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Identifying and Addressing Social Needs for Members with High Medical Cost: The KP Southern California Health Leads Pilot

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What's going on?

Kaiser Permanente Southern California (KPSC) collaborated with Health Leads to implement a social needs screening and referral program in three service areas from November 2015 through March 2017. Health Leads is a non-profit organization committed to designing and implementing social needs programs in clinical settings. The program was designed to identify social needs among KPSC members in the top 1% of predicted annual costs of care.

Why is this important?

In these service areas, 7,107 members had high predicted medical costs and were included in the pool of members eligible for this program. Health Leads staff successfully reached 4,101 (57.8%) members, screened 2,999 (42.2%) of them and identified 1,641 members (23.1% of the total, 54.7% of those screened) who had at least one social need. These needs included: low health literacy, financial insecurity, food insecurity, homelessness, unstable housing, unemployment, transportation barriers, lack of caregiver support, and social isolation.

What's being done?

Interviews and focus groups with patients and clinicians involved in the Health Leads pilot were conducted in collaboration with the KP Care Management Institute (CMI).

Video and audio interviews were transcribed, coded with themes, and analyzed for patterns and differences in feedback. Through these interviews, we learned that that members feel comfortable and appreciate KP efforts to screen and address social needs and clinicians believe that identifying and addressing social needs will improve care. Opportunities for future improvement include a need for uniform screening, easily identified documentation of needs in the health record and a directory of available resources to assist patients with an identified social need.

Through this clinical, operational, and research collaboration, KPNW is taking strides towards developing a health care system the is equipped with the tools and resources to: (1) identify and address SDH needs of its members; (2) use comprehensive EHR data that informs and improves the care delivery process; and (3) reduce the impact of SDH needs on its members' health and well-being.

What were some of the learnings?

- KPSC members with high predicted medical costs commonly had one or more social needs that could be identified through screening.
- Members were comfortable with KP screening for social needs and appreciative of efforts to assist with these needs.
- Clinicians believe that identifying and addressing social needs will improve patient care.
- Standard infrastructure to facilitate screening for social needs and documentation of those needs in the health record were identified as opportunities to improve patient care.

- An accessible and reliable database of social resources is needed to help connect patients with needed resources.

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