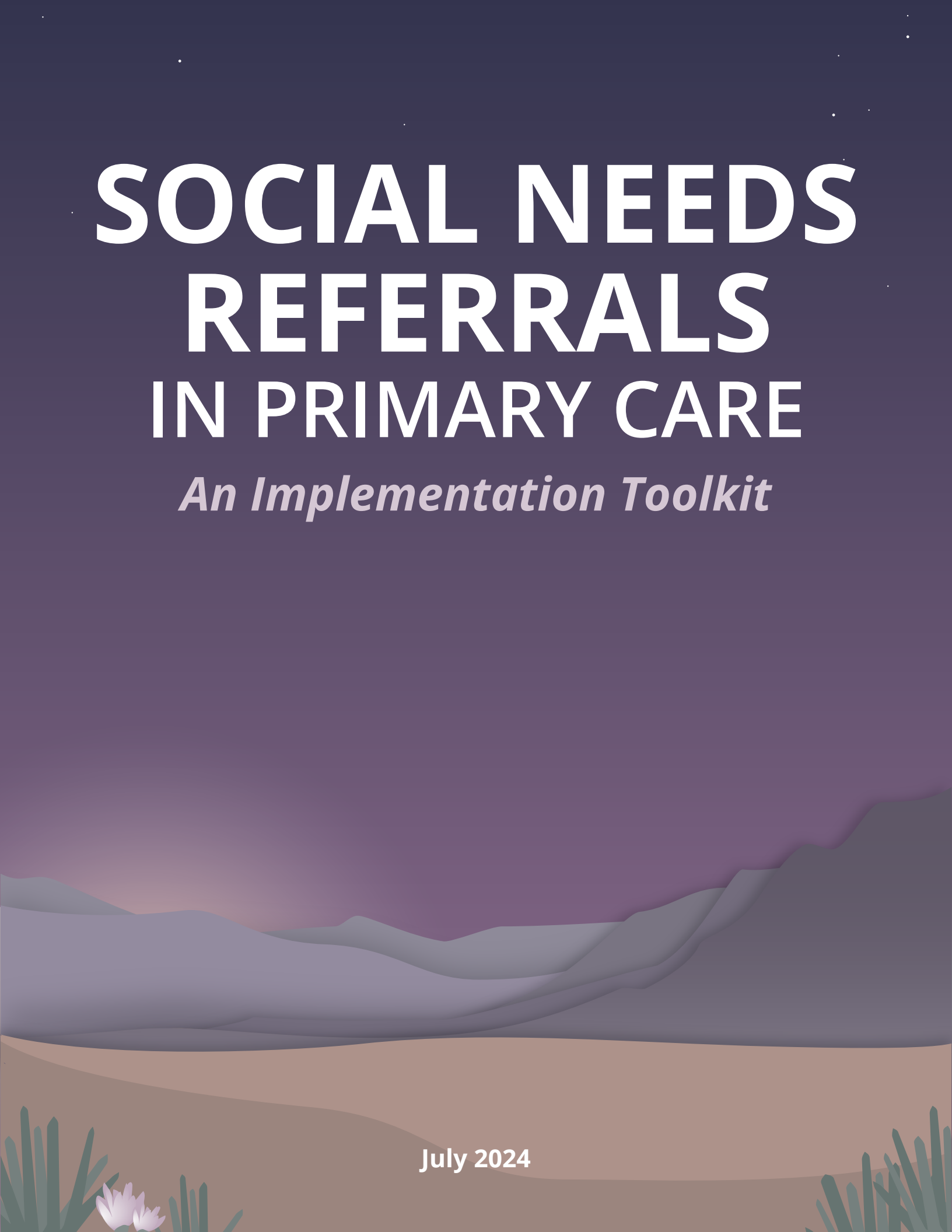
SOCIAL NEEDS REFERRALS IN PRIMARY CARE

An Implementation Toolkit



July 2024

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

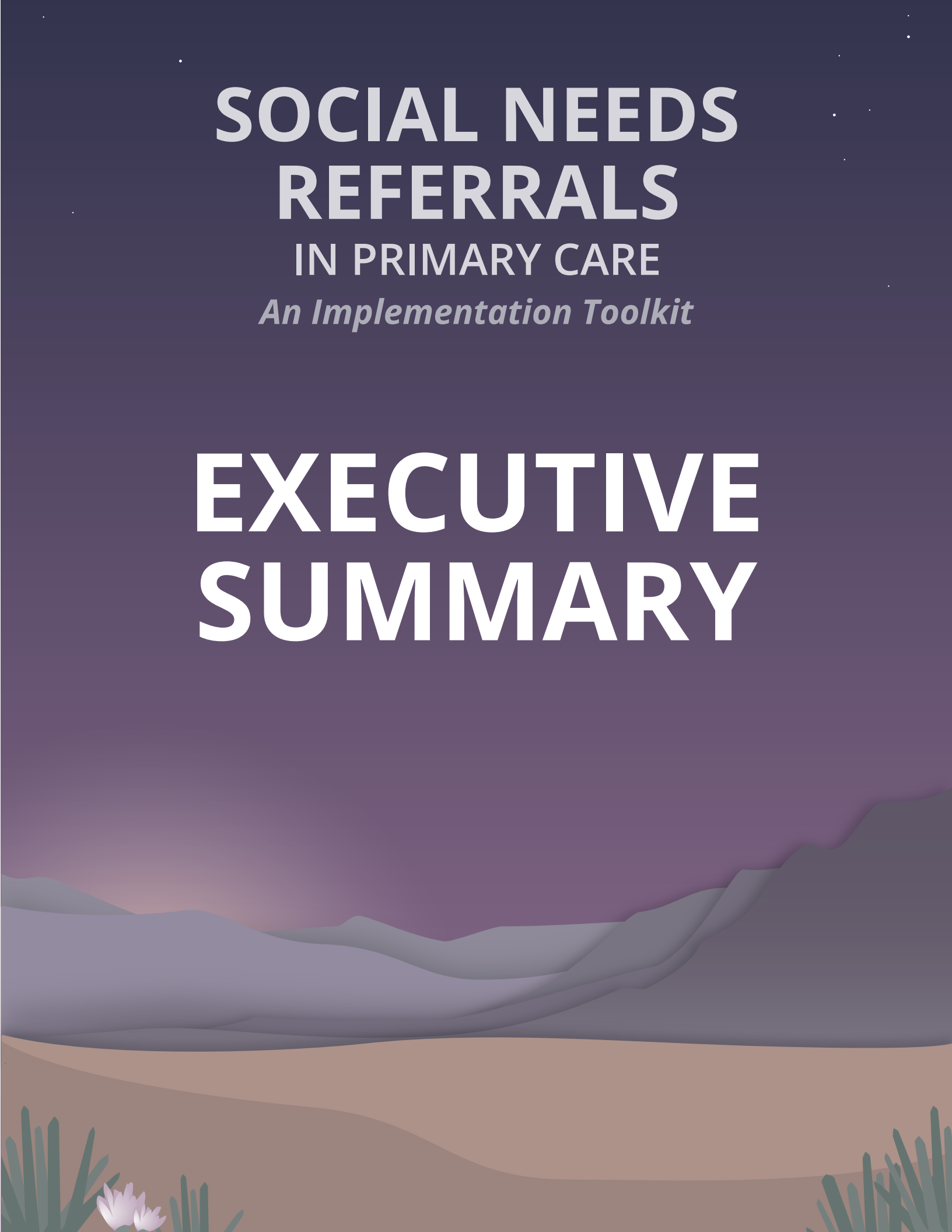
EVALUATE & SUSTAIN

APPENDIX DIRECTORY

TABLE OF CONTENTS

SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

EXECUTIVE SUMMARY



Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

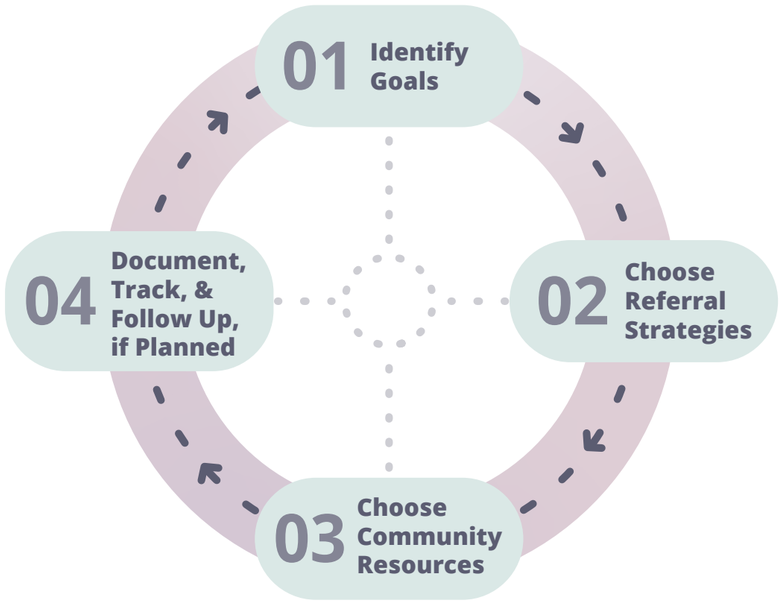
EXECUTIVE SUMMARY

About This Toolkit

As social risk screening increasingly becomes the standard of care in primary care settings, upfront planning is required to connect patients to needed community resources, maintain up-to-date information about available resources, and develop and adopt optimal workflows to support patients with getting their social needs met through community referrals.

This is a pragmatic, evidence-based toolkit intended to be used by clinic leaders, administrators, and staff to create or refine social need referral-making and related activities in primary care settings. This toolkit provides an opportunity for clinic staff to learn and collaborate with each other. Drawing on results from prior research, the toolkit can help primary care teams make four key decisions to design social needs referral programs that are relevant to their unique contexts.

Figure 1. Key Decisions for Implementing Social Needs Referrals



01 **Identify Goals:** What are your goals for making referrals? For example, which patients do you want to refer for which services and how often?

02 **Choose Referral Strategies:** How will you refer patients? For example, will you provide information about available community resources, send patients to a community health worker (CHW), or connect them with a community-based organization (CBO)?

03 **Choose Community Resources:** How will you identify local options? For example, will you use a resource directory or use a list developed at your clinic?

04 **Document, Track, and Follow Up, if Planned:** How do you plan to document these referrals? For example, will you document in a structured data field or free text? Do you plan to track social needs referrals for the purpose of following up and closing the loop? Will you proactively communicate with patients to determine if they received the resources they need?

> ***Before you can refer you will need to implement social risk screening.***
>
> *Don't have social risk screening in place yet? See companion Guide to Implementing Social Risk Screening.*

Timeline

The amount of time it will take to conduct each activity in this toolkit is variable and highly dependent on factors such as your clinic's current staffing, status of existing CBO partnerships, presence of prior social risk workflows, and organizational capacity for change. Consider developing an implementation planning timeline based on your knowledge of your clinic's capacity for change, but remain flexible and re-visit your timeline as you move through the planning process.

Some pieces will take longer to plan and implement, particularly initial engagement with CBOs and when new workflows are introduced. Other activities are ongoing and iterative and can be included in a sustainability plan, such as introducing new workflows, Plan-Do-Study-Act (PDSA) cycles, and maintaining relationships with CBO partners.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

> *"Even just the walk through of the toolkit can help prompt and guide health center-specific decision making and this serves as a catalyst for dynamic team engagement and co-creation of the process that fits the needs of the health center."*
>
> *-Health Center Toolkit Pilot Site*

How to Use This Toolkit

This is an interactive decision-making toolkit organized by important social needs referral considerations: getting ready, workflow decisions, orienting staff, evaluation, and program sustainment.

Modular, Searchable, and Flexible

Sections are one to three pages long, focused on a single topic. Designed to help meet specific social needs referral goals and objectives, the toolkit is modular, and completely searchable. Use Ctrl + F (Cmd + F on a Mac) to search for keywords.

You can use the toolkit in sequential order or skip to the sections that are most relevant to your situation. The search function transforms the toolkit into your own social needs referral reference library. Activities and checklists invite active participation to tailor solutions to your needs.

- **Use Digitally:** Interactive fields allow you to type in text boxes, mark checkboxes, and select answers to activity questions. Remember to save this document to return to your answers.
- **Use on Paper:** Print and write in names, answers, and make notes.

We hope that you find this toolkit useful!

Funding Statement

This work was supported by the National Cancer Institute (3P50CA244289-04S2, 3P30CA006516-58S2, 3R01CA237322-04S2, and 3P50CA244431-04S1). This P50 program was launched by NCI as part of the Cancer Moonshot℠ initiative. The funding source had no role in design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the toolkit.

Contributions and Acknowledgments

The development of this toolkit was led by one of seven Implementation Science Centers in Cancer Control (ISC³) - the BRIDGE-C2 Center, *Building Research in Implementation and Dissemination to close Gaps and achieve Equity in Cancer Control*, a partnership between Oregon Health & Science University's Department of Family Medicine and OCHIN. A team of contributors offered perspectives and expertise to inform the content of the toolkit, representing the Social Interventions Research & Evaluation Network (SIREN) and three additional ISC³ centers (Harvard University's ISCCCE, Washington University's ISC³, University of Washington's OPTICC). Three diverse health centers (urban and rural primary care clinics), affiliated with these ISC³ centers, conducted rapid-cycle testing of this toolkit. Their feedback was used to further refine the content of this toolkit.

The BRIDGE-C2 Center toolkit development team would like to thank the three pilot clinics and these contributors for bringing their diverse perspectives and invaluable feedback to toolkit development. All those who contributed to the development of the toolkit are listed alphabetically below:

- Angelea Brown, MPH; OCHIN – BRIDGE-C2
- Angeline Gacad, MPH; Washington University – ISC³
- Caroline Fichtenberg, PhD; SIREN
- Constance Owens-Jasey, PhD, MPH; OCHIN – BRIDGE-C2
- Cristina Huebner Torres, PhD, MA; Harvard University – ISCCCE
- Karen Emmons, PhD; Harvard University – ISCCCE
- Lourdes A. González, MPH; OCHIN – BRIDGE-C2
- Maura M. Kepper, PhD, MPH; Washington University – ISC³
- Meagan Brown, PhD, MPH; University of Washington – OPTICC
- Nathalie Huguet, PhD; OHSU – BRIDGE-C2
- Rachel Gold, PhD, MPH; OCHIN – BRIDGE-C2
- Rose Gunn, MA; OCHIN – BRIDGE-C2
- Yuri Cartier, MPH; SIREN
- Zoe Larson, MS; OCHIN – BRIDGE-C2

Suggested Citation:
Social Needs Referrals in Primary Care: An Implementation Toolkit. Oregon Health & Science University & OCHIN BRIDGE-C2, Washington University ISC3, Harvard University ISCCCE, University of Washington OPTICC; July 2024.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

GLOSSARY OF TERMS

Community-Based Organization (CBO)

Local nonprofit organizations and social service agencies serving community members and filling the gaps in traditional health care services.

Clinical Champion

Provider who works with the project champion to promote project implementation and use among clinicians.

Closed-Loop Referral Tracking

Tracking the outcomes of a referral, including whether the patient received help through the referral and whether the needs that triggered the referral were addressed.

Community Health Worker (CHW)

Frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. The CHW serves as an intermediary between health, social services, and the community to facilitate access to services.

Community Resource Referral Platform ("Referral Platform")

Technology platforms that provide community resource directories and facilitate referrals to community-based organizations. Also called referral platforms or social service resource locators (SSRLs).

Medical Assistant

Staff members who perform administrative and clinical duties; often in charge of rooming patients.

Project Champion

Clinic staff member who is authorized to drive project planning and implementation.

Project Sponsor

Executive-level leader who provides organizational support for a project and serves as the link between senior management and implementation team.

Referral Management

Making or sending referrals; can also involve tracking referral outcomes.

Referral Initiation

Beginning the process of making a referral.

Referral Receipt

A function of referral platforms that lets end users confirm whether the receiving organization accepted the referral, or in cases without a referral platform, this may be a phone call or other communication modality to a community resource about the status of a referral.

Resource Directory (Community Resource Directory)

A directory of resources and community organizations providing social services. Resource directories can be developed and maintained internally or can be accessed externally (e.g., through your local 211 or commercial vendors).

Service Verification

A function of referral platforms that lets the end user (i) verify information listed in the resource directory and (ii) identify service eligibility criteria.

Social Needs

Patients' perceptions of their critical social needs with which they want assistance. Social needs do not always align with social risks.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Social Needs Referral

Can involve providing the patient with information about local resources, referring a patient for internal consultation about such resources, directly providing support to address social needs, or externally connecting the patient with community resources. The definition of this type of referral is ultimately at the discretion of the clinic.

Social Risk

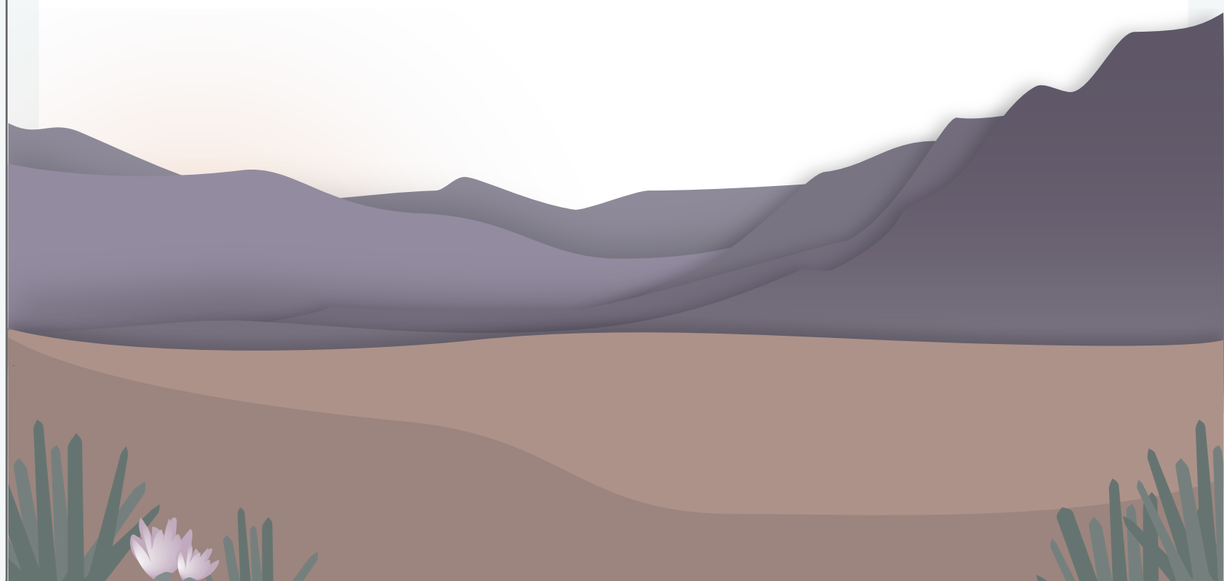
Potentially health-harming contextual factors of patients' lives, such as food insecurity, transportation insecurity, and housing insecurity.

Social Risk Screening

Assessment of social risks by querying patients.

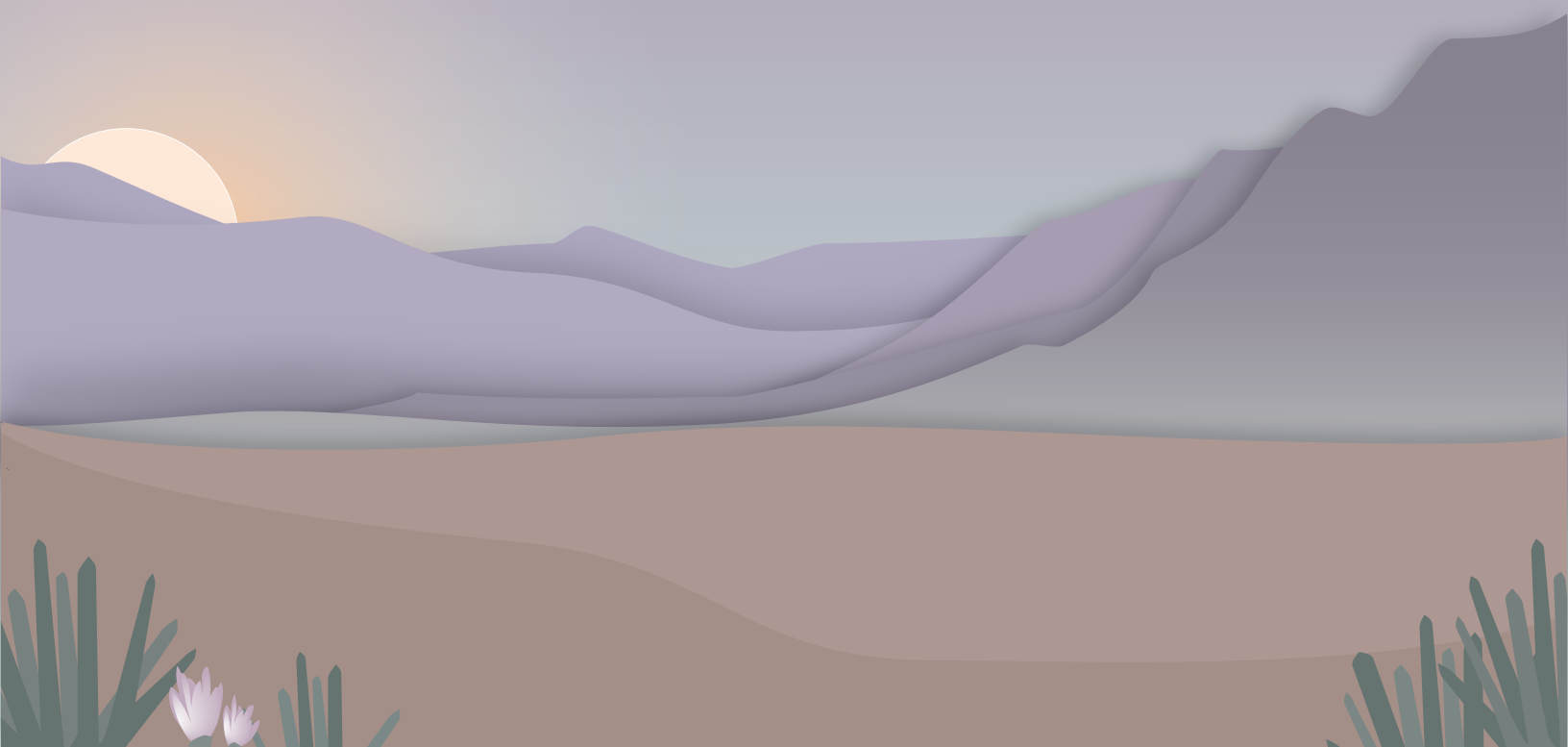
Warm Handoff

Transfer of care conducted in the patient's presence. Can be between members of the care team or between a care team member and staff at a community organization. A warm handoff is traditionally conducted in person, but there may be cases where real time phone or video chat are utilized to facilitate referrals during an office visit.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

GETTING READY



Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

GETTING READY

Congratulations on deciding to develop or improve your social needs referral program. This section will help you launch this work.

> ! *Securing leadership buy-in and convening an implementation team are highly recommended prior to developing your new program. See Appendix I and Appendix II for tips.*

Explore Your Clinic's Capacity to Support Social Needs Referrals

First identify which resources your patients most need. Consult your social risk screening data (if you have it) or the local hospital or public health community health needs assessment(s). You could also conduct a survey of patients for a short period of time to identify top risks. Finally your community board may also be able to help you identify community needs.

Next, assess your current capacity to address those needs. Consider how your clinic already coordinates services with CBOs and which needs they address. Determine whether there are CBOs in your community that can provide additional needed resources.

Describe Your Clinic's Current Capacity

The **Clinic Capacity Assessment form** provided below can help your implementation team think this through.

Fill in your answers by typing into the text fields. It's OK if you don't know all the answers right away; the purpose of this activity is to get you thinking about information your clinic will need for referral-making.

Why is your organization interested in providing social needs referrals?

What resources does your clinic have to support new initiatives such as social needs referrals? *See Appendix I and Appendix II for more on securing leadership buy-in and convening an implementation team.*

Can/does your clinic receive incentives based on social risk-related quality metrics?

☐ Yes ☐ No

What social risks does your clinic screen for?
If no social risk screening in place yet, see Guide to Implementing Social Risk Screening.

Which community partners does your clinic have relationships with?

Does your clinic have a community resource list? Where is it located?

☐ Yes ☐ No

Location:

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

How is the community resource list updated?

Do staff have protected time to help patients navigate social needs referrals (e.g., facilitate connections and follow-up)?

☐ Yes ☐ No

If yes, are there staff whose primary role is to provide navigation support for social needs referrals?

☐ Yes ☐ No

Does your clinic need to demonstrate social needs referral provision and outcomes (e.g., for quality incentives)? Describe here.

Explore Your Community's Capacity to Support Social Needs Referrals

Establish CBO Partnerships

> *"We've made a lot of connections with community-based organizations to be able to move mountains. We showed ourselves that we can accomplish great things when we ally with partners in the community."*
>
> *-Clinic Manager*

Once you know which needs you want to address through referrals, develop new (or leverage existing) relationships with CBOs that provide related services.

- First identify the types of resources your clinic wants to provide referrals for.
- If available, refer to the list of CBOs your clinic has existing relationships with and detail the services they provide.
- Consider reaching out to your local 211 or human services governmental agency to get help identifying local organizations and understanding intake processes, eligibility, and service availability. If you have a social worker or CHW on staff, they can help too.
- CBOs should accommodate cultural preferences and language needs of your patient population. Consider asking patients where they go for trusted services, or what services clinic staff are aware of.
- Engage these CBOs to establish a relationship. What are their needs and priorities? Are they accepting referrals? What's the best way to refer patients to them? Are they looking for ways to refer clients to your clinic? If so, let them know the best ways to refer to your clinic.
- Consider CBOs that offer multiple services to address different social needs.
- Be aware that it takes time to develop relationships and build trust in community partnerships.
- Co-create shared referral goals that are realistic given both clinic and CBO capacity.

For more information about how to engage with CBOs, check out these resources:

- *Value of Investing in Social Determinants of Health Toolkit*
- *Advancing Community-Based Organization & Health Care Partnerships to Address Social Determinants of Health*
- *Resources for Community-Based Organization and Healthcare Partnerships*

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Tips for Building CBO Partnerships

1. Cultivate relationships with CBOs that have the capacity to help your patients with the social risks you screen for. Ensure those CBOs are trusted in the community and can provide culturally and linguistically suitable support.
2. What are their needs and priorities? Some CBOs may want to make referrals to help establish a medical home for people that may not have a primary care provider or adequate access to health care. This is an opportunity to develop a mutually beneficial relationship that will support bidirectional referrals between your clinic and CBOs.
3. Some CBOs may not trust the health care system, particularly those that serve communities that have experienced health inequities.
4. Have patience! Clinic-CBO partnerships are not built overnight.
5. To engender trust, be transparent with your CBO partners about your goals and how you would like to collaborate.
6. CBOs may not always have the capacity to provide help. Work with your CBO partner to develop alternate plans in these instances.

Describe Your Community Partners' Current Capacities

The **Community Engagement Assessment form** provided below can help your implementation team assess CBOs' capacity to engage in your clinic's social needs referral processes.

Fill in your answers by typing into the text fields. It's OK if you don't know all the answers right away; the purpose of this activity is to get you thinking about information your clinic will need to partner with CBOs. Use these questions as a guide for initial engagement conversations.

For additional help with this assessment, remember to reach out to your local 211, human services governmental agency, or any staff in your clinic (e.g., social worker or CHW).

What local organizations are you aware of that address key community needs (e.g., housing, food, transportation, utilities)?

What local organizations provide specialized services relevant to your patient population (e.g., race, ethnicity, language, pediatric, veteran)?

What social needs are **not** addressed by local resources in your community?

Which community partners have expressed an interest in collaborating with your clinic?

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Are there potential partners in the community with whom your clinic would like to build a relationship? Who are they and how can you connect with them?

Do your community partners use a community resource referral platform ("referral platform")? If so, how do they use this tool (e.g., use this platform to respond to referrals, advertise their services)?

What is your community partners' intake process or eligibility criteria for patients to enroll in services?

How do your community partners accept referrals (e.g., call, email, e-referral via referral platform)? Are there dedicated staff for this role?

Which of your community partners have the capacity to accept new referrals?

What do your community partners hope to gain from the partnership with your clinic?

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

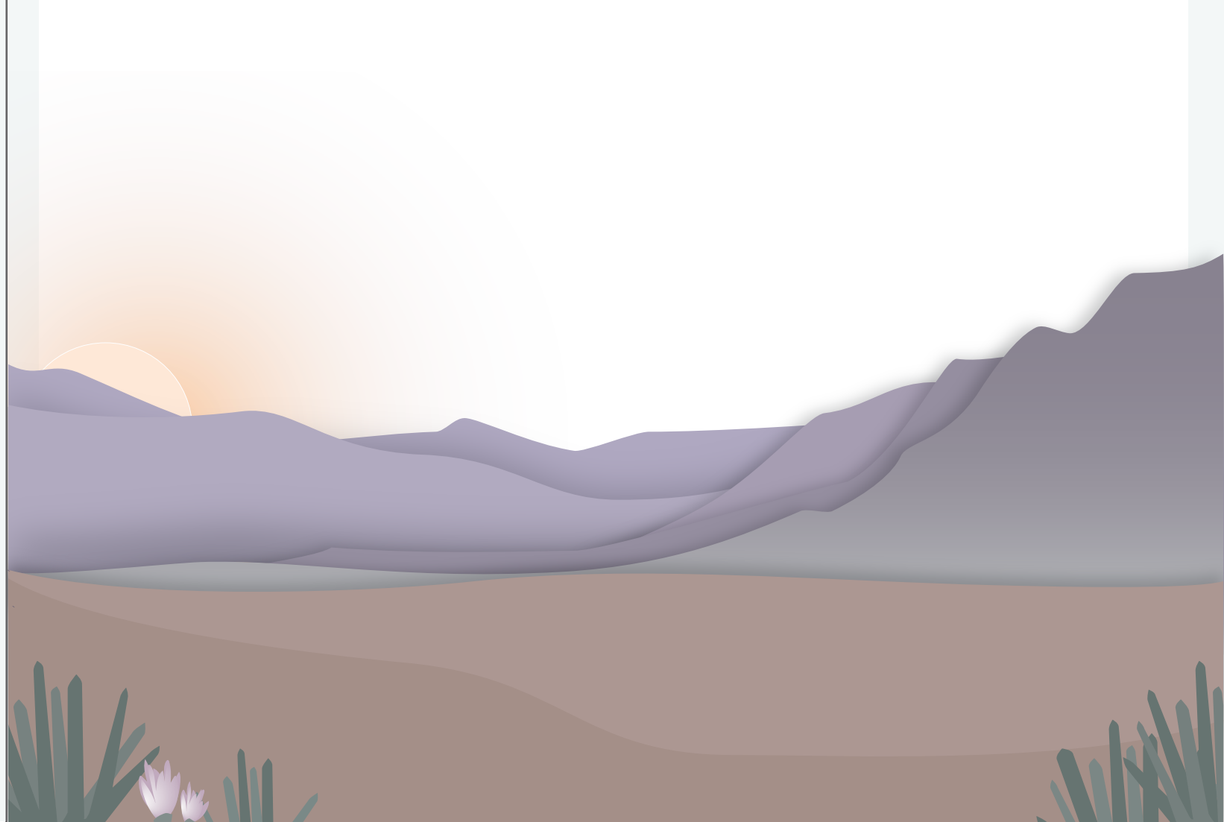
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

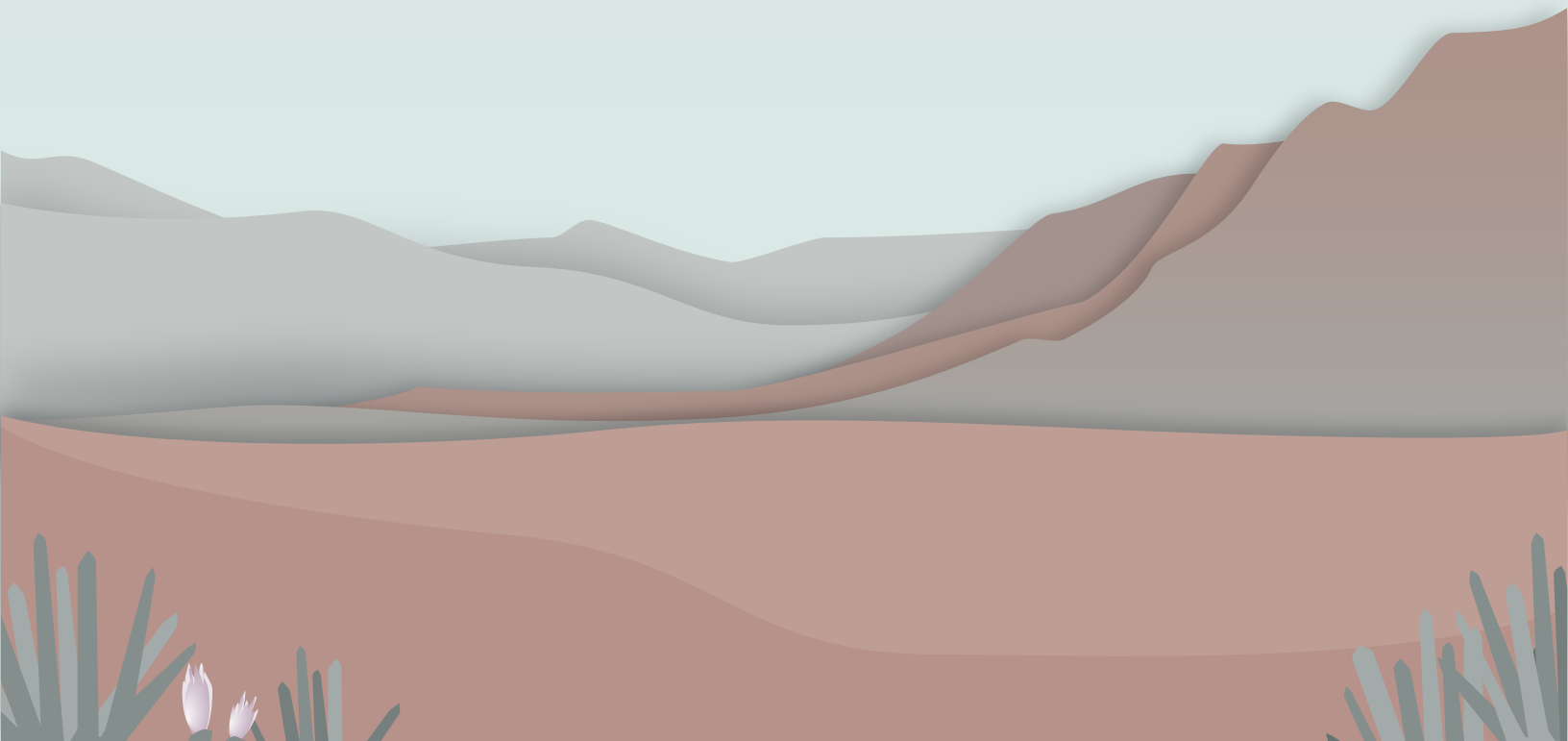
Getting Ready: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

DECISION 1: IDENTIFY GOALS



Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

DECISION 1: IDENTIFY GOALS

There are no national standards about how to make social needs referrals, so your clinic's goals should reflect what makes sense for your patients, staff, and community partners.

Your social needs referral goals should consider the purpose of these referrals as well as your clinic and community partner capacity.

Before establishing these goals, securing leadership buy-in and convening an implementation team are highly recommended. See Appendix I and Appendix II for tips.

Goal-Setting Decision Tool

Using the following decision tool will help you create goals for social needs referrals.

STEP 1: Define your purpose

Why do you want to conduct social needs referrals? The purpose you identify will inform the remaining decisions you make in this section.

Review these potential reasons and check those that apply to your clinic:

- ☐ To address patients' desire for support with unmet social needs
- ☐ To improve care quality and clinical outcomes.
- ☐ To strengthen clinical-community linkages (e.g., partnerships to address unmet social needs)
- ☐ To reduce care costs
- ☐ To meet payer requirements
- ☐ Other [Fill in blank]:

STEP 2: Define potential patient groups to focus on

Which of your patients screened for social risks do you want to provide with social needs referrals? Use the companion tool, *Guide to Implementing Social Risk Screening*, to first identify which patients to screen. From this group, pick those for whom you want to provide referrals.

Who do you want to conduct social needs referrals to:

- ☐ All patients reporting social needs

  (If this option is selected, skip to Step 3)
- ☐ A subset of patients reporting social needs (see below)

Patient Subsets:

Patients seen at all visit types, or just some visit types?

- ☐ All visit types
- ☐ New patient visits
- ☐ Non-urgent visits
- ☐ Routine annual visits
- ☐ Wellness visits
- ☐ Other visit types: specify [fill in blank]

Patients seen by all providers or just selected providers/teams?

- ☐ All providers/teams
- ☐ Just some providers/teams

Patients seen on certain days of the week?

- ☐ All days
- ☐ Certain days only

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Patient gender identity?

- [ ] Men
- [ ] Women
- [ ] Non-binary

Patient age group?

- [ ] 0–5 (and their caregivers)
- [ ] 6–12 (and their caregivers)
- [ ] 13–18 (and their caregivers)
- [ ] 19–50
- [ ] 51–65
- [ ] >65
- [ ] Other: specify

Patients with one or more chronic conditions?

- [ ] No
- [ ] Yes: which conditions?
  - [ ] Diabetes
  - [ ] Cardiovascular Disease
  - [ ] Behavioral Health
  - [ ] Other: specify

Patients with substance use disorders?

- [ ] No
- [ ] Yes: which disorder?

Patients with specific utilization patterns?

- [ ] No
- [ ] Yes: which patterns?

Pregnant patients?

- [ ] No
- [ ] Yes

Participants in other clinic initiatives?

- [ ] No
- [ ] Yes: which initiatives?

Patients being screened for other risks?

- [ ] No
- [ ] Yes: which screeners? (e.g., SBIRT, PHQ)

Other factors or patient characteristics?

- [ ] No
- [ ] Yes: which patient characteristics?

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

Step 3: Define measurable, attainable goals and set time-based targets

For this last set of questions, determine measurable targets based on patients that have screened positive for social risks.

Consider determining what is attainable for your clinic by identifying the social needs referral reach for patient groups captured in **Step 2**. Remember, you might have to iterate these targets as you develop your referral processes.

Among those who screened positive for social risks in target group(s):

% of patients who desire referrals

# of patients who desire referrals

% of patients who don't desire referrals

# of patients who don't desire referrals

Among those who screened positive for social risks and desire referrals to address unmet needs:

% of patients who received closed-loop referrals

# of patients who received closed-loop referrals

% of patients who didn't receive closed-loop referrals

# of patients who didn't receive closed-loop referrals

Based on the above results, use these prompts to set time-based targets.

In months our goal is to refer:

% of all patients with social needs

# of all patients with social needs

% of target group patients with social needs

# of target group patients with social needs

In one year our goal is to refer:

% of all patients with social needs

# of all patients with social needs

% of target group patients with social needs

# of target group patients with social needs

In months our goal is to complete closed loop referrals for:

% of all patients with social needs

# of all patients with social needs

% of target group patients with social needs

# of target group patients with social needs

In one year our goal is to complete closed-loop referrals for:

% of all patients with social needs

# of all patients with social needs

% of target group patients with social needs

# of target group patients with social needs

If your social needs referral approach also includes tracking and follow-up activities, additional measurable goals can be created to measure the impact of these activities, such as number of patients who indicated a social need received help (i.e., closed-loop referrals). See Decision 4 for more options for referral outcomes that can be used for setting goals.

As goals are likely to evolve over time, see Appendix V for tips on assessing continued relevancy of your patient target groups and social needs referral plan.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

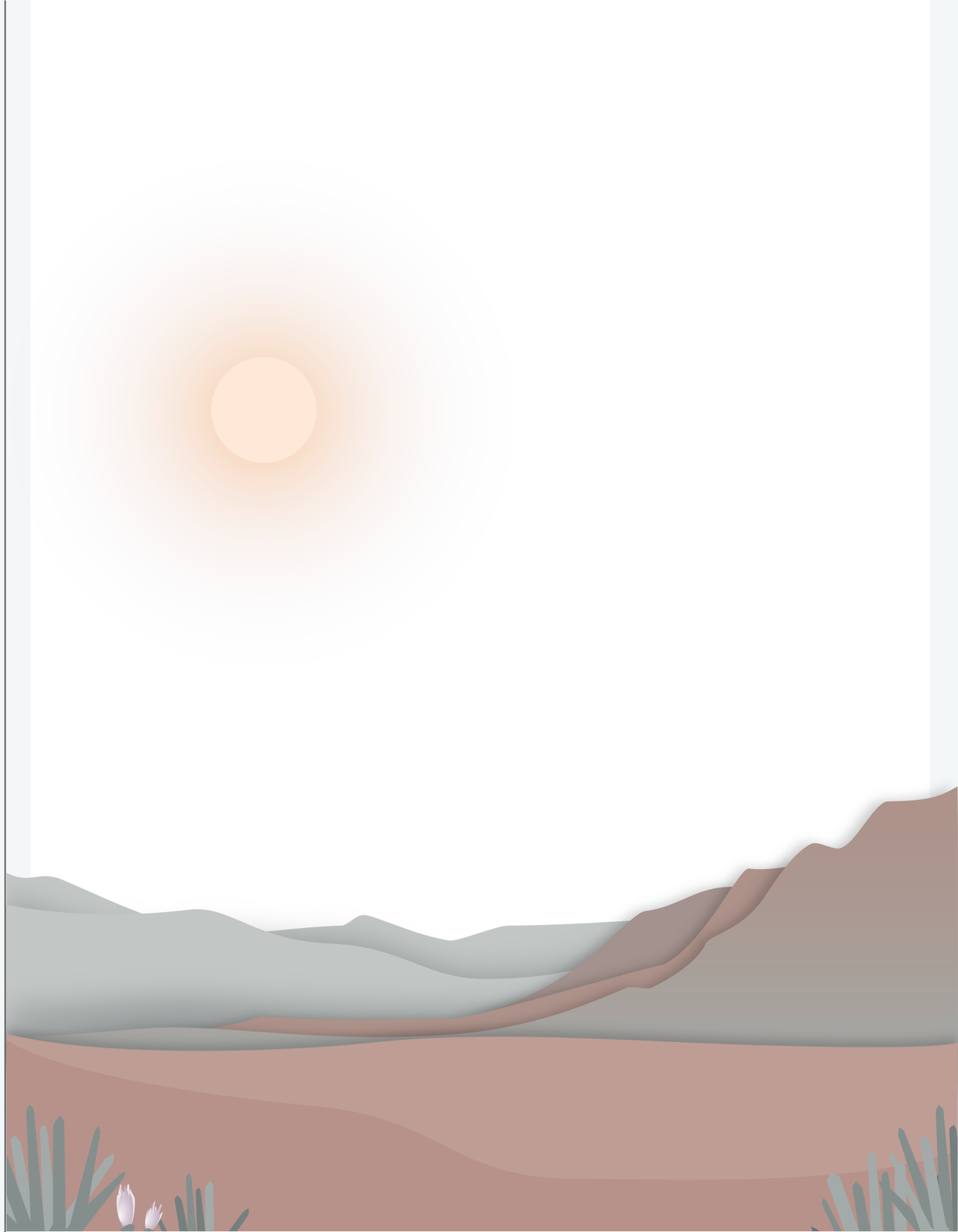
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Decision 1: Identify Goals: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

DECISION 2: CHOOSE REFERRAL STRATEGIES

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

DECISION 2: CHOOSE REFERRAL STRATEGIES

Deciding which referral strategy to use is contingent on several factors such as workflow integration, cost, staffing, and availability of resources. This section walks you through decisions about how, who, and when to take action to address social needs. Be aware that referral strategies are closely related to the type of need, acuity of social risk, and available community resources, so it is important to consider these factors concurrently.

After reading this section, use the *Decision 2 Planning Activity* below to document the decision you made.

How and When to Take Action to Address Social Needs

Develop your workflow for social needs referrals and a plan for rolling it out at your clinic.

There are many ways that you can provide social needs referrals. Many clinics use a combination of internal and external referral strategies depending on the type of need, acuity of social risk, and availability of resources. Check the approach(es) that are feasible for your clinic:

- ☐ **Internal referrals**—patient is referred to designated clinic staff responsible for maintaining information of available community resources/coordinating care to address social needs. This might be a CHW, social worker, or patient navigator.

TIP

- Internal referrals can be initiated in real time via warm handoffs as well as during social risk screening, if the staff member responsible for conducting this assessment is responsible for providing social needs referrals.
- Internal referrals using a warm handoff approach can be especially helpful in cases where a patient needs immediate help.

- ☐ **External referrals**—when a patient is referred to a CBO to address their social needs. Here are a few tips to consider:

TIP

- Use a warm handoff to make an external referral to a CBO by making a call to the CBO with the patient in the room. Depending on a clinic's capacity, some clinics use this approach to address all social needs as soon as they are identified, and some only use them for social needs that are urgent.
- Give the patient information about a community resource so that they can connect with the CBO on their own.

It also may make sense to have different processes for different social needs (e.g., for food insecurity some clinics might have an on-site food pantry, so this would be an internal referral but for housing insecurity, this might involve an external referral to a local non-profit or social service agency that provides housing support services).

Determining Who Reviews the Patient's Social Needs and Conducts Referrals

Staff Roles Involved in Social Needs Referral Workflows

When deciding who will provide and document/track social needs referrals, consider the following:

Q: Which staff should provide social needs referrals?

- Depending on organizational structure, social needs referral model, and available resources, this could be almost anyone on the care team—medical assistant (MA)/rooming staff, nurse, behavioral health provider, care coordinator, patient navigator, social worker, or CHW. In small clinics, it might be the primary care provider.
- The staff role responsible for referrals can vary in different situations, such as:
  - Specialist encounters (e.g., diabetes education, prenatal care visit)
  - Referral type (i.e., internal vs. external)
  - When a patient asks for a social needs referral outside the standard social risk screening sequence.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

Q: What should be taken into consideration when deciding which staff make referrals?

- Staff members in these roles should have the needed time, knowledge, training in appropriate patient communication techniques, and user permissions to document referrals in the electronic health record (EHR).
- Ensure all staff are educated on referral-making processes. Have a backup plan in case the responsible personnel are not available to provide a referral when one is needed.
- Attain buy-in from staff assuming these responsibilities by including them in decision-making early on and sharing with them the importance of this work.
- Be attentive to potential scope of practice and union contract implications.

Q: Who communicates the referral to others on the care team?

- Usually the person who places the referral. If this communication involves EHR documentation, this person must have the necessary EHR user permissions to document the referral.
- Consider if there is an organizational expectation for team communication about referrals via huddle or 1:1 conversation. If so, make a plan to ensure referrals are included in a standing agenda.

Q: If referral navigation is planned, which staff should track the referral and follow up on the outcome?

- Referral navigation should be done by a staff member with sufficient time allocated to conduct patient outreach (e.g., case manager, CHW, care coordinator, patient navigator, resource coordinator, population health nurse).
- Inquiring about and documenting relevant referral follow-up information can also occur in subsequent office visits, if desired. If this way of outcome follow-up is chosen, it can be done by the rooming staff or provider during the visit.

Q: Who updates community resource information in your clinic's chosen resource directory?

- This could be the same staff member(s) who is responsible for tracking and follow-up. This approach has the potential benefit of creating a regular cadence of updating the resource list, and strengthening relationships with CBOs.
- CBOs could update their own information if the directory is on the platform where they receive referrals.
- Updates could also be driven by a community volunteer or intern on an ad hoc basis.

For more on how to adapt your workflow to the evolving demands of social needs referrals, see Appendix VI. Creating a Workflow Diagram.

Empathic Inquiry

"Those working with patients have tremendous respect for the patient experience and no matter how intentional any screening tool is for capturing information, there is a human element that is needed: trust, rapport building, comfort."

-Health Center Toolkit Pilot Site

Your screening and referral process should involve asking patients if they want a referral and may involve documenting their response. However, some patients or families may not want a referral, or they may be hesitant to ask for help or reluctant to accept referrals due to negative connotations associated with needing support or fear that the referral could result in an unintended consequence (e.g., reported to state for suspected neglect of child).

Some patients or families may not want to share information about their referral needs because doing so may be traumatic.

It is important to consider the language and framing used when screening and offering referrals so you can reduce stigma and respect patients' privacy if they don't want to share information. Empathic Inquiry (EI) is a conversational approach to talking to patients about their social needs developed by the Oregon Primary Care Association (OPCA). It emphasizes compassion and empowerment, by combining motivational interviewing with

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

trauma-informed care and input from patients. Research shows patients are receptive to social risk conversations using EI.

Use the following resources to help incorporate EI in facilitating connections for referrals:

Patient-Centered Social Needs Screening Conversation Guide

Patient-Centered Social Needs Screening Observer Checklist

For more information about how to foster positive patient experiences during social care interventions and incorporate EI techniques, check out the following resources:

- EI: Oregon Primary Care Association (orpca.org)
- Collaborative Screening: Ariel Singer LLC

How to Talk to a Patient if They Request Help with a Social Need

Patient Interest in Receiving Referrals

Here are some questions you can ask to solicit patient interest in receiving social needs referrals. For patients under the age of 18, use these questions to solicit the family's desire for assistance.

How is your day going today? Are you interested in receiving support from our health care team to access resources in the community to help address your (your child's) social need(s)? I*f no/unsure, consider asking why, if patient (or family) is open to discussing.*

- Yes
- No
- Unsure

If you are interested in receiving support in accessing resources to help address your (your child's) social need(s), when would you prefer to receive this support?

- Prior to your visit
- During your visit
- After your visit
- During a follow-up visit

- Depends on the urgency of the need
- Other (Please specify)

What method of support do you prefer?

- In person
- Phone call
- Text
- Other (Please specify)

Tips for Assessing Patient Preferences

As part of the referral process, consider the following:

- **For which social need(s) does the patient want to receive support?**
  Ask the patient if there are any specific social needs they want to prioritize. Some patients may not want to receive support for all needs all at once. Determine what is most important and urgent to the patient.
- **Did the patient get to select or provide input on the community resource(s) available to address their unmet needs?**
  Ask the patient if there are any specific organizations they would like to connect with or any that they want to avoid.
- **What if the patient experiences challenges with accessing a referred community resource?**
  Patients may face barriers when accessing resources related to eligibility criteria, language barriers, completing intake paperwork, and transportation to services. Patient navigators can help with these challenges, or the CBO might have resources to address these issues. Work with your community partner to determine what is feasible for patient navigation and ensure efforts are not duplicative between organizations.
- **What if the patient is not ready?**
  If the patient is willing, provide information about the referral so they can connect with the community resource when they are ready.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

- **What if the community resource information turns out to be out of date or the CBO is temporarily limited in their capacity?** Acknowledge that resources are limited in the community, and that it can be frustrating. Provide the patient with a back-up option for which they can obtain support, and review your strategy for updating your resource list, if applicable.
- **Are there patients who would benefit from specialized community resources?** Consider the unique circumstances of patients' lives and try to identify CBOs that provide cultural safety and tailored support for specific populations (For example, older adults, refugees, children and families, veterans, individuals with disabilities, and individuals from diverse racial, ethnic, sexual orientation, gender identity, and language backgrounds.

DECISION 2 PLANNING ACTIVITY

Use the tool below to select your referral strategies, which will take place after social risk screening has been conducted. You may need to complete this activity differently depending on the type of need, acuity, and availability of resources.

Question 1: Who reviews the patient's social needs and conducts referrals.

Who will review the patient's reported social needs?

Check all that apply:

- [ ] Provider
- [ ] Behavioral health staff
- [ ] Community health worker
- [ ] Rooming staff
- [ ] Social worker
- [ ] Patient navigator
- [ ] Other

Question 2: When to conduct referrals for social needs.

When (in workflow) will you take action in response to the patient's identified social needs?

- [ ] During visit (e.g., before provider enters, after provider leaves)
- [ ] After the social risk screening is conducted (before/during visit)
- [ ] After visits (e.g., during an outreach call, by appointment)
- [ ] Other

Question 3: How to conduct referrals for social needs.

How will the designated person review social needs?

- [ ] Paper form
- [ ] Screening section in the EHR
- [ ] Flowsheet section in the EHR
- [ ] Data summary section in the EHR
- [ ] Other section in the EHR

Question 4: If a patient has a social need.

Q4a: If the patient has a social need and desires a referral to address it, what form will that referral take?

Note: See *How to Talk to a Patient if They Request Help with a Social Need* earlier in this section for more information on assessing patient readiness.

- [ ] Provide services in-house (internal referral)
- [ ] Provide navigation services, if planned
- [ ] Refer patient to CBO website
- [ ] Refer patient to referral platform

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

- [ ] Warm handoff (e.g., case manager, CHW)
- [ ] Make another appointment
- [ ] Information in after-visit summary
- [ ] Other

Q4b: If a patient has a social need and does not want a referral, what will you do?

Note: **Regardless of the approach you choose, it is important to respect patients' autonomy and not insist that they do anything.**

- [ ] Do nothing
- [ ] Encourage patient to communicate with clinic, should they change their mind
- [ ] Share CBO contact information, should they change their mind
- [ ] Place a reminder in patient chart to check back in at their next visit
- [ ] Other

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

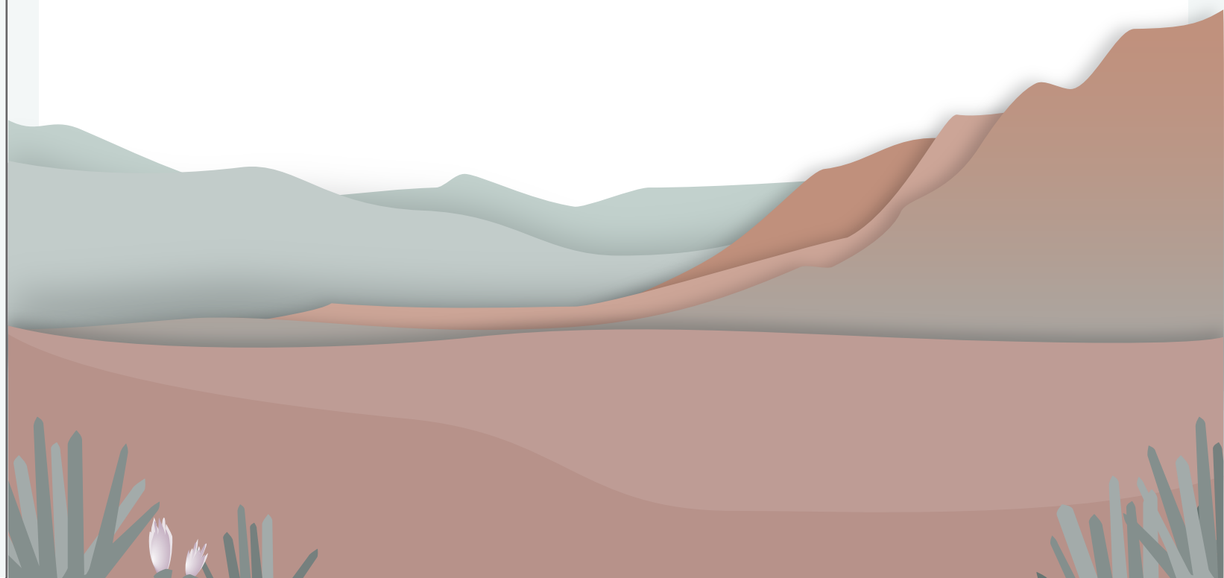
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

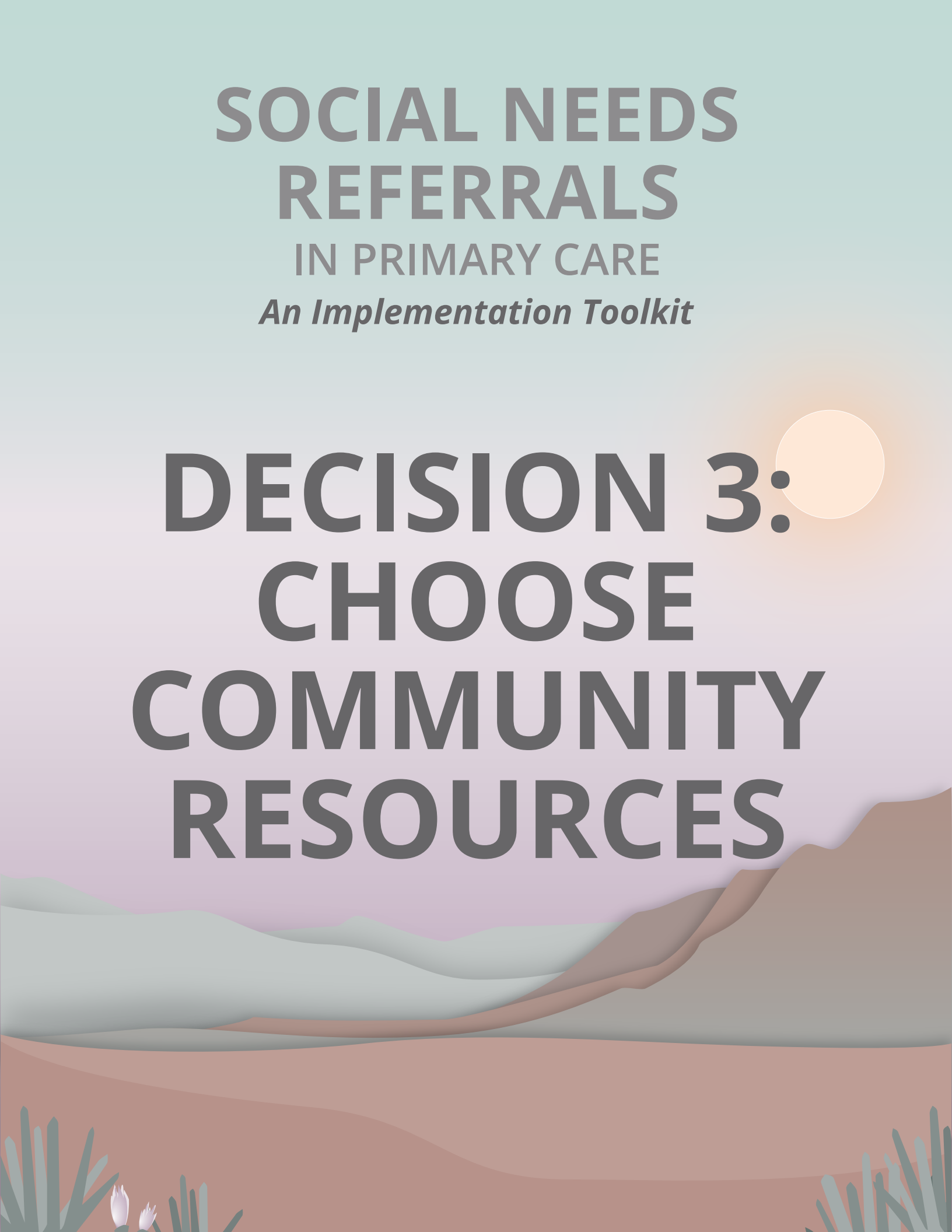
Decision 2: Choose Referral Strategies: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

DECISION 3: CHOOSE COMMUNITY RESOURCES



Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

DECISION 3: CHOOSE COMMUNITY RESOURCES

The purpose of this section is to help you make decisions about how to identify which community resource to refer patients to and how to provide appropriate referral navigation, if planned. Similar to the preceding sections, use the *Decision 3 Planning Activity* below to document the decision you made.

How Will You Identify Relevant Community Resources?

Referral Management Options

You will need to decide how to locate CBOs and social service agencies, and if you want to document and track referral activities, how to do so. Consider the following advantages and disadvantages when deciding which strategies are best for your referral program. You may wish to choose multiple strategies (i.e., hybrid approach). What matters most is that your strategy works well for your patients and staff. For real world examples of each of these strategies, see "Referral Strategy Use Cases" in the appendix.

> *"The more resources we have at our disposal the better we're able to serve the patients that we see."*
>
> *-Community Health Worker*

Community Resource Referral Platform/SSRL (Contracted Vendor)

Description: Community resource referral platforms, aka social service resource locators (SSRLs), can help locate local, state, and national community resources. They may include: a resource directory, referral management, care coordination and comprehensive case management, systems integration, and reporting/analytics tools.

See Community Resource Referral Platforms Guide for more information about community resource referral platforms and other similar technologies (e.g., community information exchanges and information and referral systems).

Referral documentation and tracking capabilities vary by referral platforms. For example, some platforms have dashboards to monitor referrals; others have text fields to make notes about referral status. Some can notify staff making the referral and/or organization to which the referral was sent.

Advantages:

- Many are web-based and accessible to clinics and community agencies, which can help coordinate services.
- Some are publicly available and let patients connect with services directly.
- Many enable referring and receiving organizations to communicate easily.
- Some enable emailing or texting referral information or reminders to patients.
- Some EHRs can integrate referral platforms to support certain referral steps including closed-loop tracking.

Disadvantages:

- These platforms are not always regularly updated risking outdated information and administrative burden to verify availability, hours, eligibility criteria, etc.
- These platforms do not "speak to" each other, causing potential redundancies if patients seek referrals from multiple settings.
- May require set up and ongoing maintenance costs, depending on referral platform and EHR
- CBOs may struggle to use these platforms as they often lead to double data entry (in the platform and in the CBOs' main data systems).
- Maintaining these platforms may require CBOs approval to be added to the platform listing and ensure compliance with privacy regulations (e.g., HIPAA).
- Inconsistent use of these platforms by CBOs can limit their ability to support referrals.
- In the case of referral platforms intended for use by patients, there may be barriers for patients that lack digital tools and digital literacy needed to utilize these platforms.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

TIP

Referral platforms may make social needs referrals efficient but cannot replace the relationships and interorganizational networks between clinics and community partners that facilitate connections. The same level of engagement and relationship building is required when referring through a referral platform as any other method to ensure referrals are made effectively.

Resource Directory in EHR

Description: Community resources presented in the EHR in the form of preference lists or similar EHR tools (e.g., community resource directory). Preference lists are EHR shortcuts for making referrals to commonly used resources; referral information can be provided directly to the patient, or clinic staff members may contact the CBO to initiate the connection on behalf of the patient. Their use can enable report generation for patient outreach for referral tracking and follow-up. Preference lists are created and maintained by the clinic.

Advantages:

- Patients may receive referral information electronically through a patient portal or other written means.
- Developed based on clinic's knowledge of the community. Typically includes organizations with which clinics have ongoing relationships, reducing the risk of unreliable referrals.
- Does not require CBOs to use a new tool or platform.

Disadvantages:

- Must be configured and updated regularly, requiring staff time.
- Lacks bidirectional communication functionality with CBOs through the EHR.
- Places responsibility of contacting CBO on patient.

Stand-Alone Resource Directory (not integrated in a referral platform or EHR)

Description: List of community resources created and maintained by clinic staff. Located in a spreadsheet, database, physical binder, website, or resource sheet. Resource information can be provided directly to the patient, or clinic staff may contact the CBO to initiate the connection on behalf of the patient. EHR documentation of referrals is not automated but may be manually recorded in free text fields in the encounter note, or in structured data fields (e.g., referral field). Using structured data fields may enable report generation for patient outreach.

Advantages:

- Patient may get a hard copy list of services.
- Developed based on clinic's knowledge of the community. Typically includes organizations with which clinics have ongoing relationships, reducing the risk of unreliable referrals.
- Does not require CBOs to use a new tool or platform.
- Physical copies of a resource list are easily transportable for home visits, street medicine, or travel between clinics.

Disadvantages:

- Must be updated regularly, requiring staff time.
- If referral information is entered in free text fields, tracking will be challenging.
- Places responsibility of contacting CBO on patient.

Personal Network—Staff Knowledge

Description: Leverage staff's knowledge of local resources, particularly those needed regularly. More effective among clinic staff who have long-standing relationships with CBOs and/or in regions with fewer resources, such as rural communities. Resource information can be provided directly to the patient, or clinic staff members may contact the CBO to initiate the connection on behalf of the patient. EHR documentation of referrals is not automated but may be manually recorded in free text fields in the encounter note, or in structured data fields (e.g., dot phrase/macros, referral field). Using structured data fields may enable report generation for patient outreach.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

Advantages:

- Referrals are based on trusting relationships.
- Referral information accessed by the person with relevant knowledge.
- Does not require CBOs to use a new tool or platform.

Disadvantages:

- Risk of preferential partnering, 'silo effect,' where clinics are not willing to refer patients outside of current networks.
- Resource knowledge is heavily impacted by turnover or staff absences.
- If referral information is placed in free text fields, tracking will be challenging.

If Your Clinic Wants to Provide Navigation Support

Navigation Support

Common barriers patients encounter with accessing resources include restrictive eligibility criteria, navigating complex application processes, and social stigma. If your clinic has the capacity, consider providing navigation support, i.e., personalized assistance to understand available resources and to connect with relevant community resources. Examples of staff who can provide this kind of navigation include social workers, patient navigators, case managers, community health workers, and peer support specialists.

What if the navigator runs into challenges with connecting patients with community resources?

Repeated outreach (follow-up) to initiate a referral and multiple referrals is an inherent part of social needs referrals. Navigators may need to defer a referral and prioritize other needs, as indicated by the patient. Listed here are common scenarios that lead to these circumstances. Ensure your strategy accounts for these challenges. Incorporate ways to monitor the availability of resources to ensure referrals are made effectively.

- Service may defer acceptance of referral due to capacity constraints, and restrictive eligibility criteria.
- Service may forward a referral to a community partner if they are unable to address a referral. A warm handoff between the community resources is expected, but is not guaranteed.

- Intake processes to enroll in services vary by CBOs.
- Patients might change their mind and defer services.
- Service may decline acceptance of referral. In this case an additional referral will have to be made to another organization.

DECISION 3 PLANNING ACTIVITY

Use the tool below to choose your community resources and navigation support processes. You many need to complete this activity differently depending on the type of need, acuity, and availability of resources.

Question 4: Community Resource Identification

Q4a: How will you identify relevant social services?

- [ ] Referral list in the EHR (e.g., preference list)
- [ ] Resource platform, EHR-integrated (e.g., findhelp, Unite Us)
- [ ] Resource platform, web browser
- [ ] List maintained by clinic (e.g., binder, Excel sheet)
- [ ] Staff knowledge
- [ ] Other

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

Question 5: Making Referrals

Q5a: Who will be responsible for providing the patient referral?

Select all that apply:

- [ ] Provider
- [ ] Rooming staff
- [ ] Behavioral health staff
- [ ] Community health worker
- [ ] Enrollment staff/eligibility specialist
- [ ] Case manager/care coordinator
- [ ] Panel manager
- [ ] Patient navigator
- [ ] Other

Q5b: Will you provide an internal referral?

- [ ] Yes
- [ ] No (if no, **skip to** Q6 in the Decision 4 Planning Activity)

Q5c: Who will be responsible for receiving the internal referral?

Select all that apply:

- [ ] Behavioral health staff
- [ ] Community health worker
- [ ] Enrollment staff/eligibility specialist
- [ ] Case manager/care coordinator
- [ ] Panel manager
- [ ] Patient navigator
- [ ] Other

Q5d: When (in workflow) will the warm handoff occur?

- [ ] During visit - Before provider enters
- [ ] During visit - Provider reviews
- [ ] During visit - After provider leaves
- [ ] Other

Q5e: If warm handoff recipient is not available, what is your backup plan?

- [ ] Follow-up phone call to patient
- [ ] Follow-up patient portal message to patient
- [ ] Other

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

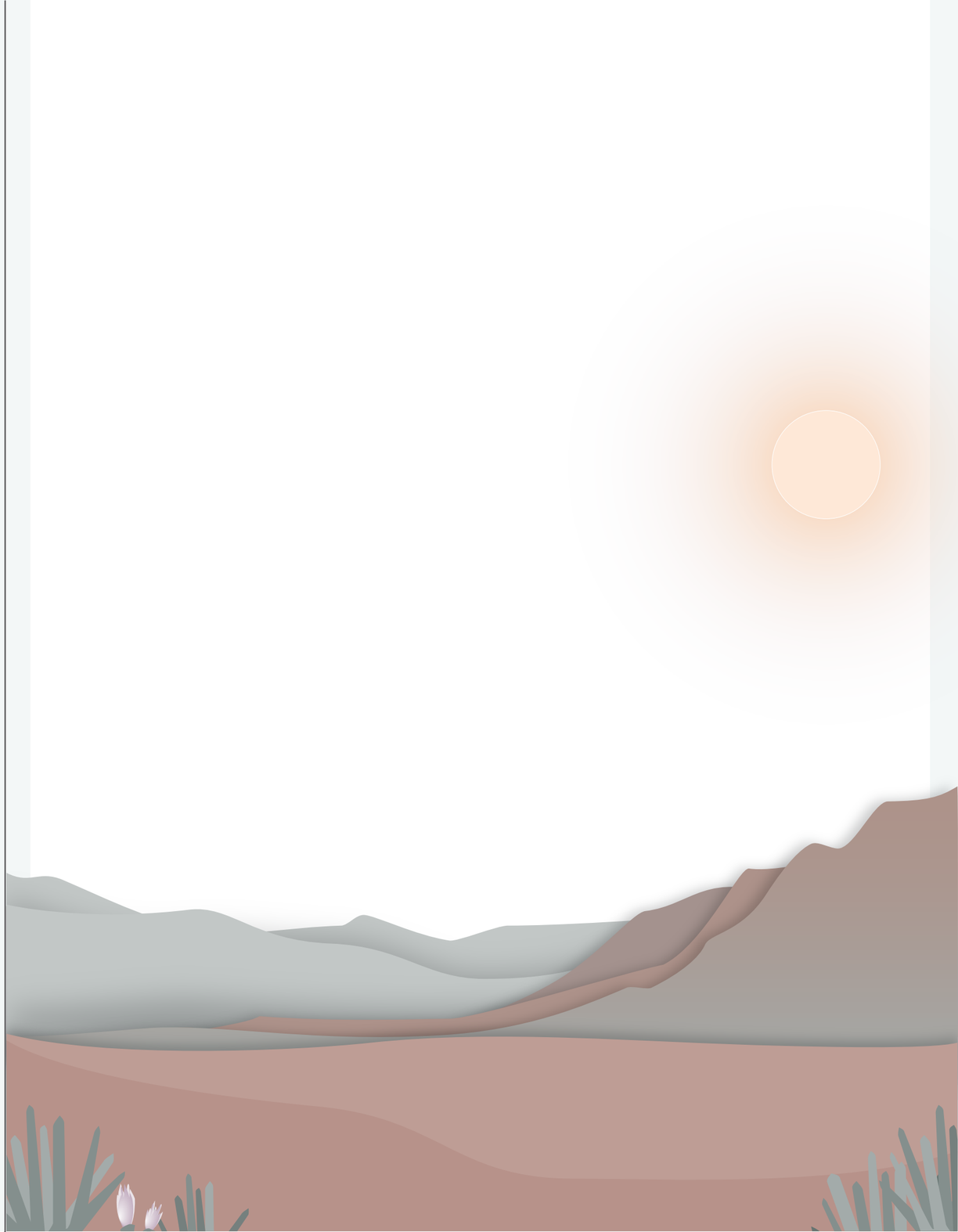
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Decision 3: Choose Community Resources: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

DECISION 4: DOCUMENT, TRACK, & FOLLOW UP, IF PLANNED

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

DECISION 4: DOCUMENT, TRACK, & FOLLOW UP, IF PLANNED

For clinics that have decided to document and track referrals, this section's purpose is to help make decisions about how, who, and when referrals will be documented and tracked for follow up. Similar to the preceding sections, use the *Decision 4 Planning Activity* to document the decision you made.

Tips to Guide Referral Documentation

What to Document

Use this checklist to select referral outcomes of interest and determine how these outcomes will be measured. This section is organized by different outcome options as well as metrics that could be used to measure each outcome. There are no standards in this area, but this section provides some possible options to consider. It is important to think about what outcomes matter the most, and if there any outcomes your clinic is required to report, and how your clinic will measure and use these data.

Referral Initiation Outcomes

Options for target outcomes to capture once a referral has been made:

- ☐ **Clinic staff was able to make a referral to community resource on behalf of patient:**
  If yes, list date:
  If no, specify why:
  Patient declined, note reason if possible:

- ☐ **Patient reported having sufficient information to pursue the resource(s) without further assistance from clinic staff:**
  If yes, list date:
  If no, specify why)

Closed-Loop Referral Outcomes

Options for tracking and follow-up outcomes to monitor after a referral has been initiated.

- ☐ **Referral acceptance—whether the receiving organization accepted the referral:**
  If yes, list date:
  If no, specify why)

- ☐ **Patient contact—whether the receiving organization and the patient interacted:**
  If yes, list date:
  If no, specify why)

- ☐ **Enrollment of services—whether the patient enrolled in services:**
  Note: This may not apply to all services
  If yes, list date:
  If no, specify why:
  Patient declined, note reason if possible:

- ☐ **Receipt of services—whether the patient received help from the organization:**
  Example: Percentage of patients who "received services" or "successfully utilized program-provided resources"
  If yes, list what services received:
  If no, specify why:
  Patient declined, note reason if possible:

- ☐ **Need resolution—whether the need that triggered the referral was resolved or is in the process of being resolved:**
  Resolved: *All needs resolved as successfully accessed (list date):*
  Partially resolved: *One or more needs resolved (there are other need(s) that have not been resolved)*
  Not resolved: *No needs were resolved as successfully accessed; or patient was disconnected; or additional resources outside the clinic's referral process are needed.*

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Patient Feedback

Options for participants' ratings of their experiences with resources.

Examples:

- [ ] **Did you get the help you need (from clinic staff) to access the service?**
  All the help I need
  Most of the help I need
  A little of the help I need
  None of the help I need
  Patient declined

- [ ] **Did you get the help you needed from the services you were referred to?**
  All the help I need
  Most of the help I need
  A little of the help I need
  None of the help I need
  Patient declined

- [ ] **How likely are you to recommend the services you received?**
  Highly likely
  Likely
  Neutral
  Unlikely
  Extremely Unlikely

- [ ] **How would you rate the timeliness of the services you received?**
  Excellent
  Very Good
  Good
  Fair
  Poor

"I like to see the data that shows what we're doing is making a difference."
-Chief Medical Officer

Where and How to Document

- Your referral documentation decisions depend on the functionality of your EHR system and documentation privileges governed by clinic role.
- Referral documentation using structured fields in the EHR creates a standardized place for care team members to visit for information, and may be used to generate reports for tracking or quality purposes.
- Some clinics document social needs referrals in the same way they do other types of referrals. In other words, one option is to use the same structured referral field for internal and external referrals.
- Don't want to use the referral field? Some clinics use different tools such as dot phrases in the chart note to indicate a referral was placed.

> ***Dot phrases**, also known as **macros**, are text shortcuts that can be built to incorporate CBO information and referral actions. Depending on the EHR system, lists within dot phrases may be configured to file discrete data. Efforts are emerging in health centers to leverage these capabilities to streamline referral documentation and reporting in the EHR.*

- Another option is to document in the body of a chart note or similar free text field. This may be a good option for EHR systems with structured documentation limitations, but could present barriers related to communication between care team members and tracking referral outcomes.
- If the staff member providing navigation is unable to document in the EHR, it's possible to document (and track) in a HIPAA-compliant database like REDCap.
- Documentation is often the responsibility of the person initiating the referral but can be another staff role. For example, a provider initiates the referral and the MA documents and appends the referral details.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Tips to Guide Referral Tracking and Follow-Up

When to track and how to follow-up?

- Your tracking and follow-up activities will be depend on which staff can do this work, which can be time-intensive.
- Helping patients meet a given need can often lead to identifying additional needs and multiple referrals. It may be necessary to innovate when a given needed resource is not available.
    - For example, helping enroll a patient in a pharmacy assistance program may reveal they struggle with medication adherence because they can't safely store medications that require refrigeration (e.g., unstable housing, difficulty paying power bills).
- When documenting follow-up on referrals, consider using an approach that notes patient referral status.
- Staff providing patient navigation support can use calendar reminders to make sure to conduct outreach post-referral on a set timeline.
- Method of patient outreach can be face-to-face, over the phone, or via patient portal.
- The more resource information a patient receives, the more successful they will be in meeting their needs. This is particularly true if referral contacts involve direct communication like phone calls or face-to-face encounters. Follow-up within 30 days supports successful referrals.
- Some EHR-integrated referral platforms have bidirectional capabilities which may facilitate clinic staff to monitor referral status as communicated by the partnering CBO.
- Regardless of the referral platform, EHR documentation is important, and outreach (e.g., call/email) to partner CBOs may still be needed to verify referral status and outcomes.

- Consider how you will define referral "success". Is it when a patient makes contact with a CBO? Or when they report a resolved need? If the referral did not yield the expected outcome, what are the next steps?
- In clinics without robust navigation, referral follow up can occur at subsequent visits.
- Consider tracking the time it takes for referrals to be made and completed. This can illuminate how long referrals can take to initiate and complete overall and by type of need and availability of resources.
- Consider tracking referral data centrally location so the care team can access it. Consider creating a shared team note about referrals and outcomes to more consistently track referrals in the EHR.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

DECISION 4 PLANNING ACTIVITY

Use the tool below to map out your plans for referral documentation, tracking, and follow-up. You may need to complete this activity differently depending on the type of need, acuity, and availability of resources.

Question 6: Referral documentation

Q6a: How will you document referral actions?

- ☐ Text shortcuts (e.g., dot phrase)
- ☐ Chart notes
- ☐ Referral documentation in the EHR
- ☐ In the referral platform/SSRL
- ☐ Other

Q6b: Who will be responsible for documenting referral actions?

- ☐ Behavioral health staff
- ☐ Community health worker
- ☐ Medical Assistant
- ☐ Enrollment staff/eligibility specialist
- ☐ Case manager/care coordinator
- ☐ Panel manager
- ☐ Patient navigator
- ☐ Other

Question 7: If follow-up on referrals is planned

Q7a: Will you follow up on social needs referrals to ensure patient received intended services?

- ☐ Yes
- ☐ No (**skip to** Q8)

Q7b: Who will be responsible for social needs referral follow-up with the patient?

- ☐ Behavioral health staff
- ☐ Community health worker
- ☐ Enrollment staff/eligibility specialist
- ☐ Case manager/care coordinator
- ☐ Medical Assistant
- ☐ Provider
- ☐ Panel manager
- ☐ Patient navigator
- ☐ Other

Q7c: When will referral follow-up with the patient take place?

- ☐ One week post-referral
- ☐ Two weeks post-referral
- ☐ One month post-referral
- ☐ Other

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Q7d: How will referral follow-up with the patient occur?

- [ ] In-person, at next visit
- [ ] Outreach phone call
- [ ] Review closed-loop data
- [ ] Other

Q7e: How will designated staff remember to follow up with the patient, if needed, about referred services?

- [ ] Calendar
- [ ] Tickler file (e.g., record of orders in EHR that support automated reminders and tracking)
- [ ] EHR reminder
- [ ] Other

Q7f: Where will follow-up be documented?

- [ ] Structured EHR field
- [ ] Interim chart note (e.g., phone encounter)
- [ ] Other

Question 8: Closing the referral loop

Q8a: When will a social needs referral be considered "resolved"?

- [ ] Patient confirms need met
- [ ] CBO confirms need met
- [ ] No need reported at next social risk screening
- [ ] Other

Q8b: Who documents the resolved referral?

- [ ] Behavioral health staff
- [ ] Community health worker
- [ ] Medical Assistant
- [ ] Enrollment staff/eligibility specialist
- [ ] Case manager/care coordinator
- [ ] Panel manager
- [ ] Patient navigator
- [ ] Other

Q8c: Who reviews the resolved referral information?

- [ ] Behavioral health staff
- [ ] Community health worker
- [ ] Enrollment staff/eligibility specialist
- [ ] Case manager/care coordinator
- [ ] Medical Assistant
- [ ] Provider
- [ ] Panel manager
- [ ] Patient navigator
- [ ] Other

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

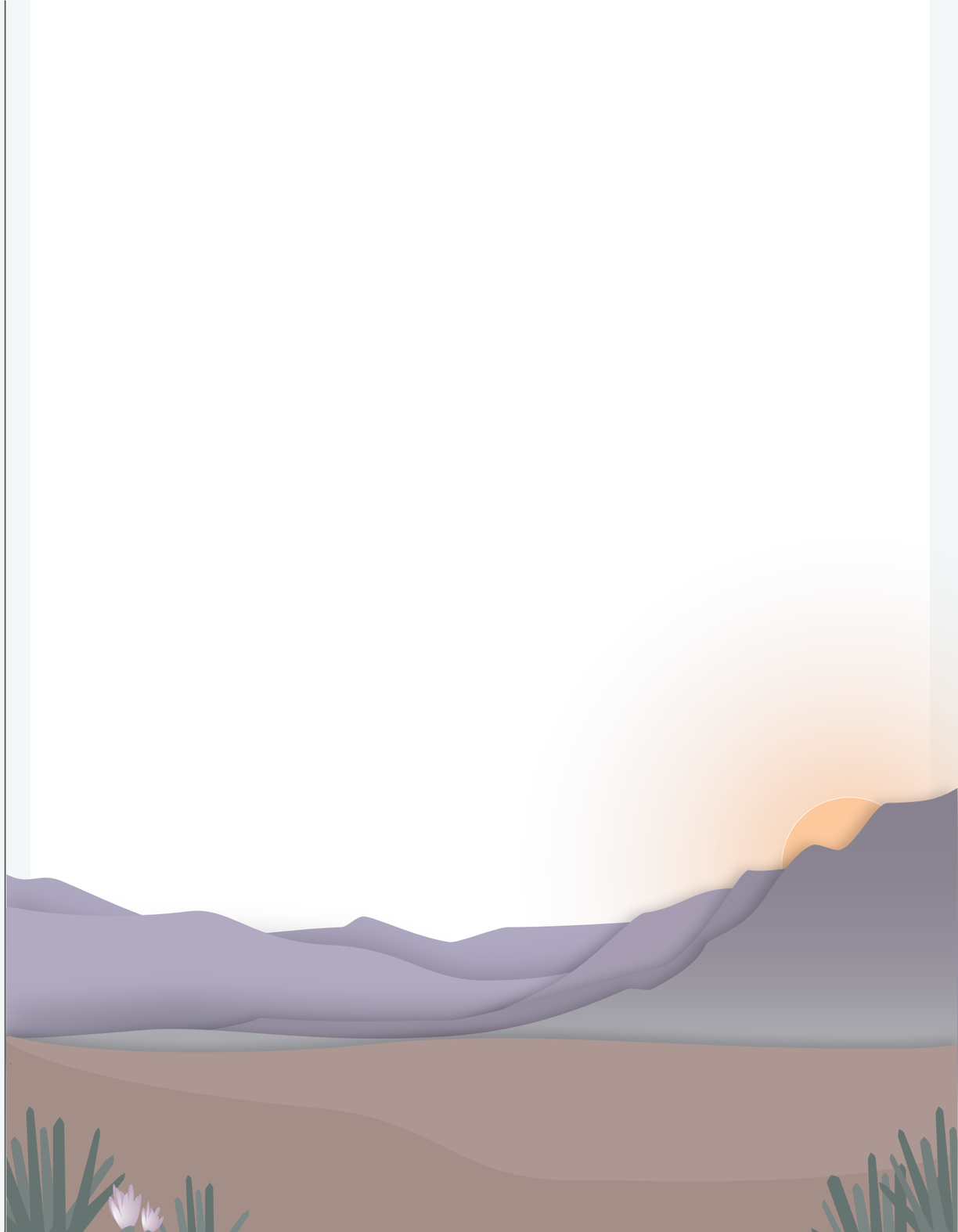
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Decision 4: Document, Track, and Follow Up, If Planned: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS
IN PRIMARY CARE
An Implementation Toolkit

ORIENT STAFF TO YOUR CLINIC'S SOCIAL NEEDS REFERRAL PROCESS

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

ORIENT STAFF TO YOUR CLINIC'S SOCIAL NEEDS REFERRAL PROCESS

Your next step is to let your clinic staff know about your social needs referral process, including intended workflows and how they will be rolled out. This guide will help you conduct this onboarding and includes orientation slides that you can adapt for your clinic.

Section 1: FAQ to Orient Clinic Staff

Why support patients with their social needs?

If a patient wants help with their social needs, providing this support may improve their ability to act on their care plan, patient-care team relationships, health outcomes, and patient/clinician satisfaction.

Do health insurers (e.g., Medicaid, private payers) require social needs referrals?

Requirements for social needs referrals vary by health insurance plans. Alternative payment methods as well as Medicaid programs that cover the costs of non-medical needs emphasize the value of supporting patients with their social needs such as Medicaid programs that cover the costs of non-medical needs like housing or food. For more information about how this occurs, see: https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs/.

Which community resources should we make referrals to?

Refer to the referral process our clinic has created and use your best judgment to choose which community-based organizations to link patients to. There is no single or "right" way to do this, but it is important to ensure the service(s) the patient is referred to:

- Accepts new referrals
- Aligns with patient needs
- Is accessible to the patient (e.g., hours of operation align with the patient's availability)
- Accurate contact information (phone, email) is available and up to date

What do we do if there are limited options for referral sources in a patient's community?

Social needs referrals are not always straightforward, and it may take multiple attempts to successfully initiate a referral. CBOs may not always have the capacity to address a referral and it can be difficult to predict their availability. These realities should be shared with the patient to ensure they are aware of these potential obstacles. Additionally, explore if the patient is willing to receive services in areas outside of their local community. Knowing the barriers your patients have can inform their social needs referral plan.

Do we need to follow the social needs referral process exactly as written?

The social needs referral process is just a guide. Referrals should accommodate patient preferences and needs as much as possible.

How can we avoid upsetting patients during the referral process?

There are trauma-informed, patient-centered ways of approaching the social needs referral conversation, such as using a technique called Empathic Inquiry (see ***Empathic Inquiry*** in **Decision 2**: **Choose Referral Strategies** for more on this approach). Additionally, if possible, conduct the referral process in a private area.

How might social needs referrals affect our relationships with patients?

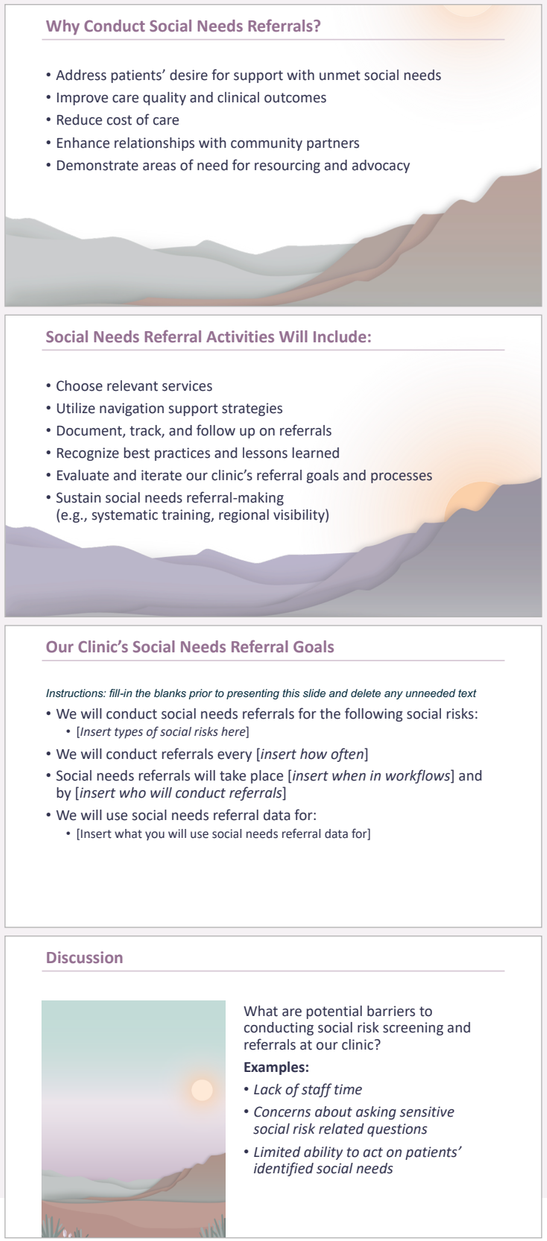
Referrals should be conducted at the patient's discretion. If they do not want a referral, that is their choice. Giving the patients this autonomy is often appreciated and can strengthen patient-staff relationships.

Section 2: Orientation Slide Deck

In Appendix X, we provide you with a slide deck template for a staff orientation. It starts with your clinic social risk screening goals, and then provides sample language to help you introduce why your clinic is conducting social needs referrals, your clinic's referral goals, and key activities involved with social needs referral processes.

Go to:
EXEC SUMMARY
GLOSSARY
GETTING READY
1. IDENTIFY GOALS
2. REFERRAL STRATEGIES
3. COMM RESOURCES
4. DOC & TRACK
ORIENT STAFF
EVALUATE & SUSTAIN
APPENDIX DIRECTORY

Figure 2. Social Risk Screening and Referral Orientation Slides



Section 3: Kick-Off Package

Tips for Engaging Staff Once Social Needs Referrals Have Begun

- **Track your progress!** That could take the form of:
  - Show progress towards your clinic's referral goals during staff meetings, through emails, via webinar platforms, or by posting them in a central place (Refer to Decision 1 for your referral goals). Use the ***Referral Goals Thermometer*** template as a tool to complete monthly or as necessary (see Appendix XI).
  - Show progress towards your clinic's referral outcomes (refer to Decision 4 for referral outcome examples). Use the ***Referral Outcomes Thermometer*** template as a tool to complete weekly or as necessary (see Appendix XII).
  - During daily/weekly huddles review your referral rates for the last week and have staff share stories about social needs referral challenges and successes.
- **Recognize lessons learned and celebrate best practices!**
  - Ask staff to share their tips for success: success stories with patients or with a community partner(s). Include testimonials from patients/community partners (only with consent).
    - Spotlight: "What Patients are Saying" and/or "What Community Partners are Saying"
  - Ask community partner champions to share best practices that support their engagement in referral processes.
  - Celebrate these leaders (staff and/or community partners) as Social Needs Referral Champions. Use the ***Certificate of Recognition*** as a template for this award (see Appendix XIII). Add your clinic logo to the certificate of recognition to personalize!

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Social Risk Screening and Referrals Kick-Off Agenda

Consider using this agenda when introducing social risk screening and referrals to your staff. You can find the agenda in Appendix XIV.

Example Agenda:

Location: Room 201

Date: 11/28/2024

Time: 9:00am

Facilitator: Dr. Ruiz

DURATION	TOPIC	LEAD
5 min	Welcome	Dr. Ruiz
10 min	Review Risk Screening and Referral Orientation slide deck	A. Lee
20 min	Why are social risk screening and referral important for our patients?	Dr. Ruiz
10 min	Clinic goals for social risk screening & referrals	A. Lee
15 min	Brainstorm workflows	A. Lee

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

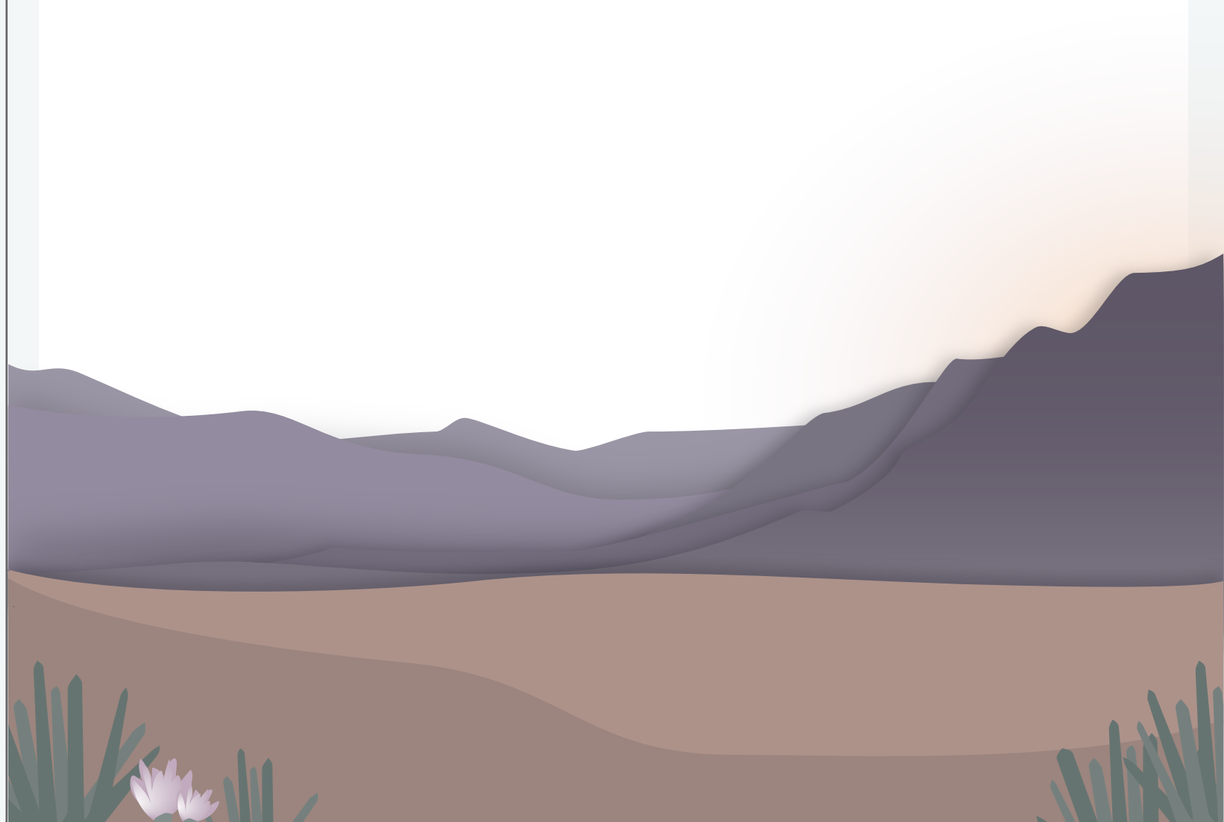
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Orient Staff to Your Clinic's Social Needs Referral Process: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



SOCIAL NEEDS REFERRALS IN PRIMARY CARE

An Implementation Toolkit

EVALUATE, ITERATE, & SUSTAIN

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

EVALUATE, ITERATE, & SUSTAIN

Once your social needs referral workflow is implemented, you can measure its impact, revise your workflows/approach, and create a sustainability plan.

Section 1. Evaluate and Iterate

How, and in what contexts, does the new social needs referral program work? Identifying measurable process components and metrics demonstrating changes in social needs will help identify pain points in the initial roll-out of your program and in continued use over time. Establishing whether the program performs as intended will also help with future impact assessment.

Here are a couple of tips for getting started:

- Use quality improvement or evaluation frameworks you already use.
- If you do not have a good approach in place, the Plan-Do-Study-Act (PDSA) cycle is a popular, evidence-based methodology used to measure both implementation and improvement.
- Leverage the goals you set at the beginning of the toolkit to identify measurable, time-based PDSA objectives. See Decision 1: Identify Goals for potential metrics to use for your PDSA cycle.

Q: What is a PDSA cycle?

As you likely know, the PDSA cycle is an integrated learning and improvement process that is structured along the following sequence:

Table 1. PDSA Cycle

STEP	TASKS
STEP 1: Plan	• Define the cycle's objective • Generate questions to be answered • Formulate a theory • Define success metrics • Determine who will collect the data
STEP 2: Do	• Implement • Document observations • Collect data
STEP 3: Study	• Analyze the data • Identify new issues or questions • Determine if the implementation resulted in expected outcomes
STEP 4: Act	• Integrate cycle learnings by adapting the workflow to mitigate identified barriers, or implement the workflow more broadly • Plan for the next cycle

The PDSA steps can be repeated for continual learning and improvement. PDSA cycles are intended to test a change on a small scale over a short period of time, often taking place over the course of a day or week. Keeping your PDSA objectives specific, measurable, achievable, relevant, and time-bound will help you stay on track, hold teams accountable, and allow for strong tracking on progress.

See Appendix XV: PDSA Example Worksheet to generate ideas about your PDSA approach. Use Appendix XVI: PDSA Worksheet Template to make plans for evaluating your initial implementation. Plans are intended to be fluid, allowing this worksheet to be used for future program improvements as well.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Prepare to revise your social needs referral program in step 4 of your PDSA cycle and consider evaluating relevant iterations in future PDSA cycles.

See these resources for more information about what to take into account when planning your PDSA cycle:

How to Improve: IHI—Institute for Healthcare Improvement

Guide to Social Risk Screening and Referral-Making Step 5 – Roll Out and Iterate

Section 2. Sustain

Adapting your social needs referral program in response to new information supports sustainability over time. Even with regular evaluation and iteration of your program, sustainability may remain a challenge, particularly in under-resourced settings.

Dynamics such as staff engagement, workflow integration, financial obligations, regulatory requirements, regional visibility, and ongoing standardized training all play a role in clinical sustainability. Asking yourself the following questions can help your clinic build capacity for social needs referral sustainability.

- Are leaders, staff, patients, and community partners engaged?
- Does your clinic have the organizational support and resources needed to effectively manage social needs referrals?
- Does your social needs referral workflow align with existing processes?
- Do you provide initial and ongoing standardized training on the social needs referral program for clinic staff? Is it part of new staff onboarding?
- Does your clinic guide social needs referral goals and implementation strategies by promoting ongoing quality improvement?
- Does your clinic monitor and evaluate the social needs referral workflow?
- Does your clinic monitor the availability of community resources (manually or via referral platform) and track when resources are no longer available?
- Does your clinic measure outcomes and impact of social needs referrals?

The Clinical Sustainability Assessment Tool is a useful resource that can be used to help you identify areas to build capacity to sustain social needs referral in your clinical practice.

Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

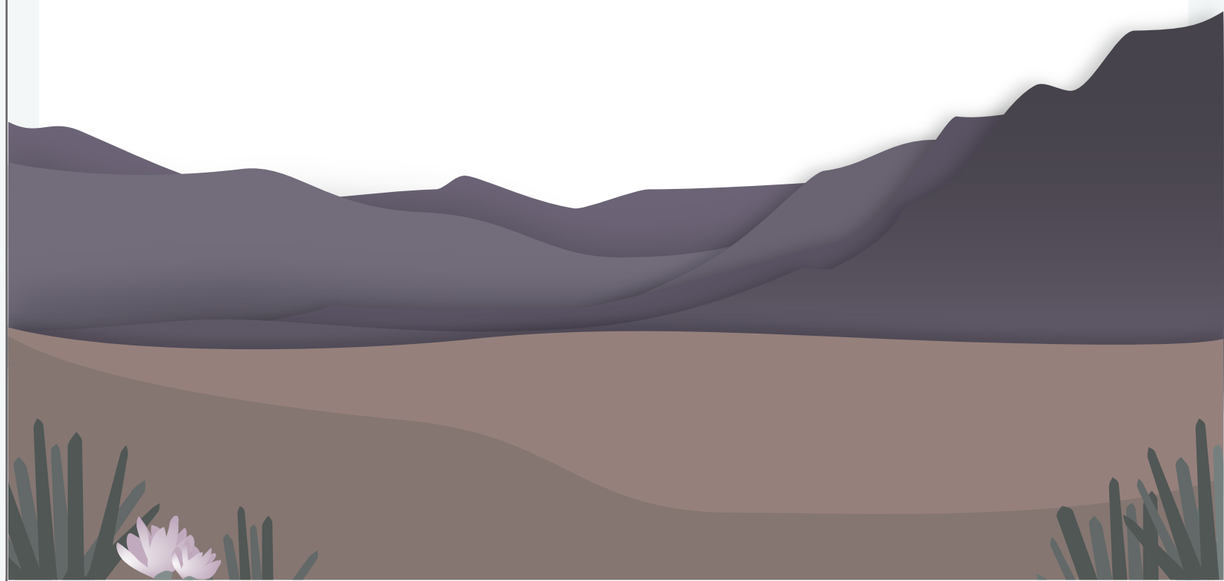
ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

Evaluate, Iterate, & Sustain: Your Notes

Use this space to document activity successes, challenges, time spent on implementation, and your tailored approaches to facilitate implementation and sustainability.



Go to:

EXEC SUMMARY

GLOSSARY

GETTING READY

1. IDENTIFY GOALS

2. REFERRAL STRATEGIES

3. COMM RESOURCES

4. DOC & TRACK

ORIENT STAFF

EVALUATE & SUSTAIN

APPENDIX DIRECTORY

APPENDIX DIRECTORY

Click on the Appendix title below to be taken directly to the page. To return to this Appendix Directory, click the button at the bottom of the page.

APPENDIX I.
Securing Leadership Buy-In

The support of clinic leaders/decision-makers is critical to social needs referral programs.

Q: How do I obtain leadership support for a social needs referral program?

Demonstrate how the program will align with organizational strategic priorities such as quality incentive measures, population health outreach, enhancing patient experience, improving chronic conditions, and mitigating provider burnout. Present anticipated barriers and potential solutions.

Q: How can leadership best support the social needs referral program?

By showing their support early and often in the following ways:

- Enthusiastically inform all staff before program implementation, focusing on its purpose and benefits. See Appendix III. Draft Email from Leadership.
- Solicit feedback and incorporate staff perspectives in leadership decision-making.
- Acknowledge the importance of individual staff member contributions in the initiative.
- Ensure staff have enough time and resources to provide and track social needs referrals.
- Motivate staff by sharing regular reminders of the work's importance and data showing its impact.
- Be available and open to problem-solving when faced with challenges.

APPENDIX II.
Convening an Implementation Team

Once leadership support is secured, the next step is to organize a group of people to plan and implement the social needs referral program.

Q: What is an implementation team and what do they do?

An implementation team guides planning, implementation, evaluation, and iteration of a new program. A social needs referral and tracking program implementation team might:

1. Obtain resources to support implementation
2. Identify facilitators, barriers, and potential solutions to support implementation
3. Develop infrastructure to support implementation
4. Build partnerships with community-based organizations
5. Engage key partners (e.g., clinic staff, patient advisory boards)
6. Provide training to clinic staff on the new approach
7. Ensure fidelity of implementation
8. Review data and process measures to evaluate implementation
9. Build a sustainability plan

These tasks are discussed in more detail throughout this document.

Q: Who is on an implementation team?

Implementation teams can be structured to meet your clinic's context and staffing structures. The team needs to be able to work collaboratively and be able to meet regularly, openly communicate with one another, and make nimble decisions. Such teams often include:

Table 3. Implementation Team Roles

TEAM ROLE	PRIMARY RESPONSIBILITIES	WHO MIGHT SERVE IN THIS ROLE?
Project Champion	• Driving force behind program • Direct each step of the implementation & delegate tasks • See "Champion Responsibilities Checklist" at the end of this step. • Has dedicated time to lead implementation • Ideally: expertise in project management/ change management • May assume one or more roles depending on expertise and availability	QI specialist, clinician (MD, DO, NP, PA), care coordinator, RN
Clinical Champion	• Communicate with clinicians about program • Address clinician-level barriers • Promote clinician workflow changes	Clinician
Project Sponsor	• Executive-level leader—provide organizational support for program • Escalation point for major issues • Champion resourcing	CMO, CEO
EHR Specialist	• Understand technological aspects of EHR documentation • Develop solutions for streamlined documentation in discrete fields • Generate reports to assess reach and effectiveness of the program	EHR specialist, IT team member
Training Specialist	• Develop and administer training materials to orient staff to new workflow	QI specialist, EHR trainer
Workflow Implementer	• Provide referrals to patients and track referral status and outcomes • Provide guidance on program development, including impacts to current workflow	MA, RN, clinician, patient navigator

APPENDIX III.
Draft Email from Leadership

A member of leadership can use this email template to inform clinic staff about your Social Needs Referral program. Copy and paste this text into your email, 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 implement a social needs referral program for patients who request help with their social need(s).

[Clinic Name] wants patients to have access to organizations that provide community resources such as transportation, food, and housing. We believe that helping patients access needed community resources will lead to improvements in their health and wellbeing.

[Clinician Champion Name] and **[Project Champion Name]** will lead these efforts and will be available to answer any questions you may have related to social needs referral activities.

The expected start date for social needs referral implementation will be **[Date]**. There will be a staff orientation on **[Date/Time]**—please plan to attend.

[Insert text on Social Needs Referral Plan (e.g. clinic goals, type of resources you'd like your clinic to provide referrals for, which CBOs you will refer to, etc.)].

Our clinic's planned workflow and roll-out plan/timeline **[overview]**.

If you have any questions and/or concerns, please reach out to **[Project Champion and/or Clinician Champion Name]**.

Sincerely,

[Leadership Name with signature]

APPENDIX IV.
Project Champion Task Checklist

Project champion name:

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.

- [ ] **Getting Ready**

  Assess clinic and community capacity, establish CBO partnerships, secure leadership buy-in, and convene implementation team.

- [ ] **Decision 1. Identify Goals**

  Identify your clinic's goals for social needs referrals.

- [ ] **Decision 2. Choose Referral Strategies**

  Decide how, when, and who takes action to address social needs, and how to communicate in a patient-centered way.

- [ ] **Decision 3. Choose Community Resources**

  Decide how you will identify community resources.

- [ ] **Decision 4. Document, Track, & Follow Up, if Planned**

  Decide how, when, and who will document, track, and follow-up on social need referrals, if planned.

- [ ] **Orient Staff to Your Clinic's Social Needs Referral Process**

  Orient staff to your clinic's social risk referral workflow and plan for implementation.

- [ ] **Evaluate, Iterate, & Sustain**

  Develop a framework for evaluating your initial social needs referral implementation, subsequent iteration, and plans for sustainability.

APPENDIX V.
Assess Relevancy of Referral Plan

If your reasons/goals for conducting social needs referrals change, consider these questions to assess relevancy of your social needs referral plan:

Does my clinic's reason for conducting social needs referrals align with patient needs and desires to receive support?

☐ Yes ☐ No

Are the target patient groups for social needs referrals benefiting from them?

☐ Yes ☐ No

Do the social needs referrals align with the available services offered by my clinic's community partners or community resources/social service agencies accessible to our patients?

☐ Yes ☐ No

APPENDIX VI.
Creating a Workflow Diagram

As you make decisions about your social needs referral activities, consider the following tips about developing and adapting a workflow diagram.

Q: What is a workflow and why is it important?

- A workflow is a set of tasks and people that are necessary to accomplish a goal grouped chronologically into processes.
- Workflows have been shown to support standardized, efficient, and equitable care. They are also important to use in assessing ongoing process improvement.

Tips for adapting this workflow to your clinic context:

- *Seek care team input when developing and adapting the workflow. Identify potential workflow challenges based on your organization's structure, patient population, and culture; ask staff for ideas on how to address them.*
- *Have similar referral workflows worked well in your setting? Consider repurposing an existing referral workflow (e.g., specialist referral).*
- *Consider including staff that already conduct social risk screening.*

Q: What is the best format for a workflow document?

Workflow documents take many forms, for example:

- Narrative or outline of the steps and staff involved
- Flowchart
- Process map
- Patient journey map
- Swim lane diagram (see examples in Appendix VII and Appendix VIII)

Q: What if changes to the workflow need to be made?

- Revising a workflow is to be expected, particularly early on.
- Communicate the changes to all involved staff.

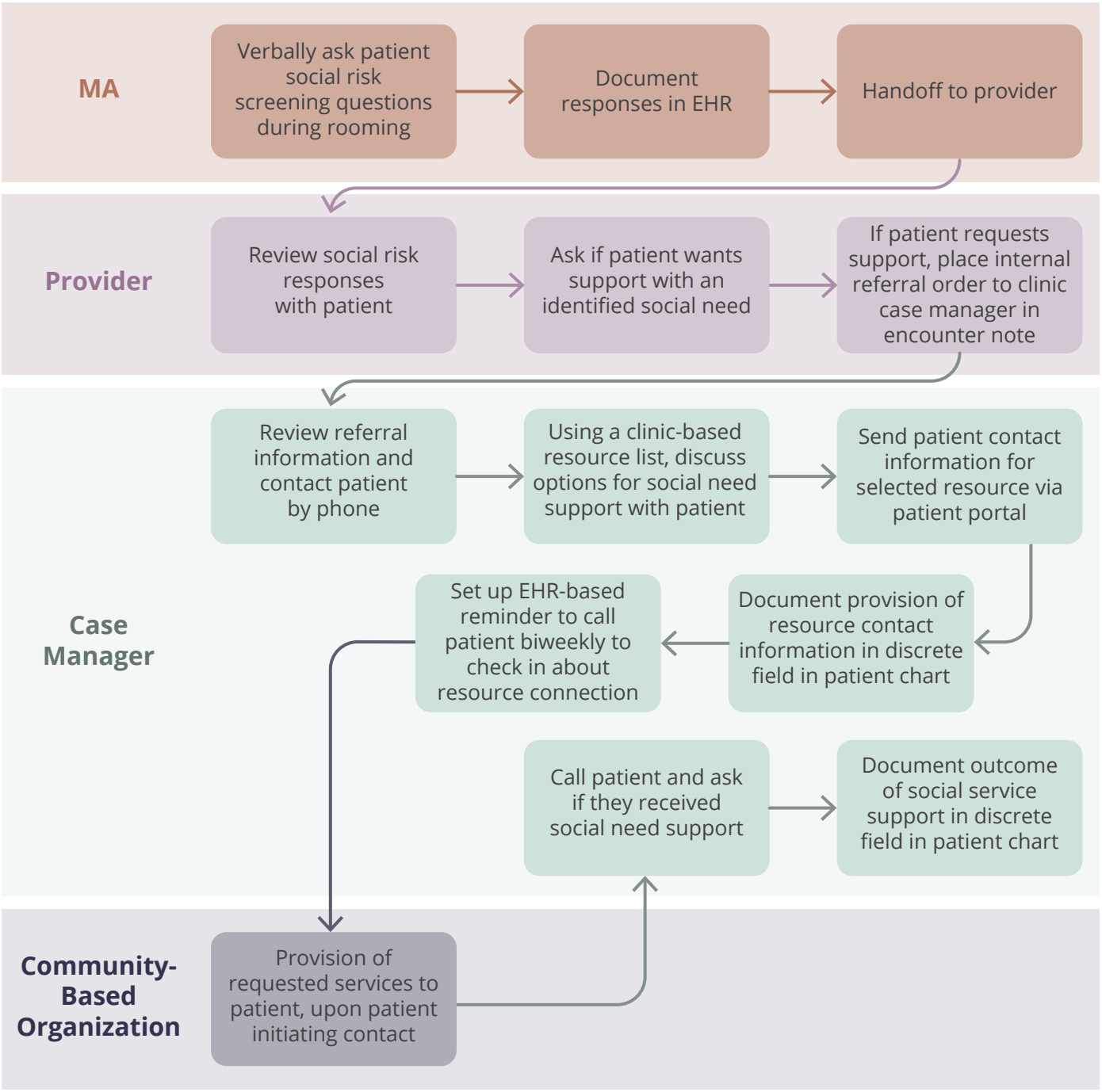
Q: What can you do when the workflow falls apart?

- Plans change—patient emergencies, staff absences, time constraints, and technological glitches can impact the provision of referrals. A well-thought-out workflow can account for unexpected issues and provide a path for accomplishing referral and tracking goals.

See Appendix VII and Appendix VIII for examples of swimlane diagrams depicting social needs referral workflows.

APPENDIX VII. Example Workflow: Internal Social Needs Referral

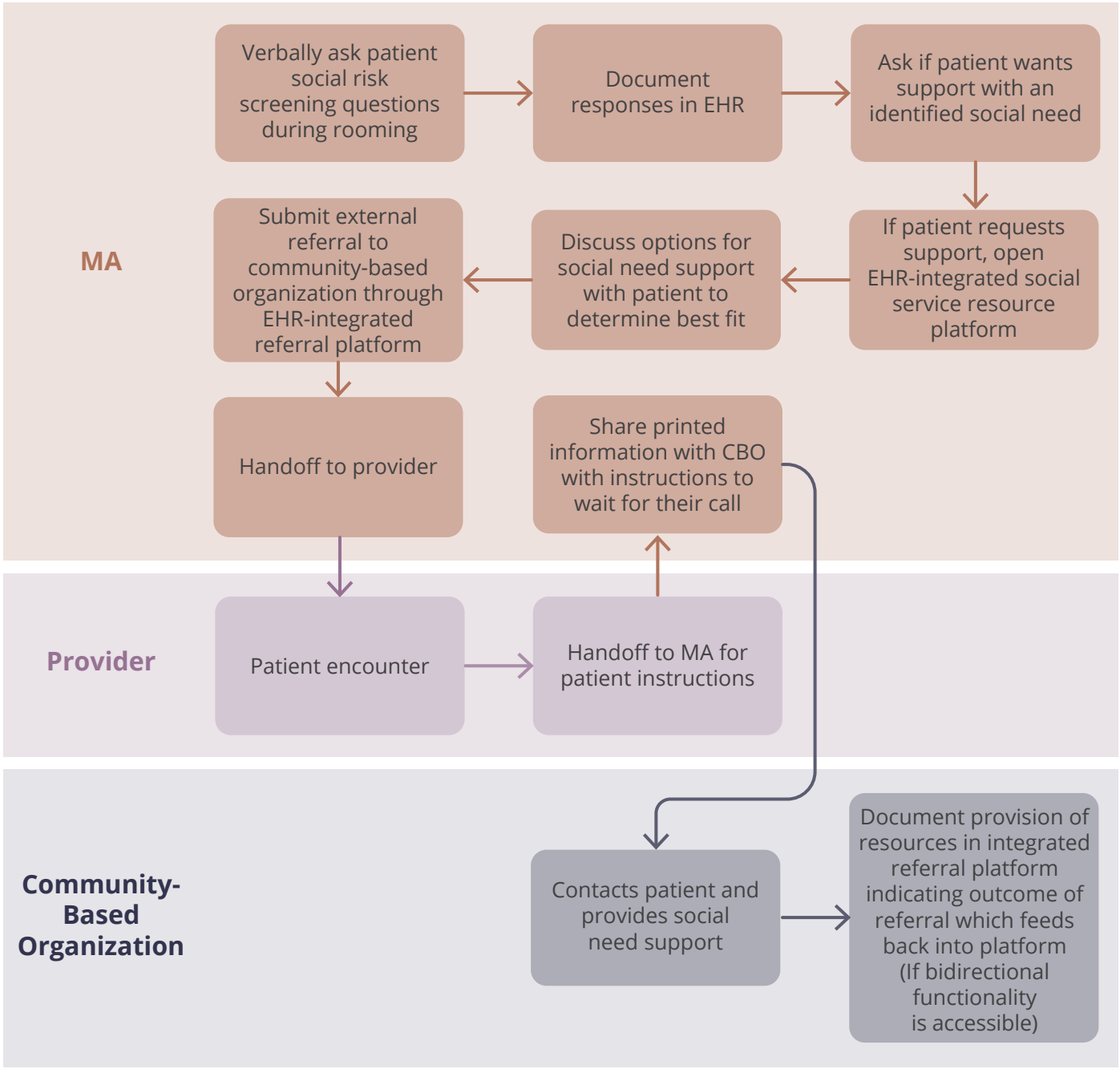
Figure 4. Example Internal Social Needs Referral



Go back to:
APPENDIX DIRECTORY

APPENDIX VIII. Example Workflow: External Social Needs Referral

Figure 5. Example External Social Needs Referral



Go back to:
APPENDIX DIRECTORY

APPENDIX IX.
Referral Strategy Use Cases

Use Case: External Referral

Clinic 1: Referral platform
Clinic has long-standing relationships with CBOs. When the clinic decided to use an EHR-integrated referral platform, they contacted their CBO partners to ask that they add their information in the referral platform, including the ability to accept electronic referrals via the integrated referral platform. The referral platform used by this clinic allows the clinic to send patient contact information through the platform. With that information, the CBO follows up on the referral by contacting the patient and entering navigation details in the shared platform.

Benefits

- EHR-integration enables resource directory of CBO services conveniently available in the EHR
- Referral platform auto-populates patient contact information
- Low burden for patients/clinic staff
- Can track and close referral loop with CBO, if platform has bidirectional functionality

Barriers

- Requires CBO to use the integrated referral platform, which may require CBO staff to do double data entry
- Necessitates referral platform and EHR vendor contracts
- May require set up and ongoing maintenance costs, depending on referral platform and EHR

Use Case: External Referral

Clinic 2: Resource directory
Clinic has long-standing relationships with CBOs. When the clinic decided to use EHR preference lists for locating commonly referred community resources, they built the preference lists based on an existing resource directory they kept in a binder. The EHR user sees a list of 15 commonly referred CBOs in the preference list and decides with the patient which option best meets their needs. The provider places the preference list order, which populates the after-visit summary (i.e., patient instructions) with CBO contact information. A care manager follows up on the referral by contacting the patient two weeks post-visit and enters tracking/follow-up details in the patient's record.

Benefits

- CBO options located in preference lists in EHR
- Structured data fields enable streamlined tracking and follow-up
- Eases documentation burden
- Does not require CBO to use a new tool or platform.

Barriers

- Requires up-front configuration and staff training
- Can be difficult to maintain
- Places responsibility of contacting CBO on patient
- No way to track referral unless patient is contacted

Use Case: External Referral

Clinic 3: Stand-alone resource directory
Patients with diabetes were referred to the clinic's diabetes educator. The diabetes educator reached out to CBOs providing nutrition resources to establish a relationship and let them know the clinic would be sharing the CBO's information with patients seeking help with food. The diabetes educator keeps an Excel file of these CBOs, copying contact information to patient instructions provided at the end of the visit. The diabetes educator asks patient if they received the help they needed in subsequent visits and documents the information in the patient's record.

Benefits

- May foster CBO-clinic relationships
- Does not require CBO to use a new tool or platform.

Barriers

- Places responsibility of contacting CBO on patient
- Time-consuming to keep database current
- No way to track referral unless patient is contacted

Use Case: External Referral

Clinic 4: Personal network
Four clinic staff have lived in a rural community with few CBOs for decades. Using their local knowledge and personal network, they will source the CBO's name and phone number and give it to the patient at the end of their visit. They note in free text in the patient's chart that they provided this information and create a follow-up reminder in the EHR to call that patient 2- and 4-weeks post-visit to ensure they received the resources they needed.

Benefits

- Referrals are based on trusting relationships
- Referral information accessed by the person with relevant knowledge
- Does not require CBO to use a new tool or platform

Barriers

- If staff leave the clinic, local knowledge cannot be accessed
- Places responsibility of contacting CBO on patient
- No way to track referral unless patient is contacted

Use Case: Internal Referral

Clinic 5: Internal Case Manager
When a patient in an urban area seeks social needs help, the clinician places an internal referral to the case manager. The case manager calls the patient to follow up and provide CBO information, calling the patient every week until they get the resources they need. Because the case manager is well-acquainted with community resources, they draw on their knowledge to help patients choose the most appropriate resource for their needs.

Benefits

- Efficient for primary care team
- Referral information accessed by the person with relevant knowledge
- Does not require CBO to use a new tool or platform

Barriers

- Patient may not have existing relationship with case manager
- Can be challenging to search case manager documentation to assess referral outcome
- Places responsibility of contacting CBO on patient
- No way to track referral unless patient is contacted

APPENDIX X.
Social Risk Screening and Referral Orientation Slide Deck

The following slides can be used during your orientation to review social risks, clinic screening goals, and introduce why your clinic is conducting social needs referrals, your clinic's referral goals, and key activities involved with social needs referral processes.

Access the Social Risk Screening and Referrals Orientation Slide Deck (Microsoft PowerPoint file) included with the **Social Needs Referrals in Primary Care** implementation materials.

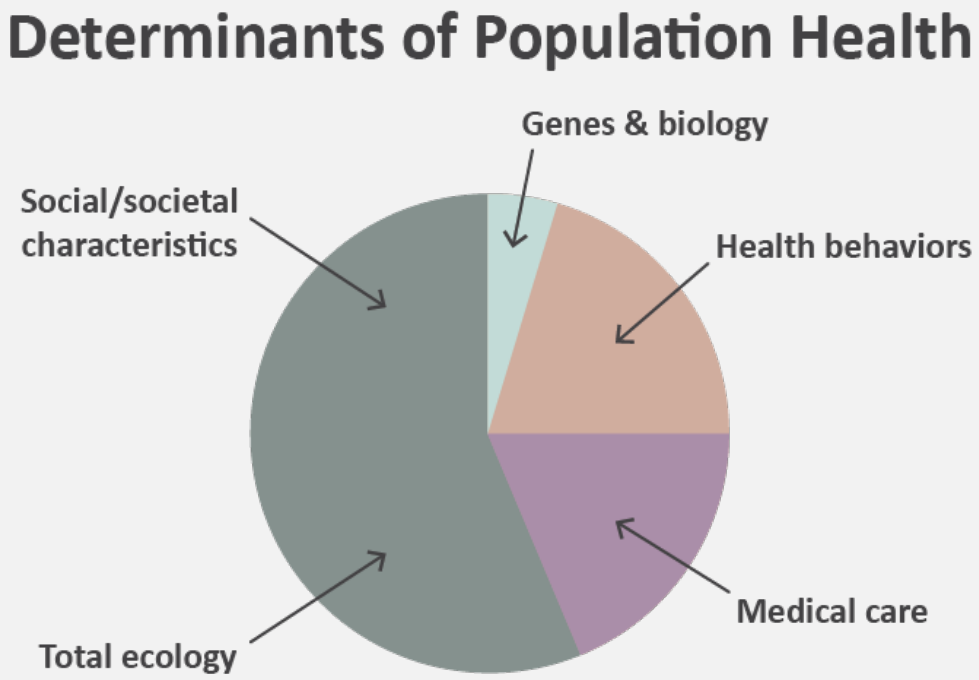
Figure 6. Social Needs Referral Kick-Off/Staff Orientation Slide Deck Title Page

Social Needs Referral Kick-Off / Staff Orientation

[Clinic Name]

[Date]

What are Social Risks (also called Social Determinants of Health)?



Tarlov, A.R., Public Policy Frameworks for Improving Population Health. Annals of the New York Academy of Sciences, 1999. 896(SOCIOECONOMIC STATUS AND HEALTH IN INDUSTRIAL NATIONS: SOCIAL, PSYCHOLOGICAL, AND BIOLOGICAL PATHWAYS): p. 281-293.

- Social risks are the conditions in which people live and work. They profoundly impact health risks and outcomes, and ability to act on care recommendations.
- Only 10-20% of health outcomes are attributed to clinical care; **social risks account for 60-80% of health outcomes.**
- Social risks that impact health include:
  - Housing stability
  - Food security
  - Access to transportation and childcare
  - Ability to pay for basic utilities
  - And more

Social Risks

Social risks that you may be able to document in the EHR include:

- *Household income*
- *Education*
- *Housing status*
- *Food security*
- *Social connection / isolation*

Why Collect Social Risk Data?

- Understand the factors affecting our patients' health
- Adapt treatment and care planning as needed
- Identify needed referrals to community social services
- Enable targeted outreach
- Demonstrate areas of need for resourcing and advocacy

Our Clinic's Social Risk Screening Goals

Instructions: fill-in the blanks prior to presenting this slide and delete any unneeded text

- Our clinic will screen the following types of patients for social risks:
  - [*Insert types of social risks here*]
- We will screen for the following social risks:
  - [*Insert types of social risks here*]
- We will screen them every [*insert how often*]
- Screening will take place:
  - [*Insert how/when in workflows and who will conduct screening*]
- We will use social risk data for:
  - [Insert what you will use social risk data for]

Why Conduct Social Needs Referrals?

- Address patients' desire for support with unmet social needs
- Improve care quality and clinical outcomes
- Reduce cost of care
- Enhance relationships with community partners
- Demonstrate areas of need for resourcing and advocacy

Social Needs Referral Activities Will Include:

- Choose relevant services
- Utilize navigation support strategies
- Document, track, and follow up on referrals
- Recognize best practices and lessons learned
- Evaluate and iterate our clinic's referral goals and processes
- Sustain social needs referral-making
  (e.g., systematic training, regional visibility)

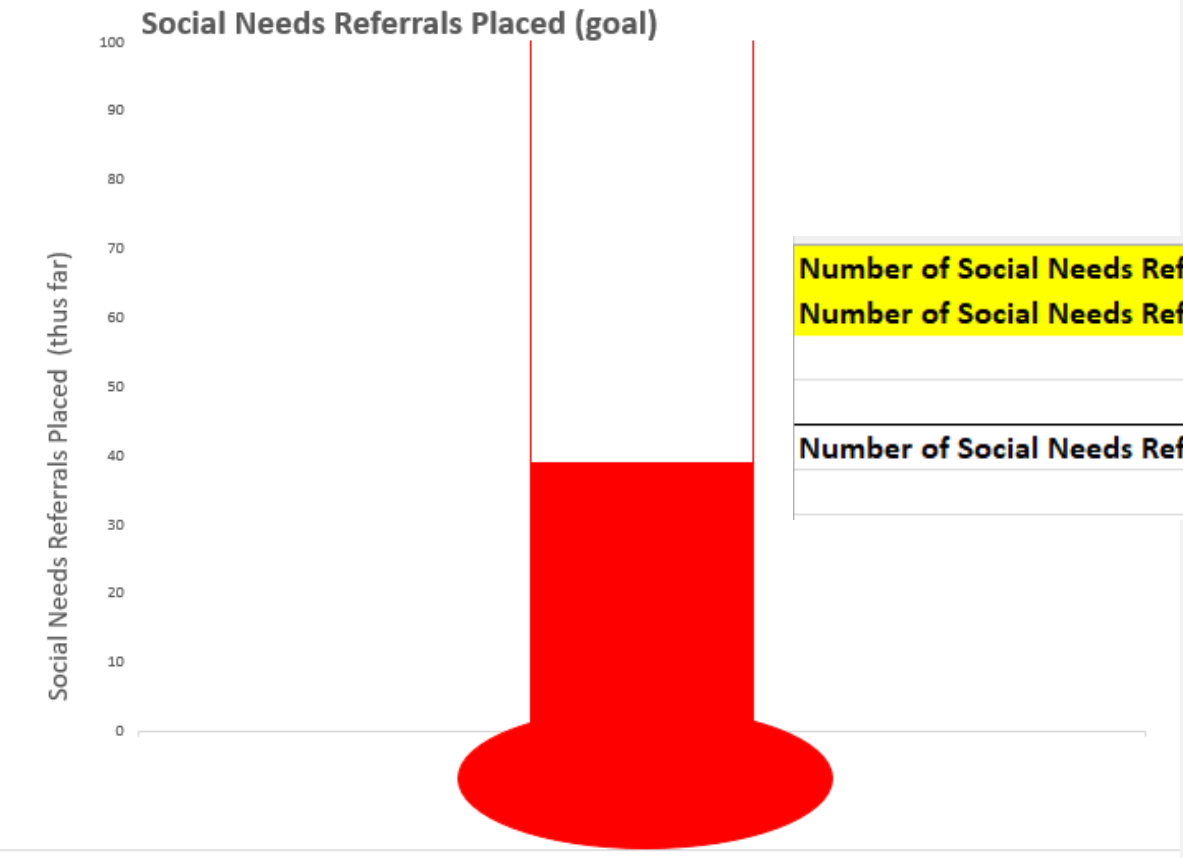
Our Clinic's Social Needs Referral Goals

Instructions: fill-in the blanks prior to presenting this slide and delete any unneeded text

- We will conduct social needs referrals for the following social risks:
  - [*Insert types of social risks here*]
- We will conduct referrals every [*insert how often*]
- Social needs referrals will take place [*insert when in workflows*] and by [*insert who will conduct referrals*]
- We will use social needs referral data for:
  - [Insert what you will use social needs referral data for]

To Track Our Clinic Goals:

We can use the Goals Thermometer

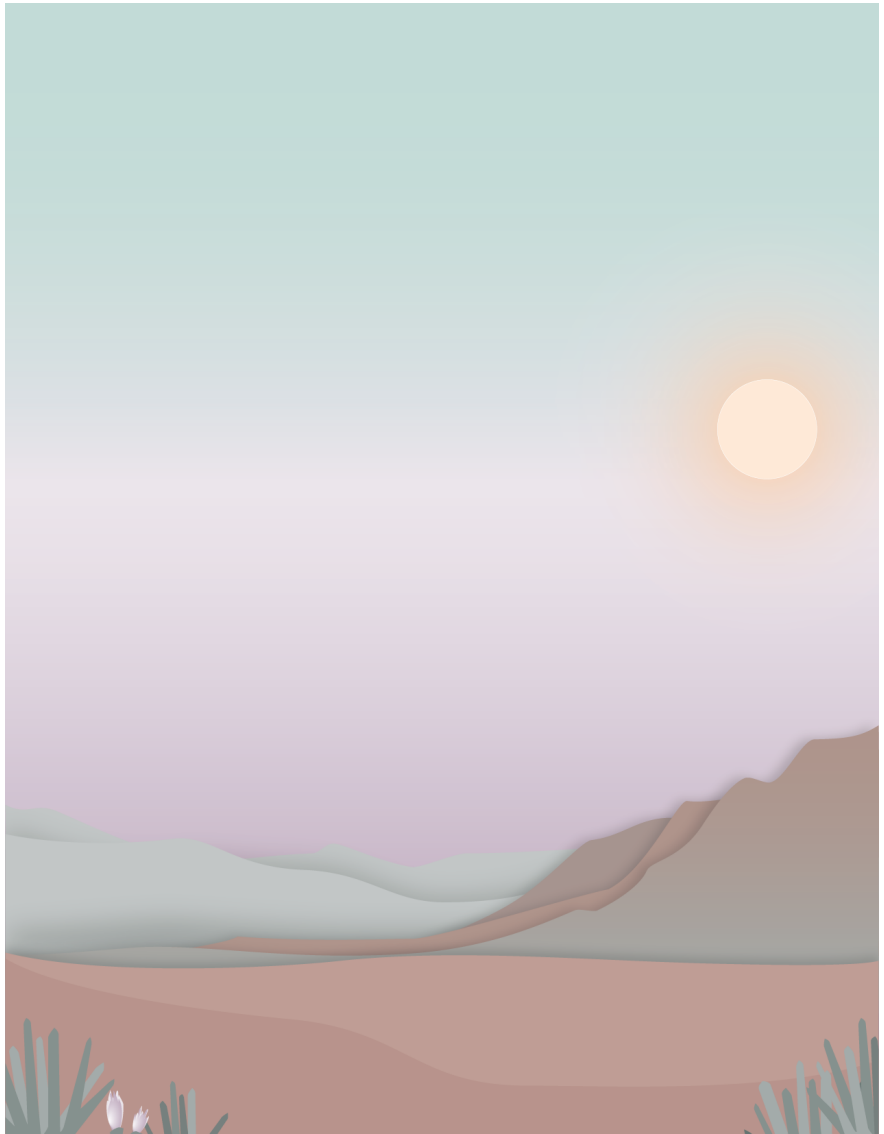


Number of Social Needs Referrals Placed (goal)	100				
Number of Social Needs Referrals Placed (thus far)	39				
	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Number of Social Needs Referrals Placed (thus far)	5	4	4	6	5

Promote Social Risk Screening and Referral Activities:

- Placing patient-facing social risk posters around the clinic
- Recognizing staff who complete social risk screens and provide referrals
- Tracking our clinic goals

Discussion



What are potential barriers to conducting social risk screening and referrals at our clinic?

Examples:

- *Lack of staff time*
- *Concerns about asking sensitive social risk related questions*
- *Limited ability to act on patients' identified social needs*

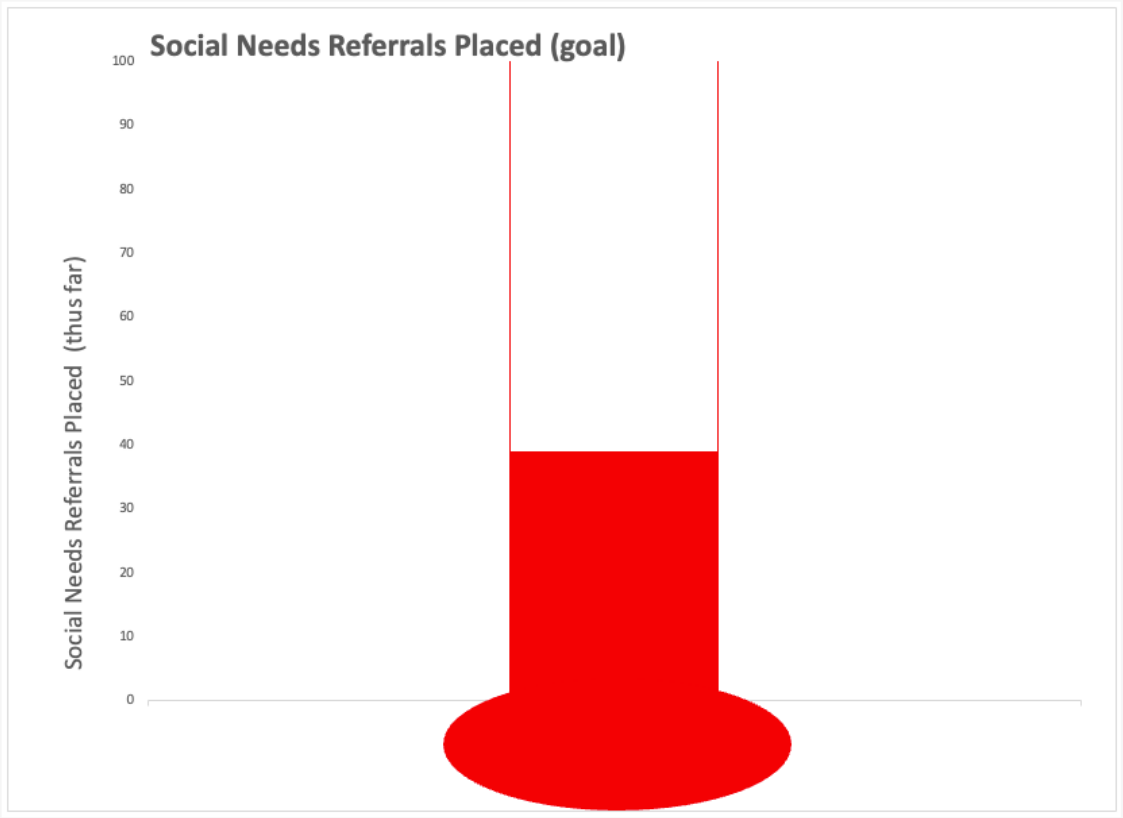
Thank you!

APPENDIX XI. Referral Goals Thermometer

Use the Referral Goals Thermometer template as a tool to complete weekly or as necessary to show progress during staff meetings, through emails, via webinar platforms, or by posting them in a central place. See Decision 1: Identify Goals for referral goal ideas.

Access the Referral Goals Thermometer template (Microsoft Excel file) included with the **Social Needs Referrals in Primary Care** implementation materials.

Figure 7. Referral Goals Thermometer

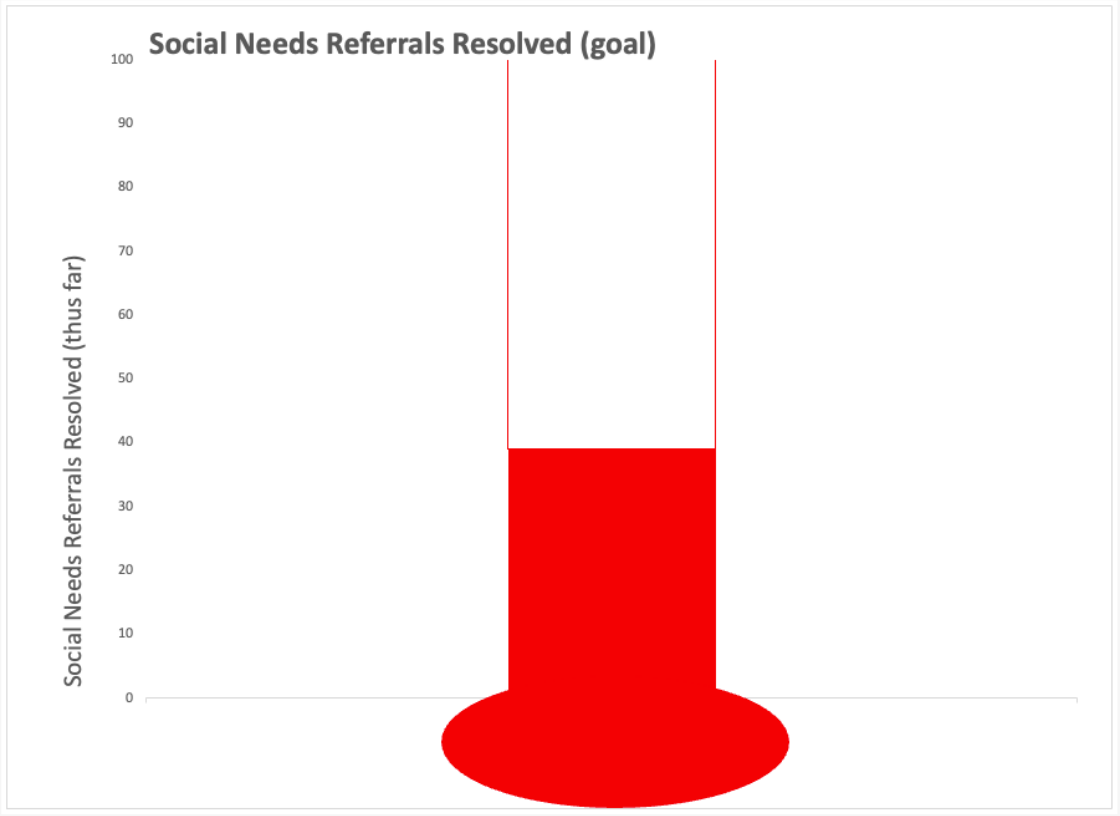


APPENDIX XII.
Referral Outcomes Thermometer

Use the Referral Outcomes Thermometer template as a tool to complete weekly or as necessary. See Decision 4: Document, Track, and Follow Up, If Planned for referral outcome ideas.

Access the Referral Outcomes Thermometer template (Microsoft Excel file) included with the **Social Needs Referrals in Primary Care** implementation materials.

Figure 8. Referral Outcomes Thermometer



APPENDIX XIII.
Certificate of Recognition Template

Use the Certificate of Recognition template on the following page (pg. 106) to celebrate leaders (staff and/or community partners) as Social Needs Referral Champions.

Type into the text fields to add the recipient's name, date and year of award, and presenter's name and title. Add your clinic logo to the certificate of recognition to personalize this recognition by inserting an image.

Once the certificate is filled out, select Print from your PDF reader toolbar menu and choose to print only **page 106**. Alternatively, use the Certificate of Recognition template (PDF file) included in the **Social Needs Referrals in Primary Care** implementation materials.

Figure 9. Certificate of Recognition Example

Go back to:
APPENDIX DIRECTORY

Certificate of Recognition

This certificate is presented to

Social Needs Referral Champion

Awarded this of

APPENDIX XIV.
Social Risk Screening and Referral Kickoff Agenda Template

Social Risk Screening and Referral-Making Kick-Off Meeting

Location: [Address or Room Number or Webinar Link]

Date: [Date]

Time: [Time]

Facilitator: [Name(s)]

TIME	TOPIC	LEAD
	[Welcome]	[Lead]
10 min	[Review Social Risk Screening and Referral Orientation slide deck]	[Lead]
20 min	[Why are social risk screening and referrals important for our patients?]	[Lead]
15 min	[Clinic goals for social risk screening & referrals]	[Lead]
15 min	[Brainstorm workflows]	[Lead]

Additional information:

[Add additional instructions or comments here]

APPENDIX XV.
Example PDSA Worksheet

Use this example social needs referral worksheet to generate ideas and make plans for PDSA development.

PDSA CYCLE DESCRIPTION

What is our goal? How long will it last? Who will lead it?

Description

Collect data on percentage of social needs referrals made for patients requesting help using referral platform.

Start Date: 12/4/2023 **End Date:** 12/11/2023

Objective

To test provision of referrals using referral platform.

Cycle #: 1 **Cycle Owner:** Care Coordinator

PLAN

What question do we want answered? What do we think will happen? What data can we collect to measure change? Who collects the data?

Question(s)

What % of social needs referrals are placed using the referral platform?

Prediction(s)

At least 85% of social needs referrals will be placed through the referral platform.

Data To Be Collected

- # of patients requesting help with a social need.
- % of referrals placed for those patients via referral platform.

Who Collects Data: Care Coordinator

DO

What did we observe?

Observations/Data

- CHWs find the referral platform easy to access and use; the platform fits in well with the workflow.
- Some patients were wary of their contact information being sent to a CBO.

STUDY

What did we learn? Did it result in our expected outcome? Did new issues come up?

Results

Of the 25 patients requesting help with their social needs during the PDSA period, 90% of referrals were made through the referral platform.

New Issues

We need to help CHWs talk to patients who express privacy concerns about the platform.

ACT

What changes do we make based on our findings? What should we test in our next cycle?

Actions

Continue using the referral platform and expand its use to all CHWs. Provide CHW training on patient communication strategies related to platform.

Next Cycle

Collect data on percentage of social needs referrals made for patients requesting help using referral platform among all CHWs. Assess qualitative feedback from CHWs on efficacy of training and impact on platform use.

APPENDIX XVI.
PDSA Worksheet Template

Use this worksheet to help plan your PDSA cycle for your social needs referral activities.

Access the PDSA Worksheet Template (PDF file) included with the **Social Needs Referrals in Primary Care** implementation materials.

PDSA CYCLE DESCRIPTION

What is our goal? How long will it last? Who will lead it?

Description

Start Date: **End Date:**

Objective

Cycle #: **Cycle Owner:**

PLAN

What question do we want answered? What do we think will happen? What data can we collect to measure change? Who collects the data?

Question(s)

Prediction(s)

Data To Be Collected

Who Collects Data:

DO

What did we observe?

Observations/Data

STUDY

What did we learn? Did it result in our expected outcome? Did new issues come up?

Results

New Issues

ACT

What changes do we make based on our findings? What should we test in our next cycle?

Actions

Next Cycle

APPENDIX XVII. References

Note: References informing appendices are included under the toolkit section they are linked to.

Glossary of Terms

Agency for Healthcare Research and Quality. Warm Handoff: Intervention. Engaging Patients and Families. Rockville, MD; 2023. Available at: https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html.

Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Q. 2019 Jun;97(2):407-419. doi: 10.1111/1468-0009.12390. Epub 2019 May 8. PMID: 31069864; PMCID: PMC6554506.

American Association of Medical Assistants. AAMA 2018–2019 Occupational Analysis of Medical Assistants. Chicago, IL; 2020.

American Association of Public Health. 2024. Community Health Workers. Available at: https://www.apha.org/apha-communities/member-sections/community-health-workers

Cartier, Y, Fichtenberg, C, Gottlieb, L. Community Resource Referral Platforms: A Guide for Health Care Organizations. San Francisco, CA: SIREN; 2019. Available at: Community Resource Referral Platforms: A Guide for Health Care Organizations | SIREN (ucsf.edu)

CDC Foundation. Community-Based Organizations. Atlanta, GA; 2023. Available at: https://www.cdcfoundation.org/community-based organizations.

Institute for Healthcare Improvement. Science of Improvement: Forming the Team. Boston, MA; 2023. Available at: https://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx.

Institute of Medicine (US) Committee on Health and Beahvior. Social Risk Factors. In: Research, Practice, and Policy. Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences. Washington D.C.: National Academies Press; 2001.

Morena AL, Gaias LM, Larkin C. Understanding the Role of Clinical Champions and Their Impact on Clinician Behavior Change: The Need for Causal Pathway Mechanisms. Front Health Serv. 2022;2:896885.

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. National Academies Press (US); 2019.

Olaniran A, Smith H, Unkels R, Bar-Zeev S, van den Broek N. Who is a community health worker? A systematic review of definitions. Glob Health Action. 2017;10(1):1272223.

Samuels-Kalow ME, Ciccolo GE, Lin MP, Schoenfeld EM, Camargo CA Jr. The terminology of social emergency medicine: Measuring social determinants of health, social risk, and social need. J Am Coll Emerg Physicians Open. 2020 Jul 20;1(5):852-856. doi: 10.1002/emp2.12191. PMID: 33145531; PMCID: PMC7593464.

Shaw EK, Howard J, West DR, et al. The role of the champion in primary care change efforts: from the State Networks of Colorado Ambulatory Practices and Partners (SNOCAP). J Am Board Fam Med. 2012;25(5):676-685.

Getting Ready

Agency for Healthcare Research and Quality. What is workflow? Rockville, MD: 2023. Available at: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/workflow.

Bibbins-Domingo K. Integrating Social Care Into the Delivery of Health Care. JAMA. 2019;322(18):1763-1764.

Cain C, Haque S. Advances in Patient Safety Organizational Workflow and Its Impact on Work Quality. In: Hughes RG, ed. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

Cartier, Y, Fichtenberg, C, Gottlieb, L. Community Resource Referral Platforms: A Guide for Health Care Organizations. San Francisco, CA: SIREN; 2019. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations.

Gunn R, Pisciotta M, Volk M, Bowen M, Gold R, Mossman N. Implementation of Social

Isolation Screening and an Integrated Community Resource Referral Platform. J Am Board Fam Med. 2023.

Hogg Graham R, Edwards K, Ely TL, Mochizuki M, Varda D. Exploring the capacity of community-based organisations to absorb health system patient referrals for unmet social needs. Health & Social Care in the Community. 2021;29(2):487-495.

Institute for Medicaid Innovation. Value of Investing in Social Determinants of Health Toolkit: Grounding Value in Authentic Partnerships. Washington, DC; 2023. Available at: https://medicaidinnovation.org/wp-content/uploads/2023/10/IMI-SDOH-Toolkit_Authentic-Partnerships_Sept-2023.pdf.

Lessard S, Bareil C, Lalonde L, et al. External facilitators and interprofessional facilitation teams: a qualitative study of their roles in supporting practice change. Implement Sci. 2016;11:97.

Li SA, Jeffs L, Barwick M, Stevens B. Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: a systematic integrative review. Syst Rev. 2018;7(1):72.

Paarlberg, Laurie & Varda, Danielle. (2009). Community Carrying Capacity: A Network Perspective. Nonprofit and Voluntary Sector Quarterly - NONPROFIT VOLUNT SECT Q. 38. 597-613.

Petchel S, Gelmon S, Goldberg B. The Organizational Risks Of Cross-Sector Partnerships: A Comparison Of Health And Human Services Perspectives: A legal and policy review to identify potential funding streams specifically for Accountable Communities For Health infrastructure activities. Health Affairs. 2020;39(4):574-581.

Shaw EK, Howard J, West DR, et al. The role of the champion in primary care change efforts: from the State Networks of Colorado Ambulatory Practices and Partners (SNOCAP). J Am Board Fam Med. 2012;25(5):676-685.

Wortman Z, Tilson EC, Cohen MK. Buying Health For North Carolinians: Addressing Nonmedical Drivers Of Health At Scale. Health Affairs. 2020;39(4):649-654.

Decision 1: Identify Goals

Byhoff E, Garg A, Pellicer M, et al. Provider and Staff Feedback on Screening for Social and Behavioral Determinants of Health for Pediatric Patients. J Am Board Fam Med. 2019;32(3):297-306.

Davidson KW, Krist AH, Tseng C, et al. Incorporation of Social Risk in US Preventive Services Task Force Recommendations and Identification of Key Challenges for Primary Care. JAMA. 2021;326(14):1410–1415.

Gurewich D, Garg A, Kressin NR. Addressing Social Determinants of Health Within Healthcare Delivery Systems: a Framework to Ground and Inform Health Outcomes. J Gen Intern Med. 2020 May;35(5):1571-1575.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Sandhu S, Lian T, Smeltz L, Drake C, Eisenson H, Bettger JP. Patient Barriers to Accessing Referred Resources for Unmet Social Needs. J Am Board Fam Med. 2022;35(4):793-802.

Schickedanz A, Hamity C, Rogers A, Sharp AL, Jackson A. Clinician Experiences and Attitudes Regarding Screening for Social Determinants of Health in a Large Integrated Health System. Med Care. 2019;57(Suppl 6 2):S197-S201.

Steeves-Reece AL, Totten AM, Broadwell KD, Richardson DM, Nicolaidis C, Davis MM. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022;62(5):e303-e315.

Decision 2: Choose Referral Strategies

Beidler LB, Razon N, Lang H, Fraze TK. "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. J Gen Intern Med. 2022;37(16):4160-4167.

Cartier Y, Fichtenberg C, Gottlieb LM. Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters. Health Aff (Millwood). 2020;39(4):662-669.

Gottlieb LM, Hessler D, Wing H, Gonzalez-Rocha A, Cartier Y, Fichtenberg C. Revising the Logic Model Behind Health Care's Social Care Investments. Milbank Q. Published online January 25, 2024. doi:10.1111/1468-0009.12690

Gunn R, Pisciotta M, Volk M, Bowen M, Gold R, Mossman N. Implementation of Social Isolation Screening and an Integrated Community Resource Referral Platform. J Am Board Fam Med. 2023.

Iott BE, Eddy C, Casanova C, Veinot TC. More than a Database: Understanding Community Resource Referrals within a Socio-Technical Systems Framework. 2021. AMIA Annu Symp Proc.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Oregon Primary Care Association. Empathic Inquiry. Portland, OR; 2023. Available at: Empathic Inquiry - Oregon Primary Care Association (orpca.org).

Singer, A. Collaborative Screening: Guidance for Person-Centered Intquiry. Portland, OR; 2023. Available at: Collaborative Screening — Ariel Singer LLC.

Singer A, Coleman K, Mahmud, A, Holden, E, Stefanik-Guizlo, K. Assessing the Feasibility of an Empathic Inquiry Approach to Social Needs Screening in 10 Federally Qualified Health Centers. The Permanente Journal.0(0):1-7.

Steeves-Reece AL, Nicolaidis C, Richardson DM, et al. "It Made Me Feel like Things Are Starting to Change in Society:" A Qualitative Study to Foster Positive Patient Experiences during Phone-Based Social Needs Interventions. Int J Environ Res Public Health. 2022;19(19).

Steeves-Reece AL, Totten AM, Broadwell KD, Richardson DM, Nicolaidis C, Davis MM. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022;62(5):e303-e315.

Decision 3: Choose Community Resources

Beidler LB, Razon N, Lang H, Fraze TK. "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. J Gen Intern Med. 2022;37(16):4160-4167.

Cartier, Y, Fichtenberg, C, Gottlieb, L. Community Resource Referral Platforms: A Guide for Health Care Organizations. San Francisco, CA: SIREN; 2019. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations.

Gottlieb LM, Hessler D, Wing H, Gonzalez-Rocha A, Cartier Y, Fichtenberg C. Revising the Logic Model Behind Health Care's Social Care Investments. Milbank Q. Published online January 25, 2024. doi:10.1111/1468-0009.12690

Gunn R, Pisciotta M, Volk M, Bowen M, Gold R, Mossman N. Implementation of Social Isolation Screening and an Integrated Community Resource Referral Platform. J Am Board Fam Med. 2023.

Iott BE, Eddy C, Casanova C, Veinot TC. More than a Database: Understanding Community Resource Referrals within a Socio-Technical Systems Framework. 2021. AMIA Annu Symp Proc.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Steeves-Reece AL, Totten AM, Broadwell KD, Richardson DM, Nicolaidis C, Davis MM. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022;62(5):e303-e315.

Decision 4: Document, Track, and Follow-up, if Planned

Beidler LB, Razon N, Lang H, Fraze TK. "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. J Gen Intern Med. 2022;37(16):4160-4167.

Berkowitz SA, Hulberg AC, Placzek H, et al. Mechanisms Associated with Clinical Improvement in Interventions That Address Health-Related Social Needs: A Mixed-Methods Analysis. Popul Health Manag. 2019;22(5):399-405.

Cartier, Y, Fichtenberg, C, Gottlieb, L. Community Resource Referral Platforms: A Guide for Health Care Organizations. San Francisco, CA: SIREN; 2019. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations.

Fiori KP, Rehm CD, Sanderson D, et al. Integrating social needs screening and community health workers in primary care: the community linkage to care program. Clin Pediatr (Phila). 2020;59(6):547-556.

Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. Pediatrics. 2015;135(2):e296-e304.

Gunn R, Pisciotta M, Volk M, Bowen M, Gold R, Mossman N. Implementation of Social Isolation Screening and an Integrated Community Resource Referral Platform. J Am Board Fam Med. 2023.

Iott BE, Eddy C, Casanova C, Veinot TC. More than a Database: Understanding Community Resource Referrals within a Socio-Technical Systems Framework. AMIA Annu Symp Proc.

Lian T, Kutzer K, Gautam D, et al. Factors Associated with Patients' Connection to Referred Social Needs Resources at a Federally Qualified Health Center. J Prim Care Community Health. 2021;12:21501327211024390.

Manian N, Wagner CA, Placzek H, Darby BA, Kaiser TJ, Rog DJ. Relationship between intervention dosage and success of resource connections in a social needs intervention. Public Health. 2020;185:324-331.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Schickedanz A, Sharp A, Hu YR, et al. Impact of Social Needs Navigation on Utilization Among High Utilizers in a Large Integrated Health System: a Quasi-experimental Study. J Gen Intern Med. 2019;34(11):2382-2389.

Steeves-Reece AL, Totten AM, Broadwell KD, Richardson DM, Nicolaidis C, Davis MM. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022;62(5):e303-e315.

Orient Staff to Your Clinic's Social Needs Referral Process

Eder M, Henninger M, Durbin S, et al. Screening and Interventions for Social Risk Factors: Technical Brief to Support the US Preventive Services Task Force. JAMA. 2021;326(14):1416-1428.

Garg A, Homer CJ, Dworkin PH. Addressing Social Determinants of Health: Challenges and Opportunities in a Value-Based Model. Pediatrics. 2019;143(4).

Gerteis J BC. Identifying and Addressing Social Needs in Primary Care Settings. Rockville, MD: Agency for Healthcare Research and Quality: 2021. Available at: https://www.ahrq.gov/evidencenow/tools/social-needs-tool.html.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Evaluate, Iterate, & Sustain

Cartier Y, Fichtenberg C, Gottlieb LM. Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters. Health Aff (Millwood). 2020;39(4):662-669.

Center for Public Health Systems Science (CPHSS). Clinical Sustainability Assessment Tool. St. Louis, MO: 2023. Available at: Assess – PSAT/CSAT (sustaintool.org).

Gold R, Kaufmann J, Cottrell EK, et al. Implementation Support for a Social Risk Screening and Referral Process in Community Health Centers. NEJM Catal Innov Care Deliv. 2023;4(4).

Gottlieb L, Cottrell EK, Park B, Clark KD, Gold R, Fichtenberg C. Advancing Social Prescribing with Implementation Science. J Am Board Fam Med. 2018;31(3):315-321.

Institute for Healthcare Improvement. How to Improve: Model for Improvement. Boston, MA: 2023. Available at: How to Improve: Model for Improvement | Institute for Healthcare Improvement (ihi.org).

Malone S, Prewitt K, Hackett R, et al. The Clinical Sustainability Assessment Tool: measuring organizational capacity to promote sustainability in healthcare. Implement Sci Commun. 2021;2(1):77.

OCHIN & Kaiser Permanente Center for Health Research. A Guide to Implementing Social Risk Screening and Referral-Making. Portland, OR; 2021. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making.

Parry GJ, Carson-Stevens A, Luff DF, McPherson ME, Goldmann DA. Recommendations for evaluation of health care improvement initiatives. Acad Pediatr. 2013;13(6 Suppl):S23-30.

Steeves-Reece AL, Totten AM, Broadwell KD, Richardson DM, Nicolaidis C, Davis MM. Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. Am J Prev Med. 2022;62(5):e303-e315.

Taylor MJ, McNicholas C, Nicolay C, Darzi A, Bell D, Reed JE. Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. BMJ Qual Saf. 2014;23(4):290-298.