

Members in Action: Managing Risk & New Payment Models

Integrated Healthcare Associates, Trinity Health – Ann Arbor, Mich. *Collaborating with Community Organizations to Screen Diverse Populations*

The AHA's Members in Action series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes, and implement operational solutions.

Overview

Integrated Healthcare Associates (IHA) implemented a social determinants of health (SDOH) screening and referral program in an effort to connect with patients, and meet the requirements of the State Innovation Model Patient-Centered Medical Home Initiative. The screening tool's goal was to identify the needs of individual patients, connect these patients with resources to meet their needs, decrease unnecessary health care utilization by addressing SDOH needs and improve the health of the population.

IHA, one of the largest multi-specialty groups in Michigan, and a member of Trinity Health, has more than 512,000 patients and 700 providers in 70 different practice locations across primary and specialty care practices. It serves Washtenaw, Livingston, Lenawee, Oakland, and western Wayne counties in southeast Michigan, where the poverty rate is nearly 15 percent, and 10 percent of the primary care patient population is covered by Medicaid.

Impact

The success of the pilot program led to the launch of the screening tool in all of IHA's practices. During the three months of the pilot program, constant communication and evaluation created an opportunity to improve existing workflows within practices. From its launch in August 2017 through January 2019, the screening and referral program completed 84,349 screens. Social isolation was identified as the highest social need, followed by food and family care. Out of the 6,850 or 8.8 percent positive screens indicating having a social need, only 1,458 or 21.3 percent requested a referral to community-based organizations to connect patients with applicable resources. IHA closed the loop on 46 percent of those referral cases. In addition, IHA received an overwhelmingly positive response from patients regarding the screening process. This process also created an opportunity for IHA to develop partnerships with multiple community resource agencies and provider organizations to better address patient needs, in addition to scaling the screening and referral process with the help of 2-1-1, a national community referral service (www.211.org).



Here's how the screening and referral program was developed:

- IHA collaborated with other local physician groups and community-based organizations and established a committee to develop a standardized screening tool and referral process to be utilized throughout the entire community. The committee ensured it included questions around the following domains: food, housing, utilities, transportation, literacy, child care, elder care, financial strain, family care and social isolation.
- IHA used the Health Leads Screening Toolkit to identify questions for each domain while community agencies recommended the best question from the toolkit. Besides Food Gatherers, who informed the decision to use the current question for food on the screening tool, IHA also facilitated partnerships with Jewish Family Services, Avalon Housing, 2-1-1, United Way, among others, to best leverage their resources when referrals are sent to them.
- Five pilot sites tested the screening tool during which a standardized workflow was established that integrated the tool in the electronic health records system to track responses, refer patients to community resources and then follow-up with patients to either provide more guidance on the referral or close the loop. The screening tool was translated into Spanish and Arabic to cater to IHA's patient population and was given out at Health Maintenance exams and new obstetrics visits.

Strategic Approaches to Inquire About Social Needs

Leading

- "What happened next?"
- "Could you tell me more?"

Open-ended

- How long have you been without food?"
- "What is the reason for your call?"
- "Where are you located?"
- "Who would you like us to call?"
- "Which service do you prefer?"

Closed-ended

- "Is this what you requested?"
- "Are you able to find transportation to your appointment?"
- "Do you have an interpreter?"
- "Did anyone help you make that appointment?"
- "Can I be of assistance?"
- "Could you find a phone to make that call?"
- "Would you like assistance with this?"

Reflective

- "It sounds like you could use some help figuring this out..."
- "I'm hearing you say that you are unsure how to proceed..."

Prior to implementing the screening tool at five pilot sites, care team members and call center representatives were trained on how to have sensitive conversations with patients who screened positive for a social need.

Scripts were developed in collaboration with the Customer Experience Specialist to ensure that the language used was "patient facing" and sensitive to the nature of the screening tool. The script helps ensure patients are comfortable with the questions being asked and accepting help, on their own terms.

Care team members were trained on how to use the script to guide flowing conversations, build a connection with patients using relatable phrases/words, understand patient priorities and provide support when necessary. In addition, IHA held trainings on empathy, active listening, communication blockers and sensitive questioning. The training helped trainees approach these calls with sensitivity towards a patient's challenges and lifestyle. For example, with active listening, staff members learned how to ask leading, open ended, closed-ended and reflective questions regarding social needs as seen in Figure 1.

Lessons Learned

Partnering with community organizations and leadership and getting their buy-in and input early on in the process was integral in building the screening tool. IHA recommends:

- Working with staff and leadership in the division to develop standardized workflow and training modules;
- Partnering with 2-1-1 or other community resource agencies to access and train with their database;
- Translate screening tool in common languages; and
- Hire more bilingual staff to support diverse patient populations.

Future Goals

IHA is taking steps to expand their program by investigating electronic solutions to better screen, provide referrals and contact patients. Additionally, IHA plans on evaluating practice-level data to identify opportunities for site-level interventions. Outside of the practice, IHA will aggregate community-wide data to better understand the prevalence of various health needs better and provide a broad view of resource needs for the region. IHA will continue to partner with community funders to discuss opportunities to address community needs.

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This case study first appeared in The Value Initiative's tool, [Screening for Social Needs: Guiding Care Team to Engage Patients](#).