Jackson Health Network

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Physician Organization Name: Jackson Health Network
Practice Name: Practice Address: NA
How many physicians in practice: NA
Description of care team (number of care team members and their degrees/qualifications): NA

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

- Implementation of the 15-question Social Determinants of Health screen occurred beginning June 2018
- Focus was on implementing the screen in 12 primary care practices participating with the State Innovation Model (SIM)
- Our goal was to identify patient needs and link them to community resources to address their needs
- Through July 2019, Jackson Health Network (JHN) administered 50,338 Social Determinants of Health screens, resulting in 4,809 unique referrals to community resources to address the 11 domains assessed
- Due to word of mouth regarding the initial successes, primary care sites not initially participating in this workflow voluntarily decided to implement this screen; we are now screening for Social Determinants of Health in 23 primary care practices

Category of Submission (see page 1): Addressing Social Determinants of Health
Title of Submission: Addressing Social Determinants of Health within Jackson Health Network

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

Jackson Health Network began introducing the concept of the Social Determinants of Health (SDoH) screen around February of 2018 to its primary care practices. Actual implementation of the screen into the practice workflow began on June 1, 2018 and is currently ongoing.

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

The goal of introducing the SDoH screen was to identify and address the unique needs of our patient population. By implementing a workflow around a 15-question SDoH screen, primary care practices began administering the screen to their total patient population, regardless of payer.

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

The intervention has underwent a PDSA cycle several times and is still evolving. JHN Care Management and affiliated primary care practices came together to identify a best-practice workflow that met the needs of both the patient and the practice administering the screen. Through collaboration at Practice Manager collaborative meetings and individual rounding at practices, JHN created a process to for patient needs to be addressed through the Jackson Care Hub. The Jackson Care Hub is the result of the clinical community linkages strategy. The Jackson Care Hub is an online platform that community organizations use to screen for social determinants, assess the individual's needs to determine the most appropriate resources and then make an electronic referral to that organization real time. The system allows the organization to manage the referral they received and work it through to completion. As the organization manages the referral, the original screening organization has access to real time feedback of the progress with the referral.

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

Upon check-in to their primary care practice, patients are given a paper version of the SDoH screen. The screen contains 15-questions that assess needs in the following domains: healthcare, food insecurity, housing & shelter, financial resource strain, family care, transportation, literacy, legal, employment & income, education, social connections and safety. The screening results are manually entered into discrete fields within a flowsheet in Epic. If the patient answers positively to any of the questions in the screen, a referral is automatically generated in the Jackson Care Hub. If there are no needs identified in the screen, the data is stored in both Epic and the Jackson Care Hub and the patient is offered the screen annually.

Once the positive screen moves to the Jackson Care Hub, the Care Manager assigned to that practice receives email notification alerting them that they have a referral to review. At this point, the Care Manager will review the patient's needs and decide to refer them to the Community Navigation Specialist and/or enroll the patient in Care Management. Referring to the Community Navigation Specialist is easy; you simply "redirect" the referral to Central Michigan 2-1-1 using the Jackson Care Hub. JHN contracts with Central Michigan 2-1-1 to provide Community Navigation services. The Navigators provide more intensive interventions than that of a typical 2-1-1 referral. They assist with longitudinal needs of patients and are the true experts of community resources. As soon as the Community Navigation Specialist makes outreach to the patient and administers a deeper assessment (or second-layer questions) to further assess the patient's needs, the Navigator will link patients to applicable resources in the community within the Jackson Care Hub.

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

Initially, any practice participating with SIM was required to implement the SDoH screen (totaling 12 practices) and were instructed to screen their total patient population annually, regardless of payer. Throughout our first year of implementation, both practices and patients felt there was great value in addressing the needs of their patients, so much so that 11 additional practices decided to voluntarily implement the screen. At present, 23 primary care practices actively screen patients for SDoH needs, with many specialty practices expressing interest in this screen and workflow.

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

Success was measured in a few different ways, consisting of both process-based and outcome-based metrics. Priorities related to outcome-based measures included patients with positive SDoH screens connecting to community resources, who could then in turn assist the patient in meeting their needs. We also aimed to measure general patient satisfaction with the SDoH screen and use of the Jackson Care Hub.

For process-based measures, the focus included how quickly patients connected with resources in the community. The workflow is such that Community Navigation Specialists utilizing the Jackson Care Hub had a 3-day expectation to reach out to a patient via phone and begin addressing needs identified on the screen. Additionally, another area of focus included the ability of the practice to follow the agreed-upon workflow to assess every patient in their practice annually for SDoH needs.

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

Through July 31, 2019, 50,338 screens were administered to patients at primary care sites. Of those screens, 15,036 identified at least one social need. It is important to note that the 50,338 screens completed were not on unique patients; some patients were screened more than once. At this point, we have not been able to effectively measure patient satisfaction; this remains a continued goal as our workflow evolves.

We struggled to ensure that every practice was utilizing our best practice workflow at the point of implementation. A few practices have decided to screen every patient, every time, while others only screen annually. This has created some concern regarding caseload volumes for the Care Management team. As a point of compromise, practices are now asking patients if they have had a change in their SDoH status at every appointment. If the answer is yes, patients are screened even if they have already completed a previous screen within the year. Please see appendix A and B for additional data/graphs.

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

The initial intent was for primary care practices to verbally administer the 15-question SDoH screen. We received overwhelming feedback that practices did not feel they could take an extra 5-10 minutes with patients to do this, leading us to revise our workflow. We were able to reach a compromise and allow practices to utilize a paper version of the screen to administer to patients, and then place the results in the standard SDoH flowsheet in Epic.

The initial process included having Medical Assistant (MA) fax every positive screen to the Community Navigation Specialists. This posed a problem at times – either because the MA would forget to fax the screen or faxed the screen regardless of if there were positive answers. Ultimately, modifications to the Jackson Care Hub decreased the human error factor. At present, once the MA enters the SDoH screen into the flowsheet in Epic,

positive responses automatically generate a referral within the Jackson Care Hub which is then routed to the Care Manager for further triage and follow-up.

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

We know many health conditions and diseases will improve by behavioral changes. Unfortunately, many of the patients we serve have unmet psychosocial needs, making it difficult for them to focus on improving their chronic condition(s) without the support of additional resources. For example, it is difficult for a patient diagnosed with diabetes to manage their condition if they do not have a safe place to sleep at night, electricity to store their insulin or access to healthy, fresh foods.

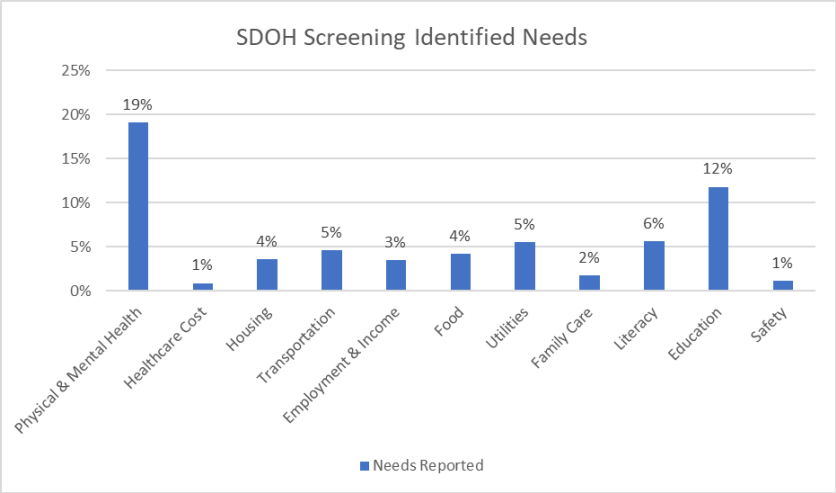
When we set out to implement this screen, we knew it was important not just to assess for Social Determinants of Health, but also to actively link patients to resources to address their identified needs. We did not anticipate over 50,000 SDoH screens would be completed in the community during the time and that 4,800 referrals would be made to community resources. We are also proud of the workflow we ultimately developed – including use of the Jackson Care Hub. When we initially began having conversations around implementing this screen, we were met with a significant amount of pushback from the practices. They were able to identify why this screen was important, but had difficulty committing their team's time to assessing for these needs. The fact that we've expanded from 12 practices to 23 practices in a little over a year, with more interested in implementing this screen, is a tremendous success for our community.

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

Funds would be used to enhance the impact of the SDoH screening via mechanisms such as incorporating SDoH screening results into population risk stratification models, improving SDoH screening workflows, enhancing patient engagement in screening and referrals, and identification of barriers to referral uptake/closure. If this submission is chosen, enhancements to the SDoH screening workflow will be implemented.

Recommendations include purchasing tablets for patients to complete the SDoH screen electronically instead of on paper, enhance Epic to automatically load screening data into the patient's chart, develop training materials for the Care Managers and practices screening and utilizing the Jackson Care Hub, and develop educational materials for patients regarding the SDoH screen. Use of the funds will largely depend on input from the practices, but our goal is to continue to evolve the screening process so that it becomes seamless for practices and patients.

Appendix A: The graph below identifies the percentage of positive responses that fall into each domain of the SDoH screen. Timeframe: June 1, 2018 – July 31, 2019.



Appendix B: Of those positive responses, the following graph identifies the number of referrals made to community resources to address the need(s) identified. Timeframe: June 1, 2018 – July 31, 2019.