WHITE PAPER

Whole Person Health for Your Whole Population: How providers can support patients' social care needs at scale

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How providers can support patients' social care needs at scale

CONTENTS:

Imagine this: A patient enters your health system presenting with flu symptoms. Through the course of conversation, the physician identifies that the patient may not have enough food at home.

Does your health system have a clear workflow in place for what to do next that makes the most of the physician's time and also gets the patient the resources they need to thrive?

New U.S. Centers for Medicare & Medicaid Services (CMS) health equity requirements require providers to show how they're addressing health-related social needs and incorporating a social care strategy into their work in 2024.

These requirements are aligned with the goal all health systems share: to ensure every patient receives the care and resources they need to live happy and healthy lives. These requirements around CMS health equity also represent an opportunity to improve patient outcomes at scale because of the significant impact social drivers of health (SDoH) have on patient outcomes.

In fact, in one study of the Chicago Southland Coalition for Transition Care (CSCTC), researchers found that by implementing a program to connect patients to social care resources in the community, the program "reduced 30-, 60-, and 90-day readmission rates by a statistically significant 14 percent or more of the sample mean, and reduced readmission costs an amount equal to CSCTC program cost."

However, most healthcare professionals have a full plate simply providing exceptional care to their patients. Exploring, vetting, and providing additional information on relevant community resources that can support social drivers of health simply isn't practical — and most healthcare professionals aren't trained on how to solve those issues, either.

"Providers across the country are increasingly overworked, burned out, and facing staffing shortages, and they don't always have the bandwidth to connect patients with the right resources at the right time," says Harrison Hancock, Sales Executive, at Unite Us, the nation's trusted technology partner for social care transformation. "We need to do what we can to save clinicians time while also connecting patients to truly helpful, community- and need-specific resources that reduce the likelihood of readmission."

Connecting patients to social care resources in the community has become a critical component of many healthcare systems' initiatives to improve whole-person care. "What does whole-person care mean?" asks Gillian Feldmeth, Director of Research and Evaluation Operations, Unite Us. "It's about recognizing that patients and care teams may need different types of support at each step of the care journey. We also have to think about the people who are providing whole-person care. Are those tools available within the systems they already work in, so they don't have to leave their electronic health record (EHR) to connect a patient to resources?" And finally, consider an asset-based approach when addressing social drivers of health."

Feldmeth goes on to explain that, for patients, whole-person care might look like not having to tell their story multiple times, or like having a community partner follow up with them instead of the other way around. It's easy to think about a lack of things (e.g. food or housing) and while those are challenges that need to be addressed, providing a 'whole-person care' approach means looking at the strengths as well. What are the assets of the patient and their community? Recognize the impact that those strengths can have on their health and well-being, as well.

Healthcare, education, social and community engagement, economic stability, and physical environment — these powerful factors can influence whether or not a patient will require additional care or be able to avoid a future visit to the emergency room. It's crucial hospital systems equip care teams with information and technology-enabled workflows that allow them to refer patients to community resources in a streamlined, scalable way.

Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to organizations in the Joint Commission's ambulatory health care, behavioral health care and human services, critical access hospital and hospital accreditation programs.

EP 1: The [organization] designates an individual(s) to lead activities to reduce health care disparities for the [organization's] [patients].

EP 2: The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

EP 3: The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

EP 4: The [organization] develops a written action plan that describes how it will address at least one of the health care disparities identified in its [patient] population.

EP 5: The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities.

EP 6: At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners and staff, about its progress to reduce identified health care disparities.

Source: The Joint Commission

Support healthcare providers in providing personalized care

Healthcare isn't a one-size-fits-all approach, and neither is social care. Providers need to be able to offer different approaches and recommendations when supporting patients based on what makes the most sense for the care team and the individual being served. But they can't be alone in offering this support — they need to be enabled at the care team and hospital level in a way that fits with how they already work.

Providers need to be able to quickly access, select, and share resources appropriate to the situation without leaving their EHR. Interoperable screening and referral platforms like Unite Us make it possible to address social care needs within the EHR so physicians and case managers aren't doing duplicate data entry to get patients the information they need.

"Right now, new regulations are requiring providers to screen for social needs, but in the future, we're anticipating that providers will also need to play an active role in addressing those social needs–including the ability to demonstrate referral outcomes," says Payton Shephard, Sales Executive, Unite Us. "Bringing in a screening and referral solution now puts providers in a proactive position to better serve patients and reduce readmissions by providing support for critical social drivers of health."

Equip healthcare providers with automated and integrated workflows

Adding manual to-dos to already strapped care teams results in confusion and overwhelm. Any process that requires physicians to leave the EHR to coordinate more care adds time, stress, and potential error to the physician's workflow. Care teams need to be able to leverage automation to streamline processes and increase efficiency so they can keep their focus on the patients, not on the paperwork.

Technology solutions like Unite Us help care teams take the next step after identifying the social care needs a patient might

"I enjoy having the shared accountability between the sender and receiver of resource referrals. This can only benefit our patients."

Nicholas King, MSW, Sarasota Memorial Health Care System

Case Study Spotlight

Together with Unite Us, Sarasota Memorial Health Care System was able to demonstrate that addressing unmet social needs can significantly improve patient outcomes while reducing overall healthcare costs.

Preliminary results of the study included:

- **70%** reduction in odds of all-cause readmissions and a **79%** reduction in the odds of postpartum-related readmissions for Medicaid enrollees
- **Over $350,000** estimated savings for all-cause readmissions per **1,000** deliveries
- **Continued reduction in odds** of hospital admission up to **12 months** after delivery

Click here to read more about Sarasota Memorial Health Care System's experience improving care outcomes and lowering costs with Unite Us.

have without adding additional time, effort, or documentation. The end result is that care teams are able to empower the patient with information and resources and give them clear next steps — without leaving the EHR.

"The future of healthcare will encompass technology-enabled workflows," says Hancock. "As they are often the first point of contact for a patient, health systems and physicians can do a lot of good by acknowledging their role in the larger ecosystem of care and being a part of referring patients to much-needed resources. It shouldn't, however, require additional time or effort on their part. And that's where technology solutions like Unite Us can help."

Give healthcare providers access to the outcomes data they need

Having clear, accurate data about referral outcomes is top-of-mind for healthcare leaders. When referring patients to social care resources, care teams need to be able to dive deep into the data to understand what's working, what's not working, and how they can adjust to best support their patients and community.

Some of the most important outcomes to measure are referral outcomes and readmission rates. Do efforts to connect patients with community resources actually result in them receiving services, and does that reduce the number of patients returning to the healthcare system for support? With a technology partner like Unite Us, it becomes easy to see where, when, and how those resources are used and the impact they have on metrics like readmission.

Provide additional support based on patient risk-level

Providers may work with high-risk, rising-risk and low-risk patient populations with varying needs. Providers need to be able to change workflow options to address the needs of these different types of patient populations. For example, low-risk patients may simply need a list of eligible resources that they can access themselves. High-risk patients, on the other hand, might require additional support along the way in the form of closed-loop referrals that are facilitated by a case manager or care team member.

Without a tool like Unite Us, it can be difficult for providers to address the needs of both high-risk and low-risk patient populations in a streamlined, efficient way. They have to make these decisions and provide these resources manually and outside their existing workflows. With the help of a technology solution, the result is time, attention, and resources that are documented in the after-visit summary, patient portal, or EHR.

"Screening is really just the tip of the iceberg," says Feldmeth. "The care teams doing this work interact with patients and families in a multitude of different ways to identify unmet social needs. At Unite Us, we want to ensure that no matter the type of need identified, these care team members can turn to Unite Us to connect the patient to a community partner for support. Our extensive service type taxonomy allows our network partners to accurately convey the wide variety of services and programs they offer to meet the diverse and evolving needs of patients and communities.

We know that enabling these community partners to leverage technology to receive referrals and close the loop on social care ensures that whenever a need is identified, there's a next step to do something about it."

"We chose Unite Us because I know if I send someone to the food bank because they need food, I know who said yes. I know they got there. And if they didn't, I know I can reach back out to that patient and make sure they're looped back in in a different way.

Our doctors don't want to just ask the question and have no way to help. By partnering with Unite Us, we're really showing the doctors that they did help and here's the proof that their patients' needs were met."

Erin Booker, Vice President for Community Health and Engagement at ChristianaCare

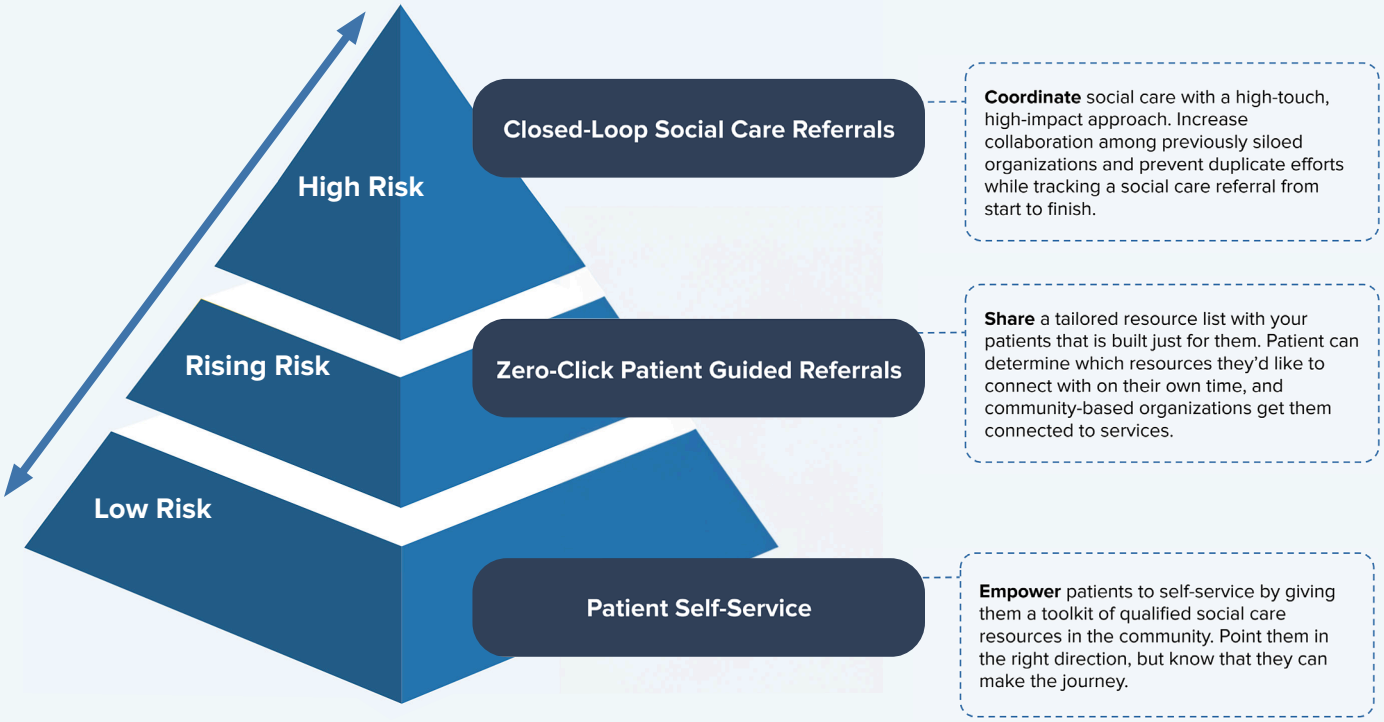
Meeting patients where they are and making room for the future of healthcare

Whether motivated by CMS's new health equity requirements or the promise of delivering excellent care and experiences to patients, health systems have one clear next step: use the technology available to bring social care resources and referrals into the healthcare ecosystem and achieve better patient outcomes. Unite Us empowers providers across the country to take a personalized approach to supporting patients, leverage automation to streamline processes and increase efficiency, and understand what happens after a patient leaves the healthcare system.

Support that scales according to patient risk level

Whole person health **for your whole population**

An enterprise technology solution that scales across your entire health system – plus a strong network and the right people to power it.



Coordinate social care with a high-touch, high-impact approach. Increase collaboration among previously siloed organizations and prevent duplicate efforts while tracking a social care referral from start to finish.

Share a tailored resource list with your patients that is built just for them. Patient can determine which resources they'd like to connect with on their own time, and community-based organizations get them connected to services.

Empower patients to self-service by giving them a toolkit of qualified social care resources in the community. Point them in the right direction, but know that they can make the journey.

When you bring whole-person health to the whole patient population, you meet patients where they are and help them take the next step at the point of care. You play a starring role in building healthier communities, while reducing the burdens and costs plaguing the healthcare system. You unite patients, families, providers, healthcare systems, and communities in one common goal — advancing quality, equitable care for all.

UNITE US

Unite Us is the nation's premier technology provider for advancing social care outcomes. Our advanced product suite streamlines processes and fosters collaboration across government, healthcare, health plans, and community-based organizations to address social drivers of health by facilitating social care services, intervention programs, and Medicaid reimbursements. The first of its kind, our closed-loop referral platform now integrates more than 1M services and securely hosts the nation's largest network of non-profits committed to improving whole-person health one community at a time. Learn more at UniteUs.com.