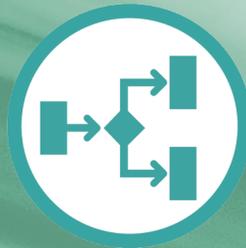


GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 3: CREATE A SOCIAL RISK PLAN



Step 3: Create a Social Risk Plan



In this step, you will develop your workflow plan for social risk data collection, review, and (if desired) referral-making. You will also develop a plan for rolling out this workflow.

Using Your EHR to Support Social Risk Screening and Related Activities.....3

Task 1: Developing Your Workflow.....4

a. Tips for Social Risk Screening Workflows.....4

b. Tips for Social Risk Review and Action Workflows.....5

c. Tips for Social Risk Data Review / Related Actions Based
on Primary Care CHCs' Experience..... 6

d. Creating and Maintaining a Community Resource List..... 7

e. Social Risk Screening and Data Collection Workflow Planning Tool..... 8

Task 2: Developing a Social Risk Rollout Plan.....9

a. Considerations for Rolling Out Your Social Risk Workflows.....9

b. Examples of Social Risk Rollout Plans Used By Other Clinics..... 9

c. Social Risk Workflow Rollout Planning Tool.....10

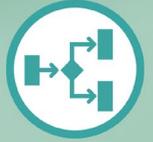
Using your EHR to Support Social Risk Screening and Referrals



Some EHRs have tools that can help with social risk screening and referral-making. Ask your IT team if your EHR can be used to:

- **Assign** social risk screening to specific patients on a set schedule
- **Identify** patients targeted for social risk screening at check-in, rooming, in the provider's schedule, or in the patient's data summary
- **Identify** patients targeted for social risk screening using roster tools to support outreach to these patients
- **Let clinic staff document** social risks at different workflow steps
- **Let patients document** their social risks through the patient portal, or on tablets in the waiting room, or directly into the EHR in the exam room
- Send targeted patients a **letter, email, or text** asking them to complete social risk screening in the patient portal
- **Document:**
 - Whether the patient wants support addressing a given social risk
 - What kind of support the patient wants
 - Which social risk the patient wants help with
- **Refer** patients with social risk needs:
 - To Community Health Workers or Case Management Services (internal referral)
 - To Community-Based Organizations (external referral)
 - By using Social Service Resource Locators to connect patients with services
- **Track** past referrals
- **Review** a given patient's social risks needs
- **Review** your clinic's social risk screening rates
- **Choose** which social risk screening tool to use (e.g., PRAPARE, AHC, individual social risk domains)
- **Add social risk codes** to the problem list or visit diagnoses

Task 1: Developing Your Workflow



a. Tips for Social Risk Screening Workflows

Q. What is a workflow?

- A workflow is a systematic set of processes that standardizes and streamlines the delivery of clinical care and services.

Q. How can we make our social risk screening workflows as efficient as possible?

- Be sure the social risk data are entered in the EHR in time for review at the encounter, if desired. Your workflow plan should say who will enter these data, and when. Data entry typically takes 1-2 minutes.
- Be flexible about modifying your target population as your workflow is revised.

Q: How can we easily identify patients for screening as part of the workflow?

- Use reporting tools to identify patients who you want to screen, and / or to show front desk or rooming staff who to screen. Your IT team may be able to help you set this up.
- Add social risk screening to routine visits (annual physicals, paperwork reauthorizations, etc.). This can reduce perceived stigma, and streamline identifying patients for screening.

Q: What should we consider if we want to use the patient portal to screen patients?

- Using the patient portal to collect social risk data only works if patients have a portal account.
- Your EHR might let you send questionnaires via the portal to patients to complete at home prior to their appointments or while they are in the waiting room.

Task 1: Developing Your Workflow



b. Tips for Reviewing and Acting on Social Risk Data

Q: Which staff are most appropriate for doing social risk screening?

- This will depend on your clinic's structure and resources. Be sure that staff assigned to social risk screening activities have the needed time, workload, expertise, and comfort level for the job, and the necessary user permissions to access the appropriate tools in the EHR.
- If you want to administer the screening in person, assign it to a staff member who can spend the needed time with the patient.

Q: How can we help these staff do social risk screening easily?

- Target patients who are easy to identify – for example, by including the social risk questionnaire in pre-set screening packets (e.g., new patients, annual physicals, annual insurance reauthorization). Train relevant staff in how to use the related EHR tools (provide at-the-elbow support, as necessary).

Q: What can staff do when patients have one or more social needs?

- Ask patients if they want clinic assistance with any identified social risk needs; document their response in the EHR, if feasible.
- Recognize that you can work with patients on additional needs at a future appointment. This is an ongoing process; not all needs can / will be solved immediately.

Q: What if we don't have resources available in our community to assist patients with certain needs, or what if we don't have the ability to assist?

- Explain to the patient that you may not have a solution to all their needs, but you are attempting to understand their life situation and priorities. (This helps to manage expectations about the clinic's ability to address reported needs.)

Q: How can we use the EHR to help with positive social risk screening responses?

- Ensure that as part of the workflow, all of the right team members check the patient's social risk answers in the EHR. This will help avoid asking questions twice in the same visit, or even between repeated visits depending on the length of time between visits. This can prevent frustration for patients.
- Make sure that staff tasked with making referrals have security clearance to access the EHR's referral tools, if this is part of your workflow.

Task 1: Developing Your Workflow



c. Tips for Social Risk Data Review / Referral-Making Based on Primary Care CHCs' Experiences

Q: Our patients often have multiple social risk-related needs—how do I prioritize?

- There is no right answer! Some organizations prioritize by asking the patient what is important to them, or by considering what resources are available to refer patients with social risk needs.

Q: Will we be overwhelmed with the number of positive responses?

- The majority of low-income patients may report at least one social risk need if screened for multiple domains. However, only a few of them may desire clinic staff help in addressing these needs. It is important to ask patients if they want this help.

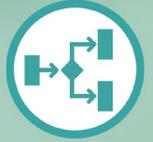
Q: How can we communicate social risk screening results back to the PCP and larger care team?

- Via EHR: Document social risk screening results into the chart note, or make a social needs referral. Add social risk needs to the problem list.
- On paper or in person: Give the PCP the completed paper social risk questionnaire to scan prior to seeing the patient, or consider using a quick in-person huddle to share social risk information with the whole care team.

Q: A patient has indicated they need / want help—what's next?

- Some clinics refer patients with social risk needs to community social service agencies. (Usually this 'referral' means giving the patient information about this agency, but it can also mean helping the patient contact the agency.) The next page will tell you how to create a list of local agencies, and document these referrals.
- Some clinics use a warm hand-off to address all social risk needs: e.g., a patient with social risk needs is sent to meet with a social worker, CHW, etc., as soon as needs are identified.
- Some use a warm hand-off only if a patient screens positive for social risk needs that are urgent.
- Some clinics have the staff person who administers social risk screening and / or enters social risk data send a generic internal referral (e.g., 'social need') to a CHW, behavioral health person, etc., for assistance either at the current visit, OR in follow-up after the visit.
- Some primary care teams have this staff person send a specific internal referral(s) based on identified needs for assistance, either at the current visit, OR in follow-up after the visit.

Task 1: Developing Your Workflow



d. How to Create a Community Social Service Resource List

Option 1:

Create and maintain a list on paper or in a spreadsheet with information on local social service organizations. List local agencies to which your teams often refer patients. Or, if you have the ability, create a page on your clinic's website or internal network that lists local resources, and refer patients to the website.

Below are two sources of information you can use to update your resource lists:

- **Google/Web Search:** can provide information on resources within a given city, zip code, or distance from your clinic.
- **AAFP Neighborhood Navigator Website:** This free website can show you community resources for different social needs based on zip code. <https://navigator.aafp.org/>

Advantages: Many primary care providers already have a community resource binder, spreadsheet, or other document with this information, and some already have this information on their clinic website.

Disadvantages: Not automatically documented in the EHR; must be updated regularly to be useful.

Option 2:

Create and maintain preference lists in your EHR for social risk referrals. List local agencies to which your teams often refer patients. As above, Google and the AAFP Neighborhood Navigator are two sources of information for keeping your preference list up-to-date.

Advantages: Staff may already know how to use preference lists. These lists are EHR-based, which enables tracking.

Disadvantages: Must be updated regularly.

Tips: Make list maintenance the responsibility of the staff person who updates preference lists. Also, make sure that the person tasked with using the preference list has the necessary user permissions to do so.

Option 3:

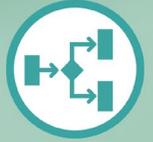
Contract with a Social Service Resource Locator (SSRL) service that provides these lists.

Advantages: These lists are updated for you by the service provider, so you can keep your binder or preference list (options 1-2) up-to-date.

Disadvantages: There is usually an associated cost with these services, and they are also not comprehensive in all regions. It may also require effort for a staff member to update the resources provided into the preference list, depending on the level of integration the SSRL provides.

- **Platform:** Most SSRLs use web-based applications to provide resource lists. They may also include case management tracking and coordination features.
- **Coverage:** No one SSRL has complete resource directories for every community nationwide.
- **Cost:** SSRLs charge an ongoing fee to use their service, and some may also charge setup fees to help them establish an initial directory for your community.

Task 1: Developing Your Workflow

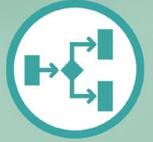


e. Social Risk Screening and Data Collection Workflow Planning Tool

See the Excel Workbook, "[Social Risk Screening and Data Collection Workflow Planning Tool](#)" to start developing your workflow.

SOCIAL RISK SCREENING & DATA COLLECTION WORKFLOW PLANNING TOOL				
Number	Question	Response (Click on cell to select from drop-down menu)	If Other, please specify:	Notes/Comments
1	Who and when will the social risk data be collected:			
1a	Who will collect social risk data?			
1b	When will social risk data collection occur during visit?			
2	How will social risk data be collected?			
3	If data collection method is the patient portal:			
3a	How often will patients be asked to complete screening?			
3b	Which patients will be batch emailed?			
3c	Who will be responsible for sending questionnaires via the patient portal?			
3d	How often will questionnaires be sent out?			
4	If data collection method is on paper:			
4a	When (in workflow) will social risk data be entered in the EHR?			
4b	Who will enter social risk data in the EHR?			
4c	How often will social risk data be entered in the EHR?			
5	If data collection method is a tablet:			
5a	Who will oversee distribution/collection of tablet(s)?			
5b	When (in workflow) will social risk data be entered in tablet?			
6	If data collection method is patient entry directly into EHR:			
6a	Who will show the patient how to complete screener?			
6b	Who will file patient data to the EHR (if applicable)?			
7	Will you document social risks in the problem list?			
8	Other comments			

Task 2: Developing a Social Risk Rollout Plan



a. Considerations for Rolling Out Your Workflow

- Small tests of change can accelerate adoption of a social risk workflow more than making large-scale changes all at once. Start with one provider, one screening, on one day, to test workflows.
- Start small, then expand once you identify and fix 'bugs' in your social risk workflow(s). Pick one or two populations of focus to start. Take what you learn from these, adapt your workflow(s) as needed, then scale up.
- Check small samples of screening rate data, daily or weekly, to decide how you need to adapt your social risk workflow(s). (You might also want to review the screening results.) Check in with both high and low performers!
- Make expanding the rollout a team effort, rather than having one person be responsible for making it happen. This will improve buy-in!
- The [Rollout Planning Tool](#) will help you select a social risk rollout plan.
- The Step 5 documents will walk you through how to test your social risk-related workflow(s) as needed, using Plan, Do, Study, Act (PDSA) cycles.

b. Examples of Social Risk Rollout Plans Used By Other Clinics

Example 1 – Red Clinic:

- Social risk collection / review was done among new patients seen by the lead clinician. Over two weeks, at team huddles, they identified and corrected glitches in the planned workflows for collecting / reviewing social risk needs data, and referring patients to community resources.
- Then social risk screening was expanded to all adult patients seen by this clinician.
- Two weeks later, the team presented their workflow to the rest of the clinic, after which the whole clinic started collecting social risk data on all patients, using the tested, revised workflow.

Example 2 – Blue Clinic:

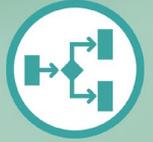
- Clinic leadership developed a social risk workflow for data collection / review / action, and presented it at an all-staff meeting, saying that these workflows would start the next day, clinic-wide.
- Over the next month, the social risk project champion identified which teams / providers were / were not screening targeted patients, by looking at weekly data. She followed up with low adopters, encouraged them to adopt the social risk workflow, and helped them as needed.
- The clinic's social risk project champion continued to review rates of social risk documentation / referral monthly and check in on low-adopting teams.

Example 3 – Yellow Clinic:

This clinic used a formal PDSA process to test their social risk workflow(s). They:

- Listed the tasks needed to implement their social risk plan.
- Implemented the plan within one clinic care 'pod.'
- After a week, the pod reported on what happened when they implemented the social risk plan.
- Clinic leadership / social risk champion used their reporting tools to review statistics on how many targeted patients the test pod screened and referred.
- Planned how to modify the workflow, made needed modifications, went back to Step 1.

Task 2: Developing a Social Risk Rollout Plan



c. Social Risk Workflow Rollout Planning Tool

See the Excel Workbook, "[Social Risk Workflow Rollout Planning Tool](#)" to start developing your rollout plan.

SOCIAL RISK WORKFLOW ROLLOUT PLANNING TOOL				
Number	Question	Response (Click on cell to select from drop-down menu)	If Other, please specify:	Notes/Comments
1	Who will start your social risk screening workflows first?			
2	If starting with one team / pod, how soon after they start the social risk screening plan will you review their adoption rates?			
3	Who will review the social risk screening rates?			
4	How often will the designated staff person review the social risk screening rates?			
5	What is your next step to expand your social risk screening?			
6	When will you expand your social risk screening?			
7	How will you evaluate adoption of your social risk screening plan?			

**Congratulations! You are ready to move on to Step 4:
Orient Clinic Staff to Your Clinic's Social Risk Plan.**