BCBSM Care Management Recognition Award Opportunity
Addressing Social Determinants of Health

Contact Information
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Physician Organization Name: Upper Peninsula Health Group
Practice Name: Upper Great Lakes Family Health Center- Hancock
Practice Address: 500 Campus Drive Hancock, MI 49930
How many physicians in practice: 2
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): 2 physician assistants, 6 registered nurses, 1 clinic assistant, 2 patient service representatives, 1 certified community health worker, 1 RN care manager

Executive Summary (5-8 bullet points, must include summary of results)
- Identified the need to screen all patients for SDOH, as previously only screening patients who were receiving care management services
- Designed PRAPARE questionnaire on iPad for patients to complete during check-in process to minimize impact on time in exam rooms
- Initiated screenings for patients scheduled for preventive exam visits at Hancock Family Health Center
- Increased screenings in Hancock Family Health Center from our baseline of 6 patients on June 14th to 94 patients by July 19th
- Implemented iPad screenings across all Upper Great Lakes Family Health Center clinics by July 31st
- Total number of 377 screenings completed since June 2019
- Patients with issues identified through the screening meet with either a care manager or community health worker through a warm handoff, and are provided support or connected to community resources as needed

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

Title of Submission: Utilizing iPad Technology to Screen for and Address Social Determinants of Health

When did the intervention start and end? (1-2 sentences)
Initial analysis of workflow began in January 2019. New workflow implemented in pilot site on June 14th. Expanded workflow across sites from July 18th -July 26th.

Goal of the Program/Intervention: (1-2 sentences)
To implement a social determinants of health screening (PRAPARE tool) to screen all patients across all clinics with minimal impact on patient intake time, and to appropriately address SDOH results by connecting patients with a community health worker (CHW)/care manager.

Who developed the program/intervention, and how? (2-4 sentences)
The Quality Manager developed the workflow by analyzing iPad functionality to ensure patients' ease of use and that structured data fields could be captured appropriately in the EHR. Training was provided for both front office and clinical staff to discuss the importance of screening for social determinants of health and to understand the process for using the iPads, completing the PRAPARE screening, and how to follow up if a patient has a need identified through the screening process.

Description of the Program/Intervention (2-3 paragraphs):
Prior to the intervention, the PRAPARE screening tool has only been administered by care managers and CHWs to patients who were receiving care management services. This was a logical place to start since care management focuses on complex patients who often also have social needs that may impact their health. Care managers and CHWs had also received formal training on connecting patients to community resources and providing support when a patient screens positive and an issue identified.

It was clear that by performing PRAPARE only on patients who were receiving care management services, we were missing opportunities across our whole patient population. Our initial approach was to simply have the rooming nurse verbally ask each patient the screening questions and fill in the responses in the PRAPARE form built into the EHR. However, the idea of adding this screening to the 5-7 other screenings a patient might need completed prior to the provider entering the room (alcohol, tobacco and substance use, and also depression and anxiety) was met with resistance. It would be difficult for nurses to meet intake time expectations and patients would be spending even more time in the exam room. All the screening questions were also detracting from the nurses' ability to work to their peak of scope, since they were becoming limited on time in the exam room to follow up on the screening results. We were in danger of screening just for data collection rather than screening to take action on the results.

The intervention to invest in iPads for each clinic to facilitate the screening process was initiated. Using the iPads, the patient can sit in the waiting room and fill out the PRAPARE questionnaire (among other screenings) privately while they wait to be called back to the exam room by a nurse. When the patient completes the screening, the nurse is able to merge the patient responses electronically into the progress note. This eliminates the need to verbally ask the patient any screening questions and significantly reduces the nursing intake time. The nurse is now able to spend time with the patient reviewing the screening results and connecting patients with a care manager/CHW as needed, before the provider enters the exam room.

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

Initial analysis suggested new patients and patients coming in for preventive exams would be an appropriate population to target. This would allow clinics to become comfortable with the process until they are ready to screen patients across additional visit types.

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

Success was measured by demonstrating an increase in the number of patients with a completed social determinants of health screening compared to baseline data (outcome based).

Success was also measured through staff and provider feedback on how using the iPads affected clinic flow and patient intake time (process-based). Patient feedback and satisfaction in regards to the use of the iPads was also monitored (process-based).

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

Staff have reported that the iPads contribute to a much easier and less time-intensive patient intake process. They have expressed the interest in expanding the use of the iPads to additional visit types much sooner than what was initially planned because of the positive impact they have had on clinic flow.

Patients have also provided positive feedback stating they would prefer to answer screening questionnaires on an iPad instead of having clinical staff verbally ask them. We have experienced some challenges with elderly populations or patients who have never used a tablet before, but staff have been able to successfully assist them.

The number of completed SDOH screenings increased from 6 to 94 in just over one month in Hancock Family Practice, and have completed 377 screenings since June (See appendix 3, SDOH Screenings Trend). Patients with issues identified through the screening meet with either a care manager or community health worker through a warm handoff, and are provided support or connected to community resources as needed. Of patients screened, we found that patients have responded as needing support in the following categories:

Material Security

SDOH	Denom
CHILDCARE	24
CLOTHING	75
FOOD	95
MED/CARE	95
PHONE	69
UTILITY	99

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

Process maps were developed for the "iPad Screening Workflow" and the "Addressing SDOH Workflow" (see Appendix 1 and 2).

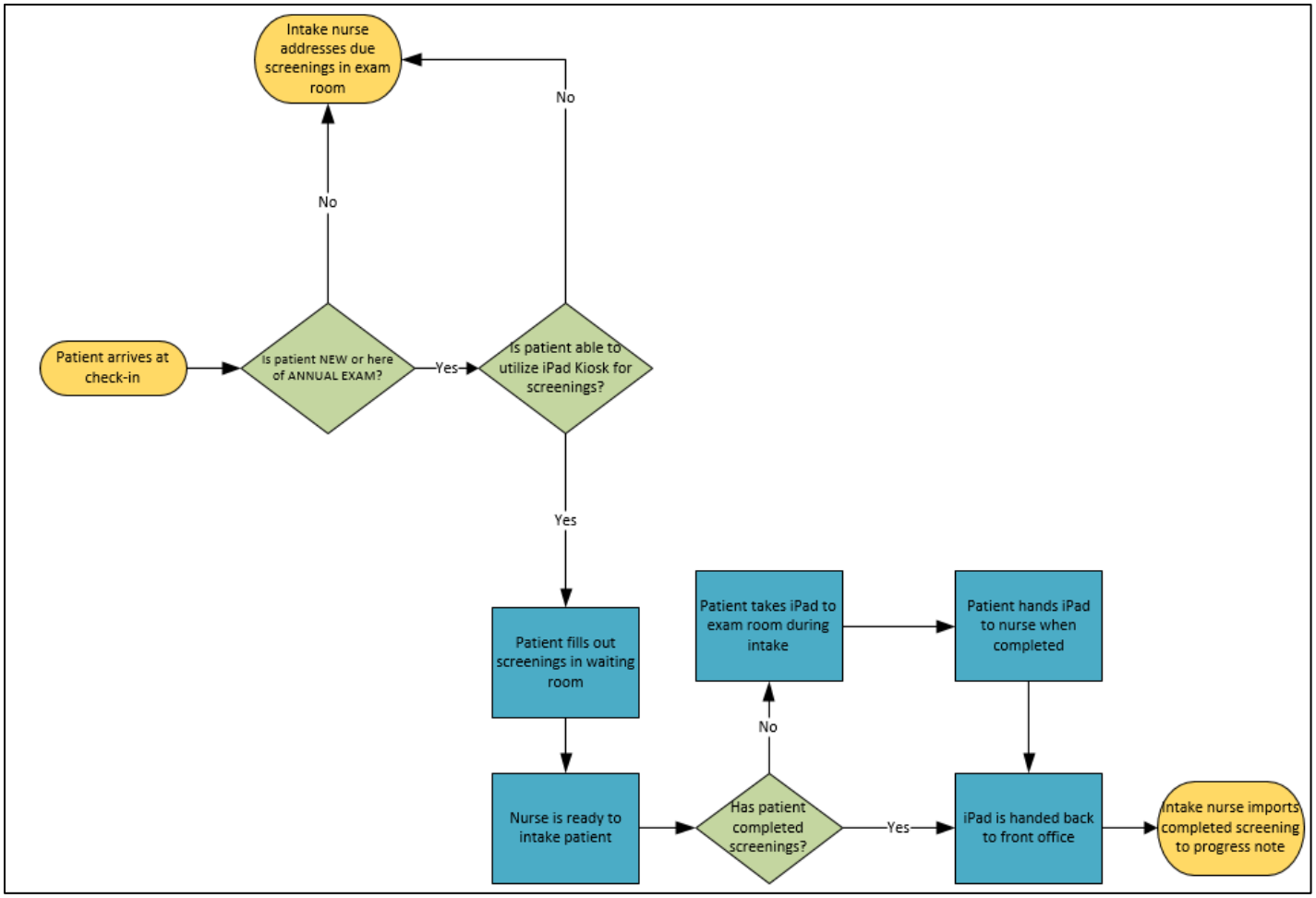
What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

We are proud to have implemented a process that enables staff to identify and respond to patient needs without increasing the staff and provider workload. We have contributed to improved staff and patient satisfaction with this process, and through the identification and follow up of SDOH, providing better quality care to patients.

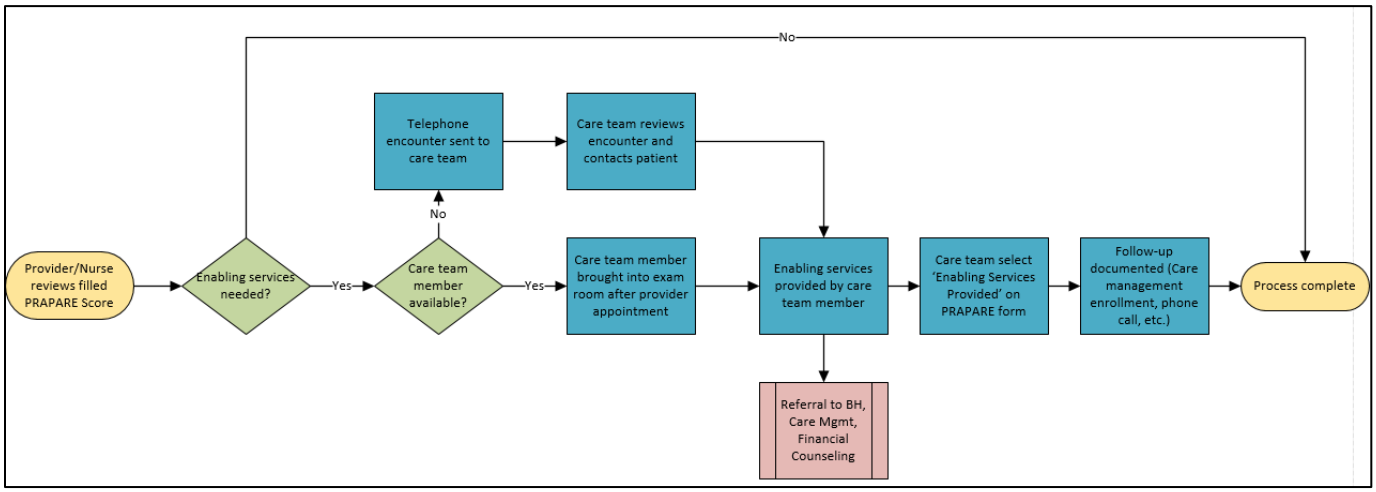
How will your organization use the funds if your submission wins? (1 paragraph)

We would plan to use the funding to support our community health worker program. With the increased number of patients who are being screening for SDOH, we are identifying more patients who are in need of support and community resource connections. CHWs are necessary to support this process and provide patients with the assistance that they need.

Appendix 1: iPad Screening Workflow



Appendix 2: Addressing SDOH Workflow



Appendix 3: SDOH Screenings Trend