Screening for Social Needs:
Tools and Strategies to Support Implementation and Equity

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UNITE US

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Disclosure Statements

Mikayla Briare

I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation
Company: EOCCO/Moda

Kellee Rosales

I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation
Company: ORPRN/OHSU

Kaleema Murphy

I do have a relevant financial relationship with commercial interest, whose products or services relate to the content of the educational presentation.
Company: Unite Us

To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review of best evidence.

Learning Objectives

1.	Describe the components of the Social Needs Screening and Referral Incentive Measure
2.	Discuss equity considerations in relation to social needs screening implementation in a clinical or community-based setting
3.	Summarize benefits of social needs screenings and indicate top social needs among EOCCO members
4.	Discuss tips for clinical and community partners engaging in social needs screenings
5.	Speak generally about the Unite Us platform and the Connect Oregon network
6.	Summarize how Unite Us supports client screenings across the network

Presentation Roadmap

Social Needs Screening & Referral Incentive Measure

Overview of intent and components of measure

AHC Social Needs Screening Project

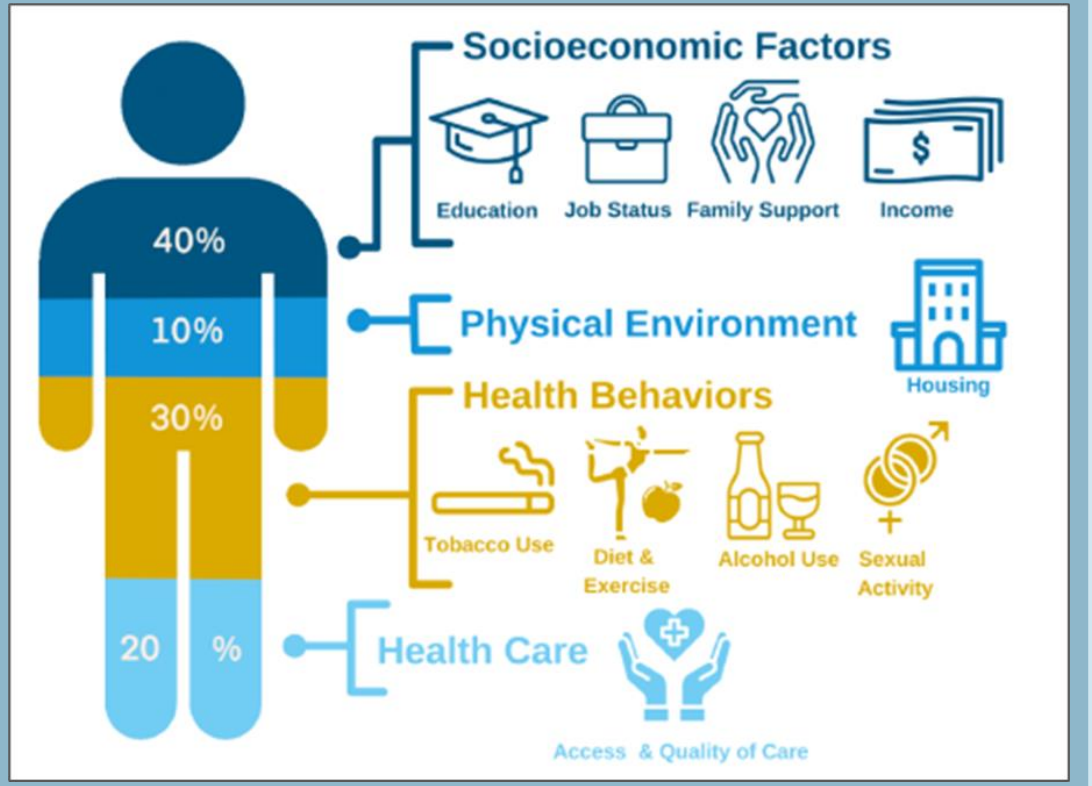
Overview of workflow and lessons learned from EOCCO/ORPRN's social needs screening project

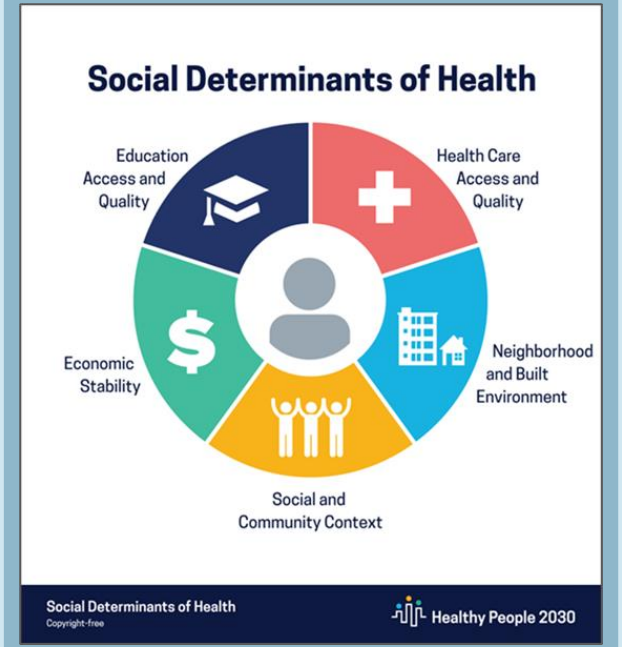
Unite US [Connect Oregon]

How Unite Us can be used to support social needs screening and referral practices

Social Needs Screening and Referral Incentive Measure

Intent and overview of measure





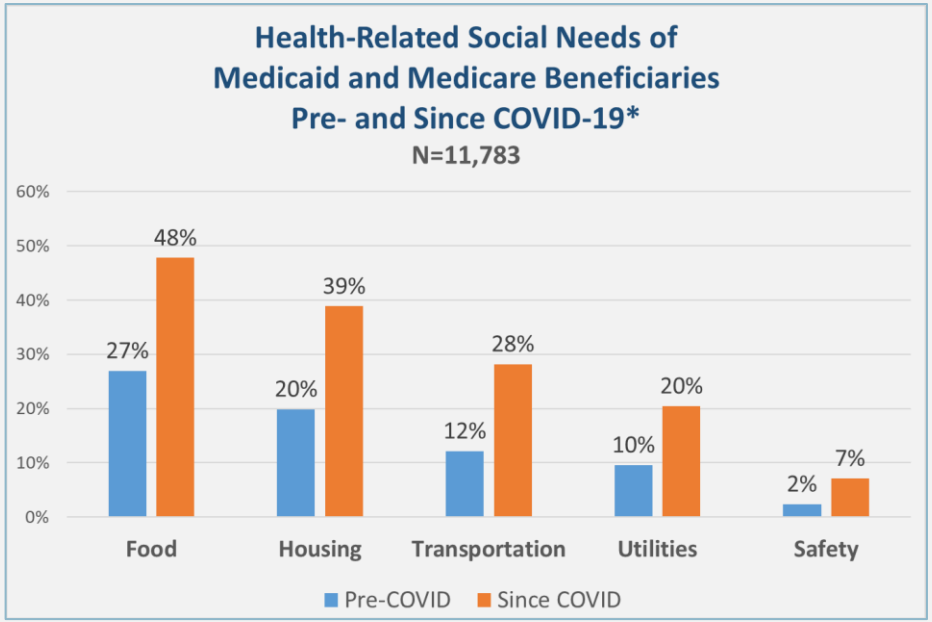
Source: https://www.uclahealth.org/sustainability/our-commitment/social-determinants-health

In 2020, **48%** of Oregon's Medicaid population had one or more social need

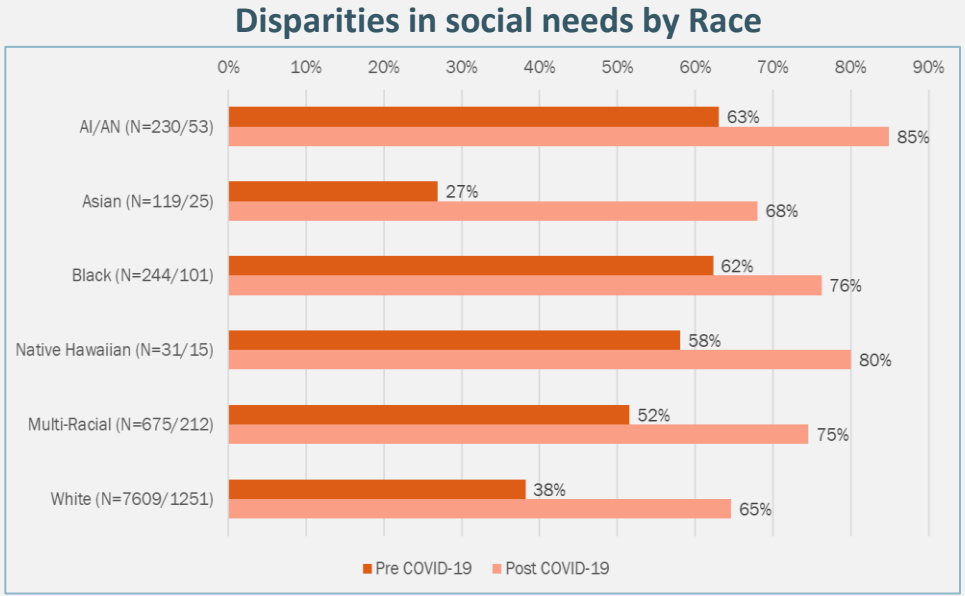
During the COVID-19 pandemic, **70%** of Oregon's Medicaid population had one or more social need

Racial/ ethnic minority populations experience disparate burden of social needs

Source: Oregon Accountable Health Communities (2020)



*12/10/18 – 3/22/20 vs. 3/23/20 – 8/20/20



Source: Anne King, MBA (OHSU/ORPRN), *Accountable Health Communities in Oregon* (2021)

Social Needs Screening & Referral Incentive Measure

1- Structural Measure (CCOs)
2023-2025

Screening Practices	Referral Practices and Resources	Data Collection and Sharing
-Develop social need screening policies and training protocols -Assess what social needs screening tools are in use -Assess where members are being screened for social needs	-Assess capacity of local resources and gap areas -Develop plan to help increase CBO capacity in CCO service area -Form agreements with CBOS that provide housing, non-medical transportation, and food services	-Conduct environmental scan of data systems used in CCO service area -Develop data systems for collecting and using REALD data -Support data-sharing among organizations within CCO service area

2- Hybrid Measure
2025-2026

Percent of EOCCO members who were screened for **housing, food, and transportation** needs at least once during the measurement year and were referred to services if needed.

Hybrid Sample: 411 EOCCO members (adult + pediatric) randomly selected by OHA

Social Needs Screening & Referral Incentive Measure Specifications:

SDOH-Metric-Expanded-Screening-Tools-3-23-23.pdf (oregon.gov)

Measure Elements

Approved Social Needs Screening Tools for Required Domains

Updated 3/23/23

	Food insecurity	Housing insecurity	Transportation
Accountable Health Communities (AHC)	✓	✓	✓
American Academy of Family Physicians (AAFP)	✓	✓	✓
Arlington	✓	✓	✓
Boston Medical Center Thrive (BMC Thrive)	✓	✓	✓
Comprehensive Universal Behavior Screen (CUBS)	*Question not recommended*	*Question not recommended*	✓
Health Begins	✓	✓	✓
Health Leads	✓	✓	✓
Housing Stability Vital Sign	*No question*	✓	*No question*
Hunger Vital Sign	✓	*No question*	*No question*
iHELP	✓	✓	*No question*
North Carolina Medicaid (NC Medicaid)	✓	✓	✓

Use of an OHA-approved Screening Tool

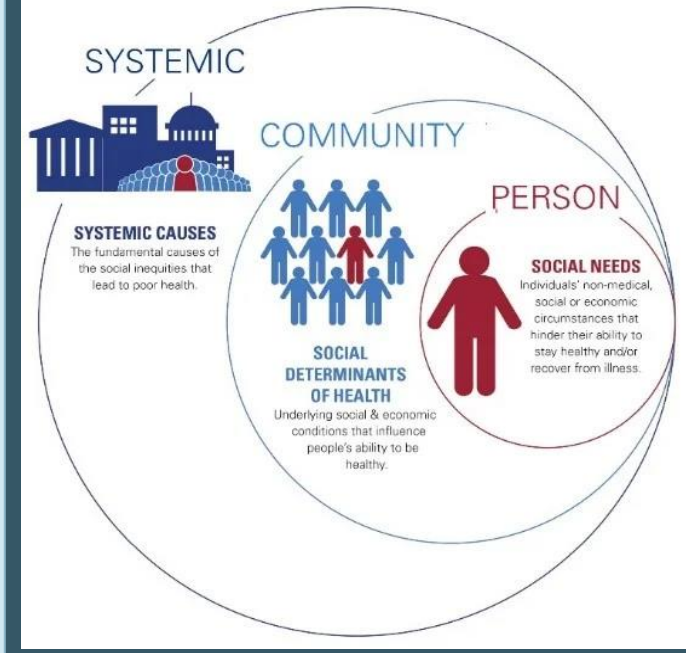
Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)	✓	✓	✓
PROMIS	*No question*	*No question*	✓
Safe Environment for Every Kid (SEEK)	✓	*No question*	*No question*
Survey of Well-being of Young Children (SWYC)	✓	*No question*	*No question*
U.S. Adult Food Security Survey	✓	*No question*	*No question*
U.S. Child Food Security Survey (Self-Administered Food Security Survey Module for Youth Ages 12 and older)	✓	*No question*	*No question*
U.S. Household Food Security Survey	✓	*No question*	*No question*
U.S. Household Food Security Survey: Six-Item Short Form	✓	*No question*	*No question*
WeCare	✓	✓	*No question*
WellRx Questionnaire	✓	✓	✓
Your Current Life Situation (YCLS)	✓	*Question not recommended*	✓

Measure Elements

Considerations:

1. Capturing and sharing social needs screening results & referral data
   a. **Code Sets**: ICD-10, SNOMED, LOINC
   b. **Data Sharing:** HIE, CIE, EHR

1. Equity
   a. **Over-screening people for social needs**
      i. Risk of causing harm, or retraumatizing individuals with a negative screening experience (repeated screening without appropriately addressing needs)
   b. **Culturally responsive screening approach**
      i. How screening is administered and by whom
      ii. Screening tools available in multiple languages
   c. **Empathetic Inquiry**
      i. Conversational, relational, approach to social needs screening



Source: American Hospital Association (2020)

HOW
- Paper form
- Online form
- Verbally

BY WHOM
- Self-administered
- CHW/THW
- Provider
- MA

AHC Social Needs Screening Project

Project workflow, stories, and lessons learned

What is the AHC Social Needs Screening Project?

Over the phone Social Needs screening looks at 5 health-related social needs:

- Food
- Housing
- Utilities
- Transportation to medical appointments
- Patient safety

AHC = *Accountable Health Communities* Screening Tool
(developed by the Center for Medicare & Medicaid Services)

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Screening Workflow

ORPRN screening team receives list of EOCCO members weekly

3 screeners on ORPRN team:

1 Spanish-speaking

Since October 2022, ORPRN has called over **5,900** EOCCO members

If member answers call*….

Ask: are they in need of community resources, and are they willing to take a survey to help connect them to resources?

YES

NO

Documented as "survey completed"

Documented as "survey declined"

- AHC screening results entered directly into Unite Us

-REALD questionnaire asked and responses documented

AHC screening and REALD data shared back with EOCCO

**all call attempts are documented in the EOCCO member call list*

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Who are we screening for social needs and HOW?

Eligibility Criteria: EOCCO members with 2+ ED visits in the past six months [pulled from Collective Medical]

- Remove members who have been included in outreach list before
- Remove members who are already enrolled in EOCCO case management
- Pull in member demographic information + assigned Primary Care Provider
- **Roughly 200 members weekly**

Screening Consent process

- ➢ Read a consent document from Unite Us to the member over the phone
- ➢ Screeners also send the consent document to the member via text, email, or mail

Referring members to community resources

1. Offer a Community Resource Packet

- Create resource packet in Unite Us
  - Automatically translated into member's preferred language
  - Can text, email, or print and mail to member
- Supplement with resources from 211info.org or Oregon Food Bank

2. Ask if member would like for a referral to be made on Unite Us to a community resource

- Inform member they will be contracted directly by CBO

How Unite Us supports referrals to meet member's social needs:

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- Based off the member's responses to the AHC screening questions, suggested referrals will come up automatically
- Unite Us makes it easy to track if members have received resources. Sometimes a member will receive resources the next day!

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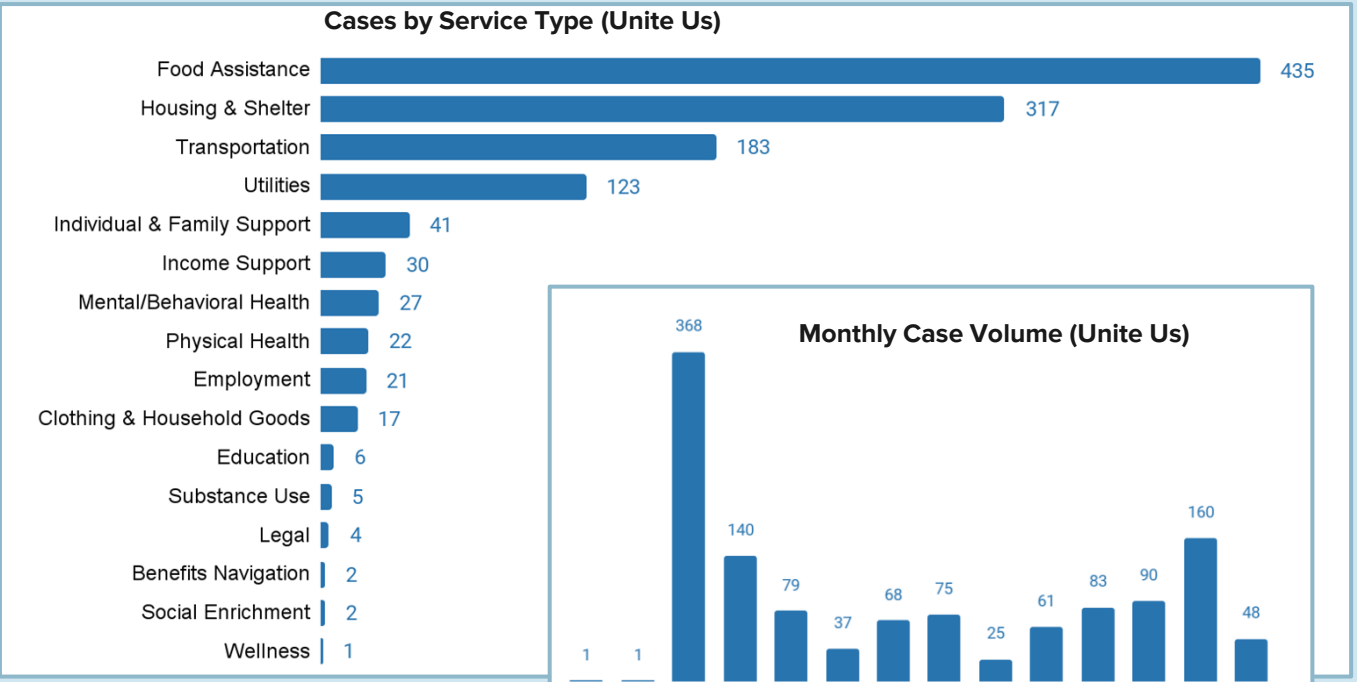
EOCCO Social Needs Data

4/12/22 - 6/30/23



Note: Includes data from EOCCO and priority providers
No data available for 4/12/22 - 4/30/22 due to launch.

Top Client Needs

35% Food Assistance

26% Housing & Shelter

15% Transportation

Client Demographics

- **21%** White
  59% Undisclosed
- **51%** Female
- **37%** Adult (18-44)

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Success Stories

What we are hearing from EOCCO members

- Member lost their health insurance after pandemic ended. He was going to wait to reapply for health insurance till after his 62nd birthday.
- Helped member with travel expenses
- Member needing feminine hygiene products
- Member out of work for 3 months
- Connecting with members who declined a social needs screening

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Lessons learned from the AHC Screening Project

Tips for clinical and community members to consider when engaging in social needs screenings

- ➔ Confidentiality
- ➔ One screening point person, or utilizing a CHW for consistent workflow

Social Need (SDoH) Screening Ideas:

QR code for member to self-administer screening

Paper form to complete at check-in

Developing call-back list if member would like to be called, texted or emailed at a later time to answer SDoH screening questions and be connected to community resources

If your clinic uses EPIC (or another EHR) adding SDoH Screening to members profile for a **1x a year reminder** to prevent over-screening

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Unite Us

Using Unite Us to support social needs screening and referral processes


CONNECT OREGON
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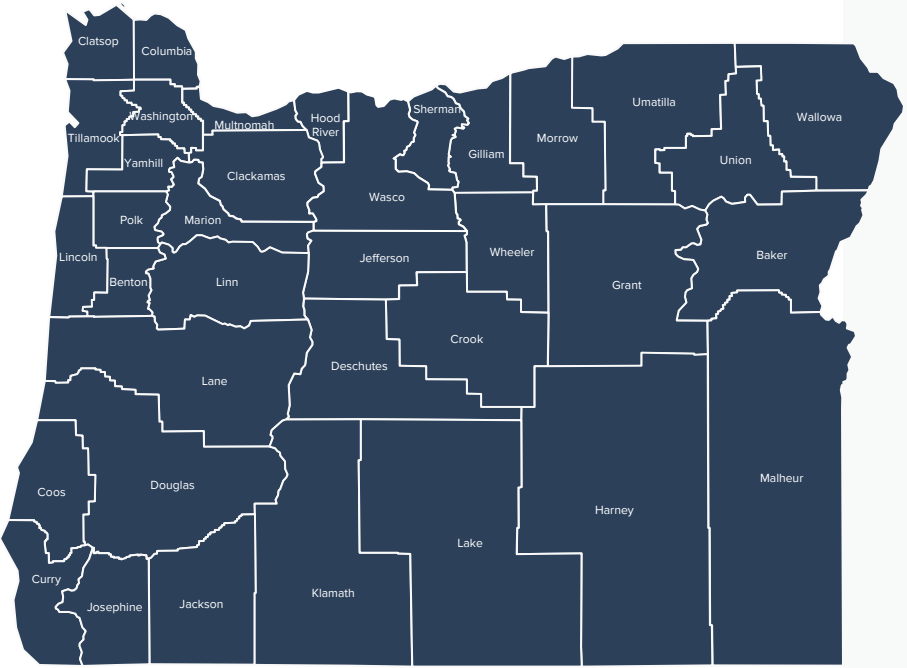
What is **Connect Oregon**?



Available in all 36 counties

Connect Oregon connects health care and social service providers to deliver integrated whole person care through **a shared technology platform. Through Unite Us, partners can:**

- Send and/or receive electronic referrals
- Securely share client information
- Track outcomes together
- Inform community-wide discussion

Connect Oregon is available Statewide and provided at **no cost** to all community-based organizations, community health centers, and healthcare providers contracted with our CCO and health system partners.

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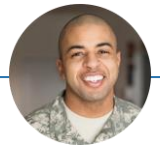
Seamlessly Integrating Screenings and Referrals **into Existing Workflows**



Entry

Donald shows up at Wallowa Memorial Hospital.

Screening

At discharge, Sue, a hospital social worker, screens Donald and identifies that he has social needs:

- Mental Health
- Individual & Family Support
- Employment

Referral

Sue uses Unite Us to **gain digital consent** and electronically refers Donald to multiple community partners.

Through the platform, Sue can securely share Donald's information and seamlessly **communicate with the other community providers** in real-time.

Resolution

Feedback

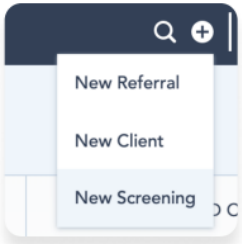
As Donald receives care, Sue receives real-time updates and tracks Donald's total health journey.

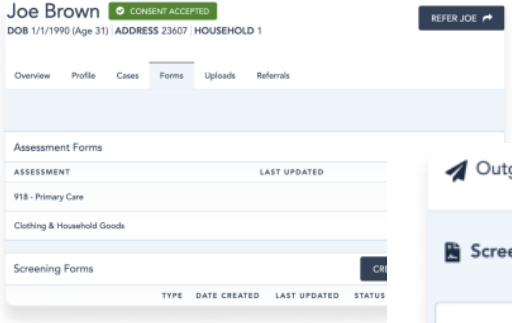
Referral status and **structured outcomes data** is delivered to Wallowa Memorial Hospital to see how needs have been met.

Unite Us Makes It Easy to Screen Patients for HRSN **Across Care Settings**

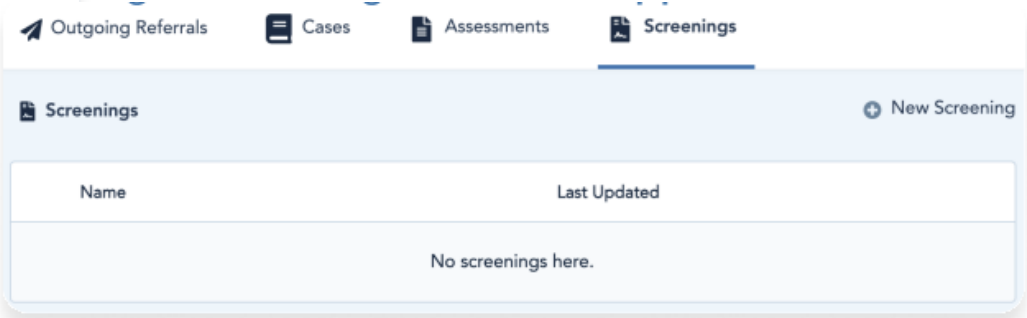
The Unite Us Platform supports custom and standard HRSN screenings for a number of health systems and hospitals. Users can initiate the screening from the web application or directly within their EMR.

Starting a screening in the **web application:**





Starting a screening in **the EMR:**



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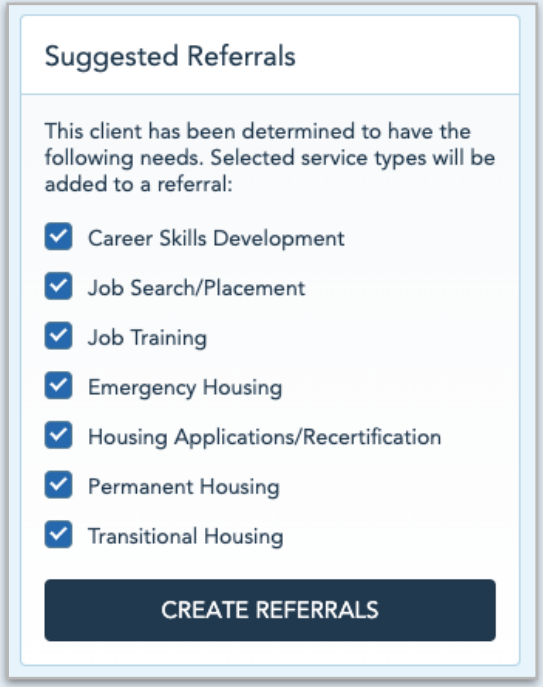
Once a Patient Is Identified as at Social Risk, **Now What?**

Unite Us Screenings: Easily Identify and Make Referrals for Social Care Needs

Our screening tools use **national core measures** to identify the risk factors and needs of community members: **You no longer have to guess which types of organizations or programs patients should be referred to.**

The Unite Us Platform will **automatically suggest a referral based on screening answers**, so you can rest assured knowing you're sending patients to organizations that are the best fit for their unique needs.



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Key Strategies to Consider

Common approaches we've seen in implementing HRSN screenings with Unite Us

Phased screening rollout: Identify specific departments or programs that would implement HRSN screening first and gather learnings that can be applied across the enterprise. This includes workflow considerations for both web application and integrated users.

Implement a single screening for HRSN assessment across the clinic organization rather than multiple, different HRSN screenings per department. This is particularly valuable for data standardization.

Many partners implement **a common, standard HRSN screening such as CMS Accountable Health Communities** across their clinic organization. This ensures screenings are time stamped and accessible to all stakeholders, avoiding duplicate engagements with clients and saving time.

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Schedule time with me here

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Visit **UniteUs.com** to learn more and request a demo.

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Thank you!

Any Questions?