Screening for Social Drivers of Health

Children's Hospitals Respond

OCTOBER 2024

CHILDREN'S HOSPITAL ASSOCIATION

Champions for Children's Health

NYOO HEALTH

Foreward

As the health care industry evolves, more awareness and discussions are emerging around social drivers of health, or social drivers, which are the factors in a person's home or community that contribute to health. Research on the importance of addressing these social drivers has risen for over a decade, and the COVID-19 pandemic highlighted their significant impact. Children's hospitals and pediatric health care providers are uniquely positioned to identify social drivers that exist in the home and community through their personal interactions with children and families.

Addressing social drivers of health is a challenging and complex, multi-sector undertaking. It requires uncomfortable conversations, changes to workflows and processes, and workforce training. Leadership commitment across hospitals and health organizations, as well as partnerships with community-based organizations, is crucial.

Children's hospitals and community stakeholders play a key roles in addressing social drivers at the patient, family, and community levels. These efforts are part of children's hospitals' and health systems' commitment to provide vital health care to all children and improve children's health. Early intervention and prevention of chronic health problems can lead to a healthier adult population, stronger workforce, and reduced costs.

Children's Hospital Association (CHA) is committed to helping member hospitals and the broader hospital industry understand social drivers of health, how they may be assessed and addressed, and their unique impact on children and their families.

Early intervention and prevention of chronic health problems can lead to a healthier adult population.

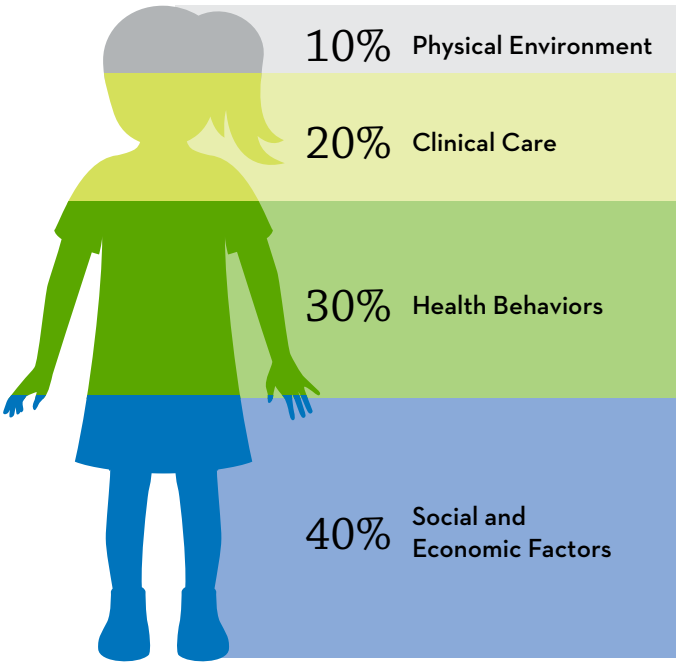
This guide provides information from 29 children's hospitals on how they screen patients and families for social drivers, respond to positive screens, build community partnerships, and improve workflows and referral processes. Information comes from acute care, specialty, free-standing, and system hospitals from all regions of the country.

Use this guide in combination with CHA's other resources, including webinars and case studies, that address the social drivers of health. For more information and additional resources, please see the Appendix and visit childrenshospitals.org/socialdrivers.

Background

Social drivers of health are nonmedical conditions that can directly impact a person's health, functioning, and quality-of-life outcomes and risks. They include the environments where people are born, live, learn, work, play, worship, and age.[1]

Research has shown social drivers influence 80% of our health and health care outcomes, including mortality, life expectancy, and health status.[2] Health outcomes can be attributed to factors such as safe and stable housing, access to food and transportation, social connection, and safety or environmental exposures. These factors are not finite and addressing them can improve the health and well-being of children, adolescents, families, and the communities where they live.



Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. countyhealthrankings.org

Screening Challenges

Children's hospitals experience challenges as they implement screening throughout their organizations. These include:

- Hesitancy to screen for social drivers because of a lack of referral resources or partners once needs are identified.
- Limited time to complete screenings.
- Modification or adoption of new clinical workflows to support screenings and referrals.
- Families' lack of trust in hospitals, care teams, or the screening process.
- Screening processes may not meet social, cultural, or linguistic needs.
- Inadequate information and training for care teams to conduct screenings or refer patients and families to needed resources.
- Sustainability of screening and referral efforts.

Unique Considerations for Children

Screening children for social drivers of health has unique considerations. Identifying these factors early can ensure they have the physical, social, and emotional capabilities needed throughout their lives.

Children rely on their families and caregivers to meet basic needs such as food, shelter, and access to health care. As a result, social drivers identified in children often impact the entire family.

In addition, screening children generally involves their caregivers, who may be protective and hesitant to provide information without knowing how it will be used or shared. Prior negative experiences with systems such as child welfare, law enforcement, and the health system may cause families to guard information on sensitive issues. Additionally, a two-generation approach is required. Often, the parent or caregiver becomes the "patient," which creates challenges for documentation in the electronic health record.

Questions to Consider

Children's hospitals should consider these questions as they determine a screening approach.

- ☐ What screening questions are being asked, and who is asking them?
- ☐ What can be done to standardize screening questions across the organization?
- ☐ Are care teams aware of training and resources available to help conduct screenings or refer patients and families to needed resources?
- ☐ How can technology be leveraged to support screening or referrals to needed resources?
- ☐ What can be done to increase access to resources for patients and families?
- ☐ Does the organization's culture support investment in screening?
- ☐ Are there champions who can be engaged?
- ☐ Which community organizations would be good partners?
- ☐ What process and outcome metrics can demonstrate success?

Tools and Processes

Currently, there is no standardized way to collect social drivers of health information. However, this work starts with a conversation. Children's hospitals must engage patient families to understand what is experienced outside the exam room walls.

Children's hospitals are screening for social drivers for some patients, but not consistently for all patients. Outpatient primary care is the most common setting for screening, but it can also take place in inpatient units, emergency departments, outpatient specialty clinics, and before patients arrive at care settings. Some or all of this information is collected in the electronic health record.

Commonly Screened Social Drivers

The three most screened social drivers are food insecurity, housing, and transportation. Children's hospitals also screen for a variety of social drivers, including:

- Ability to pay utilities.
- Caregiver stress.
- Child care.
- Economic stability—employment, income.
- Education.
- Firearm safety.
- Health behaviors.
- Health literacy.
- Interpersonal violence/safety.
- Legal issues.
- Social isolation—lack of family and social support.

Screening Tools

Children's hospitals use a variety of screening tools. Most hospitals report using hybrid tools—combinations of questions from validated screeners and those developed by their in-house experts. This allows each hospital to create a tool best suited for its patients. A drawback of this approach is that questions often are not validated and their efficacy can be uncertain.

While the majority of children's hospitals are screening for social drivers, they have not yet developed standardized questions or an organization-wide process. An exception is **Phoenix Children's Care Network** (PCCN), a physician-led, pediatric-focused clinically integrated network. PCCN developed a preferred universal screening tool that was designed to ensure screenings are short, simple, effective, and can be easily integrated into the clinical workflow.

Screening Process

The individuals who conduct the patient and family screenings vary by organization and setting. While most individuals are social workers or case workers, many hospitals have self-administered screenings. These screenings take place through portals, online forms, and tablets.

Nationwide Children's Hospital in Columbus, Ohio, is shifting its screening process in care delivery settings to self-administered tablets. This allows families to answer questions privately, without children hearing the responses. It also alleviates staff discomfort of asking patients and families sensitive questions. The information collected on the tablet integrates directly into the electronic health record. Since adopting tablets, there has been an increase in the percentage of patients being screened and those disclosing social needs. Nationwide Children's is now expanding tablet screening to Spanish-speaking families and exploring additional languages.

Self-administered screenings allow families to answer questions privately and alleviates staff discomfort.

Self-administered screening has not led to the same results in non-care delivery settings. For example, **Wolfson Children's Hospital** in Jacksonville, Florida, collects social driver information in its advocacy center, THE PLAYERS Center for Child Health. Advocacy center staff found that having in-person conversations related to social drivers allows for more honest and complete answers. As a result, instead of using a paper form, navigators conduct informational interviews to get to know families and learn what social needs they may have.

Training Care Teams

Training care teams is critical to implementation. **PCCN** learned this in 2022 as they implemented a systemwide social driver screening.

PCCN needed an efficient, standardized, validated screening tool that would provide the needed information for care teams without requiring too much time for families to complete. The network also had to establish practice workflows, determine the screening process, and plan how to address a positive screen.

A key step to implementation was training clinical practices. PCCN developed a screening tool, workflow, and resources for practices. Staff created a Network Guide with best practices and held regular webinars. They also incentivized implementation for care teams with engagement points for their quality improvement program and Maintenance of Certification credits.

Screening Tools Used by Children's Hospitals

Accountable Health Communities Health-Related Social Needs	Developed by the Center for Medicare and Medicaid Services (CMS) for use by their Accountable Health Communities and made publicly available.
EPIC	Standard and custom approaches to screening for social drivers directly within the electronic health record.
HealthBegins	28-question screening tool to assess five domains: economic stability, education, social and community context, neighborhood and physical environment, and food.
Health Leads	Modifiable social needs screening toolkit that combines Health Leads experience implementing social needs programs and clinically validated guidelines.
Hunger Vital Sign	Two-question screening tool to identify households with food insecurity. Developed by Child Watch and endorsed by the American Academy of Pediatrics and CMS.
iHELP	Pediatric-focused screening tool developed by clinicians, which includes both household needs and child-specific questions.
PRAPARE	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences is a comprehensive screening tool that includes 16 core measures as well as four optional measures.
RAAPS – PH	Rapid Assessment for Adolescent Preventative Services is a tailored social needs screener for adolescents to young adults, ages 9-24. The Public Health tool aims to identify youth most at risk for access to tangible needs such as food, water, and electricity.
WE-CARE	Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education is a clinic-based screening tool that asks parents questions about child care, food security, housing, parent education, and employment.

Guiding Principles for Screening

Children's hospital leaders should consider these principles as they conduct social driver screenings.

Trust

Building trust between patients, families, and care teams enables insight into a family's life circumstances and priorities.

Educating families about the screening process is essential to building trust. This includes sharing why the questions are being asked, how the information will be used, what resources may be provided, and when those resources will be provided. Nationwide Children's Hospital created a script for clinicians to use when screening families for social drivers. It states that all patients are being asked the questions, staff will contact the family if a need is identified, and then requests permission to move forward with the questionnaire.

Building trust also means not making assumptions about patient and family needs. Children's hospitals may feel familiar with the socioeconomic status of the families they serve and make incorrect assumptions or be inequitable in the screening process. Children's Memorial Hermann Hospital in Houston screens for social drivers in outpatient pediatric clinics. Through this work, hospital staff found positive screens occur in communities with higher economic status, not just where the team originally anticipated needs would exist. This has demonstrated families with health insurance also have social needs the hospital can help address.

Finally, building trust takes time. Care teams must be ready to accept the time it takes to build trust if patients do not wish to provide this type of information.

Guidance from Patients and Families

Many hospitals seek input from families as they develop, implement, and improve their processes for screening for social drivers of health. Children's Specialized Hospital (CSH) in New Brunswick, New Jersey, sought feedback from its Family Faculty, who are parents and family members whose children have received or still receive services. This group offers a unique perspective, understanding, and empathy for families going through similar situations. Family Faculty helped the team implement social driver screenings in outpatient, inpatient, and long-term care settings. They also provided guidance on the hospital's screening tool, the implementation process, and ways to build trust and safe spaces for these conversations.

This led CSH to develop training, scripting, and prompts to ensure all providers could assess and address patient needs in a caring and compassionate manner. Involving families highlighted the importance of offering various screening modalities in the outpatient setting—including text, email, or assistance of a family navigator—to allow families to respond in a way that is most comfortable for them.

Lucy's Story: A Patient's Experience

The following example shows how social drivers affect medical care.

Lucy is an 8-year-old patient with insulin-dependent diabetes. She was admitted to Children's Wisconsin multiple times in diabetic ketoacidosis, a potentially life-threatening condition of uncontrolled elevated blood sugar. Lucy had sporadic attendance at primary care and diabetes clinic visits. Her pediatrician, concerned that Lucy's mother may have low health literacy, engaged the community health navigator who serves Lucy's neighborhood. After meeting Lucy and her mother, the navigator learned they were homeless, moving between friends or family members' homes and abandoned buildings. Insulin must be refrigerated to maintain its effectiveness, and Lucy was often without electricity, making it impossible to manage her diabetes well, despite her mother's best efforts. Without the community health worker, clinical staff would not have the complete picture of the challenges Lucy and her mom faced, and Lucy's health would have continued to decline. By identifying this family's needs, hospital staff connected them with community resources, bringing more stability to their lives and predictability to Lucy's medical care.

Cultural Competency

It is important to consider how health care providers deliver care to patients with different values, beliefs, and behaviors. Children's hospitals are successfully tailoring their screening efforts in ways that meet patients' social, cultural, and linguistic needs.

At **Children's Minnesota**, the Community Connect program connects families seeking primary care services to community resources to address social needs. Families complete a questionnaire that asks yes or no questions about access to nutritious food, adequate housing, and other social drivers. If a family screens positive, a resource navigator taps into a network of community partners and makes warm handoffs. Resource navigators follow up over time and ensure families have access to the resources they need.

Community Connect was designed to specifically address the needs of families from diverse cultural backgrounds who experience greater disparities in health outcomes. The hospital hires resource navigators from the diverse communities they serve so they have a better understanding of families' unique needs.

Collaboration

One reason hospitals may be hesitant to screen for social drivers is because staff do not know how to address them when they are found. To overcome this, children's hospitals establish partnerships with schools, public health, and community-based organizations. It is important for hospitals to understand and assess the resources provided by community and social service organizations in their service areas and their capacity to receive referrals.

Start Small and Grow

Most social driver screening programs start small and expand over time. For example, **Children's Health, Dallas**, recently began systemwide implementation of a social driver screening program. The program started in ambulatory settings in July 2022, followed by inpatient settings in February 2024, and expanded to the emergency department in July 2024.

Timing has been critical to ensure successful implementation. The team planted the seed early, shared why this work is important, and identified staff to serve as champions throughout the implementation process. Staff helped design workflows and integrate social drivers into the electronic health record. In addition, they developed presentations, computer-based training modules, and an interactive resource guide for the teams involved with the program and trained all necessary team members prior to implementation.

Cincinnati Children's created a task force to develop an institutional approach to screen for social drivers, depression, suicide, and substance use. The hospital found screening was not taking place in a standardized way across the organization. As a result, staff identified early adopter groups and now use their experience to make recommendations on how to scale standardized efforts across the organization.

Most social driver screening programs start small and expand over time.

Process Improvement

Over time, children's hospitals work to improve the quality and efficiency of social driver screenings. **Nemours Children's Health** in Delaware and Florida has taken a Plan-Do-Study-Act approach to implementing its social drivers screening process. The six-phased approach is described in the resource guide "Developing and Scaling a Social Needs Screening and Referral Process for Pediatric Patient Families." The process continues to evolve as the health system responds to internal learning, evaluation, research, and insights from peers.

Gain Buy-In and Identify Champions

Buy-in from the right individuals is critical as children's hospitals build and scale successful social driver screening efforts. **Nemours Children's Health** involved the care team while the screening process was being designed. Other hospitals kept their screening tool short so that they could gain buy-in across service lines and departments, all of which had different capacities to incorporate screenings into their workflow.

Making an Impact

The care team can use data in patients' medical records to refer patients and families to resources, improve care and treatment options, and solve community challenges.

Addressing Community-wide Challenges

Understanding the social drivers impacting individuals and families also allows children's hospitals to make a larger impact within the communities they serve. Arkansas Children's Hospital in Little Rock began this work when the hospital's community health needs assessment identified food insecurity as a primary priority. It found nearly 23% of children in Arkansas are food insecure and one-third of households include children that do not have enough to eat.

Please refer to the case study on page nine for more detail.

Referral Process for Positive Screens

Care teams will not be able to address identified needs overnight, nor should that be the expectation. However, they play an important role in connecting patients and families to the resources they need.

Resource flyer only. Patients and families are provided with a list of general or curated resources, leaving follow up to the patient and family.	**A "warm handoff."** The care team makes a phone call or an introduction between a resource provider and the patient and family.	**Care manangement.** The care team goes beyond making the connection and they schedule the appointment for a patient and family with the resource provider.	**Closed-loop connecton.** There is ongoing communication between the care team and the resource provider to "close the loop" and ensure patients and families receive needed resources.

Data on Social Drivers

Hospitals can capture data on the social drivers of health using the ICD-10-CM codes included in categories Z55-Z65 ("Z codes"). These codes identify nonmedical factors that may influence a patient's health status. At a national level, adding this data to hospital claims allows for systemwide research to better understand social drivers impacting patients and communities. This information could also support future policy and payment reforms.

Nationwide adoption of Z codes has been slow. Leading challenges to using Z codes identified by children's hospitals include:

- Lack of training or familiarity with Z codes.
- Lack of reimbursement.
- Lack of access to electronic health record/billing team to build effective mechanism for reliable documentation.
- Lack of a fully operational system as the hospital is in the implementation phase.

Additional resources related to Z codes are included in the Appendix.

Arkansas Children's Hospital

Arkansas Children's uses a combination of internal initiatives and external partnerships to address food insecurity and improve children's health at the patient, family, and community levels at all their sites of service.

Patient
Arkansas Children's provides families with an optional screening to assess for vulnerabilities regarding food security. Those that screen positive receive access to emergency food supplies, including USDA-provided box lunches and emergency grocery bags from partner pantries.

Family
The hospital refers families to organizations that can assist with immediate food security needs as well as long-term programs for which they may qualify, such as Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP). The hospital also partners with local organizations to educate parents on budget-friendly healthy meals.

Community
Arkansas Children's partners with community-based food referral networks, such as the Hunger Relief Alliance, and school-based nutrition education programs. The hospital also supports local community gardens that harvest food for neighborhood pantries, including client choice pantry at a nearby HBCU where allergy-friendly items are available for the campus, neighborhood, and Arkansas Children's communities.

National Policy Considerations

Currently, there are no federal mandates related to screening for social drivers of health in children's hospitals. Yet, many are committed to this work as part of their mission to provide vital care to children and improve children's health.

Moving forward, external entities, including the Joint Commission, are imposing requirements related to screening for social drivers of health. The federal government has also signaled interest in hospitals' progress on health equity. As of 2024, hospitals who participate in the Inpatient Prospective Payment System (IPPS) must report two measures—Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. Although IPPS policies apply to Medicare populations, they can often influence future Medicaid policy.

CHA monitors policy issues related to screening for social drivers of health, including screening requirements, reimbursement for children's hospitals' efforts to collect, use, and share this information, and funding opportunities for community-based organizations that partner in these efforts. CHA has also developed Addressing Social Drivers of Health: Children's Hospitals Take Action, a resource that shares case examples from children's hospitals and is being used in our advocacy efforts.

Conclusion

Children's hospitals should address the social drivers of health and take action to improve children's health. Children's hospitals and community organizations play key roles to address social drivers at the patient, family, and community levels.

This resource can help children's hospitals and pediatric health care providers develop strategies that effectively address the needs of patients. Examples can guide and connect hospitals with organizations who found ways to integrate screening tools and uncover factors that contribute to poor health outcomes.

CHA will continue to learn and share best practices related to screening for social drivers.

1 "Social Determinants of Health: Know What Affects Health." Accessed May 21, 2024. Throughout this guide, Children's Hospital Association uses the term social drivers of health or social drivers. Many terms have been adopted throughout the industry to capture this same principle, including social determinants of health, health-related social needs, societal factors that influence health, or social risk factors. These terms, for purposes of this guide, mean the same.

2 "Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." Accessed May 22, 2024.

Appendix

Resources on Social Drivers

American Hospital Association
Screening for Social Needs: Guiding Care Teams to Engage Patients

American Health Information Management Association
Social Determinants of Health Data: Survey Results on the Collection, Integration, and Use

Children's Health
Implementing Social Determinants of Health Data Collection in a Large Urban Pediatric Hospital Setting

Nemours Children's Health
Developing and Scaling a Social Needs Screening and Referral Process for Pediatric Patient Families

Social Interventions Research and Evaluation Network
Research that advances efforts to address social determinants of health in health care settings.

Texas Children's Hospital
Social Determinants of Health: Screening in Clinical Settings

Resources on Social Drivers of Health Z Codes

Centers for Medicare & Medicaid Services
Improving the Collection of Social Determinants of Health Data with ICD-10-CM Z Codes

Centers for Medicare & Medicaid Services
Using Z Codes: The Social Determinants of Health Data Journey to Better Outcomes

American Hospital Association
ICD-10-CM Coding for Social Determinants of Health

Contact Us

Stacy Wathen
Director, Community Health
Children's Hospital Association
(202) 753-5341
stacy.wathen@childrenshospitals.org

Priya Bathija
Founder and CEO
Nyoo Health
pbathija@nyoohealth.com

Originally published 2018. Updated 2024.

To access additional resources, please visit childrenshospitals.org/socialdrivers.