UNITE US

McLeod Health

Case Study

More Than a Resource:
How McLeod Health and Unite Us are Improving Patient Care With Closed-Loop Referrals

Background

McLeod Health is a locally owned and managed not-for-profit healthcare system serving more than one million people across South Carolina and southeastern North Carolina. Founded more than 118 years ago, McLeod is comprised of seven hospitals that offer 988 acute licensed beds and features the strength of nearly 1,000 medical staff members, 2,900 licensed nurses, and 15,000 team members. McLeod constantly seeks to improve patient care through physician-led, data-driven, and evidence-based efforts.

The mission of McLeod Health is to improve the health and well-being of people living within South Carolina and eastern North Carolina by providing excellence in health care. Given their deep roots in the community, the health system recognized early on that social drivers of health (SDOH), while non-medical in nature, play a significant role in health disparities and inequities.

Addressing Community Health Needs

McLeod Health regularly assesses community health needs as part of its mission to improve the health of the communities it serves. Under the Affordable Care Act of 2010, non-profit hospitals are required to have a well-defined process for updating Community Health Needs Assessments (CHNA) every three years. By analyzing data on demographics, socioeconomic factors, and major health issues, the CHNA aims to uncover what health challenges exist in the community and identify resources available to address those needs. The CHNA has enabled McLeod Health to guide priorities, interventions, and resource allocation across its 18-county service area.

Challenge

The McLeod Health team was committed to addressing the social care needs of their patients. However, their prior technology solution for addressing social needs had an inefficient process that didn't close the loop on social care referrals sent to community partners. Looking for more than just a resource list, McLeod Health wanted to know what actually happened after they sent their patients to community resources. Did patients get the support they needed? McLeod Health also wanted a more formalized workflow and robust data for their team to effectively manage social care referrals at scale.

Why Unite Us?

"With our prior technology solution, we were unable to complete closed-loop referrals to a large number of our established community partners", according to McLeod Health. "In addition, as an organization heavily reliant on data and research, we found it discouraging that we struggled to extract meaningful reports, metrics, and statistics on the best ways to service our patient population. These gaps motivated our leadership team to research other available solutions in order to meet the needs of our most vulnerable patients."

Solution

When they started looking for a new SDOH technology solution, McLeod Health turned to their community and other health system partners to see what was working for them.

"We learned that a number of our established and pending community partners were currently utilizing the Unite Us Platform. We found their positive reviews of the technology, implementation process, and ease of communication with the Unite Us team post-go live to be encouraging. We were also impressed with the ability to seamlessly complete closed-loop referrals in real-time prior to the patient being discharged from the organization," explains McLeod Health.

Another key consideration for McLeod Health was the ability to seamlessly integrate with their EHR and easily pull data and reports about referrals. Unite Us' Epic integration, robust data and reporting capabilities, strong community partnerships, and trackable referral workflows ultimately led McLeod Health to partner with Unite Us.

Solutions

Resource Directory:

- A robust, searchable directory of community resources that can be shared with patients in their preferred language via text, email, or print
- SDOH screenings conducted in the EHR are automatically sent to Unite Us to inform resource recommendations
- Automatic recommendation of best-fit resources for patients based on their screening results

Data & Reporting:

- How resources are being shared with patients, including frequently recommended organizations, programs, and service types
- How the network is performing, including by specified geographies, timeframes, organizations, and demographics
- Demographic and geographic distribution of patients served, to understand whether patients are receiving equitable access to care
- Referral metrics and platform usage across the health system

Closed-Loop Referral System:

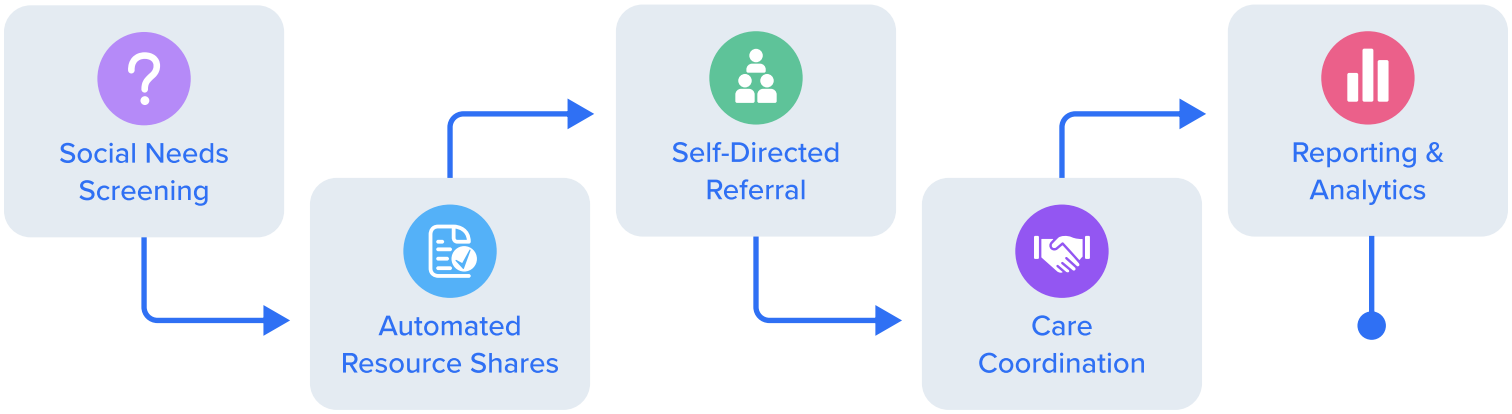
- Ability to send referrals to community partners with the click of a button from directly within the EHR via Epic EHR integration
- Chat functionality to seamlessly communicate with other providers in the network about shared referrals and cases

Impact

Since implementing Unite Us, McLeod Health has been able to streamline its referral process and more easily connect patients to resources in the community. They recognize that social care isn't a "one size fits all" solution, leveraging different workflows to meet the various needs of their diverse patient population. Some patients only need to be pointed in the right direction with an accurate list of resources that can meet their specific needs; others need more tailored support with a closed-loop referral that prompts a community-based organization to connect with the patient directly and allows the care team to track service outcomes after discharge. With Unite Us' robust screening and referral platform, McLeod Health is equipped with the tools it needs to adapt to its patients' evolving needs over time.

> "Unite Us has been extremely professional, easy to work with, and prompt to answer all questions or concerns. We are pleased to integrate Unite Us into our EHR so staff can quickly and efficiently place referrals for patients without having to navigate away from their current workspace."
>
> — MCLEOD HEALTH

ZERO-CLICK PATIENT-GUIDED REFERRAL WORKFLOW



Jane Doe is a 26-year-old patient. At her annual wellness visit, a nurse completes an SDOH screening, which indicates she is food insecure.

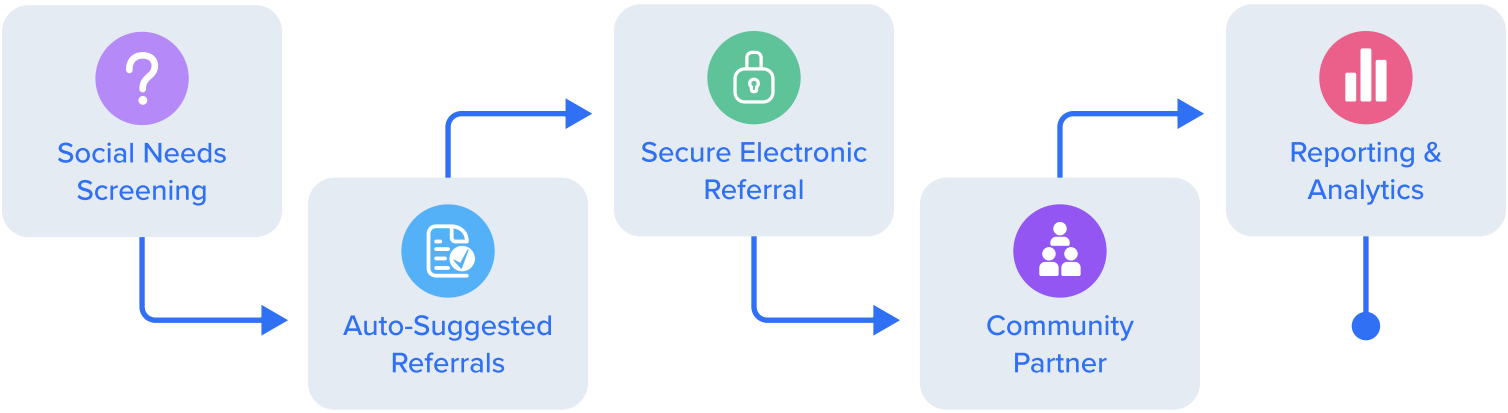
Based on the screening results, Unite Us automatically generates a tailored list of recommended resources for Jane. The care team can share this list in Jane's After Visit Summary and the patient portal for patient self-navigation.

Jane can determine which resources she would like to connect with on her own time. Community-based organizations ultimately get Jane connected to care.

When Jane returns for her next visit, the care team can see the resources shared previously wih Jane and follow up on her care journey.

Resources shared with patients roll up into the Unite Us Resource Recommendation Dashboard to track needs and identify service gaps and opportunities across the patient population.

CLOSED-LOOP SOCIAL CARE REFERRALS WORKFLOW



Jane Doe is a 26-year-old patient. At her annual wellness visit, a nurse completes an SDOH screening, which indicates she is food insecure.

Based on the screening results, a tailored list of recommended closed-loop referrals is generated for the nurse to act upon within the EHR

Nurse uses Unite Us to gain digital consent and securely refer Jane to the recommended community partners, including pertinent details about her needs.

Community partner receives referral within Unite Us. Care team can track all referral progress, notes, and service outcomes provided for Jane, directly within the EHR.

Care team receives real-time updates and tracks Jane's total health journey. Outcomes roll up into Unite Us reporting tools to track needs and identify service gaps and opportunities across the patient population.

Lessons Learned

Addressing SDOH needs is fundamental to improving health, reducing longstanding health inequities, and enhancing overall well-being and quality of life. “Access to quality health care, education, healthy food, and housing all play key factors in overall health,” added McLeod Health. “Identifying which health and SDOH issues overlap within a community is instrumental for public health planning.”

For other healthcare organizations considering investing in an SDOH technology solution, McLeod Health shares, “It’s important to think about how healthcare providers can partner with community leaders to better understand what resources are available to patients, in order to provide sustainable solutions that work within their defined communities.”

Partnering with Unite Us has enabled McLeod Health to enhance patient-centered care across the Carolinas by more effectively addressing SDOH. With a seamless EHR integration, data-driven insights, and a robust closed-loop referral system, the McLeod Health team is equipped with the tools they need to connect patients with the right resources at the right time, driving a tangible impact across their community.

To learn more, visit www.UniteUs.com/demo