A Guide to Implementing Social Risk Screening and Referral-making

Introduction

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

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

Overview

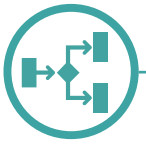
This guide uses a five-step roadmap for implementing or improving social risk screening and related activities at your clinic. It provides tools and materials to support each step, and a list of useful resources.

Step 1: Getting Ready

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

Step 2: Identify Clinic Goals

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



Step 3: Create a Social Risk Plan

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

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

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

Step 5: Roll Out and Iterate

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

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

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

GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 1: GETTING READY

Created by teams at Kaiser Permanente Center for Health Research and OCHIN, 2021

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

The Step 1 materials will help you complete these tasks.

Step 1, Task 1: Get Leadership Buy-in

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

What are social risks?

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

- Social risks are the conditions in which people live and work. They profoundly impact health risks and outcomes, and the ability to act on care recommendations. It is estimated that *social risks account for about 80% of health outcomes* (40% socioeconomic factors, 30% health behaviors, 10% physical environment); only 20% of health outcomes are attributed to clinical care (McGinnis, 2002).

- Examples of social risks that impact health include: housing stability, food security, transportation access, childcare access, ability to pay for utilities, stress, social isolation, etc.

Why should we collect information on patients' social risk?

- Social risk information gives care teams a more complete picture of the factors impacting their patients' health, helping them to:
    - Identify and make needed community referrals for a given patient
    - Inform and adjust care plans as needed
    - Conduct targeted social risk-related outreach; provide focused support / assistance
    - Conduct patient-provider conversations about barriers to health
    - Boost staff morale by encouraging high-quality interactions with patients
    - Capture previously unknown information

> "...the SDH questionnaire opens up tremendous dialogue on several levels and I absolutely love it."
>
> *– CHC provider*

- Panel-level social risk data can also be used to:
    - Demonstrate CHCs' value in serving vulnerable populations
    - Direct resources toward specific patients or areas of clinic focus
    - Meet or improve reimbursement requirements for value-based care initiatives and metrics for quality performance efforts

- Addressing social risks may reduce costs: In a 2018 study, managed care patients whose social needs were addressed (through a clinic-led referral program) had annual care costs that were $2,443 (10%) less than those whose needs were not met (Pruitt, 2018).

Step 1, Task 1: Get Leadership Buy-in

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

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

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

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

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

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

Step 1, Task 1: Draft Email from Leadership

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

Dear **(Clinic Name)** Staff –

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

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

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

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

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

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

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

Sincerely,

(Leadership Name with signature)

Step 1, Task 2: Identify and Prepare a Champion

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

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

Social Risk Project Champion tasks include:

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

Social Risk Clinician Champion tasks include:

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

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

Step 1, Task 2: Identify and Prepare a Champion

Champion Responsibilities at Each Implementation Step

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

Step 1. Getting Ready (clinic leadership activities) ☐

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

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

Step 2. Identify Clinic Goals ☐

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

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

Step 3. Create a Social Risk Plan ☐

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

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

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

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

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

Step 5. Roll Out and Iterate ☐

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

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

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STEP 2: IDENTIFY CLINIC GOALS

Created by teams at Kaiser Permanente Center for Health Research and OCHIN, 2021

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	☐

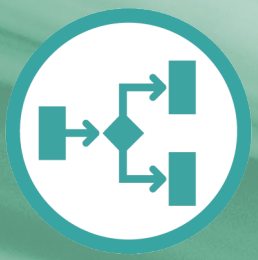
Why did you make these choices:

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

GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 3: CREATE A SOCIAL RISK PLAN



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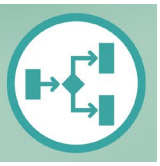
Step 3: Create a Social Risk Plan

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

Using your EHR to Support Social Risk Screening and Referrals



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

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

Task 1: Developing Your Workflow

a. Tips for Social Risk Screening Workflows

Q. What is a workflow?

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

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

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

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

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

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

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

b. Tips for Reviewing and Acting on Social Risk Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. How to Create a Community Social Service Resource List

Option 1:

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

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

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

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

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

Option 2:

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

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

Disadvantages: Must be updated regularly.

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

Option 3:

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

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

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

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

e. Social Risk Screening and Data Collection Workflow Planning Tool

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

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

Task 2: Developing a Social Risk Rollout Plan

a. Considerations for Rolling Out Your Workflow

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

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

Example 1 – Red Clinic:

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

Example 2 – Blue Clinic:

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

Example 3 – Yellow Clinic:

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

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

Task 2: Developing a Social Risk Rollout Plan

c. Social Risk Workflow Rollout Planning Tool

See the Excel Workbook, "Social Risk Workflow Rollout Planning Tool" to start developing your rollout plan.

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

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

GUIDE TO SOCIAL RISK SCREENING
AND REFERRAL-MAKING

STEP 4: ORIENT CLINIC STAFF TO YOUR CLINIC'S SOCIAL RISK PLAN

Created by teams at Kaiser Permanente Center for Health Research and OCHIN, 2021

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

Your next step is to let your clinic staff know about your Social Risk Plan, including intended workflows and how they will be rolled out, and how you will use EHR tools for social risk screening. This guide will help clinic leaders and Social Risk Champions conduct this training. It includes training slides that you can adapt for your clinic.

Step 4: FAQ for Orienting Staff to Screening & Making Referrals on Social Risk Plan, based on Other CHCs' Experiences

Q: Why collect social risk data if we can't refer patients to resources to address a given need?

- Social risks impact health, and may be considered in care decisions.
- Systematic social risk screening can provide new information about patients, and inform care planning.
- Social risk data can be used to assess needs in your community, and help clinic leaders advocate for resources, develop community partnerships, and target investments.
- Some clinics can use social risk data to adjust payment rates. Others link social risk data to reporting requirements.

Q: Which social risks should we screen for? Do we have to ask the whole questionnaire?

- There is no single or "right" way to do this; your clinic can choose which measures you want to screen for. The Step 2 documents walk you through your options.

Q: Do we need to ask the questions exactly as written?

- No. It is OK to customize the wording if that seems appropriate, or to weave the questions into a general conversation.

Q: How can staff avoid upsetting patients when we ask these potentially sensitive questions?

- Other clinics report that patients are rarely upset by social risk screening, and often appreciate being asked.
- Administer the questionnaire in a private area, if possible.
- Let the patient know that screening is universal (e.g., "We are asking all new patients these questions").
- Explain why social risk questions are being asked (e.g., "So we can connect you with resources"), and how it will be used.
- Consider sharing a PowerPoint presentation about social risk screening on your waiting room TV screen.

Q: How might social risk screening affect staff, or staff relationships with their patients?

- Some clinics say that social risk questions open the door to in-depth discussions about the patient's needs. This can help staff feel engaged, and support patient-centered care. (However, some staff may be upset by the amount of reported need, or if they cannot provide immediate help).
- Sometimes hearing about patients' social risks can be upsetting. Remind those conducting the screening to take care of themselves, and give them space to rest, take a break, or access counseling as needed.

Q: What do clinic staff need to know to support the adoption of social risk screening and related activities?

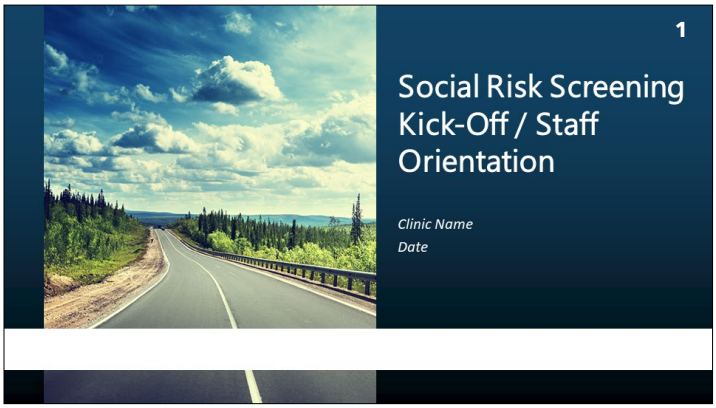
- Ensure that staff are comfortable asking the social risk questions.
- Ensure that staff know how to enter the social risk data in the EHR.
- Ensure that staff know how to follow up on positive social risk screening results - how to: acknowledge need, hand the patient off to a staff person who can help, make internal or external referrals, and / or give information about community resources.
- It is normal for staff to have many pre-implementation concerns about social risk screening / referral activities. Most of those concerns diminish with program participation.

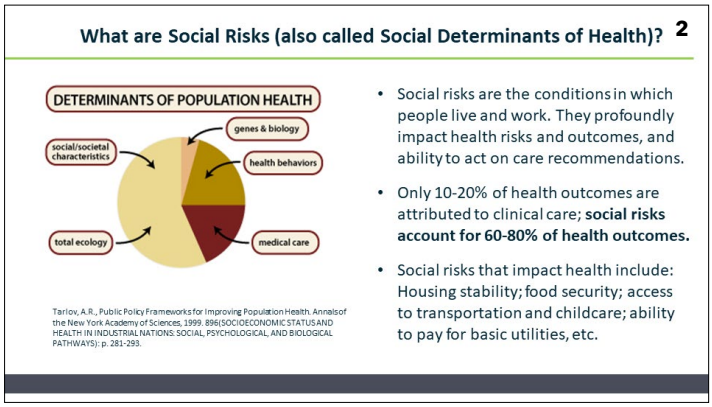
Tip: Use the social risk question about stress as an ice breaker.

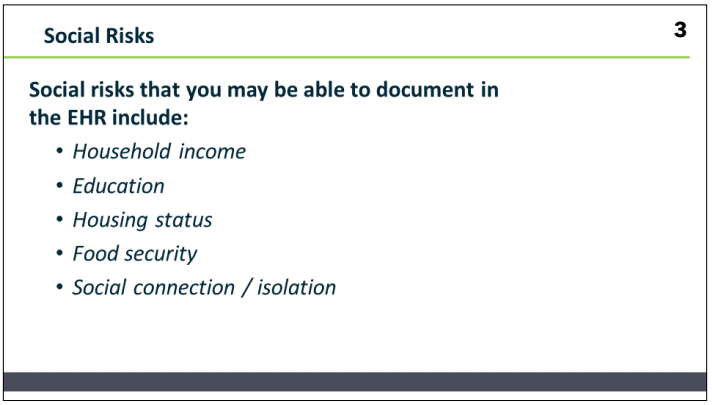
Tip: Conduct social risk screening in a way that supports relationship-building. See: Principles for Patient-Centered Approaches to Social Determinants of Health Screening.

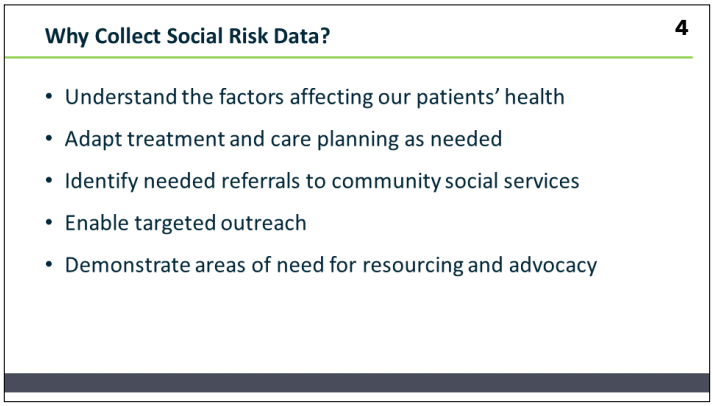
Step 4: Orientation Slide Deck

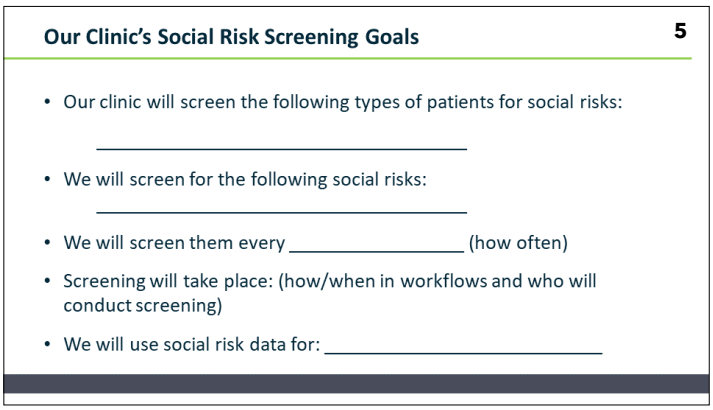
You can use this slide deck at an upcoming staff meeting to train your staff on social risk screening and referrals. Start by reviewing social risks, why your clinic is collecting social risk data and how the data will be used, and your clinic screening goals.

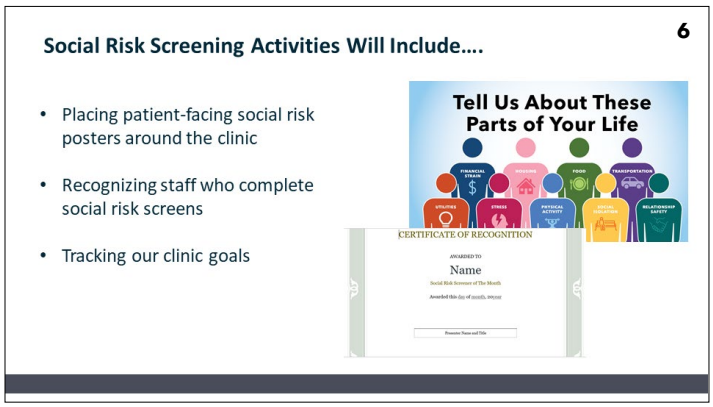












Step 4: Orientation Slide Deck

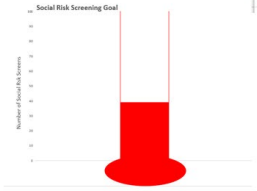
To Track Our Clinic Goals…

7

….we can use the Goals Thermometer

Goal (Total Number of Social Risk Screens)	100
Number of Social Risk Screens So Far	39

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Number of Social Risk Screens	5	4	4	6	5	7	8



DISCUSSION

8

What are potential barriers to adopting social risk data collection 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*

9

Step 4: Kick-Off Package

a. Tips for Engaging your Staff in Social Risk Screening and Referral-Making

When you're getting started with social risk screening / referrals:

Only you know how best to engage your staff, but these tips can help!

1. Bring in staff **early** in the process of planning your social risk screening / referral-making efforts!
2. Use the email template from Step 1 to inform staff of your social risk screening and referral-making efforts.
3. Have a **kick-off event** (in-person or virtually) as part of an existing all-staff meeting! At this meeting, you could:
    - Talk about why social risk screening is important for your patients, and how your clinic will use social risk data. To start that discussion, you could:
        - Use the Step 4 slide deck.
        - If in-person, write reasons why social risk screening is important on a whiteboard; ask staff to brainstorm other reasons, then write a star by reasons they find most relevant for your clinic. If meeting virtually, present reasons on a PowerPoint slide; ask staff to chat in reasons.
        - Show one of the **videos** listed on the next page.
        - Ask staff to talk about their experiences with patients' social risk needs. If they have concerns about social risk screening, discuss how to address them. Click here for tips on how to conduct social risk screening.
        - Ask for **volunteers** to help figure out your clinic's social risk-related **workflows** (at a follow-up meeting).

Once your social risk screening / referral efforts have begun:

1. Share monthly data on your screening rates – and the responses to those screenings – with your staff.
    - Show them at staff meetings, through emails, via webinar platforms, or by posting them in a central place.
2. **Recognize** the team or staff person who is doing the most screening!
    - Create a 'Social risk Screener of the Month' certificate and present it in a frame.
    - Ask these champions to share their tips for success with the whole clinic, at staff meetings.
3. Track your progress and celebrate successes! That could take the form of:
    - A **thermometer** on paper that you fill in every week to show progress towards your screening goal.
    - Weekly **huddles** to look at your screening rates for the last week, and to have staff share stories about social risk screening challenges and successes.
    - A **prize** to the team that does the most screening every month.

Step 4: Kick-Off Package

Below are resources that might be helpful when engaging your staff!

Videos on Social Risks

Health Leads

https://www.ted.com/talks/rebecca_onie_what_if_our_health_care_system_kept_us_healthy?language=en

https://www.youtube.com/watch?v=qykD-2AXKIU

Patient Facing Videos on Social Risks

https://www.youtube.com/watch?v=1iSuZngvCpY

https://www.youtube.com/playlist?list=PLpSTG5tnkLBWxj90NbpCFGqVSsXxMwFzA

Empathic enquiry—an approach to social needs screening

https://www.orpca.org/initiatives/empathic-inquiry

Tips from the National Association of Community Health Centers

PRAPARE Implementation and Action Toolkit. Available at:

http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Full-Toolkit.pdf

Step 4: Kick-Off Package

** HIGHLIGHTS FROM THE PRAPARE TOOLKIT MODIFIED FOR THIS GUIDE**

Why are we asking patients about their socioeconomic situation?

Emphasize: Collecting social risk data will help your clinic better understand your patients and their needs, to provide better care.

Explain: How social risk activities align with other work your organization is already doing (care management, enabling services, etc.).

Emphasize: This information will inform care, services, and community partnerships to improve your patients' health.

What if we do not have resources to address patients' needs?

Explain to your staff that you have to start somewhere; data collection is that first step.

Collecting social risk data will help you know which services you can provide in-house, and which community organizations you should partner with to provide needed services.

Example Message for the Patient:

" We would like to ask you some non-medical questions to better understand you as a person and any needs you may have. We want to make sure we provide the best care and services possible to meet your needs. This information will help us determine if we need to add new services or programs to better care for you.

This information will be kept private and secure. Only clinic staff will have access to this information. Your decision to answer or to refuse to answer will NOT impact your ability to receive care. This information can help us determine if you are eligible for benefits, programs, or services."

b. Social Risk Screening and Referral-Making Kick-Off Agenda

Consider using this agenda when introducing social risk screening and referral-making to your staff. You can find the agenda here.

Location:	Address or Room Number or Webinar Link
Date:	Date
Time:	Time
Facilitator:	Name(s)

Suggested Time	Topic	[Lead]
10 min	Why is social risk screening important for our patients?	[Lead]
20 min	Review step 4 slide deck	[Lead]
15 min	Clinic goals for social risk screening	[Lead]
15 min	Brainstorm workflows	[Lead]

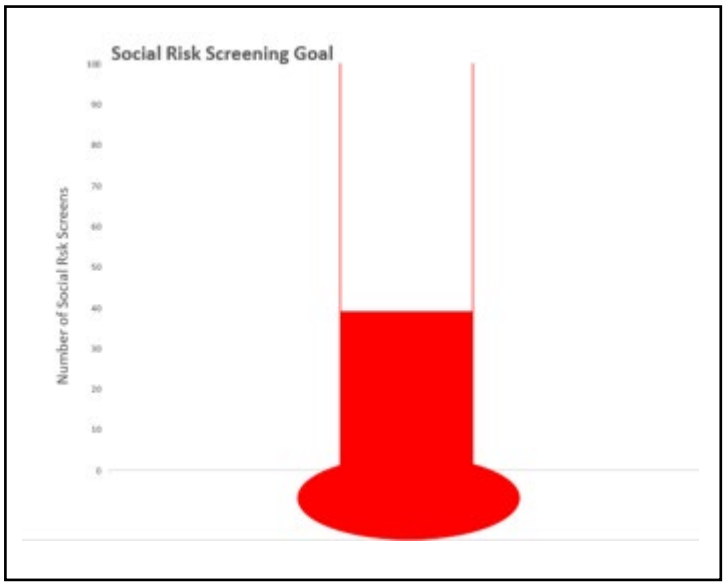
Additional information

Add additional instructions or comments here.

c. Goals Thermometer

Use the goals thermometer to track your clinic's social risk screening success.

You can find the goals thermometer here.



Goal (Total Number of Social Risk Screens)	100						
Number of Social Risk Screens So Far	39						
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Number of Social Risk Screens	5	4	4	6	5	7	8

The following printable items are on the next few pages:

d. Certificate of Recognition

This can be used to recognize the team or staff person who is doing the most screening. You can also find the Certificate of Recognition here.

e. Social Risk Screening Poster

Print and place this around your clinic to encourage social risk screening. Included are two slides—one has a plain white background and the other is in blue gradient. Depending on the circumstances, one might print better than the other. Also provided are an English and Spanish version of the poster. You can find a PowerPoint version of the poster here and a PDF version here.

Tip: Add your clinic logo to the certificate of recognition and social risk screening to personalize these materials!

Congratulations! You are ready to move on to Step 5: Roll Out and Iterate

CERTIFICATE OF RECOGNITION

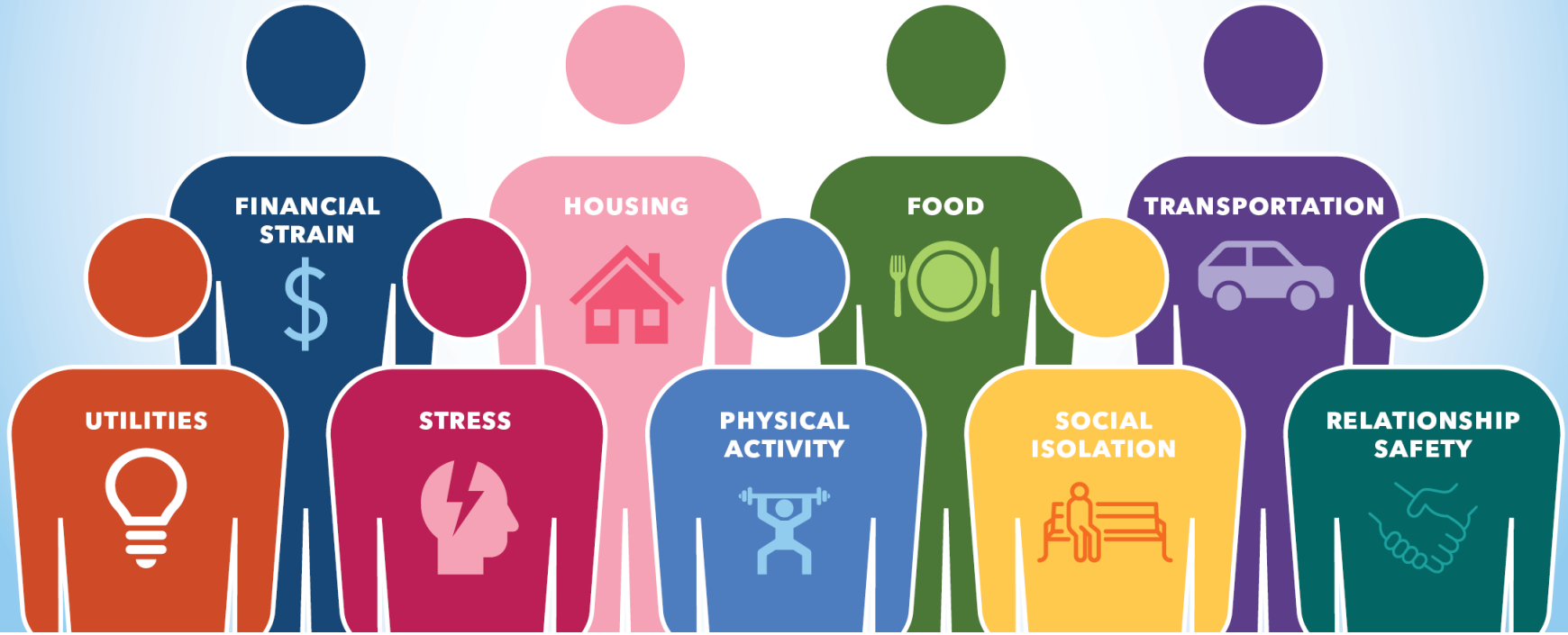
AWARDED TO

SOCIAL RISK SCREENER OF THE MONTH

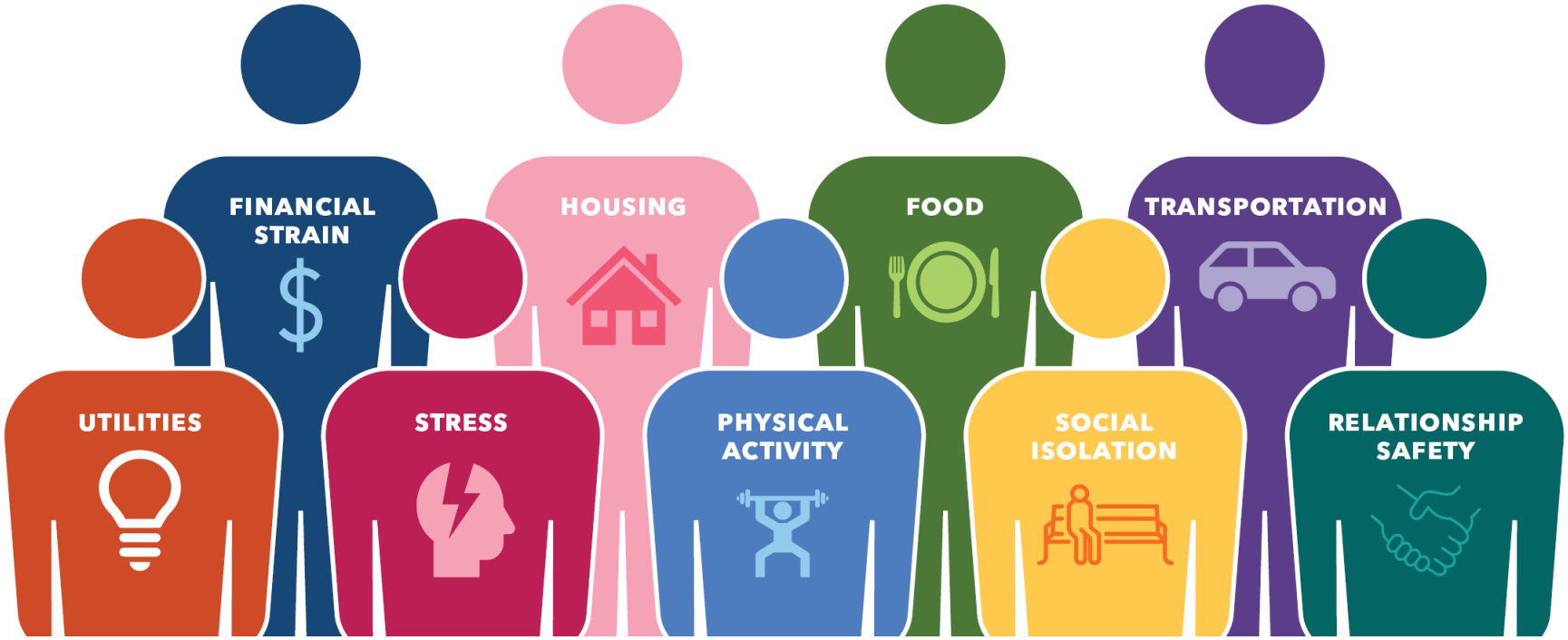
Awarded this day,

Presenter name and Title

Tell Us About These Parts of Your Life



Tell Us About These Parts of Your Life



Cuéntenos sobre estas partes de su vida

Cuéntenos sobre estas partes de su vida

GUIDE TO SOCIAL RISK SCREENING AND REFERRAL-MAKING

STEP 5: ROLL OUT AND ITERATE

Created by teams at Kaiser Permanente Center for Health Research and OCHIN, 2021

Step 5: Roll Out and Iterate your Social Risk Plan

Your final step is to implement your Social Risk Plan, and revise it as needed using a PDSA cycle.

This guide will help your Social Risk Project Champions in these tasks.

Step 5: Plan, Do, Study, Act (PDSA) Cycle Steps and Considerations

What is a Plan, Do, Study, Act (PDSA) Cycle?

PDSA cycles are a way to test changes in your clinic by planning, doing, observing results, and acting on what is learned. Below are steps and considerations when creating your PDSA cycle.

	Steps	Considerations
Plan	• Define cycle's **Objective**: Collect Data / Develop Change; Test a Change; Implement a Change • Define specific **Questions** to be answered in this cycle • Try to **Predict** the answer to these questions, noting the basis for the prediction • Define an **Action Plan** to answer: What (actions), Who, Where, When, How • Create detailed **Data Collection and Analysis plan**	• Are data available to answer the questions, or is new data needed? • Does the team agree on the predictions? • How will the data be collected and analyzed? • Who will collect and analyze the data? Is training needed for this person? • Is the plan consistent with the project charter? • Can the plan be tested on a small scale? • Will people outside the team be impacted by this plan? • Has a change management plan been considered?
Do	• Carry out the plan • Capture observations in carrying out the plan, especially if unexpected • Begin analysis of data	• What happened that you did not anticipate? Did anything go wrong? • Were there any events that affected the data you collected?
Study	• **Analyze** the data and observations • Compare data with **predictions** • Summarize **what was learned** (new knowledge) in this cycle • Develop / update graphical tools; include in PDSA cycle document	• Do results of the cycle agree with your predictions? • Under what conditions might the cycle's conclusions differ? • What are implications of the unplanned observations? • Do the data / observations answer the questions posed? • Are charts, graphs or diagrams annotated with what was changed / learned? • Can learnings be applied in other areas?
Act	• List changes that can be made to the process • Define the **objective** for the next cycle	• What is the next cycle objective, based on learning from this cycle? • Are you ready to develop possible changes? • Are we ready to test a change? • Are we ready to implement a change? • Do we need more data?

Step 5: PDSA Cycle Worksheet

Use this PDSA social risk example as a guide to help you develop PDSAs for social risk screening and data collection workflows in your clinic. Improvement and PDSAs are ongoing, as you apply what you learn from each cycle. Here is an example of a social risk implementation PDSA cycle.

PDSA Cycle Name and Brief Description		
Test time required to screen and document social risk data **Cycle description:** Data collection for documentation time of social risk screening	**Start Date:** 9/1/18	**End Date:** 9/8/18
Objective of Cycle: Test efficiency of MA social risk screening and documentation	**Cycle #:** 1	**Cycle Owner:** RN Care Manager

PLAN: Identify questions. Predict results. Determine data to be collected and by whom.			
Questions:	**Predictions:**	**Data to be collected:**	**Who collects data? How long will they collect data?**
How long will it take to enter screening results into the workflow?	Entering screening results into flow sheet will take 8 minutes.	1. Time needed to screen patients with X questions. 2. Time needed to enter screening results into flowsheet.	1. MA will keep track of time it takes to ask and enter screening results in Epic. 2. MA will track time points for one week.

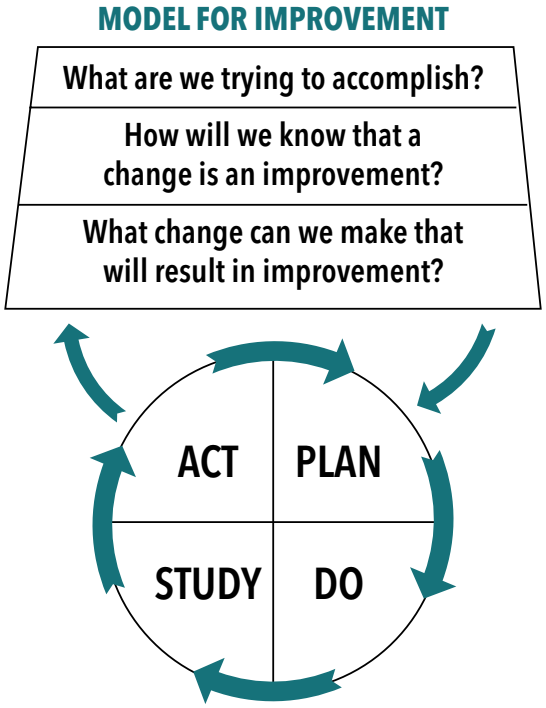
DO: Carry out the change or activity, collect the data. Document what happened (+/-).
Results: Entering screening results into Epic took an average of 2 minutes per screening.

STUDY: Summarize what you learned; identify any new questions / issues; compare with predictions; compare results across teams / MAs.		
Learnings: Entering screening results into social risk flowsheet did not take as long as predicted. Some patients did not want assistance, despite reported social risk difficulties.	**Results:** No significant time burden to enter screening results into Epic flowsheet.	**New Issues or Questions:** We need to track patients who decline assistance, so someone can check in at their next visit. We need to update our list of external resources.

ACT: Determine next steps based on what you learned in this cycle. Choose whether to test under different conditions (e.g., different day of the week) to confirm or disprove improvements.		
Actions: Continue entering social risk screening results into Epic. Update our list of external resources.	**Next Cycle:** Track the number of patients identifying social risk needs yet declining assistance.	**Who will be involved:** CHWs, BH providers, medical assistants, patients?

Step 5: Additional PDSA Tips

- To get input from various points in the process that is valuable to improvements/learnings, always complete the Study Step with all members involved in social risk data collection.
- Assign a PDSA Cycle Lead to coordinate the cycle.
- Consider completing PDSA to coincide with team meetings (e.g., team meetings occur every Monday, run a PDSA cycle from Monday to Monday).
- Move to testing changes when you have good theories and changes to test.
- Test on a small scale to maximize learning and reduce risk.
- Implementation plans should consider a change management plan to ensure control in schedules, scope, communication, and resources and minimize the impact of the change.
- Document only enough to ensure there is a well-defined plan, observations and data are collected and analyzed, and learning is captured.
- The Act step becomes the beginning of the Plan step on the next cycle.



Associates in process improvement - home. API. http://www.apiweb.org/. Accessed September 15, 2021.

Step 5: PDSA Cycle Form

Use this template to create a PDSA cycle for your social risk screening activities.

PDSA Cycle Name	**Start Date:**	**End Date:**
Brief Description	**Cycle #:**	**Cycle Owner**
Objective of Cycle: ☐ Collect Data / Develop Change ☐ Test a Change ☐ Implement a Change		

PLAN: Identify questions. Predict the results. Determine data to be collected and by whom.	
Questions	**Predictions**
Data to be Collected	**Assignments**
DO: Carry out the change or activity and collect the data. Document what happened (+/-)	
STUDY: Summarize what you learned. Identify any new questions/issues. Compare data with predictions.	
Learnings:	
Results:	**New Issues or Questions:**
ACT: Determine next steps from what you learned.	
Next Cycle:	**Ad Hoc Members:**

Step 5: PDSA Cycle Tracker

Use this template to track your PDSA cycles.

Improvement Project Name:

Aim Statement:

Cycle #	Cycle Name	Cycle Owner	Start Date	End Date	Questions	Predictions	Results
1							
2							
3							
4							
5							
6							
7							

Congratulations!!!

You completed Steps 1-5 of implementing social risk screening and referral-making!

Resources to Support Implementing Social Risk Data Collection

Implementing social risk screening

- A guide to implementing the PRAPARE Screening Tool (developed by the National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, and Oregon Primary Care Association): https://www.nachc.org/research-and-data/prapare/toolkit/
- Another guide to social risk activities implementation: AAPCHO. Enabling Services Data Collection Implementation Packet. 2018. https://aapcho.org/enabling-services-data-collection-implementation-packet/
- A tool to help primary care practices screen and refer patients for social needs: Gerteis J, Booker C. "Identifying and Addressing Social Needs in Primary Care Settings." Agency for Healthcare Research and Quality. 2021. https://www.ahrq.gov/evidencenow/tools/social-needs-tool.html
- A comprehensive set of resources and tools for implementing social risk screening: Oregon Primary Care Association (OPCA). Social Determinants of Health (SDH) - Tools & Resources: Social Needs Resources & Tools. See Programs and Services tab: https://orpca.org/initiatives/social-determinants-of-health/social-needs-resources
- Another guide to implementing social risk screening: Center for Health Care Strategies. Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. 2017. https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf
- Why healthcare entities should document social risks: Institute of Medicine. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: The National Academies Press; 2014. https://www.nap.edu/catalog/18951/capturing-social-and-behavioral-domains-and-measures-in-electronic-health-records
- Barriers and facilitators to implementing social risk screening; see Chapter 6: https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health

Social risk screening tools

- Compare existing tools: https://sirenetwork.ucsf.edu/social-needs-screening-tool-comparison-table
- The PRAPARE Screening Tool (translated into 26 languages): https://www.nachc.org/research-and-data/prapare/about-the-prapare- assessment-tool/
- Health Leads Screening Toolkit: https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/
- The Accountable Health Communities tool:
  - Billioux A, et al. Standardized Screening for Health-Related Social Needs in Clinical Settings. The Accountable Health Communities Screening Tool (Discussion Paper). National Academy of Medicine Perspectives; 2017: https://nam.edu/wpcontent/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf
  - Centers for Medicare & Medicaid Services. Accountable Health Communities Model. https://innovation.cms.gov/innovation-models/ahcm
- The EveryONE project toolkit on health equity in family medicine: American Academy of Family Physicians. The EveryONE Project Screening Tools and Resources to Advance Health Equity. Toolkit (aafp.org)

Resources to Support Implementing Social Risk Data Collection

Tools that promote empathic communication when screening for social risk

- Empathic Inquiry, a conversational approach to social needs screening, Oregon Primary Care Association: https://www.orpca.org/initiatives/empathic-inquiry
- Webinar: Empathic Communication In Virtual Practice, Center for Care Innovations. 2020: https://www.careinnovations.org/ resources/webinar-empathic-communication-in-virtual-practice/
- Collaborative Screening, a person-centered approach to asking about people's lives: https://arielsinger.com/collaborative-screening

Making social risk referrals and other interventions

- Whether and how to partner with a social service resource locator: Community Resource Referral Platforms: A Guide for Health Care Organizations | SIREN (ucsf.edu)
- Research on effective health care assistance interventions: Gottlieb LM, et al. A Systematic Review of Interventions on Patients' Social and Economic Needs. Am J Prev Med. 2017;53(5):719-729 A Systematic Review of Interventions on Patients' Social and Economic Needs - ClinicalKey

Paying for social risk screening

- Making the financial case for social risk screening: Pruitt Z, et al. Expenditure Reductions Associated with a Social Service Referral Program. Popul Health Manag. 2018. https://www.liebertpub.com/doi/abs/10.1089/pop.2017.0199
- How to document social risk screening: https://sirenetwork.ucsf.edu/tools-resources/resources/compendium-medical-terminology-codes-social-risk-factors
- Accounting for social risk factors in payment models:
  - National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: The National Academies Press; 2016. https://www.nap.edu/catalog/21858/ accounting-for-social-risk-factors-in-medicare-payment-identifying-social
  - "Health Equity and Value-Based Payment Systems: Moving Beyond Social Risk Adjustment," Health Affairs Blog, July 28, 2021. DOI: 10.1377/hblog20210726.546811. https://www.healthaffairs.org/do/10.1377/hblog20210726.546811/
  - Adjusting Quality Measures for Social Risk Factors Can Promote Equity in Health Care. Nerenz DR, et al. Health Affairs 2021 40:4, 637-644. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01764

Coding for social risk screening

- Social Determinants of Health (SDH) ICD-10 Z Codes, Oregon Primary Care Association (OPCA): https://www.orpca.org/files/OPCA%20SDH%20ICD%2010%20Z%20codes%204.27.18.pdf
- The Gravity Project: Standardizing social risk codes in electronic health records (EHRs): https://www.hl7.org/gravity/
- Medical terminology for social risk factors: https://sirenetwork.ucsf.edu/tools-resources/resources/compendium-medical-terminology-codes-social-risk-factors

Resources to Support Implementing Social Risk Data Collection

Workflows useful in social risk screening

- Social Determinants of Health (SDH) Screening Sample Workflow: Steps for Non-Clinical Staff **Before** the Clinical Visit, Oregon Primary Care Association: OPCA SDH non-clinical-staff-before-visit.pdf (orpca.org)
- Social Determinants of Health (SDH) Screening Sample Workflow: Steps for Clinical Staff **During** the Clinical Visit, Oregon Primary Care Association: OPCA SDH non-clinical-staff-during-clinical-visit.pdf (orpca.org)
- Social Determinants of Health (SDH) Screening Sample Workflow: Steps for Non-Clinical Staff **After** the Clinical Visit, Oregon Primary Care Association: OPCA SDH non-clinic-staff-after-visit.pdf (orpca.org)
- Social Determinants of Health (SDH) Screening Sample Workflow: Steps for Using a "No Wrong Door" Approach, Oregon Primary Care Association: OPCA SDH no-wrong-door.pdf (orpca.org)
- Workflow Implementation, PRAPARE Implementation and Action Toolkit, Chapter 5: https://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt5.pdf

Social risks / social determinants of health in general

- From the World Health Organization: Social determinants of health (who.int)
- The MacArthur Research Network on Socioeconomic Status and Health: Research Network on Socioeconomic Status & Health - MacArthur Foundation (macfound.org)

Social risk screening in health care settings

- Easily searchable online resource library for research on social risk screening and interventions in health care settings: https://sirenetwork.ucsf.edu/tools/evidence-library
- How healthcare entities can incorporate social risks into clinical care: https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the- nations-health
- Kreuter MW, et al. Addressing social needs in health care settings: evidence, challenges, and opportunities for public health: https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-090419-102204