

Assessing the Social Drivers of Health: Considerations for ACOs

Introduction

Efforts by the health care sector to address patients' social needs have the potential to improve health outcomes, advance health equity, enhance the appropriate use of medical services, and lower health care costs. The National Academies of Sciences, Engineering, and Medicine has identified five key activities to [better integrate social services into health care delivery](#): awareness, adjustment, assistance, alignment, and advocacy. This Issue Brief focuses on awareness activities – specifically assessments of patients' social risk factors.¹

Prepared in conjunction with a [Learning Collaborative on Addressing the Social Drivers of Health](#) convened by the Institute for Accountable Care (IAC) and the National Association of Accountable Care Organizations (NACCOS), this document highlights key themes from the Learning Collaborative's discussions and provides links to relevant resources. Subsequent Issue Briefs will explore how ACOs can work with community-based organizations to address patients' social needs, work with payers to support social services and assess the potential return on investment from these programs.

Planning and Implementation Considerations

There is no “one size fits all” approach to documenting social risk factors. Many ACOs are [just beginning](#) to implement standardized assessment processes and the [evidence base](#) to inform best practices is limited. ACOs will need to consider a variety of questions in determining how to identify the social risk factors experienced by their patients:

Why assess social risk factors? Developing an accurate understanding of patients' social risk factors is fundamental to developing an effective strategy to address social needs. ACOs should establish [explicit objectives](#) for social risk assessment that will guide future planning and implementation. Does assessment seek to identify social risk factors at the patient-level, population-level, or both? To what extent is assessment intended to support specific organizational goals, such as reducing avoidable emergency department utilization or decreasing hospital readmissions? Will assessment be limited to social risk domains for which the ACO is willing to invest in interventions and response capacity? To what extent is social risk assessment being shaped by payer requirements or incentives? ACOs are more likely to be successful if they have a [fully articulated rationale and clear priorities for their social risk assessment activities](#).

¹ Social risk factors are measurable and intervenable individual-level social and economic conditions that are shaped by broader social and structural determinants of health. Social needs are social risk factors that a patient prioritizes as important to address.

Which screening tool to select or adapt? A wide variety of [multi-domain screening tools](#) are available to assess social risk factors. The tools vary widely in scope, length, language accessibility, cost and other characteristics. Domains commonly included in existing risk assessment tools are food insecurity, intimate partner violence, housing instability, transportation access, financial strain, and social isolation. Evidence is limited regarding the [validity and reliability](#) of these multi-domain screening tools.

Absent clear guidance on optimal methods for identifying social risk factors, ACOs should select or adapt screening tools that best address the needs of their patients and organization. Considerations in screening tool selection include:

- Organizational priorities for social risk assessment.
- Availability of resources to respond to social risks identified,
- Ability to integrate screening tools and assessment results into electronic health records,
- Ease of administration,
- Staff capacity,
- Compatibility with screening tools already in use.

Which populations to screen? While universal screening may be preferable to reduce bias and stigma, most ACOs will need to prioritize patients for screening particularly when social risk assessments are first initiated. In selecting targeted patient groups for screening, ACOs may consider focusing on high-risk patients (e.g., those under care management), patients utilizing routine services (e.g., Annual Wellness Visits, annual physical examinations, new patient visits), patients in risk-based contracts, patients residing in targeted geographic areas, or patients in pilot provider practices staffed by motivated clinical champions. The periodicity and mode of screening must also be considered and may vary across patient groups.

Who should administer social risk screening? Social risk screening may be conducted by care managers, social workers, nurses, primary care providers, medical assistants, community paramedics, community health workers, and volunteers. Choosing which staff will administer or facilitate assessments will depend on staff capacity, which patients are targeted for screening, existing clinical workflows, and available modes of data capture. Social risk screens can also be incorporated into patient portals, enabling patients to self-report while at home or in the waiting room. However, patients most at risk may not have access to patient portal accounts. Successful implementation of social risk assessment may require flexibility in terms of where, how, and by whom data are collected and these approaches are likely to evolve over time as workflows are refined.

What is the utility of third-party data to assess social risk factors? Patient-level data related to social risk factors, such as demographic and socio-economic information, are available for purchase through third party vendors (e.g., credit reporting agencies). Population-level data are available which characterize the [social vulnerability](#) of geographically defined communities. Such data may provide valuable insights, such as identifying patients or neighborhoods for additional outreach and screening. However, ACOs should exercise caution in utilizing these data sources for assessing patients' social

risk factors. Proprietary patient-level data can be costly, are not typically validated, may fail to identify specific social needs, and raise ethical concerns regarding patient privacy and consent. Community-level data can inform decision making but may not accurately identify the social risk factors of individual patients. Low-risk patients may reside in high-risk communities and, conversely, high-risk patients may reside in low-risk communities.

Implementation Challenges and Concerns

As efforts to implement social risk assessments in clinical settings are still new, several challenges and concerns may confront ACOs advancing this work:

Patient privacy and autonomy. Social risk screening inherently addresses sensitive topics that have the potential to be stigmatizing for patients. Concerns regarding stigma and privacy are commonly cited by clinical staff as perceived obstacles to social risk screening. However, such screening has been found to be [acceptable to patients](#) and may strengthen relationships with the health care team when conducted in a patient-centered manner that emphasizes respect, empathy, assistance in responding to identified needs, and attention to privacy protections. Patients should be informed of, and provide consent to, all potential uses of screening data. Access to this information should be well protected to prevent unauthorized access or release. Ideally, screening processes should identify the social risk factors a patient prioritizes for assistance (i.e., social needs) to ensure interventions focus on resources and services the patient actually wants. Efforts should also be made to minimize reporting burden for patients by avoiding duplicative requests for social risk information from multiple members of the care team.

Electronic Health Record integration. Integration of social risk screening tools and assessment documentation in the EHR both improves the efficiency of data collection and makes these data more accessible and actionable for clinical staff. While EHR software vendors may include some “off the shelf” functionality to document social risk factors, ACOs should anticipate the need for customization that may require significant investments of time and resources. The lack of widely accepted data standards for social risk documentation complicates EHR integration efforts. One effort to develop standards is [The Gravity Project](#), which is convening stakeholder groups to facilitate electronic health information exchange for social risk data. The project has developed a [compendium](#) of medical terminology codes to document screening processes, assessments, and treatment/interventions.

Staff Receptivity and Training. Clinical staff may have concerns that influence their receptivity to social risk assessment. In addition to patient stigma and privacy issues, staff may also have concerns about the time burden associated with conducting screens and making referrals, potential disruptions to established workflows, the adequacy of referral resources to address identified needs, and their comfort level with the assessment role. ACOs can address these concerns with investments in staff training, [workflow planning](#), referral resource development, support for referral processes, and (possibly) staff incentives for screening.

Many ACOs are now conducting social risk assessments and beginning to use the information to address adverse social drivers of health. For both ethical and practical reasons, ACOs must ensure that information collected through social risk assessments are leveraged to improve health outcomes. The value of social risk assessments ultimately depends on how this information is used to support clinical decision making, facilitate referrals to community partners, identify opportunities for strategic investments, and advance advocacy priorities.

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