Contact Information

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Physician Organization Name: The Physician Alliance

Practice Names, Address and Number of Physicians:

PRACTICE NAME	ADDRESS	ZIP	# OF PHYSICIANS
Be Well Medical Center	1964 W Eleven Mile Rd	48072	1
Deighton Family Practice	22250 Providence Dr, Ste 500	48075	9
Family and Athletic Medicine - Novi	26750 Providence Pkwy, 210	48374	2
Family and Athletic Medicine - Milford	1050 Corporate Office Dr, Ste 100	48381	2
Harper Family Practice	19901 E Ten Mile Rd	48080	3
Livonia Family Medicine Associates	33523 Eight Mile Road, Ste M2	48152	9
Masonic Medical Center	21099 Masonic Blvd	48082	6
Medical Pavilion Ii Internal Medicine	7633 E Jefferson Ave, Ste 290	48214	1
Northpointe Pediatrics, PC	30061 Schoenherr Rd, Ste A	48088	8
Providence Park Pediatrics	26850 Providence Pkwy, 455	48374	11
River District Family Practice	4014 River Road, Building 6	48054	6
South Lyon Medical Center	51619 Ten Mile Road	48178	9
St. John Center for IM	19251 Mack Ave, Ste 333	48236	17
St. John Family Medical Center	24911 Little Mack, Ste C	48080	7
St. John Pediatrics Associates	46591 Romeo Plank, Ste 205	48044	9
			100

Description of care team:

The care team varies by practice. Most practices have providers (MD, DO, NP, PA), Care Managers/Care Coordinators, Medical Assistants and front desk registration involved in this work.

Executive Summary:

- Research identifies that social determinants of health (SDoH) impacts both patient outcomes and cost.
- TPA's mission includes improving the health and reducing cost for our population.
- Best practice workflow for SDoH screening was defined and implemented.
- 88% of the patients were screening but only 42.7% received a referral when they had a positive screening.
- Ease of identifying and referring patients was determined as a barrier to referrals.

- An SDoH health database vendor was selected (NowPow – a community resource database) and implementation has begun.

Category of Submission: Addressing Social Determinants of Health

Title of Submission: TPA Social Determinants of Health Screening Workflow and Resource Database Development and Implementation

When did the intervention start and end?

The interventions began in November 2017 with 15 practices which had many Medicaid members. Interventions are still occurring, with the scope of the project expanded to include all patients across multiple sites of care (ambulatory, inpatient, community resources, and others) to complete SDoH screenings and make appropriate referrals using a standardized, vetted, quarriable database.

Goal of the Program/Intervention:

1. Assure that all patients are screened at least annually for social determinants of health.
2. Provide a database to easily identify and provide appropriate referrals to community resources based on the patient's SDoH needs.

Who developed the program/intervention, and how?

The interventions were developed using a team approach with leadership from The Physician Alliance, Partners in Care, and the Ascension Medical Group. Collaboration occurred with Ascension's registration system vendor to assist in including a standardized SDoH questionnaire for electronic completion and provide reporting. The program expanded to include a securement and build of a quarriable database of community resources.

Description of the Program/Intervention:

Since no standardized SDoH screening tool existed in the EMR's a standard SDoH screening tool was developed and implemented in 15 practices using a defined workflow to screen all patients for SDoH. Some practices used the Ascension registration platform to screen electronically and others used a paper form. Analysis of the screenings were tracked (volume of needs identified by category and documentation that a referral was made on the patient's behalf). A barrier identified was that practices were challenged to match patients with SDoH needs to the appropriate resource.

In 2018, a team reviewed potential vendors for developing a SDoH resource database. The vendor NowPow was selected and a team of care mangers and leadership assisted to build the SDoH tool. The NowPow database spans across our 5 counties (Macomb, Oakland, Wayne, Livingston, and St. Clair) and all care sites that screen for SDoH can access the database to query for appropriate resources based on the patient's unique needs. In April 2019, the database was piloted by 32 users for validation of scope and that queries were actionable.

Widespread expansion of NowPow users is occurring with multiple monthly trainings. A goal of expanding to 500 NowPow users in PCP and Specialist practices, inpatient social work and care management and community sites by year end 2019 is set. See Appendix B graph of NowPow users.

How were patients identified for the program/intervention?

An all payer all patient approach to SDoH screening was used. Any patient that did not have a SDoH screening in the last year is flagged to screen. Any positive SDoH need is to result in a referral to a community resource.

How was success measured? Please delineate whether metrics were process-based or outcome-based: The process-based measures were:

1) The number of patients being screened for SDoH and documented in the medical record.
2) Number patients agreeable to SDoH referrals and the percentage that were referred.
3) Number of NowPow users trained on the database.

What were the program results? Include qualitative data/graphs:

Number of referrals had decreased some from 49.6% in December 2018 in to 42.7% in March 2019. Ease of access to community referrals for patients was determined to be a barrier. Implementation of NowPow began in May 2019. Monthly on boarding is scheduled with the goal of having 500 users trained with licenses by year end 2019. See attached graphs on Appendixes A & B.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

New tools included the development of a standardized SDoH questionnaire, inclusion of SDoH screening tool in the Ascension registration tablet, reporting tools, and access to the NowPow community resource database. SDoH standardized screening questions are identified on Appendix A.

What are you proudest of regarding this submission? Why does this work matter?

Our proudest accomplishment was recognizing that the key barrier was the ability to easily provide actionable resources to patients SDoH needs. This resulted in the implementation of NowPow. Screening for SDoH matters because healthcare studies demonstrated that social determinants of health are highly predictive of a population's overall wellbeing. In fact, healthcare professionals site that somewhere between 50 - 80 percent of patient health is determined by social factors. TPA believes that offering providers a tool that helps link patients with community resources will fill a gap in service and benefit our communities.

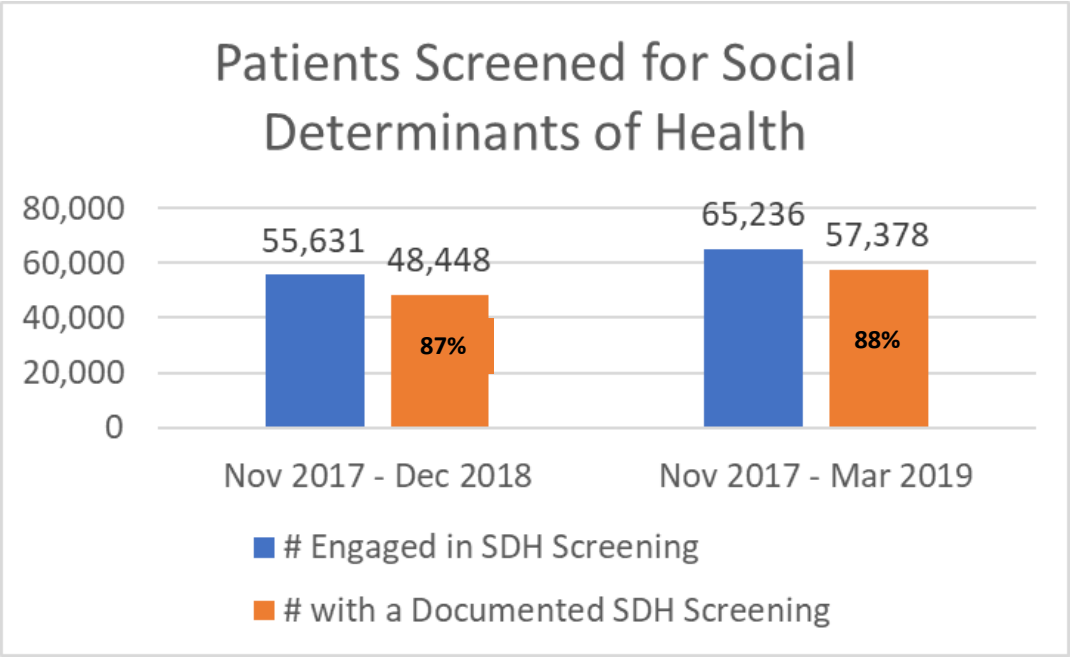
How will your organization use the funds if your submission wins?

Funding will be used to expand the reporting functionally in NowPow so our organization can identify population level needs, expand geography of the data base to more counties and add more users having access to NowPow. Funding will also assist in implementing the "ping back" functionality in NowPow that confirms that patients did access the resource for which the patient was referred.

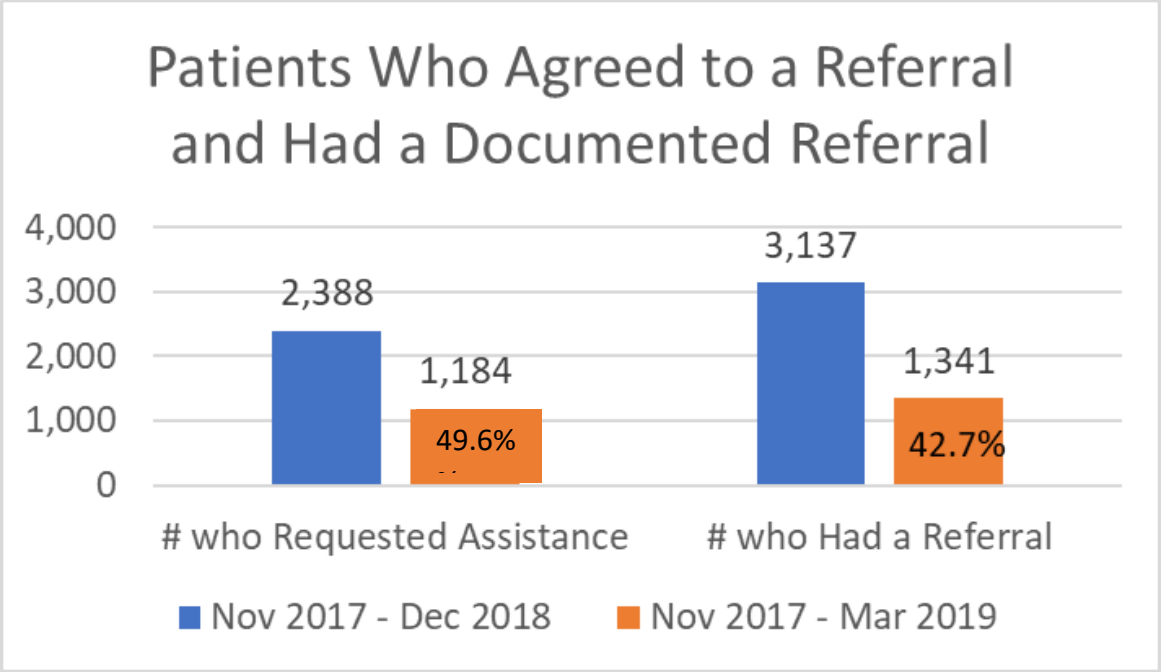
Appendix A

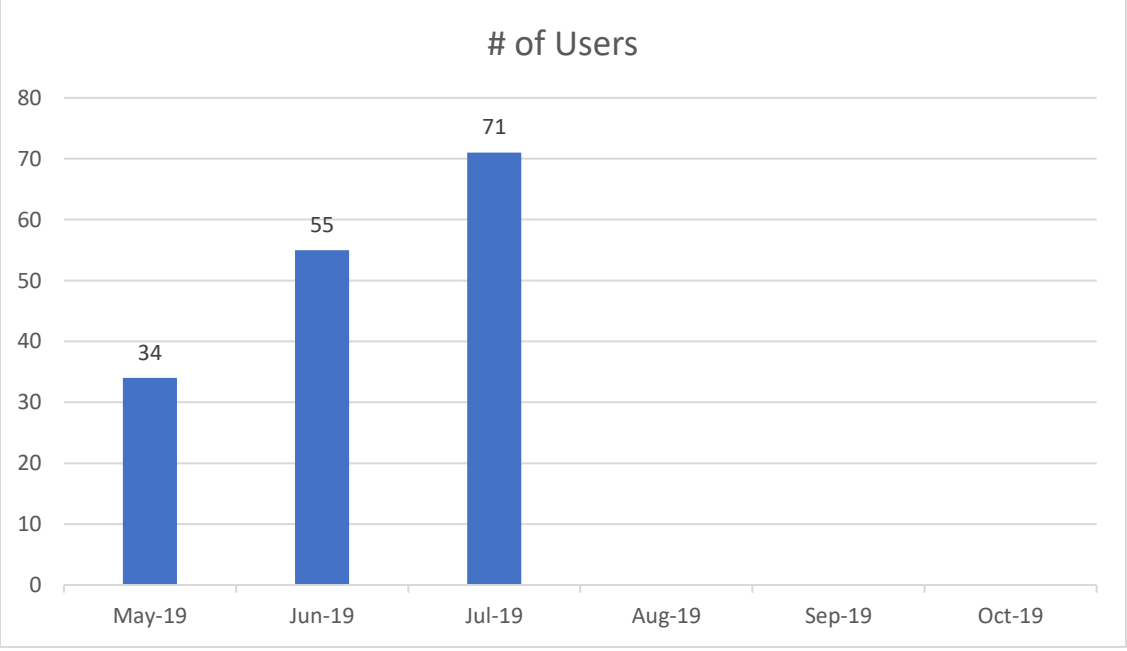
Standard SDoH Screening Questionnaire

	Question
Employment	Do you have a job or other steady source of income?
Education	Do you think it would help you to get more education or training? This might mean getting a GED, going to college or learning a trade.
Financial Insecurity & Healthcare (Health Services Access)	In the last 12 months, was there a time when you needed to see a doctor but could not because of cost?
Financial Insecurity & Healthcare (Medication Affordability)	In the last 12 months, did you skip medications to save money?
Transportation	In the last 6 months, have you ever had to go without health care because you didn't have a way to get there?
Housing Instability	Do you need assistance to be able to stay in your current housing? Or do you need help to find a place to live that is safe and more stable than where you live now?
Utility Needs	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
Food	In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?
Clothing & Household Needs	Do you have the household supplies you need? Things like clothes, shoes, blankets, mattresses, diapers, toothpaste, and shampoo?
Family Care	Do problems caring for children or other family members make it difficult for you to work or study?
Intimate Partner Violence	Are you afraid you might be hurt in your apartment building or house?
	Would you like to receive assistance with any of these needs?
	Are any of your needs urgent?



APPENDIX B


Patients Who Agreed to a Referral and Had a Documented Referral
4,000
3,000
2,000
1,000
0
2,388
1,184
49.6%
3,137
1,341
42.7%
who Requested Assistance
who Had a Referral
Nov 2017 - Dec 2018
Nov 2017 - Mar 2019


# of Users
80
70
60
50
40
30
20
10
0
34
55
71
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19