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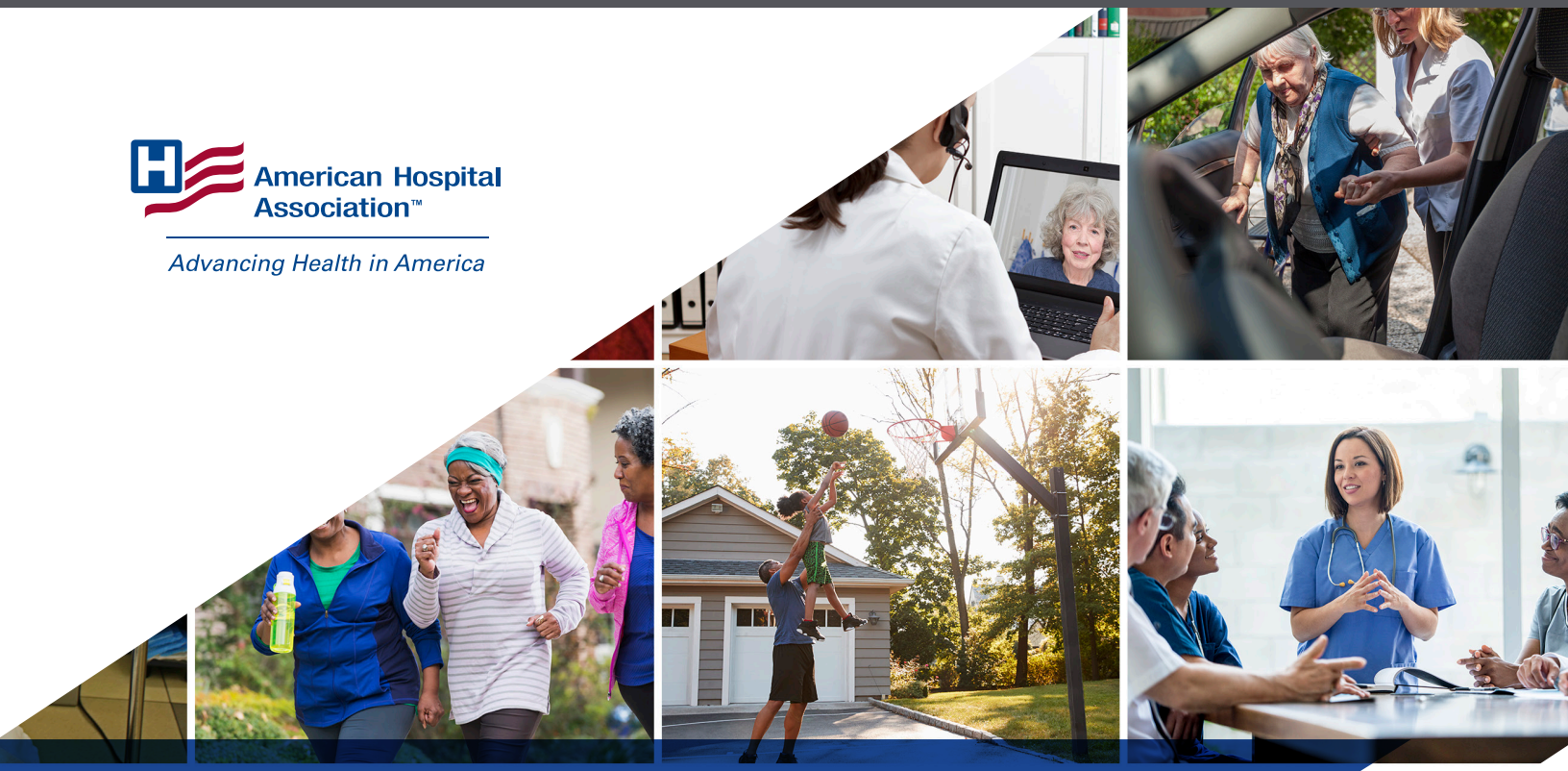

Screening for Social Needs:

Guiding Care Teams to Engage Patients

THE Value Initiative

Screening for Social Needs: Guiding Care Teams to Engage Patients

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Foreword

Over the past year and a half, the American Hospital Association's (AHA) effort, *The Value Initiative* has been working with hospitals and health systems around the country to help improve affordability and promote value. As part of that work, we have identified and shared proven strategies to help hospitals lower costs, improve outcomes and enhance the patient experience.

A broad variety of value-based strategies include taking action to address the social determinants of health. Hospitals are addressing social determinants in a number of ways. They have *partnered with rideshare companies* to ensure patients keep follow-up appointments, stocked their own *food pantries* with healthy options, and even *invested in affordable housing*, among other *important efforts*. This is complex and nuanced work that involves stakeholders in the public and private sectors. It begins with understanding patients' lives beyond the walls of the hospital and addressing their social needs.

To treat patients' social needs, we must first identify them through a screening process. In our work through *The Value Initiative*, we have heard first hand from hospital and health system leaders that screening for social needs is challenging. For example, hospital care teams may feel uncomfortable engaging in conversations about social needs, there may not be enough time in a patient encounter to collect social needs information, or in some cases, patients are reluctant to discuss their social needs.

This tool will help guide hospital leaders as they navigate the best way to engage their patients in screening conversations. In addition, we know that addressing the social needs of individuals and communities takes more than a screening conversation. It requires community partnerships. Hospital care teams also will need workflows and referral processes, among other things, to respond when a patient screens positive for a social need. But, it does all start with a conversation.

We hope this tool is helpful in those screening conversations and that you tap into AHA's other tools and resources aimed at addressing the social determinants in our communities. For more information and additional resources, please see the Appendix and visit *www.aha.org/ValueInitiative*.

Screening for Social Needs: Guiding Care Teams to Engage Patients

Background

As hospitals and health systems work to drive value by enhancing the patient experience, improving outcomes and reducing cost, they are recognizing the necessity of addressing the myriad nonmedical factors that affect health. An individual's ability to achieve good health is influenced by more than access to high-quality medical services; 80 percent of health outcomes are shaped by the social determinants of health – the conditions in which people are born, grow, work, live and age.[1] These factors include safe and stable housing, access to food and transportation, social connection, safety and environmental exposures.[2] Social determinants of health disproportionately impact vulnerable communities, contributing to the persistence of health inequities.

Social determinants and social needs are interrelated yet distinct concepts. Efforts to address the *social determinants* of health focus on the underlying systemic social and economic conditions in which people live that prevent individuals and communities from achieving their highest potential for health. Interventions to address *social needs* are done at the individual level to mitigate unique acute social and economic challenges.

Addressing the full scope and complexity of social determinants of health is a massive, multi-sector undertaking. As cornerstones of their communities, hospitals and health systems play a key role – in partnership with other community stakeholders – to positively impact the social needs of the individuals they serve by screening for and addressing the needs of their patients. A crucial step to addressing patients' social needs is having a conversation with individuals and families to understand what they are experiencing outside the exam room walls.

A comprehensive social needs screening strategy has numerous components; this tool focuses on one piece – how care teams can engage patients in conversations about what they are experiencing and the importance of addressing their social and environmental needs. It offers strategic considerations and principles for how hospitals and health systems can employ patient-centered strategies to have meaningful and empathic discussions about social needs. The tool also provides case studies of organizations at the front edge of this work.

Challenges in Screening for Social Needs

In a national survey of hospitals, 88 percent of respondents reported screening for social needs, yet a quarter of the screenings are performed only occasionally on a select population.[3] While there are many reasons for this, some persistent provider-side barriers to screening for social needs include:

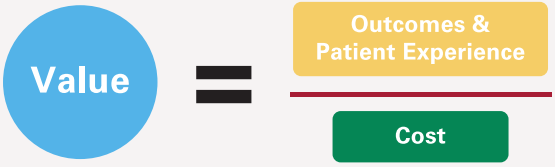
- **Discomfort engaging in conversations about social needs.** Some clinicians feel uncomfortable initiating conversations about potentially sensitive subjects, such as social needs. They worry that patients will perceive the questions as intrusive or offensive if not broached in an empathic manner.[4]
- **Insufficient time for collecting social needs information.** Given limited appointment time, expertise and lack of compensation for screening, providers tend to prioritize medical issues over social needs.[5]
- **Lack of systems to document and track social needs data.** Hospitals may not have a standardized process for documenting social needs or tracking referrals.
- **Perceived lack of efficacy to address social needs.** Clinicians may question whether they can impact their patients' complex underlying social, behavioral and economic conditions that are beyond their control and sphere of influence.[6] A Robert Wood Johnson Foundation survey found that four out of five physicians do not feel confident in their ability to meet their patients' social needs and approximately half of physicians feel ill-informed about the resources available.[7]

Patients also may be reluctant to discuss their social needs with anyone, including their care provider. There are numerous reasons that an individual may be hesitant to share their social needs, including:

- **Shame** for not being able to provide for their family;
- **Fear** of what the provider will do with that information; for example, that their children might be taken away, that they will not be able to stay in their home, or that they might be treated differently;
- **Stigma** of others thinking less of them for needing extra support;
- **Trauma** may make it challenging to talk about difficult situations in their lives;
- **Power dynamics** may create a perception that patients have less power than their clinician and inhibit their active disclosure of information; and

Driving Value by Addressing Social Needs

The American Hospital Association's The Value Initiative is addressing affordability through the lens of value. The AHA expresses value as a complex concept comprised of improving outcomes, enhancing the patient experience and reducing cost. By addressing patients' social needs alongside their medical ones, hospitals have the opportunity to positively impact each component of the value equation.



For example, Advocate Aurora Health implemented a nutrition screening and education program for adult patients at-risk or malnourished at four of its hospitals that led to better outcome and lower costs. The program yielded significant reductions in 30-day hospital readmission rates and reduced average lengths of stay by almost two days. Health care costs were reduced by $3,800 per patient and the program achieved over $4.8 million in savings.[8]

Additionally, University of Illinois Hospital's Better Health Through Housing program recently reinvested funds to establish supportive housing options for chronically homeless patients that frequent the emergency department (ED). Working with a community partner, Center for Housing and Health, patients accepted into the program are located by an outreach worker, and transitioned within a few days into bridge housing. From there, they are assigned to a housing case worker at one of 27 supportive housing agencies, who helps them select a suitable permanent supportive housing unit. Through this program, the hospital reduced ED utilization by 57 percent, and health care costs by 21 percent for this population.[9]

- **Social and cultural norms** shape how different cultures view sharing struggles and getting support for social needs.

The challenges on both the provider and patient sides point to an opportunity to enhance how hospitals screen for social needs. By developing a systematic process that trains care team members to be empathic and inclusive, patients and care team members may be more inclined to work together to meet medical and social needs.

Guiding Principles for Screening

There is no one-size-fits-all strategy for social needs screening. Each hospital should adapt its approach based on its specific operational and community needs; all hospitals should consider how to incorporate the guiding principles described in Table 1 into their social needs screening strategies.

Table 1. Guiding Principles for Social Needs Screenings

Empathy. The ability to understand and share the feelings of another.	Empathy builds connections between clinicians and their patients to better understand their life circumstances and emotions. It allows the clinician to listen and react nonjudgmentally to the patient's challenges.
Respect. Regard for the feelings, wishes, rights or traditions of others.	Demonstrate respect by considering patients' willingness to share their challenges related to socioeconomic risk factors. Asking patients about their priorities demonstrates respect for their wishes and goals.
Autonomy. The right of patients to make independent decisions about their care.	Respect individual autonomy to make decisions about what social support they want to accept. The patient's choice is critical in seeking his or her buy-in for the screening process and any subsequent actions.
Trust. The reassuring feeling of confidence in the clinician.	Build trust with patients to reduce the barriers discussed above; this enables a clinician to gain insight into a patient's life circumstances and priorities, and elicit their on-going input on their health status and social needs. Key traits related to trust include competence, compassion, privacy, confidentiality, reliability and communication.[10]
Dignity. Sense of self-respect.	Recognize patients as an equal, value their needs, inform them about their medical diagnoses and social risk, recommend treatment, but give them the right to make decisions.
Collaboration. Working with someone to create an outcome.	Partner and foster relationships with community stakeholders to develop strategies that meet the unique social needs of patients and community members.
Support. The act of helping or assisting someone.	Show support by valuing patients' priorities, giving them time to comprehend their health and social needs, and respecting their decision to seek help, based on their preferences.
Sensitivity. An appreciation of others' feelings.	Recognize the sensitivities associated with individuals being asked to share their deepest concerns. Build a safe environment for patients to share their life circumstances.
Cultural Competence. Being respectful and responsive to the health beliefs and practices of diverse population groups.	Recognize the diversity of the community and establish a culture where clinicians acknowledge that societal norms and attitudes towards health are grounded in culture. Leverage this openness to empower individuals to address their health and social needs in a culturally appropriate manner.
Community-engaged. The process of working collaboratively with community groups and members to address issues that impact the well-being of those groups.	Prioritize engaging patients and the community the hospital services by partnering with community organizations and listening to the life experiences of community members to gain insight on community needs as well as assets.

Source: American Hospital Association, 2019.

Implementing Social Needs Screening

Social needs screening approaches should be unique based on the needs and preferences of the organization and community. Hospitals need to determine which approaches best fit their needs. Here are four components to consider in the design and implementation of social needs screening strategies.

Co-designing the Screening Process

Co-designing the social needs screening approach creates an opportunity to collaborate with providers, patients and community stakeholders.

- **Providers.** Collaborating with clinicians to create the screening tool fosters a sense of ownership of the questions and process. They can apply their expert knowledge of their patient population and clinical processes to ensure that the social needs approach dovetails with their clinical work.
- **Patients.** Individuals are experts in their own experiences and culture, and can provide valuable insight into how clinicians can discuss social needs with others in their communities and the most important questions to ask.
- **Community stakeholders.** Community-based organizations have expertise in the communities they serve. Collaboratively designing the social needs screening process can strengthen the partnership between the health care organization and the other community stakeholders. It is important to invest the time to build and maintain relationships with community stakeholders since they are essential partners for addressing identified social needs. Hospitals and their community partners should be sensitive to each other becoming overwhelmed by an increase in positive screens for social needs and referrals.

Creating the Conditions for Screening

There are numerous locations, modes of communication and points of contact throughout the patient encounter where providers can screen for social needs. While each of the following approaches can add value, the co-design process should help inform which of these methods is be best for your hospital's population.

- **Locations.** Hospitals can screen patients in an office space, exam room or electronically from their home. Screens conducted electronically at home can be followed up on during their visit. Screenings should be done in a private setting where the patient is able to talk openly without being overheard.

At Chicago's Rush University Medical Center, care team members ask patients questions about social determinants of health in the ED and across the Rush system. Patients' responses are entered real time into the social determinants of health screening tool, which is integrated into their electronic health records. This method gives the care team member the ability to address patient needs expediently and connect patients to community resources via text and email, as well as provide direct referral to some partner agencies.

- **Modes of communication.** Hospitals can inquire about their patients' social needs on paper, electronically and/or through in-depth conversations. Screening questions can simply be incorporated into existing health assessments that patients fill out. The medium also may vary by the social need being asked about; for example, patients may be more willing to disclose household violence or substance use disorders in an electronic format than in conversation.[11]

- **Point of contact.** The care team can engage in conversations about social needs before, during and after a patient encounter and in multiple settings. Settings will vary based on an organization's workflow, patient volume, availability of care team members and access to a private space.

  Boston Children's Hospital established a Community Asthma Initiative in 2005 to address social determinants and reduce asthma hospitalizations and ED visits, which are disproportionately high for African-American and Latino children. Families of children enrolled in the program receive home visits and environmental assessments to identify and reduce asthma triggers. In addition, nurse-supervised case managers connect families to local resources for educational, financial and housing support as well as programs that promote physical activity.

Regardless of where or when the screening takes place, hospitals should ensure that there is sufficient time to connect with patients, so as not to make the process feel rushed.

Screening Tools

Numerous tools offer screening questions that can be integrated into an electronic medical record. The Social Interventions Research & Evaluation Network (SIREN) summarized the most widely employed *social needs screening tools*, such as the *Protocol for Responding to and Assessing Patients' Assets*, *Risks and Experiences (PRAPARE)* and *Accountable Health Communities Tool*, which can be used to help hospitals suggest screening questions or adapt existing screening tools.

Identifying the Right Care Team Members to Conduct the Screens

Health care providers are uniquely positioned to talk with individuals about their social needs. Not only can they identify social needs during a patient visit, they can address clinical needs that stem from social needs, follow up on future visits and ensure that the referral loop is closed. Yet physicians are not the only care providers who can – or should – discuss social needs with patients. Other care team members include nurses, medical assistants, patient navigators, community health workers (CHW) and social workers. In fact, CHWs may be well positioned to work with patients around social needs by allowing them to work with someone from their community who understands their daily realities.

The Women-Inspired Neighborhood (WIN) Network at Henry Ford Health System, in Detroit, is a neighborhood-based infant mortality reduction program where CHWs co-facilitate group prenatal care sessions with certified nurse midwives. As part of their first contact with mothers, CHWs help mothers complete a needs assessment tool, discuss and offer necessary support services in the community for priority needs and help them identify resources for which they are eligible. Through this process, CHWs form a relationship with mothers as they become their point of contact throughout the pregnancy and help track and achieve the patient's goals related to improving the health of the individual and baby.

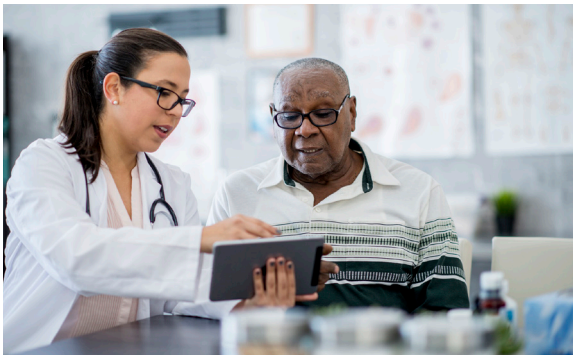
Documenting Social Needs

The field continues to advance its approach to standardizing documentation for social needs. Screening results should be routinely and consistently documented in the medical record so that it can be incorporated in the treatment plan. *ICD-10-CM codes* allow the care team to electronically code for social needs reported during the

assessment process. Results of the screen should be accessible to all care team members. According to the patient's identified need, establish a screening frequency to determine any changes in patient's conditions from the first assessment, as suggested in *HealthBegins' screening tool*.

Patient-centered Conversations about Social Needs

Providers regularly have conversations with their patients about their medical conditions; however, given the sensitivity around social needs, patients and families need to be asked the right questions in the right way to engage them and elicit their stories. In other words, patients will be more inclined to share their life circumstances in a safe, nonjudgmental environment where their care team members exude compassion, openness and empathy. This approach creates an opportunity for hospitals to build trust, better understand patient needs and deliver patient-centered care.



As hospitals implement social needs screening that includes sensitive questions, providers should be supported in their crucial role in identifying and addressing social needs and ways to establish trust and respect among care team members and patients. Table 2 features approaches that can support care teams in asking sensitive questions about social needs. See the Appendix for corresponding tools.

Table 2. Skills for Engaging in Sensitive Conversations

Approach	Description
Cultural Competency. The ability to interact effectively with people from different cultures.	Cultural competency training helps care team members increase their sensitivity to cultural diversity, reduce language barriers and build understanding for life experiences that shape a person's identity.[12]
Motivational Interviewing. Counseling method that helps people resolve challenges and find the internal motivation to change their behavior.	Motivational interviewing empowers patients to take control of their own health and behaviors by setting goals based on their wishes and current circumstances.[13]
Active Listening. Technique where the listener fully concentrates, understands, responds and remembers what is being said.	Active listening teaches providers how to properly listen to what patients are saying, identify any underlying hesitance and in return ask leading, open-ended, closed-ended and reflective questions related to their challenges.
Empathic Inquiry. The technique that integrates motivational interviewing and trauma-informed care to facilitate collaboration and emotional support.	Empathic inquiry trains care team members to connect with patients, increase relatability and suggest nonjudgmental approaches to improve health.
Asset-based. An approach to care that focuses on the individual's strengths and potentials.	Recognize that, alongside having needs, patients and communities have many assets that can be leveraged to address their social needs. An asset-based approach allows the provider-patient conversation to be reframed from a focus on deficits to connecting with their strengths, interests and areas the patient fiends meaningful. At the community level, an asset-based approach helps identify, partner with and leverage resourceful organizations such as schools, community-based or faith-based organizations, government, local businesses, etc., and people in the community to collectively build on existing resources and form new community connections.
Trauma-informed. A framework that involves understanding and responding to behaviors/actions and needs as a result of trauma.	Trauma-informed care is a holistic approach of treating a patient, where it is assumed that each individual has a history of trauma and coping mechanisms. Integrate questions and practices that are trauma-sensitive to increase resiliency and build a culture that supports personalized patient care.[14]

Source: American Hospital Association, 2019.

Referral Process for Positive Screens

Hospitals should have an established workflow that is responsive when a patient screens positive for a social need that includes:

- **Define roles and responsibilities of the care team members.** Leverage the expertise of other professionals (e.g., social workers, community health workers, community benefit, IT, etc.) within the hospital with knowledge on referrals, community relationships, data, etc. Empower the care team with tools, skills and time to learn, implement and track the screening and referral process. View *workflow example* from VCU Health System.
- **Create a centralized system to capture data** and incorporate coding the results of patient screens into an electronic medical record system. Learn about *coding for social needs*.
- **Foster partnerships with community-based organizations** to create a referral network, raise awareness about services provided and bridge any gaps in care. Refer to *A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health* to identify key community partners.
- **Develop a referral and community resource database.** Integrate the inventory of community resources into a web-based or software system to generate and better track referrals.
- **Close the referral loop by developing a bidirectional process,** where the care team follows up with the patient to see if the referral was received and then again in one-two weeks to ensure needs were met. Develop a system to track referrals and measure the success of the screening and referral process. In order to facilitate referrals, technology is being developed to connect individuals with the resources they need. Organizations involved in this work include *NowPow*, *Health Leads*, *2-1-1* and *Healthify*.

View the Appendix for electronic tools and local resources hospitals can use to connect patients with identified needs to community resources.

Empathic Inquiry: Screening Sensitively

The Oregon Primary Care Association (OPCA), a nonprofit membership association for Oregon's federally qualified health centers, created Empathic Inquiry as a conversational model for social needs screening that promotes partnership, affirmation and patient engagement. Empathic Inquiry was developed through the synthesis and application of input from patients and other stakeholders, along with key concepts and skills from motivational interviewing and trauma-informed care. The pilot training program provided in-person training and remote support to nurses, medical assistants and community health and outreach workers from 10 Oregon community health centers in 2018. Survey results from training participants showed improvements in confidence and comfort in conducting social needs screening, as well as perceptions of patient partnership and autonomy. Similarly, patient experience surveys revealed the following:

- Patients agree that the empathic inquiry conversation strengthened their relationship with their care team (64 percent strongly agree and 28 percent somewhat agree).
- Nearly all patients agreed that the conversation was a good use of their time (83 percent strongly agree and 14 percent somewhat agree).
- More than 70 percent of patients said, "After my conversation today, I know more about how the clinic can assist me with needs beyond medical care."

Tailoring Screenings

To ensure a hospital's social needs screening approach aligns with their unique organization and community, hospitals should consider the strategic approaches outlined in Table 3 to determine how best to customize their approach.

Strategies to Scale Screenings

As hospitals build their social determinants strategies, they are using data to scale screenings outside of the local health system and into the community to identify community needs, better detect associations between social factors and health outcomes, and implement population health programs. Below are some strategies hospitals can adapt to extend social needs screenings beyond their walls.

- **Start small.** Pilot a screening approach such as holding an open forum or community dialogue to learn and engage with community members. As the screening process is implemented, continue to observe what does and does not work and make adjustments accordingly.
- **Know the community.** Continue to learn about the patient populations served by analyzing data from screenings, medical records, claims and community health needs assessments.
- **Raise awareness.** Develop internal engagement strategies to support work around social needs.
- **Train.** Continue to train care team members on cultural competency, motivational interviewing and empathy to reduce stigma around speaking about social needs. Refer to Table 2 for examples of practices.
- **Collaborate.** Strengthen existing relationships with community stakeholders and build new ones to develop population health programs around prominent social needs in the community. This is not the job of one organization alone.

Screening for Social Needs in the Community

Lankenau Medical Center, part of Main Line Health, is situated on the border of Montgomery and Philadelphia counties, the third-healthiest and least-healthiest counties in Pennsylvania, respectively. In an effort to address the health care disparities between these neighboring counties, the hospital spent several years establishing and strengthening its community health and equity programs.

One such effort is Lankenau's Medical Student Advocacy Program, a partnership with Philadelphia College of Osteopathic Medicine that provides second-year medical students with the tools necessary to address patients' nonmedical needs that may be an obstacle to accessing medical care. These needs include transportation to appointments, utility assistance, health education, food assistance, child care, housing, personal care and social support needs.

Since 2012, the program has screened more than 1,200 patients and identified more than 3,000 resource needs in the community. Therefore, in 2018, screening efforts were expanded beyond the clinical setting into the community. Lankenau now partners with five library branches, a school, a federally qualified health center, farmers markets and two corner stores to screen for social needs in the community and allocate the appropriate resources to support these needs.

Table 3. Strategic Considerations for Social Needs Screenings

Engage Community Stakeholders
• Gain insight into what questions should be asked • Identify any community sensitivities or perceived barriers to asking questions • Identify community advocates to support social needs screening processes beyond the clinical settings • Build relationships with community members and organizations to identify existing community resources to address social need challenges
Create a Safe Space for Conducting Screenings
• Consult with community stakeholders about options for where to screen • Allow adequate time to discuss social needs • If in person, make sure the space is quiet and private
Get Buy-in from the Patient
• Explain the purpose of social needs screening and its value for tailored or personalized patient-care • Ask permission to ask sensitive questions • Recognize the patient's autonomy • Recognize the sensitivity of the questions being asked and ensure confidentiality • Be transparent. Clarify that they are not being singled out or discriminated against • Communicate the possibility of connect them to resources • Show support and respect at all times
Learn from the Patient
• Identify patient priorities • Recognize the tradeoffs they need to make for their health • Learn how a patient perceives their social needs • Inquire about their language preference • Practice empathy by putting yourself in their shoes
Train Clinicians and Care Team Members
• Educate staff about various social needs and data on the community served • Encourage relationship-building with patients • Bring in resources to acquire knowledge on cultural competency, motivational interviewing, and trauma-informed care, as seen in Table 2
Apply Cultural Competency Skills
• Note any stigma or cultural concerns • Withhold judgement • Express empathy and respect • Note any cultural attitudes or beliefs that might impact screening • Develop screening tool, questionnaire and other forms of educational material in multiple languages to reduce language barriers and increase better understanding
Identify Individual and Community Strengths and Assets
• Reframe deficits as assets • Promote self-efficacy • Identify the individual's strengths
Develop Effective Documentation Processes
• Standardize a screening tool and a place such as the electronic health record to record answers • Account for screening answers in future encounters to avoid having similar conversation multiple times
Develop Actionable Next Steps
• Create a workflow plan for when a patient is screened positive • Partner with community organizations to identify existing resources • Equip clinicians and care team with referral sources
Scale the Screening Process
• How can the organization screen everyone? Who might need extra attention? • Work with other internal departments and physician practices to streamline screening approaches and data collection • Use insights and data from screening to develop community initiatives

Source: American Hospital Association, 2019.

Conclusion

The transition to value-based care has been influential in shifting the health care field's focus to examining the social determinants of health, as more hospitals are identifying and addressing various social needs in their communities. Part of addressing social determinants of health includes screening for social needs to determine the likelihood of socioeconomic challenges an individual may be experiencing. The first step in examining social needs from the patient's perspective involves asking sensitive questions and having crucial conversations. A successful screening program:

- **Values the patient.** Understanding the patient and allowing him or her the time to articulate his or her social needs and seek recommendations to address it adds value to the screening process, and informs equitable, patient-centric care.
- **Partners with the patient.** Providers can truly become partners with the patient by actively listening, creating a safe space for a patient to share concerns, and accounting for the patient's preferences and language barriers. These approaches help build a relationship that's positive, empathic, encouraging and empowering.
- **Partners with the community.** Whether it is gathering input from community stakeholders on screening tools, engaging them in referral processes post screenings or bringing screening into their settings, partnerships with community-based organizations and others in the community provide a venue for hospitals to reach the depths of the community and impact larger populations.
- **Trains clinical and nonclinical staff.** Hospitals can tailor their screening approaches to meet patient needs by equipping care team members with the training, time and tools necessary to guide sensitive conversations and make screenings an integrated component of patient care.

This screening approach enhances patients' understanding of their own health to improve their health outcomes and well-being, builds relationships with community organizations, creates an empathic and culturally competent environment and creates opportunities to improve population health by scaling screening tools and approaches outside of clinical walls and into the community. It is an important step for improving the value of health care and advancing health in America.

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Appendix

AHA Resources on Social Determinants of Health

AHA offers a range of tools and resources for hospitals, health systems and clinicians that address the social determinants of health.

Addressing Social Determinants of Health Presentation. This adaptable presentation deck gives you the tools and talking points to start the social determinants of health discussion in your hospital and community.

ICD-10-CM Coding for Social Determinants. ICD-10-CM Codes allow clinicians to code for social needs. This document reviews what the codes are and how hospitals can use them to record and track patients' social needs.

Social Determinants of Health Guides. AHA is producing a series of guides on how hospitals can address various social determinants of health. Below are the topics covered to date:

- *Food Insecurity and the Role of Hospitals*
- *Housing and the Role of Hospitals*
- *Transportation and the Role of Hospitals*

Social Determinants of Health Curriculum for Clinicians. To help clinicians address social determinants, the AHA's Physician Alliance created a web-based virtual expedition to train and equip staff with how-to actions and companion resources. Modules include an overview of social determinants, introduction to upstream quality improvement, and a focus on addressing food and housing insecurity as well as transportation.

The Value Initiative Issue Brief 3: Connecting the Dots: Value and Health Equity. This issue brief frames the connection between equity and value and affordability, highlighting how hospitals are improving value by addressing social determinants of health and equity.

Referral Tools for Positive Social Needs Screens

In addition to the AHA resources listed above, hospitals and health systems may find these electronic tools and resources useful in their efforts to connect patients with identified needs to community resources:

- *1Degree*
- *2-1-1*
- *Aunt Bertha*
- *Healthify*
- *Health Leads Reach*
- *NowPow*
- *Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER)*
- *Purple Binder*

Skill-building Tools for Patient-centered Conversations

Discussions about social needs require a safe, nonjudgmental environment where providers exude compassion, openness and empathy. As mentioned in "Patient-centered Conversations about Social Needs" section, there are several approaches to support care team members engage in these sensitive conversations. Listed below are commonly used tools that help develop skills for patient-centered conversations. This does not constitute or imply endorsement from the AHA.

Active Listening

- *Harvard Business Review - Making Time to Really Listen to Your Patients*
- *TEDx - The Importance of Listening in Healthcare*

Asset-based

- *American Hospital Association - A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health*

Cultural Competency

- *Industry Collaboration Effort - Cultural Competency Training for Healthcare Providers: Connecting with Your Patients*

Empathic Inquiry

- *Oregon Primary Care Association - Empathy Inquiry Implementation Tools*
- *Oregon Primary Care Association - Empathic Inquiry: A Patient-centered Approach to Social Determinants of Health Interviewing*
- *Charter for Compassion - How to Show Empathy*
- *Feeding America and Humana - Food Insecurity and Health: A Tool Kit for Physicians and Health Care Organizations*

Trauma-informed

- *Missouri Hospital Association - Trauma-Informed Care: Improving Health and Resiliency*

Motivational Interviewing

- *Health Catalyst - 10 Motivational Interviewing Strategies for Deeper Patient Engagement in Care Management*
- *Stephen Rollnick - Motivational Interviewing in Health Care: Helping Patients Change Behavior*
- *American Journal of Preventive Medicine - Motivational Interviewing in Health Care Settings*

Members in Action: Managing Risk & New Payment Models

Baylor Scott & White Health – Dallas, Texas

Community Advocates Create a Safe Environment for Social Needs Screening

Overview

To lower unnecessary hospital utilization and improve health outcomes, Baylor Scott & White Health collaborated with local universities to create the Community Advocates Program. Approximately 4.8 million Texans are uninsured and burdened with lack of resources, unaffordable care and increasing avoidable emergency department (ED) visits and hospital readmissions rates. Baylor Scott & White Health, one of the largest health systems in Texas, utilizes an innovative model called the Community Advocates Program as an opportunity to connect with community members, learn about their health needs – medical and social – and link them to existing resources in the community.

"Serving as a Community Advocate allowed me to experience what it truly means to deliver compassionate and comprehensive care. Helping a patient find a way to pay their bills, get a doctor's appointment that they weren't able to before, or secure a meal for their family for the next month was the best feeling."
– Sana Iqbal, Community Advocate

This volunteer program trains undergraduate students to become Community Advocates and conduct social needs screenings. Community Advocates screen patients for social resource needs and connect them with appropriate services related to food, housing, health insurance, childcare, adult education, job training and other services. These advocates are recruited from Baylor University, the University of Mary Hardin-Baylor, the University of Texas at Dallas and the University of North Texas. To date, 34 volunteers are enrolled in the program, with six more joining late 2019.

Community Advocates undergo intensive learning and training before screening patients:

- A one-day boot camp walks advocates through their role, familiarizes them with the program's model, provides pertinent site-specific tools, teaches them how to work with their clinical teams, how to identify cultural norms when interacting with patients, as well as role-play exercises to understand different patient-interaction scenarios.

- Role playing exercises teach students that may be clinically inexperienced how to articulate their voice, be intentional with their body language, address communication tendencies and identify an interaction they may be unfamiliar or relatively uncomfortable with (i.e., speaking to a physician in the emergency department). By the end of the training, students know how to overcome these barriers with various communication tools and methods, such as reading patient cues.

- Under the clinical supervision of a nurse or social worker, trained Community Advocates shadow their clinical team at nine clinical sites for the first few weeks and then are able to screen patients within a target patient population to provide resource referrals, navigation to needed community, faith-based or government services, and case management.

Additionally, Baylor Scott & White's "Community Advocates Pathways" for trained advocates provides strategic, yet sensitive considerations for navigating patient interactions. The pathways include guidelines and questions around the overall health of the individual, their education and employment status, and the need for basic commodities. For example, if a patient has expressed English is their second language, an advocate would ask "Do you need more support on reading, writing or speaking English?" If the response if yes, the patient will be directed to ESL classes in the community.

Impact

Because of the Community Advocates program, patients at all participating sites have been receptive to receiving additional assistance with their social needs. To date, 1,621 patients have been screened, and overall, 80 percent identified having a social need. The top three health needs identified by the patients were access and affordability of health care, access to food and lack of commodities. As a result of this program, 56 percent of positively-screen patients at one of the sites accepted assistance via referrals, while 30-day readmission rates of enrolled patients dropped by 87.5 percent.

"This is a volunteer program like no other," said Anne Horton, LBSW, ACM-SW, Baylor Scott & White, CCHW Compressive Care Management. "The advocates get to experience real and meaningful interactions while the advocate guides the patient through the process of connecting with community agencies that can fulfill their social needs."

Lessons Learned

Being available, flexible and understanding is a must for the volunteers in the Community Advocates program. Additionally, the program is driven by collaboration, whether it is with internal stakeholders such as clinicians and nurses for Community Advocates to learn about the patient population they serve, or with external organizations such as local universities to bring in students interested in developing skills and knowledge around health and patient needs. Additionally, the Community Advocates Pathways were beneficial for volunteers to direct conversations with patients in a nonjudgmental and respectful manner, where the patients were queried more based on their comfortability to share.

Future Goals

The Community Advocates Program will collaborate with other institutions to recruit both students and adult volunteers. The program started in seven sites of care at Baylor Scott & White but now has expanded to three other sites within the health system.

Contact: Community Health

Email: *communityhealth@bswhealth.org*

Members in Action: Managing Risk & New Payment Models

Integrated Healthcare Associates, Trinity Health – Ann Arbor, Mich.

Collaborating with Community Organizations to Screen Diverse Populations

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.

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.

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.

Figure 1: 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…"

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*).

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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