Michigan Value Collaborative

Helping improve the health of Michigan through sustainable, high-value healthcare

MVC Virtual Semi-Annual Meeting

October 22nd, 2021

Housekeeping

- Please ask any questions through the Zoom Q&A function
  - In doing so, please provide your name and hospital/PO affiliation
  - We will do our best to answer some of these questions in the Q&A function, and at the end of each section
- MVC Component of the BCBSM P4P Program PY21 Bonus Point
  - If you are dialing in from a cell or didn't enter your details on admission to the meeting, please add your name and institution in the chat
- Please also complete the MVC/BCBSM post-meeting survey

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Acknowledgements: Today's Speakers

Dr. Nicole J Franklin

ASSISTANT MEDICAL DIRECTOR

McLaren Bariatric & Metabolic Institute

Leah Corneail

DIRECTOR – UTILIZATION & POPULATION HEALTH

Integrated Healthcare Association (IHA)

Melissa Gary

COMMUNITY LIAISON

Great Lakes Physicians Organization

Carol Gray

PROGRAM MANAGER

Michigan Social Health Interventions to Eliminate Disparities (MSHIELD)

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Agenda

Welcome and MVC Updates	10:00am – 10:10am
MVC Medicaid Data	10:10am – 10:15am
Setting the Scene: Social Risk and Health Equity	10:15am – 10:25am
MSHIELD: Aligning Partnerships to Achieve Health Equity	10:25am – 10:35am
Question and Answer	10:35am – 10:40am
The Health Gap: An Exploration of How McLaren Flint is Working to Bridge the Gaps Between Health Care and Social Care	10:40am – 10:50am
Question and Answer	10:50am – 10:55am
IHA Efforts to Screen and Address Patient Social Influencers of Health	10:55am – 11:05am
Question and Answer	11:05am – 11:10am
Great Lakes Physician Organization: Redesigning Our Care and Investing in Patients	11:10am – 11:20am
Question and Answer	11:20am – 11:25am
MVC Next Steps	11:25am – 11:30am

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MVC Updates

- Welcome new MVC members
  - Munson Healthcare Manistee
  - Paul Oliver Memorial Hospital
- New MVC Team Members:

Jana Stewart
COMMUNICATIONS SPECIALIST

Kristen Palframan
ANALYST

Carla Novak
ADMINISTRATIVE ASSISTANT

MVC Updates

- Medicaid data added to the MVC registry
- New Health Equity report launched
- Increased custom analytic reporting
- P4P selections for PY23/24
- Virtual site visits

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MVC Component of the BCBSM P4P Program

PY21 COVID-19 Exclusion and Selections for PY 23 & 24

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P4P PY21 COVID Update

Episodes with COVID-19 will be excluded from P4P for PY21 ONLY.

Exclusion Criteria:

ICD Dx Code U07.1

First three diagnosis codes

Facility claims

Inpatient setting

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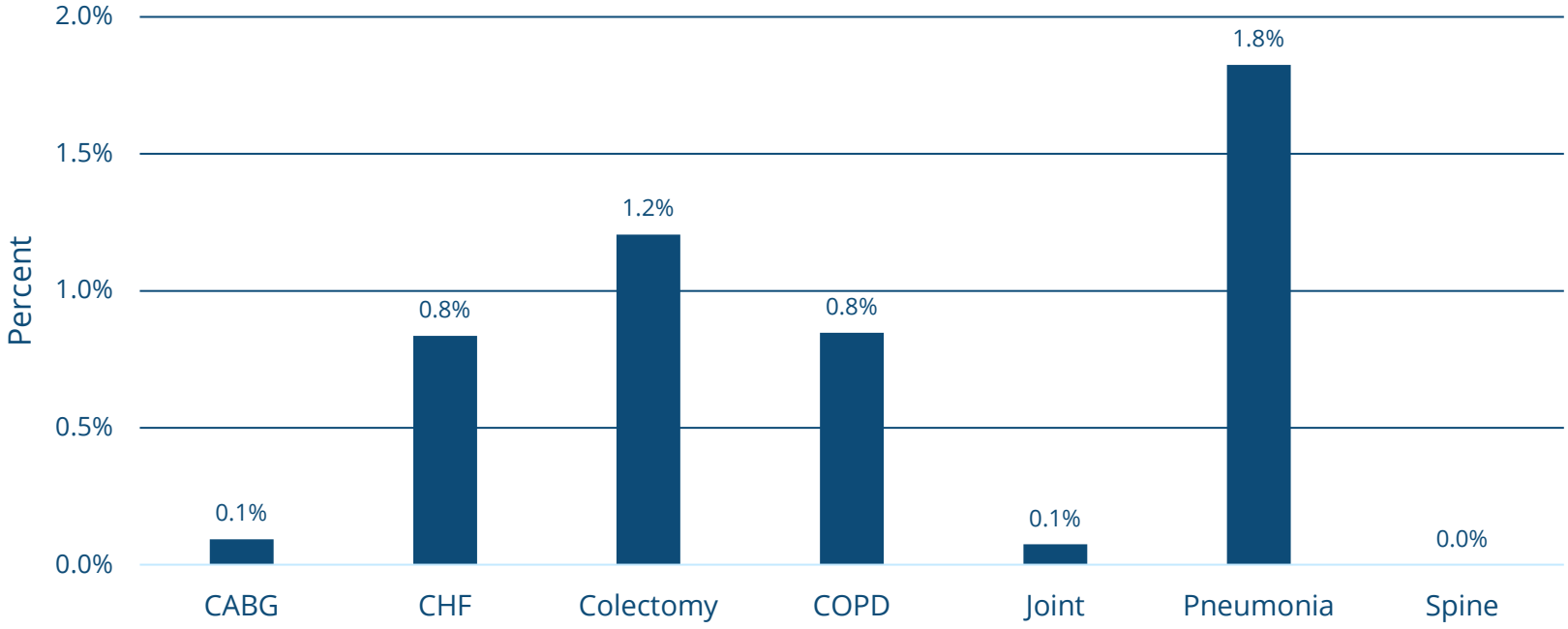
COVID-19 in P4P Conditions: 2020 Q1-Q2



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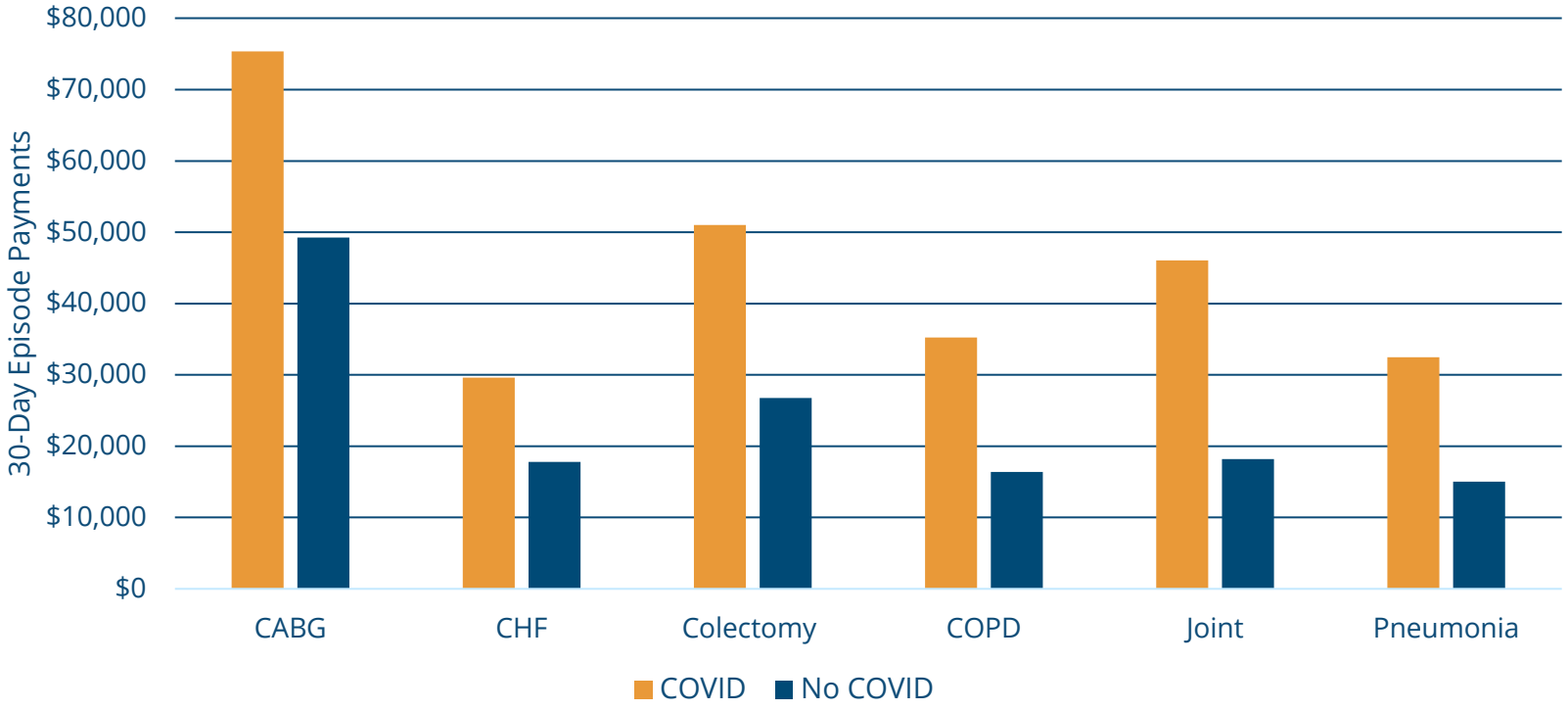
Risk Adjusted Episode Payments By COVID-19 Status: 2020 Q1-Q2



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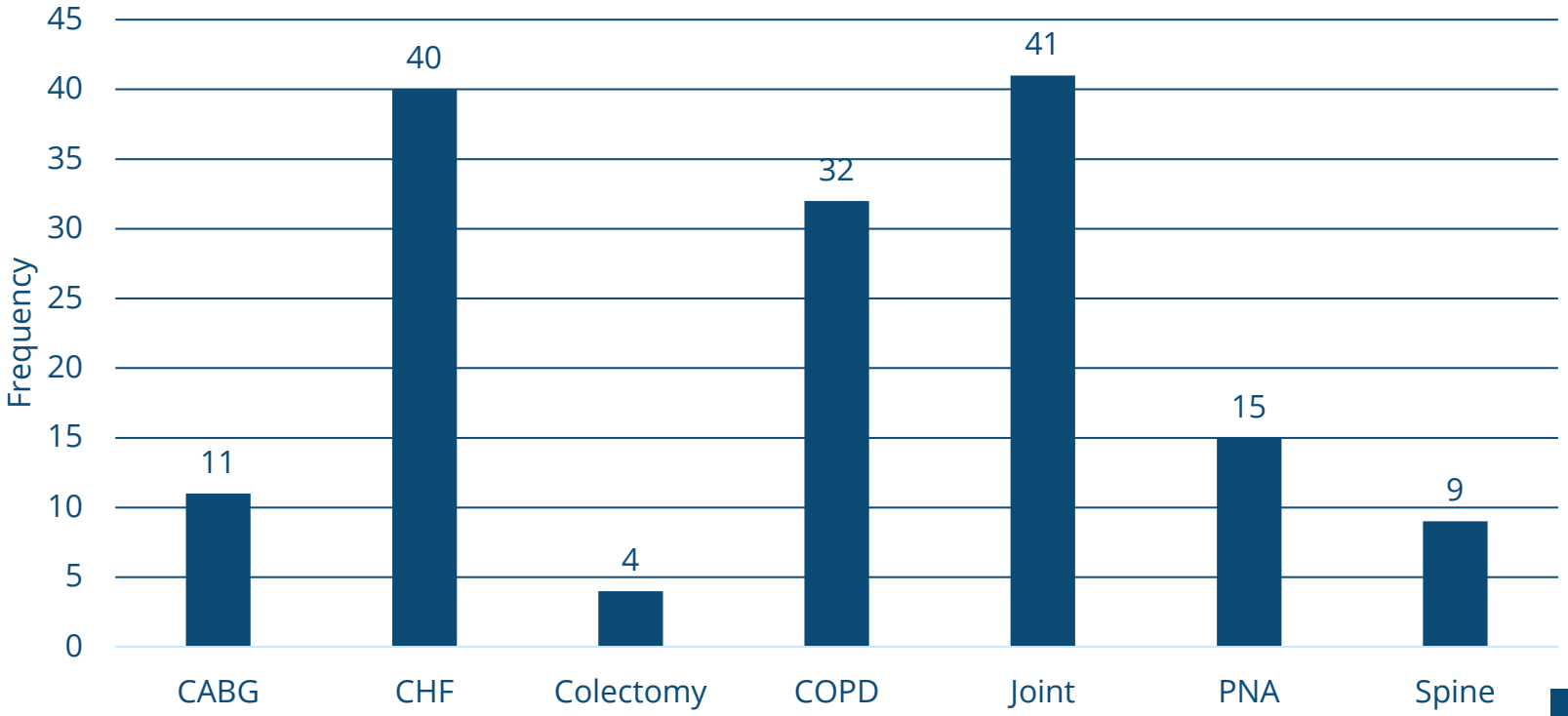
PY 23 & 24 Distribution of Selections



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MVC Michigan Medicaid Data

John Syrjamaki
MVC Manager of Analytics

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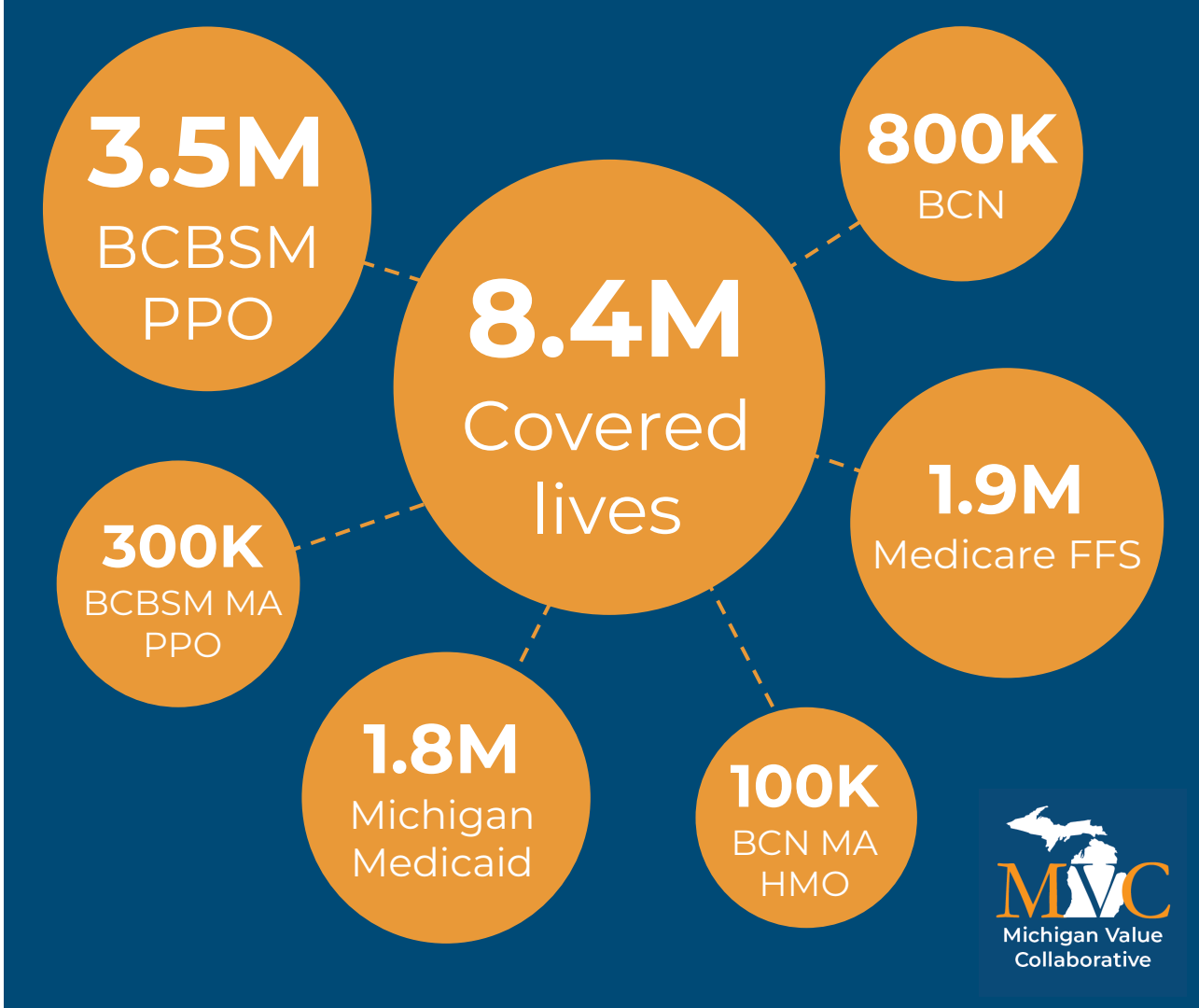
DATA SOURCES

MVC administrative claims data comprises > 80% of Michigan's insured population



319,140 episodes

Index events from 1/1/2015 – 6/30/2020

Fee-for-Service and Managed Care

256,889 beneficiaries

19.4% of all episodes

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Demographic Comparison

Medicaid vs. BCBSM/BCN Commercial

Medicaid episodes represent a younger population with a higher proportion of females, but similar number of Hierarchical Condition Categories (HCCs).

	Medicaid	BCBSM/BCN Commercial
Mean Age	**42.4**	**50.0**
% Female	**67.0%**	**64.4%**
Mean # of comorbidities	**2.1**	**2.0**

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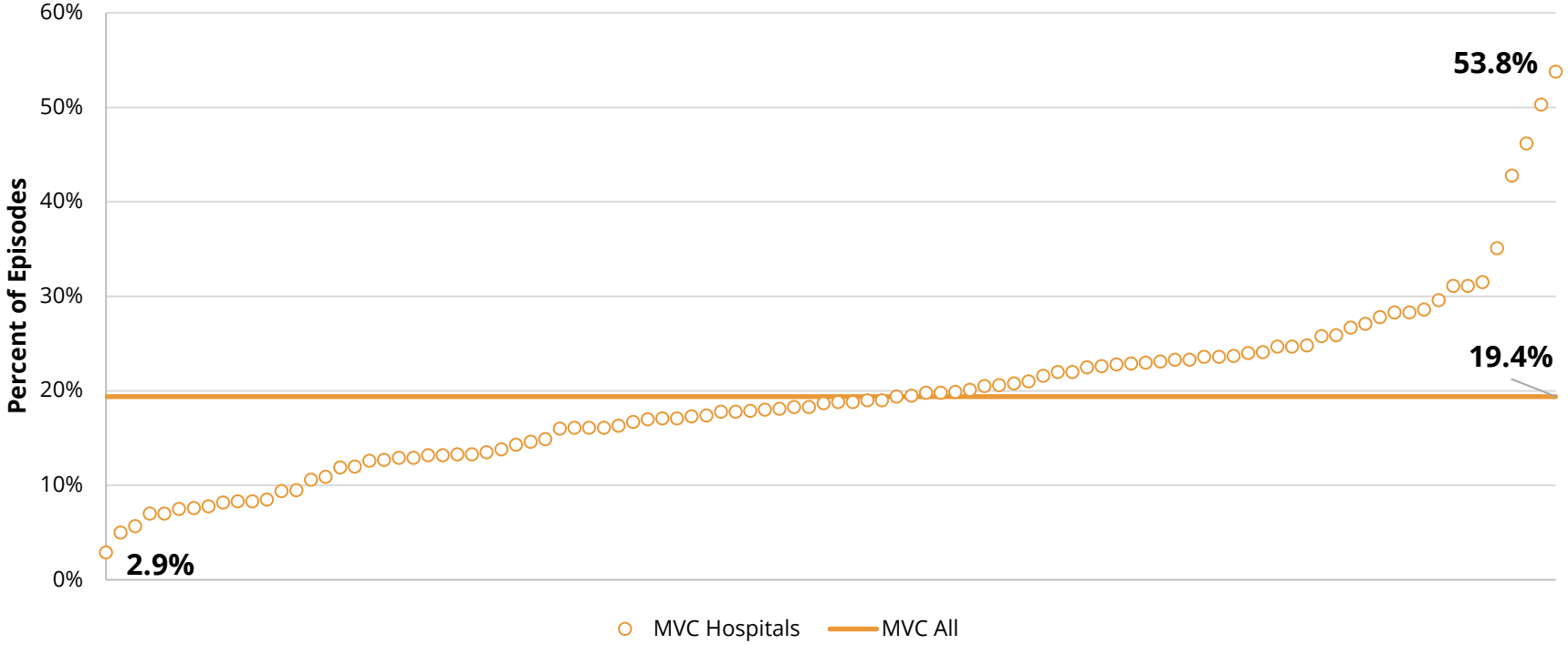
% Medicaid Episodes



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Top 5 High Volume Conditions

Medicaid

1. C-Section
2. Sepsis
3. Vaginal Delivery
4. Cholecystectomy
5. COPD

BCBSM/BCN Commercial

1. Vaginal Delivery
2. C-Section
3. Joint Replacement
4. Sepsis
5. Cholecystectomy

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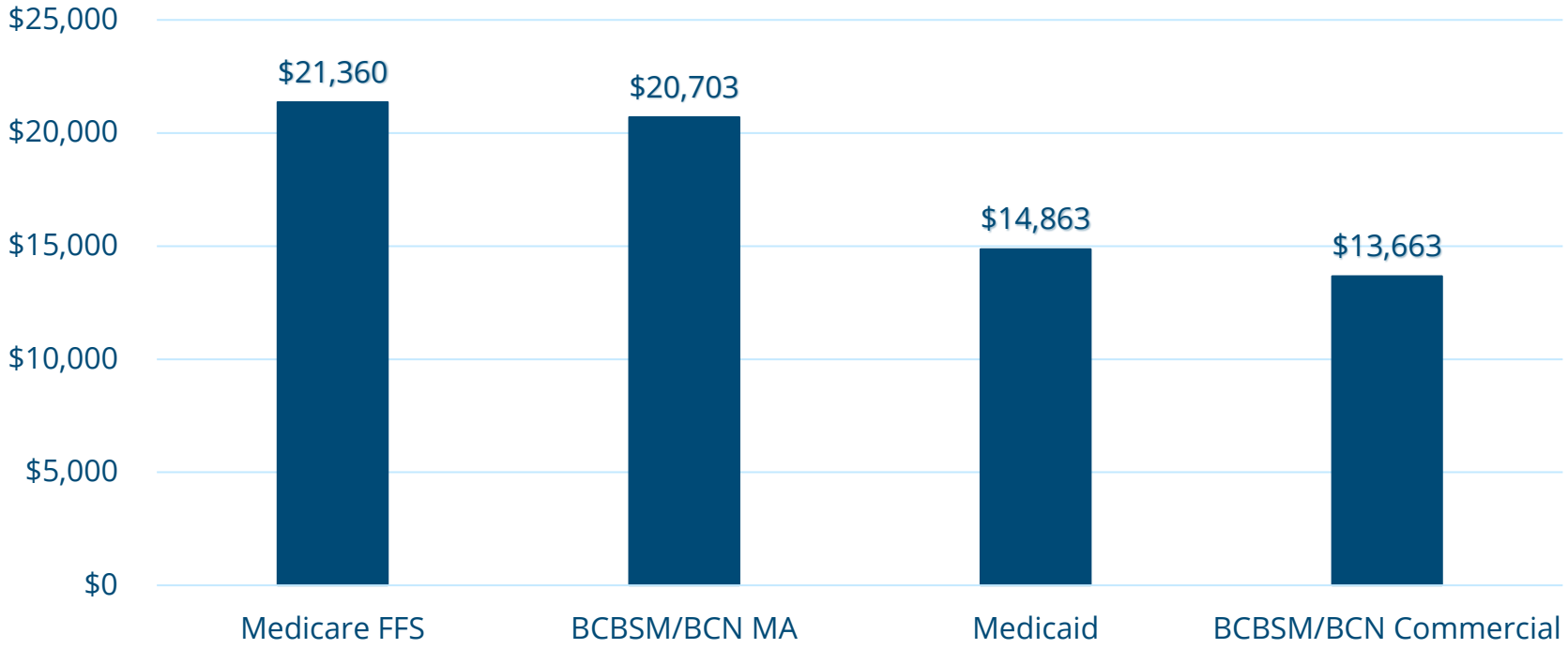
90-Day Episode Payments by Payer



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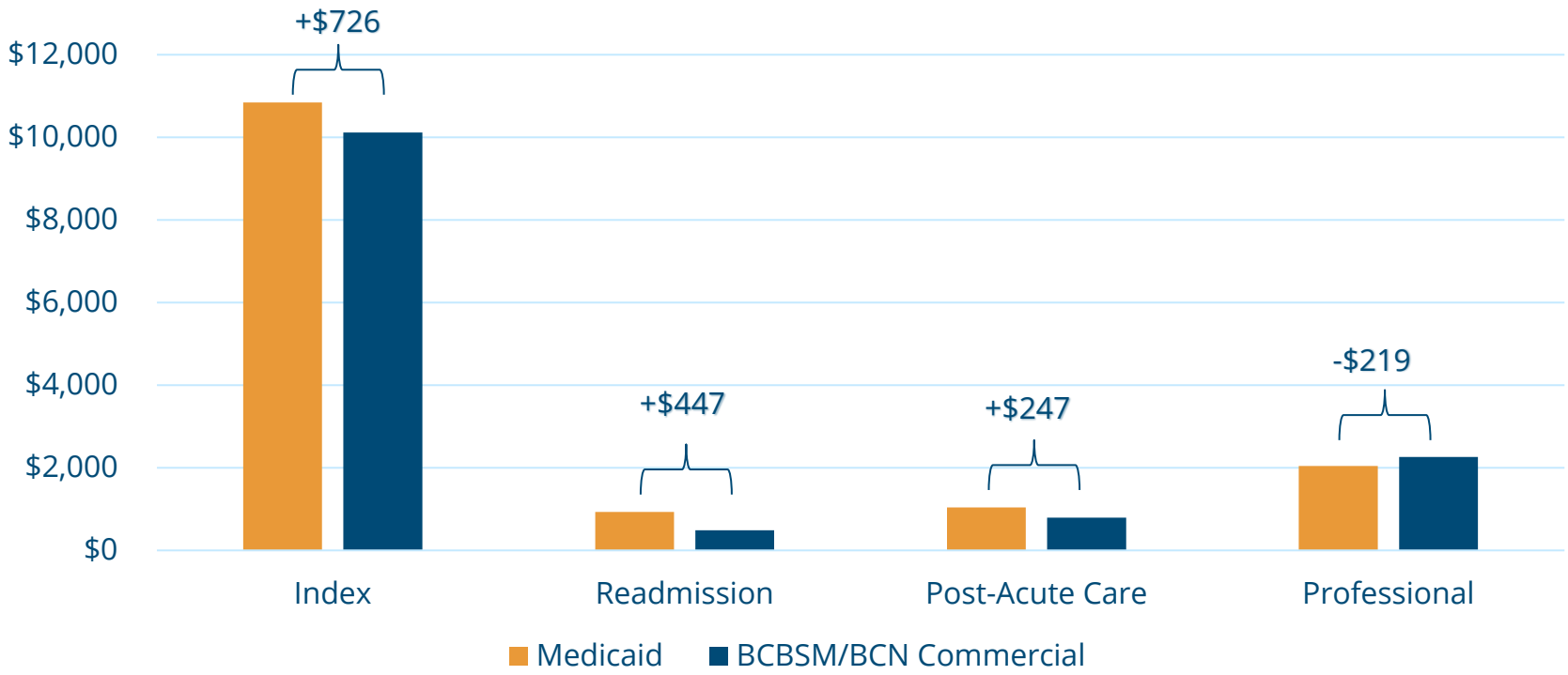
Payment Components by Payer



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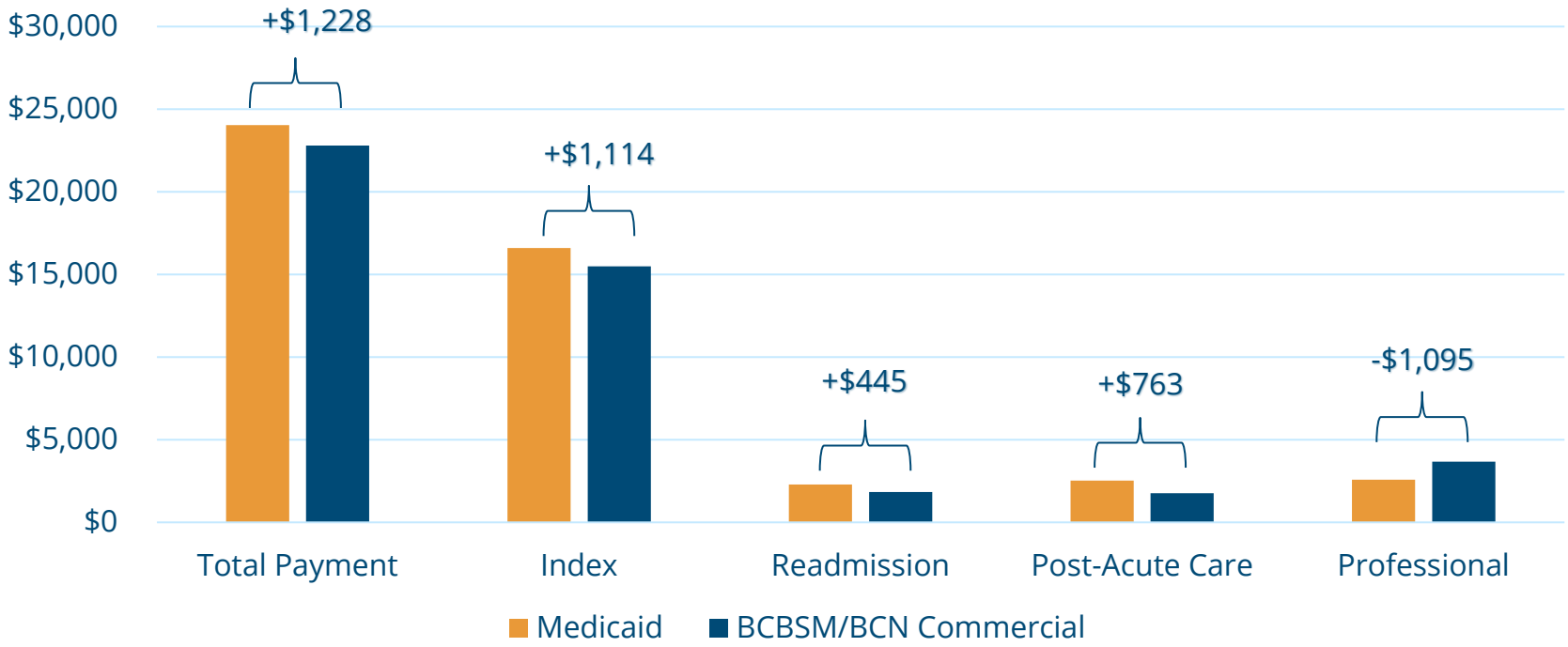
Sepsis Payments by Payer



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Takeaways

Unique population

Social determinants of health, healthcare inequities, and other challenges will be important to address.

Registry Reports

Medicaid data is now available on the MVC registry, with multiple enhancements planned.

Push Reports

The Health Equity report is now available, with other Medicaid-specific reports planned for next year.

Feedback

What information would be helpful to you in improving the care of Medicaid patients?

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Setting the Scene: Social Risk & Health Equity

Bonnie Cheng
MVC Analyst

Michigan Value Collaborative

Let’s review some definitions

Data Sources

- Medicare FFS 30-day episodes (Index Admissions 1/1/15 – 6/30/20)
- Master Beneficiary Summary Files

Dual Eligibility

- Medicare and Medicaid coverage

Race/Ethnicity

- White
- Black
- Hispanic
- Other

Comorbidities

- Groupings of Hierarchical Condition Categories (HCCs)
- Assessed from claims data

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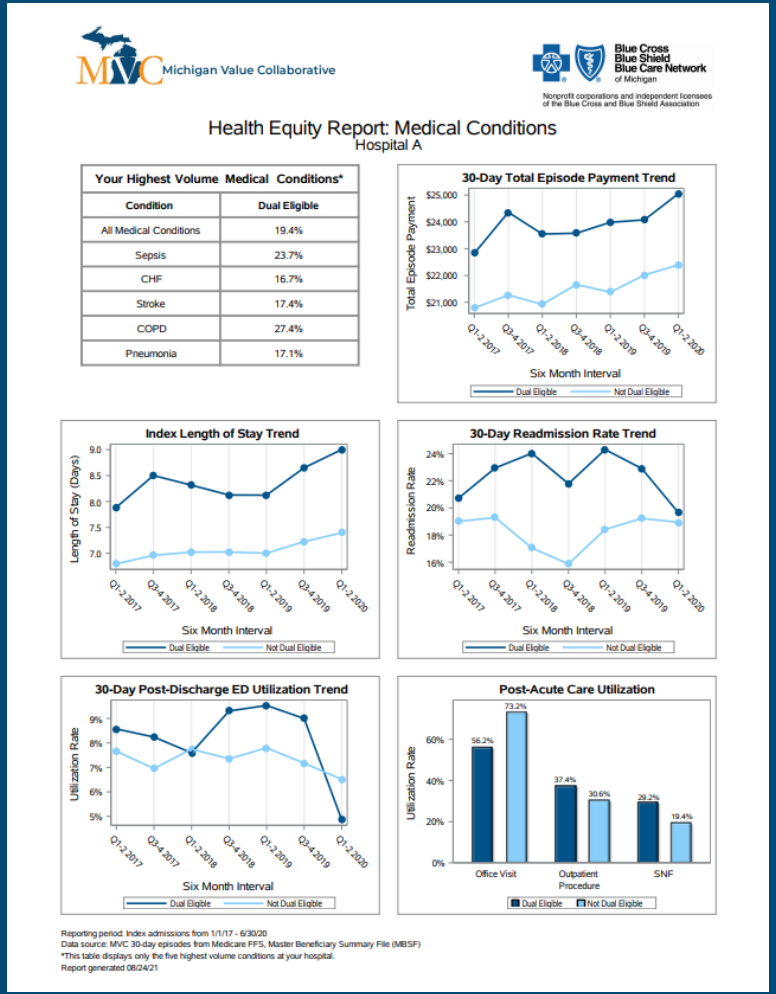
Health Equity Report

Objective

Assess variation and within-hospital differences between dual-eligible and non-dual-eligible patient outcomes.



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Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Health Equity Report: Medical Conditions

Hospital A

Your Highest Volume Medical Conditions*	
Condition	**Dual Eligible**
All Medical Conditions	19.4%
Sepsis	23.7%
CHF	16.7%
Stroke	17.4%
COPD	27.4%
Pneumonia	17.1%

Reporting period: Index admissions from 1/1/17 - 6/30/20
Data source: MVC 30-day episodes from Medicare FFS, Master Beneficiary Summary File (MBSF)
*This table displays only the five highest volume conditions at your hospital.
Report generated 08/24/21

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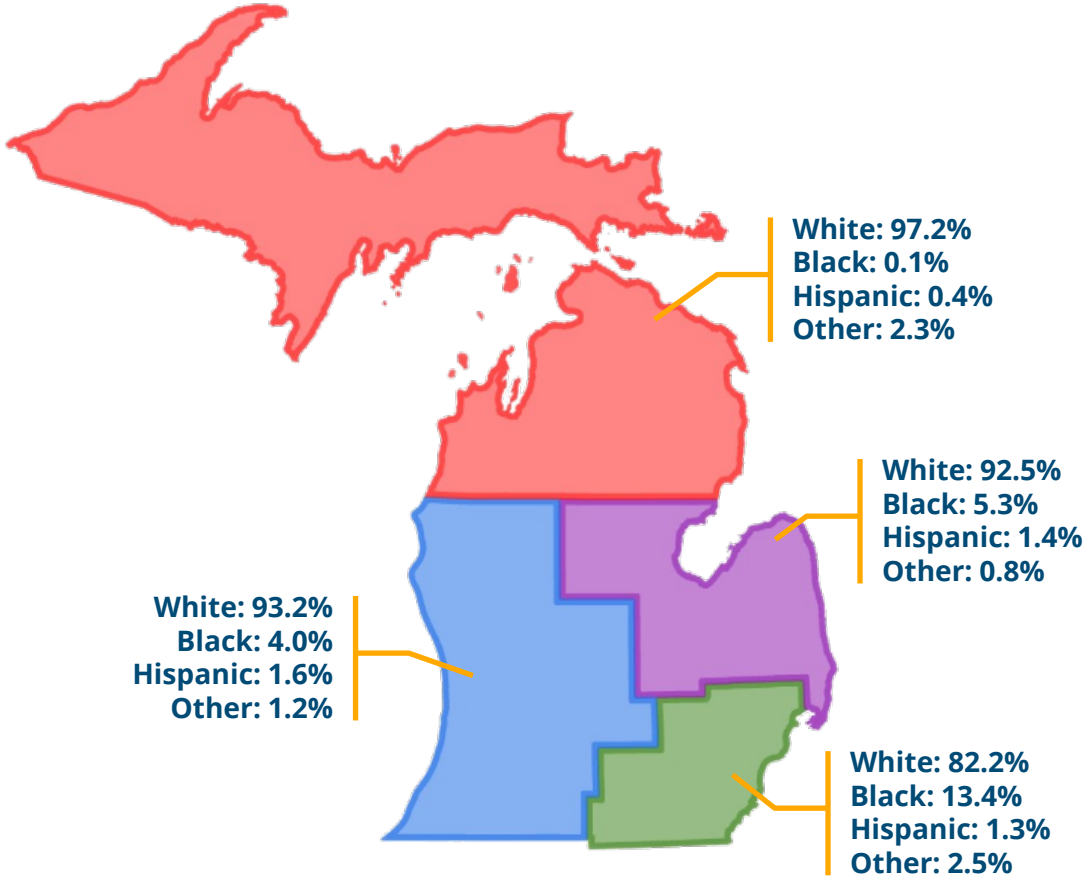
Racial/Ethnic Variation Across MI

Key Point

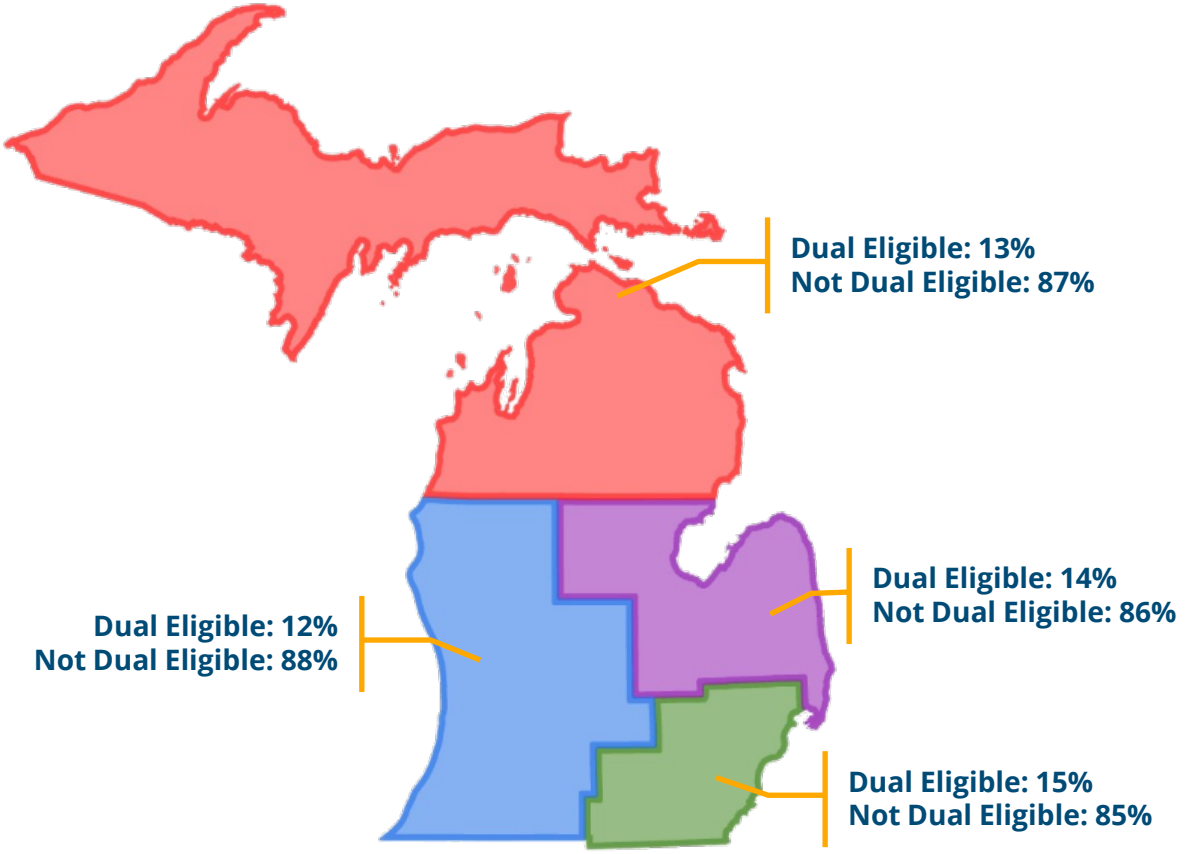
Michigan's population is predominantly White, though there is some variation between regions. At the hospital level, low variability and low case counts can make race-stratified analyses difficult to interpret.



Dual Eligiblity Variation Across MI

Key Point

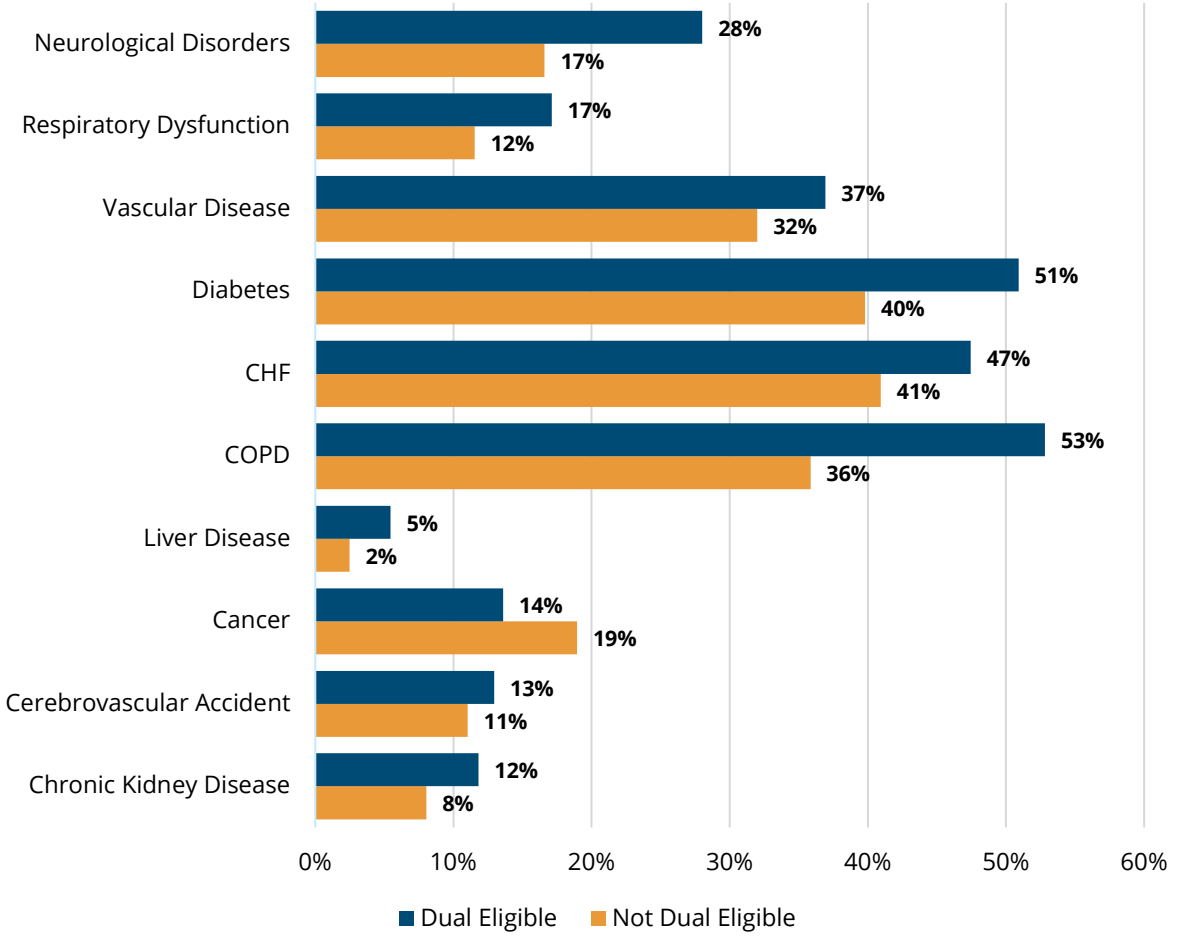
The proportion of dual-eligible patients is similar across regions. Medicaid eligibility is a good indicator of SES when using claims data since it is income-based, and studies have shown that there is a strong association between low-income status and adverse health outcomes.



Comorbidity Prevalence

Key Point

Among all MVC episodes, there is generally a higher prevalence of comorbidities among dual-eligible patients compared to those that are not dual-eligible.



Inter-Hospital Variation Among Pneumonia Episodes

Hospitals with at least 20 dual-eligible pneumonia episodes 2015 – Q2 2020

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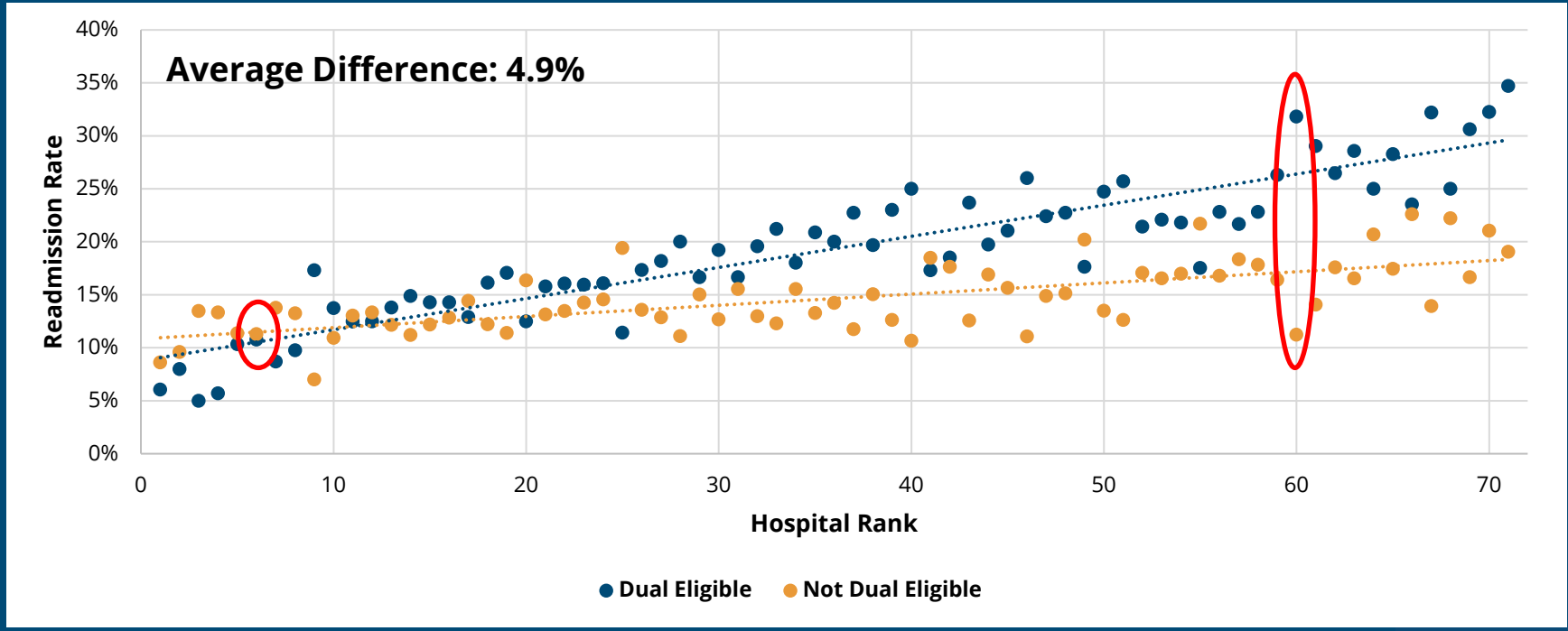

30-day Readmission Rate

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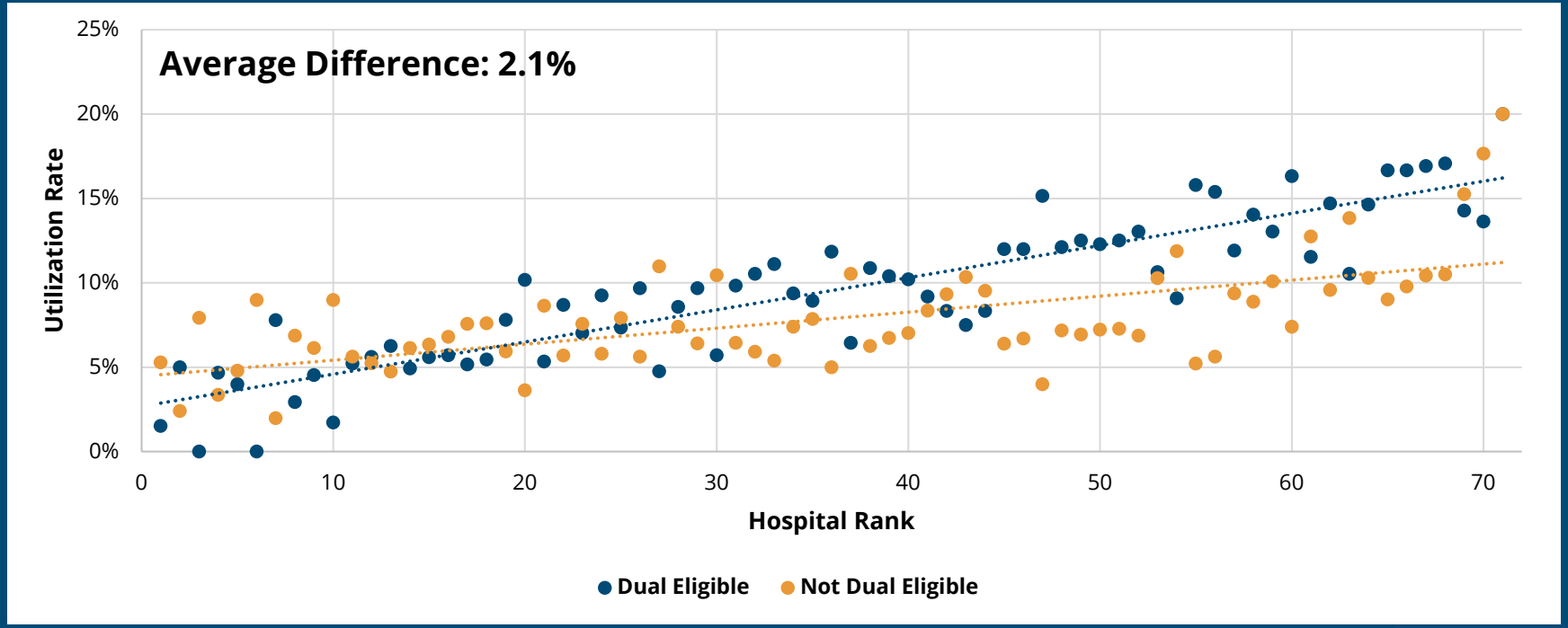

30-day ED Utilization Rate

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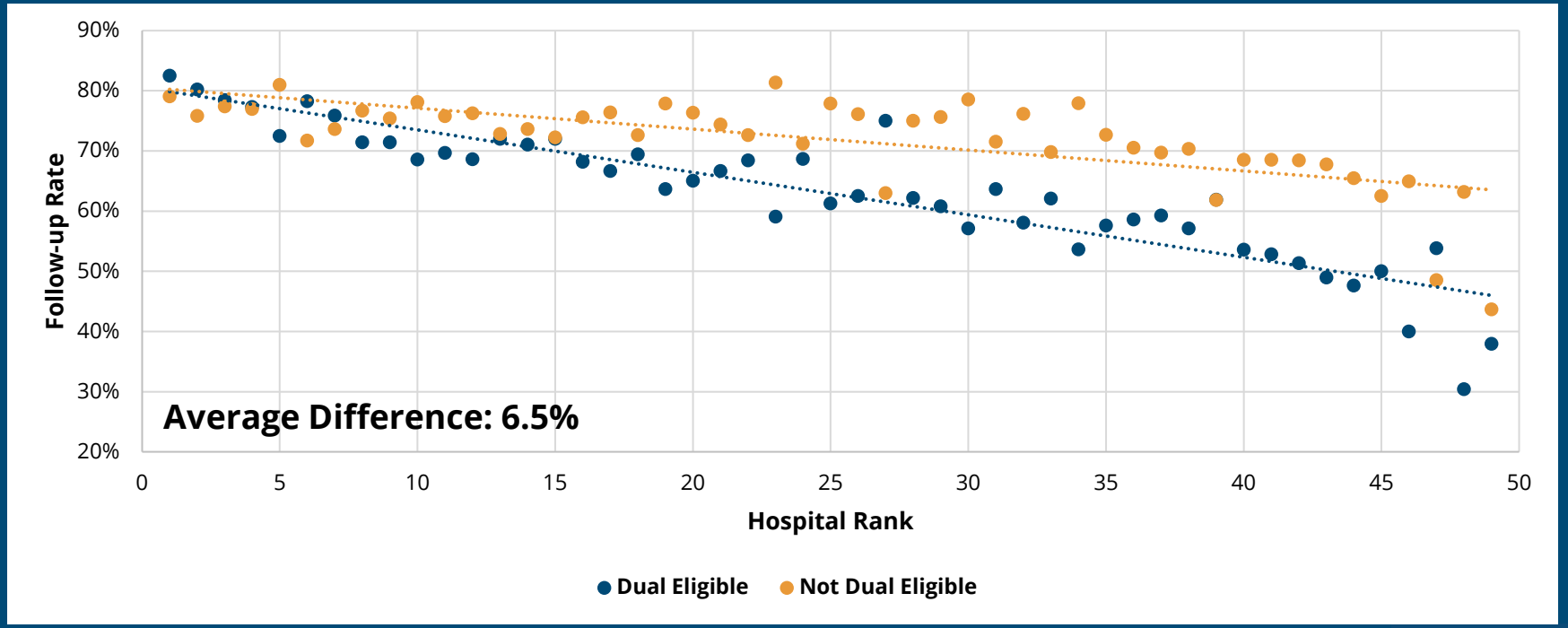

7-day Follow-up Rate

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Takeaways

- There is a lot of variation between dual-eligible and non-dual-eligible patients when it comes to comorbidity prevalence
- Disparities vary by outcome and likely vary by condition, but disparity is exacerbated by overall poor quality
- There is wide outcome variation between hospitals
- There is wide variation in the magnitude of disparities within hospitals
- While the disparities may be due to patient risk factors such as comorbidities, risk adjustment does not erase disparities

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MSHIELD

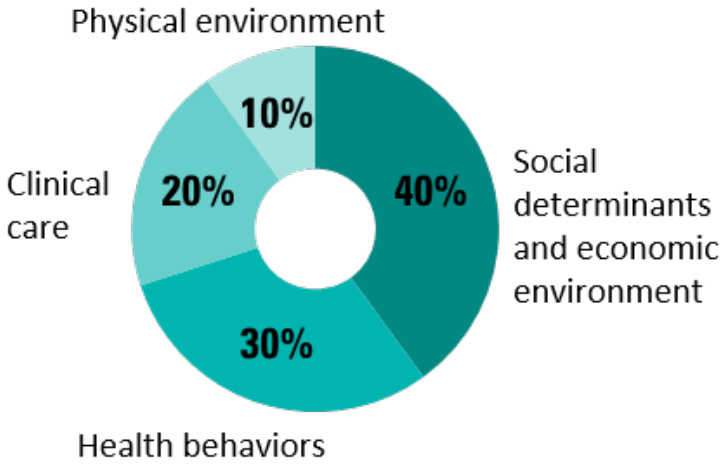
MICHIGAN SOCIAL HEALTH INTERVENTIONS to ELIMINATE DISPARITIES

Aligning Partnerships to Achieve Health Equity

Carol Gray, MPH
Program Manager | MSHIELD
University of Michigan

Under-investment in social health needs results in low-value care and health disparities.

Social determinants of health account for 40% of health outcomes.



MSHIELD

Social health needs have a significant impact on who needs care and how they recover afterwards.

- 62-year-old woman, lives alone
- Poor nutrition
- Poor access to care
- Many comorbidities
- Untreated stomach ulcer

Discharged to same environment

- No assistance at home
- Poor diet
- Misses follow-up care
- Exacerbation of underlying medical condition

- Septic shock from perforated ulcer
- Emergency surgery
- Intensive Care Unit

- Readmitted for: Dehydration, Heart failure, COPD, Asthma, Diabetic complications, etc.

MSHIELD

There is a growing evidence base that social health interventions can improve value and health equity.

FOOD INSECURITY

HOUSING INSTABILITY

COMPLEX CARE NAVIGATION

Ask, Assist, Align: Identifying high-risk, high-need patients and then connecting them with local community partners.

ASK

Screen all patients in participating CQIs for unmet social health needs to identify the specific areas of intervention for each individual patient.

ASSIST

Refer patients who screen positive for social health needs to the specific community partners that provide the specific services that they need.

ALIGN

Work with both patients and community partners to ensure availability and follow-through after referral so that these efforts are truly aligned with patients' needs.

MSHIELD serves to interface with both the health system and our patients' local communities.

HEALTH SYSTEM

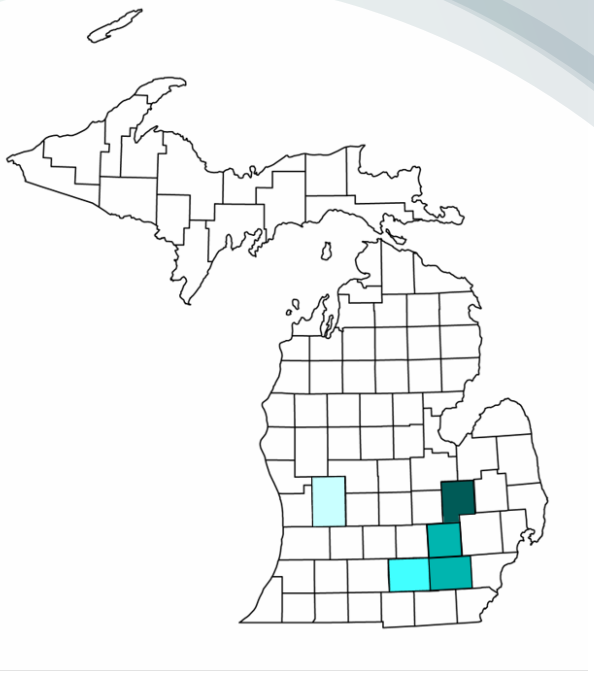
MSHIELD

MICHIGAN SOCIAL HEALTH INTERVENTIONS to ELIMINATE DISPARITIES

DATA

SERVICES

COMMUNITIES



MSHIELD will rely on existing relationships and structures to link patients to the services they need.

- **Community Health Innovation Regions (CHIRs)** across Michigan already have developed close community partnerships to address social health needs in their own communities
- MSHIELD will identify patients from the BCBS CQIs that screen positive for social health needs and work with CHIRs to link patients to partners and services in their own communities

MSHIELD


MSHIELD
MICHIGAN SOCIAL HEALTH INTERVENTIONS
to ELIMINATE DISPARITIES

Our Team

Renu Tipirneni, MD, MSc
MSHIELD Co-Director
Primary Care and Internal Medicine

John W. Scott, MD, MPH
MSHIELD Co-Director
Trauma and Acute Care Surgery

Carol Gray, MPH
MSHIELD Program Manager

Dilhara Muthukuda, MPH
MSHIELD Health Equity Specialist

Questions?

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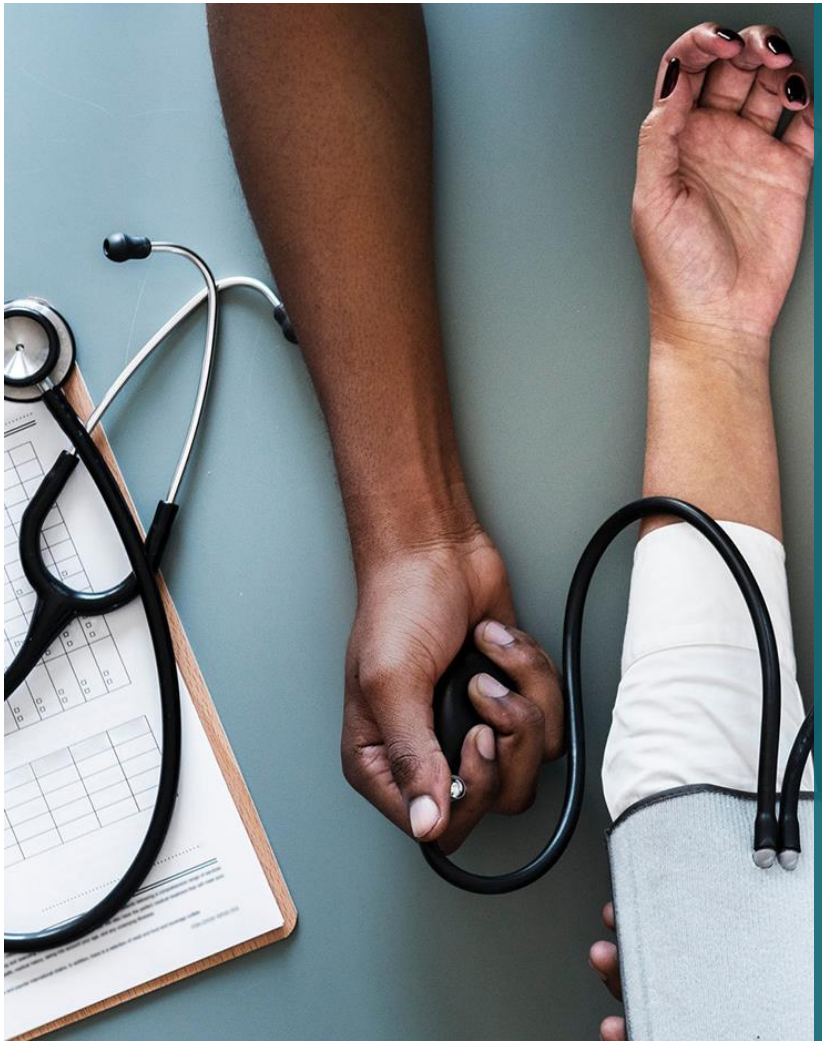


The Health Gap: An Exploration of How One Hospital is Working to Bridge Gaps Between Health Care & Social Care

Dr. Nicole Franklin

Assistant Medical Director – McLaren Bariatric & Metabolic Institute

Agenda

Welcome and Wellness

McLaren Health Care Corporation's Diversity and Inclusion Mission

Remembering a Resident & Friend

Actions Taken

Next Steps

Welcome and Wellness

- Everything is not cancelled.
  - Love is not cancelled
  - Kindness is not cancelled
  - Conversations are not cancelled
  - Devotion is not cancelled
  - Music is not cancelled
- Think of 1 thing that you are thankful for.

Diversity & Inclusion Vision

Unified in our Purpose

Strengthened by our Differences

We commit to creating an inclusive and equitable environment where **everyone is valued and empowered for success.** Our environment reflects the communities we serve, learns from all perspectives, delivers culturally appropriate care, and provides the best value in health care as defined by quality outcomes and cost.

Diversity and Inclusion: A Strategic Business Imperative

Unified in our Purpose
Strengthened by our Differences

We commit to an inclusive and equitable environment where everyone is valued and empowered for success. Our environment reflects the communities we serve, learns from all perspectives, delivers culturally appropriate care, and provides the best value in health care as defined by quality outcomes and cost.

Strategic Pillars	TALENT	PATIENTS/ MEMBERS	COMMUNITY	GOVERNANCE AND CORPORATE RESPONSIBIITY	SUPPLIER DIVERSITY
	• Talent Acquisition • Talent Development • Succession Planning • Employee Training • Employee Engagement • Employee Retention • Talent Pipeline Development	• Patient Experience • Patient Outcomes • Health Promotion • Reducing Healthcare Disparities • Culturally and Linguistically Appropriate Services • Member Services (Health Plans)	• Community Outreach and Engagement • Community Health Needs Assessments • Community Partnerships	• Diversity in Executive Leadership and Boards • Leadership commitment to an inclusive culture • D&I Goals • Strategic Partnerships	• Partnerships with a broad range of suppliers (small business enterprise, women owned, minority owned, veteran owned)

McLaren

Kimberly Keaton Williams, VP Talent Acquisition and Development & Chief Diversity Officer for McLaren Health Care

Subcommittees

ONE:
Employee Resource Groups

TWO:
Patient Outcomes

THREE:
Community Outreach

FOUR:
Employee Education

FIVE:
Talent Acquisition

SIX:
Cultural Calendar

REMEMBERING A FAMILY MEDICINE RESIDENT AND HER CALL FOR EQUALITY IN COVID-19 CARE

McLaren Flint is mourning the loss of Susan Moore, MD, a former Family Medicine resident who passed away in Indiana from COVID-19. Dr. Moore, who was a McLaren Flint resident from 2003 to 2006, made national news in December by documenting her COVID-19 experiences at two Indiana hospitals.

Unconscious Bias & You Training


TAKE THE FIGHT TO COVID.
A live virtual panel discussion about the COVID-19 vaccine with Q&A.
The myths | The concerns | The truths
Why you should take the fight to COVID-19.
Wednesday, February 10, 2021 | 7:00 p.m.
Panelists
Moderator:
Nicole Franklin, PsyD, ABPP
Asst. Medical Director
McLaren Bariatric and
Metabolic Institute
Dennis Perry, MD, MPH
Chief Medical Officer
McLaren Health Plan
Lawrence Reynolds, MD
Medical Advisor to
Flint Mayor and Genesee
County Board of Health
Randall Taylor, PharmD
Director of Pharmacy
McLaren Health Plan
Asa Ascencio-Zuccaro
Executive Director
Latinx Technology &
Community Center
Bishop Urundi Knox
Pastor of Ebenezer Ministries
Go to mclaren.org/FlintFightCOVID to register and receive the link.
ASL interpreters will appear on screen during live discussion.
For questions or registration assistance, please call (810) 342-4473.
Brought to you by the McLaren Flint Diversity & Inclusion Committee
McLaren FLINT
McLaren HEALTH PLAN

SOCIAL MEDIA GRAPHICS

Take the Fight to COVID Virtual Panel Discussion Survey

21 Responses 05:31 Average time to complete Closed Status

1. Before watching the Take the Fight to COVID webinar, how knowledgeable were you about the COVID-19 vaccines?

Very knowledgeable	8
Somewhat knowledgeable	12
Not knowledgeable	1

2. Was the information provided during the Take the Fight to COVID webinar helpful?

Very helpful	17
Somewhat helpful	3
Not helpful	1

3. What percentage of the information presented in the Take the Fight to COVID webinar was new to you?

0%	1
25%	12
50%	6
75%	2
100%	0

4. After watching the webinar, do you feel that you now have enough information to make an informed choice regarding if COVID-19 vaccination is right for you?

Yes	20
No	0
Maybe	1

5. Did the Take the Fight to COVID webinar increase the likelihood that you would take one of the COVID-19 vaccines?

Yes	17
No	4

THE BIG 3

Johnson & Johnson, Pfizer, and Moderna

Part 2 of the Take the Fight to COVID Webinar.

A live discussion on how to safely get your vaccine.

Tuesday, April 27, 2021 | 12:00 - 1:00 p.m.

Panelists

Moderator:

Nicole Franklin, PsyD, ABPP
Asst. Medical Director
McLaren Bariatric and
Metabolic Institute

Gregory Forstall, MD
Infectious Disease,
Internal Medicine
McLaren Flint

Randall Taylor, PharmD
Director of Pharmacy
McLaren Health Plan

Dennis Perry, MD, MPH
Chief Medical Officer
McLaren Health Plan

To watch the webinar live through Zoom, go to **mclaren.org/FlintFightCOVID**.
(An ASL interpreter will be available through Zoom.)
The panel discussion will also be streamed live on McLaren Flint's Facebook page.
Dial into the panel discussion by calling **1-646-558-8656**.
Use webinar ID **983 8801 6651**.

For questions, please call **(810) 342-4473**.

Brought to you by the McLaren Flint Diversity & Inclusion Committee

McLaren FLINT McLaren HEALTH PLAN

TAKE THE FIGHT TO COVID – PART 2

PATIENT OUTCOMES SUBCOMMITTEE

Virtual Community Resource Day

- Dept. of Health & Human Services
- Ennis Center
- Housing Assessment Resources Agency
- MTA Rides to Wellness

Patient to PCP pipeline

Community Outreach Subcommittee

Partnered with Karmanos Cancer Institute and other local agencies to sponsor a golf classic.

- Colorectal test kits distributed

FLINTSTONES GOLF "SPECTACULAR"

Dedicated to the Memory of Mancine Broome

Saturday, July 17th, 2021

Captain's Club at Woodfield

10200 Woodfield Dr.
Grand Blanc, MI 48439

Registration: 7:00 AM
Shot Gun Start: 8:00 AM
$70.00 Per Person, incl. Lunch
($25.00 is Tax Deductible)

THE GREATER FLINT AFRICAN AMERICAN SPORTS HALL OF FAME

Make All Checks Payable to:
The Greater Flint African American Sports Hall of Fame
P.O. Box 310502
Flint, MI 48531

www.gfaashof.org

Contest Prizes
Door Prizes

For more Information Contact:
David Gibson (810)569-9414 or info@gfaashof.org
Melvin Smith (810)691-6029 or info@gfaashof.org

Karmanos CANCER INSTITUTE | McLaren FLINT

Past community organizations that McLaren Flint has supported

*City of Flint (Turkey Giveaway)
*Boys & Girls Club of Greater Flint
*International Center of Greater Flint
*Greater Flint African American Sports Hall of Fame Induction (GFAASHOF)
*Valley Area Agency on Aging

Prevention and cure are only part of the story

- **Humility**
  - requires you to step outside of yourself and be open to other people's identities, in a way that acknowledges their authority over their own experiences
- **Advocacy**
  - Helping patients access health care
  - Educating patients so they can make well-informed healthcare decisions

Diversity is having a seat at the table. **Inclusion** is having a voice & **Belonging** is having that voice heard.

- Liz Fosslien

Next steps….

Develop

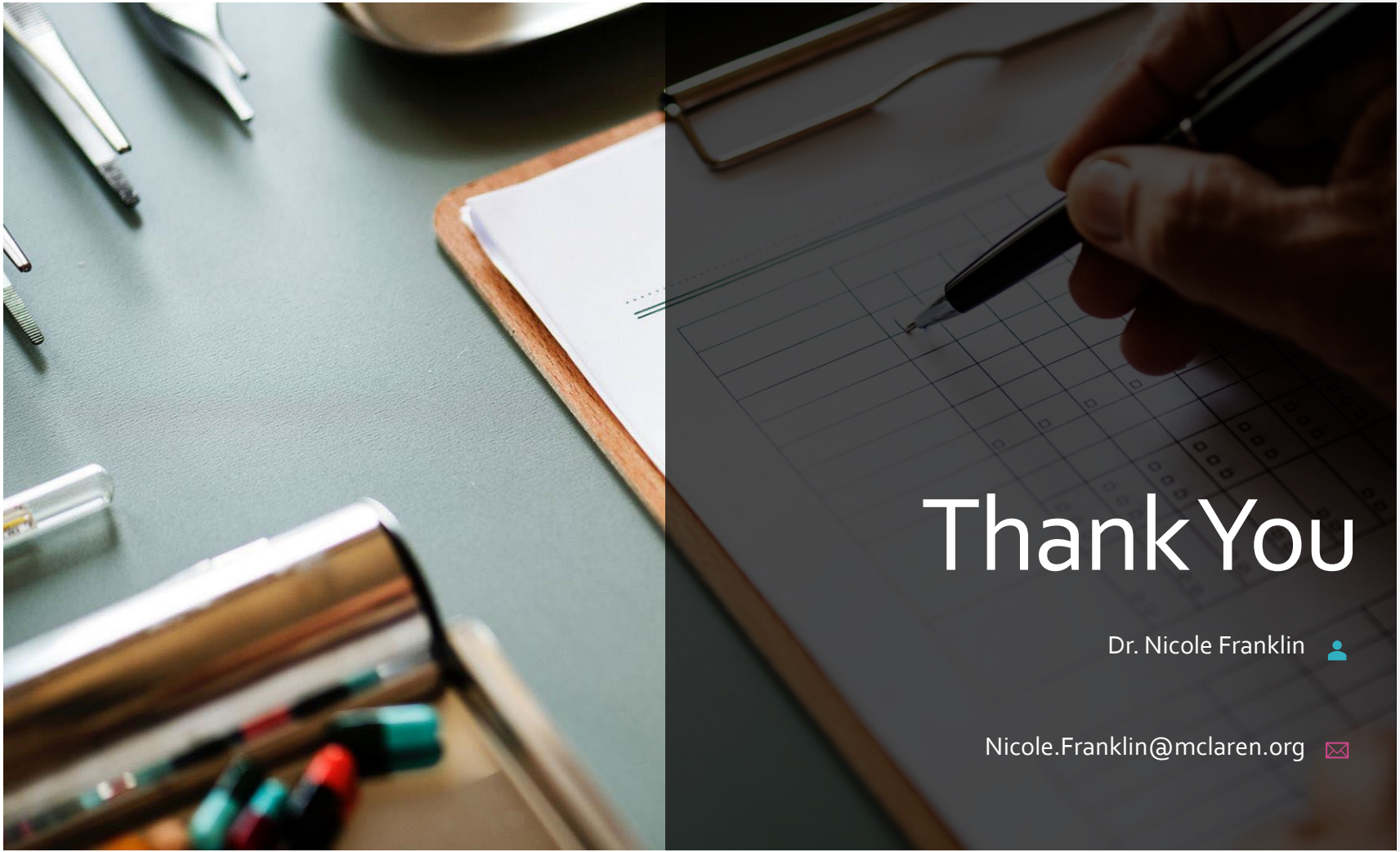
Develop information exchange capabilities to support the timely use of actionable data.

Expand

Expand working relationship with community partners.

Assist

Assist new and existing stakeholders with initiatives to reduce health disparities.



Thank You

Dr. Nicole Franklin

Nicole.Franklin@mclaren.org

Questions?

Michigan Value Collaborative

IHA Efforts to Screen and Address Patient Social Influencers of Health

MVC Semi-Annual Meeting

October 22, 2021

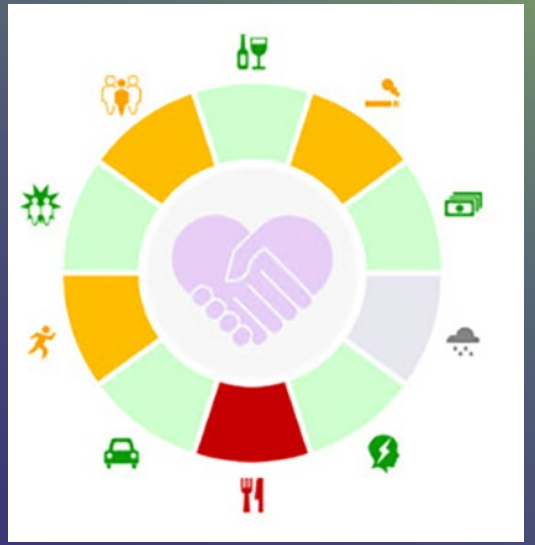
Agenda

- Brief history of screening for SIOH
- Transition to Epic and roll out of new workflow
- SIOH data
- Improving SIOH screening rates and follow up
- Questions

IHA

Brief history of screening for SIOH

- In 2015, CMS awarded Michigan $70 million over four years to test and implement an innovative model for delivering and paying for healthcare in the state, called the State Innovation Model (SIM)
- SIM PCMH provided PMPM dollars to POs to support primary care infrastructure development if PO met care delivery requirements, including screening for SIOH with a standard set of domains
- In Southeast Michigan, IHA, Michigan Medicine, and HVPA partnered to create standard SIOH screening and began screening for SIOH in 2017
- In early 2020, IHA transitioned to Epic and leverages Epic social needs module to screen for and display patients' social needs



SIOH Screening Questionnaire

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.

   Never True Sometimes True Often True

2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

   Never True Sometimes True Often True

3. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

   Very hard Hard Somewhat hard Not very hard

4. Are you worried that in the next 2 months you may not have stable housing?

   Yes No

5. I can get a variety of food, including fruits and vegetables.

   Yes No

6. Within the last 3 months, how many times did you visit the emergency department for your medical care? Number: _____

7. Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

   Yes No

8. Has the lack of transportation kept you from medical appointments or from getting medications?

   Yes No

9. How often do you feel lonely or isolated from those around you?

   Never Rarely Sometimes Often Always

10. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

    Never Rarely Sometimes Often Always

11. Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?

    Yes No N/A

12. Do you need help finding or paying for care for your loved ones? For example, childcare or elderly care for an older adult?

    Yes No

13. Are you afraid that you might be hurt by violence in your neighborhood?

    Yes No

14. Are you afraid that you might be hurt by violence in your apartment or home?

    Yes No

15. If you checked YES to any boxes above, would you like to receive assistance with any of these needs?

    Yes No

15a. Are any of your needs urgent? For example, I don't have food tonight or I don't have a place to sleep tonight

    Yes No

IHA

New Workflow to Screen for SIOH

- New workflow piloted at 4 practices in fall 2020, rolled out to all adult and pediatric primary care and Ob/Gyn practices by January 2021

- Screening completed in advance via MyChart or at visit on paper (primary care) or verbally via telephone (Ob/Gyn)

- New in Epic: MA (primary care) or OB Nurse (Ob/Gyn) review any positive screenings and provide resources at point of care via Aunt Bertha

- Follow up:
  - Call center attempts to contact patients who screened positive and desired assistance within 2 weeks
  - Up to two attempts to contact patient are made
  - Inquire if needs were met and if the patient needs additional assistance, call center trained to provide additional resources if needed
  - All communications are documented in a telephone encounter

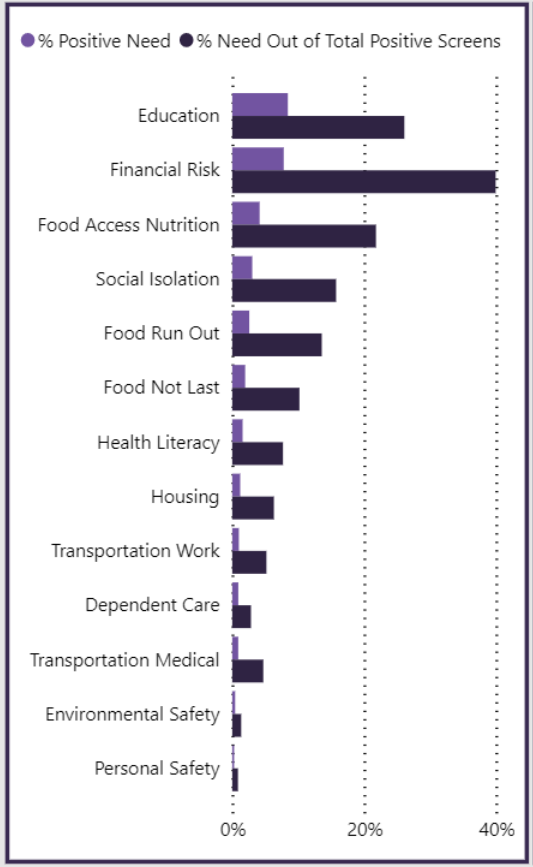
IHA

SIOH Data on Population Health Dashboard

Screenings Between: 1/1/2021 8/31/2021

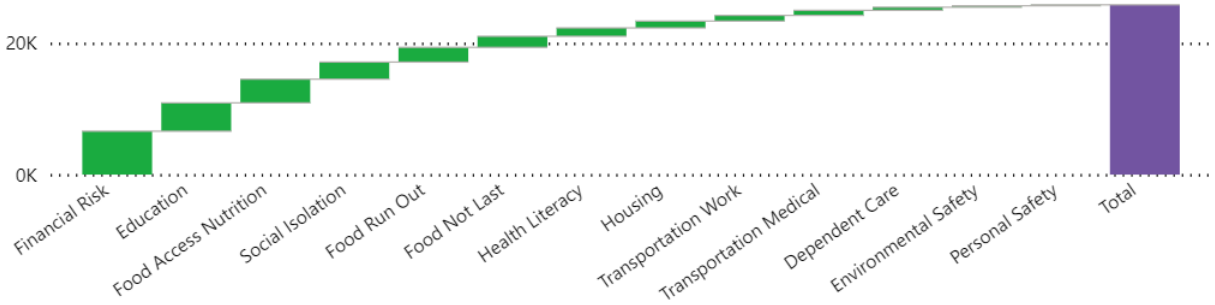
Currently viewing by **PCP** Location/Provider

Click to view by Rendering Location/Provider



PCP Org, Division, Practice, Provider	Completed Screens	Positive Screens %	Total Needs	Assistance Needed %	Positive Screens With One Need %	Positive Screens With Mulitple Needs %
IHA	**72,632**	**19.0%**	**21,093**	**1.7%**	**71.5%**	**27.2%**
Family And Internal Medicine	**60,039**	**19.2%**	**17,748**	**1.9%**	**71.0%**	**27.6%**
IHA Arbor Park Primary Care	3,101	22.3%	1,109	2.1%	68.8%	29.6%
IHA Brighton Family Care	3,347	18.7%	952	1.1%	71.1%	27.6%
IHA Brooklyn Primary Care	1,100	11.9%	174	0.2%	78.6%	21.4%
IHA Canton Primary Care	2,404	21.4%	816	3.0%	66.0%	31.7%
IHA Chelsea Primary Care	1,785	18.9%	469	1.4%	76.6%	22.2%
IHA Cherry Hill Village Primary Care	4,626	11.4%	765	1.2%	72.2%	26.2%
Total	**86,008**	**19.2%**	**25,845**	**2.0%**	**70.2%**	**28.6%**

Positive Needs Out of Total Needs Identified



SIOH Data on Population Health Dashboard

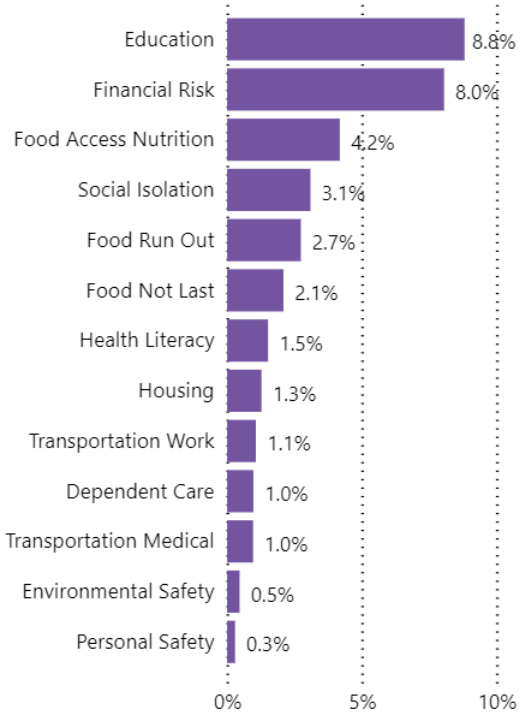
From Date: 1/1/2021 To Date: 8/31/2021

PCP Org: All

PCP Division: All

PCP Location: All

Positive Needs



Positive Screens by Demographics

Race	Positive Screens %	Total Needs
White	17.5%	19,897
Black Or African American	33.6%	5,187
UNKNOWN	23.9%	2,526
Asian	23.7%	873
Declined	22.3%	601
Total	**19.5%**	**29,244**

Language	Positive Screens %	Total Needs
English	19.3%	28,277
Other/Unknown	24.8%	497
Spanish	40.8%	208
ARABIC	35.7%	48
Mandarin	45.2%	26
Total	**19.5%**	**29,244**

Ethnicity	Positive Screens %	Total Needs
Not Hispan/Lat	19.1%	23,899
UNKNOWN	22.6%	2,323
Declined	18.4%	1,882
Hispanic/Lat	27.0%	1,136
	13.3%	4
Total	**19.5%**	**29,244**

County	Positive Screens %	Total Needs
⊞ **WASHTENAW**	**21.5%**	**9,400**
⊞ **WAYNE**	**20.0%**	**8,044**
⊟ **LIVINGSTON**	**18.2%**	**4,077**
48843	18.7%	1,108
48116	16.7%	558
48169	17.1%	495
48114	14.5%	355
48189	21.9%	324
Total	**19.5%**	**29,244**

SIOH Screening Rate is IHA FY22 Priority

Overall goal: All IHA patients offered SIOH screening once per year

FY22 Metric: % of patients who haven't been screened in 365 days offered SIOH screening at eligible appointment

Denominator: Any patient with an eligible visit in time frame

Numerator: Any patient who completed or declined a screening at* eligible visit OR had been screened in 365 days prior to eligible visit

*In order to capture MyChart screenings done prior to the visit, we include any screenings done within a specified time frame before and after the eligible visit

First Step – *Root Cause Analysis Action Plan*

SIOH Data Validation

Final validation of BI report in process

Interviews with PMs of low-performing practices

For additional insight into best workflow practices

Shadowing Reception Staff & MAs

Illuminate workflow challenges and differences between practices

IHA

Key Takeaways – *Workflow Issues*

Time Limitations
Common for patients to not have enough time to fill out the SIOH screen

MAs Enter Data Post-Appt.
MAs don't discuss positive screen with patient or notify physician of positive screen

Lack of Awareness
Providers tend to have little to no awareness of the SIOH screening process

Patients Are Not Receiving Resources
MAs are not using Aunt Bertha to recommend resources

Next Steps

- **Education and re-training organization wide**
  - Mandatory HealthStream training for all staff and providers
  - Annual provider training
  - Hands-on workflow training for clinical and office staff

- **Expansion to Specialty and Surgery Divisions**
  - Recovery Medicine
  - Breast Surgery
  - Colorectal Surgery
  - General Surgery

- **Pilot CHW referral process**
  - Partnership with Washtenaw Health Plan
  - IHA Social Workers at 4 highest need practices will refer most complex patients to Community Health Workers

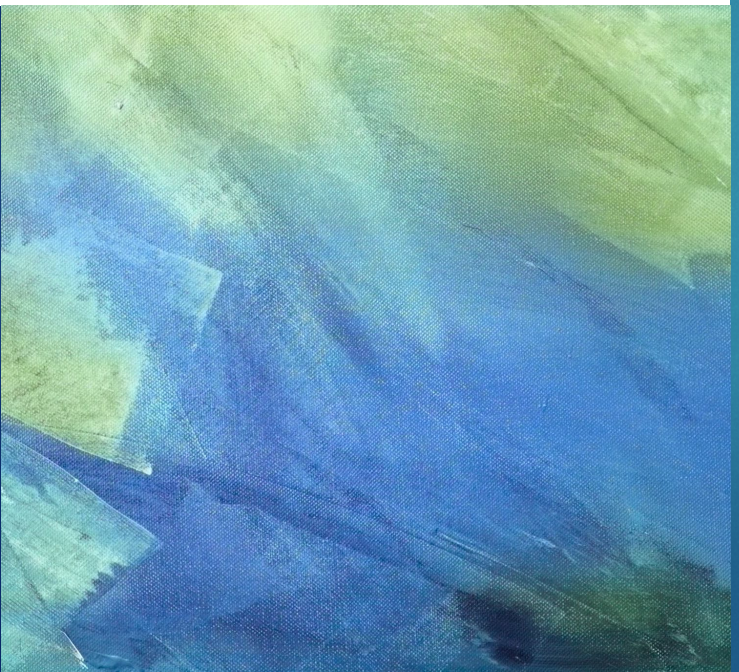
- **Participate in Trinity Health System Office workgroups to roll out SIOH screening in ED and Inpatient settings**
  - All of Trinity on one instance of Epic, so patients' SIOH should be visible to any Trinity provider once screened
  - Coordination needed for patients who screen positive to ensure appropriate follow up

IHA

Questions?

Michigan Value Collaborative

Great Lakes
PHYSICIANS ORGANIZATION



Great Lakes Physicians Organization

Redesigning Our Care & Investing in Patients

MELISSA GARY, CNMT

COMMUNITY LIAISON

Great Lakes
PHYSICIANS ORGANIZATION

Independent Practitioners
72 PCP's 190 Specialist
Not connected to a health system
25 different EMR's
Not a nonprofit

12 Counties (Rural)
Not Part of CHIR

Barriers

12

SDoH Questionnaire

Patient Screening Questionnaire

This form is to help assist our providers to determine what form of assistance and what type of resources our office can assist you with, to ensure that you are meeting your basic needs and maintaining a quality of life. Please fill this form out and return to our front desk. Our office will follow up with you. Thank you!

Make sure you enter the patient's county of residence!

NAME:_____BIRTH DATE:_____DATE:_____COUNTY:_____

DOMAIN	QUESTION			
HealthCare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school, or hobby?	No	Yes	N/A
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	No	Yes	N/A
Food	Do you ever eat less than you feel you should because there is not enough food?	No	Yes	N/A
Employment & Income	Do you have job or other steady source of income?	No	Yes	N/A
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent or share?	No	Yes	N/A
Utilities	In the past year, have you had a hard time paying your utility company bills?	No	Yes	N/A
Child Care	Does getting child care make it hard for you to work, go to school or study?	No	Yes	N/A
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	No	Yes	N/A
Transportation	Do you have a dependable way to get to work or school, and your appointments?	No	Yes	N/A
Clothing & Household	Do you have enough household supplies? For ex: clothing, shoes, blankets, mattress, diapers, toothpaste and shampoo.	No	Yes	N/A
General	Would you like to receive assistance with any of these needs?	No	Yes	N/A
	Any of your needs urgent?	No	Yes	N/A
Abuse	Do you feel unsafe or scared at home or anyone physically or mentally causing you harm?	No	Yes	N/A

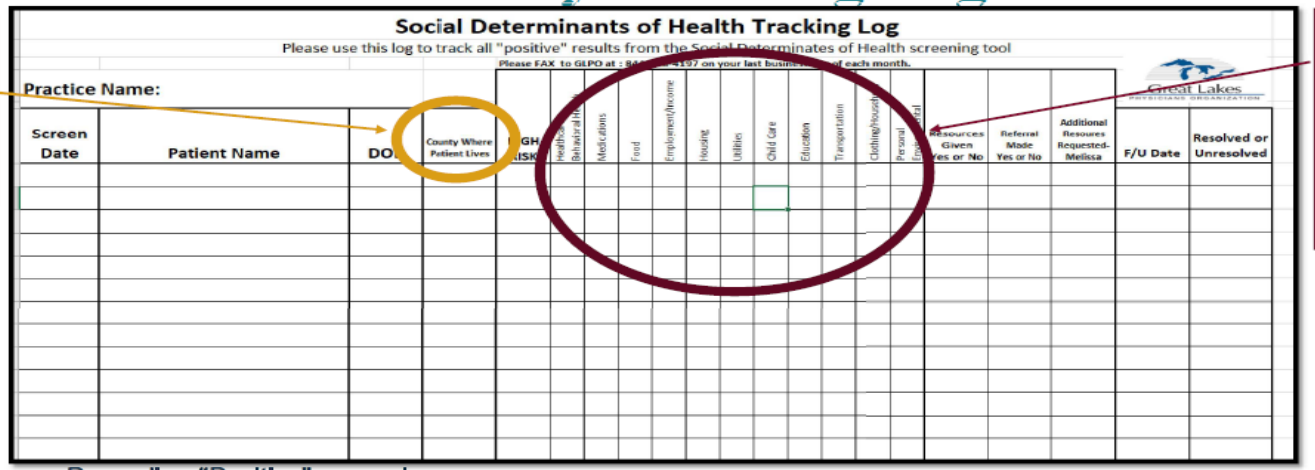
12 Questions

Pediatric Version

Yes or No

SDoH Monthly Tracking Log

Be Sure your version has the County



Social Determinants of Health Tracking Log

Please use this log to track all "positive" results from the Social Determinates of Health screening tool

Please FAX to GLPO at : 84[illegible]4197 on your last business day of each month.

Practice Name:

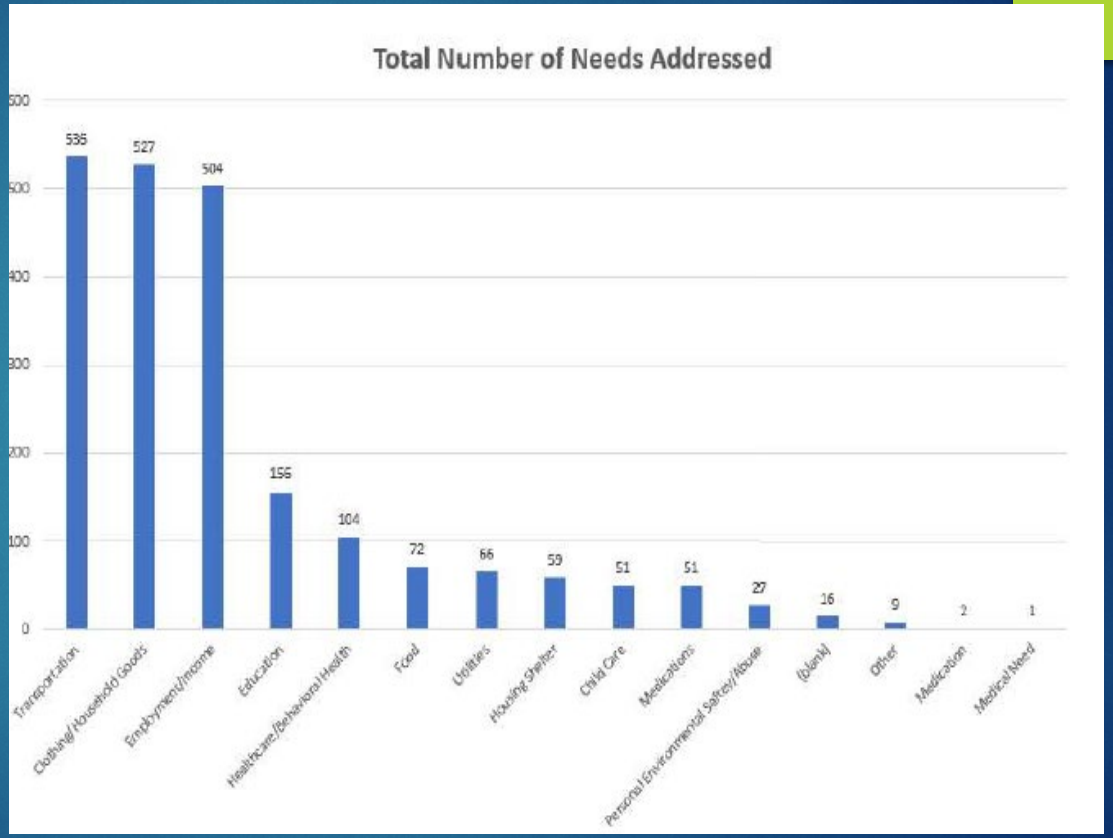
Screen Date	Patient Name	DOB	County Where Patient Lives	HIGH RISK	Healthcare/ Behavioral Health	Medications	Food	Employment/Income	Housing	Utilities	Child Care	Education	Transportation	Clothing/Household	Personal Emotional	Resources Given Yes or No	Referral Made Yes or No	Additional Resources Requested- Melissa	F/U Date	Resolved or Unresolved

Make Sure the NEED is marked

- Recording "Positive" screenings
  - Only record the patients that had a need in one or more areas on the SDoH Questionnaire
- Fax the tracking log to GLOSC on the last day of the month (or first of the next month)
- Provides GLOSC traceable information
- Practice Level Incentives – IF FILLED OUT APPROPRIATELY and LEGIBLE

Social Determinants of Health 2020

- Through consistent screening and racking practices helped 2181 patients in 2020.
- This is double the amount from 2019
- Highest needs:
  - TRANSPORTATION
  - CLOTHING/HOUSEHOLD
  - EMPLOYMENT/INCOME



Future

RN Care Manager

- Hired to work within a local hospital
- Bridge the gap between Independent & hospital
- Working on
  - Readmissions
  - Enhancing discharge handoff from inpatient to outpatient

SDOH

- Streamline
  - Electronic Referral
  - Human Hubs in every county (Nonprofits)

Questions?

Michigan Value Collaborative

Upcoming Events

Virtual Workgroups

- **CHF:** 11/3, 2-3 pm
- **Joint:** 11/11, 1-2 pm
  - MARCQI speaking
- **CDM:** 11/16, 11-12 pm
- **COPD:** 12/1, 1-2 pm
- **Sepsis:** 12/7, 2-3pm
  - HMS speaking
- **Diabetes:** 12/16, 11-12 pm
  - MCTD2 speaking

2022 Semi-Annual Mtgs:

May 13, 2022

October 28, 2022

MVC
Michigan Value Collaborative