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Pathways to Identify Basic Resource Needs

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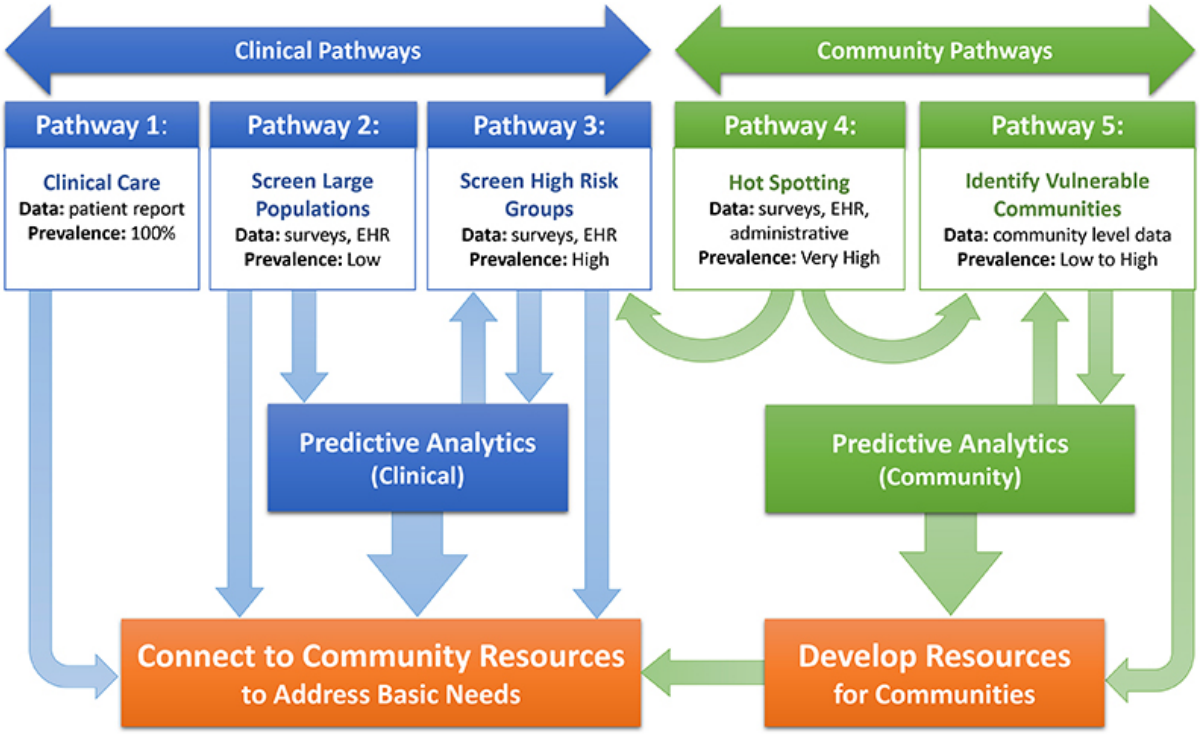
What's going on?

Kaiser Permanente (KP) has committed to identifying basic resource needs such as food, housing, and transportation in its members "as a standard part of quality healthcare and to achieve health equity." In the process of developing an inventory of programs to identify and mitigate these basic resource needs within KP, the Social Needs Network for Evaluation and Translation (SONNET) identified 4 pathways that help identify a member who is contending with one or more of these needs (Figure 2 of SONNET Issue Brief | September 2018).



Clinical Practice (Pathway 1) – A KP member may identify a basic resource need during a clinical encounter. For example, he or she may say that they did not pick up a prescription because they lacked transportation to a KP pharmacy.

Population-based Screening (Pathway 2) – Large groups of KP members can be surveyed to identify critical needs. Examples include screening for food insecurity in KP pediatric clinics, or screening for social isolation and food insecurity with the Medicare Total Health Assessment.

Screening in High-Risk Groups (Pathway 3) – Subgroups of KP members may be selected for screening on the basis of care complexity, financial vulnerability (KP members receiving Medicaid benefits or medical financial assistance), or high utilization and costs of care. To date, most programs to assess social needs in KP members have adopted this approach.

Geographic Analysis (Pathway 4) – Publicly available, community-level data from the US Census and other sources can help identify geographic clusters of need, such as neighborhoods lacking access to grocery stores or transportation. Information such as enrollment rates in the Supplemental Nutrition Assistance Program (SNAP), or median income may also substitute for member-level indicators of basic resource needs that are not available in the electronic health record.

Why is this important?

Each pathway places specific demands on the design and execution of programs that identify and address social needs.

- **Pathway 1:** Clinicians who identify social needs in their patients can be assisted by internal referral protocols to trained KP staff such as patient navigators in KPNW (Friedman, Perm J, p.63), community resource specialists in KPWA (Hsu, Perm J, p.6), or community specialists in KPCO (Stenmark, Perm J, p.71). Once referred to these staff, they can then manage the process of connecting members to community-based resources. (Note: the page numbers referenced above are to The Permanente Journal Supplement, Fall 2018).
- **Pathway 2:** When members with social needs are identified through population-based screening, the next step should generally be re-screening to confirm the need that prompted the referral, because some individuals who initially report a social need do not confirm the presence of that need when asked a second time (Steiner, Perm J, p.40). For those with persistent needs, the presence of other social needs should be assessed, since these needs tend to cluster. The trained staff who conduct these assessments often report that many members may not request assistance from KP in resolving their needs, and their autonomy must be respected.
- **Pathway 3:** In high-risk KP members, social needs screening is likely to identify fewer "false positives" and a higher prevalence of concurrent needs. Such "social complexity" often coexists with equally complex biomedical and behavioral health needs. Prioritizing and addressing this complex array of concerns often requires the skills of KP social workers and case managers who work in multidisciplinary teams with front-line clinicians and behavioral health specialists.
- **Pathway 4:** The communities served by KP reflect the poverty distribution of their service regions and range from affluent to severely under-resourced. The use of community data, guided by geographic and multilevel analyses, can identify communities that require special attention to the social and physical dimensions of health for all residents, not just KP members. If large numbers of individual KP members with social needs have been identified through population-based or high-risk screening programs, geographic "hot-spotting" analyses can also identify vulnerable neighborhoods or communities.

What can we expect?

KP has many tools to help address the social needs of its members. Compassionate inquiry by KP clinicians and staff is the fundamental requirement. Individual compassion is extended and informed by validated survey tools such as the Your Current Life Situation (YCLS) or Medicare Total Health Assessment surveys (MTHA) developed by KP's Care Management Institute. These individually-based approaches can be further refined and extended by statistical methods for predictive analytics. We have developed analytical models that aim to further narrow down the screening pool of high-risk patients. Sophisticated analytical models may help to narrow down the most vulnerable subgroups of members in population-based screening programs, can estimate the impact of addressing social needs on the care outcomes of high-risk members, and can incorporate geographic as well as clinical variables to achieve even greater accuracy in predicting clinical outcomes and social needs .

The combination of communication skills, population health assessment, clinical process design, and sophisticated analytics has made KP a national leader in improving clinical quality. These tools will serve us equally well as we identify and mitigate the basic social needs of our most vulnerable members.

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