Contact Information
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Physician Organization Name: **Bronson Network**
Practice Name:
Practice Address:
How many physicians in practice:
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): The ambulatory care management team at Bronson has: 26 Ambulatory Care Mangers (ACM) who are all registered nurses (RN), 24 Ambulatory Medical Social Workers (LMSWs), and a centralized team comprised of 2 Health Coaches (Medical Assistants) & 1 Health Coach Specialist (RN).

Executive Summary (5-8 bullet points, must include summary of results)

- Bronson began screening patients in the primary care practices for Social Determinants of Health (SDoH) using a paper questionnaire in 2017.
- Although the paper form is helpful in identifying immediate needs of patients, it did not allow us tracking of the volume of patients with positive screens or monitoring of the degree of follow up with patients.
- In May of 2019, six Bronson primary care practices began a pilot of an electronic SDoH screening process.
- The pilot was a success, and Bronson has expanded the electronic screening process to an additional four practices as of July 29, 2019.
- In order to ensure high-risk patients receive appropriate follow up, Bronson implemented a new department: Centralized Disease and Care Management. This team assists with a number of processes including performing follow up calls for all patients with a positive screen on the electronic SDoH questionnaire.
- Bronson's innovative approach to electronic SDoH screening allows a centralized team to follow up on patients who screened positive. This ensures patients receive appropriate resources while allowing the practice care management teams to work at the top of their license and focus on chronic care management.

Category of Submission (see page 1): Addressing Social Determinants of Health

Title of Submission: Bronson Electronic Social Determinants of Health Screening & Follow Up

When did the intervention start and end? (1-2 sentences)

Bronson primary care practices began to screen patients for Social Determinants of Health (SDoH) needs using a paper questionnaire in 2017; once complete the paper questionnaire was scanned into the patient's chart. Bronson began to perform electronic SDoH screenings at six pilot practices on May 28, 2019 and expanded to an additional four practices on July 29, 2019.

Goal of the Program/Intervention: (1-2 sentences)

The goal is to screen all Bronson attributed primary care patients annually for SDoH needs at wellness, new patient, and preventative visits. Likewise, Bronson strives to provide a follow up phone call to all patients who screen positive in one or more SDoH domains within seven days to ensure patients are connected with appropriate resources to meet their needs.

Who developed the program/intervention, and how? (2-4 sentences)

Bronson practice leaders, primary care providers, and the ambulatory care management leadership team initiated the electronic SDoH screening with assistance and input from the Bronson Information Technology Department and Epic Ambulatory team. Leaders formed a workgroup to assess the current paper process, identify any gaps/barriers, and develop a new process for electronic SDoH screenings. The project team developed standard work and educated the practice care team on changes to workflows and the benefits of changing to an electronic screening process. This team supported the Epic workflow process for screening patients electronically and implemented the workflow for those involved in the screening and patient outreach processes.

Description of the Program/Intervention (2-3 paragraphs)

Patients attributed to Bronson primary care providers receive a questionnaire at defined visit types to screen annually for SDoH. Ten Bronson primary care practices are currently utilizing the electronic screening process. At practices utilizing the electronic process, the questionnaire is completed prior to the patient visit via the patient portal. If patients are not active on the portal, the patient fills out the screening on paper while they wait to be roomed. Once they are roomed, the Medical Assistant (MA) enters their responses to the questionnaire in the Electronic Health Record (EHR). Patients who trigger positive in one or more domains are either provided with the appropriate resource at the practice or receive an outreach call to connect them with the resource within 7 days. These follow up calls are performed by centralized care management Health Coach MAs.

Bronson's Centralized Disease and Care Management team is new in 2019. The goal of this new team is to assist the practice Ambulatory Care Managers (ACM) and Medical Social Workers (MSWs) in working to the top of their license by moving certain tasks appropriate for MAs to a central team. The central team performs outreach to those patients that trigger positive in one of the SDoH domains and connect the patient with appropriate resources. This allows the ACM and MSW in the practice to focus on chronic care management while still ensuring that patients receive necessary SDoH support.

To ensure ease of providing resources to patients, community resources have been gathered and saved in an electronic format sorted by SDoH domain and county in which the resource is available. Available community resources are reviewed and updated at least annually to ensure accurate resource information is available to all team members. Health Coaches provide the resources to patients verbally, through email, mail, or via patient portal depending on patient preference. When a health coach identifies a patient with needs beyond those of a resource, they provide a warm handoff to the MSW in the practice who connects with the patient to further explore and provide additional support.

How were patients identified for the program/intervention? (1-2 paragraphs)

Bronson PCP attributed patients (both adult and pediatric) are screened at least annually for SDoH needs. Screenings are performed during wellness visits, preventative visits, and new patient appointments. Implementation of the electronic screening process included implementation of a health maintenance notification within the electronic health record (EHR) to alert providers that a patient is due to complete SDoH screening. Patients with access to the patient portal automatically receive the questionnaire seven days prior to their annual preventative visit. The front desk is able to see if the questionnaire was completed at check-in. If it was not or if the patient does not have portal access, the front desk initiates the screening process. Once the SDoH questionnaire is completed in Epic, it satisfies the health maintenance topic, and the patient will not alert again for SDoH screening for 365 days.

The Health Coach MAs receive an in-basket message within the EHR when a patient flags positive for one or more SDoH domains. The Health Coach MA performs a chart review upon receiving the notification, contacts the patient via telephone to perform follow up, and connects the patient with appropriate resources. The Health Coach MA makes two attempts to contact patients who flag positive. They document the attempts, resources provided, and/or any further follow up needed in the patients EHR.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)

Metrics are both process and outcome-based. Bronson tracks the percent of patients who completed the SDoH questionnaire; the number of patients who have a completed SDoH screening (numerator) divided by the total number of patients that need screening (denominator). This process metric provides information on how often the practices are completing the process as intended.

For outcomes, Bronson tracks the number of patients that screened positive for one or more SDoH domains. Bronson is also working on a report that will show how many patients with a positive screening were contacted within seven business days. This assists in tracking the quality of outreach and ensures that patients are appropriately connected to resources when a need is identified.

In the future, we hope to be able to further demonstrate the success of the program through a decrease in missed appointments due to this barrier. We are ultimately successful when we decrease health risks, improve outcomes, increase access to care and improve quality of care. Finally, we hope to continue to receive positive patient feedback that our follow up was helpful.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

Prior to implementing the electronic SDoH screening process, Bronson encountered a number of barriers with reporting on the percentage of patients that were appropriately screened for SDoH needs. This was due to the

fact that screening was performed on paper. Although the paper was scanned into the chart, there was limited ability to report off of the scanned document and no ability to verify that the document that was scanned met the requirements for being complete unless staff performed a manual review of each document. Preliminary data on number of screenings scanned compared to total attributed patient population demonstrated that in 2018 Bronson sites performing SDoH screening on paper screened only 21.9% of the population (target was 100%).

Implementation of electronic SDoH screening has led to improvement in Bronson's ability to report on both process and outcome metrics related to SDoH screening. Practices that are live on the electronic SDoH process have performed SDoH screening for 84.4% of patients due for this annual screening who were seen in the practice with an appropriate appointment type since May 28, 2019.

Another improvement to reporting is the ability to now report on the percent of patients that are triggering high risk in one or more domains. From May 28 through July 31, 2019, 5.4% of the population screened electronically flagged high risk in one or more domains on the SDoH questionnaire. The centralized team has already completed a total of 248 follow up calls to patients who screen high risk for SDoH. The population screened to date shows the following:

Data for May 28 – July 31, 2019	
Domain	**% of positive responses**
Family Care Concern	0.92%
Financial Strain	1.75%
Food Scarcity	0.39%
Food Worry	0.79%
Medical Transportation Needs	3.24%

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

The electronic SDoH screening project team developed the following new tools, processes, and resources: the SDoH module build within the EHR, created standard work for all team members with a role in SDoH screening, put together tip sheets that outline electronic workflow, and provided education to the practice care team on the new process. The central team structure was an entirely new process for everyone and included hiring new team members that could provide appropriate follow up to patients with SDoH needs. Bronson modified the SDoH questionnaire to align with the SDoH module in the EHR. A project group was formed consisting of key stakeholders in order to oversee the rollout and to continuously monitor for process improvement efforts.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

Bronson is most proud of our innovation and commitment to improving population health through the implementation of electronic SDoH screening and follow up. This project has allowed our practices that are participating to minimize barriers to patient health care needs, provide increased support to our patient population, and link patients to appropriate community-based resources. Expanding our screening process and care team in order to provide more outreach and connection to resources leads to a positive impact on our patients, practices, and health system. Outcomes, goals, and satisfaction are all achieved through what we do each day. Gratification is accomplished when our team recognizes a patient need and is able to connect them with the appropriate resource(s).

How will your organization use the funds if your submission wins? (1 paragraph)

These funds will support the budget of the Centralized Disease and Care management team to continue providing resources to high-risk patients. Funding will ensure that we can add an additional MA resource to our team to expand the electronic SDoH process to all 27 Bronson primary care practices. It will also allow for team expansion to take on additional responsibilities, such as providing outreach to patients discharged from the emergency department and address gaps in care needs. This will allow the Ambulatory Care Managers (ACMs) to focus on chronic care management patients' needs and provide continuous efforts to improve population health. We would also like to explore incorporating community resources within the EHR to allow for electronic generation of resource rosters and referrals. With this, we would be able to work with community resources to collaborate in having closed-loop referrals and communicate with outside agencies. Expanding this intervention will support patients within our communities in a vast number of ways, such as improving overall patient health and outcomes through access to resources and quality care.

Standard Work – Social Determinants of Health

Process: Social Determinants of Health Assessment		**Date:** 7/15/2019
Major Step	Key Point	Reason Why
SDoH will be addressed at specific visit types	1. Preventative Visit 2. Medicare Annual Wellness Exam 3. New patient visit 4. Well-child visit 5. Beach Bash – Bronson Rambling Road Pediatrics offices (summer physicals)	Social Determinants of Health assessment should be given at these visit types. These questions help identify social risks for a patient and are a requirement of participation in our care management payor programs.
Format for questions	Patients respond to questions on paper or via MyChart if active. A paper form will be available at appropriate health literacy level and will also be available in Spanish and Arabic. MyChart questions will remain worded the same as Epic.	These questions must be available even if the patient doesn't have MyChart and in appropriate language.
Front desk staff will determine if patient used eCheck-In for visit	If patient is checking in for above visit types, PSA will ensure that patient either: 1. Received and completed SDOH questionnaire in MyChart OR 2. Receives paper form to complete in waiting room. Instruct patient to give completed form to MA when called back for appointment.	This ensures that patients receive and are given time to complete questionnaire at appropriate appointment types.
Medical Assistant will collect questionnaire from patient and enter responses in Epic.	If patient completed SDOH screening in My Chart, there are no further steps for MA. If patient fills out paper form while waiting to be called back MA will: 1. Ask patient for completed questionnaire upon calling back 2. Enter patient responses into Epic. SDOH questionnaire is found in the medical history section	MA will enter patient responses in Social Determinants of Health activity in Epic.

<table>
<tr>
<td>Completed questionnaire</td>
<td>The following responses to the SDOH questionnaire will trigger follow up from the Centralized Care Management team when entered in Epic:
<table>
<tr><th>Domain</th><th>Question</th><th>Response triggering follow up</th></tr>
<tr><td>Financial Resource Strain</td><td>How hard is it for you to pay for the very basics like food, housing, medical care, and heating?</td><td>Hard
Very Hard</td></tr>
<tr><td>Food Insecurity</td><td>Within the past 12 months, you worried that your food would run out before you got money to buy more.</td><td>Often True</td></tr>
<tr><td>Food Insecurity</td><td>Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.</td><td>Often True</td></tr>
<tr><td>Transportation Needs</td><td>In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?</td><td>Yes</td></tr>
<tr><td>Family Care</td><td>Do you need help finding or paying for care of loved ones? Such as child care or day care for an older adult.</td><td>Yes</td></tr>
</table>
</td>
<td>Trigger responses will notify appropriate staff to follow up with the patient.</td>
</tr>
<tr>
<td>Centralized Care Management Team reviews positive responses</td>
<td>The first domain which elicits a positive response on the questionnaire will fire a message into an InBasket called Best Practice Folder. This folder will be monitored by the Centralized Disease and Care Management team. The team will review each positive response and use a Patient Outreach encounter to connect them to appropriate resources. The centralized team will follow standard work to determine when a referral to the PCP MSW may be appropriate.</td>
<td>Centralized Care Management team will contact patient for follow up and refer to community resources or practice MSW as appropriate.</td>
</tr>
<tr>
<td>Patient chart</td>
<td>Responses to social determinants of health questions will be visible in the Medical History and Longitudinal Plan of Care Sections of Epic. Documentation of follow-up and connection to community resources will take place within Patient Outreach encounters performed by the centralized Care Management team and Practice MSW. These can be found in chart review in Epic.</td>
<td>Responses will remain in the patient chart until the next visit type requiring SDoH in the next calendar year; or as follow-up SDOH is given.</td>
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Dev. 3/20/19