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)

- By using the Jackson Care Hub, Jackson Health Network care coordination staff (Care Managers and contracted Community Navigation Specialists) can more efficiently connect patients with community resources most relevant to their social needs.
- The workflow streamlines how Care Managers refer patients to the Community Navigation Specialist.
- The partnership between Jackson Health Network and Central Michigan 2-1-1 (Jackson Chapter) for community navigation services provides an environment which allows both the Care Managers and Community Navigation Specialists to work at top of licenses best utilizing their respective skills.
- Overall satisfaction with the experience: 94% were "very satisfied" 4% "somewhat satisfied" and 2% "not very satisfied" and 92% of respondents felt their need was met, 6% of respondent felt their need was "somewhat" met and 2% felt their need was not met.
- Now that better workflows have been established, funding to support piloting a Community Navigation Specialist in primary care practices could demonstrate if this co-located resource can further enhance workflow efficiencies and the amount of time it takes to address unmet social needs.

Category of Submission (see page 1): Best Practice – Workflow

Title of Submission: Community Navigation Specialist (CNS) Collaboration with Care Management

When did the intervention start and end? (1-2 sentences)
Jackson Health Network initiated a contract with the Central Michigan 2-1-1 (Jackson Chapter) for Community Navigation Services starting July 1, 2017 and it is renewed annually. Overtime, workflows around referrals have been revised to achieve optimum efficiency.

Goal of the Program/Intervention: (1-2 sentences)
The goal of the workflow is to connect patients with community resources most relevant to their social needs more efficiently and ensure each care team member is functioning at the top of their license. By implementing this workflow, the process for a Care Manager to assign needs-based tasks to the CNS is much more streamlined and organized. Thereby allowing each discipline to function at top of license and utilizing their respective skills.

Who developed the program/intervention, and how? (2-4 sentences)
The workflow was created collaboratively between JHN and Central Michigan 2-1-1. The need for a streamlined workflow is critical as the CNS are a shared resource among multiple primary care practices and can receive referrals from a variety of locations. Their value as care team members, in particular their ability to address unmet social needs, is viewed so highly that they are sustained through the JHN care management-funding model. High productivity in their duties requires LEAN workflows as much as possible.

Description of the Program/Intervention (2-3 paragraphs):
Patients are assessed for social needs using the Social Determinants of Health screening (SDoH). SDoH screenings occur regularly as a component of the Comprehensive Health Assessment for patients enrolled in care management, or during the patient's annual visit with their primary care provider within the Primary Care Medical Home (PCMH). A patient may also receive an ad hoc SDoH screening if a concern for a social need is noted outside of the annual visit or care management enrollment. If the patient acknowledges a social need on the SDoH screening, and agrees to further assistance, a referral is made by the Care Manager to the Community Navigation Specialist.

The CNS reviews the referral and makes outreach to the patient within 3 business days. Next, a secondary assessment of each of the identified needs is completed, and the CNS works to establish a rapport with the patient, and documents barriers discussed by the patient. Once available resources are identified, the patient prioritizes his/her needs with the CNS and chooses the agencies to which he/she agrees to be referred. Among many things, patients receive assistance with appointment making and education on the importance of keeping appointments, along with barriers that prevent them from being successful. The patient is given information about community resources both verbally via phone and by hard copy via mail.

At the beginning of the JHN Central Michigan 2-1-1 partnership, referrals were made by fax and communication occurred between the Care Manager and the CNS by phone or secure email. This process, though valuable, reduced efficiency and created a barrier for the care managers working with the CNS. For example, feedback from the Care Manager indicated that it was "easier" for them to just handle the issue identified, than to have to include another person in the care team. Over time, the CNS demonstrated their value by uncovering additional unmet needs not discovered by the Care Manager, and by being knowledgeable about a plethora of resources not widely known to those not providing navigation services. As the Care Managers begin referring more to the CNS, it became clear that a lengthy phone call, completing a hand-written referral, or typing an email was not an efficient way to provide pertinent about the patient or the reason for the referral. In early 2019 the Care Managers and CNS transitioned to using the Jackson Care Hub. The Jackson Care Hub was designed as result of the clinical community linkages strategy. This is an online platform that allows for Care Managers and CNS to screen for social determinants, assess the individuals needs to determine the most appropriate resources and then make an electronic referral to the patient-selected organization in real time. The system then allows that organization to manage the referral that they were sent and work it through to completion. As the organization manages that referral, the original screening organization is provided with real time feedback of the progress being made with that referral to the Care Manager and/or CNS.

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

Social Determinants of Health screenings (SDoH) assess for needs in the following areas: Physical and Mental Health; Healthcare Costs; Housing; Transportation; Employment; Income; Food; Utilities; Family Care; Literacy; Education; and Safety. Patients receive a SDoH screen from their PCP's care manager when enrolling in care management, during an annual wellness exam with a PCP, on ad hoc basis or when barriers to care are noted. If a patient has a positive response to any of the SDoH questions and indicates he/she would like assistance with the need, a referral is sent to the practice's care manager.

After receiving the screening, the care manager reviews the screening to determine the most appropriate next steps. For example, the care manager will make outreach to patients with more complex (or multiple needs) while single, or more straightforward needs, may be directed to the CNS. Our best practice is to also educate the CNS on the types of patients most appropriate to refer back to care management. For example, one need may be identified, but upon further assessment by the CNS, they may find that additional support (i.e. for medical or behavioral management) may be warranted. We have learned that sometimes what initially appears to be a simple referral can be more complex in nature. When this happens, both the Care Manager and the CNS work together to ensure the patient's comprehensive needs are addressed.

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

When a patient closes their case with a CNS, the patient is asked to complete a short-survey. Since one of the primary goals of the program is to connect patients with community resources most relevant to their social needs, the survey asks the patient if they feel their need was met, if the patient feels barriers to resources were addressed or reduced, and if they received needed information from their CNS.

Since we strive to empower our patients toward self-management, it is important to assess if the patient feels both more aware of community resources, and more confident reaching out to them. Additionally, there is a question that assesses overall satisfaction. These outcomes-based program measures were chosen as key to measuring program effectiveness. We posit that if our processes were not efficient, patients would not have ranked us as favorably as they did on the surveys.

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

The graph below shows patient satisfaction data for September 1, 2017 through November 30, 2018. During this period there were 344 patients referred to the CNS and 258 cases closed. Only fifty-one (51) or 20% of the people with closed cases completed satisfaction surveys.

Four of the survey questions are based on a scale of 1-5 with 1 being 'not satisfied' and 5 being 'very satisfied'. The results for people completing the survey during this timeframe are below. It should be noted that with the switch to the Jackson Care Hub in early 2019 a new survey process was initiated, however, to date only 5 surveys have been completed.

Satisfaction with your overall experience?	Count
Very Satisfied	48
Somewhat Satisfied	2
Not Very Satisfied	1
Do you feel your need was met?	
Yes	47
Somewhat	3
No	1
I feel more confident reaching out to community resources	4.25
I feel more aware of resources in the community	4.60
I feel like I received the information/answers I needed from the Community Navigation Specialist	4.71
I feel my barriers to accessing resources were addressed or reduced	4.35

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

Initially, a detailed workflow was developed outlining the steps for both the Care Managers and CNS. Included in this was a paper referral form that was faxed when a social need was identified. In early 2019, both the Care Managers and CNS switched to using the Jackson Care hub. The Jackson Care hub provides them a way to share SDOH screening results, refer to the CNS, and monitor and communicate referral progress.

Using the Jackson Care hub is a best practice for Care Managers and the CNS of JHN. While we did not create the technology around the Hub, we were key stakeholders in testing its functionality, and providing valuable insights for how it could be used to enhance our former time-consuming workflow. As our process continues to evolve, enhancements continue to be made to the Jackson Care Hub to meet the needs of our best-practice workflow.

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

It is an honor that through this partnership we are able to impact our community in such a positive way and that those working with a Care Manager and/or CNS see the value they bring. Some of the comments returned with the satisfaction surveys included "I'm very satisfied"; "You helped me out a lot"; I didn't know there was all of these resources out there", "This program was a blessing", "You provided me with information I could use", "You opened my eyes a lot", "Very grateful for this service" and many more. Evidence-based medicine shows that by helping people address social needs, they are more likely to have better health outcomes.

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

If this submission wins and we are awarded funding, we would like to use it to implement a pilot where the CNS is co-located in at least three of our primary care practices. This resource would be able to address positive SDoH screens in real-time in the practice. Ideally, we would like to compare outcomes of practices with and without a co-located CNS. The intent would be for this valued care team member to continue to use the Jackson Care Hub in order to meet patient needs, but provide this service in-person while the patient is in the office instead of via phone.