Screen for homelessness, housing instability & other unmet social needs and link to services

Overview of this strategy

Evidence continues to build that demonstrates the many ways in which substandard housing, housing insecurity, homelessness and other health related social needs impact physical and mental health and also contribute to inequities in health outcomes (Whitman et al., 2022 and Cooper, 2019). As of time of writing, there are a number of federal and state based policy levers, such as CMS and Joint Commission requirements and state Medicaid waivers, that are creating momentum for consistent and reliable screening and linkages for social needs. A range of potential benefits as well as risks exist for screening for housing conditions.

Potential benefits:

- **Upstream intervention.** Hospitals, federally qualified health centers and other primary care settings are great 'early detection' system points because they are often accessed 'upstream' from the homeless response system. Screening for housing related social needs in these environments leads to knowing on an individual level who is experiencing housing instability and can prompt connections to stabilization services: legal support, rental assistance, behavioral health support, etc. that might divert someone from the homeless response system and reduce inflow.
- **Connection to services.** Linking people who screen positive for homelessness to the Coordinated Entry System and other community-based services through referrals, navigation or case management programs may improve the individual's experience of the system of care and potentially accelerate their connection to much needed services.
- **Better health care**. Screening for homelessness may enhance the patient-provider relationship and allow health care teams to better partner with the patient in developing a shared plan of care responsive to the patient's needs (Byhoff and Gottlieb, 2022).
- **Lower cost**. Social needs screening and navigation services may reduce ED utilization and health care expenditures (Rojas, 2023).
- **Support strategic investments**. Screening universally across a health care system in a community can provide data to better understand prevalence, trends and correlations between patient housing needs, health outcomes, and healthcare utilization. In the long term, this data can support strategic planning and investments. At the system level, this may mean efforts to improve discharge planning, creation of medical respite and other complex care services, and developing care coordination and case conferencing practices.

Risks:

- **Potential for harm**. Social needs screening, such as asking about housing insecurity or interpartner violence, inquires into private and potentially stigmatized aspects of a patient's life. Ways to mitigate this risk could involve training staff on responding in an empathetic and trauma-informed way.
- **Moral injury due to no resolution of needs.** Clinicians may, understandably, be hesitant to screen for social needs when there is no effective response pathway for positive screens, they don't know where to refer someone, or they aren't allowed time to address social needs in an empathetic and meaningful way. Consider mitigating this risk proactively through education about existing homeless response services and social need services in the community and by emphasizing the range of current and potential benefits of social needs screening, listed above.

As health systems develop screening processes that help them better understand the social needs of their patients, they should look to partner with community organizations including the CoC lead agency to co-design interventions, programs, and services that may offer solutions for unmet needs.

Resources and tools for implementing this strategy

- The Joint Commission's "Requirement, Rationale, and References for Addressing Social Needs and Providing Information"
- America Hospital Association: Screening for Social Needs: Guiding Care Teams to Engage Patients
- CMS: Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool
- American Academy of Family Physicians: A Practical Approach to Screening for Social Determinants of Health

Practical advice from the field

While pilot sites agreed that screening for housing instability and other social determinants of health is important, there was a wide range of opinions as to how easy it would be to sustain this activity long term.

Generally, pilot sites reported a much higher level of confidence in their ability to sustain a screening process than their ability to sustain meaningful linkages to community-based services and supports. This speaks to a need to focus on building up and investing in robust, local ecosystems of care and ensuring the healthcare and homeless response system continue the foundation-building work of bidirectional commitment and governance, including providing education to clinical staff to understand the impact that homelessness and housing instability have on people's physical, mental and emotional health.

Some of the enabling conditions for screening and referring mentioned by pilot teams were:

- Ability to share data across sectors
- Momentum around federal, state, and accreditation requirements
- Strong partnerships among CoC members and between health care systems and homelessness response systems and awareness of services offered by the other system
- Standardized screening questions and process, including how it would be documented in the medical record

Tactics & change ideas

- Provide education and supports to clinical staff in how to address positive screens and creating the response pathways that allow needs identified to be addressed at the point of care.
- Situate homeless response case managers or liaisons in hospitals for warm referrals to resources and coordination between systems after outpatient visits or pre-discharge
- These roles can also inspire and educate health system staff about what is available in the community for housing and homeless response services
- Screen for SDOH as close to admission as possible, using a screening tool to identify a range of social determinants including the experience of housing instability/literal homelessness
- Investing in training to ensure a healthcare system has a consistent, trauma informed way of asking screening questions.
- Develop clear and consistent guidance/workflows about what to do when an unmet need is surfaced
- Develop an asset map of available community resources or lean on existing web-based platforms used in your community (such findhelp.org, Healthify, Health Leads, NowPow, One Degree, 211, etc) to refer people to needed services
- Focusing existing care coordination and care management programs on patients experiencing homelessness and creating linkages to services.
- Learn about trends and reasons for housing instability/homelessness to make the case for investments or programs, particularly those that can close equity gaps

Bright spots and examples from the field

- West County Health Centers (WCHC) connect their patients everyday with services that they need to improve health and wellbeing – from food banks to shelters
- Oregon Primary Care Association's Empathic Inquiry approach to social needs screening

References:

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