GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 2: IDENTIFY CLINIC GOALS

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Step 2: Identify Your Clinic's Goals

The next step is to decide why your clinic wants to conduct social risk screening, including which patients you want to screen for which social risk measures. This is a guide on how to make these decisions.

If you are already conducting social risk screening, use this guide to clarify how you want to expand your current efforts, and how you want to use the data you collect.

Step 2: Considerations for Setting your Goals

Your goals for social risk screening include which patients you want to screen, which social risk measures to screen for, and how often to screen. If you are already doing social risk screening, use this guide to set your goals for expanding existing efforts.

There are no wrong choices when setting these goals. Your goals should reflect: 1) How you want to use patients' social risk information, and 2) What is best for your clinic.

There are no national standards about which patients to screen for which social risk in what timeframe. Therefore, your social risk screening goals will be driven by what makes sense for your clinic, and how you want to use the social risk data you collect. Consider engaging patients to inform clinic goal-setting.

Things to Consider When Setting Your Goals

Consider…		**How does this relate to my clinic?**
How do you want to use the social risk data?	For example, if the data will be used to understand need in your community, screening a sample of patients is adequate. If the data are being used to enable targeted outreach, you will want to screen all targeted patients for social risks.	
Starting small	Prioritize a subset of patients and / or social risk measures to target while you dial in your workflows. You can expand on this when you feel ready.	
Choosing an easy target population	This will depend on your clinic's capacity and priorities. Choose a target population based on routine, easy-to-identify visits (e.g., annual physicals, new patient visits, or visits where other annual screenings are conducted). This will help staff identify which patients to screen, and help you track your success at screening your target patients.	
Other screenings you conduct	What other sensitive screenings are conducted at your clinic, such as Intimate Partner Violence? Consider using these screenings as models for social risk screening activities, or adding social risk screening to these workflows.	
Your clinic's strategic priorities	For example, if your clinic has prioritized improving care for high ED utilizers, would screening for social risks help in this population?	
Your clinic's resources / partnerships	For example, if your clinic already has a partnership with local legal services, or an on-site social worker, it might impact what you screen for.	
Known areas of need in your community	Does your community have needs that your clinic wants to highlight or quantify with the social risk data you collect?	
Available community resources	You may want to limit screening to social risks for which there are local resources such as support groups, food banks, and housing.	
Staff resources and time commitment	Consider the capacity of your staff and teams, and the time it will take to screen for social risks.	
Other social risk initiatives	Are you participating in any programs or initiatives that require screening for certain social risks on a specific schedule?	

Step 2: Goal-Setting Decision Tools

Which Social Risk Screening Tool?

- There is no evidence that any social risk screening tools are better than others. Just use the one that your clinic likes, or that you are required to use.
- If your EHR gives you the option to do so, you can also choose to just screen for individual social risk domains.
- Consider using a pre-screening tool. Then you can conduct more in-depth screening just for patients with positive responses to the pre-screening.
- This resource compares different screening tools:
  https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Use the following decision tool to help set your clinic's goals for social risk screening and related activities.

Identifying your clinic's goals for social risk documentation will help you decide:

a. How your clinic intends to use the collected social risk data
b. Which patients to screen for social risks
c. How many patients you want to screen, and how often
d. What social risks to screen for

Step 2: Goal-Setting Decision Tools

a. Why do you want to screen your patients?

Review these potential uses for social risk data; **check those that apply** to your clinic's goals. If your goals for social risk screening change, consider whether / how that affects which patients you screen, how often, and for which social risk. Note that there are many reasons to screen for social risks other than making community referrals!

1. To provide contextual information that could impact individual patients' treatment plans	
☐	**Inform treatment, care planning; know what is affecting patients** E.g.: Change homeless patient's prescription to one that doesn't require refrigeration
☐	**Identify and make needed social service intervention referrals** E.g.: Refer patient with diabetes, who lacks healthy food, to food bank
2. To use in population health management / targeted outreach ("segmentation" of your patient population)	
☐	**Enable targeted outreach to vulnerable patients** E.g.: Identify patients with transportation barriers (i.e., those in communities with little public transportation), and refer them to transportation assistance
☐	**Prioritize management of complex patients** E.g.: Community health worker identifies patients with social needs for care management program
3. To understand areas of need in your clinic / community	
☐	**Support organizational changes - Identify needed staff, allocate resources** E.g.: Ensure that a social worker is available to address patients' experiences of relationship violence; use social risk data to decide where to locate a new community health worker staff position
☐	**Support development and capacity building in the community - Provide data for advocacy** E.g.: Inform local government about need for housing resources
☐	**Create new partnerships with new / other community agencies** E.g.: Use data on patients' legal needs to create a medical-legal partnership with an organization in your community
4. To respond to external requirements	
☐	**Conduct screening as required by our health system, state, ACO, etc.** E.g.: Screen for housing needs as required by your CCO

b. Which patients do you want to start screening for social risk? This may mean expanding your current social risk screening efforts. Pick all that apply. Leave rows blank if not relevant.

Potential patient groups to target for social risk screening
All of your clinic's patients or just a subset ☐ All patients, as time allows (skip to section d) ☐ A subset of our patients (complete the rest of this section)
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 type:
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:
Gender ☐ Men ☐ Women ☐ Other
Age ☐ 0-5 ☐ 6-12 ☐ 13-18 ☐ 19-50 ☐ 51-65 ☐ >65 ☐ Other:
Target patients with chronic or comorbid medical conditions? ☐ No ☐ Yes: which conditions? ☐ DM ☐ CVD ☐ Behavioral health ☐ Other:
Target patients with substance use disorders? ☐ No ☐ Yes: which disorders?
Target patients with specific utilization patterns? ☐ No ☐ Yes: which patterns?
Pregnant women ☐ No ☐ Yes
Participants in other clinic initiatives ☐ No ☐ Yes: which initiatives?
Patients being screened for other needs? ☐ No ☐ Yes: which one? (e.g., SBIRT, PHQ):
Other factors or patient characteristics ☐ No ☐ Yes: which patient characteristics?

c. How many patients do you want to screen for social risks and how often?

Please refer back to this page when developing your PDSA cycle in Step 5.

Our clinic will screen once every:
☐ Visit
☐ 3 months
☐ 6 months
☐ 12 months
In the first _____ months:
☐ All patients
☐ _____ % of targeted patients
☐ _____ # of targeted patients
In the first year:
☐ All patients
☐ _____ % of targeted patients
☐ _____ # of targeted patients

Step 2: Goal-Setting Decision Tools

d. What social risks do you want to screen for?

	Check which social risk domains you want to screen for / record in the EHR
Financial resource strain	☐
Housing insecurity / living situation	☐
Transportation insecurity	☐
Food insecurity	☐
Utilities insecurity	☐
Relationship safety	☐
Stress	☐
Social isolation	☐
Health literacy	☐
Employment	☐
Education level	☐
Physical activity	☐
All of these	☐

Why did you make these choices:

Please refer back to "Considerations for Setting your Goals," (page 3), when using this decision tool.

Congratulations! You are ready to move on to Step 3:
Create a Social Risk Plan