Social Needs Screening Protocol: Prevention of Over-Screening

Protocol Background:

Research on social needs screening finds that many patients approve of social needs screenings being done by healthcare providers (1,2). But social needs screening can also be harmful to patients who have had bad experiences with social needs screenings in the past (1,3,6). Patients who have experienced discrimination in a medical clinic, office, or hospital might also have resistance to being screened for social needs (1,3,6). It is important that anyone who screens people for social needs understands that it can be scary and hard for people to share that type of information (6). Social needs screenings should be done in a caring way that considers each person's identities, unique life experiences, culture, and disability needs (6).

EOCCO developed a Protocol which lists the steps screeners should take to help people feel safe and respected when they are being screened for social needs. This Protocol will also help make sure people are not being screened for social needs too often, which can be harmful, especially to people who have had negative screening experiences.

Protocol 1: What to do before screening a member for social needs

In the Social Needs Screening & Referral Incentive Measure, the Oregon Health Authority (OHA) asks that all Oregon Health Plan (OHP) members be screened for social needs <u>at least once per year.</u>

However, the incentive measure is not official guidance on how often people should be screened for social needs. Some people may benefit from being screened for social needs more often depending on their type of needs and life situation.

Before screening someone for social needs, screeners should look at a person's screening history and their social, health, cultural, language and disability needs.

This will help a screener decide <u>when</u> and <u>how</u> to screen a member for social needs.

Steps to take before screening an EOCCO member for social needs:

Step	Data Sources
1. Look at a member's social needs screening history. **Ask:** • When was the date of this member's last social needs screening? • What was the result of this member's last social needs screening? (i.e., did the member screen positive or negative for social needs)	• AHC Social Needs Screening Project (EOCCO) • Unite Us
2. Look at member's REALD information and their health needs **Ask:** • Does this member have any disability needs? • Does this member have a preferred language other than English? • Has this member had a primary care appointment in the past year? • Does this member have any chronic health conditions?	• EOCCO Member List • EOCCO Member REALD data

Protocol 2: What to do when screening a member for social needs

Social needs screening research shows that taking time to tell a patient what social needs screenings are and how they impact health can help patients who might be feeling confused, hesitant, or annoyed about the screening (6). The research also shows that that telling patients how they will be helped if they have any social need(s) can help prevent harm that can come from social needs screenings (4,5,6).

Steps to take when screening an EOCCO member for social needs:

Step	Notes

1. Make sure the screening can happen in the member's preferred language	• If a bilingual screener is not available, make sure a certified health care interpreter can join the screening
2. Make sure the screening can be adjusted to meet member's needs	• If member is deaf or hard of hearing make sure the screening can be done in a way that feels best for the member (i.*e. screening done online or mailed to the member*)
3. Share what a social needs screening is with the member	• Describe the Social Determinants of Health (SDoH) • Describe why screening for social needs is important
4. Ask if the member would like to complete a social needs screening (get consent)	• Document social needs screening consent • Make sure the member knows they can refuse to answer any of the screening questions • Make sure the member knows they can stop the screening at any time

5. Share what will happen if a member screens positive for any social needs	• Describe how a member can be helped:
	  o Local resource guide
	  o Referral to an organization or program for assistance
	  o Health-related services/Flex services through EOCCO
	  o Health-related social needs (HRSN) benefit through EOCCO
	  o Referral to EOCCO case management
	• Make sure the member knows they can refuse assistance if they screen positive for social needs

6. Let the member know how their screening results will be shared	• Make sure members know that their information is protected • Make sure members know that screening results will only be shared with an organization outside of their health care team/EOCCO if they ask to receive a referral for any social needs

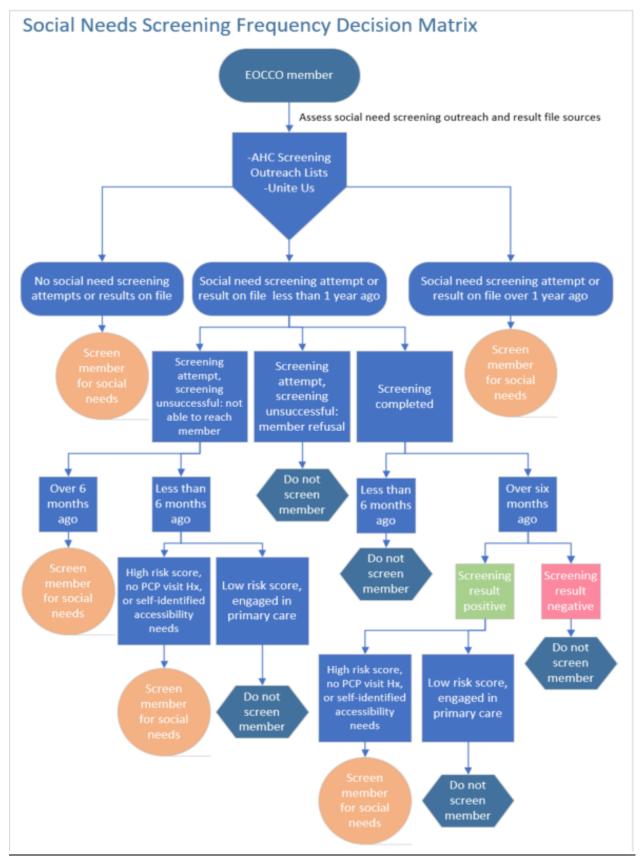## Protocol 3: What to do after screening a member for social needs

Screeners should document the results of a member's social need screening and how a member was helped if they screened positive for any social needs. Screeners should also document if a member refused to take the social needs screening, and why. Documenting this information can help make sure members are not being screened for social needs too often.

Steps to take when documenting a social needs screening:

Step	Notes

1. **Document screening results and the action taken to address any social needs**	• Document screening results in the data file
	   ○ Be sure to include the date that the screening happened
	• Document how a member was helped for each of their identified social needs that they requested assistance for
	   ○ Be sure to document if a member refuses assistance for any of their identified needs
	• If a referral was made to an organization or program, make sure the status of the referral is tracked over time (i.e. did the organization/program accept or deny the referral)

2. **Document if a member refuses to take a social needs screening**	• Document screening refusal in the data file ○ Be sure to include the date of the screening attempt • Document why a member refused to take the screening if they give a reason

The Social Needs Screening Frequency Decision Matrix [on page 6] is a tool screeners can use to help decide if and when an EOCCO member should be screened for social needs.

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Social Needs Screening Frequency Decision Matrix

EOCCO member

Assess social need screening outreach and result file sources

- AHC Screening Outreach Lists
- Unite Us

No social need screening attempts or results on file
→ Screen member for social needs

Social need screening attempt or result on file less than 1 year ago

- **Screening attempt, screening unsuccessful: not able to reach member**
  - Over 6 months ago → Screen member for social needs
  - Less than 6 months ago
    - High risk score, no PCP visit Hx, or self-identified accessibility needs → Screen member for social needs
    - Low risk score, engaged in primary care → Do not screen member
- **Screening attempt, screening unsuccessful: member refusal** → Do not screen member
- **Screening completed**
  - Less than 6 months ago → Do not screen member
  - Over six months ago
    - Screening result positive
      - High risk score, no PCP visit Hx, or self-identified accessibility needs → Screen member for social needs
      - Low risk score, engaged in primary care → Do not screen member
    - Screening result negative → Do not screen member

Social need screening attempt or result on file over 1 year ago
→ Screen member for social needs

The following research articles helped inform EOCCO's Social Needs Screening protocols:

(1) Brown, E., Loomba, V., De Marchis, E., Aceves, B., Molina, N., & Gottlieb, L. (2023). Patient and Patient Caregiver Perspectives on Social Screening: A Review of the Literature. *JABFM*, 36(1), 66-78. https://doi.org/10.3122/jabfm.2022.220211R1

(2) Byhoff, E., De Marchis, E., Hessler, D., Fichtenberg, C., Adler, N., Cohen, A., Doran, K., Ettinger, S., Fleegler, E., Gavin, N., Heubschmann, A., Lindau, S., Tung, E., Raven, M., Jepson, S., Johnson, W., Olson, A., Sandel, M., Sheward, R., & Gottleib, L. (2019). Part II: A Qualitative Study of Social Risk Screening Acceptability in Patients and Caregivers. *AJPM*, 57(6), 38-46. https://doi.org/10.1016/j.amepre.2019.07.016

(3) De Marchis E., Hessler, D., Fichtenberg, C., Adler, N., Byhoff, E., Cohen, A., Doran, K., Ettinger, S., Fleegler, E., Lewis, C., Lindau, S., Tung, E., Heubschmann, A., Prather, A., Raven, M., Gavin, N., Jepson, S., Johnson, W., Ochoa, E., Olson, A., Sandel, M., Sheward, R., Gottlieb, L. (2019). Part I: A Quantiative Study of Social Risk Screening Accetability in Patients and Caregivers. *AJPM*, 57(6), 25-37. https://doi.org/10.1016/j.amepre.2019.07.010

(4) Drake, C., Batchelder, H., Lian, T., Cannady, M., Weinberger, M., Eisenson, H., Esmaili, E., Lewinski, A., Zullig, L., Haley, A., Edelman, D., & Shea, C. (2021). Implementation of social needs screening in primary care: a qualitative study using the health equity implementation framework. *BMC Health Services Research*, 21. doi: 10.1186/s12913-021-06991-3

(5) Fitchenberg, C., Marchis, E., & Gottlieb, L. (2022). Understanding Patient's Interest in Healthcare-Based Social Assistance Programs. *AJPM*, 63(3), 109-115. https://doi.org/10.1016/j.amepre.2022.04.026

(6) Pfeiffer, E., De Paula, C., Flores, W., & Lavallee, A. (2022). Barriers to Patients' Acceptance of Social Care Interventions in Clinic Settings. *AJPM*, 63(3), 116-121. https://www.ajpmonline.org/article/S0749-3797(22)00250-1/pdf