Mass General Brigham

Social Determinants of Health Screening and Referral

Medicaid ACO SDOH Overview, Epic Workflows, and Tools

March 2021

Outline

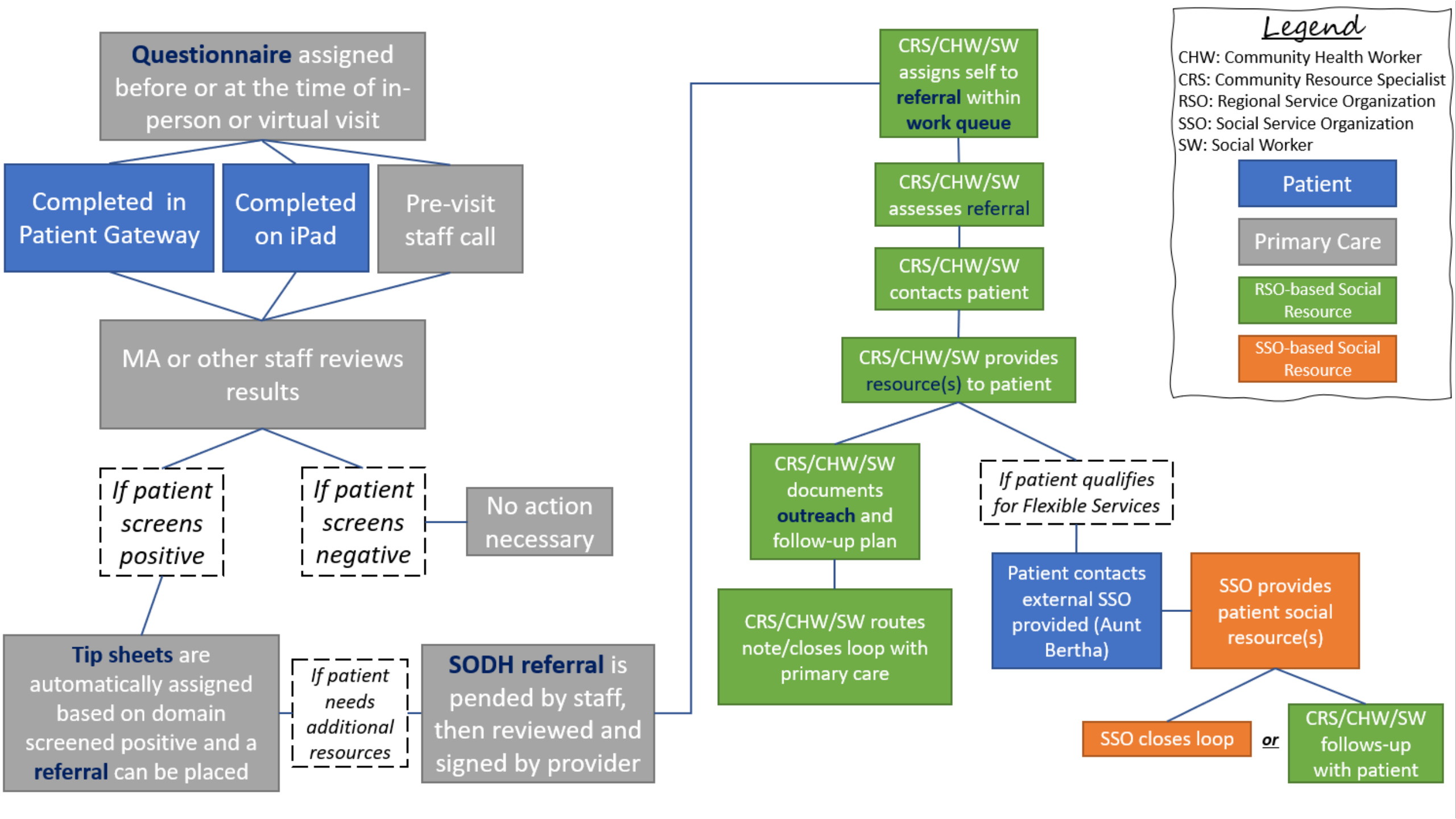
Screening and Referral Workflow

Outreach Encounter

Epic Reporting Workbench (Reports)

Tableau Dashboard

Medicaid ACO Workflows


Questionnaire assigned before or at the time of in-person or virtual visit
Completed in Patient Gateway
Completed on iPad
Pre-visit staff call
MA or other staff reviews results
If patient screens positive
If patient screens negative
No action necessary
Tip sheets are automatically assigned based on domain screened positive and a **referral** can be placed
If patient needs additional resources
SODH referral is pended by staff, then reviewed and signed by provider
CRS/CHW/SW assigns self to **referral** within **work queue**
CRS/CHW/SW assesses referral
CRS/CHW/SW contacts patient
CRS/CHW/SW provides resource(s) to patient
CRS/CHW/SW documents **outreach** and follow-up plan
CRS/CHW/SW routes note/closes loop with primary care
If patient qualifies for Flexible Services
Patient contacts external SSO provided (Aunt Bertha)
SSO provides patient social resource(s)
SSO closes loop
or
CRS/CHW/SW follows-up with patient
Legend
CHW: Community Health Worker
CRS: Community Resource Specialist
RSO: Regional Service Organization
SSO: Social Service Organization
SW: Social Worker
Patient
Primary Care
RSO-based Social Resource
SSO-based Social Resource

This form gives us more information about you and your family. Your answers will help us put more support services in place in the future.

	Has the lack of transportation kept you from medical appointments or from getting medications?	◯ Yes	◯ No		
	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	
	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	
	What is your housing situation today?	◯ I do not have housing *(staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)*	◯ I have housing	◯ I choose not to answer	
	How many times have you moved in the past 12 months?	◯ Three or more times	◯ Two times	◯ One time	◯ Zero (I did not move)	◯ I choose not to answer
	Are you worried that in the next 2 months, you may not have your own housing to live in?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble paying your heating or electricity bill?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble paying for medicines?	◯ Yes	◯ No	◯ I choose not to answer	
	Are you currently unemployed and looking for work?	◯ Yes	◯ No	◯ I choose not to answer	
	Are you interested in more education?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble with childcare or the care of a family member?	◯ Yes	◯ No	◯ I choose not to answer	
	Would you like information today about any of the following topics?				
☐ Transportation		☐ Food		☐ Housing	
☐ Paying utility bills		☐ Paying for medications		☐ Job search or training	
☐ Education		☐ Childcare		☐ Care for elder or disabled	
In the last 12 months, have you received assistance from an organization or program to help you with any of the following:					
☐ Transportation		☐ Food		☐ Housing	
☐ Paying utility bills		☐ Paying for medications		☐ Job search or training	
☐ Education		☐ Childcare		☐ Care for elder or disabled	

SDOH Screening Questionnaire Contents

- Domains of social risk
  - Food (2 questions), Housing (3 questions), Medications, Transportation, Utilities, Child or Family Care, Education, Employment
- What resources patients are already receiving
- Domains of social need
  - Would you like more information about: food resources, housing, transportation, utilities, affording medications, child or family care, education, job search or training

SDOH Questionnaire Visit Type Assignment Logic

- For in-person visits, the SDOH questionnaire is automatically assigned for:
  - New patients
  - Well visits (Annual physical, Well child)
  - Non-urgent follow up

- For virtual visits, the SDOH questionnaire is automatically assigned for:
  - New patients (Integrated Zoom and Standalone)
  - Annual physical, Well Child Visits (Integrated Zoom)

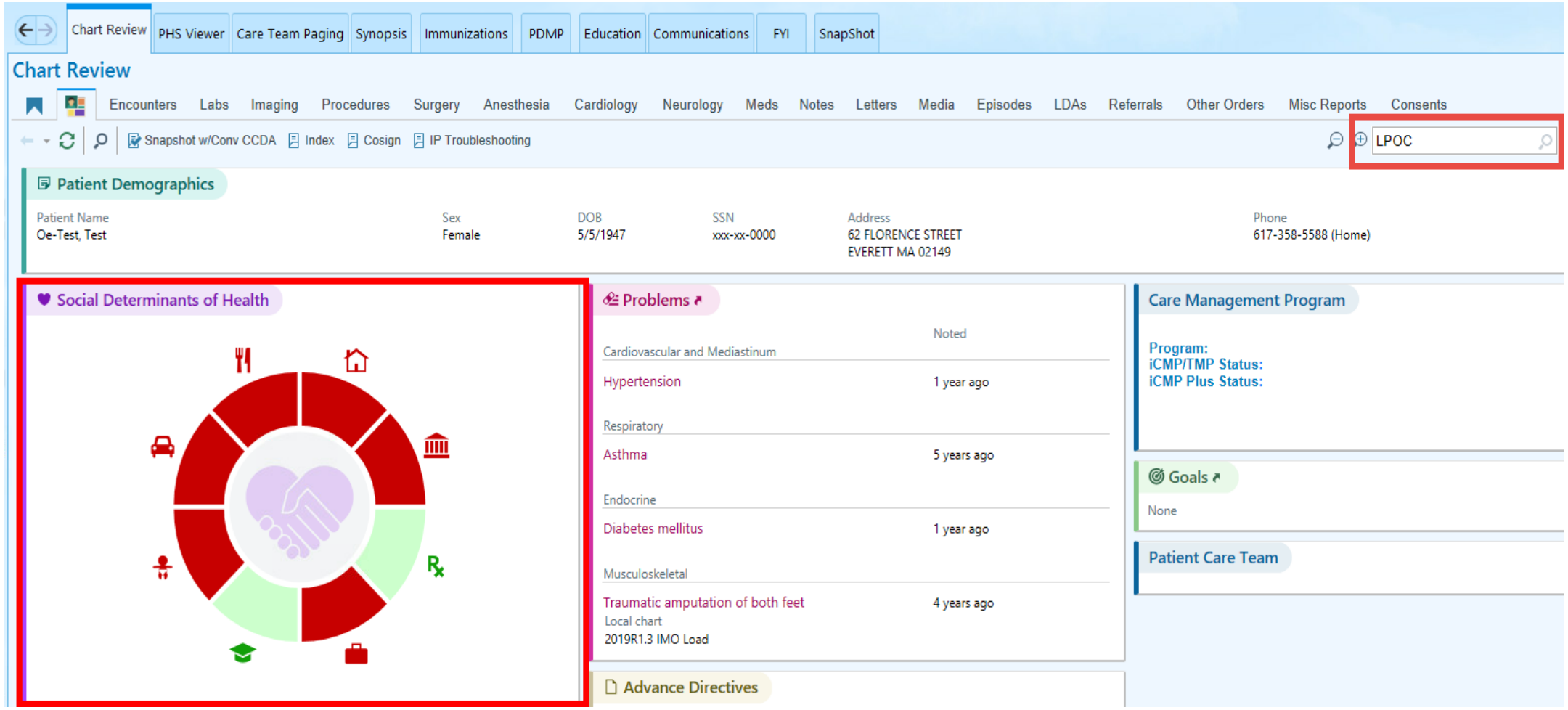
- RSOs or specific practices can add additional visit types by request

Completing the SDOH Questionnaire

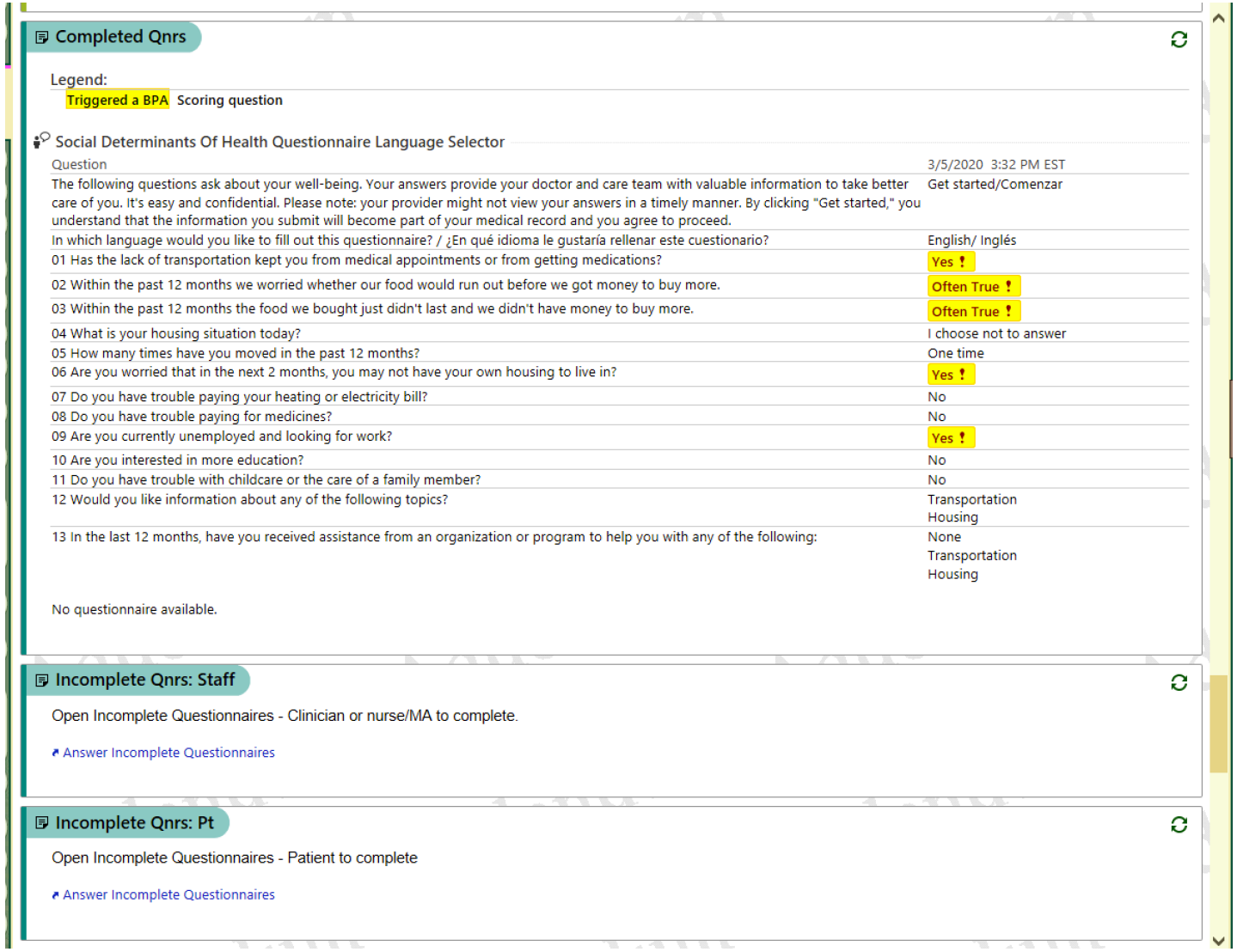
- Automatic assignment of the questionnaire allows a patient to fill out the questions on Patient Gateway before the visit or on an iPad in the waiting room.
  - Automatically assigned questionnaires will also attach the questions for staff to complete via “Incomplete Questionnaires” in the Rooming or Screening tab
  - Staff may also complete the questions on a patient’s behalf using the SDOH Color Wheel

- If an SDOH questionnaire is not automatically assigned, but staff would like a patient to have access to it, they can manually assign the questionnaire to the patient
  - Manually assigned questionnaires can be completed by the patient on Patient Gateway, or by staff using the Color Wheel or the ”Incomplete Questionnaires” section
  - Staff may manually assign if doing a proactive phone call where they screen a patient for SDOH

SDOH Color Wheel



Viewing Patient Responses – Rooming or Screening Tabs



Completed Qnrs

Legend:
Triggered a BPA Scoring question

Social Determinants Of Health Questionnaire Language Selector

Question	3/5/2020 3:32 PM EST
The following questions ask about your well-being. Your answers provide your doctor and care team with valuable information to take better care of you. It's easy and confidential. Please note: your provider might not view your answers in a timely manner. By clicking "Get started," you understand that the information you submit will become part of your medical record and you agree to proceed.	Get started/Comenzar
In which language would you like to fill out this questionnaire? / ¿En qué idioma le gustaría rellenar este cuestionario?	English/ Inglés
01 Has the lack of transportation kept you from medical appointments or from getting medications?	Yes !
02 Within the past 12 months we worried whether our food would run out before we got money to buy more.	Often True !
03 Within the past 12 months the food we bought just didn't last and we didn't have money to buy more.	Often True !
04 What is your housing situation today?	I choose not to answer
05 How many times have you moved in the past 12 months?	One time
06 Are you worried that in the next 2 months, you may not have your own housing to live in?	Yes !
07 Do you have trouble paying your heating or electricity bill?	No
08 Do you have trouble paying for medicines?	No
09 Are you currently unemployed and looking for work?	Yes !
10 Are you interested in more education?	No
11 Do you have trouble with childcare or the care of a family member?	No
12 Would you like information about any of the following topics?	Transportation Housing
13 In the last 12 months, have you received assistance from an organization or program to help you with any of the following:	None Transportation Housing

No questionnaire available.

Incomplete Qnrs: Staff

Open Incomplete Questionnaires - Clinician or nurse/MA to complete.

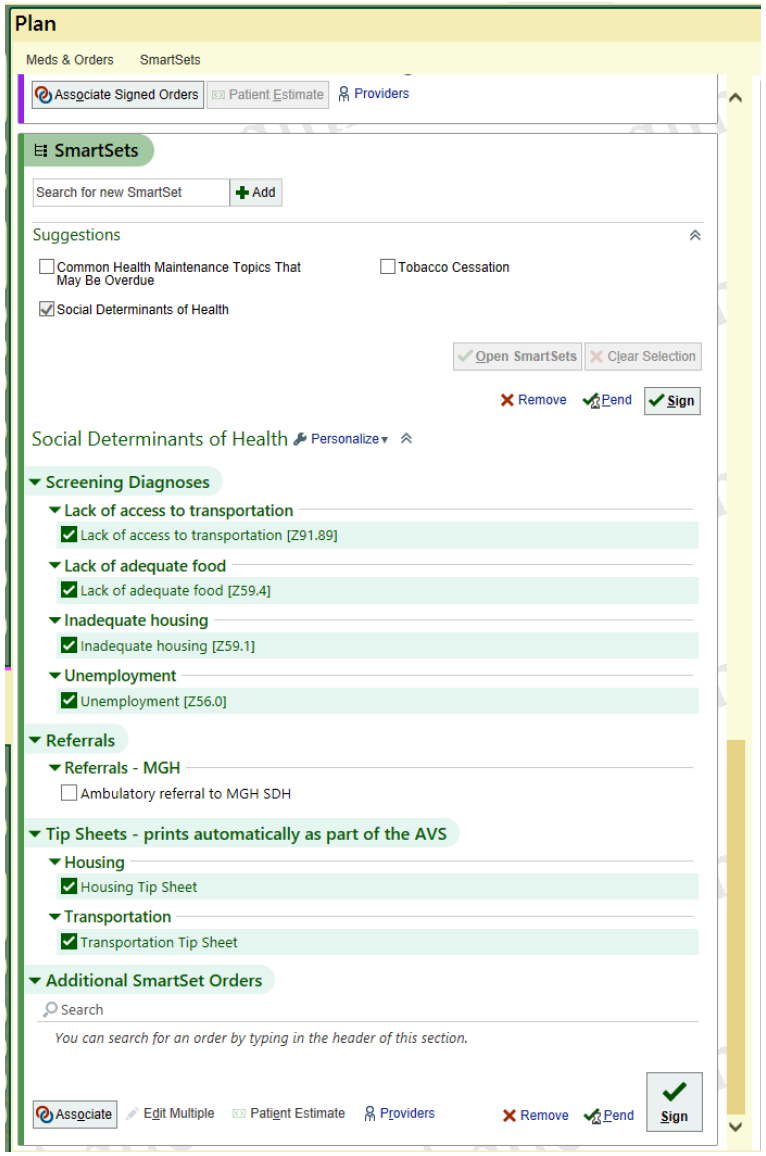
Answer Incomplete Questionnaires

Incomplete Qnrs: Pt

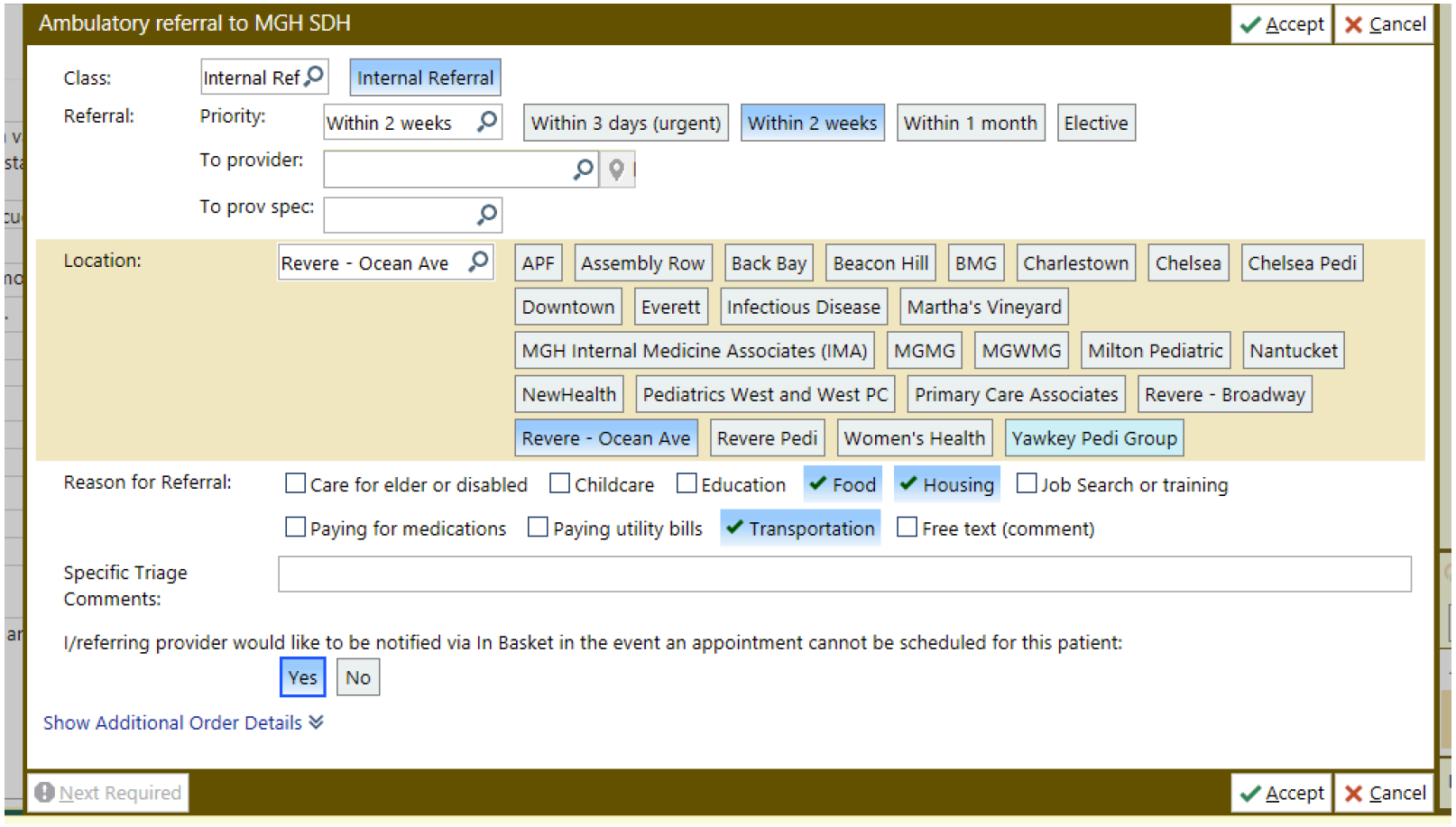
Open Incomplete Questionnaires - Patient to complete

Answer Incomplete Questionnaires

SDOH Order Set



Provider Referral to SDOH



Outreach Encounter

SDOH Referral Workqueue and Outreach

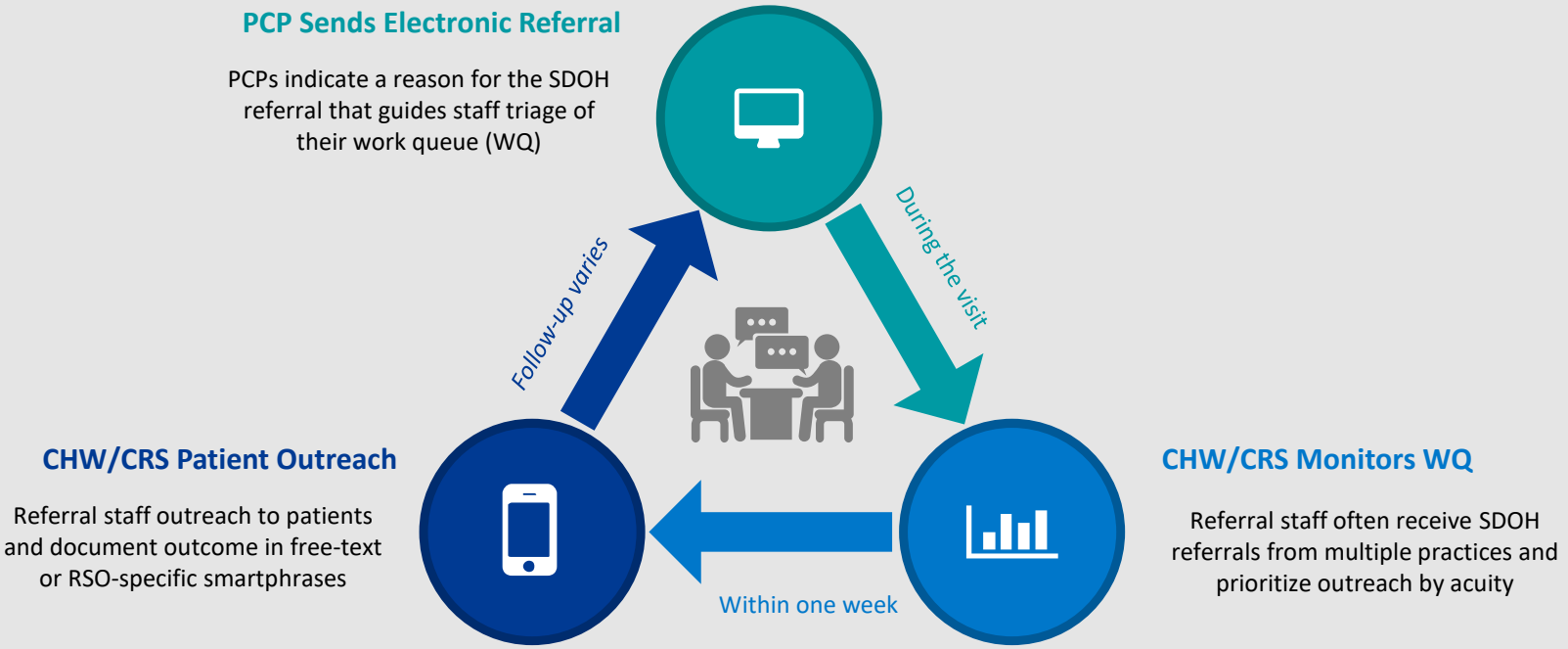
- After an SDOH referral order is placed, the referral appears in a workqueue
  - Referral workqueues are monitored by a Community Resources Specialist (CRS), Community Resource Navigator (CRN), Community Health Worker (CHW), or Social Worker (SW)
- Referral staff document outreach attempts and what resources were provided to the patient
- Currently documentation and tracking practices vary by RSO
- SDOH Outreach Encounter is currently being implemented to standardize this work
- Structured data from the Outreach Encounter flows to a consolidated report, with plans to include in future Tableau Dashboard updates

SDOH Outreach Encounter

Closed Loop Documentation in Epic

Problem Statement

The central SDOH build does not facilitate closed-loop referral documentation to easily communicate the referral outcome to the care team or to collect data for process improvement



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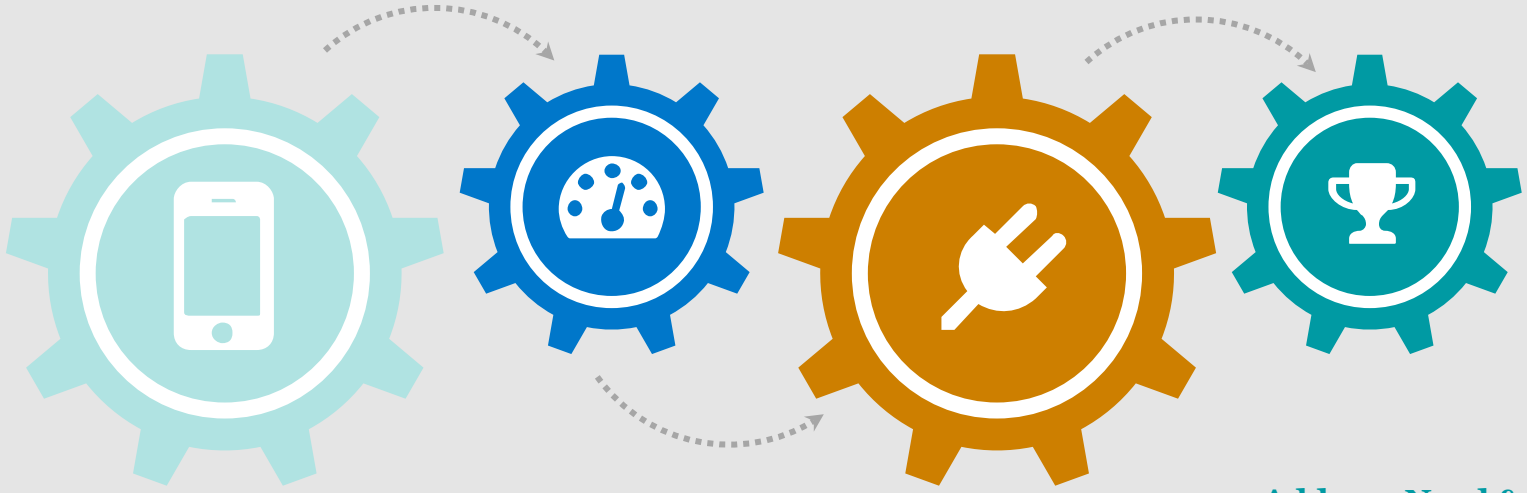
SDOH Outreach Encounter

Closed Loop Documentation in Epic

Proposed Solution

Development of a patient outreach encounter for SDOH referral staff in Epic with structured, discrete fields for documentation that can be routed back to the PCP



Outreach to Patient
Referral staff would indicate the type of outreach encounter and whether the patient was reached

Assess Need & Resource Eligibility
Referral staff would confirm the patient's needs and ask about resources the patient is using

Connect to Resource
Referral staff would indicate to which resource(s) they were able to connect the patient during the encounter

Address Need & Confirm Connection
Referral staff would follow-up on if resources could be accessed and if patient's need were met

Visibility of these efforts is key to enable care planning and coordination

SDOH Outreach Encounter in Epic

Initial

- Document outreach attempts by phone or in person
- Confirmation of health-related social needs
- Document if patient would like resources
  - If not, why not
- What resources the patient is already using (eg, SNAP)
- What resources were provided to the patient and how
  - Eg Referral to Project Bread, material sent by Patient Gateway
- Follow up plan

Follow up

- Was patient able to access resources
  - If not, why not
- Do they have ongoing needs and would they like additional resources for those needs
- Follow up plan

Outreach Encounter Resources

- Tip sheets available through Central Team and eCare
- Video demonstration of workflow - https://web.microsoftstream.com/channel/dcfc4d2e-f460-4c77-b0aa-4aa6253ecf35

Epic Reports

Uses of Epic Reports

- Identify patients in last 90 days who have screened positive or requested more information
- Check that patients who have screened positive had referral placed if needed
  - RSOs run reports regularly to find missed patients
- There are 2 main reports now used in SDOH workflows:
  - **PHM Consolidated SDOH**
    - Information on screening, referral, and outreach phases of SDOH workflow
  - **PHM Flexible Services Screening Identification**
    - Identifies patients with food or housing insecurity and Flex eligible medical conditions

Consolidated SDOH Report

Population – Completed Questionnaire OR Referral Placed

Patient ID

- Patient Name
- MRN
- DOB
- PCP / Resident PCP
- PHM Program Flag
- iCMP Flag
- Payer
- Patient Portal Status
- Appointment Dept / Time
- Encounter Provider

Screening and Referral

- Food positive (any)
- Housing positive (any)
- Medication affordability
- Transportation
- Utilities
- Child care
- Employment
- Education
- Domains for more information
- Domains receiving help
- SDOH Referral Order
- Referral Location
- Referral Reason

Outreach and Follow Up

- SDOH Outreach Status
- Domains Addressed
- Resources Provided
- On-Going Needs
- Last Contact Date
- Next Contact Date

Flexible Services Report

PHM Flexible Services Screening Identification

- Patient Name, MRN, CSN, DOB
- Department, Encounter provider, Appointment Time
- Flexible Services Enrollment Status, iCMP Status
- Positive for any SDOH food screening, Positive for any SDOH housing screening
- Response to request for more information
  - Lists specific domains
- Problem List
  - Used to identify qualifying chronic conditions
- Disease-specific eligibility information
  - Last BP value and date; Last HbA1c value and date; Last PHQ-9 score and date; Last GAD-7 score and date; Last BMI; Last pediatric BMI percentile; Dates of last ED visits; Pregnancy status

Legacy SDOH Epic Reports

- Legacy Reports –
  - Base population is patients who have completed (or partially completed) an SDOH Questionnaire
    - **PHM Pediatric Social Determinants of Health Questionnaire Responses**
    - **PHM Social Determinants of Health Questionnaire Responses**

- Limitations –
  - Patients may have referral placed without completing a screening – not in report
  - Does not yet list data elements collected through Outreach Encounter documentation

Fields Included in Legacy SDOH Reports

- Patient Name, MRN, CSN, DOB
- Department, Encounter provider, Appointment Time
- Response to 11 domain screening questions
  - Food (2), Housing (3), Medications, Transportation, Utilities, Child care, Education, Employment
- Response to request for more information
  - Lists specific domains
- Response to resources already being used
  - Lists specific domains
- SDOH Referral Order

Tableau Dashboard

Uses of Tableau Dashboard

- Reporting on operational goals over time
  - Completion rates of questionnaire, Referrals and Tip sheets
  - Quick drill down to RSO and practice levels
- Data source for research and evaluation
  - Full export capability (includes PHI) for up to 2 key personnel at each RSO

Current State – Tableau Dashboard

- Global operational metrics
  - Patients assigned questionnaire, Patient screened positive, Patients who received referral, Patients who received tip sheet
- Geography of patients who screen positive
- Completion status view
  - Age, race, ethnicity
- Positive screens and information requested by domain
  - By pedi/adult and by domain over time
- Documented referrals and tip sheets by domain
  - Comparison to positive screens

Dashboard Updates in Development

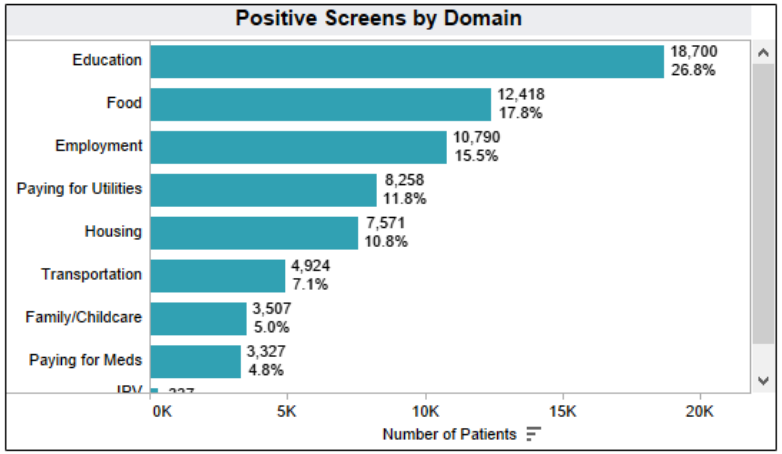
Based on RSO user feedback collected in 2020

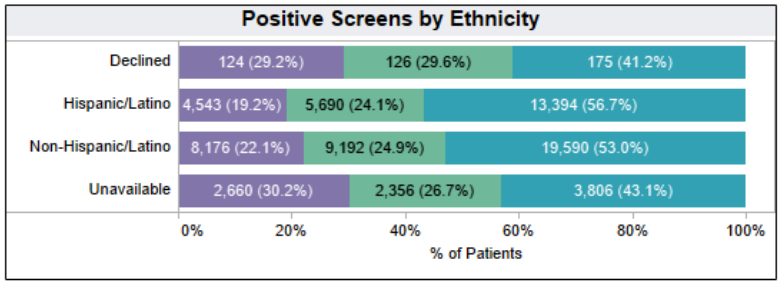
- For Medicaid ACO, information about denominator of whole ACO
  - Distribution of member age and REaL
- Completions Tab
  - Comparison by REaL
- Positives Tab
  - By patient - % positive screen, % requesting more information
  - Patients with 1, 2, 3+ positives, as well as by domain
  - Comparison by REaL
- Referrals Tab
  - By patient - % Referred or % Tip sheet out of all patients with positive screens
  - Comparison by REaL

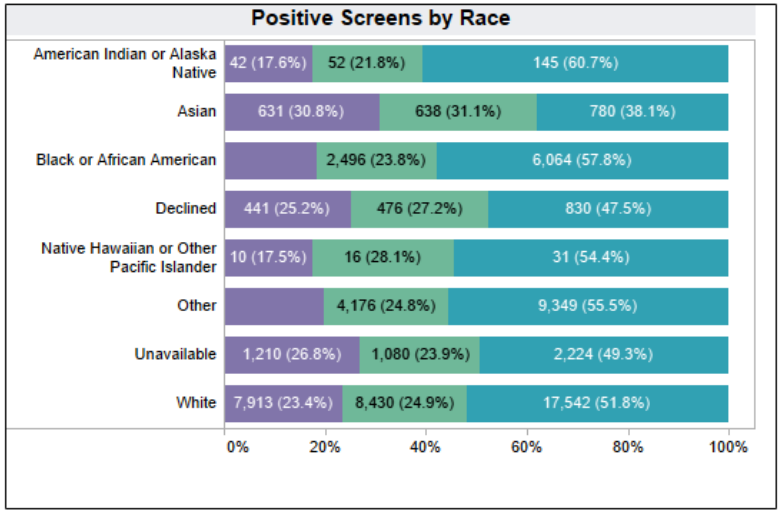
Dashboard Updates in Development

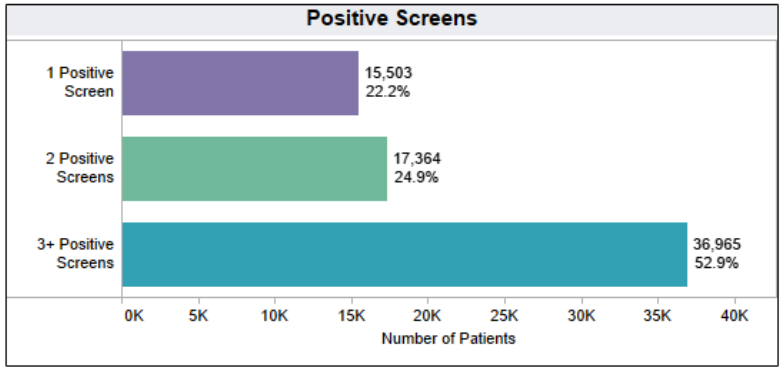
Outreach Encounter Structured Data Elements

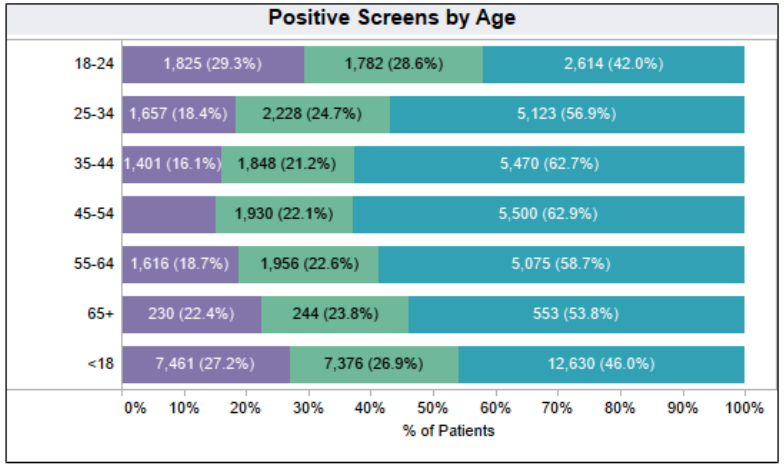
- SDOH Outreach Encounter structured data elements (SDEs)
  - Assessment / Outreach:
    - Confirmed needs, interest in engagement, resources provided (what and how)
  - Follow-up:
    - Resources accessed, needs addressed, needs ongoing, interest in further assistance

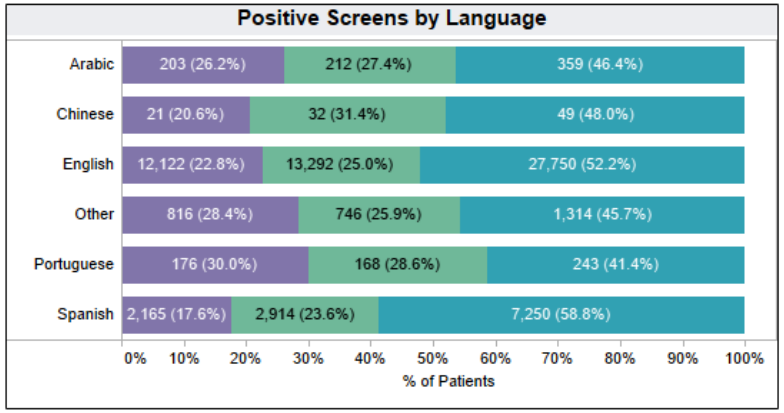

Positive Screens by Domain
Education
18,700
26.8%
Food
12,418
17.8%
Employment
10,790
15.5%
Paying for Utilities
8,258
11.8%
Housing
7,571
10.8%
Transportation
4,924
7.1%
Family/Childcare
3,507
5.0%
Paying for Meds
3,327
4.8%
0K
5K
10K
15K
20K
Number of Patients

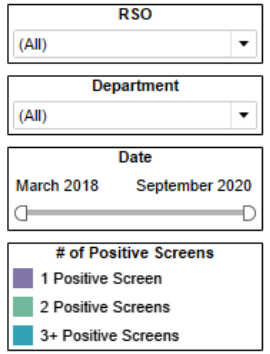

Positive Screens by Ethnicity
Declined
124 (29.2%)
126 (29.6%)
175 (41.2%)
Hispanic/Latino
4,543 (19.2%)
5,690 (24.1%)
13,394 (56.7%)
Non-Hispanic/Latino
8,176 (22.1%)
9,192 (24.9%)
19,590 (53.0%)
Unavailable
2,660 (30.2%)
2,356 (26.7%)
3,806 (43.1%)
0%
20%
40%
60%
80%
100%
% of Patients

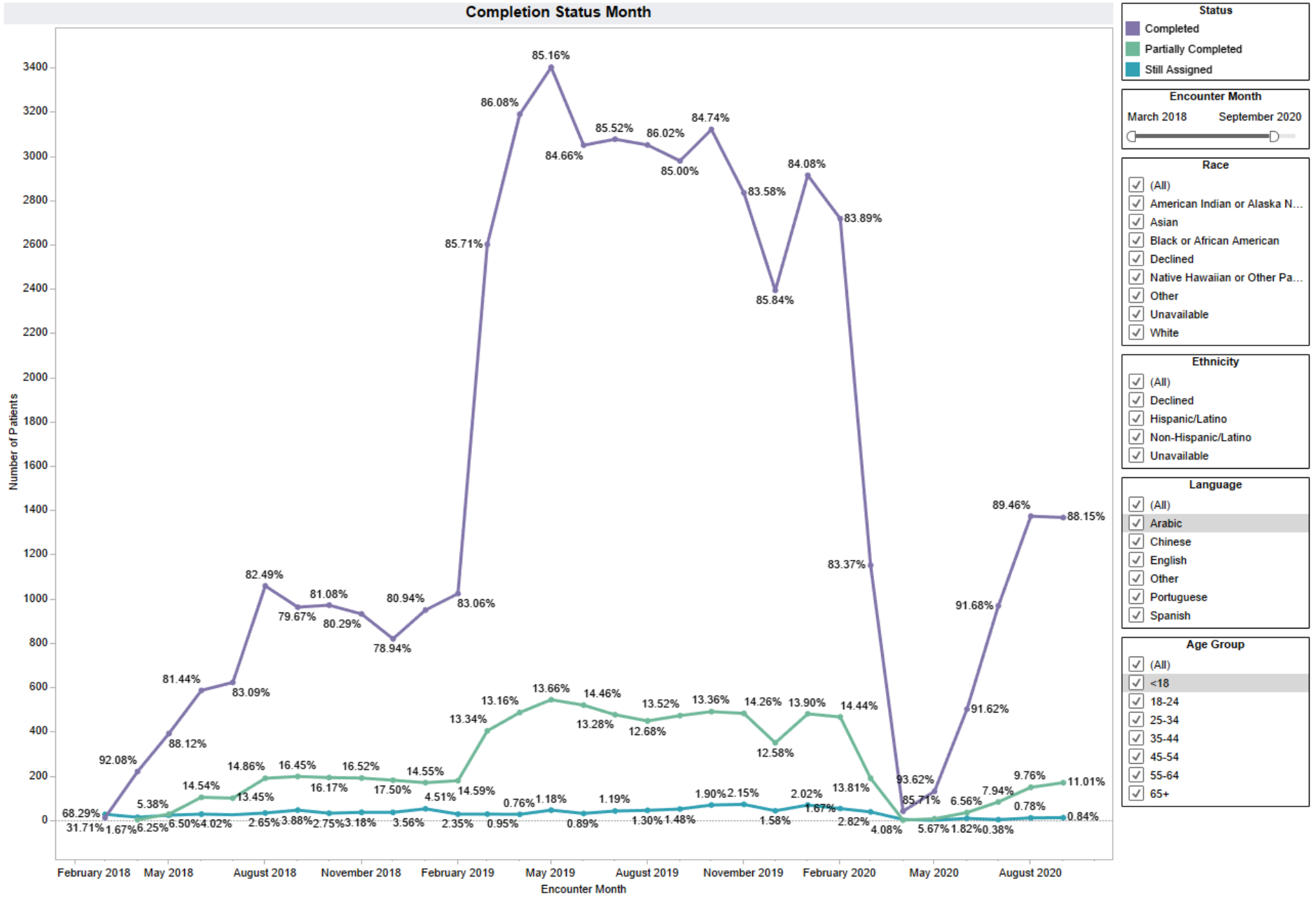

Positive Screens by Race
American Indian or Alaska Native
42 (17.6%)
52 (21.8%)
145 (60.7%)
Asian
631 (30.8%)
638 (31.1%)
780 (38.1%)
Black or African American
2,496 (23.8%)
6,064 (57.8%)
Declined
441 (25.2%)
476 (27.2%)
830 (47.5%)
Native Hawaiian or Other Pacific Islander
10 (17.5%)
16 (28.1%)
31 (54.4%)
Other
4,176 (24.8%)
9,349 (55.5%)
Unavailable
1,210 (26.8%)
1,080 (23.9%)
2,224 (49.3%)
White
7,913 (23.4%)
8,430 (24.9%)
17,542 (51.8%)
0%
20%
40%
60%
80%
100%


Positive Screens
1 Positive Screen
15,503
22.2%
2 Positive Screens
17,364
24.9%
3+ Positive Screens
36,965
52.9%
0K
5K
10K
15K
20K
25K
30K
35K
40K
Number of Patients


Positive Screens by Age
18-24
1,825 (29.3%)
1,782 (28.6%)
2,614 (42.0%)
25-34
1,657 (18.4%)
2,228 (24.7%)
5,123 (56.9%)
35-44
1,401 (16.1%)
1,848 (21.2%)
5,470 (62.7%)
45-54
1,930 (22.1%)
5,500 (62.9%)
55-64
1,616 (18.7%)
1,956 (22.6%)
5,075 (58.7%)
65+
230 (22.4%)
244 (23.8%)
553 (53.8%)
<18
7,461 (27.2%)
7,376 (26.9%)
12,630 (46.0%)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% of Patients


Positive Screens by Language
Arabic
203 (26.2%)
212 (27.4%)
359 (46.4%)
Chinese
21 (20.6%)
32 (31.4%)
49 (48.0%)
English
12,122 (22.8%)
13,292 (25.0%)
27,750 (52.2%)
Other
816 (28.4%)
746 (25.9%)
1,314 (45.7%)
Portuguese
176 (30.0%)
168 (28.6%)
243 (41.4%)
Spanish
2,165 (17.6%)
2,914 (23.6%)
7,250 (58.8%)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% of Patients


RSO
(All)
Department
(All)
Date
March 2018
September 2020
# of Positive Screens
1 Positive Screen
2 Positive Screens
3+ Positive Screens


Completion Status Month
Number of Patients
Encounter Month
February 2018
May 2018
August 2018
November 2018
February 2019
May 2019
August 2019
November 2019
February 2020
May 2020
August 2020
Status
Completed
Partially Completed
Still Assigned
Encounter Month
March 2018
September 2020
Race
(All)
American Indian or Alaska N...
Asian
Black or African American
Declined
Native Hawaiian or Other Pa...
Other
Unavailable
White
Ethnicity
(All)
Declined
Hispanic/Latino
Non-Hispanic/Latino
Unavailable
Language
(All)
Arabic
Chinese
English
Other
Portuguese
Spanish
Age Group
(All)
<18
18-24
25-34
35-44
45-54
55-64
65+


Mass General Brigham