Referral Procedures for Addressing Members' Unmet Social Needs

Procedure Purpose:

Research on social needs screenings finds that some people may not want help or assistance for social needs they are experiencing (2). Help or assistance for social needs could include a referral to an organization that can provide resources/services or sharing a guide of local resources/services available (1,2,3,7).

There are many reasons why a person may not want help or assistance for their social needs (2). Some people might prefer to navigate accessing resources or services themselves and on their own time. Other people might have a past negative experience with social needs screenings or accessing resources/services, have shame around receiving assistance or help for any social needs, or believe there are no resources or services available that could help their situation current situation (2,4).

A person's choice to not receive help or assistance for their social needs should always be respected, but there are certain things the screening **entity** (i.e. the clinic, organization, or person who is screening someone for social needs) can do to help make accepting help or assistance for social needs easier. This includes:

1) The screening entity knowing what local resources or services are available and might be a best match for a person's social needs, a person's location, and/or a person's cultural needs or preferences (1,2,6).
    a. The screening entity should also know the current capability of local organizations to provide social need services or resources (5).

2) The screening entity clearly communicating what type of support or resources they can provide if a person has any social needs before the social needs screening happens (2,4,5).
3) The screening entity helping to address any issues or challenges a person might face when trying to access resources or services. This could include: helping to fill out applications, transportation to resources/services, and translation or other language supports to ensure a person can receive services in their preferred language (6).

EOCCO has developed **Referral Procedures** which list the steps EOCCO staff should take to help address social needs for members in a culturally responsive and trauma-informed way. Partner organizations can reference or adapt these Procedures when creating their own social needs screening and referral guidelines.

Key Terms:

'Social Needs' or Social Determinants of Health (SDoH): Social, economic, and environmental (the place you live) factors that affect people's health. Some of these factors include: having safe housing, having a stable job, having low-cost and healthy food options, feeling safe in your neighborhood, and having clean air in the place you live. When we use the term *social needs* we are talking about the social determinants of health.

Trauma-informed practices: A care approach that understands that past or current trauma can impact a person's behaviors and health. This approach recognizes the signs of trauma and works to create safe care practices.

Cultural Responsiveness: Being able to learn from different communities and respond to issues with an understanding that peoples' identities and culture affect their needs and experiences.

Referral Procedures for Addressing Members' Social Needs

1-How to support social need help or assistance acceptance among members

- Follow the steps listed in **EOCCO's Social Needs Screening Protocol for the Prevention of Over-Screening**
    - The Protocol includes clearly sharing why a member is being screened for social needs and how they can be helped if they do have any social needs
- Ask a member for consent to provide help or assistance for any social need(s) they are experiencing after they are screened for social needs
    - Document member consent and what type of help or assistance they accepted
    - If the member does not want help or assistance for any social need(s), document as "assistance declined". Inform the member that support is available if they decide that they would like help or assistance for their social need(s) in the future

2- Types of help or assistance that can be provided to members

This includes the help or assistance that EOCCO can provide to members to address their social needs. *The type of help or assistance your organization can provide might look different*.

Creating a Community Resource Guide

A Community Resource Guide is a detailed list of local organizations that could provide resources or services to help address a member's social needs.

EOCCO uses the **Unite Us Community Information Exchange (CIE)** tool to develop Community Resource Guides for members. Community Resource Guide development standards include:

1) Listing organizations that are local when possible (within a member's zip code or county) and provide services or resources specific to a member's social needs
2) Making sure a member is eligible for an organization's services before listing the organization in the Guide [this could include referencing an organization's income guidelines or geographic areas served]
3) Prioritizing organizations that deliver services in the member's preferred language or serve populations that the member is a part of

Once the Community Resource Guide is developed the Guide should be translated into the member's preferred language and shared with the member through their preferred method: text, print or email.

If EOCCO cannot find specific services or resources in Unite Us to meet a member's social or cultural needs other tools or databases will be used to develop a Community Resource Guide including:

- **FindHelp:** https://www.findhelp.org/
- **Oregon Food Bank: Food Finder**: https://foodfinder.oregonfoodbank.org/
- **Oregon Housing and Community Services: Rental and Housing Assistance:** https://www.oregon.gov/ohcs/housing-assistance/Pages/find-affordable-housing.aspx

Sending a referral to connect members to organizations or services that address their social needs

In some cases, a screening entity might provide resources or services that can help address specific social needs. The screening entity could place an **internal referral** to connect members to the services/resources their organization provides. For EOCCO, internal referrals could be placed for the **Health Related Social Needs (HRSN)** benefit or **Health-Related Services (HRS)/Flex Services** if the member's social needs could be addressed by those benefits/services and they meet specific eligibility requirements [*see below*].

EOCCO provided benefits to address member's health-related social needs	
Benefit	Eligibility Requirements
Health Related Social Needs (HRSN)	**1-Housing, Climate or Food (starting Jan 2025) related need** **2-HRSN Priority Population** • Adult or youth released from incarceration in the past 12 months • Adult or youth discharged from Institutions for Mental Disease (IMDs) in the past 12 months • Individual who is currently or who has previously been in the Oregon child welfare system • Individual transitioning from Medicaid-only to dual eligibility (Medicaid and Medicare) status within the next three months or past nine months • Individual who is homeless or at-risk of becoming homeless **3- Enrolled in CCOA or CCOB Plan** **4- Clinical or Social Risk Factor that algins with requested HRSN benefit [housing, climate or food]**
EOCCO HRSN Request Form: https://www.eocco.com/web-forms/health-related-social-needs/	
Benefit	Eligibility Requirements
Health-Related Services (HRS)/ Flex Services	**1-Currently enrolled EOCCO member** **2- Service/resource requested is: intended to improve member health and is consistent with member's treatment plan** **3-Service/resource requested CANNOT be a covered services under Medicaid**
ECCO HRS Request Form: https://www.eocco.com/-/media/EOCCO/PDFs/Member/Resources/EOCCO-Form-Health-Related-Services-claims-and-FAQ.pdf	

If EOCCO cannot directly meet a member's social needs through HRSN/HRS, EOCCO will utilize the **Unite Us** platform to create and send referrals to an external organization that provides the resources or services a member needs. Social Need Referral creation and sending standards include:

1) Sending referrals to organizations that are local when possible (within a member's zip code or county) and provide services or resources specific to a member's social needs

    a. **Tip:** Cast a 'wide net' to help increase the likelihood that a member's social needs will be addressed by sending the referral to multiple organizations through the Unite Us platform
2) Making sure a member is eligible for an organization's services before sending the referral [this could include referencing an organization's income guidelines or geographic areas served]
3) Prioritizing sending the referral to organizations that deliver services in the member's preferred language or serve populations that the member is a part of
4) Sending any referrals to address a member's social needs within 2 business days following the social needs screening
    a. **Tip:** If the referral receiving organization does not respond within 2 business days of the referral being sent, recall the referral and send it to a different organization that can provide services or resources to meet the member's social needs
5) Noting the outcome of the referral (i.e. referral receiving organization provided the services to meet the member's social need) for 'closed loop' documentation

The following research articles helped inform EOCCO's Social Need Referral Procedures:

(1) Byhoff et al. (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

(2) Fitchenberg et al. (2022). Understanding Patients' Interest in Healthcare-Based Social Assistance Programs. *AJPM*, 63(3): 109-115. https://doi.org/10.1016/j.amepre.2022.04.026

(3) Marchis et al. (2020) Assessment of Social Risk Factors and Interest in Receiving Health Care Based Social Assistance Among Adult Patients and Adult Caregivers of Pediatric Patients. JAMA Network Open, 3(10). doi:10.1001/jamanetworkopen.2020.21201

(4) Pfeiffer et al. (2022) Barriers to Patient's Acceptance of Social Care Interventions in Clinical Settings. American Journal of Preventive Medicine, 63(2): 116-121. https://www.ajpmonline.org/article/S0749-3797(22)00250-1/pdf

(5) Rudisill et al. (2023). Patient and Care Team Perspectives on Social Determinants of Health Screening in primary Care A Qualitative Study. *JAMA Network Open*, 6(11). doi:10.1001/jamanetworkopen.2023.45444

(6) Steeves-Reece et al. (2022). Social Needs Resource Connections: A Systematic Review of Barriers, Facilitators, and Evaluation. *American Journal of Preventive Medicine*, 62(5): 303-315. https://doi.org/10.1016/j.amepre.2021.12.002

(7) Steeves-Reece et al. (2023). Patients' Willingness to Accept Social Needs Navigation After In Person versus Remote Screening. *JABFM*, 37(3). https://doi.org/10.3122/jabfm.2022.220259R1