Screening for Health Needs

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Learning Objectives:

1. List up to 5 possible topics to consider for screening across your patient population
2. Describe an example of how multiple social factors affecting health could be screened for in a diverse patient population

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How we got started...

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- Initial identified best practices through ongoing CAFMR PCMH/QI group collaborative meetings
  - Paper vs EHR flowsheet
- Took initial list and worked with our Patient and Family Advisory Board on content and language, how to get to patients effectively
- Further vetting of form through SCL health literacy committee

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How We Used It

- Given to all patients on 1 day per week
  - Changed days over times to broaden group of patients
- Given to all patients throughout week coming in for TCM, ED follow-up, OB intake
- Scored by Care Managers
  - Ideally at time of visit
  - Score >10 triggers automatic consult with CM team

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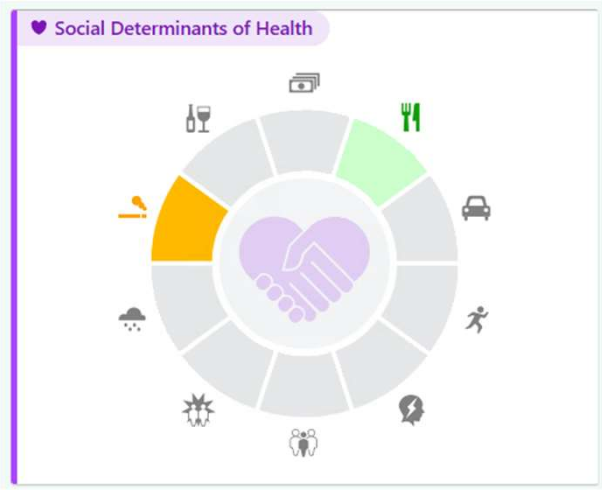
Slide 3

1 I think we can have handouts of the form, rather than put on a slide?
Jonathan Burdick, 10/13/2019

Next Steps...

- Lessons learned:
  - Screening is useful in identifying previously unknown needs
  - Whole team effort
  - Difficult to get all patient population screened

- Epic upgrade Fall 2019:
  - New functionality of SDOH wheel and Plan of Care report



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Identifying Care Gaps

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Learning Objectives

1. List potential causes for care gaps across various SDOH factors
2. Describe several limitations and challenges that exist in using data to identify care gaps across patient populations
3. Describe a process you might use for using data to identify preventive care gaps in your patient population

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How we got started

- Bruner has a large patient population that includes a large proportion of uninsured and underinsured
  - ~50% Medicaid
  - ~30% Uninsured
- Multiple parties emphasizing the need provide providers data on health disparities
  - ACGME
  - CPC+
  - PCMH

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What the data showed...

			Black or African American			Other			White or Caucasian	
Blue		No	20	40.82%		89	46.35%		83	49.70%
		Yes	29	59.18%		103	53.65%		84	50.30%
		Total	49			192			167	
Green		No	30	45.45%		79	42.70%		87	50.29%
		Yes	36	54.55%		106	57.30%		86	49.71%
		Total	66			185			173	
Red		No	17	38.64%		77	45.29%		70	48.95%
		Yes	27	61.36%		93	54.71%		73	51.05%
		Total	44			170			143	

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Challenges

- Data:
  - Not “clean” data
    - Blanks
    - Multiple races/ethnicities listed
  - Required multiple layers of manipulation and exclusion
  - Limited to single preventive measure

- Providers:
  - Low individual patients per provider numbers, so wide range of percentage disparate gaps

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Next Steps...

- Get Providers individualized data
- Include multiple preventive measures
- Break down by more than race:
  - Language
  - Payer
  - ? other

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