The Joint Commission

Boston Medical Center SNAPSHOT

Featured Health Equity Topic Area:
Assess Health-Related Social Needs

Related Joint Commission Requirement:
Standard LD.04.03.08, EP 2

About

Boston Medical Center (BMC) is a 514-bed, private, not-for-profit, academic medical center located in Boston's historic South End. With 70 medical specialties and subspecialties, over one million patient visits are conducted per year. BMC believes that everyone has the right to health and wellness, no matter who they are, where they live, what they do, or where they are from. As the largest safety net hospital in New England, BMC has provided accessible care for everyone for over 180 years. BMC serves a diverse population with complex medical needs. Nearly 75% of BMC patients come from structurally marginalized populations, and more than 27% of patients do not speak English as a primary language. BMC recognizes the importance of addressing the health-related social needs that further impact on their patients' health and wellbeing.

Boston Medical Center	
	Boston, Massachusetts
	Academic Medical Center
	Safety Net Hospital
	514 beds
	Operational, Grant Support

Mission

BMC has been driven by a commitment to care for all people, regardless of their ability to pay, providing not only traditional medical care, but also programs and services that wrap around that care to enhance overall health. All of this supports their mission to provide exceptional care, without exception.

Setting the Stage for Change

In 2018, MASSHEALTH decided to partner with hospitals to transition to a value-based Accountable Care Organization (ACO) model. BMC was prepared for this transition as they had been preemptively directing resources into ensuring their medical record and claims reflected the complex needs of their patients. BMC patients are greatly impacted by Health-Related Social Needs (HRSN), serving 70% of patients identifying as marginalized racial groups (60% Black, 10% Latinx) and 30% who do not speak English as their primary language. In 2017, they began pilot testing to develop their THRIVE Social Determinants of Health (SDOH) Screening and Referral Program to systemically identify and address their patients' needs. The process not only asks patients if they are experiencing challenges but also connects patients to resources that address social needs in several different domains (e.g., housing, food, employment, financial hardship, social support, and education).

Taking Action

Start Small then Expand. A pilot of the THRIVE screener was introduced in March 2017 after an interdisciplinary team of experts (e.g., social science and health services researchers, community engagement specialists, residents and medical students, operations managers, health care clinicians, medical assistants, health literacy experts, IT analysts) determined which domains to screen for by soliciting input from existing literature, clinicians, front line staff, and patients. BMC developed a paper process flow for the implementation of the screener in one of their outpatient primary care clinics. Patients were given a paper screening tool when they checked in at the front desk. The medical assistant reviewed each tool, and provided resource referral guides. At the end of the visit, the clinician applied an ICD-10 code to the patient's diagnosis and referred the patient to Care Coordination or Patient Navigation, as needed. The pilot helped the primary care clinic learn what they needed to expand and improve.

Evaluate and Streamline. BMC shifted their efforts to automate the screening process through their EHR before expanding the program to all outpatient primary care, pediatrics, OB/GYN, infectious disease, bariatrics, and emergency departments. Currently, patients are screened every 6 months, and if a patient screens positive for one or more domains, the EHR automatically generates an order set which applies the appropriate ICD-10 codes to the encounter visit diagnoses. Additionally, the EHR automatically queues an order set to print out relevant patient resource referral guides (in the patient's preferred language) if a patient indicates that they would like assistance in the domains for which they screened positive.

Celebrate Success. Since launching THRIVE in 2017, several clinics (e.g., General Internal Medicine, Family Medicine) have implemented screening and report that 70-80% of eligible patients are screened every 6 months. Over 100,000 unique patients have been screened for social needs that may be impacting their overall health. Almost 30% of the patients screened have identified at least one social need with many of those patients requesting supportive resources to assist with their need(s).

Iterate and Improve. Beyond expanding screening into other clinical settings, BMC is striving to improve their resource referral system. As an information only intervention, all patients that screen positive receive a referral guide to available resources in their preferred language. At the discretion of the clinicians and depending on clinic resources, patients are connected with a patient navigator who can access the THRIVE directory, a web-based platform integrated in EPIC, with resources based on language, zip code, domain of need. BMC is moving toward developing a closed-loop referral system that will go beyond resource referral to identifying patients who access and utilize those resources to impact their health and well-being.

"Our goal isn't charity; it is to give people the tools that they need to thrive." – Dr. Pablo Buitron de la Vega, Clinical Lead for THRIVE program

Challenges Encountered

Limited Ability to Screen All Patients. BMC patients speak and read in many different languages. Screening and referral resources were available in English and Spanish only, which created a challenge and limited BMC's ability to screen all patients.

Navigating Sensitivity. Asking questions related to social needs can be difficult for both patients and staff to discuss.

Time Constraints. Ambulatory visit times limited the ability of clinicians to discuss and address these issues with patients.

Information Sharing. Although the paper screener allows for patients to answer questions while they wait for their appointment, this method does not facilitate the information learned from the patient to be shared across the BMC care team.

Finding and Distributing Supportive Resources. Collecting information about resources to include in referral guides requires time and effort dedicated to finding new resources and updating existing resource guides. It can be a challenge to identify which patients will do well with an information only approach and which will need a patient navigator.

Solutions

- **Expanded Screening Tool and Referral Resources.** The screening tool was expanded to include additional languages (i.e., Haitian Creole, Portuguese, Vietnamese).
- **Use Discretion with Screening Results.** Screening results are not included in the after-visit summary to treat social needs with sensitivity.
- **Use a "Train the Trainer" Model to Educate Clinicians and Staff.** This appropriately framed the way in which sensitive questions should be asked and the reason for asking them. Clinicians are trained using a liberation health model to affirm that social needs are a result of inequities and injustice rather than personal failings.
- **Developed Tools and Workflows.** This facilitated referrals to appropriate internal and external resources.
- **Leveraged the EHR.** EPIC enabled the creation of a universal SDOH database so that all clinicians have access to patient screeners. This helped prevent patients from being screened more frequently than every 6 months.
- **Integrated the Screener and Referral Guides into EHR Workflows.** The screener and referral guides were integrated seamlessly into the clinic's EHR workflow. Referral information can be printed, emailed, or sent via text message to patients. The THRIVE directory houses thousands of resources across several domains. "Favorite Folders" allow teams to organize the resources they find most valuable.

Lessons Learned

- **It takes a team**. Assessing and addressing patient social needs requires a team approach.
- **Think About Sustainability.** Relying on paper is not a sustainable or easily scaled model. This also makes it time intensive to learn from the data and understand trends that can determine how BMC can better serve patients. Identifying and sharing SDOH needs is a critical component of BMC's program and the THRIVE Screener allows them to advance this effort.
- **Standardization is key.** One screening tool for all patients allows BMC to capture data for advocacy and ease of implementation.
- **Collaboration.** Screening for HRSN has allowed BMC to engage in advocacy beyond the walls of the hospital based on the data. Effectively managing and using the THRIVE directory requires collaboration with many community programs across several domains. These collaborations are only effective through deep relationships with community-based organizations.
- **There is Always Room for Improvement.** BMC continues to improve the THRIVE program by looking for new ways to support teams and empower patients to thrive in their health goals. Expanding beyond the original goals of the TRHIVE program is important. For example, several pilot projects are in the works in other settings (e.g., NICU, Pharmacy) as are updates to staff training and employee onboarding processes.