

A Guide to Implementing Social Risk Screening and Referral-making

Introduction

Adverse social determinants of health – referred to in this guide as **social risks** – include contextual factors such as food, transportation, and housing instability, and social isolation. Collecting information on these risks can help ambulatory care teams understand and address how these factors impact their patients' health.

This pragmatic guide will help your clinic implement social risk screening and (if desired) referral-making, or improve your current practices. It is meant to be used by any primary / ambulatory care staff interested in implementing social risk screening and referral-making.

Overview

This guide uses a five-step roadmap for implementing or improving social risk screening and related activities at your clinic. It provides tools and materials to support each step, and a list of useful resources.



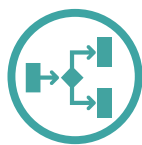
Step 1: Getting Ready

Materials include: Orientation to social risks; Clinic champion orientation; Draft email from leadership to staff



Step 2: Identify Clinic Goals

Materials include: Recommendations for setting goals; Goal-setting decision tool



Step 3: Create a Social Risk Plan

Materials include: Overview of social risk tools in the EHR; Workflow examples; Workflow development tool



Step 4: Orient Clinic Staff To Your Clinic's Social Risk Plan

Materials include: Overview; FAQs for staff; Orientation slide deck; Kick-off package (Poster, social risk champion certificate, tips for engaging staff, goals thermometer, etc.)



Step 5: Roll Out and Iterate

Materials include: Overview; Steps; Considerations and tips; Example; Roll-out template



Resources to Support Implementing Social Risk Data Collection and Referral-Making

This guide was developed as part of an NIH-funded study (1R18DK114701-01) by teams at the Kaiser Permanente Center for Health Research and OCHIN, Inc. The purpose of this study was to test the effectiveness of targeted implementation support at enhancing social risk screening adoption in primary care settings and community health centers.

GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 1: GETTING READY



Table of Contents



There are two tasks needed to get started: get leadership buy-in, and identify and prepare a champion or champions to lead your social risk implementation work.

The Step 1 materials will help you complete these tasks.

Task 1: Get Leadership Buy-in	3
Draft Email from Leadership to Staff.....	5
Task 2: Identify and Prepare a Champion	6

Step 1, Task 1: Get Leadership Buy-in



Use this page to orient your clinic leadership to social risks and why your clinic might want to screen patients for these risks.

What are social risks?

Adverse social determinants of health – referred to in this guide as **social risks** – are potentially health-harming contextual factors of patients' lives, such as food, transportation, and housing instability. Collecting information on these risks can help primary care teams understand and address how these factors impact their patients' health.

- Social risks are the conditions in which people live and work. They profoundly impact health risks and outcomes, and the ability to act on care recommendations. It is estimated that *social risks account for about 80% of health outcomes* (40% socioeconomic factors, 30% health behaviors, 10% physical environment); only 20% of health outcomes are attributed to clinical care (McGinnis, 2002).
- Examples of social risks that impact health include: housing stability, food security, transportation access, childcare access, ability to pay for utilities, stress, social isolation, etc.

Why should we collect information on patients' social risk?

- Social risk information gives care teams a more complete picture of the factors impacting their patients' health, helping them to:
 - Identify and make needed community referrals for a given patient
 - Inform and adjust care plans as needed
 - Conduct targeted social risk-related outreach; provide focused support / assistance
 - Conduct patient-provider conversations about barriers to health
 - Boost staff morale by encouraging high-quality interactions with patients
 - Capture previously unknown information
- Panel-level social risk data can also be used to:
 - Demonstrate CHCs' value in serving vulnerable populations
 - Direct resources toward specific patients or areas of clinic focus
 - Meet or improve reimbursement requirements for value-based care initiatives and metrics for quality performance efforts
- Addressing social risks may reduce costs: In a 2018 study, managed care patients whose social needs were addressed (through a clinic-led referral program) had annual care costs that were \$2,443 (10%) less than those whose needs were not met (Pruitt, 2018).

“...the SDH questionnaire opens up tremendous dialogue on several levels and I absolutely love it.”
– CHC provider

Step 1, Task 1: Get Leadership Buy-in



How can clinic leadership support the adoption of social risk data collection and (if desired) referral-making?

Your role is critical to encourage social risk screening adoption. To leverage this:

- Tell your staff about your social risk screening plans early (and often!). See draft email text, on page 5.
- Enthusiastically support staff in the adoption of social risk screening and related activities.
- Explain every staff member's contribution to your social risk efforts.
- Make sure that appropriate staff have time to gather, review, and act on social risk data.
- Create a sense of excitement and buy-in around screening for and acting to address social risks. Consider having a kick-off event; see the Kick-off Package in Step 4. Let your staff know:
 - How social risks impact health
 - Why your clinic is doing social risk screening / what your clinic will do with social risk data
- Appreciate individuals' contributions. Consider sending a monthly email to thank staff for the work they do to document and act on social risks.
- Inspire and motivate your staff - remind them often how important social risks are to your patients' health. Be clear about how your clinic's social risk collection goals relate to your mission.
- Share preliminary data where possible. Displaying the data on how many screenings have been conducted shows staff what they are contributing to, which is impactful.
- Be proactive in problem solving, supportive of staff needs – and persevere!



One last tip: Consider building partnerships with local social service agencies. This will make it easier to know which agencies welcome social risk-related referrals.

* For more on messaging to stakeholders, see Chapter 2: Engage Key Stakeholders:
http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt2.pdf

* For more on building partnerships, please visit Chapter 8: Building Capacity to Respond to Your Data:
http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt8.pdf

Step 1, Task 1: Draft Email from Leadership



If desired, use this email template to inform your clinic staff about your Social Risk Plan. Fill out the bold sections with your clinic's information, and customize as desired.

Dear **(Clinic Name)** Staff –

(Clinic Name) is excited to announce that we are going to start systematically collecting information on our patients' social risks, and taking action to address identified social risk needs.

Social risks are non-clinical factors that profoundly impact health risks and outcomes, and ability to act on care recommendations, such as housing and food insecurity. Collecting social risk information will help give our teams a more complete picture of the factors impacting our patients' health, and their ability to act on care recommendations.

(Clinician Champion Name) and **(Social Risk Project Champion)** will lead these efforts and will be available to answer any questions you may have related to social risk activities.

The expected start date for social risk data collection will be **(Date)**. There will be a staff orientation on **(Date/Time)** – please plan to attend.

[Insert text on Social Risk Plan (e.g. clinic goals, who you plan to screen, which social risks to screen for, how often etc.)]

Our clinic's planned workflow and rollout plan / timeline **(overview)**

If you have any questions and or concerns, please reach out to **(Clinic Champion Name)**.

Sincerely,

(Leadership Name with signature)

Step 1, Task 2: Identify and Prepare a Champion



It is important to pick champions to oversee the implementation of social risk-related activities. Ideally, you should identify a Social Risk Project Champion and a Clinician Champion. Their responsibilities are listed below. Make sure that these champions have protected time to do this work and are people who have influence at your clinic.

These champions will lead your clinic's effort to start and / or improve existing social risk-related activities.

Social Risk Project Champion tasks include:

- Lead goal-setting and workflow development activities
- Oversee all social risk implementation activities
- Test and revise workflows
- Orient new staff to social risk-related processes
- Track your social risk screening progress

Social Risk Clinician Champion tasks include:

- Support the Social Risk Project Champion with all social risk activities
- Actively encourage social risk screening adoption among fellow providers and answer questions

Both champions will work together to decide your clinic's goals and develop your workflows.

Step 1, Task 2: Identify and Prepare a Champion



Champion Responsibilities at Each Implementation Step

Below is a list of champion tasks at each implementation step with a list of the resources for that step which are included in this guide. Check off each step once it is complete.

Step 1. Getting Ready (clinic leadership activities) _____

- Obtain leadership support for implementing social risk-related activities.
- Identify a clinician champion for social risk activity adoption.
- Identify a social risk project champion for social risk activity adoption.
- Give the champion(s) dedicated time for social risk efforts.

To help with this step, the following resources are included: Orientation to social risks, Draft email from leadership to staff, List of social risk-related resources.

Step 2. Identify Clinic Goals _____

- Identify your clinic's goals for social risk screening (why you want to do social risk screening, what you will do with the social risk screening results, which patients you want to screen, how this screening fits your clinic's vision, etc.). Your goals may be to adapt or scale up your existing social risk screening efforts.

To help with this step, the following resources are included: Considerations for Identifying Your Clinic's Goals and a Decision tool.

Step 3. Create a Social Risk Plan _____

- Create a workflow plan to meet your clinic's targeted social risk data collection goals, and social risk-related actions.
- Create a plan to roll out this workflow, and a plan for tracking your clinic's adoption of social risk screening and related activities.

To help with this step, the following resources are included: Examples of social risk data collection / review / action workflows, Workflow planning tool, and a Guide on using the EHR in social risk activities.

Step 4. Train clinic staff in the Social Risk Plan _____

- Orient clinic staff (e.g., at a staff meeting, via email, etc.).
- If changes are made to the plan, orient staff to the changes.
- Train new staff as needed.

To help with this step, the following resources are included: Orientation slide deck; a Kick-off package.

Step 5. Roll Out and Iterate _____

- Roll out your planned social risk-related workflow.
- Use social risk screening rates / workflow review to improve your social risk-related activities.

To help with this step, the following materials are included: PDSA cycle steps and considerations, PDSA cycle worksheet, Additional tips, PDSA cycle form and Tracker template.