Beyond Vitals: Bridging Care Gaps

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Framework for today's Discussion

- Social and Environmental Factors that Influence Health Outcomes
- Nursing Perspectives
- CMS and TJC Health Equity Requirements
- Meaningful Use Attestation – Hospital Inpatient Quality Reporting program
- Utilization of SDoH and HRSN Data to Drive Strategic Initiatives to Eliminate Health Disparities

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What are we talking about?

- SDoH – Social Drivers/Determinants of Health
  - Conditions in which people are born, grow, live, work, and age, which are shaped by socioeconomic factors, environmental conditions, and other social influences. SDOH include factors such as access to healthcare, education, employment, socioeconomic status, social support networks, and the physical environment.
- HRSN – Health Related Social Needs
  - Social, economic, and environmental factors that significantly impact a person's health outcomes. HRSN includes factors such as housing, food insecurity, transportation, education/literacy, employment/income, social support, community safety, and access to healthcare
  - TJC uses the term HRSN instead of social determinants of health (SDOH) to emphasize that HRSNs are a proximate cause of poor health outcomes for individual patients as opposed to SDOH, which is a term better suited for describing populations

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Demographic Classifications

- REAL – Race, Ethnicity, and Language
  - Demographic information related to an individual's racial or ethnic background and the language(s) they speak that helps identify healthcare disparities and tailor services to meet diverse population needs.
- SOGI – Sexual Orientation and Gender Identity
  - Information about a person's sexual orientation and gender identity which is important for providing inclusive and culturally competent healthcare services.

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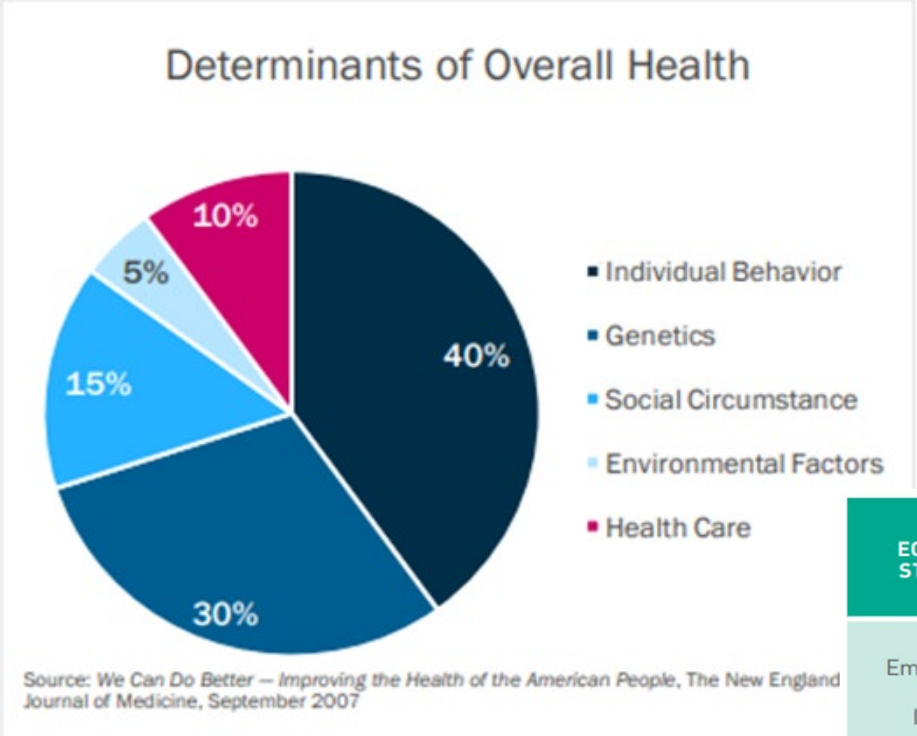
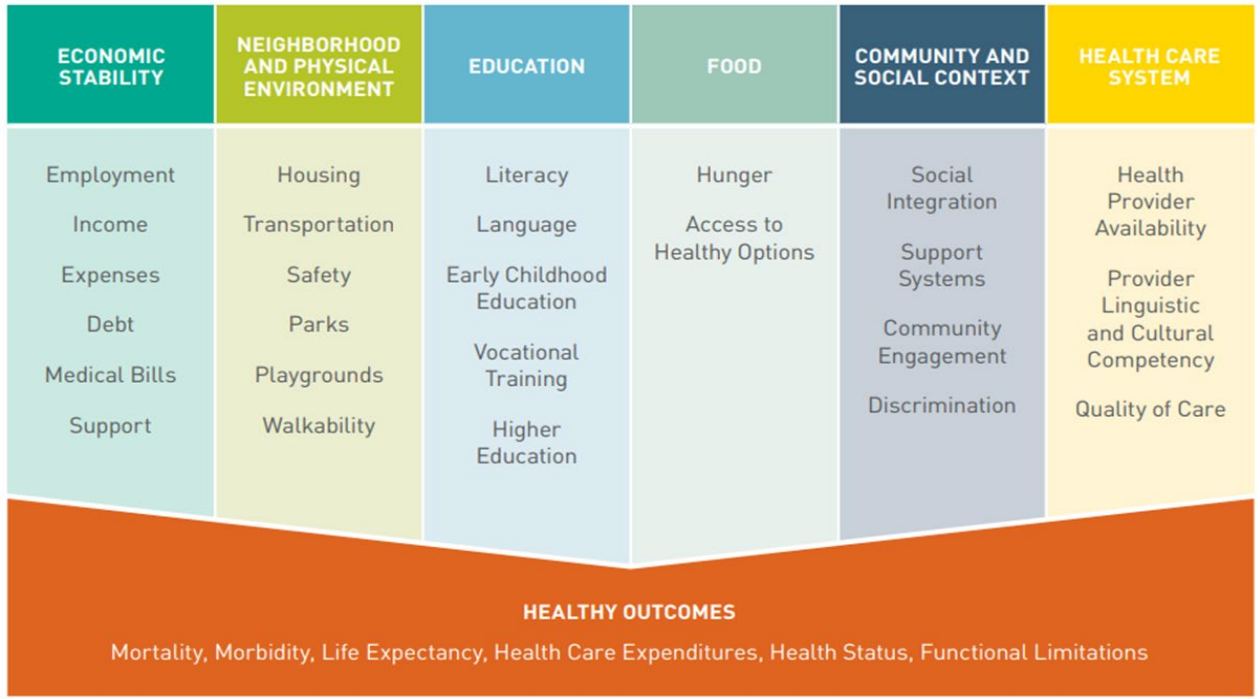
Why SDoH Screening?



Social determinants of health (SDOH) are the conditions in which people are born, live, learn, work, play, worship, and age that affects a wide range of health, functioning, and quality-of-life outcomes and risks.

Health care only contributes to 10-20% of a person's health.



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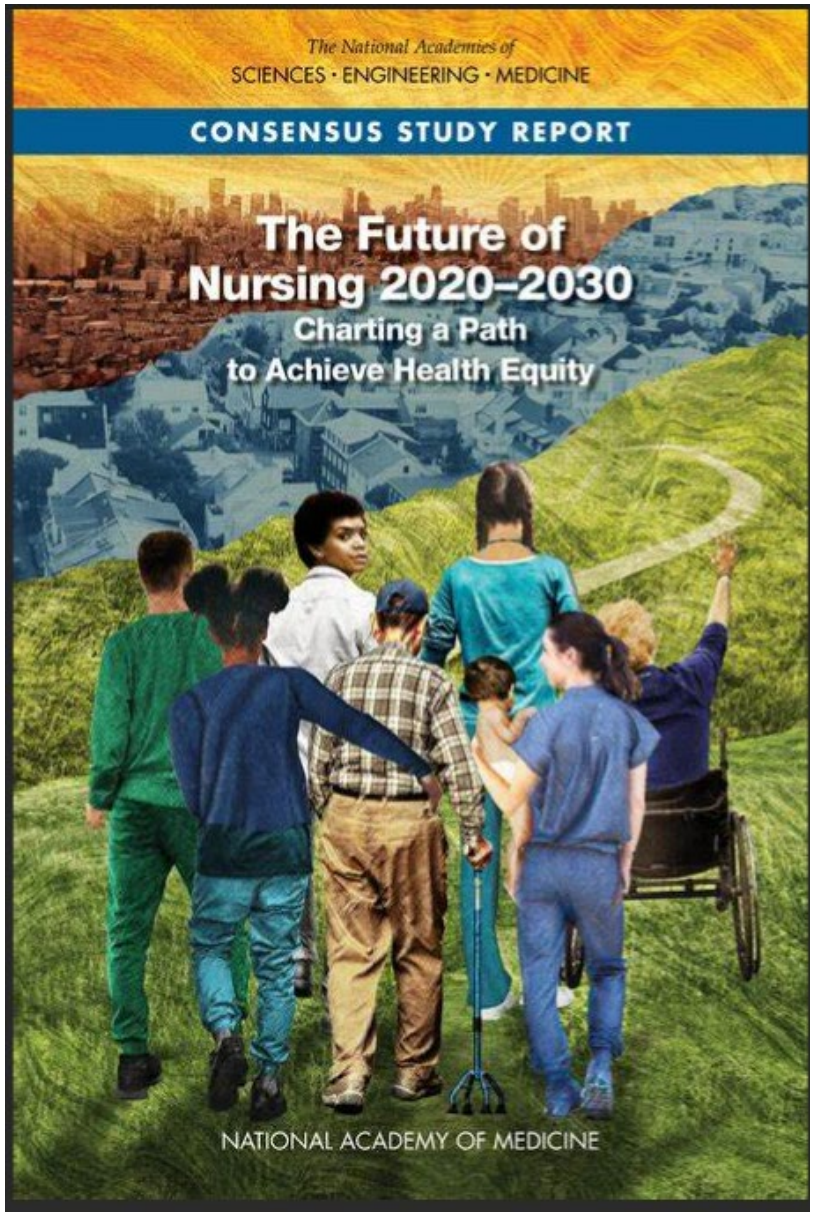
Nursing Perspectives



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Health Care Professionals' Perspectives on Universal Screening of Social Determinants of Health: A Mixed-Methods Study

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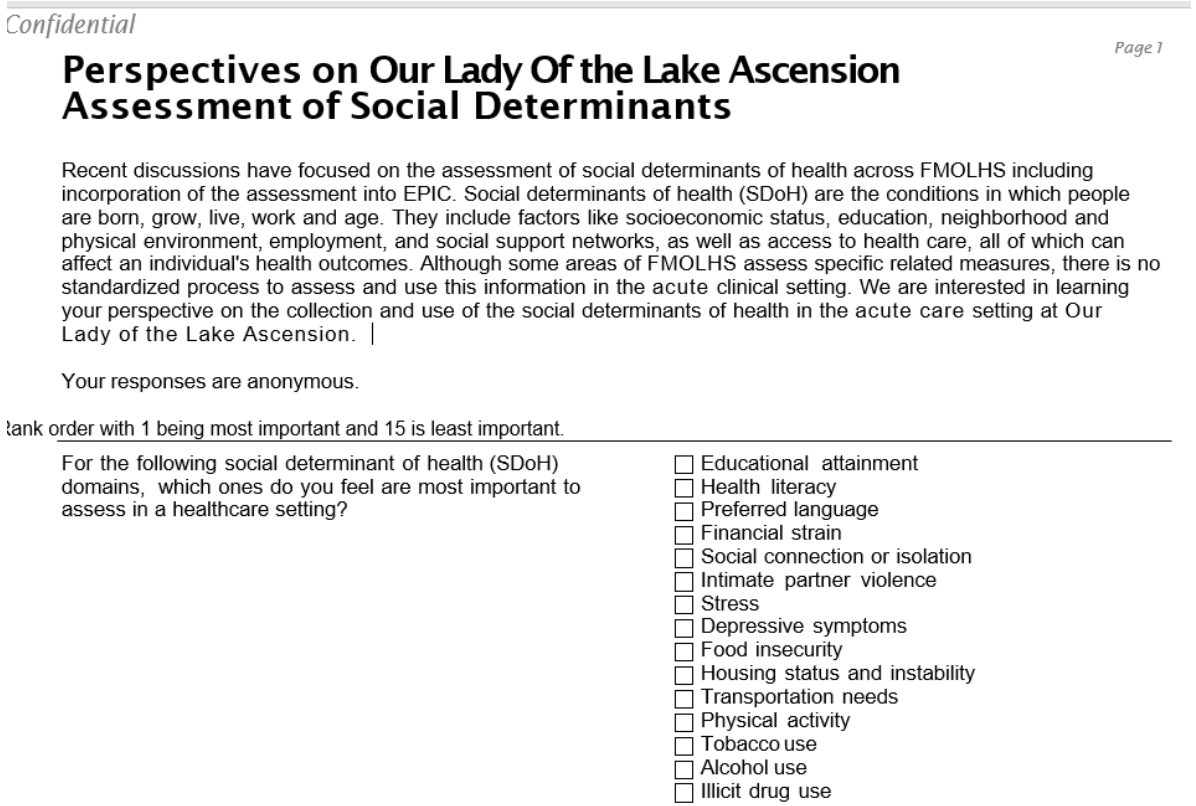
Nursing Perspectives – One Organization's Journey



Confidential

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Perspectives on Our Lady Of the Lake Ascension Assessment of Social Determinants

Recent discussions have focused on the assessment of social determinants of health across FMOLHS including incorporation of the assessment into EPIC. Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care, all of which can affect an individual's health outcomes. Although some areas of FMOLHS assess specific related measures, there is no standardized process to assess and use this information in the acute clinical setting. We are interested in learning your perspective on the collection and use of the social determinants of health in the acute care setting at Our Lady of the Lake Ascension.

Your responses are anonymous.

Rank order with 1 being most important and 15 is least important.

For the following social determinant of health (SDoH) domains, which ones do you feel are most important to assess in a healthcare setting?

- ☐ Educational attainment
- ☐ Health literacy
- ☐ Preferred language
- ☐ Financial strain
- ☐ Social connection or isolation
- ☐ Intimate partner violence
- ☐ Stress
- ☐ Depressive symptoms
- ☐ Food insecurity
- ☐ Housing status and instability
- ☐ Transportation needs
- ☐ Physical activity
- ☐ Tobacco use
- ☐ Alcohol use
- ☐ Illicit drug use

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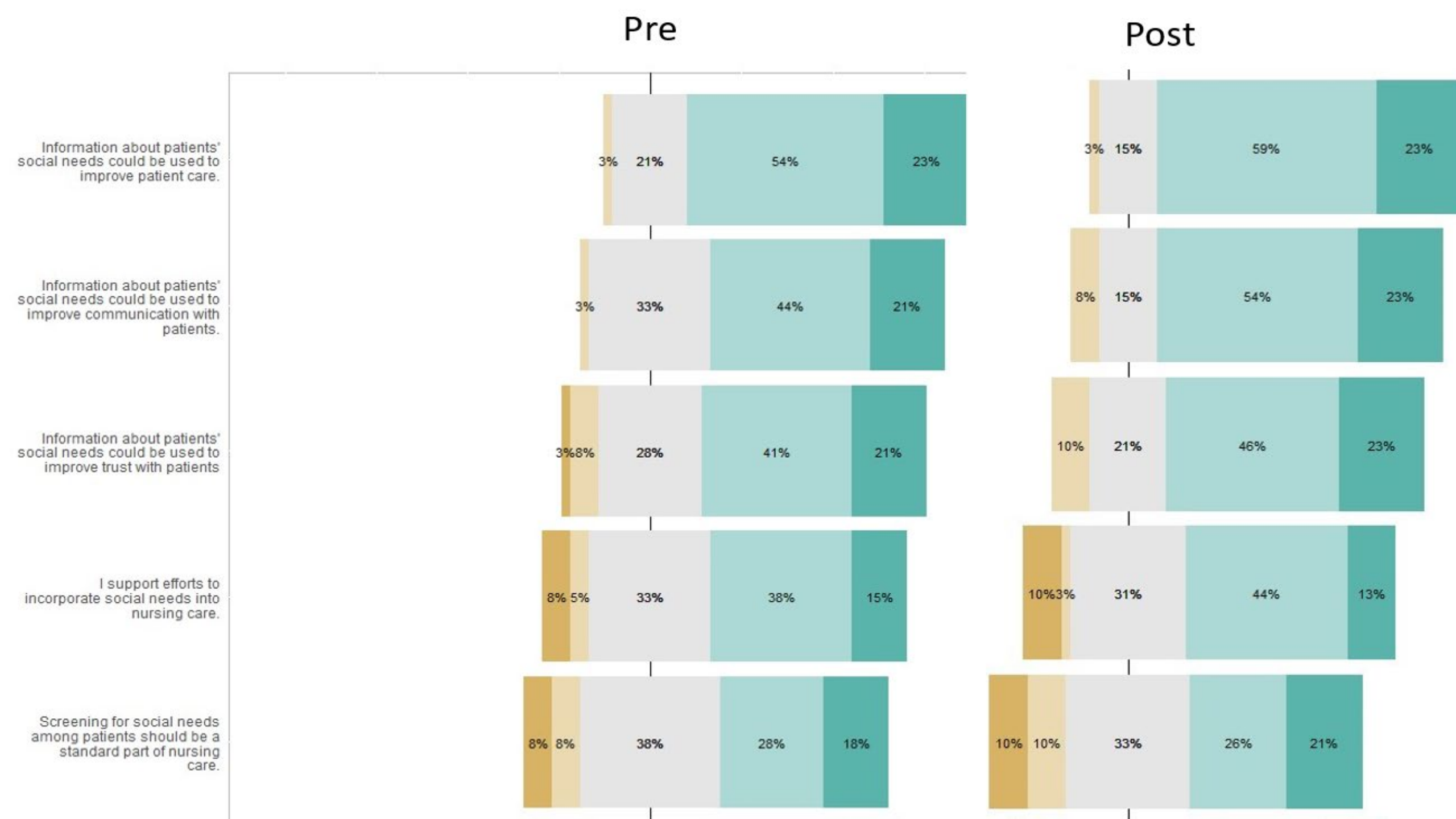
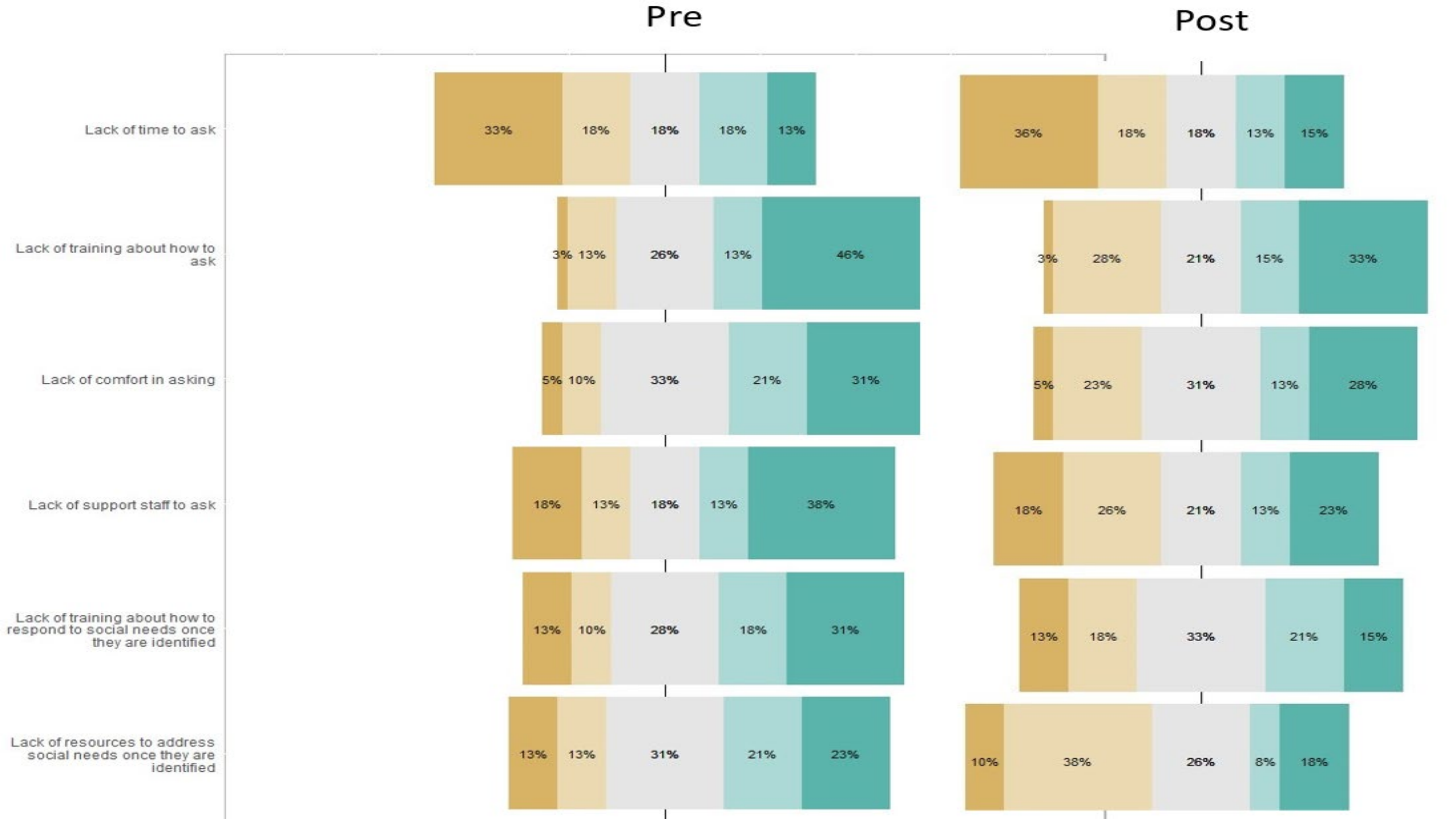

Pre
Post
Information about patients' social needs could be used to improve patient care.
3% 21% 54% 23%
3% 15% 59% 23%
Information about patients' social needs could be used to improve communication with patients.
3% 33% 44% 21%
8% 15% 54% 23%
Information about patients' social needs could be used to improve trust with patients
3% 8% 28% 41% 21%
10% 21% 46% 23%
I support efforts to incorporate social needs into nursing care.
8% 5% 33% 38% 15%
10% 3% 31% 44% 13%
Screening for social needs among patients should be a standard part of nursing care.
8% 8% 38% 28% 18%
10% 10% 33% 26% 21%


Pre
Post
Lack of time to ask
33%
18%
18%
18%
13%
36%
18%
18%
13%
15%
Lack of training about how to ask
3%
13%
26%
13%
46%
3%
28%
21%
15%
33%
Lack of comfort in asking
5%
10%
33%
21%
31%
5%
23%
31%
13%
28%
Lack of support staff to ask
18%
13%
18%
13%
38%
18%
26%
21%
13%
23%
Lack of training about how to respond to social needs once they are identified
13%
10%
28%
18%
31%
13%
18%
33%
21%
15%
Lack of resources to address social needs once they are identified
13%
13%
31%
21%
23%
10%
38%
26%
8%
18%

Screening Questions for Social Determinants Of Health

How We Care for the Whole Person

We are called to care for the whole person, and the more we know about you, the better we can care for you. We know there are many things that affect your health in addition to the issues that prompted this visit to the hospital. Research shows that 80% of a person's health is determined by factors other than illness or medical conditions. These factors are referred to as Social Determinants of Health.

For us to identify what these factors might access your MyChart to answer questions related to your social conditions. If you do not have access to your MyChart, one of our team members will ask the questions, which include topics such as:

- Housing stability
- Food insecurity
- Utilities
- Transportation needs
- Intimate partner violence

For any identified needs, our team will connect you with resources that can help you address them.

We Listen. We Heal.

Housing Stability

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

☐ Yes ☐ No ☐ I prefer not to answer

In the last 12 months, how many places have you lived?

# of places lived: _____

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?

☐ Yes ☐ No ☐ I prefer not to answer

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or fro getting medications?

☐ Yes ☐ No ☐ I prefer not to answer

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

☐ Yes ☐ No ☐ I prefer not to answer

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got the money to buy more.

☐ Never true ☐ Sometimes true

☐ Often true ☐ I prefer not to answer

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

☐ Never true ☐ Sometimes true

☐ Often true ☐ I prefer not to answer

Utilities

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Currently without services

☐ I prefer not to answer

Intimate Partner Violence

Within the last year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ I prefer not to answer

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

☐ Yes ☐ No ☐ I prefer not to answer

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

☐ Yes ☐ No ☐ I prefer not to answer

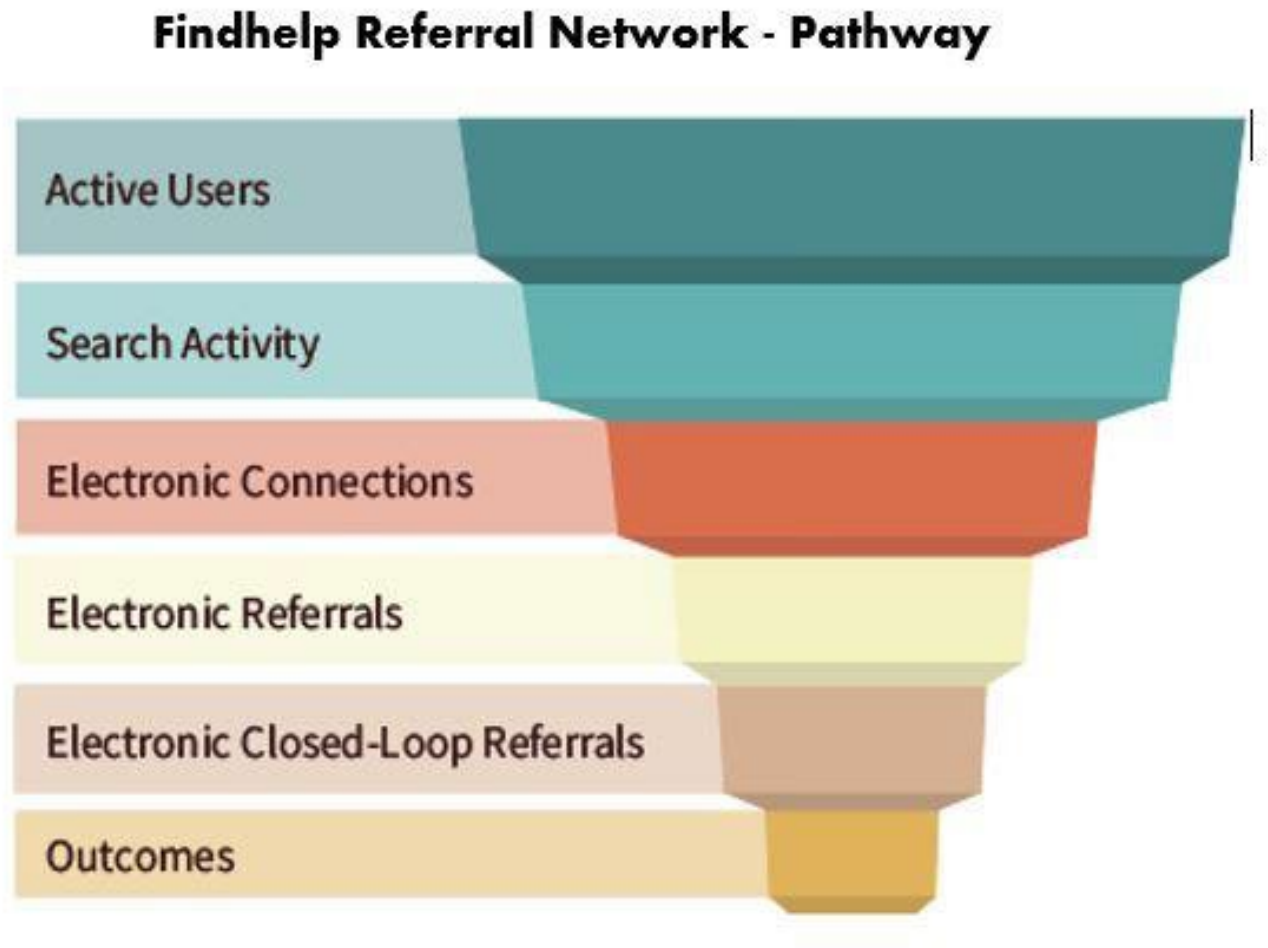
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

☐ Yes ☐ No ☐ I prefer not to answer

Questions meet CMS and TJC Regulatory Reporting Requirements

Decreased questions in Nursing Admission from 17 To 11

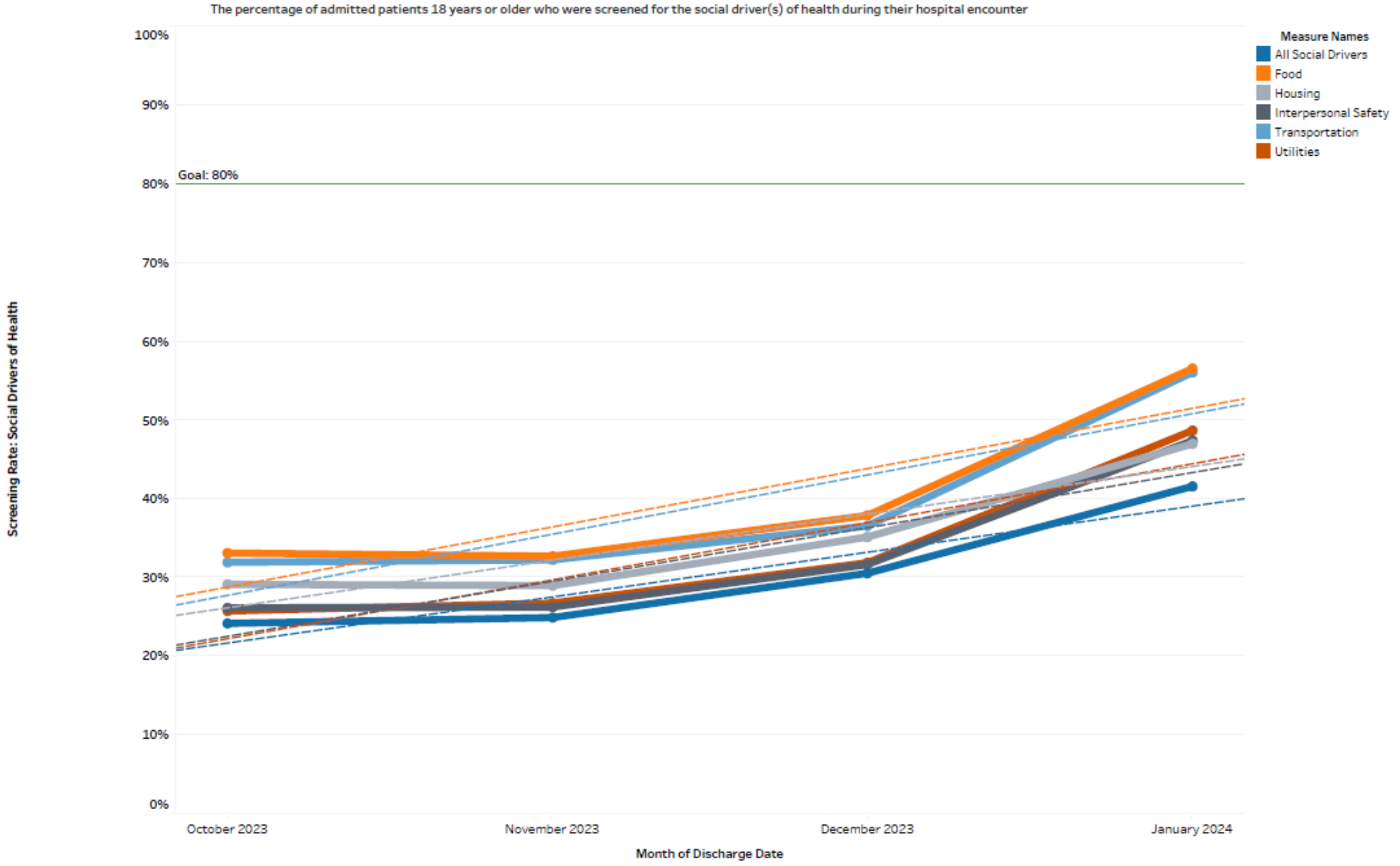
Referral Management Systems



Progress in Screening

- Barriers to Screening identified and addressed
  - Within the scope of nursing practice
  - Comfort, confidence and time
  - Resources
  - Standardized social needs assessment screening tool
    - Kostelanetz, et al. (2021)
- Best Practices for Screening and Referral
  - Screening tool embedded in an electronic health record
  - Integrated into current workflows
  - Universal screening of all patients
  - Referrals are easily accessible and relevant
  - Staff workflows incorporate screening time
  - Track and report utilization of screening tool
    - Berry, et al. (2020)

Screening Rates by Month_Trendline: OLOLRMC & OLOL Ascension Adult Inpatient Units



The trends of All Social Drivers, Food, Housing, Interpersonal Safety, Transportation and Utilities for Discharge Date Month. Color shows details about All Social Drivers, Food, Housing, Interpersonal Safety, Transportation and Utilities. The data is filtered on Discharge Date, Discharge Date Year and Department and Cost Center. The Discharge Date filter includes the last 12 months. The filter associated with this field ranges from 3/1/2023 to 2/29/2024. The Discharge Date Year filter ranges from 2023 to 2024. The Department and Cost Center filter has multiple members selected.

Is your institution prepared?

- Do you or your representative currently assess for social needs?
- Do you know who in your organization is charged with collecting this data?
- Do you know which systems or tools are available to collect this data?
- How are you stratifying and using this data?
- Has SDoH data been used to prioritize performance improvement?
- Is health equity a part of your organization's strategic plan/direction?

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Breaking down the CMS vs TJC Changes

			2023	2024
CMS Requirements	**HCHE:** Hospital Commitment to Health Equity Measure	NEW Process Measure with 5 Domains	Mandatory	Mandatory The 5
	SDOH-01: Screening for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory
	SDOH-02: Screen Positive Rate for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory
TJC Requirements	**Standard LD.04.03.08:** Reducing Health Disparities	NEW Standard with 6 Elements of Performance (EPs)	Mandatory	Mandatory
	Standard RC.02.01.01 EP25: Collecting Race & Ethnicity Data	Existing EP for hospitals NEW EP for critical-access hospitals and others	Mandatory	Mandatory
	Standard RI.01.01.01 EP29: Prohibiting Discrimination	Existing EP for hospitals NEW EP for critical-access hospitals and others	Mandatory	Mandatory

How to Meet Your Hospital's Health Equity Requirements | Medisolv

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Data Stratification

- Data stratification is the systematic approach of categorizing and analyzing data based on specific variables or factors (such as demographic groups or populations)
- By Stratifying SDoH data, hospitals can identify what health disparities and unique challenges exist within their patient population

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SDoH Example of Stratification

- Diabetes Outcomes Example
  - Income Stratification
    - By categorizing patients into income groups, you can examine if there are disparities in diabetes control or complications among different income levels.
  - Education Level Stratification
    - By categorizing patients into levels of education, you can examine if there are disparities in diabetes outcomes based on educational attainment.
  - Access to Healthy Food Stratification
    - By categorizing patients based on their access to healthy food options, you can examine if there are disparities in diabetes control associated with food access.
- The hospital can now identify specific patient groups that may be at higher risk for poor diabetes management due to income, education, or food access disparities.

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How Can SDoH and HRSN Data Be Used?

- Identify Disparities
  - Reveal patterns and disparities among demographic groups or populations that are disproportionately affected by certain health conditions or have higher rates of negative health outcomes
- Tailor Care
  - Tailor care plans and interventions to meet the specific needs of patients by understanding social and economic circumstances and personalizing treatment plans to address barriers to care
- Collaborate with Community Organizations
  - Identify community organizations, resources, and programs that address social determinants of care in which patients can be referred
- Care Coordination
  - Collaborate with multidisciplinary teams to ensure patients receive comprehensive care that addresses both medical and social needs

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How Can SDoH and HRSN Data Be Used? (cont)

- Targeted Interventions
  - Develop targeted interventions and programs to address the identified health disparities
- Policy and Advocacy
  - Leverage Data to advocate for policy changes that address social determinants of health and reduce health disparities at the system or community level
- Continuous Monitoring and Evaluation
  - Regularly analyze data to monitor the impact of strategic health equity initiatives and identify areas for improvement

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GREATER BATON ROUGE FOOD BANK

Member of Feeding America

Wednesday October 18, 2023 News

The Food Bank Receives $450,000 from Healthy Blue's Affiliated Foundation to Continue 'Food is Medicine' Program

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Food Is Medicine: A Presidential Advisory From the American Heart Association

Kevin G. Volpp, Seth A. Berkowitz, Shreela V. Sharma, Cheryl A.M. Anderson, LaPrincess C. Brewer, Mitchell S.V. Elkind, Christopher D. Gardner, Julie E. Gervis, Robert A. Harrington, Mario Herrero, Alice H. Lichtenstein, Mark McClellan, Jen Muse, Christina A. Roberto, Justin P.V. Zachariah and on behalf of the American Heart Association

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LONL

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Information and Resources

- SDOH_Measure_FAQs_April2023[7981].pdf
- Quality ID #487: Screening for Social Drivers of Health (cms.gov)
- R3 Report Issue 38: National Patient Safety Goal to Improve Health Care Equity | The Joint Commission
- CMS_Disparities Impact Statement_worksheet[7991].pdf
- Using-Data-to-Reduce-Disparities-2021_Final.pdf (chcs.org)
- Data Driven Care Delivery ifdhe_real_data_toolkit_1.pdf (aha.org)
- Epic's EHR Optimization Mitigates SDOH, Promotes Care Coordination (ehrintelligence.com)
- SDOH Pathways Platform Software - SDOH Solutions
- The AHC Health-Related Social Needs Screening Tool[8016].pdf
- CMS Framework for Health Equity 2022–2032
- Improving and Promoting Social Determinants of Health at a System Level | The Joint Commission

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Thank you!!

Questions?

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