Bridging Communities and Primary Care: Addressing Unmet Social Health Needs via Process Improvement

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Unified Quality Improvement Symposium

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Background / Introduction

- Research has shown that up to 80 percent of an individual's health is determined by social and environmental factors (Bibbins-Domingo, 2019), prompting healthcare systems to identify ways to systematically screen for, identify, and universally document unmet social health needs in diverse clinical settings

- Identifying and addressing social health needs which can be referred to as social determinants of health, nonmedical drives and drives of health; can improve long term populations health outcomes and reduce health costs.

- Coordination and communication between and with healthcare systems and human service organizations remains siloed and disjointed

Background

- The team reviewed pre-existing clinical data that showed only 11.5% of total emergency department (ED) follow-up patients seen on one medical module for a one-month period were screened for a social health need.

- After additional review, there appeared to be a trend among the clinic's entire patient population, not just ED follow-up patients.

- After speaking with medical staff, we found a lack of consistency in screening tool utilization, with many providers utilizing no standardized screening tools to address social health needs.

- Minimal system-wide screening and no standardized screening measures
  - 15-20% of total patients screened for social health needs within ECU FM Clinic
  - 2-4% screened on selected pilot module

Collaborative Team Members

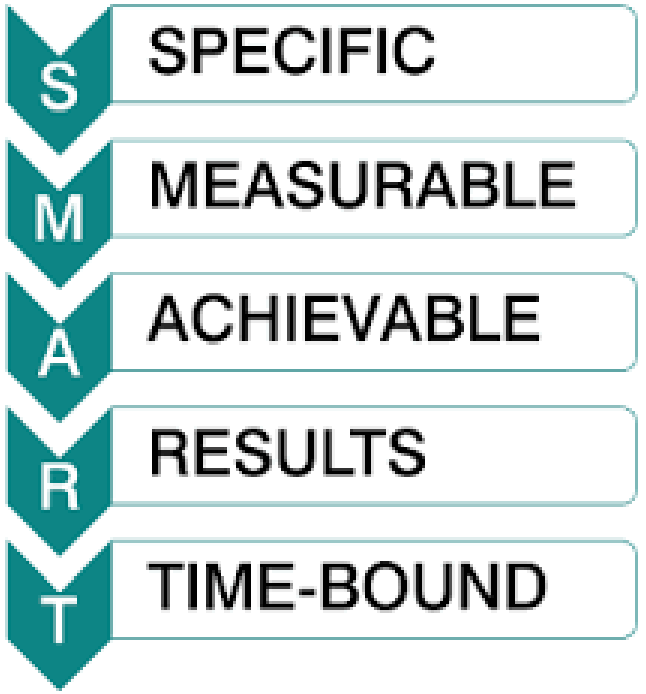
Social Health Needs Advisory Team (Macro- and Micro-Level Team Members):

- **NCCARE360 Senior Engagement Manger, Unite Us** – Megan Carlson, MPH; Abby Butright
- **ECU Family Medicine Clinic Administration**, Jason Foltz, MD and Jennifer Blizzard, RN
- **NCCARE360 Coordinator & Quality Nurse Specialist/Health Coach**, Megan Thomas, BSN, RN
- **Gold Module Nurse Manager**, Judith Wade, BSN, RN
- **Community Health Liaison**, Megan Freeze, MD (C)
- **3rd Year Resident**, Luke Gergoudis, MD
- **Quality Improvement Faculty**, Lisa Hager, MBA
- **Behavioral Medicine Faculty**, Erika Taylor, MS, LMFT, BC-TMH
- **Research Assistant**, Hannah Barnett, MPH
- **Nutrition Faculty**, Kay Craven, MPH, RDN, LDN, CDCES
- **Interdisciplinary Student Learners**, Kathryn Clary, MD (C); Caroline Porter-Miller, PhD (C); Kayla Neal, BSN; Kaitlyn Vinson, MD (C)

AIM Statements

- **Global Aim:** To increase systematic identification of social health needs in ED and hospital follow-up (HFU) patients at ECU Family Medicine Center's Gold Module.

- **Specific Aim**: Increase screening, identification and referral measures for unidentified social health needs in ED and HFU patients of ECU Family Medicine Center's Gold Module by 3% over six months (May 2020).



Process Improvement Practice-Based Objectives

- Identify potentially unmet social health needs (i.e., transportation, housing, and food access) in ED and hospital follow-up (HFU) patients to optimize health outcomes and impact recidivism
- Institute a standardized screening process and community referral workflow
- Utilize internal staff to meet patient's emergent social health needs
- Provide patients with a more comprehensive set of wrap-around services and patient-centered intercollaborative care
- Minimize the pre-existing gap among health and community systems of care
- Increase prioritization of health risks related to non-medical drivers of health
- Improve documentation of social health needs in the electronic health and records (EHR) system.

Implementation Timeline

Early October 2019

- QI project permissions
- NCCare360 Training
- Team compilation

Mid-October 2019

Screener creation

Late October 2019

Creation of:

- Fishbones
- PDSA Cycles
- Flow Chart

November 2019

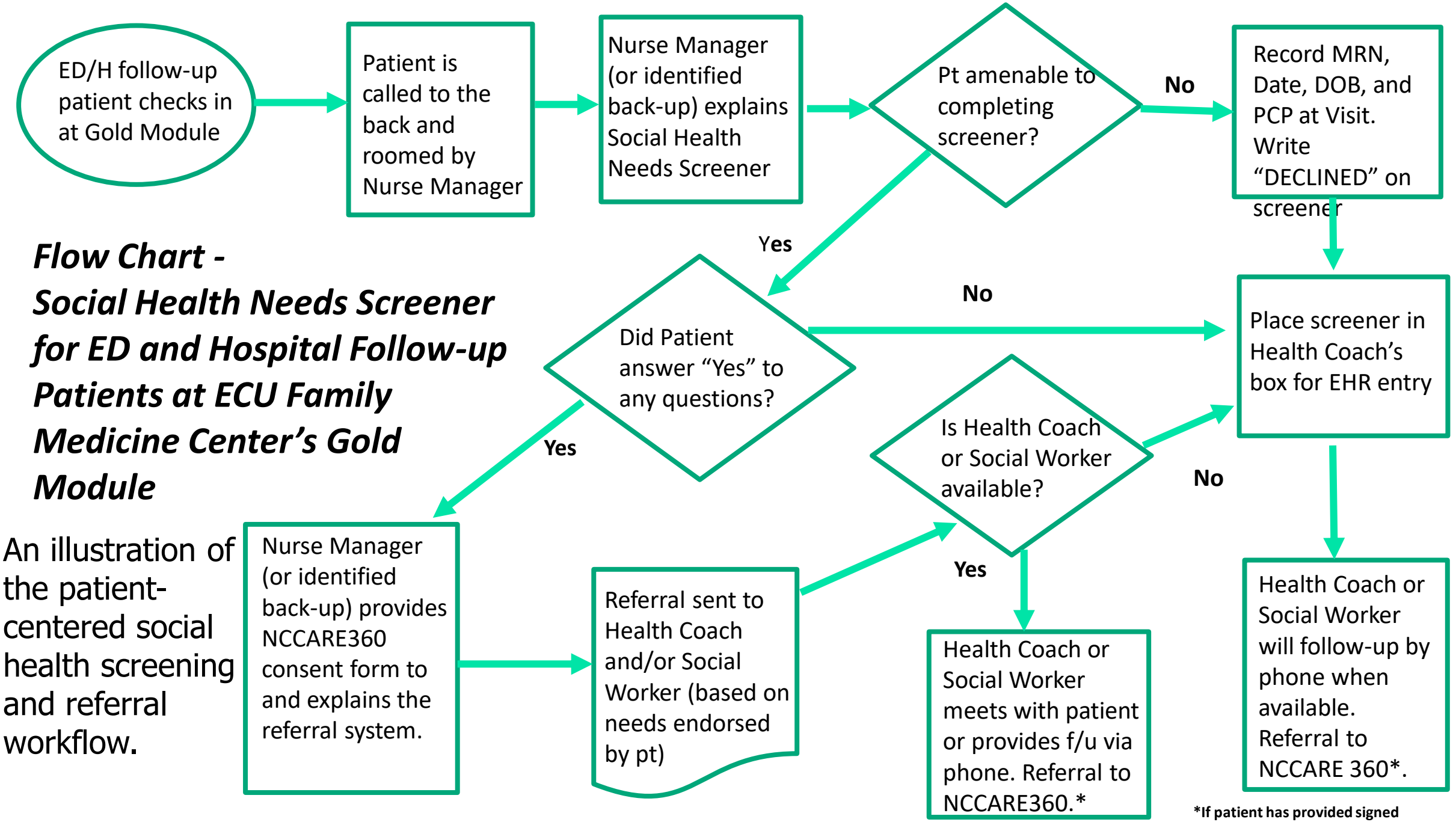
- Pilot of Screener Implementation
- Launch of NCCARE360 Network Integration

November 2019- May 2020

Screening continues

Flow Chart - Social Health Needs Screener for ED and Hospital Follow-up Patients at ECU Family Medicine Center's Gold Module

An illustration of the patient-centered social health screening and referral workflow.

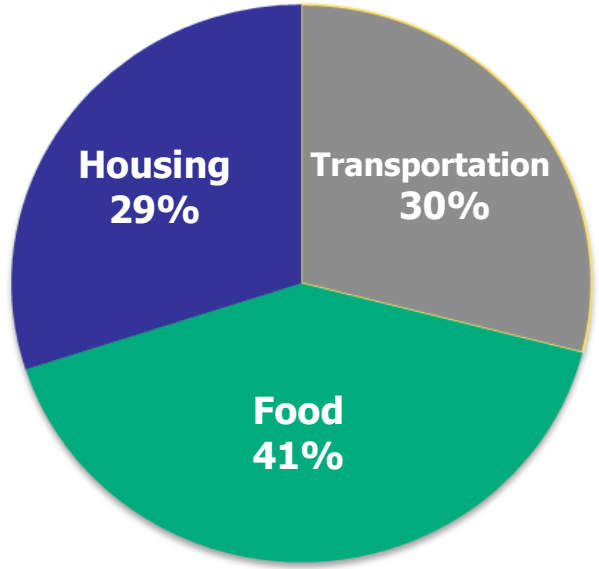


*If patient has provided signed NCCARE360 consent form

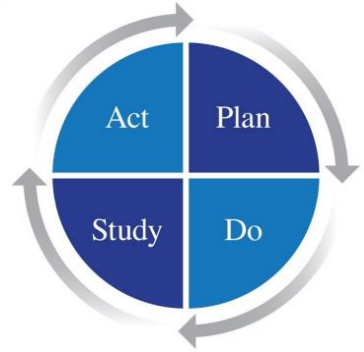
Baseline Data

Weekly Tracking						
Week	**Dates**	**Total Screened**	**Negative**	**Positive**	**No-Shows**	**Missed**
Pilot	11/4-11/8	8	5	3	3	0
Week 1	11/11-11/15	4	2	2	2	0
Week 2	11/18-11/22	1	0	1	0	1
Week 3	11/25/11/29	0	0	0	1	0
Week 4	12/2-12/6	3	2	0	0	0
Week 5	12/9-12/13	2	2	0	0	2
Week 6	12/16-12/20	0	0	0	2	5
Week 7	12/23-12/27	0	0	0	0	3
Week 8	12/30-1/3	0	0	0	0	5
Week 9	1/6-1/10	2	1	1	N/A	N/A
Total		**19**	**12**	**7**	**8**	**16**

Indicated needs by type



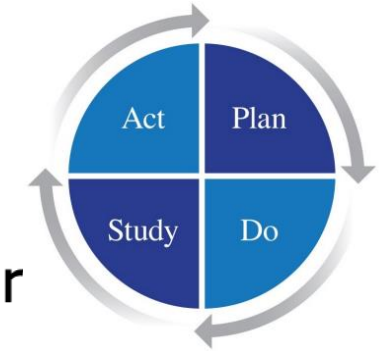
Improvement Strategies Employed



PDSA 1: Screener Creation

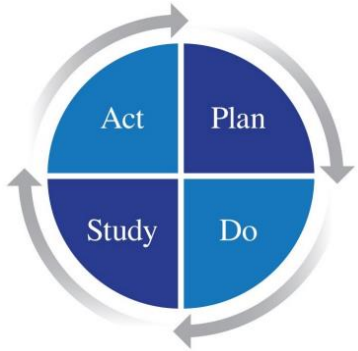
- Screener developed (English and Spanish versions) using pre-existing social health questions found in the Electronic Health Record (EHR; EPIC)
  - Questions captured needs in the following domains: housing, food, and transportation
  - Provided to all Gold Module ED and hospital follow-up patients over age 18
- Included a section for patient to identify immediacy of endorsed need(s)
- Included a consent for referral to human service org to meet need(s)
- Over the course of project, screener was updated to include ARS, health insurance, PCP at time of visit, and easier-to-read font for patients
  - Data collection tool created to track all information
  - Micro QI Team created an alternate workflow for screening patients with visual impairments or those who were illiterate

PDSA 2: Pilot Phase



- Screener was tested for one week with ED follow-up patients whose primar provider is ECU Family Medicine-Gold Module and had a scheduled an appointment the pilot week.
- Received a self-administered social health needs screener while in the room for their medical visit.
- Screeners were administered by the module's Nurse Manager the entire week.

PDSA 3: NCCARE360 Integration



- Community Health sector of QI team obtained lists of active human services organizations in ECUP catchment area and identified organizations to recruit into the system.
- Team members contacted each non-represented human service organization by telephone, utilizing a script with information on how to enroll into NCCARE360
- Bi-weekly review of active community organizations enrolled in NCCARE360, which was compared against previous lists to limit duplication of phone calls.

NCCARE360

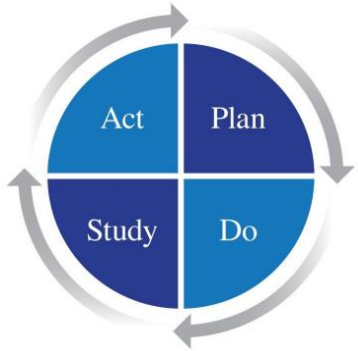
- A state-wide coordinated care network utilized by our care team to meet non-emergent social health needs.

- Unites healthcare and human service organizations

www.nccare360.org

- Determined the large number of non-represented human services organizations may be better informed through more global efforts, like a community-wide education session. An NCCARE360 lunch and learn was scheduled and personal invites were made.

PDSA 4: Improving Missed Screener Rates

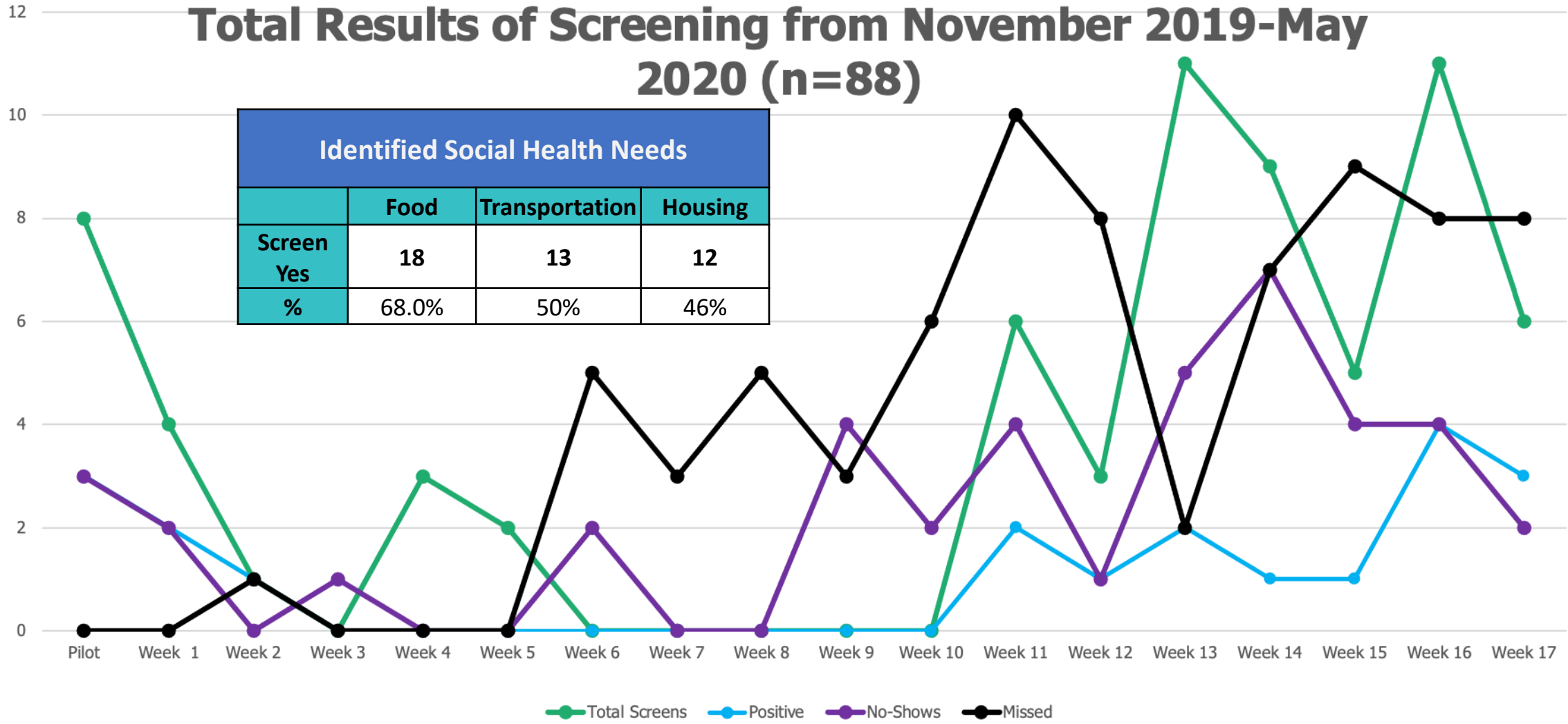


- Decrease number of patients meeting project inclusion criteria that are not screened.
- Implement a paper reminder system targeting Gold Module staff
- Evaluate whether missed screening rates lowered post-reminder system.
- Continue enforcing reminder system or revise process.

PDSA 5: Improving Screening Rates

- Increase number of patients screened.
- Consider incorporating an additional patient population or including a provider's full patient panel. QI team determined to include a full-time provider's full patient panel.
- Pilot the inclusion of full patient panel for one day/week or one week. Evaluate test of change to determine efficacy in increasing days per week.
- Utilize percentage of change in screening rates post-inclusion of patient panel to determine whether to increase number of days the provider's patient panel is screened.

Outcomes



Identified Social Health Needs			
	Food	Transportation	Housing
Screen Yes	18	13	12
%	68.0%	50%	46%

Lessons Learned Through QI Efforts

- High staff turnover and lowered staff volume led to increase in missed screenings
- Reduction in in-person patient visits due to COVID-19 precautions
- Decreased engagement of human service organizations within NCCARE360, resulting in longer wait times for resources
- Increased taxation of healthcare system in response to COVID-19 and re-prioritization of care needs
- Medicaid expansion currently on-hold in NC
- No virtual screening option available for virtual visits
- Possible underreporting of needs

Source: https://luis-goncalves.com/lessons-learned-scrum-coach/

Next Steps

- Continued to implement screening and resource referral protocols throughout ECU Family Medicine
  - Currently working with the Geriatric Module to screen for social health needs in patient population

- Incorporated a virtual screening option through MyChart, using REDCap to distribute the screener before the patient's appointment to streamline the process, with the help of a LINC Scholar

- Offered a starter framework for other primary care clinics seeking to model this work.

Source: https://www.positivelyaware.com/articles/next-steps

Questions?

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