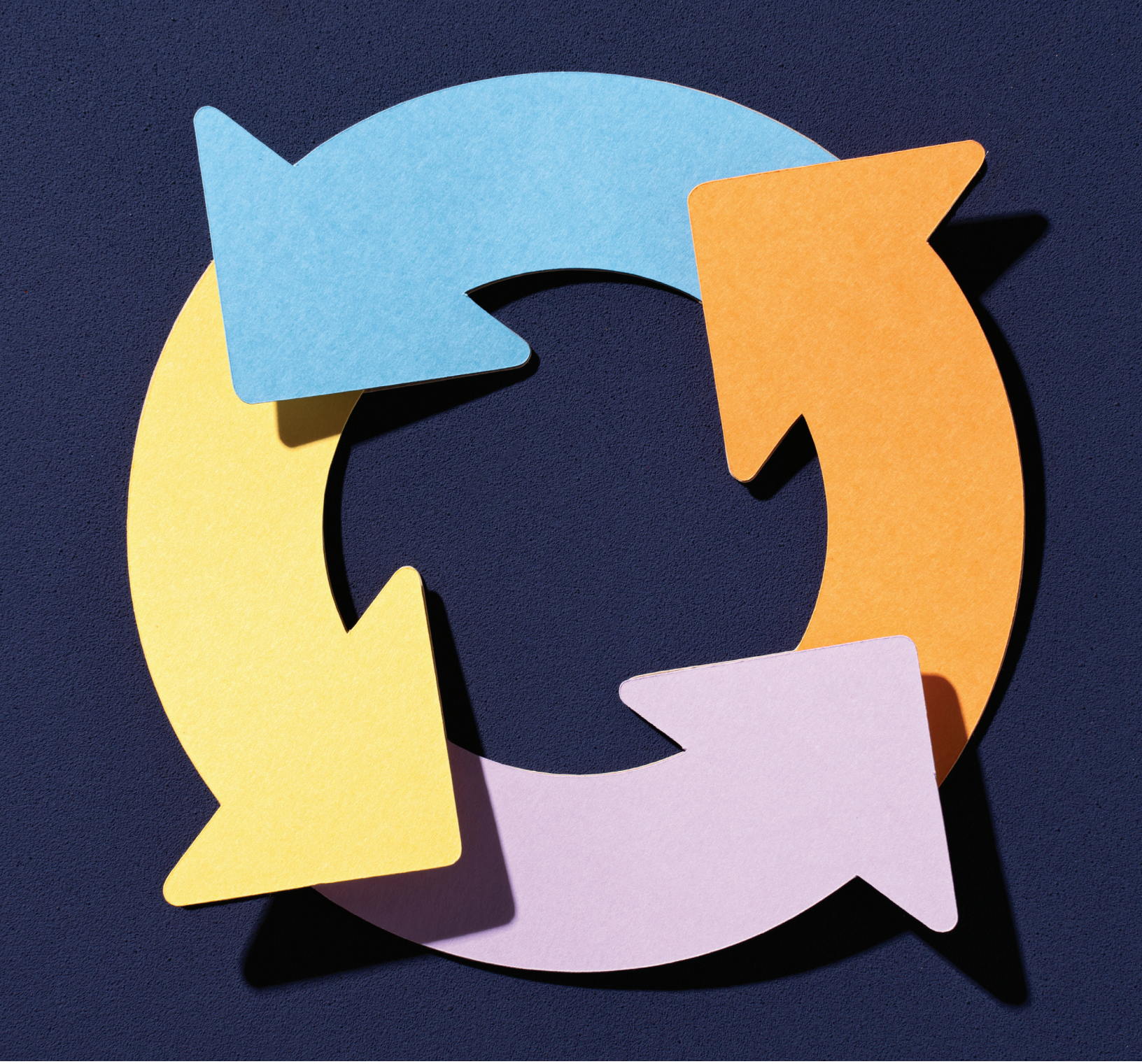

IMPROVING HEALTH FOR INDIVIDUALS, POPULATIONS AND COMMUNITIES AT LARGE BY LEVERAGING CLOSED-LOOP REFERRAL PLATFORMS AND PROCESSES

MHA
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SUMMARY

As the health care landscape continues to rapidly evolve, health care organizations actively seek to integrate appropriate technologies to address nonclinical factors, including social and economic concerns, impacting health care delivery and outcomes. **As of Jan. 1, 2025, acute care hospitals are required by the Centers for Medicare & Medicaid Services to screen all inpatients 18 years and older for housing, food, transportation, violence exposure and access to utilities.** This screening process requires hospitals and providers to connect patients with resources to meet their identified needs.[1] Evidence of the impact of nonclinical factors that can affect an individual, shifting payment models from volume- to value-based care, support by provider organizations such as the American Academy of Family Physicians, and reports published by the National Academies of Sciences, Engineering, and Medicine, have catalyzed provider organizations to act on addressing the nonclinical factors of health.[2,3]

Health care organizations routinely rely on community-based organizations to address nonclinical factors; however, there is often a lack of awareness of services, coordination, team buy-in and a streamlined referral mechanism to ensure a fully functioning closed-loop referral process to support seamless care coordination. **Understanding each organization's responsibility in the referral process is essential to ensuring a well-coordinated approach that delivers positive health outcomes.**

While closed-loop referral platforms often highlight their unique capabilities — social needs screening, comprehensive resource directories, referral management, care coordination/management, compliance with privacy/security protections, seamless integration of electronic health record systems, customer service responsiveness and sophisticated reporting and analytics — proper vetting by all stakeholders is important to support acceptance and implementation.

This brief outlines the purpose, value and possibilities of closed-loop referral platforms, supports alignment across entities, and provides case studies of platforms in use by Missouri health care organizations.

ACRONYMS TO KNOW

CBO: Community-based organizations

CMS: Centers for Medicare & Medicaid Services

CPESN: Community Pharmacy Enhanced Service Network

CHW: Community health workers

ED: Emergency department

EHR/EMR: Electronic health records/electronic medical records

SDOH: Social determinants of health

INTRODUCTION AND BACKGROUND

Changing the current negative trajectory of health outcomes will require organizations to deploy a holistic approach that focuses on clinical and nonclinical factors of health.[4] The U.S. Department of Health and Human Services' Healthy People 2030 program through its Office of Disease Prevention and Health Promotion defines social determinants of health as "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[5]

The 2014 County Health Rankings and Roadmap Model of Health (Fig. 1) illustrates that, while clinical care impacts an individual's health 20% of the time, the remaining 80% constitutes health behaviors, socioeconomic factors and physical environment.[6] Identifying the barriers that stand between individuals and their health can provide care teams with valuable information to support individualized care plans that seek to meet people where they are on their journey, capitalize on their personal strengths and support their access to resources. While overall health outcomes have improved in key areas over the last few decades, disparities in health improvements continue to widen among certain demographics based on a variety of nonclinical factors such as income, education, employment, food insecurity, housing, race and ethnicity.[7] The polarity of such disparities demonstrates the need for a community partnership approach to mitigate the barriers impacting people's health. This requires health care organizations to work beyond the four walls of their hospitals and clinics and collaborate with social care organizations to address nonclinical factors.

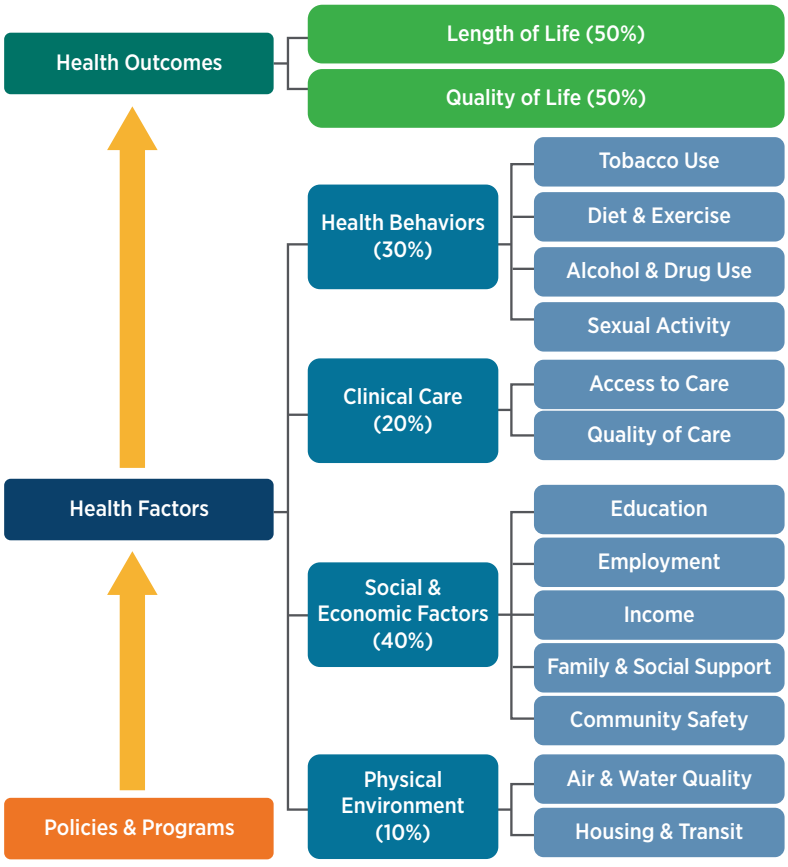


Figure 1: 2014 County Health Rankings and Roadmap Model of Health, www.countyhealthrankings.org

Examples of SDOH Screening Tools

CMS Accountable Health Communities Health Related Social Needs Screening Tools

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)

American Academy of Family Physicians Social Needs Screening Tool

Screening patients for SDOH at different points of entry into the health care system provides care teams with information necessary to make decisions based on each patient's unique needs. Understanding the immediate nonclinical needs and connecting individuals with resources to mitigate SDOH have been shown to improve health outcomes.[2,3] While screening for SDOH is a recommended strategy, lack of clarity on who can screen, lack of time, lack of reimbursement for staff time and effort, lack of standardized and validated screening tools, and lack of resources to meet the immediate needs of patients, among other factors, have contributed to slow adoption.[8,9,10] Training staff tasked with screening for SDOH is vital because of patients' hesitancy to share such information due to distrust, shame, fear of what might happen to them, social and cultural norms, trauma, and established power dynamics.[11] Accurately coding SDOH to Z codes per the ICD-10 guidelines can help organizations understand the top social barriers; thereby, informing their performance improvement efforts at the individual, population and community health levels. Stratifying this data by different categories such as geography, payer, race and ethnicity, age groups, and mapping by health outcomes can provide important information to inform interventions.

Multiple research studies have linked the impact of nonclinical factors and health outcomes.[4] According to the MOST Policy Initiative report published in 2021, these factors pose a risk in the high maternal

mortality rate and health disparities in Missouri.[12,13] Research studies suggest that people in certain income brackets, age ranges and at-risk categories have worse postoperative surgical outcomes or higher mortality risk.[14,15]

Data derived from the exploreMOhealth platform shows disparities in health factors and outcomes for each of Missouri's 114 counties and the City of St. Louis. Case studies have shown that geography is a better predictor of health than DNA.[16,17] Dashboard modules aimed at empowering individuals with health data on MissouriHealthMatters provide insights and trends for health outcomes and health factors among different geographies in Missouri. These platforms provide county and subcounty data; thus, helping organizations to target their intervention(s) with the needed specificity for maximum impact.[18] Data from a 2023 HIDI HealthStats report demonstrates the disparities that exist between ZIP codes. For example, out of 935 ZIP codes in Missouri, ZIP code 63124 (Ladue) was the No. 2 healthiest ZIP code, while ZIP code 63133 (Pagedale, Wellstone and Hanley Hills) — only 3 miles away — ranked 869. The variance between the two ZIP codes equated to a 434.5 disparity factor (Fig. 2). Ladue noted a childhood poverty rate of 1% compared to 54% for the ZIP code comprising Pagedale, Wellstone and Hanley Hills — a disparity factor of 44.6.[2,19]

Three Miles Away, Worlds Apart in St. Louis

	63124 Ladue	63133 Pagedale, Wellston, Hanley Hills	Disparity Factor
Overall ZIP Health Ranking out of 935	2	869	434.5x
Medicaid Hospital Visits per 1,000	15.75	827.12	52.5x
Childhood Poverty	1%	54%	44.6x
Assault Hospital Visits per 1,000	0.81	16.85	20.9x
Less Than High School Education	1%	20%	19.5x
Dental Caries Visits per 1,000	1.02	10.70	10.4x
Deaths Before Age 75 per 1,000	0.65	4.46	6.8x
Mental Health Visits per 1,000	3.79	24.09	6.4x

Figure 2: 2023 HIDI HealthStats publication

This is not an isolated case and is a representation of fluctuating barriers to health care across different geographies in Missouri.

Leveraging innovative technologies, unleashing the power of data, and establishing seamless clinical community linkages into care plans for patients have the potential to improve health outcomes and lower costs while promoting individual, population and community health.

BEHAVIORAL HEALTH AND NONCLINICAL FACTORS

Community members identified with behavioral health conditions have much higher rates of hospital readmissions.[19] In many cases, the underlying reasons for these readmissions are due to nonclinical factors. Significant responsibility is placed on patients to navigate the myriad complexities of our health care ecosystem, including a labyrinth of referrals to needed resources and services. Predictably, referrals and follow-up care often are not kept — up to 50% of referrals are not completed.[20] The barriers and negative impacts felt by patients and health care systems are at a critical juncture, shining a light on growing concerns surrounding the need to reduce high rates of hospital readmissions related to behavioral health.

Targeted interventions and enhanced care coordination between levels of care and providers are necessary to fully support behavioral health care needs. Improving post-discharge support, creating pathways for community-based care connections and addressing the specific needs of vulnerable populations are a few examples. Closed-loop referrals are one way to establish a stronger connection between levels of care and providers.

Closed-loop referrals have the potential to ensure that diverse needs are met through more effective case management of patient referrals and follow-ups. As we continue to witness and research the profound impact of nonclinical factors on community members, it becomes imperative to adopt innovative approaches that best enable comprehensive and continuous care coordination.

TECHNOLOGY TOOLS TO SUPPORT CLOSED-LOOP REFERRAL PROGRAMS

Technology-based platforms such as Community CareLink, FindHelp, Unite Us, CharityTracker, CrossTx, Healthify, NowPow, One Degree, Pieces Iris and MOConnect, among others, have gained momentum as health care organizations and their partners look for solutions to streamline their referral processes.

While technology is an important tool in solving problems surrounding the referral process, establishing a multisector collaboration with key stakeholders such as community-based organizations is extremely important. Engaging patients and care team members, such as patient navigators, social workers, community health workers, care coordinators, physicians, nurses and community-based organizations, early in the process provides valuable insights into developing and defining patient care processes and documentation.

Training staff and partners to perform health and social factor screening and referrals, setting clear goals and objectives, holding accountability, and establishing feedback channels are important to ensure effective implementation. The ability to run reports for care teams and community-based organizations can aggregate referrals and response trends and identify opportunities for improvement.

Successful implementation of closed-loop referral platforms requires a thoughtful approach that is built on a solid foundation with input from key stakeholders tasked in utilizing the platform.

CASE STUDIES

A recent case study published by Unite Us revealed how Ballad Health, an integrated community health improvement organization, partnered with the Virginia Department of Health and the Virginia Hospital & Healthcare Association to reduce overall emergency department utilization and lower the cost of care while improving health outcomes.[21]

Some notable results include the following: 1) an 8.5% reduction in ED utilization, 2) a 16.2% mean decrease in ED visits for patients referred within the last six months, 3) a 24.8% reduction in ED visits for patients who worked with Ballad Health CHWs within six months post-referral, and 4) an $825,000 estimated annualized cost savings per 1,000 patients. It is imperative to note that these results were attributed to the effective use of the Unite Us platform, the power of data to effect change and a streamlined care coordination infrastructure among users.

MISSOURI-SPECIFIC CASE STUDIES

Organizations in Missouri engaged in this work have used a variety of closed-loop referral platforms to address the nonclinical factors of health. Some of the most common platforms are Unite Us, FindHelp, Community CareLink and MOConnect. Some of these platforms work closely with hospitals and health systems to strategically integrate into clinical electronic health records to allow for a seamless flow of information. The organizations utilizing these platforms seek to streamline the referral process, use the power of the data gathered to make decisions, improve health outcomes and promote community engagement among partners. **The following case studies demonstrate how Missouri organizations have leveraged these platforms within their communities.**

Community CareLink: Overview of a Social Referral Platform

Will Steffen, vice president of growth, Community CareLink

Community CareLink, founded in 2018, has rapidly expanded from operating in two states to serving organizations across 17 states. The platform facilitates an average of 52,000 referrals per year in Missouri, with a high percentage of closed-loop referrals that surpass market standards. Designed for use by hospitals, federally qualified health centers, community-based organizations and state governments, Community CareLink serves as a centralized community case management and referral system that seamlessly integrates with existing EHRs through Fast Healthcare Interoperability Resources-Enabled Application Programming Interphase and High Level Seven International standards. Implementation follows a "begin with the end in mind" approach, ensuring the system is tailored to an organization's specific goals, whether that includes expanding community support, improving care coordination in infant and maternal health programs, streamlining services for substance use disorder programs, or addressing nonclinical factors through housing and food assistance initiatives. Training is comprehensive, providing up-to-date materials, real-time support and scheduled refreshers for social workers, CHWs and other users.

Built with CBOs at the center of its workflow, Community CareLink streamlines operations by reducing system redundancies and simplifying adoption at the community level. Post-implementation support is available on demand, ensuring that new and existing staff can access assistance as needed. The platform provides robust reporting capabilities, allowing organizations to track referral volume, measure changes in nonclinical factors over time and analyze key program outcomes, such as improved maternal health indicators or increased treatment adherence in substance use recovery programs. Community CareLink also supports community needs assessments, helping organizations identify gaps in care and allocate resources effectively. Additionally, its community-level care management functionality, powered by a streamlined data federation strategy, ensures accurate data sharing and minimizes duplication. With its user-friendly interface and strong technical adaptability, Community CareLink empowers organizations to enhance service coordination, improve data integrity and ultimately drive better outcomes for the communities they serve.

Community Pharmacy Enhanced Service Network

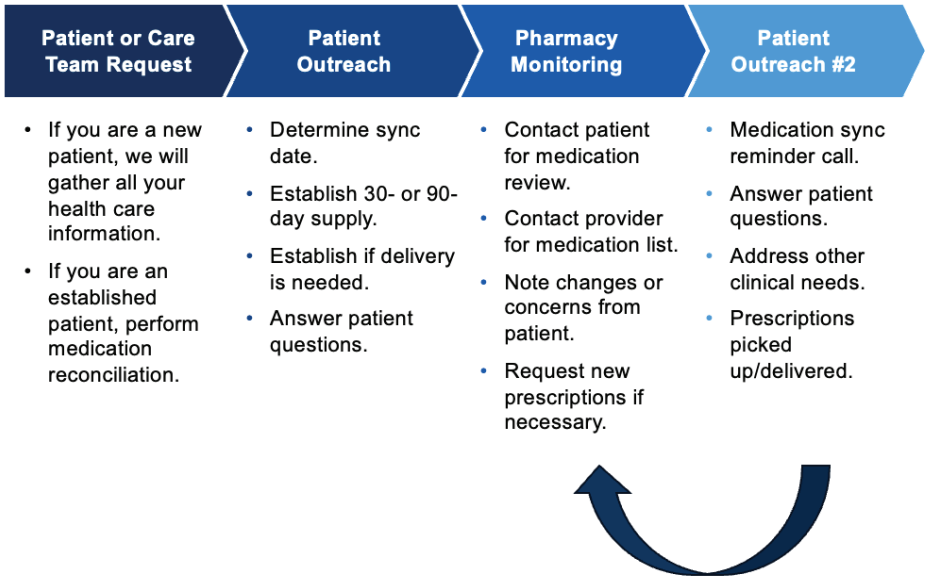
Annie Eisenbeis, director of practice development, Missouri Pharmacy Association

Community pharmacies are uniquely positioned to impact both clinical and social gaps in care. Traditionally, the role of the community pharmacist has been tied to medication expertise and dispensing. The medication dispensing service offered at all community pharmacies is foundational to the impact the local pharmacy teams could have. This is what brings patients into the pharmacy 35 times per year on average and gives the pharmacy a starting place to reach out and build local relationships and rapport. Often, the pharmacy is the last stop before home for a patient, but it also can serve as a gateway to care. While the pharmacist is the most accessible health care provider, the pharmacy team has substantial access to patients and the community to reach people where they live, work, grow and play. Community pharmacies can expand the reach of primary and preventive care with cross-trained pharmacy technicians who can provide social work extension. When you think about pharmacy, think about more than "meds," think about community care.

There are more than 3,500 pharmacies across 45 states that have joined a clinically integrated network known as the Community Pharmacy Enhanced Service Network. With national and local network infrastructure, these independent pharmacies can aggregate under one signature for value-based contracting and partnerships across the state and nation. In CPESN Missouri's network, there are more than 180 local pharmacies actively participating — more numerous than CVS or Walmart pharmacies in the state. The pharmacies in these local and national networks are committed to providing quality clinical care services in addition to traditional pharmacy dispensing services. For this reason, CPESN Missouri has prioritized offering services which also address nonclinical factors. Most pharmacies in Missouri's network have cross-trained pharmacy technicians to also function as CHWs. Community pharmacy teams across the nation are interested in scaling this idea and CPESN offers a CHW certification course specifically for pharmacy personnel across all 50 states. This is a sustainable model for CHWs in general, and CPESN offers a pathway for both scalability and sustainability.

Community pharmacies offer different opportunities to reach patients and close social, economic and environmental gaps in care. No appointment is required to ask the pharmacist or CHW/technician a question. The pharmacy cannot operate without a pharmacist on duty, so in this setting, a CHW is always six feet away from a clinician, allowing for a referral pathway to clinical care with the pharmacist and social resources with the CHW. Patients often have other reasons beyond clinical care and external motivation to visit the pharmacy, such as picking up medication for family members, over-the-counter medications, equipment, or even cards, milk and other front-end convenient items. Additionally, most local pharmacies, especially CPESN pharmacies, offer free delivery to their communities, which allows for home visits, screenings and referrals by CHWs who accompany delivery drivers. Those that offer a Medication Synchronization program, which all CPESN pharmacies do as a minimum service, have an opportunity to use this process to integrate those longitudinal touchpoints to close care gaps and address nonclinical needs. These programs often include a review of the patient's current and new medications and setting a date for

their readiness to pick up or deliver, prioritizing convenience for all chronic medications and any requested vitamins or other OTC medications to be ready for the patient. This process allows for at least one call and one in-person touchpoint per month. Of note, patients expect pharmacy calls, so there are higher rates of answering calls, patient follow-through with the outreach and ensuring the pharmacy has the most updated phone number to contact them.



Source: CPESN Missouri Training Documents 2025, www.cpesnmo.com

Community pharmacies look different than other health care settings, so the services provided can and should look different. Other providers may review questions through a standardized one-time survey with patients at intake or admission, then provide resources based on responses. Community pharmacies can provide longitudinal touchpoints, follow-up and monitoring combined with a community-centric model for implementation.

Consider a 35-year-old female, married with two children. She and her spouse fill their chronic medications at a local pharmacy and, on average, she picks up (or the pharmacy delivers) at least twice a month. If they are enrolled in the pharmacy's Med Sync program, they also would receive a call from the pharmacy to touch base on the monthly medications to be delivered or picked up, any recent health changes, and any questions from the pharmacy. With this monthly call, the pharmacy team facilitates a five- to 15-minute conversation that will include asking questions such as, "Did your doctor change the dose on your diabetes medication? If not, can you tell me why you don't want to pick up that medication this month?" This type of information can seamlessly lead to additional assessments of nonclinical factors, rather than the more standardized survey questionnaire language. CPESN Missouri's pharmacies recently added five to 10 minutes onto these calls to provide vaccine hesitancy education and close vaccine gaps to include nonclinical needs. In 10 months, more than 75,000 interventions were provided, with approximately 22% of vaccine gaps closed through the longitudinal education and outreach calls layered into the Med Sync workflow of community pharmacies.

The community pharmacy team, through CPESN, can serve as your "health care accountability buddy" to support, remind, refer and walk through the follow-up and monitoring between primary care appointments. They can help patients manage chronic conditions such as diabetes or hypertension. Throughout the clinical care gap closure, they can weave and layer in addressing nonclinical factors, with consistent and longitudinal follow-up to close those gaps.

Children's Mercy Hospital in Collaboration with FindHelp and Innovaccer

Luke A. Harris, senior director of operations and population health management, Children's Mercy Kansas City

Implementing a Screening and Referral Process for Pediatric Patients

When health care organizations have a uniform nonclinical factors screening and referral process, they can provide whole-person health care equitably across different patient demographics. In this case study, Children's Mercy Kansas City partnered with Innovaccer and FindHelp to roll out a closed-loop SDOH screening and referral process for pediatric patients that connects them and their caregivers with reliable community-based organizations to improve their long-term health.

Children's Mercy Integrated Care Solutions lacked a system for closed-loop nonclinical factor screening and referrals, and pediatric patients' nonclinical needs were unrecorded and unaddressed. Families and caregivers were often uncomfortable sharing their socioeconomic hardships with CMICS, and they were uncertain whether the health care collaborators could resolve their needs. As a result, the documentation of such needs was inconsistent, and pediatric patient needs were not fully met.

CMICS determined they needed to develop a trustworthy network of CBOs that could provide tangible benefits to patients and their families and caregivers. They also wanted a platform that could manage the referral process, facilitate bidirectional communication with CBOs and measure how interventions were positively impacting pediatric patients' health. Without robust data-tracking mechanisms, it would be difficult to assess the effectiveness of interventions and justify investments in SDOH initiatives. CMICS needed a platform with technological and analytical capabilities to track the utilization of social services, measure health outcomes and demonstrate value.

Action Plan — How the Collaborators Worked Together to Reduce Friction

CMICS used Innovaccer to streamline data aggregation from various sources, including EHRs, claims data, social services databases and community resource directories. Having all this data in one platform gave the organization a more comprehensive and accurate understanding of patients' social and clinical needs and allowed the organization to make better informed decisions about patient care.

CMICS partnered with FindHelp to access community resources through their social care referral platform and built a trusted network of CBOs. This collaboration was essential for creating a streamlined referral process where each primary care practice had one primary CBO to refer families for any nonclinical needs. CMICS established a memorandum of understanding with each agency and provided funding to support the use of FindHelp's closed-loop referral system, demonstrating CMICS' commitment to the partnership.

Innovaccer and FindHelp worked together to integrate FindHelp's social care referral platform into Innovaccer's point-of-care platform. This enabled efficient social need referral management and coordination by the providers and the CBOs. As a result, pediatric patients and their families and caregivers could receive timely access to necessary social services, and the care team could easily be kept up to date. CMICS also leveraged their EHR and Innovaccer's population health management platform to enhance data collection, analysis and decision-making related to nonclinical factors.

Points of Light — Outcomes Achieved Through Collaboration

CMICS implemented the screening process across 36 of their clinics in 2020 and their screening rate increased to 79% in 2023, with nearly 198,000 screenings captured and 16,000 of the screened patients with one or more of their social needs identified with applicable ICD-10 Z codes. The number of end users leveraging the Innovaccer system and accessing training within the system has increased over time, contributing to the increase in screenings. The volume of monthly closed-loop referrals went from zero in the second quarter of 2021 to more than 300 in the first quarter of 2024.

Addressing family and caregiver needs led to better health outcomes for pediatric patients. For example, patients' parents or guardians have received help finding furniture for new apartments, preparing for job interviews, accessing food pantries, paying rent and utility bills, and finding clothing. This contributed to improved pediatric patients' health outcomes.

Lessons Learned — What Best Practices Can Other Organizations Apply?

Before implementing a closed-loop referral system, health care organizations and CBOs must make sure their leaders are aligned. It is easier to roll out a standard process across several clinics when leaders have aligned their expectations and goals and are

committed to the investment. CMICS aligned their goals with their main payer organization's goals, further creating unity around what metrics to measure.

Health care organizations must build trusting and strong relationships with CBOs; this includes providing compensation for adopting closed-loop referral processes. Additionally, organizations can build goodwill and lay the groundwork for a successful long-term relationship by establishing agreements that provide flexibility in how funds are used (e.g., process, resources, technology) and committing to respond to CBO challenges.

Clinical end users will not retain everything they learn during the initial training and implementation. Additionally, processes may periodically change and improve. Thus, health care organizations should offer frequent training sessions to empower end users and identify knowledge gaps that are hindering referral outcomes.

What's Next? — Vision for the Future

Looking ahead, Children's Mercy is going to expand partnerships with trusted CBOs. For example, CMICS is considering partnering with CBOs that help patients who are non-English speakers. Because the number of referrals and organizational requests is increasing, CMICS also is looking at increasing funding for CBOs so they can support more resources.

To meet future challenges, CMICS is researching which nonclinical limitations have the greatest impact on long-term health outcomes. Transportation is one of these limitations, so we are considering initiating pilot programs to improve patients' access to transportation.

If your organization is considering a similar project, here are some things to keep in mind: The largest lifts are getting provider/organization buy-in for a uniform screening and referral process, and establishing a fully integrated closed-loop referral system accessible at the point of care. After establishing a network of full-service CBOs and achieving the initial technology setup, scaling is more manageable as the relationships, systems and processes are in place, and facilities can adopt processes and use best practices for training and implementation.

Costs increase with expanded geography but can be managed with strategic sourcing and allocation of funds when establishing metro-specific CBO networks. CMICS had to financially compensate the CBOs to ensure a closed-loop referral process. Importantly, each CBO was a full-service CBO (i.e., positioned to address all social needs), and the five partner CBOs were well distributed across the metropolitan area. While the cost was not substantial in this case (CMICS worked with only five CBOs), it could become burdensome for organizations that are scaling the model across many metropolitan areas. Health care organizations with wide geographic coverage should source funding from each geographic market and similarly launch a narrow network of distributed, full-service CBOs.

Saint Luke's, the West Region of BJC Health System

Meredith Cantrell, program manager, community health initiatives, Saint Luke's – BJC Health System
Kristin Repp, director of population health, Saint Luke's – BJC Health System

Saint Luke's, the West Region of BJC Health System, is a faith-based, nonprofit, aligned health system caring for patients in 65 specialty services across 67 counties in Missouri and Kansas. In 2022, Saint Luke's embarked on a journey to better address patient nonclinical factors. Beginning with 13 primary care clinics, universal screening was implemented using an adapted version of the Health Leads questionnaire. Patients were screened yearly either through the patient portal eCheck-in process or by the medical assistant when the patient was roomed during the clinic visit. A goal was set to screen 50% of patients. In the first year, the primary care teams exceeded this goal, screening 86% of patients (more than 130,000 unique patients).

The data gathered this first year of screening provided powerful insight into the food, housing, transportation and social isolation needs of our primary care patients. With this data in hand, Saint Luke's Population Health team added social work support and CHWs. This social care team made more than 10,000 telephone outreaches to patients, handled more than 300 referrals a month and longitudinally managed hundreds of patients in 2024. Additionally, technology was leveraged through the FindHelp social care platform to better integrate the ability to connect patients to resources through the Epic electronic medical records.

The FindHelp Community Resource Directory is embedded within the Epic EMR workflows, allowing staff to easily select resources related to each patient's identified needs and place the information on the *After Visit Summary*. This workflow is accessible to all Epic users and all staff are empowered to provide a resource. For patients who have more complex needs, a best-practice alert facilitates a referral to the primary care social workers and CHWs for further assistance.

When a patient is in an acute health and social crisis, navigating the social care landscape can be overwhelming. Saint Luke's set out to build a trusted network of CBOs that would take direct referrals through the FindHelp platform and close the loop by providing information on what assistance the patient received.

In 2022, Saint Luke's launched a closed-loop referral pilot with three CBOs for patients experiencing food insecurity. CHWs completed outreach to patients who screened positive and indicated they wanted assistance. With the patient's consent, a referral was placed within the FindHelp platform to the CBO, who then directly outreached to the patient. The pilot was successful and today, Saint Luke's works with 10 CBOs

that take referrals for housing, utilities, food and transportation assistance as well as case management and other programs such as job and financial coaching.

In 2024, 497 referrals were sent, with 41% of referrals receiving help. The CHWs work collaboratively with the CBO teams to make sure patients receive assistance, and the CBOs provide updates within the FindHelp platform on what type of assistance each patient received. These collaborations have resulted in positive outcomes for many patients, including preventing evictions and utility disconnections, obtaining SNAP benefits, home repairs and enrollment in programs for longer-term stability. Saint Luke's CBO collaborators also have expressed their satisfaction with working more closely with the health care community. Both organizations are often working with the same community members, and there has been great benefit in coordinating and better meeting the health and social needs of patients.

Saint Luke's has continued to adapt their programs based on lessons learned. In late 2023, screening was expanded to inpatient and emergency department visits, with care progression teams providing resources to patients with identified needs. Acknowledging that patient circumstances can change at any time, in 2025, ambulatory services moved to a rolling six-month screening to ensure patients are screened at least twice a year.

Funding within the CBO community has been and continues to be a challenge. When Saint Luke's started their CBO collaborations, many CBOs had increased capacity with COVID-era funding. As that funding has expired, CBOs are experiencing constraints in resources. It is important that the Saint Luke's teams making referrals understand those constraints. The closed-loop referral process is just one of several avenues to connect patients to resources. Saint Luke's also works to build the capacity of their CBO collaborators by providing community benefit funds to support their work. The CBOs have used these funds for a variety of purposes, including computers, refrigerators to increase capacity within their food pantries or direct financial assistance to community members.

As Saint Luke's began its nonclinical factors screening journey, emphasis was placed on educating both staff and patients why they ask these questions. This education continues as more departments and locations start screening and provide resources. Saint Luke's believes that everyone deserves an equal chance at healthy living and understanding a patient's socioeconomic needs helps the care teams address the broader aspects of each patient's well-being. The work Saint Luke's is doing in this space supports these efforts and helps ensure all patients who seek their services has a fair and just opportunity to attain their highest level of health.

Saint Luke's produced a short video that highlights the importance of screening for nonclinical factors from a patient's perspective.

Mercy Health: Unite Us Platform

Rocco Gonzalez, community health, access and informatics director, Mercy Health

Overview

Mercy Health implemented the Unite Us platform around February 2020. The key positions tasked with conducting nonclinical factor screenings were CHWs, social workers and nurses. Screenings are completed and documented through the Epic EMR in the emergency department, for inpatient admission, and in specific primary care clinics. Care team members tasked with screening were offered training on the Epic EMR and workflow process. Staff used core questions in Epic's SDOH assessment: utilities, housing, transportation, medications, food and safety. As far as leveraging the closed-loop referral platform, the care team referred patients screening positive to CBOs accepting referrals who would then "close the loop" on the Unite Us platform when the need was met. It's worth noting that while Mercy Health has collaborated with more than 100 CBOs, 20 are currently actively engaged with the Unite Us platform.

Some of the initial successes realized were the intuitive workflow and functionality of the program and initial buy-in to the closed-loop platform through focused community engagement. An early lesson was to recognize that the platform is just a tool. Staff need to ensure ongoing engagement and communication with CBOs for onboarding, training and tracking referral trends. CBOs may lack the capacity for utilizing these platforms, and without the ability to see the closed-loop functionality, Mercy caregivers stopped using the tools. The technical implementation of the platform does not equate to the actual performance of the network of partners.

It is hard to achieve economies of scale without financial incentives connected to use, especially since it is duplicating other tracking systems from the CBOs. Intentional, grant-funded programs are most effective in ensuring platform utilization due to focused population and funding incentives. Creating a governing body to help close and navigate certain referrals to expand the capacity of CBOs remains essential to their success. Working with local foundations and state funding entities to secure financial incentives is key to the sustainability of any platform.

Various payers are starting to look at nonclinical factors through Z coding, thus leading to real dollars being reimbursed for health providers. Whether through fee-for-service or more valued-based risk arrangements, the funding will not be enough to realize the collective impact needed for true community-wide change. Braiding these resources with local foundations, grants or other finances can close the loop between health care organizations and CBOs to achieve optimal utilization of the platform. Also, without trust and relationships, these referrals will follow the bridge to nowhere. That is why it's imperative to engage with CBOs before implementing technology and attempting to onboard these teams.

CONCLUSION

Closing the current gaps in care will require deliberate efforts guided by the power of data and a well-trained workforce that leverages innovative technology to deploy programs that seek to meet people where they are in their health journey and operationalize systems to deliver safe, effective and efficient care through collaboration with partners. Successful implementation of closed-loop referral technology will require organizations to do their due diligence in understanding the factors that bring value to patients in need of referred services. It also will require health care organizations to simplify the process of securing the needs sought by patients by building strong partnerships with CBOs that deliver those services.

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RECOMMENDATIONS

Below is a list of recommendations that are key to implementing social referral platforms.

Development

- All organizations that interact with patients with nonclinical factors should be invited early in the process to promote buy-in and engagement.
- Patients should be included in the planning and implementation process, which is important to ensure that the end user's needs are met.
- Organizations should consider how the platform integrates with EHRs and other platforms utilized by collaborating organizations. It is imperative to consider how the closed-loop referral platforms align with workflow for health care organizations and CBO partners.
- Organizations should consider utilizing a single social referral platform to avoid redundancies.
- Proper training of staff tasked with screening, referring and receiving referrals is key. This should be integrated into the new staff onboarding and ongoing professional development processes.
- Consult with legal counsel early in the process to ensure that all privacy and security protocols are addressed.
- Organizations should become well-versed in billing codes and payment models that support CMS' SDOH Z-coding, or nonclinical factors, screening and referrals.
- Organizations should consider grant, contract and foundational funds to support health care outcomes.

Implementation

- Ensure the closed-loop referral platform has efficient and responsive customer support to address issues as they arise.
- Identify champions who are empowered to address issues and can support timely resolution.
- Establishing accountability channels is essential to ensure each organization is meeting service expectations and goals.
- Executive-level support is important to ensure the sustainment of this work, especially for CHWs who are not currently reimbursed by Missouri Medicaid for their time.

Growth and Improvements

- To ensure ongoing engagement, establish channels to share news about platform updates, success stories and challenges around the feedback loop and analytics.
- Identify and track key metrics that will be part of the ongoing programmatic evaluation process. Share this information during regularly scheduled meetings to identify gaps and continual opportunities for improvement.
- Platforms should be audited on a regular basis to ensure the information and resources are up to date to meet patient needs.
- Periodically assess organizations and end users utilizing the platform to identify opportunities for improvement.

While these recommendations are not exhaustive in nature, they provide important points of consideration in the successful implementation, growth and maintenance of a closed-loop referral platform. Reviewing case studies from organizations that have successfully implemented these platforms can provide additional learnings.

METHODOLOGY

This brief includes case studies from five hospitals and health care organizations. Case studies were collected by the Missouri Hospital Association, with data and information shared through 2025.

MISSOURI HOSPITAL ASSOCIATION

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