Social Determinants of Health (SDoH) Screening in Emergency Departments

A Playbook for Implementing Social Determinants of Health Screening in the Emergency Department in Partnership with Your Community-based Organizations

Illinois Health and Hospital Association

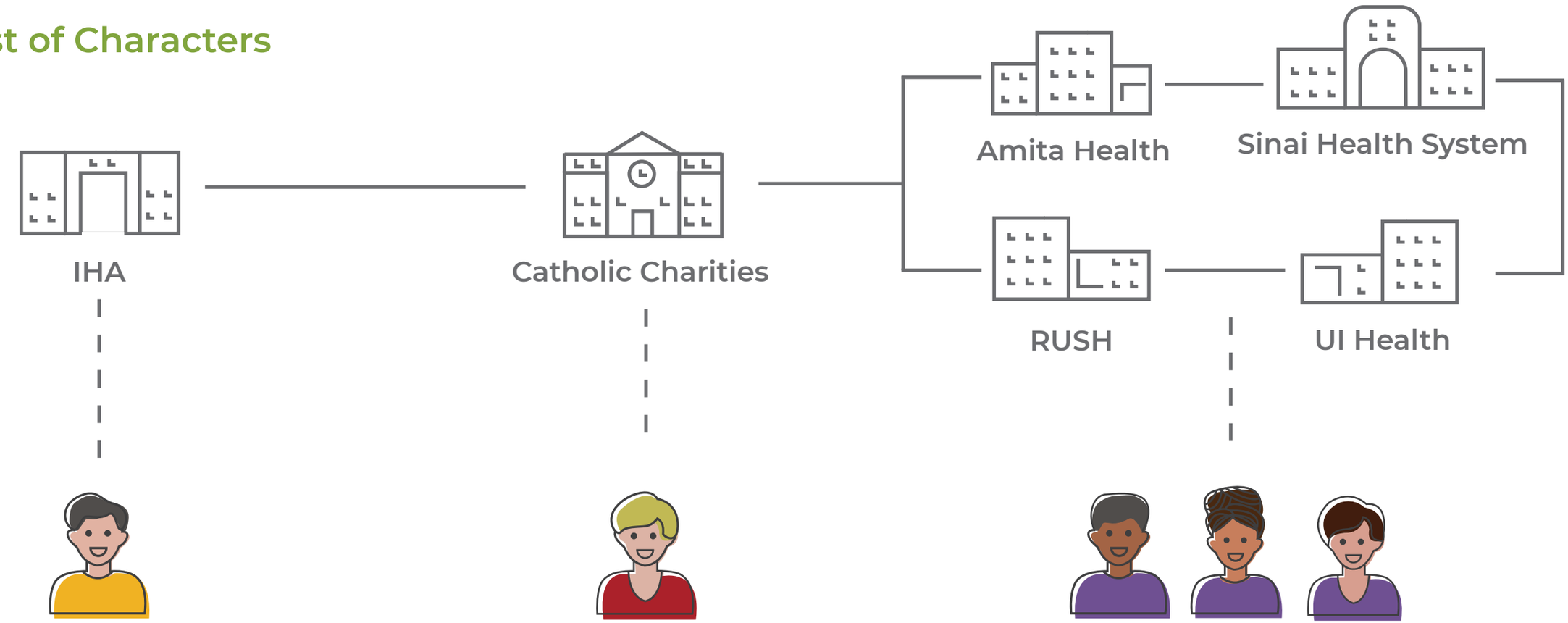
The CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO

West Side ConnectED

GREAT LAKES PARTNERS FOR PATIENTS

WESTSIDE CONNECTED PLAYBOOK TEAM

Cast of Characters



Through the Hospital Improvement Innovation Network (HIIN), IHA worked with the Westside ConnectED coalition to support SDoH screening in hospitals, and create the implementation playbook that will be used to spread the successes of this work to other communities.

With the focus on supporting community members and outreach initiatives, Catholic Charities leads and facilitates the Westside ConnectED work. Catholic Charities bridges the gap between clinical and community-based care.

As part of the Westside ConnectED coalition, four hospitals on the west side of Chicago work to screen ED patients for SDoH. These hospitals work with community based organizations to ensure patients receive resources through a model that promotes health equity.

HOSPITAL IMPACT STATEMENTS

AMITA HEALTH - Just over 25% of the patients screened to date indicated at least one need.

RUSH - Completes approximately 136 weekly emergency department screens for social needs.

SINAI HEALTH SYSTEM - In the first 3 months of screening, more than half of the patients that screened positive expressed their highest needs are lack of primary care provider, lack of insurance and food insecurity.

UI HEALTH - Less than 1% of the patient's we've screened have declined to answer the screening questions.

ABOUT THIS PLAYBOOK

Why It's Important to Do

Linking the community and clinical sectors have proven to be effective with preventing and controlling chronic disease and addressing Social Determinants of Health (SDoH). Healthcare care professionals have the opportunity to work with community based organizations to establish partnerships that addresses the clinical, behavioral, and social factors that impact a patient's health and improve the health and wellness of the community. The ED is open 24 hours a day, 7 days a week, and is a place patients can seek medical care regardless of acuity or payment status. The ED treats a community's most vulnerable patients. Implementing a screening and referral process to impact a patient's SDoH while they are seen in the ED provides a comprehensive care approach that will support patients when they return to the community. This playbook will walk your hospital ED through steps to successfully implement a SDoH screening process to support patients in your community.

Project Background

Westside ConnectED has been convening since 2016 to address SDoH of patients utilizing the emergency departments of RUSH, UI Health, Sinai and Amita. A screening tool was developed to identify patient needs in the areas of utilities, transportation, food, housing and primary care. Input was received from patients, hospital staff and community-based partners to identify potential closed loop and referral sources. These resources were also identified and utilized via community resource and referral platforms such as NowPow, Aunt Bertha, and Healthify to strengthen the community-clinical linkage that Westside Connect members had put in place. This resulted in warm-hand offs from hospital emergency department staff to community-based organizations with capacity to address one or more of the aforementioned determinants. This model promotes health equity by meeting people where they are, respecting what they need and facilitating a seamless process by which those needs can be met. At the heart of Westside ConnectED is person-centered, clinical and community-based care.

What You Can Do

Westside ConnectED convened SDoH screening in 2018, and by spring 2019 all four hospital partners had started offering screenings in their Emergency Department (ED). This playbook will walk your hospital ED through steps to successfully implement a SDoH screening process to support patients in your community. While this playbook outlines different steps for implementing screening, developing those community partnerships are key to the underlying success of this work. Through the partnership with IHA, The Westside ConnectED coalition worked to collect screening data. In one year, over 700 screenings were completed. Identifying the success of the Westside ConnectED coalition, Do Tank worked closely with IHA, Catholic Charities, and the hospital teams to develop and design this playbook as a tool other hospitals can use to implement SDoH screening in their EDs.

ABOUT THIS PLAYBOOK

Playbook Steps

STEP ONE

Read the playbook guidelines and appreciate the context and the people that are involved.

STEP TWO

Walk through each of the phases and take advantage of the external information where available. You may need to refer back to the guidelines from time to time. The Playbook aims to inspire hospitals to be able to pick this up, knowing nothing about the process, and after reading it have a good handle on what the process is and what steps they could take to replicate it.

STEP THREE

Digest the results and impacts and review where the process steps make sense and/or could be a challenge for your hospital. Completing the Key Steps in each phase ensures success for subsequent steps down the line.

STEP FOUR

Gather your team and plan your critical next steps to making this happen at your hospital.

Phase Summaries

PHASE ONE: ESTABLISH PARTNERSHIPS AND ASSESS CAPACITY

In phase one you will be establishing your internal team, identifying CBOs, and assessing the CBOs capacity for referrals. Start by working with hospital leadership and ED staff to make a case for implementing a SDoH screen. Next, you will work to build your internal team that will oversee the work. Finally, you will identify the CBOs in your area and identify their ability and capacity to accept referrals. Regular communication with CBOs about their capacity will be an ongoing as you implement this process.

PHASE TWO: DESIGN SCREENING WORKFLOW

Phase two is when you will design the screening workflow. Integration of SDoH screening into existing workflows is important to prevent staff from feeling overwhelmed. Many of the steps in this phase can be done simultaneously including: identifying screeners, determine population of patients to screen, choosing a screening tool, and developing a system for tracking and monitoring data. You will also want to work with CBOs to develop a closed-loop referral process based on your patient's SDoH screening results.

PHASE THREE: SCREEN AND REFER PATIENTS

Phase three is when you will screen and refer your patients. You will train SDoH screeners on how to administer screening questions, the protocols in your ED, and the community resources that are available to patients. Your screeners will ask patients the screening questions and identify next steps for your patients based on their responses to their questions. This is an opportunity for your hospital to provide a warm handoff for patients and connect them directly with CBO services if patients are willing. As you implement this screening process we encourage you to track your results to demonstrate the impact you are having on patients in the community.

1

ESTABLISH PARTNERSHIPS AND ASSESS CAPACITY

"Looking at the cost savings from similar models shows that meeting the social needs of patients resulted in an overall reduction of 10% in health care costs over the subsequent 12-month period which amounted to an average of $2,443 per patient."

Who Is Involved?

- Leadership (executive sponsorship)
- Community-based organizations (CBO)
- Physician (ED or facility medical director)
- Nursing
- Social work/case management
- Patient Family Advisory Council (PFAC)

Key Steps

- [x] Make the case with hospital leadership and ED staff for implementing a screen for Social Determinants of Health (SDoH) [1] [2]
- [ ] Identify key champions (physician leadership or executive sponsorship) and key team members (nursing, social work, case management, etc) within the hospital
- [ ] Establish and build a relationship with a CBO and identify their capacity for referrals [3]

"Having relationships with community based organizations is key. Being able to connect people to food only one block away from their home was a success. That same patient later saw the hospital screener and let them know how much they had appreciated the help."

"Identify the partners and develop relationships early. Be mindful of what organizations can commit to capacity wise. An organization may have the will, but it's important to make sure they have the capacity to execute on referrals."

REFERENCE MATERIAL

1. Community Referral & Resource Platforms: WCED Toolkit: Other Helpful Resources
2. Wellcare Study
3. WCED Tool Kit: Community Clinical Partnerships 101
4. IHA Patient and Family Engagement Tools

Keys to Success

ED teams need to have a collaborative element; this approach helps with group accountability and establishes workflow

CBOs should be categorized by SDoH service offer

Engage patient and family voice in designing the workflow and as critical partners [4]

"The patient voice is critical. Health care is not just treating illnesses, but incudes patients and their care givers as partners in making decisions related to their care."

"As a screener, screening for SDoHs has helped connect patients with primary care physicians. One patient mentioned they didn't like their doctor, and through discussions we identified a new doctor and scheduled a follow-up appointment for that patient on the spot. The patient was grateful because they didn't understand they had a choice of who their doctor could be".

Challenges

SDoH connections are perceived as less of a priority than primary care follow-up appointments

Demonstrating financial impact up front for screening

Hospitals have varied relationships with CBOs

Screening for SDoH is not considered billable hours

2

DESIGN SCREENING WORKFLOW

REFERENCE MATERIAL

1. Rush Workflow
2. WCED Toolkit: Integrating into Existing Workflows
3. WCED Toolkit: Identifying SDoH to be Addressed in Hospital EDs
4. WCED Toolkit: Creating SDoH Screening Tool
5. WCED Screening Questions
6. WCED Toolkit: Utilizing Technology to Identify and Refer to Appropriate Local Resources
7. WCED Toolkit: Data Collection, Analysis and Reporting

Who Is Involved?

- Department leaders
- Screeners
- Social Workers
- Patient Access
- Nursing
- Community Health Workers
- Patient Care Navigator
- Project Champions
- Emergency Department Staff
- IT/Decision Support
- Care Managers

"It is so important to make sure you refer patients to places that speak their language, which is not always easy to do."

"30% of low acuity patients at our hospital screen for food insecurity. We know this because of data collection."

Key Steps

- [x] Integrate SDOH screening within current ED workflows [1] [2]
- [ ] Identify screeners
- [ ] Determine which patients will be screened for SDOH [3]
- [ ] Determine which SDOH(s) to screen for
- [ ] Develop and/or choose a SDOH screening tool [4] [5]
- [ ] Determine how data will be tracked and stored
- [ ] Include which community resources/platforms as appropriate [6]
- [ ] Develop closed-loop referral process for patients services based on SDOH screening results
- [ ] Develop a system to track and monitor data [7]

"Screeners need to have a depth of experience and a rich background in this work to be successful at connecting people to needed resources."

Keys to Success

Work with leadership in ED and other designated departments to determine staff has adequate/dedicated time for SDOH screening

Select screeners with high levels of emotional intelligence & cultural humility

Consider hospital capacity, access to resources, and data when determining which patients to screen

Review patient medical records to determine eligibility for obtaining resources

Consider various factors to determine who needs to be screened including: poverty level, income level, demographics, disease, risk factors, high utilizers, increasing /rising risk, etc.

"Rush's tool is the quickest at 3-minutes. Implementing a 3-minute tool is more acceptable by CEO, staff, & patients."

Keep screening tool simple and succinct with clear and concise questions that address patient literacy levels, and have a tool translated into common language of patient population

Identify a process to escalate to social work or mental health services

Consider integration of screening tool into EHR

Develop process for tracking and entering data into tracking system (directly into EHR or transcribing paper responses into electronic format)

"Guidelines and processes aren't prescriptive but need to incorporate flexibility to cater to your organization's needs and capacity. "

"Keeping the screening tool brief and concise helps gain buy-in from busy ED staff. "

Challenges

Incorporating screening or additional work into existing workflows

Screening on overnights & weekends due to staffing constraints

Choosing a subset of the appropriate screening population can be a challenge during periods of increased volumes of patients

Including behavioral health screening with a SDoH tool can be challenging because behavioral health screening requires additional training

> Workflows operate in a similar way. They create a foundation on top of which business activity can happen more efficiently. Know the importance of workflow is one thing but having a sense of an effective workflow in the next step"

> A challenge that screeners encounter is the addition of work in a full ED workflow, so being sensitive to the timing of ED procedures, tests, and time patients need to spend with medical staff improves rapport with the staff and gains support for the importance of SDoH screens."

Assuring that screening does not interfere with high acuity workflow

Length of time it could take to build questions into EHR

Other screening is happening in ED (for example domestic violence screening or substance use screening) and staff feel overwhelmed with the additional amount of screenings

Develop survey repository

Provider hesitation around asking SDoH questions in the event facility has no way to connect patient with necessary resources

3

SCREEN AND REFER PATIENTS

Who Is Involved?

- Project champions
- Screeners
- Trainers
- Patients
- Case Management
- Social Work
- Navigator
- CBOs

> "It's important to ask the patients for their permission to ask them the questions and explain to patients that the hospitals' social work department is here to help them

Key Steps

- [x] Train SDoH screeners to conduct screening, on ED protocols, and available SDoH community resources and challenges [1]
- [ ] Conduct shadow training sessions with screeners
- [ ] Develop a script that explains why SDoH screening questions are being asked [2] [3]
- [ ] Get informed consent from patient
- [ ] Evaluate patient's response to screening questions and identify next steps based results [4]
- [ ] Access community resource platforms as appropriate
- [ ] Identify appropriate CBO with capacity for referrals (based on the services provided)
- [ ] With patient consent, provide an in person navigation referral

REFERENCE MATERIAL

1. USDA Screening Tool Guide
2. Rush SDoH Scripting
3. Rush-SDoH Scripting #2
4. UI Health Social Determinants of Health Screening Decision Table

> The SDoH screening tool took off when Social Workers screened. Patients respond well to social workers who are culturally humble & aware screeners."

Keys to Success

- Communicate with hospital staff when SDoH training is being conducted
- Train multiple departments to administer screening in response to a patient's medical scenario
- Use motivational interviewing
- Demonstrate systems if applicable
- Time screening administration for when no doctors or nurses are in the room

> 99% of low acuity patients do accept screening. This success can be attributable to approaching people the right way. Saying "I'm here to serve you" helps a lot and asking "Is now a good time?"

> Having the ability to give patients as much information about their health care, insurance plan, and choosing a primary care physician is helpful with ensuring success. "

- Identifying patient needs requiring additional help
- Ability for a warm handoff during in person navigation to CBO
- Provide patient with follow up information
- Include resource referral information on discharge paperwork

> Warm handoffs with patients help prevent communication breakdowns that can occur when a patient is discharged. Warm handoffs are a great way to engage patients and family and build relationships between patients, hospital staff, and CBO staff."

> Healthcare costs went down for people who completed food pantry referrals."

Challenges

Lack of awareness of the Homelessness Z-code ICD-10-CM

Patient discomfort with answering additional screening questions

Barriers to getting resources and patients being waitlisted

Follow-up with patients

> Asking screening questions about insurance is difficult. When patient's understand the screeners' intention to help them with getting insurance, they tend to open up.

> It is important to show genuine caring and empathy to the patients. When people understand that the screener cares about them – they tend to open up."

> Patients that are homeless often do not have a phone, so making connections can be a challenge. Patients that do not have phones are given business cards so they can contact CBOs for help.

CLOSING STATEMENT & CALL TO ACTION

Don’t Go It Alone

If you’ve decided to move forward with exploring the implementation of this Social Determinant of Health (SDoH) Screening in Emergency Departments program then please contact the IHA & Catholic Charities Teams. We are here to help you with guidance and resources you may need, and would love to hear from you.

Contact US

IHA | ihen@team-iha.org

Catholic Charities Association | 312-655-7305

Illinois Health and Hospital Association

The CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO