Care Management Recognition Awards: Best Practice Submission

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Executive Summary:

Managing Social Determinants of Health (SDoH) in primary care practices is complicated. Challenges with perception, the lack of available resources, and inadequate technologies to document, track, and share SDoH processes and outcomes has not been adequately demonstrated in Michigan. For those few who have successfully developed an electronic and integrated SDoH platform, the sustainability of such projects have been an even further concern. Great Lakes Organized Systems of Care (GLOSC) recently embarked on building a SDoH program by first hiring a Community Health Liaison (CHL) whose initial role has been to ensure that the building blocks for SDoH management are in place for 2019. The CHL has acted as a project lead for building the program as well as a personal community resource hub for practice and patient needs. To the knowledge of GLOSC, this model has not been implemented by similar groups throughout the state.

Despite performing SDoH screenings to meet Patient-Centered Medical Home (PCMH) requirements, it has been discovered that many GLOSC practices did not have the means to resolve patient needs after they were screened. Knowing that current SDoH resource hubs are not robust enough to serve our rural regions, we set out to satisfy the resource deficit. After assessing practice workflows, addressing false staff perceptions regarding SDoH, developing unique processes, and building an extensive repository of public & private community resources, we were able to demonstrate a significant increase in the confidence of GLOSC practices in administering and acting upon the results of a SDoH questionnaire (Appendix A). GLPO was also able to act as an overflow and further resource for cases where traditional resources were unable to help.

Category: Social Determinants of Health
Title: *Improving the Management & Sustainability of Social Determinants of Health in Primary Care*
Start date: September 2018 **End Date:** July 2019
Goal: Increase the volume and effectiveness of SDoH health screenings in all GLOSC primary care practices by increasing the number of patients connected to clinical community linkages (CCLs).

Development:

Marie Wendt, Director of Quality & Care Management, and Melissa Gary, Community Health Liaison, worked to develop GLOSC's SDoH program starting in the fall of 2018. Prior to hiring the CHL, a group of GLOSC stakeholders convened in September 2018 to discuss the current status of SDoH, relevant requirements and initiatives being encouraged by payers throughout the state, and other future considerations. The stakeholders were comprised of care managers, social workers, primary care office managers, behavioral health counselors, GLOSC care manager lead, GLOSC practice transformation specialists, and an internal IT interoperability consultant.

Together, the stakeholders documented various SDoH screening processes -including how results are documented, tracked, and follow-up on. We then examined how results could be tracked in the future. The team also examined what they believed SDoH would require in the state of Michigan over the next five years. Current community partners were reviewed, and lacking community resources were assessed. Consideration was also taken to the fact that GLOSC was in the early stages of developing a new patient record called Community Health Cloud, which could potentially serve as a tool to track, collect, and connect information about SDoH to care teams, patients, and community hubs.

Program Description:

Based on the findings of the stakeholder meeting, GLOSC hired a Community Health Liaison (CHL) on January 1, 2019 to lead its SDoH program. This position was designed to help practices with all SDoH needs. Initially, this included staff education and addressing negative perceptions related to SDoH needs of their patients, which were commonplace.

During the first 3 months, the CHL met with practices individually to understand workflows, build relationships, and support SDoH work needing to be addressed. The CHL then performed an informal assessment of individual primary

care practices in each of the 12 counties. Gathered information included which staff is performing the screening tool, which staff are locating resources, what resources are known to practices, and what needs were currently not being addressed. Lack of community resource support was also assessed. The process varied significantly by practice and geographically, and at the time most practices were not able to resolve the majority patient needs.

To better understand the inconsistencies with the CHL's informal assessment, a formal assessment was provided to all GLOSC office managers in March 2019 to determine how many primary care and specialist practices were currently providing SDoH screening questionnaires to patients, which patient populations were being screened, who is responsible for administering the screening, and who is addressing the patients' need(s). These formal and informal practices assessments assisted the CHL to uncover a lack of understanding of purpose in the SDoH process, as well as a lack of commitment to the associated roles and responsibilities. Moreover, it was also found that most office managers were not aware of staff responsibilities related to SDoH.

Acting as a personal hub for connecting community resources to individual patient needs for all GLOSC practices, the CHL worked to develop a 12-county repository of community resources. This repository is maintained and updated by the CHL. In addition, a process was developed after meeting with each practice. A process for all practices, regardless if there is an embedded care manager present or not, includes the following:

1. All patients (all-payer) to be screened via paper format (EMR if available) by practices based on individual workflows best suited to that independent office. Screening tools ranged from 5-12 questions with the intent to ensure all practices are utilizing the 12-question version eventually.
2. Screenings occur during yearly wellness exams and additionally when indicated or requested.
3. Within the practice, positive patient screens were given to RN or Social Worker Care Manager to address (medical assistant addressed if no care manager on staff).
4. Identified patient needs that were unable to be addressed by the care manager is referred to the CHL via phone or email under HIPAA guidelines (encrypted). The CHL addresses patient needs working through care manager or other office staff. This process requires little patient identifier information being transferred. The CHL does not have patient interaction.
5. Working with several county community collaboratives, the CHL continually develops and updates a robust repository of community resources through both the public and private sector and will provide regularly and at request.
6. The CHL collaborates with the practice care manager or office staff to determine the best resolution for the individual patient need.
7. The CHL then provides clinical community linkage information to the care manager or office staff via email, phone or in person.
8. To ensure the need is resolved, the CHL contacts the care manager or office staff within 2 weeks to determine loop closure.

In following this process, it was paramount that the front-line staff play a significant role in setting the stage and addressing perceptions and needs regarding social determinants. The CHL provided education to care teams regarding addressing negative perceptions and how to appropriately ask the screening questions to illicit genuine patient responses. The CHL was able to improve staff perceptions, increase number of screenings, and enhance authentic answers to screenings.

A trial was performed by providing comprehensive resource binders to 5 practices for medical assistants to have as a quick reference following SDoH screenings. The thought was that this resource would allow for quick, efficient provision of resources to patients and families while still in the exam room. This trial proved to be a very valuable workflow improvement for these practices. The CHL monitors and updates the binders quarterly and as new resources become available and as changes are made. In September 2019, these resource binders will be provided to all practices following implementation of the longer 12 question SDoH screening tool. A web-based repository of information is concurrently being built into the GLOSC website for quick reference and ease of updating.

Patient Identification:

Patients were identified through various SDoH screenings at practices throughout the 12 counties during annual wellness exam appointments. Changes in patient events and personal requests also prompted SDoH needs screening. Patients with complex needs requiring further resources were referred to the CHL for securing resources.

Measurement of Success:

Success of the program were measured with process outcomes.

1. Increase in confidence level of staff performing SDoH screenings
2. Dispersal of quick tool reference binders for front line staff to 100% of GLOSC PCP practices (September 2019)

Outcomes

In the first 6 months of 2019, the CHL was able to directly address 208 patient needs and provide loop closure with public and private resources. These patients needs being addressed by the CHL are only those which are not able to be addressed by the traditional means through office staff, which is reflective of the enormous volume of patients which are being referred to community resources by GLOSC practice. The CHL has built a personal catalog of 2,868 community resources which is constantly being updated and will eventually be put into electronic format for access by GLOSC members on the GLOSC website.

Practices were assessed by the GLOSC team to their level of confidence related to screening patients routinely and realistic SDoH needs. A qualitative analysis of practice confidence levels in screening for SDoH revealed that, one a scale of 0 to 5 (0 being least confident, 5 being most confident), practices increased their average confidence level from 3.4 to 4.2 based on two snapshots in June 2018 and June 2019, respectively (Appendix A).

In addition to the success of the practices in administering the surveys and taking action upon the results, there are a myriad of individual case examples which could be used to demonstrate the success of GLOSC's nascent SDoH program. One exceptional case of a homeless mother with two small children (children covered under father's BCBSM plan) who had been moving between daytime and night-time homeless shelters daily. After various referrals and communication between the family and the GLOSC CHL, it took only five days for this mom of two find an apartment, utilities, dishes, food, clothing, and household supplies.

Processes & Resources Utilized:

The single most important process of the program is having the CHL acting as a hub for practices to collaborate regarding patient needs. Although 211, a popular source for such services, is accessible, it is limited with resources for our rural regions. Joining community collaborative groups was also essential to provide a voice for our practices and for uncovering needed resources. A master repository of community resources was developed by the CHL through connections made within the public and private sector. An easy to follow binder with one-page handouts for resources related to screening questions was developed, trialed, and will be distributed organization-wide in the short-term future.

Why this Work Matters:

What happens outside of a patient's clinical care has an impact on their overall health. It has been reported that approximately 80% of poor health care outcomes are attributed to environmental and/or socioeconomic factors and individual behaviors. Solutions to resolving these influences is crucial to improving outcomes and reducing cost to the healthcare system.

Utilization of Funds:

Funds received through this award will be utilized in two ways. First will be to expand the CHL role to all GLOSC practices, including specialists. Roles such as the CHL will continue to be a critically important to quality outcomes and key to the health care team. They offer the real possibility of bettering patient lives by connecting them one-on-one to vital resources while reducing costs and improving health outcomes. Funding will aid in adding additional staff to conduct patient reach-out and assistance in the real of community health. This would utilize approximately 50% of the funding opportunity.

The second utilization of funding would be for establishing connectivity between developing GLOSC technology and a SDoH gateway which would ultimately land at a hub. This would allow for a standardized process for SDoH screening, referral, and follow-through. In addition, GLOSC would be able to track and trend any results along with cost, quality, and utilization metrics. GLOSC would also be able to further participate in use cases regarding sending and receiving SDoH information. While it has been successful, having one CHL act as a personal hub is not sustainable nor scalable. It is estimated that such an integration into GLOSC technology would utilize approximately 50% of the funding opportunity.

While the cost is much less than the two aforementioned items, any funding would also be used to pay for Mental Health First Aide courses for all care managers and care coordinators. This would cost approximately $5,000.

Appendix A

Confidence Level Using SDoH Screening Tools (2018 vs 2019)
0 being least confident, 5 being most