result in a high number of positive screens, whereas transportation, utilities, and safety will yield fewer (see data on percent of social needs identified through screening in Oregon below). Thus, workflows need to be tailored to the volume of positive screens anticipated.

# Social Needs of Oregon Medicaid Patients (5)

# Who Screens

# Screening in Oregon health care settings is conducted by medical assistants, care coordinators, community health workers, social workers, nurses, physicians, and others. Key questions to consider regarding the decision of which resource should screen include the following:

# Do the needs being addressed require a screener with an advanced scope of practice?

# Do the staff selected have the ability to screen in languages spoken by the patients?

# Is it possible for patients to screen themselves?

# Patient preference can inform the decision regarding who should screen. A recent study on screening in medical clinic for food insecurity found that 41% of patients preferred being asked by a nurse, 34% preferred to screen themselves, and 19% preferred to be asked by a physician. These preferences were the same regardless of food security status (2). The survey did not cover other roles such as community health workers, care coordinators, or medical assistants.

# Frequency of Screening

# Oregon screening practices point to several schools of thought regarding screening frequency, including: once a year to avoid excess trauma, only when a need is suspected, and whenever the member is encountered by specific staff members, such as care coordinators, behavioral health, or community health workers. (5)

# Clinical Workflows

# Within Oregon clinics, screening is occurring in waiting rooms, exam rooms, and via telephone. It is being administered by a wide range of providers including: physical health providers, behavioral health providers, community health care workers, and social workers. Screening is occurring on paper, tablets, and directly into electronic records.

# When developing a workflow, it is important to determine if there will be enough time within the selected workflow to add the screening. For example, adding a 5-minute long screening tool in primary care provider visits is likely not feasible given that those visits last approximately 15-minutes. However, that same tool may be feasible during the longer annual exams, or if patients screen themselves in the waiting room and bring the data into the provider visit.

# The Accountable Health Community study in Oregon is examining the ability of clinics to screen via various workflows. Clinics are allowed to change workflows over the course of the study. Of the over 50 sites, 70% of clinics chose to have patients screen themselves in the waiting room. Selection of screening media by clinics included the following:

# Paper forms (nearly 50%)

# Stand-alone tablets (23%)

# EHR-connected tablets (21%)

# Approximately one-quarter of the clinics in the study have switched from tablet to paper screening since the project started. Primary reasons for switching include the time that tablets add to patient check-in process, and patient difficulty using tablets (5).

# Finally, although clinics in the study were expected to screen every Medicare and Medicaid patient that entered the clinic, and were provided financial reimbursement for doing so, clinics are screening well below their volume. For example, primary care clinics (N=36) are screening roughly 12% of eligible patients. Staff turnover, lack of buy-in, and competing priorities are the most commonly cited reasons for low screening numbers (5).

# Follow Up

# There is little research on patient preferences regarding screening follow up. A 2020 study of food insecurity screening found that 76% of patients preferred to receive a list of food bank locations, 72% preferred to receive a list of local community organizations, and 75% preferred to receive a referral to financial assistance programs. There were no differences in preference regardless of food insecurity status (2).

# References

1. CCO survey conducted for SDOH Measurement Workgroup, April 2020.
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5. Oregon Accountable Health Communities study, May 2020.

Social Needs Screening Background Brief for the Social Determinants of Health Measurement Workgroup

**Social Needs Data Collection Systems in Health Care**

Making social needs information available at the point of care for individual and population health improvement is a high priority for health care. Government agencies, Coordinated Care Organizations, and numerous health care systems in Oregon have developed methodologies to collect, store, and leverage data on social needs, and even more efforts are underway. Data are often stored in stand-alone systems. Recent efforts to collect and share social needs data in Oregon include expansions of electronic health record modules and care management software, and investments in community information exchange platforms.

# Social Needs Data Collection

# Social needs information is collected by physical, behavioral and mental health care providers, social service agencies, federal and state agencies, health plans, community-based organizations, and patients and caregivers themselves. In Oregon, Coordinated Care Organizations (CCOs) ask social needs questions as part of their required health risk assessments which may be conducted in-person, by telephone, or through the mail. Health risk assessments are also frequently conducted by CCOs as a part of intensive case management/care coordination.

# Social Needs Data Storage for Health Care Use

# In health care, information on social needs is stored in many types of systems, including electronic health records (EHRs), analytics systems, and care management software. Federal alternative payment programs, such as the Comprehensive Primary Care Plus Initiative (CPC+), have increased the presence of social needs information in EHRs. CPC+ requires that clinics collect psychosocial information about their patients in an accredited EHR. This requirement prompted EHR vendors to build new modules to store screening information, such as social needs, and unhealthy alcohol and drug use.

# Bi-Directional Sharing of Social Needs Data

# Demand for social service resource directories, and the ability to have bi-directional sharing of information across health and social service sectors, has led to the development of community information exchange software products. A community information exchange (CIE) is a software platform that supports electronic referrals to social service agencies, and provides outcomes information back to the referring partner (i.e. bi-directional communication.) The demand for this type of product over the past few years has resulted in the release of several CIE software platforms with national footprints. Recently in Oregon, the Oregon Health Authority and HIT Commons convened a multi-stakeholder CIE Advisory Group to develop a roadmap for a statewide CIE and determine if CIE efforts can be coordinated, standardized and/or centralized.

# Some CCOs and health systems have implemented CIE software already, or are on a path to do so (see Table 1 below). Products in use thus far in Oregon include: Unite Us and Aunt Bertha. Currently some EHR vendors are developing direct links to CIE products, such as Unite Us, Aunt Bertha, and NowPow, to facilitate referrals from the medical record.

# Social Needs Data Collection & Storage Advantages and Challenges

# Social needs data collection, storage and sharing platforms allow providers to factor patients’ social needs into care plans and connect patients in need of support to care managers, community health workers, and social services. Platforms also allow users to avoid repeat screening, and leverage data across patients for population health efforts.

# Challenges include a proliferation of software and screening questions, different data standards, difficulty pulling data out of systems, and challenges analyzing data collected using different tools and methodologies.

**Table 1. Oregon Health System and CCO SDOH Data Storage Technologies in Use/Planned (as of 7/1/20)\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCO or Health System** | **County** | **Electronic Health Record** | **Care Management System** | | | **Community Information Exchange System** |
| **Advanced Health** |  |  | Implemented | | |  |
| **AllCare CCO** | Curry, Douglas |  | Implemented | | | Pricing |
| **AllCare CCO** | Josephine, Jackson |  | Implemented | | | LOI |
| **Asante** |  |  |  | | |  |
| **Cascade Health Alliance CCO** | Klamath |  | Implemented | | | Implementing |
| **Central Oregon Health Council** | Deschutes, Crook, Jefferson |  |  | | | Implementing |
| **Columbia Pacific CCO** | Clatsop, Columbia, Tillamook |  | Implemented | | | Contracting |
| **Community Health Centers** | Statewide | Implemented | Implemented | | | OCHIN pilots |
| **Eastern Oregon CCO** | Eastern OR Counties |  | Implemented | | |  |
| **Health Share CCO** | Clackamas, Washington, Multnomah |  | Implemented | | | Contracting |
| **Jackson Care Connect CCO** | Jackson |  | Implemented | | | Contracting |
| **Kaiser Permanente** | Washington, Clackamas, Multnomah, Lane, Marion, Polk, Yamhill | Implemented | Implemented | | | Live |
| **Legacy Health System** | Clackamas, Multnomah, Washington, Marion, |  | Implemented | | | LOI |
| **Oregon Health & Science University** | Multnomah, Washington, Clackamas | Implemented | Implemented | | | Pricing |
| **PacificSource--Central OR CCO** | Deschutes, Crook, Jefferson, Klamath |  | Implemented | | | LOI |
| **PacificSource--Gorge CCO** | Wasco, Hood River |  | Implemented | | | LOI |
| **PacificSource--Lane County CCO** | Lane |  | Implemented | | | LOI |
| **PacificSource--Marion/Polk County** | Marion, Polk |  | Implemented | | | LOI |
| **Providence Health System** | Statewide | Implemented | Implemented | | | Pricing |
| **Samaritan Health System/InterCommunity Health Network CCO** | Linn, Lincoln, Benton |  | Implemented | | | Live |
| **St. Charles Health** | Deschutes, Crook, Jefferson | Implemented | Implemented | | | Implementing |
| **Trillium CCO/Health Net** | Lane, Clackamas, Washington, Multnomah |  | Implemented | | | Live |
| **Yamhill CCO** | Yamhill |  | Implemented | | | Pricing |
| \*LOI: Letter of Intent with Vendor to Contract by September 30, 2020 |  |  | |  |  | |

Social Needs Screening Background Brief for the Social Determinants of Health Measurement Workgroup

**ICD-10 Z-Codes: Advantages and Challenges**

Due to growing evidence that social needs influence health, there is substantial discussion regarding how to use existing medical classification systems to document and share social needs data across systems. The ICD-10 system contains standardized diagnostic codes used for documenting health conditions and diagnoses. ICD-10 includes a number of supplemental diagnosis codes called “Z-Codes” to document socioeconomic and psychosocial circumstances (1). Although alternative coding systems have emerged, ICD-10 is the most widely used medical coding system in the world.

**ICD-10 Z-Codes**

ICD-10 codes are used internationally and are, in essence, a universal language for government, healthcare organizations and providers for documenting diagnoses, billing, and surveillance. The International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10), contains “Health Factor” codes, known as Z-codes. Z-codes classify health-related information, including socioeconomic and psychosocial circumstances. Given the proliferation of Z-codes across the health care and governmental sectors, they have the potential to efficiently integrate social needs information across data systems (1,2,3). While Z-codes offer many advantages, they are not broadly in use in the U.S., and there is not yet alignment on which codes to use.

**Z-codes in Oregon**

Most social needs data are stored in electronic health records, care management platforms and proprietary databases. Although there has been discussion in Oregon of the potential of Z-codes to align data systems to collect social needs information, according to a recent survey of CCOs, Z-codes have not been widely used (4). A project by the Oregon Primary Care Association is examining the feasibility of using Z-codes to support documentation for alternative payment methodologies (5).

**Advantages of Z-Codes to Identify and Share Social Need Information**

* Documents social needs through existing claims systems, and could facilitate risk-adjustment and alternative payment methodologies such as value-based payments.
* Creates interoperability for social needs information; facilitates data exchange within and across organizations, institutions and agencies (6).
* The ICD-10 already includes codes to record social needs information (3).
* Individual codes for social needs may be superior to chart notes which have to be disaggregated.

**Challenges of Z-Codes**

* Lack of synchronicity between screening tools and codes could create complications in linking responses to a code (e.g. screening tool measures with a Likert scale, and corresponding code is binary).
* Screening tools may ask questions about social needs (e.g. transportation, utilities) that do not have a corresponding ICD-10 Z code.
* Some codes are not granular enough and would require additional charting.
* Since some codes are very general and others are more specific, different codes could be used to indicate the same social need.(1)

**Alternative Coding Systems to ICD-10**

* Logical Observation Identifiers Names and Codes (LOINC): designed for observable data; can record genetic, lab, clinical, lifestyle and environmental information.
* Systemized Nomenclature of Medicine- Clinical Terms (SNOMED-CT): systematically organizes and classifies medical terms, codes, synonyms and definitions that are commonly used in healthcare.
* Common Procedural Technology (CPT): codes assigned to tasks and services provided by medical professionals are primarily used for reimbursement, although there is the ability to code that a screening took place (1,6).
* Electronic Health Record (EHR): EHRs, such as Epic, NextGen, eClinical Works, Cerner, and Greenway, include screening tools to capture standardized social needs information.(7)

**Z-Codes Related to Socioeconomic and Psychosocial Circumstances (Z55-Z65)(8)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Z55 – Z55.9** | Illiteracy and low-level literacy; schooling unavailable and unattainable; failed examinations; school underachievement; educational maladjustment and discord | **Z61 – Z61.9** | Problems related to negative life events in childhood; loss of love relationship; removal from home; altered pattern of family relationships; events resulting in loss of self-esteem; problems related to alleged sexual abuse; problems related to alleged physical abuse; personal frightening experience |
| **Z56 – Z56.9** | Unemployment, unspecified; change of job; threat of job loss, stressful work schedule; discord with boss and workmates; uncongenial work; other physical and mental strain related to work | **Z62 – Z62.9** | Other problems related to upbringing; inadequate parental supervision and control; parental overprotection; institutional upbringing; hostility towards and scapegoating of child; emotional neglect of child; other problems related to neglect |
| **Z57 – Z57.9** | Occupational exposure to risk-factors; exposure to noise; exposure to radiation; exposure to dust; exposure to other air contaminants; exposure to toxic agents; exposure to extreme temperature; exposure to vibration; exposure to other risk-factors; exposure to unspecified risk-factors | **Z63 – Z63.9** | Other problems related to primary support group, including family circumstances; problems in relationship with spouse or partner, parents and in-laws; inadequate family support; absence of family member; disappearance and death of family member; disruption of family by separation/divorce |
| **Z58 – Z58.9** | Problems related to physical environment; exposure to noise; exposure to air pollution; exposure to water pollution; exposure to soil pollution; exposure to radiation’ exposure to other pollution; inadequate drinking-water supply; exposure to tobacco smoke | **Z64 – Z64.9** | Problems related to certain psychological circumstances; problems related to unwanted pregnancy; seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful; seeking and accepting behavioral and psychological interventions known to be hazardous and harmful; discord with counsellors |
| **Z59 – Z59.9** | Problems related to housing and economic circumstances; homelessness; inadequate housing; discord with neighbors/lodgers/landlord; problems related to living in institutions; lack of adequate food; extreme poverty; low income; insufficient social insurance and welfare support | **Z65 – Z65.9** | Problems related to other psychosocial circumstances; conviction without imprisonment; imprisonment and other incarceration; problems related to release from prison; problems related to other legal circumstances; victim of crime and terrorism; exposure to disaster, war, and other hostilities |
| **Z60 – Z60.9** | Problems related to social environment; problems of adjustment to life-cycle transitions; atypical parenting situation; living alone; acculturation difficulty; social exclusion, rejection, discrimination |  |  |

**Additional Reading**

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5. Oregon Primary Care Association. “PDF.” Portland, April 27, 2018.
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7. Cantor, Michael N., and Lorna Thorpe. “Integrating Data On Social Determinants Of Health Into Electronic Health Records.” Health Affairs 37, no. 4 (2018): 585–90. <https://doi.org/10.1377/hlthaff.2017.1252>.
8. Chapter XXI Factors influencing health status and contact with health services (Z00-Z99), World Health Organization, <https://icd.who.int/browse10/2019/en#/Z55-Z65>, 2019

|  |  |  |  |
| --- | --- | --- | --- |
| APPENDIX  Adult and Multi-use Screening Tools | | | |
|  | [AHC-Tool](http://sirenetwork.ucsf.edu/tools-resources/mmi/accountable-health-communities-health-related-social-needs-screening-tool) | [PRAPARE](http://sirenetwork.ucsf.edu/tools-resources/mmi/prapare-protocol-responding-and-assessing-patients%E2%80%99-assets-risks-and-experiences) | [Health Leads](https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/) |
| Food Insecuri­­ty | **Within the past 12 months, you worried that your food would run out before you got money to buy more.**  **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**  Often trueSometimes trueNever true  ten trueSometimes trueNever true | **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?**  Food: Yes/No | **In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food?**  Yes/No |
| Employment | **Supplemental: Do you want help finding or keeping work or a job?**  Yes, help finding workYes, help keeping workI do not need or want help | **What is your current work situation?**  UnemployedPart-time or Temporary WorkFull-time workOtherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) |  |
| Housing Insecurity | **What is your living situation today?**  I have a steady place to liveI have a place to live today, but I am worried about losing it in the futureI do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) | **What is your housing situation today?**  I have housingI do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)I choose not to answer this question  Are you worried about losing your housing? Yes/No | **Are you worried that in the next 2 months, you may not have stable housing?**  Yes/No |
| Housing Quality | **Think about the place you live. Do you have problems with any of the following?**  CHOOSE ALL THAT APPLY Pests such as bugs, ants, or miceMoldLead paint or pipesLack of heatOven or stove not workingSmoke detectors missing or not workingWater leaksNone of the above |  |  |
| Transportation | **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**  Yes/ No | **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?** Check all that apply.  Yes, it has kept me from medical appointments or from getting my medicationsYes, it has kept me from non-medical meetings, appointments, work, or from getting things that I needNo  I choose not to answer this question | **In the last 12 months, have you ever had to go without health care because you didn’t have a way to get there?**  Yes/NoYes/No |
| Interpersonal Violence | Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.  **How often does anyone, including family and friends, physically hurt you?**  **How often does anyone, including family and friends, insult or talk down to you?** Never (1)Rarely (2)Sometimes (3)Fairly often (4)Frequently (5)  **How often does anyone, including family and friends, threaten you with harm?**  **How often does anyone, including family and friends, scream or curse at you?**  Never (1)Rarely (2)Sometimes (3)Fairly often (4)Frequently (5)  A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe. | **In the past year, have you been afraid of your partner or ex-partner?** |  |
| Utilities | **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**  YesNoAlready shut off | **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed**  Utilities: Yes/No Phone: Yes/No | **In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?**  ​Yes/No |
| Veteran Status |  | **Have you been discharged from the armed forces of the United States? Yes/No** |  |
| Desire for Assistance |  |  | **If you checked YES to any boxes above, would you like to receive assistance with any of these needs?** *Yes/No*  **Are any of your needs urgent? For example: I don’t have food tonight, I don’t have a place to sleep tonight** *Yes/No* |

|  |  |  |  |
| --- | --- | --- | --- |
| Adult and Multi-use Screening Tools | | | |
|  | [Health Begins](https://healthbegins.wufoo.com/forms/upstream-risk-screening-tool-2015/) | [MLP IHELP](https://medical-legalpartnership.org/screening-tool/) | [Medicare Total Health Assessment](http://sirenetwork.ucsf.edu/tools-resources/mmi/total-health-assessment-questionnaire-medicare-members) |
| Food Insecuri­­ty | **Which of the following describes the amount of food your household has to eat:**  Enough to eatSometimes not enough to eatOften not enough to eat |  | **Do you eat fewer than two meals a day?**  Yes/No  **Do you always have enough money to buy the food you need?**  Yes/No |
| Employment | **Which best describes your current occupation?**  Homemaker, not working outside the homeEmployed (or selfemployed) full timeEmployed (or selfemployed) part timeEmployed, but on leave for health reasonsEmployed but temporarily away from my job (other than health reasons)Unemployed or laid off 6 months or lessUnemployed or laid off more than 6 monthsUnemployed due to a disabilityRetired from my usual occupation and not workingRetired from my usual occupation but working for payRetired from my usual occupation but volunteering | **Please indicate if the following describes a concern you have related to employment**.  I am unable to earn income as a result of a disability. |  |
| Housing Insecurity | **In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?**  Yes/No  **In the last 12 months, how many times have you or your family moved from one home to another?** | **Please indicate which of the following describe a problem(s) with your housing situation. You may select none or more than one answer:**  Bugs (e.g. roaches) or rodentsGeneral cleanlinessLandlord disputesLead paintUnreliable utilies (e.g. electricity, gas, heat)Medical condition that makes it difficult to live in current houseMold or dampnessOvercrowdingThreat of evictionOther (please specify)  **Are you living in section 8/public housing?**  Yes/No | **Which of the following best describes where you currently live?**  Apartment, condo, trailer, house, townhouse, etc. (a living situation where meals and household help are not routinely provided by paid staff)Assisted living, retirement facility, etc. (a living situation where meals and household help are routinely provided by paid staff)Nursing Home (a living situation where nursing care is provided 24 hours a day)Other |
| Housing Quality | **In the last month, have you had concerns about the condition or quality of your housing?**  *Yes/No* | **Please indicate which of the following describe a problem(s) with your housing situation. You may select none or more than one answer:**  Bugs (e.g. roaches) or rodentsGeneral cleanlinessLandlord disputesLead paintUnreliable utilies (e.g. electricity, gas, heat)Medical condition that makes it difficult to live in current houseMold or dampnessOvercrowdingThreat of evictionOther (please specify) | **Does the place where you live have the following safety concerns?**  No working smoke alarm in one or more bedrooms or levelsPoor lighting or lack of hand rails on stairsSlippery flooring in the tub or shower or no grab bars |
| Transportation | **How often is it difficult to get transportation to or from your medical or follow-up appointments?**  Does not applyNeverSometimesOftenAlways |  |  |
| Interpersonal Violence | **Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?**  **Within the last year, have you been afraid of your partner or ex-partner?**  **Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?**  **Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?** | Please indicate which of the following describe a problem(s) with your personal and family stability. You may select none or more than one answer.  **Are you afraid of someone you love?**  **Do you have guardianship or custody issues?**  **Are you concerned about the welfare of one of your children or a child that you live with**? |  |
| Utilities |  |  |  |
| Veteran Status |  |  |  |
| Desire for Assistance |  |  | If for any reason you have difficulty or cannot do one or more of these activities of daily living, do you get the help that you need?  I get all the help I need  I could use a little more help  I need a lot more help  I don’t need any help |

|  |  |  |  |
| --- | --- | --- | --- |
| Adult and Multi-use Screening Tools | | | |
|  | NAM Domains | WellRx | Your Current Life Situation |
| Food Insecuri­­ty |  | **In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn’t have money for food?** | **In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply) Food**  **In the past 3 months, how often have you worried that your food would run out before you had money to buy more?**  *Never*  *Sometimes*  *Often*  *Very often*  **Optional: Are you easily able to get enough healthy food to eat?**  *Yes*  *No* |
| Employment |  |  |  |
| Housing Insecurity |  | **Are you homeless or worried that you might be in the future?** | **Which of the following best describes your current living situation? (Select ONE only)**  *Live alone in my own home (house, apartment, condo, trailer, etc.); may have a pet*  *Live in a household with other people*  *Live in a residential facility where meals and household help are routinely provided by paid staff (or could*  *be if requested)*  *Live in a facility such as a nursing home which provides meals and 24-hour nursing care*  *Temporarily staying with a relative or friend*  *Temporarily staying in a shelter or homeless*  *Other*  **Do you have any concerns about your current living situation, like housing conditions, safety, and costs?**  *Yes*  *No*  If YES:  *Condition of housing*  *Lack of more permanent housing*  *Ability to pay for housing or utilities*  *Feeling safe*  *Other* |
| Housing Quality |  |  | **Do you have any concerns about your current living situation, like housing conditions, safety, and costs? Condition of housing** |
| Transportation |  | **Do you have trouble finding or paying for a ride?** | **In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply)** *Transportation*  **Has lack of transportation kept you from medical appointments or from doing things needed for daily living? (Select ALL that apply)**  *Kept me from medical appointments or from getting medications*  *Kept me from doing things needed for daily living*  *Not a problem for me* |
| Interpersonal Violence | **Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?**  **Within the last year, have you been afraid of your partner or ex-partner?**  **Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?**  **Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?** | **Do you feel unsafe in your daily life?**  **Is anyone in your home threatening or abusing you?** | **Optional: In the past 12 months, have you been physically or emotionally hurt or felt threatened by a current or former spouse/partner, a caregiver, or someone else you know?**  ***Yes [Follow-up: Current spouse/partner; Former spouse/partner; Caregiver; Someone else]***  ***No***  **Optional: Has a spouse/partner, family member or friend ever been financially abusive towards you? That is, stolen money from you, not paid back a loan, etc.?**  ***Yes***  ***No*** |
| Utilities |  | **Do you have trouble paying for your utilities (gas, electricity, phone)?** | **In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply) Heat and electricity** |
| Veteran Status |  |  |  |
| Desire for Assistance |  |  | **If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need?**  *I don’t need any help*  *I get all the help I need*  *I could use a little more help*  *I need a lot more help*  **Which of the following would you like to receive help with at this time? (Select ALL that apply)**  *Food*  *Housing*  *Transportation*  *Utilities (heat, electricity, water, etc.)*  *Medical care, medicine, medical supplies*  *Dental services*  *Vision services*  *Applying for public benefits (WIC, SSI, SNAP, etc.)*  *More help with activities of daily living*  *Childcare/other child-related issues*  *Debt/loan repayment*  *Legal issues*  *Employment*  *Other*  *I don’t want help with any of these* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pediatric Screening Tools | | | | |
|  | iHELP | SEEK | SWYC | We Care |
| Food Insecuri­­ty | **Do you have any concerns about having enough food?**  **Have you ever been worried whether your food would run out before you got money to buy more?**  **Within the past year has the food you bought ever not lasted and you didn’t have money to get more?** | **In the past 12 months, did you worry that your food would run out before you could buy more? Yes/No**  **In the past 12 months, did the food you bought just not last and you didn’t have money to get more? Yes/No** | **In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food? Yes/No** | **Do you always have enough food for your family?**  **If NO, would you like help with this?**  **Yes**  **No**  **Maybe later**  **If yes, do you need food for tonight?**  **Yes**  **No** |
| Employment |  |  |  | **Do you have a job?**  **Yes**  **No**  **If NO, would you like help finding employmentand/or job training?**  **Yes**  **No**  **Maybe later** |
| Housing Insecurity | **Do you have any concerns about being evicted or not being able to pay the rent?**  **Do you have any concerns about not being able to pay your mortgage?** |  |  | **Do you think you are at risk of becoming homeless?**  **If YES, would you like help with this?**  **Yes**  **No**  **Maybe later**  **If yes, is this an emergency?**  **Yes**  **No** |
| Housing Quality | **Do you have any concerns about poor housing conditions like mice, mold, cockroaches?** |  |  |  |
| Transportation |  |  |  |  |
| Interpersonal Violence | **[DO NOT ASK IN FRONT OF CHILD 3 OR OLDER OR IN FRONT OF OTHER PARTNER] “From speaking to families, I have learned that violence in the home is common and now I ask all families about violence in the home. Do you have any concerns about violence in your home?”** | **Do you sometimes find you need to slap or hit your child? Y/N**  **Thinking about the past three months**  **Have you and a partner fought a lot?Yes/No**  **Has a partner threatened, shoved, hit or kicked you or hurt you physically in any way? Yes/No** | **In general, how would you describe your relationship with your spouse/partner? No tension/Some tension/A lot of tension/Not applicable**  **Do you and your partner work out arguments with: No difficulty/Some difficulty/Great difficulty/Not applicable** |  |
| Utilities |  |  |  | **Do you have trouble paying your heating bill for the winter?**  **If YES, would you like help with this?**  **Yes**  **No**  **Maybe later**  **If yes, are you at risk of having your utilities shut off in the next week?**  **Yes**  **No** |
| Veteran Status |  |  |  |  |
| Desire for Assistance |  | **Other things you'd like help with today: (fill-in)** |  |  |

Link to Screening Tools Adult Comparisons: <https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/adult-nonspecific>

Link to Screening Tools Pediatric Comparisons: <https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/peds>

**Acronyms Cheat Sheet:**

* AHC Tool: Accountable Health Communities
* MLP (IHELP): Medical-Legal Partnership (income and insurance, housing and utilities, education and employment, legal status and personal stability)
* NAM domains: National Academy of Medicine
* PRAPARE: Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences

Information in the tables is reproduced with permission from the Social Interventions Research and Evaluation Network (SIREN) https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/adult-nonspecific, accessed 5/4/20.

A close up of a logo

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