
Considerations in the Development of Social Needs Screening Policies and Procedures

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure

January 30, 2022



ORPRN
*Oregon Rural Practice-Based
Research Network*



Upcoming Technical Assistance (TA) Opportunities

Webinar Series

- **OHA measure specifications**
- **Best practices** for developing screening, referral, and data sharing policies and procedures
- **Presentations from experts** in the field

For all CCO staff and community partners who may be directly or indirectly involved in implementing the Social Needs Screening and Referral Metric

Learning Collaboratives

- Identify and support **collaboration and alignment** in implementing the SDOH metric
- Next Learning Collaborative on February 13th
- **Policies and procedures developed with member input**

For one to three representatives from each CCO most directly involved in metric implementation.

Individualized Technical Assistance

- One-on-one technical assistance is available to all CCO staff responsible for metric implementation
- Support tailored to the needs of individual CCOs

Review - Measure Year 2023 Specifications

A. Screening practices	
Collaborate with CCO members on processes and policies	Must pass
Establish written policies on training	Must pass
Assess whether/where members are screened	Must pass
Establish written policies to use <u>REALD</u> data to inform appropriate screening and referrals	Must pass
Identify screening tools or screening questions in use	Must pass
Establish written protocols to prevent over-screening	Must pass
B. Referral practices and resources	
Assess capacity of referral resources and gap areas	Must pass
Enter into agreement with at least one CBO that provides services in each of the 3 domains	Must pass
C. Data collection and sharing	
Conduct environmental scan of data systems used in your service area	Must pass

Agenda for Today's Webinar on Screening Practices

- Screening measure requirements
- Currently-approved screening tools
- Screening considerations
- Qualitative findings from patient and screener perspectives
- Upcoming TA opportunities

Measure Year 2023 Specifications: Screening Practices

Screening Practices: MY(2023) Must-Pass Elements

1. Collaborate with members on processes and policies
2. Establish written policies on training
3. Assess whether/where members are screened
4. Establish written policies to use Race, Ethnicity, Language and Disability (REALD) data to inform appropriate screening and referrals
5. Identify screening tools or screening questions in use
6. Establish written protocols to prevent over-screening

Centering equity in social needs screening and referral

- Member voice informs policies and procedures
- Member privacy concerns are addressed
- Screening is provided in appropriate language, format & health literacy level
- Screening takes place in the settings where members experiencing health inequities are most likely to get care
- CCOs use data to identify, screen, refer and follow up with members experiencing the greatest inequities (REAL-D)
- CCOs form partnerships with community organizations that offer culturally-specific services
- Service provision is prioritized for members with the greatest social needs
- Prioritization of screeners that are trusted members of the communities they are screening (e.g., Community Health Workers)
- Training protocol includes cultural sensitivity, trauma-informed practices

Screening Tools – Considerations

- Tools that **yield actionable information**, both at the point of care and when data is aggregated
- Tools that are **culturally responsive**, absent of apparent equity concerns, **available in multiple languages**, appropriate for the population being screened, **trauma-informed**, and designed at a lower relative reading level
- Tools that are **already in use** in Oregon or can integrate with current electronic health records systems

Current OHA-Approved Screening Tools

Adult screening tools for selected domains	Food	Housing	Transport
American Academy of Family Physicians (AAFP)	✓	✓	✓
Accountable Health Communities (AHC)	✓	✓	✓
Arlington	✓	✓	✓
Boston Medical Center Thrive (BMC Thrive)	✓	✓	✓
Health Begins	✓	✓	✓
Health Leads	✓	✓	✓
Housing Stability Vital Sign	<i>No question</i>	✓	<i>No question</i>
Hunger Vital Sign	✓	<i>No question</i>	<i>No question</i>
North Carolina Medicaid (NC Medicaid)	✓	✓	✓
Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)	✓	✓	✓
Your Current Life Situation (YCLS)	✓	<i>Question not recommended</i>	✓
Pediatric screening tools for selected domains			
Housing Stability Vital Sign	<i>No question</i>	✓	<i>No question</i>
Hunger Vital Sign	✓	<i>No question</i>	<i>No question</i>
iHELP	✓	✓	<i>No question</i>
Survey of Well-being of Young Children (SWYC)	✓	<i>No question</i>	<i>No question</i>
WeCare	✓	✓	<i>No question</i>

Overlap with National Measures

The following tools are on both the National Committee for Quality Assurance (NCQA) Social Need Screening and Intervention (SNS-E) and Oregon's SDOH measure:

- [American Academy of Family Physicians \(AAFP\)](#)
- [Accountable Health Communities \(AHC\)](#)
- [Health Leads](#)
- [Housing Stability Vital Sign](#)
- [Hunger Vital Sign](#)
- [Protocol for responding to and assessing patients' assets, risks and experiences \(PRAPARE\)](#)
- [WeCare](#)

OHA plans on recommending additional SDOH measure screening tools for the SNS-E. OHA will also be adding tools to the SDOH measure approved list.

Additional Considerations

- Who screens
- Frequency & length of screening
- Location & mode of screening
- Patient experience

*See last slide for additional social needs screening resources

In Summary

- Social needs screening in health care is an effort to address health disparities and inequities in access to health-related social resources.
- The metric included a comprehensive community engagement process in development and this continues through implementation.
- CCOs have a glide path for implementation across three years. The first year is critical to establishing a foundation.
- The list of approved screening tools is available.

Questions?



Telephonic Screening for Health-Related Social Needs:

Perspectives of Patients and Screeners

Anna Steeves-Reece, PhD, MPH, MA (she/her)

Oregon Community Health Information Network (OCHIN)

Kate Wells, MPH, CPH (she/her)

Oregon Rural Practice-based Research Network (ORPRN)

Q&A with Katherin Gomez, BSW (she/her/ella)

Oregon Rural Practice-based Research Network (ORPRN)

Fostering Positive Patient Experiences When Screening for Social Needs

DOI: <https://www.mdpi.com/1660-4601/19/19/12668#>



SCHOOL OF
PUBLIC HEALTH

Oregon
Health
Authority

Accountable Health Communities (AHC) Model Intervention Centers for Medicare & Medicaid Services (CMS)

Eligibility: Community-dwelling Medicare and Medicaid beneficiaries accessing health care at participating clinical delivery sites.

Screening Tool:

1. Food insecurity
2. Housing instability and quality
3. Utility needs
4. Transportation needs
5. Interpersonal violence



Alley et al. (2016)
Billieux et al. (2017)

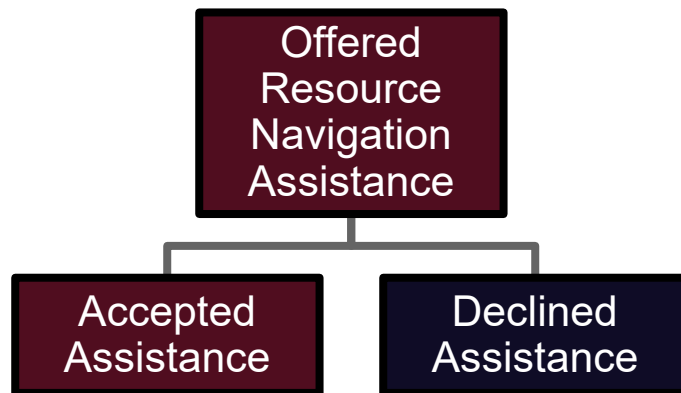
AHC Model Intervention Participants

Participants

Medicare & Medicaid Beneficiaries
Participated in the AHC Model Intervention
Qualified for Navigation Assistance
Accepted Resource Navigation Assistance

Clinical Delivery Sites

Emergency Department
Federally Qualified Health Center
Phone-based screening & referral
ED: 211 Navigators
FQHCs: FQHC Navigators



Pragmatic Qualitative Study

Interview Guide Development

Purposeful Sampling Strategy (Maximum Variation)

Recruitment, Data Collection, and Information Power

Melissa Frangie

Reflexive Thematic Analysis

Melissa Frangie, Katherin Gomez-Arboleda, Chrystal Barnes, and Minnie Kang

Participant Characteristics: Demographics (N=34)

Race and Ethnicity (Combined)*	n (%)
American Indian or Alaska Native	2 (6%)
Asian	1 (3%)
Black or African American	5 (15%)
Hispanic, Latino/a, or of Spanish Origin	10 (29%)
Native Hawaiian or Other Pacific Islander	1 (3%)
White	17 (50%)
Other	7 (21%)
No Response	3 (9%)
Spanish Language Interview	n (%)
No	29 (35%)
Yes	5 (15%)

Sex	n (%)
Female	20 (59%)
Male	14 (41%)
Age	n (%)
<20	2 (6%)
20-29	7 (21%)
30-39	3 (9%)
40-49	4 (12%)
50-59	7 (21%)
60-69	10 (29%)
>69	1 (3%)

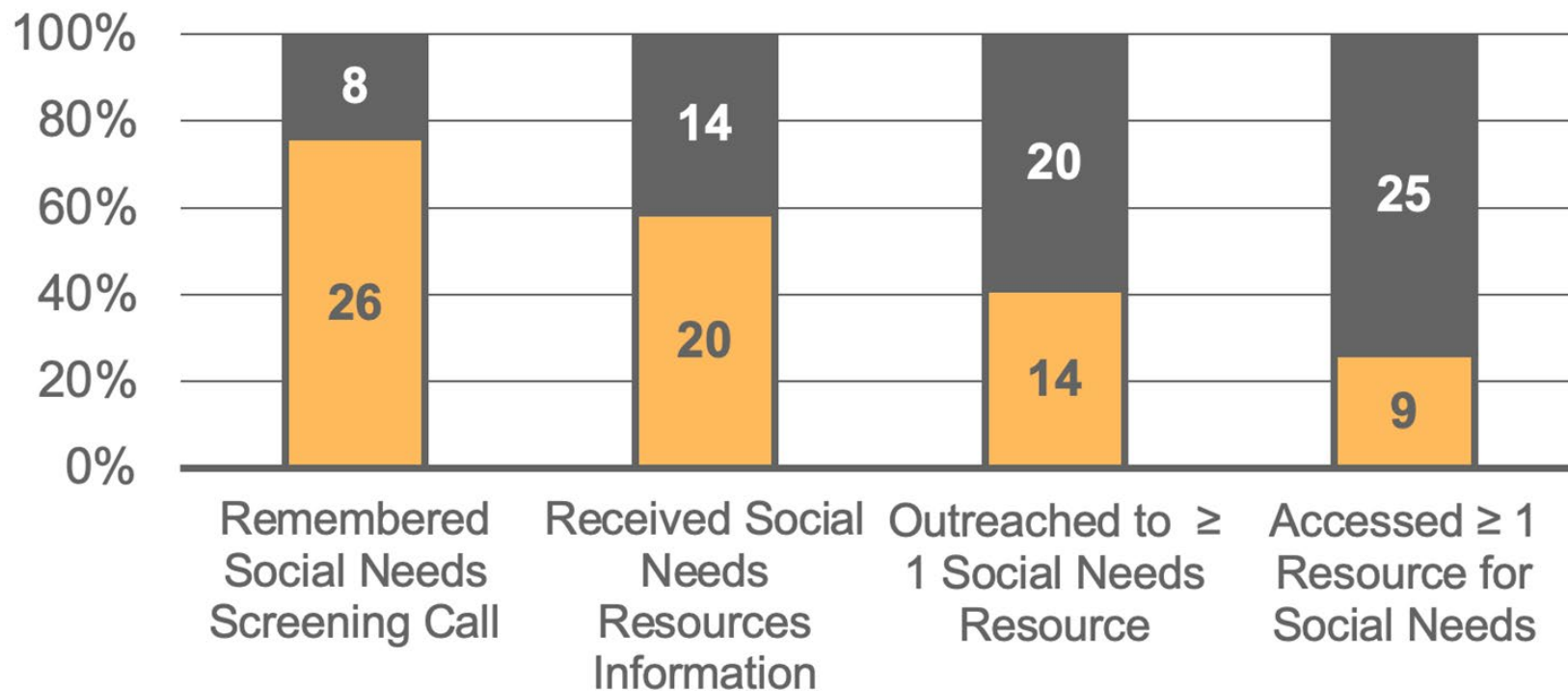
* Percentages do not add up to 100%

Participant Characteristics: Social Needs (N=34)

Types*	n (%)
Food	27 (79%)
Housing	26 (76%)
Transportation	16 (47%)
Utilities	8 (24%)
Interpersonal Safety	3 (9%)
Quantity	n (%)
1	8 (24%)
2	10 (29%)
3	12 (35%)
4	4 (12%)
5	0 (0%)

* Percentages do not add up to 100%

Participant Characteristics: Intervention Outcomes (N=34)



Theme 1 – Patients were likely to be initially skeptical and/or have reservations about the social needs questions.

“I’m very inquisitive when it comes to that ... At first [I ask], ‘Where are you calling me from? Why are you calling me?’ Not just anyone is going to be helping a person. Sometimes they just do it to grab your information.”

49-year-old female (translated from Spanish)

“With my daughter’s disability there was [Department of Human Services] involved quite a bit in our household. Maybe it would cause her more problems to admit to some of this stuff.”

66-year-old female

Theme 2 – Immediate transparency and ongoing respect for autonomy were fundamental.

“It seemed like a scam at first, but because I know [the healthcare organization] and I’ve been going there since I was like two years old, I was like, ‘No, there’s no way it’s a scam.’”

22-year-old female

“I mean, I don’t want to be hassled if I tell them that everything is good ... If I’m not in a good place, I’ll ask them. I don’t want to be pressured or hassled.”

50-year-old male

Theme 3 – Showing kindness for the patient through one’s demeanor was important.

“The tone of voice she maintained the whole time was also really helpful ... Just maintaining maybe a soft, it doesn’t always have to be soft, but just like a calming [voice] ... It’s very stereotypical, but it does work.”

19-year-old female

“She wasn’t very kind, too. Just quick and short ... The tone in her voice, it seemed like she was in a big hurry ... I had the feeling she didn’t have her morning coffee ... There was just no life and no concern, no personal interest in what she was saying.”

58-year-old female

Theme 4 – Demonstrating a genuine intention to connect patients with resources mattered.

“As long as I think it’s gonna help me and not hurt me, I’m willing to answer the question.”

52-year-old female

***Interviewer:** “Is it okay to ask [about social needs], even when help or resources cannot be guaranteed?” **Interviewee:** “It depends on the person. Look, there are times when, if they are going to help you, that’s fine! But if they are one of those people who doesn’t want to help, they will not explain it to you. **Interviewer:** “So, more like what are the intentions [of the person]?” **Interviewee:** “Yes.”*

51-year-old male (translated from Spanish)

Theme 5 – The degree of attentiveness and responsiveness to patients’ circumstances and requests impacted their experience.

“I’m just really anxious about stuff like that, especially in regards to paperwork and legal stuff, I would have been too afraid of doing it wrong.”

23-year-old female

“Well, I told him, ‘I live in [County A], so do you [have] anything in [County A]?’ But they gave me the [number for County B] ... That’s the problem ... I don’t need [County B].”

48-year-old male

Theme 6 – Patients could be left feeling appreciative or hopeful, whether they accessed resources or not.

“I was happy [to be asked the social needs screening questions] because it made me feel like things are starting to change in society ... I really felt important and like things are starting to change.”

29-year-old female (Didn't Access Resources)

“The way that my situation was handled ... [it] went above and beyond what I needed even ... Honestly, I didn't know that it was something that healthcare organizations took care of. I mean, it's more of a well-being business, you know, as opposed to just health. And that's something that I didn't realize that you guys did.”

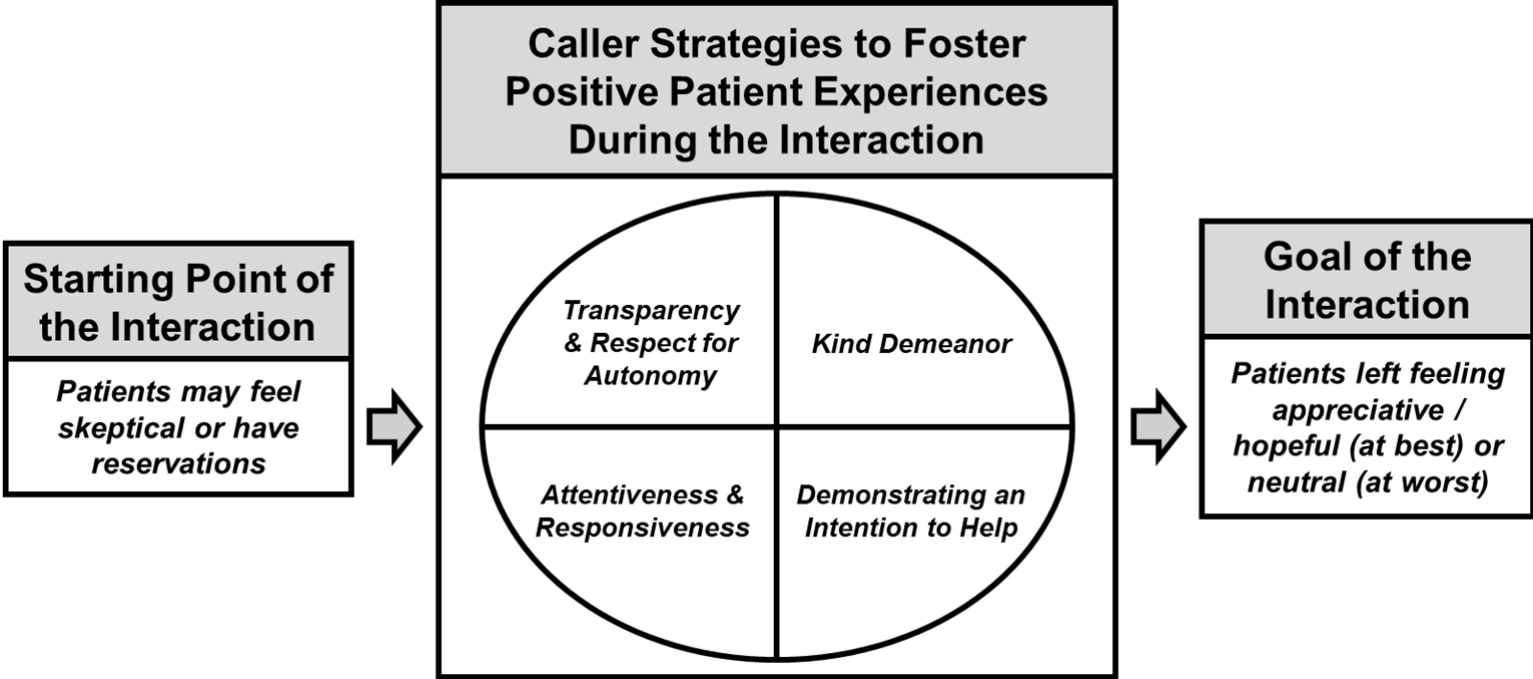
22-year-old male (Didn't Access Resources)

Theme 6 – Patients could be left feeling appreciative or hopeful, whether they accessed resources or not.

“It’s giving so much hope and kindness ... Because of COVID ... because of my heart condition and health condition ... I have to stay away from people, I don’t have the vaccine yet because of my heart and everything. So I’m not as social as I used to be. And some people, their lights go dim. And you guys are like the lighthouse on the beach, saying, ‘Here’s the light, I’m trying to shine it to you.’”

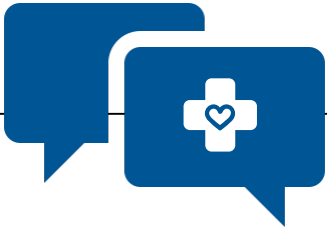
47-year-old female (Accessed Resources)

Framework for Fostering Positive Patient Experiences During Phone-based Social Needs Screening & Referral Interactions



Perspectives of Health-related Social Needs Telephonic Screeners in the Accountable Health Communities Model: Successes and Challenges

A Qualitative Study





Purpose and Research Question

Purpose

Examine principles of quality and equitable practice to inform universal HRSN screening practices.

Question

What do telephonic screeners perceive to be successful techniques and encountered barriers in the process of screening for HRSN?



Interview

Questions examined:

- Variations on time spent on screening calls
- Screeners' level of comfort asking questions
- Perceived value of the process
- Successful approaches and techniques
- Patient engagement and trust



Data and Themes

3 main themes, 10 sub-themes

Structural Considerations	Demographic Considerations	Successes and Challenges
<ul style="list-style-type: none">• Call time• Training• Screening questions• Information exchange	<ul style="list-style-type: none">• Parents/caregivers• Language and culture• Older patients	<ul style="list-style-type: none">• Patient engagement and trust• Barriers and facilitators to patient support• Recommendations



Structural Considerations

- Call times
- Training
- Screening tool
- Community Information Exchange (CIE)

“

I had calls that lasted for at least 15 to 20 minutes. And that was usually because the person had multiple issues that they needed to address.

... how to be more trauma informed, or how to approach difficult situations, or if the person's had (certain) responses then how can we address it. So I feel like within our team, we were always able to address those type of situations.

And then you can go in, see what they're eligible for. And then you send the referral off. And then they either accepted or rejected, if they accept it, then they of course, reach out. But yes, it is the direct social service themselves. And it helps.

”



Demographic Considerations

- Parents/caregivers
- Older patients
- Language/culture

“

I think just again, trying to articulate as early on as possible, you're not CPS.

Or maybe (they) had experience like scamming before and I think older generations are more nervous about it...so it was more probing into who I am and what I'm doing.

...but when you're going outside of English and Spanish, I can't be of help,...and that can be really hard. Because if they have no English, you know, I don't want to just hang up on them.

”



Successes and Challenges

- Patient engagement and trust
- Barriers + facilitators to patient support
- Screening techniques

“

...people were (generally) happy to know that healthcare was reaching out. Because most of the times they did not expect healthcare to care about their living situations.

And, sometimes people would ask me to send proof of my identity, just because, you get this random call.”“...she didn't have a whole lot of faith in our system, or in any system.

Are these people actually getting their needs met, I was only doing one part of the puzzle piece and never saw it from start to finish.

I think there was a food bank near her that she didn't know about. And so she was like, Oh, that's awesome. Like, it's on my way home from work. So that was really good. ”



Key Takeaways

Equity

- Ensure access to interpreters for all languages
- Budget enough time for patients with cultural or linguistic needs

Training and Infrastructure

- CIE allows screeners to have more direct impact
- More direct connection between screeners and navigators for seamless handoff and optimal patient experience
- Provide adequate training and leverage team structure for peer-sharing



Anna Steeves-Reese, PhD



Kate Wells, MPH



Katherin Gomez, BSW

Questions?



Upcoming Technical Assistance (TA) Opportunities

- Social Needs Screening Learning Collaborative on February 13, 2023
 - Topics: Screening networks; Policies & procedures developed with member input
- Ongoing one-on-one TA with Anne King (king@ohsu.edu) and Nancy Goff (nancy055@gmail.com)

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Additional Resources

- [Background Research in Social Needs Screening](#) – Nancy Goff & Associates, ORPRN, OHSU
- [Empathic Screening Techniques](#) – Oregon Primary Care Association
- [State of the Science on Social Screening in Healthcare Settings](#) – Social Interventions Research & Evaluation Network (SIREN)
- [Social Needs Screening Tool Comparison Table](#) – Social Interventions Research & Evaluation Network (SIREN)