The Joint Commission

University Health SNAPSHOT

Featured Health Care Equity Topic Area:
Assess for Health-Related Social Needs

Related Joint Commission Requirement:
Standard LD.04.03.08, EP 2

About

University Health (UH) has provided healthcare to Kansas City's most vulnerable patients for over 150 years. As the area's only essential safety net hospital, the community has come to rely upon UH as a provider of safe high quality "care for all" regardless of ability to pay. UH serves an at-risk patient population facing a number of complex health related social needs including homelessness, food insecurity, language barriers, limited access to transportation and job instability. UH is committed to meeting patients where they are, by providing personalized care for individualized needs. They recognize that health outcomes are driven not only by medical care, but by a complex interplay of social, emotional and behavioral factors that must be carefully considered during the healthcare delivery process.

University Health	
	Kansas City, Missouri
	Academic Medical Center
	Safety Net Provider
	Hospital Size: 256 beds
	Foundation, Grant Support

Mission

University Health *"is an academic health center providing accessible, state-of-the-art quality healthcare to our community regardless of the ability to pay."*

Setting the Stage for Change

The influence of social needs on health outcomes and utilization has gained increased recognition over the last several years. With mounting evidence, knowledge, and policy support, healthcare organizations across the country are piloting systematic approaches to identify unmet social needs, refer and navigate patients needing support, foster community partnerships, and utilize data to drive improvement. In 2019, UH partnered with Health Leads as part of a national Collaborative to Advance Social Health Integration (CASHI). This 18-month initiative funded by the Commonwealth Fund focused on the identification and diffusion of strategies to assist patients in addressing social impediments to health. The Collaborative shared approaches to building a business plan aimed to support and sustain medical care and social needs integration.

Taking Action

Be Specific. Prior to their involvement with CASHI, UH did not have a standardized process for assessing patients for health-related social needs. They began by targeting the ambulatory setting where patients were less focused on urgent medical needs (compared to inpatient and the emergency department), "The outpatient setting had the greatest potential for impact, so we started there."

Start Small and Be Strategic. In 2019 the team set up a resource table by the pharmacy inside the hospital. The goal was to provide an opportunity for patients to stop by "organically" and be screened for social needs. In order to better understand the areas of greatest perceived need, conversational interviews were conducted with 100 patients. Findings from these interviews helped to provide direction and scope for the development of their screening tool.

Pick (and Share) the Low Hanging Fruit. Numerous patients visiting the resource table spoke of frequent hunger and limited food. The results of the initial prescreen revealed that nearly 2/3 of respondents indicated that on most days, they did not have enough food. Soon thereafter, a bowl of bananas was placed at the resource table where an influx of patients stopped to get a snack, talk with the team, be screened, and access referrals for identified needs. The "Banana Table," as it is now referred to, has been a catalyst for UH's large scale efforts to address one of the most prevalent social needs faced by their patient community – food insecurity.

Build It and They Will Come. Assessing and addressing food insecurity was a clear priority for UH. Their goal was to increase access to fresh produce and culturally appropriate food. With the assistance of the Cultural Food Equity Partnership – a collaboration of regional food banks, the local health department and organizations focused on reducing hunger in the Kansas City area – the team assists in food distribution for a monthly "pop up pantry" where patients who screen positive for food insecurity can take home a bag of groceries at no cost. The weekly "pop-up" food pantry was so successful that it has grown into a fully operational pantry, located in the hospital, now known as the "UH One World Pantry."

"It is not our job to do everything. We just need to put the ripples in the water and one day they will become a wave." – Dr Shauna Roberts, University Health Physician Champion

Challenges Encountered

Providers are often reluctant to screen patients for HRSNs for several reasons:

- The sensitive nature of the questions can create uncomfortable patient/provider interactions. Providers seek to develop positive and productive relationships with patients, and some have found that asking questions about social needs creates anxiety for patients and can have a negative impact on the open and trusting patient/provider relationship that is crucial for the delivery of high quality and effective clinical care.
- Education and training help to foster the skills necessary to successfully obtain HRSN patient information. However, time constraints can make it difficult for busy providers to participate in training.
- Providers have limited time to evaluate and treat each patient. Many find it difficult to devote time to HRSN screening questions when they must focus on addressing more immediate and urgent medical concerns.

Patients may have negative reactions to HRSN screening questions due to the sensitive nature of the topics.

- Questions about social needs such as homelessness, legal issues (e.g. immigration status), food insecurity, safety in the home environment and surrounding community (e.g. gun violence, domestic violence) may be traumatic and can cause patients to "shut down" due to anxiety, fear and lack of trust.

Assessment Tools in the public domain tend to be perceived by providers as too long and complicated.

- 80% of patients at the UH OB/GYN clinic preferred a paper screening tool versus an electronic screening tool. This was due to the privacy that a paper screening tool allows. Patients could complete it on their own and indicate information that they might not otherwise state out loud if the questions were asked verbally and entered in to the electronic health record (HER). This was especially important for patients that were in unsafe living environments and abusive situations and in circumstances where abusive partners may accompany patients to medical appointments.
- Paper forms required manual data entry which became difficult to manage due to the hours of time required to manually input information into the EHR.

Solutions

- Adapt existing screening tools to meet organizational needs. UH selected three areas to focus on. They modified the Health Leads Screening Tool and settled on only three questions to get started:
  1. *In the last 12 months, did you ever skip medications to save money?*
  2. *In the last 12 months, did you ever eat less than you thought you should because there wasn't enough money for food?*
  3. *How often have you missed a doctor's appointment or going to the pharmacy because of transportation?*
- Worked with EHR vendor to build an electronic HRSN screening tool, while maintaining the flexibility to provide a paper screening tool for patients that request and insist upon the paper format.
- Share the "why" and the "how." Provide an explanation for the intention and purpose behind collecting information on social needs.
- Help providers and others throughout the organization to understand how social needs impact health status and outcomes, explain the ways this information will be used to link patients to community resources to address identified needs. A senior leader at UH noted, "Now it's not just a task to do, it is a purposeful action that makes sense (to providers). Screening patients is the first step in a bigger process to address health-related social needs."

Lessons Learned

- **Be Purposeful.** Efforts to deliver equitable healthcare can be daunting and overwhelming. Be strategic in considering where your organization is on this journey and what you are capable of doing (e.g. select assessment questions with intentionality). Organizations aren't expected to "fix everything but need to start somewhere."
- **Connect the Dots.** Explain the importance of assessing for and documenting patient social needs and how this information will be used to help improve patient outcomes and reduce health disparities
- **Foster Mutual Learning.** Learn from each other. Be certain that the screening questions asked are the "right" questions to help uncover patient social needs.
- **Provide Support and Guidance.** Education and training should be thoughtful and accessible to busy providers. Foster and develop interview skills that are necessary to effectively and comfortably communicate with patients in order to obtain information about health-related social needs.
- **Be sensitive to Burnout.** Be cognizant of the demands on staff and the fact that asking staff to do more when they are already "burned out" can be burdensome

To learn more about University Health's commitment to reducing disparities and achieving health care equity, visit their ***Social Determinants of Health Resource Center****.*

Check out the Joint Commission's Health Care Equity Standards and Resource Compendium

Assessing Health-Related Social Needs Resource Collection

Access sample scripts for sensitive conversations, screening tools, and more