

# Social Determinants of Health Workflow

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# ProMedica Health System

- ▶ Serves 27 counties in Northwest Ohio and Southeast Michigan
- ▶ 11 Hospitals and numerous health care centers with an extensive array of specialties.
- ▶ Health Specialist of Lenawee is the only RHC practice in the entire system.
- ▶ Independent RHC
- ▶ HSL joined ProMedica in 2019



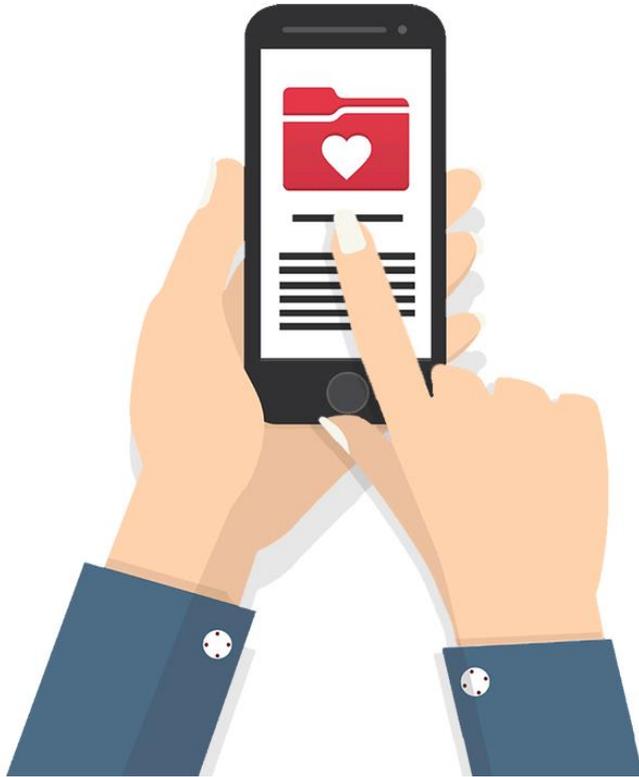
# ProMedica's Primary Care Guideline for Screening Patients (BCBS PCMH 10.7 & 10.8)

- ▶ Practice and Providers have the responsibility to identify patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching and established health and treatment goals.
- ▶ Referrals to community resources should be tracked for high-risk patients. Practices are encouraged to create a process to ensure vital services are tracked appropriately.
- ▶ The purpose of tracking the referrals is to ensure that the high-risk patients receive the services that they need.
- ▶ Patients may be particularly responsible for the tracking process.
- ▶ The process includes a mechanism to track patients who decline care and obtain information about reasons care was not sought.

# ProMedica's Screening Process for Social Determinants of Health (SDOH)

- ▶ When patients arrive in the practice, they are offered the opportunity to complete the Social Determinants of Health Screening (SDOH)
- ▶ Our goal is to screen patients annually. (Well exams, MAWV)
- ▶ Social Factor Screening areas:
  - ▶ Financial Resource Strain
  - ▶ Food Insecurity
  - ▶ Housing Instability
  - ▶ Lack of Transportation

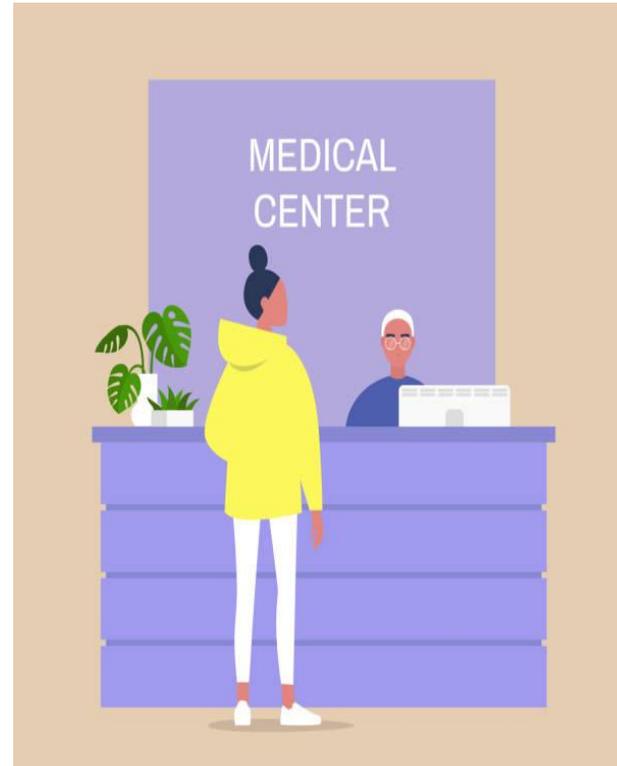
# eCheck-In via ProMedica MyChart



- ▶ Available to patients prior to visit.
- ▶ Screenings can be assigned to complete during check-in.
- ▶ SDOH screening is available to complete 7 days before a patient's scheduled appointment.
- ▶ When completed, the SDOH screening response are reviewed by the clinical staff and added to the patient's medical record.

# In-Office Check-In

- ▶ Check-In staff will review Department Appointment Report (DAR) for eligible patients.
- ▶ The reports first column displays if the SDOH questionnaire is needed or not.
- ▶ Red stop sign indicates patient needs to complete SDOH screening.
- ▶ Green checkmark-indicates questionnaire is on file and was completed in the last 305 days.
- ▶ If the patient needs to complete the SDOH screening, we provide scripting to aide the receptionist with the conversation.



# Department Appointment Report (DAR)

SD...	A..	Arrival Time	Time
✓		7:15 AM	7:30 AM
✓		7:15 AM	7:30 AM
✓		7:30 AM	7:45 AM
✓		7:30 AM	7:45 AM
⊘		7:45 AM	8:00 AM
✓		7:45 AM	8:00 AM
✓		7:45 AM	8:00 AM
⚠		7:45 AM	8:00 AM
⊘		7:50 AM	8:05 AM
⚠		8:00 AM	8:15 AM
⊘		8:00 AM	8:15 AM
⚠		8:00 AM	8:15 AM
✓		8:00 AM	8:15 AM
⊘		8:00 AM	8:15 AM
⊘		8:00 AM	8:15 AM
⊘		8:05 AM	8:20 AM
⊘		8:10 AM	8:25 AM
⊘		8:15 AM	8:30 AM
⊘		8:15 AM	8:30 AM
✓		8:15 AM	8:30 AM

- ▶ Green Check Mark- Completed in the last 305 days.
- ▶ Red Stop Sign- SDOH Screening is due to be completed.
- ▶ Yellow Triangle- Patient is under the age of 18.

# Tablet Workflow



- ▶ When patients arrive at registration for their provider the patient is handed a tablet.
- ▶ This tablet is linked to the DAR and a bar code scanned.
- ▶ This allows the patient to complete the screening in complete confidence.

# Epic SDOH Best Practice Advisory (BPA)

BestPractice Advisory - Zztest, Kevin

**! Positive Social Factor Screen**

The patient has screened positive for social factors. Please assign appropriate visit diagnoses for the following needs:

- ✓ Food Insecurity
- ✓ Housing Instability

Add Visit Diagnosis	Do Not Add	Financial Resource Strain
Add Visit Diagnosis	Do Not Add	Food Insecurity
Add Visit Diagnosis	Do Not Add	Housing Instability
Add Visit Diagnosis	Do Not Add	Intimate Partner Violence
Add Visit Diagnosis	Do Not Add	Social Connections

Acknowledge Reason \_\_\_\_\_

I am aware

✓ Accept    Dismiss

- ▶ BPA purpose is to assist in capturing required billing codes.
- ▶ Patients complete the SDOH screening via MyChart eCheck-in or tablet
- ▶ If a screening is positive for one of the following Social Factors, the BPA will trigger for the clinical staff (rooming staff) once the chart is opened.
  - ▶ Financial Resource Strain
  - ▶ Food Insecurity
  - ▶ Housing Instability
  - ▶ Clinical staff will select the appropriate buttons to “Add Visit Diagnosis” for the identified positive needs.
  - ▶ To complete the BPA, the clinical staff will select “I am aware” Acknowledgement Reason, then “Accept”
  - ▶ The z-code diagnosis will then be added and displayed in the Visit Diagnosis section of the encounter.

# Visit Diagnosis- Screen Shot

**Visit Diagnoses**

Search for new diagnosis + Add Previous Problems

Common Encounter for screen... Special screening for...  
Encounter for screen... Encounter for screen...  
Asymptomatic meno... Encounter for immun...  
Contact with and (su...

P		ICD-10-CM		PL
▼ 1.	Food Insecurity	Z59.41	△ Change Dx	+ 🗑
▲ 2.	Housing Instability	Z59.1	△ Change Dx	+ 🗑



# Financial Opportunity Center (FOC)

- ▶ Automated Referral
- ▶ If a patient screens positive for financial insecurity and/or housing instability on the SDOH Questionnaire
- ▶ BPA creates a task for the Financial Counseling Center
- ▶ The patient is contracted for follow-up on identified resource needs
- ▶ Based on patient responses, the staff will identify individual needs, perform assessments, make recommendations and applies interventions

# Food Insecurity

When a patient screens positive for food insecurity on the SDOH Screening:

- Patient completes two question screening at each visit.
- We worried whether our food would run out before we got money to buy more. Was that often, sometimes, or never true in the last 12 months?
- The food that we bought just didn't last and we didn't have enough money to buy more. Was that often, sometimes or never true in the last 12 months?



# Food Insecurity



- ▶ Positive screens when patient answers “often true” or “sometimes true” to either question.
- ▶ Confidential conversation takes place with patient.
- ▶ Ask if patient would like a referral to the ProMedica Food Clinic?
- ▶ Patient will be sent home with a food bag and list of Food Banks and Veggie Mobile locations.

# ProMedica Farms



- ▶ Located on the campus of ProMedica Charles and Virginia Hickman Hospital.
- ▶ Started by a two-year grant that was secured by Frank Nagle, Director of Community Impact-ProMedica Michigan.
- ▶ Grant was provided by Michigan Health Endowment Fund.
- ▶ The food then helps to feed individuals with food insecurity.



# Lack of Transportation

- ▶ If a patient screens positive for lack of transportation on the SDOH screen, the practice will connect patients with appropriate community resources.
- ▶ Offer bus tokens
- ▶ Offer virtual visits
- ▶ Schedule visits around public transportation schedule.

# Care Navigation

- ▶ RN with experience
- ▶ Coordinates care
- ▶ Provides Resources
- ▶ Embedded in practices
- ▶ Ensures patients have necessary resources upon discharge
- ▶ Ensures patients have TCM Appointments scheduled
- ▶ Acts as a Social Worker



*let us*

TAKE CARE OF YOU