Perceptions and Experience of Patients, Staff, and Clinicians with Social Needs Assessment

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ABSTRACT

Context: Assessment of social needs is expanding at Kaiser Permanente (KP), but little is known about how members and clinicians experience the incorporation of social needs into health care.

Objective: To assess how KP members and clinicians experience social needs assessments incorporated into care.

Design: Qualitative and descriptive analysis of data from member and clinician focus groups, interviews, and surveys among 68 members and family caregivers who had participated in social needs assessment programs and 90 clinicians and staff in the KP Colorado, Georgia, Northern California, Northwest, and Southern California Regions.

Main Outcome Measures: Members' and clinicians' perceptions and experiences of social needs assessment.

Results: Members and clinicians understood the impact of social needs on health and why a health care system representative would ask about food, housing, transportation, and other social needs. Members and clinicians supported social needs assessment at KP and agreed that KP should help address identified social needs. However, both groups emphasized the importance of assessments yielding actionable information. Members were also concerned about how the information would be used and by whom.

Conclusion: Our findings support the continuing assessment of social needs at KP and identify issues that require attention as it expands. Assessment should not outpace organizational capacity to connect members with resources. Careful attention to communications is required because members may be uncertain or concerned about the purpose of the assessment and the dissemination of sensitive information. Messaging should assure members about data use and dissemination and what they can expect after screening.

INTRODUCTION

Despite substantial improvements in clinical care, disparities in health persist and mounting evidence suggests that traditional clinical care models are insufficient at closing these health gaps.[1] Nonclinical health-related social needs, such as housing instability, food insecurity, financial stress, and transportation limitations, have been shown to influence care utilization and ultimately have an impact on health outcomes.[2-6] Thus, health care systems are increasingly interested in implementing programs to identify and to address social needs,[7] moving care "upstream" to intervene in nonclinical drivers of population health outcomes. In addition to having the potential to reduce barriers to clinical care, health system interventions to identify and to address social needs can improve clinicians' ability to tailor their care planning through a more holistic understanding of patients' circumstances, to reduce clinician burnout,[8] and to improve linkages with community resources that are best suited to work with patients to address outstanding social needs.[9,10]

Since 2012, there have been at least 3 dozen interventions in Kaiser Permanente (KP) Regions that include the use of questionnaires to screen for and to document social needs, as well as pilots to address identified needs. However, little is currently known about the prevalence and distribution of social needs among KP members. Similar knowledge gaps exist about which needs are best addressed by health care systems in general and about KP member and staff perceptions of more systematic efforts to assess and to address members' social needs.

There is also a paucity of evidence about the effectiveness and acceptability of social needs interventions.[7] Information about patients' perceptions and attitudes about whether social needs affect health and whether health care systems should address social needs is lacking; an exception is a report in the pediatric setting providing evidence of parental willingness to share social needs information with their child's care team.[11] However, there is also evidence that the screening mode may affect patients' and parents' willingness to share.[12] More, albeit still limited, evidence is available about physician perceptions of patients' social needs. In a 2018 survey of 240 physician faculty members in an academic medical center, respondents, on average, believed that social determinants affect health and that benefits of screening for social needs outweighed risks.[13] Olayiwola et al[8] found support for incorporating social needs into care from primary care physicians practicing in 3 delivery systems in San Francisco, CA, where greater clinician belief in the system's ability to address patients' social needs was associated with lower burnout.

The purpose of this project was to assess how KP members and clinicians experience the incorporation of social needs into care.

METHODS
Design

Between April 2017 and December 2017, we partnered with the KP Colorado (KPCO), Georgia (KPGA), Northern California (KPNC), Northwest (KPNW), and Southern California

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(KPSC) Regions to understand member and clinician experiences of screening for social needs in programs that incorporated the use of a standardized assessment instrument. The qualitative and descriptive assessment served as an initial evaluation of the feasibility, acceptability, and effectiveness of social needs screening within diverse care settings and informed interregional quality improvement efforts related to social needs.

We assessed 2 interventions to improve care coordination through team-based primary care models for patients with complex health and social needs (Primary Care Plus onboarding for Medicare members in KPCO and the High Risk Care Coordination program for Medicare members in KPGA), as well as a care coordination intervention that integrated social needs screening into Medi-Cal member onboarding (Model of Care onboarding in KPNC). Additionally, we assessed a patient navigator intervention to screen for social needs and to connect members to community resources in primary care settings and the Emergency Department (ED; Community Health Navigator in KPNW) and a phone-based intervention to screen for and address the social needs of members who were predicted high utilizers of care (Social Needs Screening Toolkit [Health Leads, Boston, MA] in KPSC). Among the included interventions, the most frequently used survey instrument was Your Current Life Situation.[14]

Data Collection and Analysis

The information we sought varied by regional needs and programmatic opportunities (Table 1). In general, we gathered leadership, member, clinician, and staff attitudes and experience with social needs assessment and social needs referrals and follow-up as well as their general perceptions of how social needs assessment influences care delivery. Key topics included members' perceptions of screening for social needs in the health care setting, the usability and acceptability of assessment instruments, preferences for modes and timing of screening administration, and experiences and improvement opportunities throughout the process of sharing social needs information, working with community resources to address needs, and collaborating with care teams to adjust care plans depending on identified social needs. Similarly, for clinicians and staff, we focused on assessing perceptions and experiences of incorporating social needs into care, documentation preferences, ideas for program improvement, and the usefulness of available social needs information.

We used a combination of focus groups, journey mapping,[15] member and clinician interviews, and surveys to gather the perspectives of 68 members and family caregivers and 90 clinicians and staff. Members were recruited to participate in focus groups or interviews if they were enrolled in one of the regional programs of interest (Table 1) and had been exposed to a social needs assessment tool. Focus group and interview recruiters contacted members by phone with an invitation to participate in an interview or group at a KP medical center office. In KPGA, where mobility and transportation concerns posed an initial barrier to participation, recruiters offered an in-home interview option.

Clinicians and staff in all participating Regions except KPCO were recruited for in-person interviews and group discussions via emails from their chiefs and managers, encouraging them to join discussions that typically took place during lunch breaks onsite at their workplaces. At KPCO, clinicians and staff received emails from their chiefs, managers, and regional leadership, asking them to complete an online survey that was administered to collect feedback and their perceptions of incorporating social needs into care.

When possible, data collection tools, such as interview guides and survey instruments, were standardized across Regions to facilitate interregional learning and comparisons. Responses to

Table 1. Study Regions, interventions, topics, and data collection methods			
KP Region	Intervention, screening questionnaire	Key evaluation topics	Data collection method, no.
Northern California	Model of Care onboarding for Medicaid members, YCLS	Referral appropriateness resulting from YCLS screening Comfort with administration Ease of accessing resources	Member interviews, 4 Staff group discussions, 21
Southern California	Health Leads (Boston, MA) phone outreach for predicted high utilizers of care, proprietary instrument	Perceptions and expectations of incorporating social needs into care	Member surveys and focus groups, 43 Staff surveys and group discussions, 42
Colorado	Primary Care Plus onboarding for Medicare members with complex needs, YCLS	Usefulness of questionnaire Comfort using responses to inform care Perceptions and expectations of providers and staff	Provider and staff survey, 27
Georgia	High Risk Care Coordination program for Medicare members with complex needs, YCLS	Ease of use reviewing and acting on information Member expectations for information use and experience of having needs met	Member interviews and journey mapping, 10
Northwest	Community Health Navigator program for one Primary Care Physician's panel, modified YCLS	Rescreening preferences Willingness to share social needs information Experience engaging with resources Questionnaire usefulness	Member and caregiver interviews and journey mapping, 11

KP = Kaiser Permanente; YCLS =Your Current Life Situation.

surveys were summarized descriptively. All in-person interviews and focus groups were video-recorded, transcribed, and coded for common themes within each Region. All written findings were aggregated to protect confidentiality, and all participants who were video-recorded consented to sharing their footage for quality improvement purposes.

RESULTS

How Members and Clinicians View Social Needs in General

Most interviewed members and clinicians believed that it was important to capture information about members' social needs, that social needs influence health outcomes, and that equipping care teams with information about member social needs could improve care. Clinicians we interviewed in KPSC and surveyed in KPCO believed that social needs were an issue for most of their members with complex needs. Clinicians in KPCO and KPSC reported that they use social needs information in medical decisions and care planning. For instance, surveyed clinicians in KPCO agreed that social needs were an issue for most of their Primary Care Plus patients (average score, 4.2 on a 5-point scale from 1 [strongly disagree] to 5 [strongly agree]) and that they used information about social needs in medical decisions and care planning (mean score, 4.1).

Prevalence of Social Needs and Types of Member- and Clinician-Reported Needs

In interviews and focus groups with 43 KPSC members, 36 (83%) indicated that they had not experienced any social needs. In contrast, among 140 Medi-Cal patients in KPNC screened for social needs, 74 (53%) were identified as needing support. Among specific needs identified by members or member engagement specialists, difficulty paying for basic living expenses and difficulty paying for healthy food and food insecurity were most frequent. Social isolation and stress were also common. Other social needs reported by members included a lack of transportation to get to work or to medical care, housing problems or homelessness, and difficulty understanding written medical information.

Clinicians identified the same categories of needs but with different frequency. Surveyed clinicians reported members with social needs as most frequently having difficulty with affordable or available transportation and social isolation, followed by difficulty affording basic living expenses. Other reported needs, in decreasing frequency, were difficulty affording healthy food, homelessness or other housing problems, and other needs that included caregiver or mental health support and the inability to afford medications. In discussion groups, clinicians identified patients as being unable to afford the costs of medication, office visits, and basic living expenses, as well as having health problems arising from low literacy.

What Members and Clinicians Think about Assessing Social Needs

Among members, the majority thought that KP should ask about social needs, including affording healthy food or basic living expenses, housing problems and homelessness, social isolation, difficulty finding or affording transportation to work and medical care, and difficulty understanding written medical information.

Among surveyed KPCO clinicians, the mean score on a 5-point scale for an item assessing if they asked patients about social needs was 2.8, indicating that they are not assessing on average. Data from KPSC clinicians suggested that time and lack of resources were primary reasons that clinicians did not assess social needs. However, in discussion groups, KPSC staff and clinicians reported that assessing social needs was an opportunity to obtain valuable information to inform care decisions and improve communication with their patients. Assessment of social needs would promote a holistic view of members and allow clinicians to tailor care. As one said, "The more you learn about patients and the more comfortable they are, you know exactly what to do for them." Having this information available would also raise awareness among all clinicians of the importance of social needs to members' health.

In discussion groups, KPSC clinicians wanted information on a range of social needs, such as living situation, food insecurity and difficulty with meal preparation, transportation, substance abuse, domestic violence, literacy and learning disabilities, and insurance coverage and copayments. However, they voiced concern about having too much information. They suggested that an easily understood format, such as yes/no questions about difficulty with transportation, paying for medications, and financial concerns would help reconcile this dilemma. Clinicians noted that assessing social needs could not replace clinician-patient discussions. As one explained, "[The information] needs to promote engagement. It needs to be a conversation because, through interactions, not only do you build trust, [you] also set a tone that allows members to better understand the questions."

How Members Experience Social Needs Assessments

Members and caregivers who completed a social needs screening questionnaire and provided feedback about their experience reported that they welcomed the assistance and that the assessment comprehensively addressed their needs. The discussion with a care coordinator around their needs was generally perceived as friendly and caring; one member said, "I enjoyed the call. I felt like he was getting to know me so he could help, not just check the boxes." Some members found the assessment process reassuring. One member said, "No one has ever called me before just to ask if I need help. That was wonderful." Another said, "He really affirmed for me that it was okay to ask for help and receive and accept services."

On the other hand, members also wanted to know more about how the information would be used and with whom it would be shared. One said, "I was happy to share. I just didn't know where the information was going." Some were concerned about how to update the information when their status changed. One member commented, "I think that information should be used judiciously and should be used properly. Once it's in there [the electronic health record], it's not getting out, and I don't know how to update it once my status changes."

Members who had been screened for social needs suggested doing so earlier. "A lot of the reasons that brought me to the ED could have been remedied a lot sooner, had I had a frank discussion about cause and effect."

Members participating in interviews and focus groups in KPSC described preferences for multiple modes of assessing social needs: Online assessment (kp.org); in-person assessment during a hospital stay, outpatient visit, or ED encounter; and over the phone. Similarly, they preferred multiple ways to access information about addressing social needs and referrals.

Actionable Information is Key

Both members and clinicians emphasized the importance of social needs assessments leading to actionable information. As one member said, "I need to know what's going to be done or where to start. I don't want to just have a conversation."

Clinicians wanted to be able to respond effectively to information about social needs. One clinician said, "We do not want to ask questions we do not have the answers to." Surveyed clinicians were generally aware of resources to address patients' social needs. Another clinician indicated the need for an accurate and current list that could be used to connect patients directly with resources. "We need something immediate that we can address right there … someone who can engage and get the process started." Another clinician noted that responsibility for addressing social needs needed to be clear: "We need a better point of contact, so they aren't shifting members from one person to another or waiting weeks to open a case. If it's not clearly identified who is going to do the work, then it's not going to be done."

Connection to Resources

Between March 2016 and February 2017, approximately 1.5% of the 300 members who were onboarded in KPNC received a referral to a Health Care Coordinator. Of these, 31% received a total of 295 resources; 77 (29%) addressed undefined social needs, food insecurity, and housing.

Members who were connected to resources in KPNW and KPGA identified enablers and barriers to making successful resource connections. Direct help accessing resources enabled successful connections, as did having a trustworthy person available to educate and support members in addressing their needs. Said one member, "I never feel like I'm getting in [the Care Coordinator's] way. She makes it easy for me to pick up the phone and ask for help if I need it." However, members also found it challenging to follow through on plans to access resources for a variety of reasons, including misplaced information, scheduling difficulties, impersonal handoffs, and processes that were simply too burdensome.

Challenges of Screening for Social Needs

When asked how the assessment could be improved, some members noted opportunities to clarify question wording, reduce repetition, and minimize confusion about choosing the appropriate response. Members were also concerned about the sensitivity of the information collected. Said one, "I would like to be asked if it was okay [for my clinician] to share this information with the next person on my care team." Another noted that it was important that clinicians not make assumptions on the basis of the information provided: "I would just ask that the team use this information to know more about me, not make assumptions about me."

Another challenge is identifying the population to be screened. When asked who should be screened, surveyed clinicians identified varying populations: All members, predicted or actual high utilizers of care, members with complex clinical conditions, and those with one or more chronic conditions.

DISCUSSION

Surveys, interviews, and focus groups with members and clinicians in 5 KP Regions revealed that they understood the relationship of social needs to health and why a representative of the health care system would ask about food, housing, transportation, and the like. Members and clinicians supported social needs assessment at KP and agreed that the health care system has a role in addressing social needs. However, that role is not without limits; members and clinicians emphasized the importance of assessments that yield actionable information. Members were also concerned about how the information about their social needs would be used and by whom.

Strengths of our analysis include that it is the first, to the best of our knowledge, to assess the experiences of patients and clinicians with social needs assessment. It includes both members' and clinicians' experiences of social needs assessment integrated into usual care and their perceptions about how that experience could be improved.

Several limitations deserve mention. Our analysis drew on a relatively small number of individuals at a few sites; had we included more members and clinicians at more sites, our findings might have been different. A similar limitation is the likelihood that member and clincian experience with social needs assessment depends on the context in which it occurs. Assessing social needs in the ED or via an unanticipated telephone call is likely to differ from the same assessment conducted as part of an ongoing relationship with a health care clinician. We did not include enough members and clincians in varying contexts to elucidate the nature of these differences. The novelty of social needs assessment may have affected our findings; as members and clinicians accumulate experience that includes both assessing needs and subsequently addressing them, their perspectives may change. Finally, our findings may not be generalizable to other settings.

Our findings have several implications. They provide strong support for continuing social needs assessment throughout KP, using the resulting information to tailor treatment plans to available resources and connect members to needed services in their local communities. Our findings also provide some cautionary notes. Members and clinicians alike expressed a clear desire for social needs assessment that leads directly to meaningful follow-up to help members address identified needs; as social needs assessment activities expand, they must not outpace organizational capacity to connect members with resources. Finally, social needs assessment is categorically different from gathering health status data, such as blood pressure; members may be uncertain or concerned about the purpose of the assessment and dissemination of information they view as sensitive. Related communications should assure members about how the data will be used and what they can expect after screening.

CONCLUSION

Future research should identify the population most likely to benefit from social needs assessment. It should also focus on the appropriate timing for follow-up assessments after social needs screening and test the effectiveness and acceptability of various modes of administering social needs screening assessments: In person, by phone, and online. Members' concerns about privacy and stigma should be explored, as should the relationships between having social needs, wanting help from KP to address them, and sharing decision making about prioritizing multiple needs. ❖

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Humanity

Humanity in physicians manifests itself in gratuitous services to the poor.

— Benjamin Rush, 1746-1813, physician, politician, social reformer, humanitarian, educator, and signer of the Declaration of the Independence