

Addressing the Social Determinants of Health

Designing a Successful Patient Screening and Referral Process



For more information, contact:

Jill Miller, President, Bethesda Inc.
jill_miller@bi3.org 513-569-6652

Jennifer Zimmerman, Director of Grants and Evaluation, bi3
jennifer_zimmerman@bi3.org 513-569-6673

About bi3

bi3 is Bethesda Inc.'s grantmaking initiative to transform health in Greater Cincinnati. Bethesda Inc. is a nonprofit entity and co-sponsor of TriHealth, a leading integrated health system in Cincinnati.

bi3 invests in innovative ideas with the ability to spark and scale new approaches to improving community health and healthcare.

Since 2010, bi3 has awarded \$40.3 million in grants to fund innovative ideas to transform health and healthcare, ranking it as one of Ohio's largest health-focused funders. Our work has helped reduce Cincinnati's infant mortality rate, increase access to better health care, elevate the importance of planning for end-of-life care and leverage additional funding to spread successful efforts to transform health.

Learn more at bi3.org.

Acknowledgments

Thank you to our funded partners who shared their learnings:

Julie Geiler, Grant Projects Administrator, TriHealth

Sarah Mills, Chief Executive Officer, and **Shane Satterfield**, Care Coordination Supervisor,
Health Care Access Now

Elaine Fink, Managing Attorney, and **Elicia Schultian**, M-HeLP Project Coordinator, Legal Aid
Society of Greater Cincinnati

Jill Huynh, Vice President New Business Development, and **Kerry McPhail**, Parenting Specialist,
Beech Acres Parenting Center

bi3 Learning Series

bi3, Bethesda Inc.'s grantmaking initiative to transform health in Greater Cincinnati, focuses on linking health and social service systems to address all factors impacting people's health. To better inform future work, bi3 convened four of its funded partners to share their experiences in designing and implementing screening and referral processes to address social needs that affect the health of people in Greater Cincinnati. This paper summarizes key learnings of our funded partners.

bi3's Funded Partners: Beech Acres Parenting Center, Health Care Access Now (HCAN), Legal Aid Society of Greater Cincinnati and TriHealth

WHY SCREEN FOR SOCIAL DETERMINANTS OF HEALTH?

Efforts to improve health have typically focused on providing access to clinical care. However, in recent years, a substantial body of research suggests an individual's health is largely driven by factors outside of hospital walls. Health-related social needs—or social determinants of health—can impact a patient's ability to access care and comply with treatment recommendations. Food and housing insecurity, transportation access, health illiteracy and social isolation are all barriers to achieving positive health outcomes.

While healthcare providers recognize the need to address social determinants, they also face significant barriers in doing so. Challenges include lack of time, staff and tools to effectively perform screenings, as well as a scarcity of programs, community partnerships and financial resources required to address a patient's social needs, even if identified. Additionally, efforts to engage patients in addressing social determinants of health are frequently unsuccessful due to challenges individuals face navigating available health and community services.

In 2018, the Center for Medicare and Medicaid Innovation (CMMI) awarded grants to fund the implementation of the Accountable Health Communities (AHC) model in 30 communities. The AHC model enables the CMMI to evaluate how screenings, referrals and community navigation services might reduce healthcare costs and improve health. Greater Cincinnati, the home of bi3, is one of those communities.

To inform the AHC model in Cincinnati, bi3 convened four of its funded partners, representing both healthcare and community-based organizations, to capture their successes, challenges and learnings. They identified three essential components to implementing a successful screening and referral process.



#1 Engage and Train Frontline Staff

Start with “Why.” First and foremost, a successful screening and referral process begins by engaging and educating staff to build a shared understanding and commitment to the effort. It is essential to articulate how this new process will add value for both **them** and their patients. While healthcare professionals are committed to providing quality patient care, they face competing priorities within healthcare and nonprofit systems. Thus, it is important to provide appropriate training and address any questions and concerns. Training should be delivered to **all** staff throughout the organization or clinic, including physicians, nurses, medical assistants, practice administrators and front desk staff. Incentives can also be a valuable tool to motivate staff.

Identify champions to help drive buy-in. Champions are in the position to make decisions, remove barriers and drive processes and workflows. They draw others into the work and build strong teams grounded in mutual respect.

#2 Co-Design a Screening and Referral Process

Once champions within the healthcare system and social organizations are identified and staff members are bought in, co-develop a shared vision, goals and process with patients and staff. The result should be clarity, consistency and agreement on the goals and intended outcomes of the new screening and referral process.

Desired outcomes and available resources should drive decisions about design, implementation, resource allocation and accountability. When defining the target population, it is important to ensure programmatic assets (e.g., funding, staff, etc.) can support the level of work required to deliver agreed-upon outcomes.

The screening process should clearly outline **who, what, when, where** and **how**:

- **Who** will be screened and **how** they will be identified (e.g., inclusion criteria).
- **Who** will administer the screening, in what **time** frame and **where**.
- **How** to communicate benefits to and engage with patients (e.g., a standard script or written materials).
- **What** screening questions will be asked and **how** answers will be recorded (e.g., paper-based or electronic).
- **Who** will review the screening results and **how** the need for a referral will be determined.

“The screening form is a ‘gateway’ into challenges patients face. I use it to start the conversation about social topics. For example, I say, ‘I see you marked that you are having struggles with stress in the home,’ and then use that to explore their needs and to find ways to help them.”

– TriHealth Pediatrician, Parent Connex Program

Once the screening process has been completed and social needs are identified, it is important to engage patients in understanding screening results and options for next steps. Sharing the decision-making process and using techniques, such as motivational interviewing, can help improve patient engagement and increase the likelihood of follow-through. The method of connecting patients from one service provider to another should be as seamless as possible.

The referral process requires attention to ensure patients receive timely and adequate assistance to connect with resources. Staff making referrals should receive training and support on how to communicate referral information with patients, including getting referral consent. Upon patient consent, one of the following referral approaches must be selected:

- Staff provides patient information about available community resources to **pursue on their own**.
- The healthcare provider (referring organization) **facilitates the connection** to the resource. Either the patient or the community resource will then follow up to ensure the connection is made.
- The healthcare provider provides a personal introduction of the patient to **on-site resources**.

“A seamless, warm handoff leverages the existing relationship between the patient and healthcare team and allows the patient to receive help right when the need is identified. It facilitates engagement for patients who might not otherwise seek services in the community.”

– Julie Geiler, Grant Projects Administrator, TriHealth



Referral protocols should include:

- **What** patient information will be shared with community resources receiving the referral.
- **How** referrals will be documented and **where** (e.g., electronic health record).
- **Who** is accountable for documenting referrals.

Once the process and workflows are developed, it is important to create written protocols that are accessible to all participants. This helps ensure a shared understanding and accountability for the execution of the referral process. The integration of the process into existing workflows as standard practice will support its success.

Two considerations were gleaned from our learnings:

- **Incentives drive engagement.** Consider incorporating specific incentives for healthcare staff to complete patient screenings and/or appreciation events for high levels of engagement. For example, competitions between departments or small gifts for high-performing individuals can help boost participation.
- **Pilot before scaling.** Executing a test of the screening and referral process before full implementation will allow patients and staff to provide feedback that will ultimately lead to greater efficiencies and better patient outcomes.

#3 Practice Quality Improvement and Learning

Quality improvement practices can drive a screening and referral program to make data-driven decisions and develop best practices — ultimately creating a strong program that achieves its goals. To be effective, organizations must dedicate resources to capturing screening and referral data and ensuring data quality. Timely and ongoing data analysis is needed to evaluate the process. Key **process** metrics include:



- The percent of **patients screened** (of the total targeted population).
- The percent of **refusals by patients**.
- The percent of screens that indicated the **need for a referral** (e.g., positive screens).
- The percent of positive screens that **led to a referral**.
- The types of referrals provided to **identify trends or gaps** in community resources.

Patient engagement is key to achieving better health outcomes. A screening and referral process without data on the referral results cannot reflect the full impact on patients and, therefore, must include a feedback mechanism to communicate what happened after a patient referral was made. These communications can come in the form of data (e.g., the number of patients completing the referral, the number of patients gaining access to resources, etc.) and patient testimonials.

Our funded partners have found that communicating referral results with the right story in a timely way can deepen staff understanding of their patients, the barriers they face and the importance of connecting them to resources. This adds value and importance to *their* work.

“We provide the referring healthcare team with a monthly report on the status and result of every referral. Patient advocates also share client narratives to demonstrate the impact of a referral and generate buy-in among partners in a way that data alone cannot. This conveys a sense of achievement and motivates team members to continue making referrals.”

– Elicia Schultian, M-HeLP Project Coordinator, Legal Aid Society of Greater Cincinnati

Quality improvement efforts should include regular analysis, review and discussion of the data to identify successes, breakdowns or barriers, trends and opportunities for improvement.

An emphasis on learning can capture best practices and integrate them into organizational culture, increase the capacity to engage in quality improvement and elicit deeper buy-in to the process.

Our funded partners have identified two key learnings that support the development of a successful screening and referral process:

- When designing and executing a new screening and referral process, **flexibility is essential**. Organizations must be willing to adapt to their individual environments, address challenges and implement improvements. As changes are made, staff may need to be re-educated on the evolving model. Ongoing training is also needed as staff members change roles or leave the organization.
- **The entire process is built on a foundation of trust**. Healthcare staff must buy-in to the organization's commitment to addressing patients' physical health and social needs. Patients must trust their healthcare providers, so they feel comfortable disclosing information asked on the screening tool and pursuing referrals. Providers and patients need to trust community organizations receiving the referrals.

"We realized that the rotating schedule of providers in the healthcare clinic required us to re-think our staffing structure to develop strong working relationships. We changed the model to have a consistent person, the Intake Specialist, working with the clinic for referrals. The new process was less confusing for the residents and clinic staff because they had one "go to" person for referrals. It also allowed the Intake Specialist to really focus on engaging clients. As a result, the referral conversion rate to active clients improved. The flexibility of the teams led to an improved process."

– Sarah Mills, Chief Executive Officer, Health Care Access Now

Trust takes time to build, and relationships must constantly be nurtured through communication and data sharing. Building an effective screening and referral program to address social determinants of health requires planning and time. With a strong foundation of trust and a thoughtful approach, healthcare providers can help connect patients to the services they need to improve their health and well-being.



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