CONTACT INFORMATION

Submitter Name: Christina Hildreth
Submitter Title: Executive Director
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Physician Organization Name: Metro Health Integrated Network
Practice Name: Metro Health employed primary care offices (Alger Heights, Allendale, Caledonia, Cascade, Cedar Springs, Community Clinic, Comstock Park, Grand Rapids Northeast, Hudsonville, Jenison, Lowell, Rockford, Southwest-East, Southwest-IM, Southwest-Peds, Southwest-West, Wayland)
Practice Address: Various. CIN address: 5900 Byron Center Ave SW, Wyoming, MI 49519
How many physicians in practice: 72
Description of care team: 72 physicians, 55 advanced practice providers, 18 RN care managers, 17 MSW care managers, 7 PharmD care managers, 18 clinical RNs, 14 certified diabetes educators, 149 MAs

EXECUTIVE SUMMARY

Opportunity: Many health conditions and diseases are impacted by unmet social needs.

Mission: Metro Health committed itself to identify those social needs that are unmet in our patient population.

Your Solution: Our multi-pronged solution addresses staff education, technology (EHR) integration, patient engagement, and community linkages.

Market Focus: Patients attributed to a Metro Health primary care physician.

Expected Returns: Screening attributed patients seen in a Metro primary care office, connecting them with appropriate community resources to address their social needs, and expanding and strengthening Metro Health's collaboration with community agencies are the target returns.

Category of Submission: Addressing Social Determinants of Health

Title of Submission: Integrating Social Determinants of Health (SDoH) Screening in the Primary Care Setting

When did the intervention start: On April 9, 2018, acting as the pilot sites, two primary care practices began screening patients for social needs using the SDoH screening tool. On July 2, 2018, after refining the screening tool, process for screening, and completing staff training, all Metro Health primary care practices implemented SDoH screening.

Goal of the Program/Intervention: The goal of the project was twofold. First, we wanted to establish and implement a standardized SDoH screening tool. Second, we wanted to use the information gathered to identify patients with social needs and link them to the appropriate community resources.

Who developed the program/intervention, and how: After approval from system senior leadership, the program was developed with the use of a dedicated workgroup consisting of CIN quality leadership, practice leadership, care providers, care managers, and representatives from IT. The workgroup was led by the CIN.

Description of the Program/Intervention: The first part of the program, establishing and implementing a standardized SDoH screening tool, included extensive research for existing, recognized screening tools. This research also included ensuring all existing requirements of the various programs/initiatives Metro Health participated in were satisfied. The workgroup also developed the workflow to be utilized at the practices, including scripting to be used by office staff. This script provided opening conversation starters to begin SDoH screening. Finally, the workgroup engaged Metro Health's IT-Clinical Informatics department to provide the necessary build in the EHR to support the established workflow, to allow others throughout the health system to see the results (Appendix), and to be in a format that allowed for tracking and reporting.

The second part of the program, was using the information gathered to identify patients with social needs and link them to appropriate community resources. The workgroup also surveyed multiple stakeholders and audiences regarding the survey tool, and modifications based on that feedback was made, while still ensuring all program/initiative requirements remained satisfied (Appendix). The workgroup researched and engaged several community agencies and developed a SDoH community resources document (Appendix). This document provided any practice staff who may come in contact with the patient during their visit with direct resources that could, and were expected to be shared with the patient. Additionally, business size cards were created for the five counties in Metro Health's primary service area. These "county cards" are given to patients with identified or potential needs and contain contact information for key community resources in their respective county of residence.

Finally, education and training was provided to the practices. The training objectives were; defining SDoH, explaining the five key domains of SDoH, understanding the importance of screening, describing the screening and documentation process, utilizing proper tools and resources, and identifying patients in need of follow-up.

How were patients identified for the program/intervention: The workgroup determined all attributed patients with visits to their Metro Health primary care office were identified for screening and intervention. The patient was given the questionnaire upon check-in at the front desk. The questionnaire was collected during the rooming process and recorded in the EHR. During the office visit, the team utilized appropriate resources to address all identified needs.

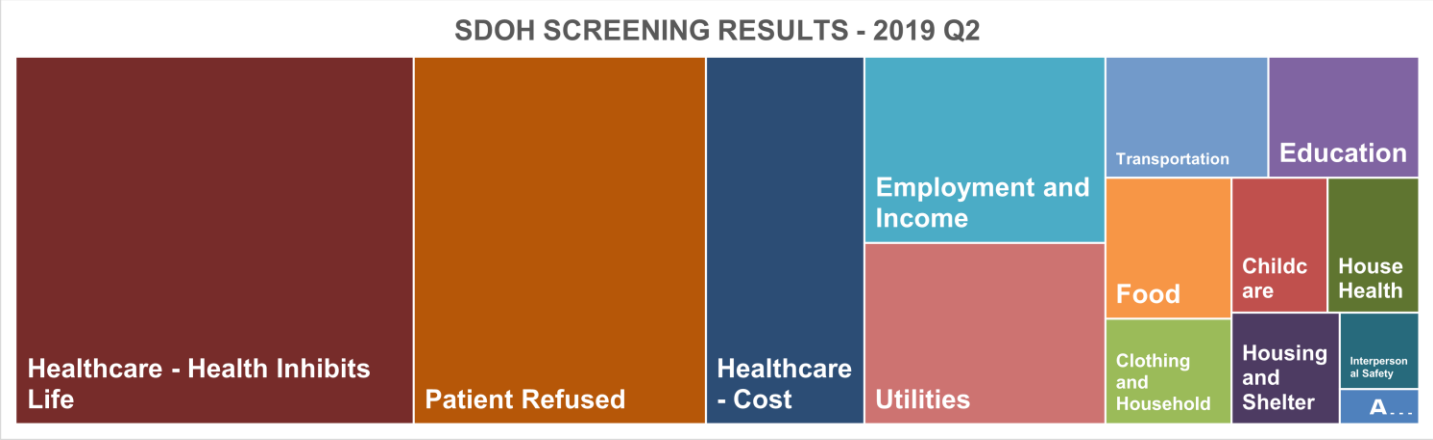
Any patient identified during their screening could be connected with a care manager, if appropriate and desired. Any patient during their screening who answered "yes" to any of the questions Metro Health deemed "priority" questions, was automatically referred to care management.

How was success measured: The measurement of success for the implementation of the screening process was process based. In collaboration with IT, a SDoH report was developed. This report tracked the number of screenings completed. The report was initially run on a weekly basis to determine how many patients with primary care encounters were screened. The results were shared with both the SDoH workgroup and the leadership at the primary care practices. Additional training, if warranted, was provided to ensure adoption of the process. After three months, adoption of the process was deemed achieved, and monitoring was moved to monthly.

The measurement of success for the workflow was both process and outcome based. The practices were engaged to share their initial feedback on; the effect of the new workflow on the practice, the perceived benefit to the patients who were screened, and any direct feedback received from the patients.

Once beyond initial implementation, an outcome based report was developed in conjunction with IT. This report tracked the number of patients who received community resource information as a result of SDoH screening.

What were the program results: At the conclusion of the implementation phase, 44,502 unique Metro Health patients were screened for social needs using the SDoH screening tool. By the end of 2019 Q2, 71,425 patients were screened. The program was deemed successful. Not only were patient needs identified, patients were connected with needed resources. Also, through this process, care team members became aware of the impact unmet social needs have on the success of their patients' health. This led to a deeper understanding of the patient and allowed the provider to modify their approach and care plan for the patient to account for their needs.



Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention: As mentioned earlier, the project resulted in the SDoH screening tool, the SDoH workflow process, and both the Epic SDoH section and the community resources documents developed. While all tools, processes, and resources are in a continual state of monitoring for effectiveness and opportunities for improvement, those developed as part of this initiative have proven beneficial.

What are you proudest of regarding this submission: Metro Health is proudest of the fact that we were able to screen 44,502 unique patients within three (3) months, provide care management and community resources to those patients with identified social needs, and record this information in our EHR in a method that is clear to understand, shared throughout the health system, and actionable.

How will your organization use the funds if your submission wins: If this submission wins, Metro Health will use the funds in the following ways:

- Provide financial reward to those practices who undertook this effort,
- Fund the effort to integrate more community resource information in the common EHR so it is available system-wide and at the caregivers fingertips,
- Toward funding a centralized PO staff member to focus on improvement of our SDoH efforts that will benefit the entire health system.

APPENDIX

Social Needs Questionnaire

Metro Health Integrated Network

Name (please print) _____ D.O.B. _____

	Are you worried that you may not have safe housing that you own, rent or share in the next few months?	❑ Yes ❑ No
	Do you have any problems with housing, such as: rodent or bug infestation, lead, water leaks, heat not working, etc where you currently live?	❑ Yes ❑ No
	Does your current level of education keep you from supporting yourself or your family?	❑ Yes ❑ No
	Does getting child care or elder care make it hard for you to work, go to school, or study?	❑ Yes ❑ No
	During the past few months, was there a time you needed to see a doctor, but didn't because of cost?	❑ Yes ❑ No
	During the past few months, have you not been able to pay your utility bills?	❑ Yes ❑ No
	Do you need household supplies, such as: clothing, shoes, blankets, diapers, toothpaste and shampoo?	❑ Yes ❑ No
	Do you need a job or other steady source of income?	❑ Yes ❑ No
	Are you feeling threatened by a partner or ex-partner, or currently experiencing verbal, emotional, physical or sexual abuse?	❑ Yes ❑ No
	Do you feel stress – tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled all the time? ❑ Not at all ❑ Only a little ❑ To some extent ❑ Rather much ❑ Very much	
	In a typical week, how many times do you talk on the phone with family, friends or neighbors? ❑ Never ❑ Once a week ❑ Twice a week ❑ 3 times a week ❑ More than 3 times a week	
	How often do you get together with friends or relatives? ❑ Never ❑ Once a week ❑ Twice a week ❑ 3 times a week ❑ More than 3 times a week	
	How often do you attend church or religious services? ❑ Never ❑ 1 to 4 times a year ❑ More than 4 times a year	
	How often do you attend meetings of the clubs or organizations you belong to? ❑ Never ❑ 1 to 4 times a year ❑ More than 4 times a year	
	Are you now: ❑ married ❑ widowed ❑ divorced ❑ separated ❑ never married ❑ living with a partner	
	How hard is it for you to pay for basic items, like food, housing, medical care and heating? ❑ Not hard at all ❑ Not very hard ❑ Somewhat hard ❑ Hard ❑ Very hard	
	Within the past 12 months, you worried that your food would run out before you got money to buy more. ❑ Never True ❑ Sometimes True ❑ Often True	
	Within the past 12 months, the food you bought didn't last and you didn't have the money to get more. ❑ Never True ❑ Sometimes True ❑ Often True	
	In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	❑ Yes ❑ No
	In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?	❑ Yes ❑ No

❑ By checking this box, I verify that I have read the above questions and I do not wish to answer them at this time.

Signature _____

Relationship to Patient _____ Date _____

To be completed by staff: MRN#: _____

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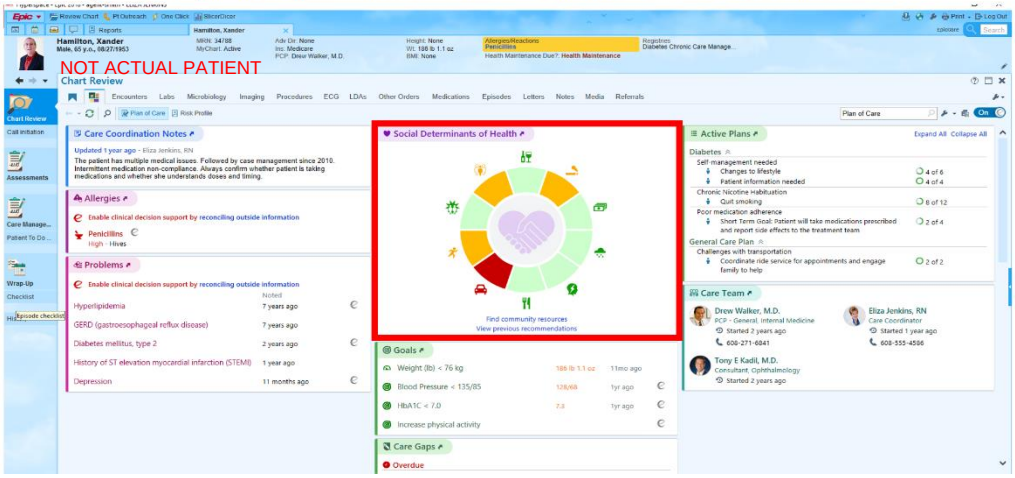
Longitudinal plan of care – click the SDOH section header outlined in red



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Metro Health Integrated Network

Thank you for completing the healthcare questionnaire today. Based on your answers, you may have needs that are affecting your health and wellness. Below are resources that may be able to help. Please contact the agencies directly for assistance. If you have additional questions/concerns, contact your doctor's office and a care manager or other staff member will help you.

Access to Health Care/Coverage

- HealthCare.gov (Marketplace to get healthcare under the Affordable Care Act)
- MI Bridges (Michigan Department of Health & Human Services/MDHHS) www.michigan.gov/mibridge (apply for Medicaid, food, and cash benefits)
- Enroll Michigan.com (assistance if applying for Medicaid)
- Call your active insurance plan (back of card)

Allegan County Healthcare Resources

- Area Agency on Aging Western Michigan 616-456-5664
- Commission on Aging 269-673-3333
- Allegan Community Mental Health 269-673-6617

Barry County Healthcare Resources

- Pathways to Better Health 1-866-291-8691
- Commission on Aging 269-948-4856
- Barry Community Mental Health 269-948-8041

Kent County Healthcare Resources

- Area Agency on Aging Western Michigan 616-456-5664
- Disability Advocates 616-949-1100
- Network 180 616-336-3909

Montcalm County Healthcare Resources

- Area Agency on Aging Western Michigan 616-456-5664
- Montcalm Care Network 989-831-7520
- Commission on Aging 989-831-7476
- Pathways to Better Health 1-866-291-8691 (Option #2)

Ottawa County Healthcare Resources

- Disability Network-Lakeshore 616-396-5326
- Ottawa Community Mental Health 616-392-1873
- Pathways to Better Health 1-866-291-8691 (Option #2)
- Senior Resources of West Michigan 231-739-5858

Food Resources

- Feeding America West Michigan 616-784-3250 www.feedwm.org
- MI Bridges - food assistance applications https://www.mibridges.michigan.gov/access/#

Employment, Education & Disability

- Michigan Works! 517-371-1100 www.michiganworks.org/
- Unemployment Insurance Agency 1-866-500-0017
- Michigan Rehabilitation Services www.michigan.gov/mdhhs
- Women's Resource Center 616-458-5443
- Job Corps 616-243-6877
- Goodwill Greater Grand Rapids 616-532-4200
- Jubilee Jobs (felony-friendly) 616-774-9944
- Social Security Office www.ssa.gov

(front and back of card)

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Kent County Mental Health Services

Network 180 (Community Mental Health 24 hour crisis access) . . . . . (616) 336-3909
Suicide Hotline 1-800-273-TALK (8255)
Psychiatric Hospitals:
Forest View. . . . . (616) 942-9610
Pine Rest . . . . . (616) 455-9200

Mental Health & Substance Use Services

Alcohol & Drug Abuse Helpline. 1-800-662-4357
Alcoholics Anonymous. . . . . www.aa.org
Pine Rest . . . . . (616) 455-5000
Arbor Circle . . . . . (616) 456-6571
Family Outreach Center. . . . . (616) 247-3815
Cherry Health . . . . . (616) 235-7272
Network 180 . . . . . (616) 336-3909
Psychiatric Associates of West Michigan. . . (616) 719-4488
Bethany Christian Services . . . . . (616) 224-7617
Wedgwood Christian Services . . . . . (616) 942-7294
Claystone Clinical Associates . . . . . (616) 949-7460
Integrative Health Consultants . . . . . (616) 773-2908
North Kent Guidance Services . . . . . (616) 361-5001
Human Resource Associates . . . . . (616) 458-0692
Third Chair (Teens) . . . . . (616) 916-3711

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Call 211 for 24/7 connection to health and human services.

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Kent County Resource Card

Dept of Health & Human Services (DHHS). (616) 248-1000
Kent County Health Department . . . . . (616) 632-7100
Child & Adult Protective Services
CPS/APS (24/7) . . . . . (855) 444-3911
Social Security Administration . . . . . (877) 319-5710
Kent County Veterans Affairs . . . . . (616) 632-5722
VA Wyoming Healthcare Center . . . . . (616) 249-5300

Personal Safety (24 hours a day)

Safe Haven (domestic crisis center) . . . . . (616) 452-6664
YWCA (domestic violence, sexual assault, crisis line) . . . . . (616) 454-9922

Immediate Needs

Salvation Army Grand Rapids. . . . . (616) 454-1459
Housing Assessment Program . . . 211 or 1-800-887-1107
Feeding America (food bank locator). . . . . (616) 784-3250
Grand Rapids Housing Commission . . . . . (616) 235-2600
Wyoming Housing Commission . . . . . (616) 534-5471
Mel Trotter (shelter) . . . . . (616) 454-8249
Community Action Agency . . . . . (616) 632-7950
United Church Outreach Ministry (UCOM) . (616) 241-4006

Senior & Disability Resources

Disability Advocates of Kent County . . . . . (616) 949-1100
Senior Neighbors . . . . . (616) 459-6019
Area Agency on Aging. . . . . (616) 456-5664
Reliance Community Care Partners . . . . (616) 956-9440

Call 211 (or 1-800-887-1107 on a cell phone) for 24/7 connection to health and human services.

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