Physician HealthCare Network

Contact Information

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Physician Organization Name: Physician Healthcare Network
Practice Name: CHC Yale
Practice Address: 105 Commerce Drive, Yale, MI 48097
How many physicians in practice: One MD, One NP
Description of Care Team: Two Care Managers, RN and one Care Coordinator, BS

Executive Summary

- SDOH screening tool implemented at 3 pediatric clinics for all patients. Each patient that answers positively to a screening question is provided assistance.
- Background of Social Determinates of Health screening tool
- SDOH screening process
- Resources provided
- Successes with SDOH
- New process and resources developed for SDOH

Category: Addressing Social Determinates of Health

Care Management Intervention for SDOH Resources

Physician Healthcare Network began implementing the SDOH screening tool at our CHC Yale clinic starting in August of 2018. The screening tool was also implemented at our CHC Stone and CHC Fort Gratiot locations at that time. The use of the SDOH screening tool is ongoing and does not have an end date. We plan to implement the SDOH screening tool at our other six Family Practice/Pediatric locations by the first quarter of 2020.

The goal of the program is to identify patients who may need extra resources that may not be referred through our Care Management referral process. Typically, patients are referred by Primary Care Physicians, Mid-level Practitioners, Medical Assistants, other office staff, and through ADT reports. Patients may also be outreached to from lists generated from our EMR as well as lists provided by various payers.

The program was developed by our Care Management team. We utilized the template provided by the State Innovation Model program as our guide to create our screening tool.

We perform the Social Determinates of Health (SDOH) survey (see Appendix A) on all of our patients, in every practice. If a patient reports a positive response to any question, the staff will begin the process by offering community services information materials. Each clinic has a community services bin that provides contact information plus program offers. Staff will notes the information that was provided to the patient/guardian.

All surveys are scanned back into Athena and routed to the Care Coordinator's "bucket." She reviews each form and determines the need of each patient. She will then outreach to each patient/guardian to address their needs. When needs are determined to be high intensity patients are also set up with an appointment to see a Care Manager. Examples of high intensity needs include housing/shelter, food insufficiencies, clothing/household items, personal or environmental safety, and depression. The Care Manager will set an alarm for follow-up with the patient to ensure services were received.

We utilize Athena as our EMR to document follow up through either an encounter or patient case. All communications are documented in the patients' chart. Each patient is followed with Care Management on an individualized follow up basis. Additional resources are provided as needed.

Patients are identified through the SDOH survey (see Appendix A). All patients seen in the practice, regardless of insurance type, are given the survey to fill out while in the waiting or exam room. The answers will then be entered into the patients' chart through corresponding questions located in the Social History. The form is also scanned back into the patients' chart. The EMR will also show an alert when the patient is due to be screened again.

Success of our program is measured by outcomes and processes. We first measure our success by the outcomes for our patients. Our goal is to be able to meet the needs of our patients that are identified through our SDOH screening tool. Our Care Management Department along with our clinics has information and resources on hand to be able to meet any need that is identified. Every patient that has a positive response on their survey is either immediately provided with information or set up with a Care Manager. We define success as no patient getting missed.

We also measure out success by our processes. Implementing a new process within a clinic is not done quickly or easily. The first three clinics where this was implemented are considered our pilot clinics. We learned what worked to get the staff and providers on board with distributing the forms to patients and how the streamline recording those results. We define success with our process and now being confident to role this program out to all of our clinics in the near future.

Physician Healthcare Network has had great results from this program. At our CHC Yale clinic, from August to December of 2018, 121 services were received by patients. During the first eight months of 2019 at CHC Yale, 284 services were received by patients. Out of all patients outreached to that indicated a need for services from their SDOH survey, only one patient declined any assistance.

PHCN has had many great success linking up our patients to resources and other assistance through our SDOH and Care Management Program. Please see Appendix B for examples of resources we have utilized for our patients. Below is an example of a patient we were able to identify and assist through the SDOH survey by one of our Care Managers, Krystal.

- "Stephanie, our Care Coordinator, was contacted regarding an SDOH survey filled out by the mother of a 9 year old child with a seizure disorder. Stephanie reached out to the mother and left a voicemail. The mother contacted CHC Yale in response to the voicemail she received and was scheduled for a Care Management appointment by Audrey (receptionist at CHC Yale). Upon meeting with the mother, I discovered that the child was in need a bed. At the time, he was sleeping on an air mattress that was having a hard time holding air. Mom had a metal bed frame but could not afford a mattress for the frame. Mom stated that she looked at multiple places but just could not find a bed that she could afford. I contacted multiple resources and the Lions Club was willing to purchase a mattress and box spring for the child. The Lions Club worked very quickly and he had a new bed within a couple days. As a Care Manager, I am excited to see the changes we are making in peoples' lives."

Many new tools and process have been developed to aid in implementing this program. Most importantly, our Care Management department has researched a wealth of resources to provide to our patients. Any issue that a patient may need assistance, we are able to provide them help with. We have a variety of contacts to help with anything from food, employment, housing, household items, clothing, education, family care, transportation, utilities, personal safety, and depression. Each clinic has a bin with resource information to give to patients. The Care Management Department also works closely with organizations such as the United Way of St. Clair County, 2.1.1., Salvation Army, Community Mental Health, Head Start, Kids in Distress and so many more.

An important new process that was developed to aid in this program was to integrate survey responses into the patients' charts. Originally, staff was only able to scan the survey back into the patients' chart. We were able to add these same questions into the patients' Social History so that they could become part of the chart. We are now able to run reports to track the patient, date of the survey, provider, location, what the issue was, and the date the patient was contacted. We

also use a tracking code to be able to create a report to show the volume of services provided. Previously all tracking has been manual.

We have begun submitting the SDOH survey data via ACRS files to MIHIN.

We are most proud of this submission because it shows Physician Healthcare Network's commitment to make a difference in our patients' lives. Through Care Management, we not only improve health outcomes for our patients, but help them through rough times. Surveying for SDOH helps to fill in the gaps that the healthcare system is not able to provide.

If our submission wins, Physician Healthcare Network plans to use the funds to hire an additional Care Coordinator to assist in processing SDOH surveys to identify patients in need. We would also move our current Care Coordinator from part time to full time status.

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Appendix A

SOCIAL DETERMINATES OF HEALTH (SDOH)

Domain	Question	Response		Resources Provided
Healthcare	In the past month, did poor physical or mental health keep your family member from doing your usual activities, like work, school or a hobby?	YES	NO	Referral to Community Mental Health (CMH), Outreach (Health Dept.), DHHS, Depression screen (PHQ 2/9) as indicated below, Discussing PT/OT referral with physician.
	In the past year, was there a time when your family member needed to see a doctor but could not, because it cost too much?	YES	NO	Referring patient to see Case Managers at DHHS or Outreach to help with attaining medical/prescription coverage. Medication resources: SimpleFill, Medicare Extra Help Program, Harbor Impact Ministries (free insulin), Rx Advocates, GoodRx, Pharmaceutical assistance programs
	Are you not taking your medications because they cost too much?	YES	NO	
Food	Do you ever eat less than you feel you should, because there is not enough food for your family?	YES	NO	Provide vouchers to local Food Pantries, Vantage Pointe Farmers Market (seasonal), Local Churches, CMH market, Mid City Nutrition, 2-1-1
Employment & Income	Does anyone in your household struggle with finances?	YES	NO	Blue Water Community Action (BWCA) finance classes, CMH ACT Team. Michigan Works. DHHS
Housing & Shelter	Are you worried that in the next few months, your family may not have safe housing that you own, rent, or share?	YES	NO	Refer to Habitat for Humanity (HFH), BWCA, Housing Assistance Resource Agency (HARA), Landlords Association, Housing Commission, DHHS, Homeless Shelters, CMH, BWCA
Utilities	In the past year, has your family had a hard time paying utility company bills?	YES	NO	THAW through DTE, LSP through SEMCO, DHHS, 2-1-1, BWCA
Family Care	Do you need help finding or paying for care of loved ones? For Example, child care or day care for an older adult?	YES	NO	Council on Aging (COA), Respite.org, Referral to Visiting Nurse, Private Duty Nursing, Children with Special Needs , Head Start, BWCA, 2-1-1
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	YES	NO	2GEN Learning Center, Michigan Works, BWCA, 2-1-1, DHHS, CMH
Transportation	Has there been a time your family were unable to get to an appointment because there was no transportation?	YES	NO	Logistacare (Medicaid & Humana Medicare), COA, BWCA, DHHS for free bus passes
Clothing & Household	Does your family need help in getting household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste & shampoo	YES	NO	Vouchers to: Salvation Army, Kids in Distress (K.I.D.S.), BWCA, 2-1-1, Free Store/Port Huron, Harbor Impact Ministries, Food Pantries
Personal & Environmental Safety	Do you or your family ever feel unsafe in your home or neighborhood?	YES	NO	Blue Water Safe Horizons/Carolyn's Place, 9-1-1, BWCA, 2-1-1
General	Are any of your family needs urgent?	YES	NO	
Depression	Have you or a family member had little pleasure or interest in doing normal activities?	YES	NO	Perform PHQ 2 or 9, Refer to CMH if necessary, If patient is suicidal call the Mobil Crisis Unit 810-966-2575 *see Depression flow chart*
	Have you or a family member been feeling down, depressed or hopeless?	YES	NO	

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Appendix B

- **Food Assistance Provided**

DEMOGRAPHIC	DATE	SERVICE PROVIDED
• Single 50 year old Female • One child , 19 years old	4-22-2019	• Blue Water Food Depot • Food Pantry list for St Clair County • 2-1-1 • Vantage Pointe Farmers Market • Blue Water Community Action
• Single 42 year old Female • One child, 11 years old	5-7-2019	• Same as above
• Married 40 year old Male • Two children, 17 years old and 18 years old	5-21-2019	• Same as above

- **Clothing and Household Items**

DEMOGRAPHIC	DATE	SERVICE PROVIDED
• Single 27 year old Female • One child, 16 months old	4-2-2019	• Kids In Distress (K.I.D.S.), clothing, diapers, wipes and a dresser • Salvation Army, clothing, bed
• Single 40 year old Female • One child, 5 years old	4-2-2019	• Same as above, for clothing and shoes
• Single 39 year old Female • Two children, 10 and 13 years old	5-20-2019	• Same as above , for clothing and shoes
• Single 30 year old Female • Two children, 9 and 12 years old	6-2-2019	• Same as above, for mattress, box spring, bedding and towels
• Single 20 year old Female • One child, 15 months • Pregnant and due in a few weeks	6-15-2019	• Same as above , for baby supplies, clothing, formula, diapers • Head start for newborn support • WIC information