Collecting and Reporting SDOH Data

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Lewis County Health System

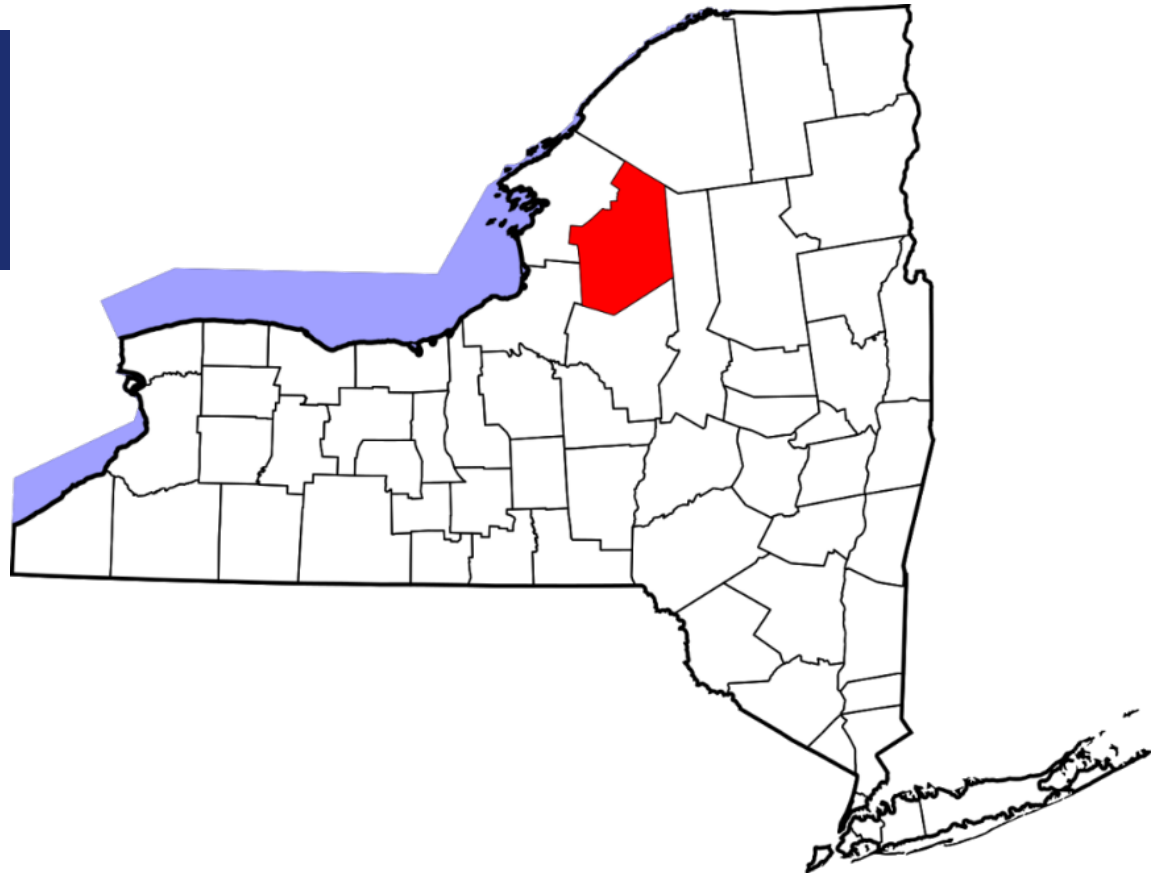
Lewis County Health System
Your Health Partner

Lewis County Health System

- Lewis County General Hospital – 25 bed Critical Access Hospital with a 24/7 ER and functioning OR.
- Primary care/specialty clinics
- Residential Healthcare Facility – 160 bed long term care/skilled nursing facility
- Home Health and Hospice

Lewis County, New York

- Population – 26,456
  - Male: 49.9%
  - Female: 50.1%
- Race/Ethnicity
  - White: 95%
  - Hispanic or Latino: 2%
  - Multiracial: 1%
  - Black, non-Hispanic : 1%
  - Other single race: 1%



Lewis County Resident Data related to SDOH

- **Education**
  - 91% of residents have at least a high school education
  - 18% have a bachelor’s degree or higher
- **Income**
  - Median household income: $56,192
- **Food insecurity**
  - 13% of households receive SNAP benefits
- **Transportation**
- **Housing**
- **Health Insurance**
- **Other**
  - lack of broad band or phone service

Implementation

Effective January 1, 2023, The Joint Commission (TJC) released the required *standard LD.04.03.08* to address health care disparities for patients as a quality and safety priority.

We are approaching implementation with a five-step plan:

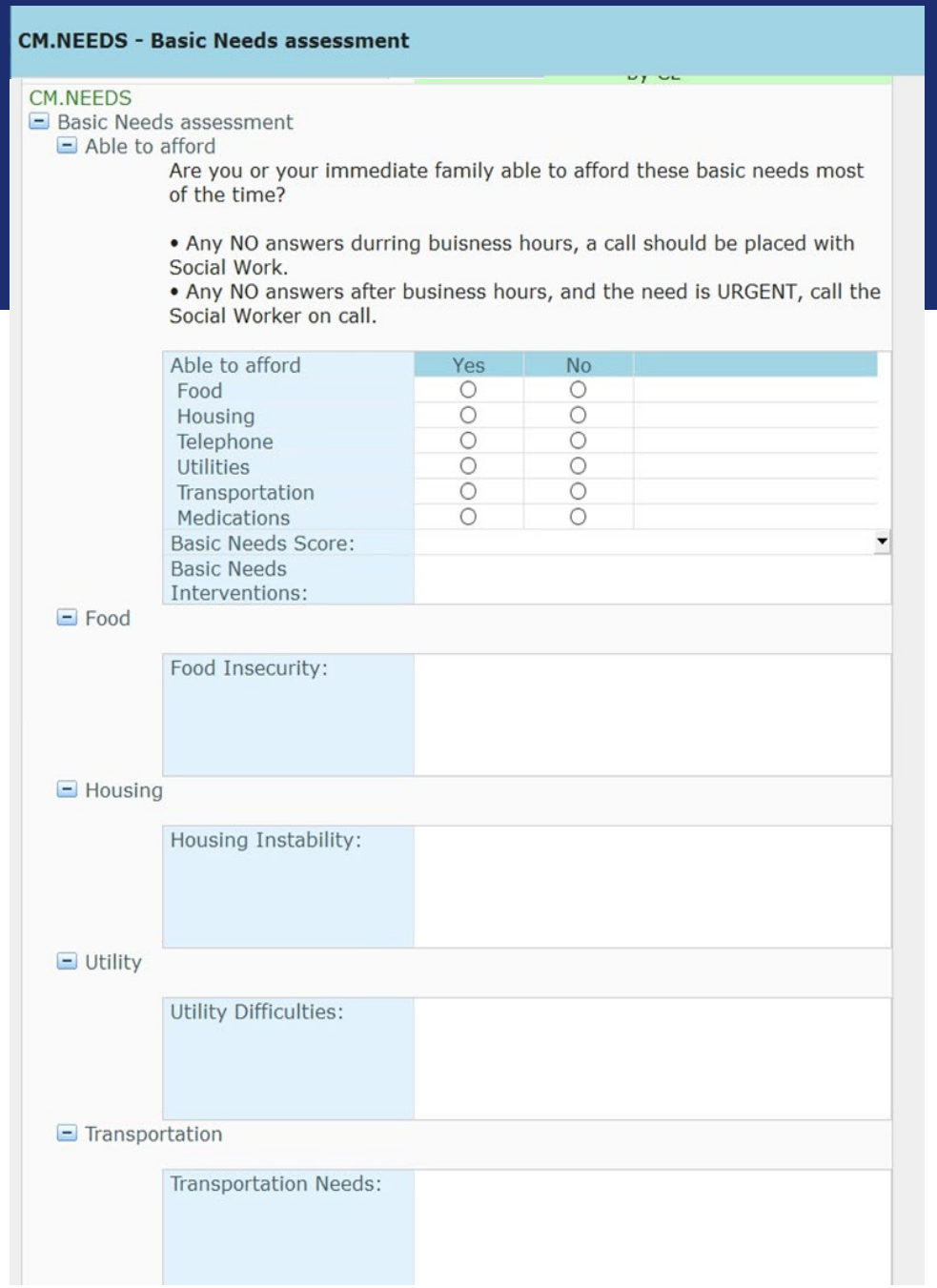
1. Regulation into policy
2. Facility Assessment
3. Revision of current intervention
4. Staff Education
5. Evaluation

Step 1: Regulation into policy

- LD.04.03.08 EP 2: The organization assesses the patient's health-related social needs and provides information about community resources and support services.
- Health related social needs based upon the needs in Lewis County include:
  - Access to transportation
  - Difficulty paying for prescriptions or medical bills
  - Education and literacy
  - Food insecurity
  - Housing insecurity
  - Utility insecurity

Step 2: Facility Assessment

- What is currently in place?
- What patient population are screening?
- What services are triggered for follow up?
- How is follow up evaluated?



CM.NEEDS - Basic Needs assessment

CM.NEEDS

Basic Needs assessment

Able to afford

Are you or your immediate family able to afford these basic needs most of the time?

- Any NO answers durring buisness hours, a call should be placed with Social Work.
- Any NO answers after business hours, and the need is URGENT, call the Social Worker on call.

Able to afford	Yes	No
Food	○	○
Housing	○	○
Telephone	○	○
Utilities	○	○
Transportation	○	○
Medications	○	○

Basic Needs Score:

Basic Needs Interventions:

Food

Food Insecurity:

Housing

Housing Instability:

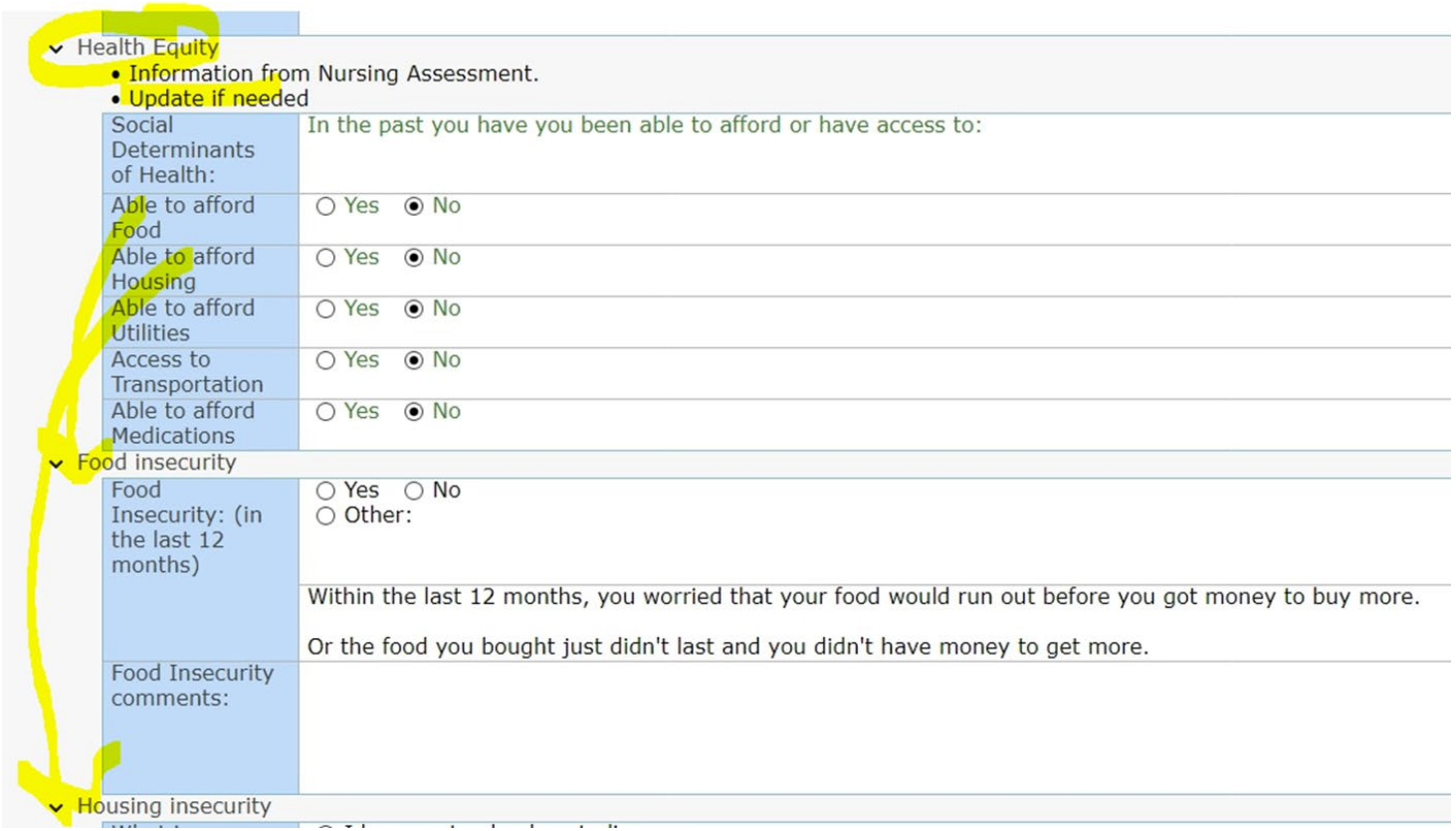
Utility

Utility Difficulties:

Transportation

Transportation Needs:

Step 3: Revision of current intervention



Health Equity

- Information from Nursing Assessment.
- Update if needed

Social Determinants of Health:	In the past you have you been able to afford or have access to:
Able to afford Food	○ Yes ◉ No
Able to afford Housing	○ Yes ◉ No
Able to afford Utilities	○ Yes ◉ No
Access to Transportation	○ Yes ◉ No
Able to afford Medications	○ Yes ◉ No

Food insecurity

Food Insecurity: (in the last 12 months)	○ Yes ○ No ○ Other:
	Within the last 12 months, you worried that your food would run out before you got money to buy more. Or the food you bought just didn't last and you didn't have money to get more.
Food Insecurity comments:	

Housing insecurity

Step 4: Staff Education

- Electronic education platform on hire and annual:
  - Social Determinants of Health (SDOH)
  - Health Equity in the health care setting
  - Cultural diversity
- Skills day

Surveillance Board

East Wing ... 17 | EW Fall Board 17 | ICU Fall Board 4 | Location - R... 21 | SDOH Surve... 3 | Add to My List | Open Hand Off | Patient Reports | Open Patient Summary

Room-Bed / Name / Service / Arrival Date	Age BirthSex / Length Of Stay / Isolation	Triggers	Reason For Visit / Attending Provider	Ord/Referral	Birthdate / Basic Needs	Basic Needs / Safety / Meds	Substance / Screening / Screen / Screening	ER Discharge/Tran / Discharge Dispositio...	Discharge / Discharge Disposition	DC	30 Day Re-Admit
289-2					09/18/1943						
[redacted]	79 M	12/05/22 13:00 Relig...	DEBILITY	09/29/22 12:08 C...	12/01/22 10:00 Basi...	Basic Needs		09/29/22			Yes
SB	84	12/01/22 10:00 Basi...	JAGANATHAN,DAISY					Admit to Critical Acce...			
09/29/22	Standard precautions					Can't Afford Meds					
290-2					10/23/1929						
[redacted]	93 M	12/22/22 02:32 Resi...	WEAKNESS, ELEVATE...	12/21/22 21:15 R...	12/22/22 02:32 Basi...	Basic Needs		12/22/22			No
OBV	1	12/22/22 02:32 Basi...	Strassburg,Alex	12/22/22 02:48 R...				Admit to Critical Acce...			
12/21/22	Droplet			12/22/22 02:48 C...		Can't Afford Meds					
294-1					08/13/1978						
[redacted]	44 M	12/21/22 22:01 Resi...	UTI		12/21/22 22:01 Basi...			12/21/22			No
OBV	1	12/21/22 22:01 Wan...	Strassburg,Alex				SBIRT	Admit to Critical Acce...			
12/21/22	Standard precautions	12/21/22 22:01 Relig...									
		. . .									

- Social work notification: Basic Needs
- Case management notification: Can't Afford Meds

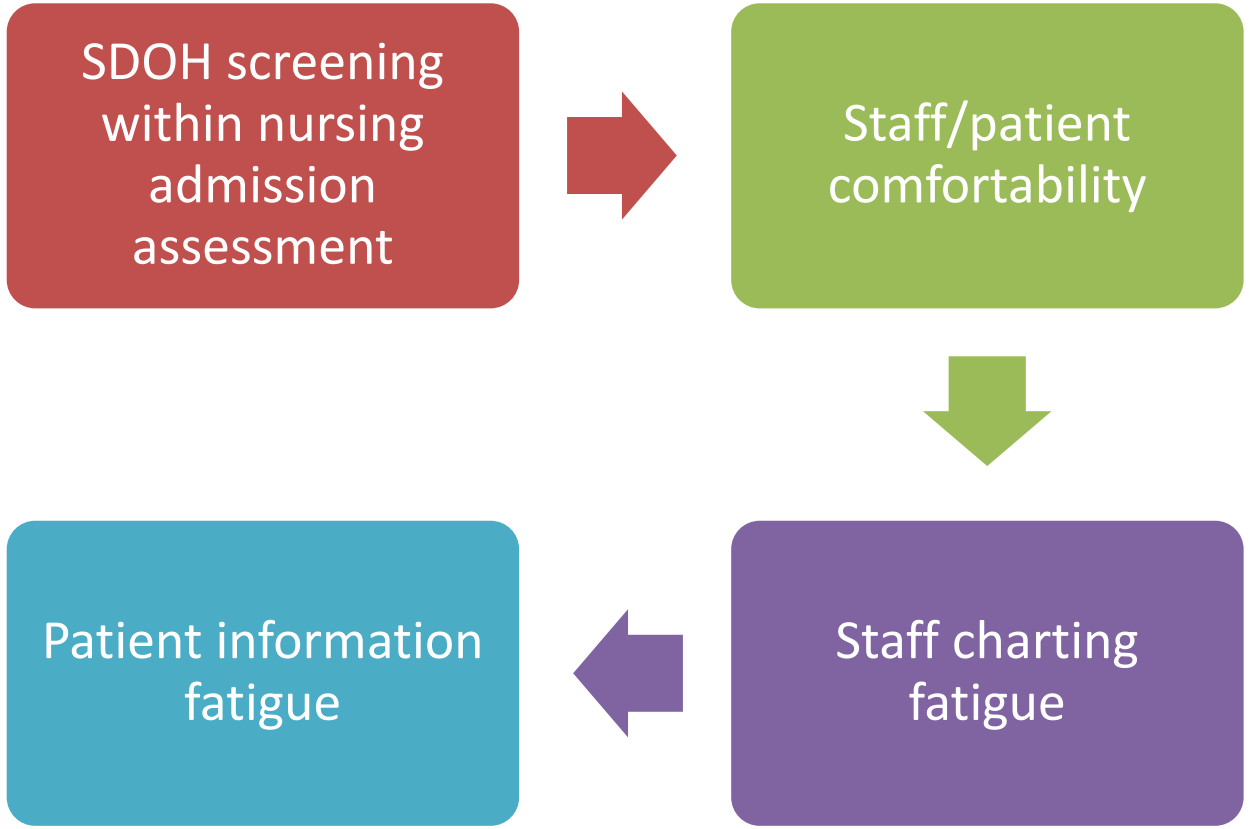
Step 5: Evaluation

- Social work/case management
- Medisolv (Encore) for data abstraction: SDOH 1 and SDOH 2

Equitable Care SDOH Measure Results

CMS ID	Alt ID	Reportable	Measure Name	Strata	Equity Strata	Initial Population	Denominator	Exclusion	Numerator	Exception	In Denominator Only	Result
CMS1186v0	SDOH-1	Yes	Screening for Social Drivers of Health		Unstratified	790	790	45	570	0	175	76.51%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Overall	Unstratified	576	576	6	9	0	561	1.58%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Food Insecurity	Unstratified	576	576	6	0	0	570	0.00%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Housing Instability	Unstratified	576	576	6	0	0	570	0.00%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Transportation Needs	Unstratified	576	576	6	2	0	568	0.35%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Utility Difficulties	Unstratified	576	576	6	0	0	570	0.00%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Interpersonal Safety	Unstratified	576	576	6	7	0	563	1.23%

Barriers


SDOH screening within nursing admission assessment
Staff/patient comfortability
Staff charting fatigue
Patient information fatigue

Process Improvement

	Care Item			Last Done	Status/ Due	Today 07:00	Today 08:30	Today 09:00	NOW	Tod 12:
A	(ADM) *Teach- Initial disease/Safety	ONCE	A I	2d	Complete					
A	(ADM) Admission Assessment Adult	ONCE	A I	2d	Complete					
A	(ADM) Immunization/Vaccine Assessment	ONCE	P I	2d	Complete					
A	(ADM) SDOH Screening Tool	ONCE	A I		-0m					
A	(ADM) Thrombosis Risk 61-75	ONCE	A I	2d	Complete					
A	(CP) Alteration in comfort plan of care	CPAM	A I	25h	Complete					
A	(CP) Care Plan Fall Risk	ONCE	A I	2d	Complete					
A	(CP) Care Plan Integumentary	CPAM	A I	22h	Complete					
A	(CP) Careplan Infection/Isolation	CPAM	A I	25h	Complete					
A	(CP) DVT/VTE Risk Protocol Plan of care	CP	A I	21h	Complete					

Process Improvement

Housing: Are you worried that in the next 2 months, you may not have a safe or stable place to live?

Utilities: In the past 6 months, has the electric, gas, oil or water company threatened to shut off your services?

Food: In the last 6 months, did you worry that your food could run out before you got money to buy more?

Transportation: In the last 6 months, has lack of transportation kept you from medical appointments or getting your medications?

Medications: In the last 6 months, did you have to skip buying medications or going to doctor's appointments to save money?

Food: In the last 6 months, did you worry that your food could run out before you got money to buy more?	○ Yes ◉ No ○ Decline ○ Unable
Housing: Are you worried that in the next 2 months, you may not have a safe or stable place to live?	◉ Yes ○ No ○ Decline ○ Unable
Utilities: In the past 6 months, has the electric, gas, oil or water company threatened to shut off your services?	○ Yes ○ No ○ Decline ◉ Unable
Transportation: In the last 6 months, has lack of transportation kept you from medical appointments or getting your medications?	○ Yes ○ No ◉ Decline ○ Unable
Medications: In the last 6 months, did you have to skip buying medications or going to doctor's appointments	○ Yes ○ No ◉ Decline ○ Unable

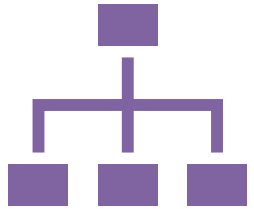
Patient flow

- Inpatient case management – Readmissions
- ER Case management – Screens all high utilizers(3 or more visits within 6 months).
  - Data is reported to Utilization review and QAPI meetings.
  - Coordinates and shares data with community organizations.
- Primary Care
- NEW: Obstetrical department

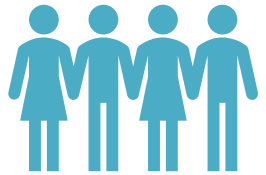
Reporting Plan

QAPI

Quality Council



Board of Managers



Community Organizations

Priorities Council

Next Steps

- “We ask because we care” campaign
  - Community education: Website, posters, brochures
  - Staff education: All staff that will interact with patients during admission; clerk, nurse

References

2022-2024 Community Health Assessment

Community Health Improvement Plan. Lewis County Public Health. https://lewiscountyny.gov/wp-content/uploads/2023/03/2022-Lewis-County-Community-Health-Assessment-Submitted.pdf

Centers for Medicare & Medicaid Services. (2022). Building an organizational response to health disparities. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf

The Joint Commission (TJC): Standard LD.04.03.08