Identifying Food Insecurity in Diabetes Population

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BronxCare Health System

BronxCare Health System

The largest voluntary, not-for-profit health and teaching hospital system serving the South and Central Bronx, with **859 beds and more than 4,500 employees**.

Two main hospital divisions, comprehensive psychiatric and chemical dependency programs, a long term care facility and an extensive outpatient network**.**

BronxCare is among the largest providers of outpatient services in NYC, with **nearly one million visits annually**.

Our emergency department is one of the busiest in New York, with **141,000 visits per year**.

BronxCare Health System

- BronxCare's service area, in the south and central Bronx, is among the poorest in the nation.
  - High disease incidence,
  - Large minority and immigrant populations,
  - Low socioeconomic status,
  - High SDOH risks,
  - 80% of the population is non-white (Hispanic and Black), and
  - 32% of the population is not proficient in English.

- BronxCare is a "safety-net" provider. We serve many Bronx residents who are on public insurance programs or are uninsured, and who have high rates of obesity, diabetes, asthma, hypertension, heart disease, mental illness and substance abuse.

- Health metrics in BronxCare's service area demonstrate **greater mortality and morbidity, and worse health outcomes than most areas in New York city and New York state**.

- BronxCare leadership is committed to addressing the health disparities and social care needs of its service area to improve overall health outcomes. We have a number of initiatives in place to do so.

Problem statement

What we wanted to address

There was no standardized practice and workflow to identify food insecure diabetic inpatients and provide needed social services

By utilizing best practices implemented in our outpatient areas, the interdisciplinary team will assess food insecurity needs in admitted patients with a medical history of diabetes.

Patients that are identified thru this assessment will be connected to community food insecurity distributors.

Gap Assessment Identified the Following:

- No automated process/workflow in the EMR for other disciplines to screen patients and refer to Social Work
- EMR did not have any type of work list or action list for Inpatient Social Work to easily identify those patients requiring intervention

Where we started (May 2022)

- Since 2021- The Hunger Vital Sign questions developed by Children's' Health Watch organization were included in The Outpatient Social Work Needs Assessment and Outpatient Nutrition Assessment templates to assess patients with diabetes.
- BronxCare team discussed whether we wanted to capture all of the SDOH, or focus on one specific aspect of SDOH.
- We assembled an inpatient team, including:
  - Health Information Management
  - Medicine and Family Medicine
  - Nursing
  - Nutrition
  - Social Work/Care Management
- We were collecting data in our EMR, but it was not standardized.
- Organizational leadership discussed improving data collection through stratifying data by race, ethnicity, gender and language.
- The IT and HIM departments began exploring how to use the EMR problem list to identify patients with diabetes.
- When identifying community partners, organizational leadership considered Harvest Home and God's Love We Deliver.

What we did this year

What we have accomplished through AHEI:

IT improvements

- Included PRAPARE and Hunger Vital Sign questions in multiple locations to effectively share information across disciplines (Social Work/Care Management, History & Physical, Nursing, and Nutrition Assessments).
- IT and SDOH Team improved data collection processes to streamline data.
- Migrated existing outpatient action list to inpatient EMR to show patients' answers to food insecurity questions. This improved care transition communication and allowed Social Work to access this information in both settings (Inpatient and Outpatient).

Staff education

- Trained Social Work and Care Management staff to use PRAPARE and Hunger Vital Sign questions. Training covered how to ask these questions, types of interventions, and connecting with multiple community agencies.

Community partnerships

- Formed new partnerships with Harvest Home and God's Love we Deliver.
- Updated food insecurity resource lists, using Hitesite.org.

Harvest Home

Harvest Home Mt. Eden, Bronx NY
Fresh Food Stands

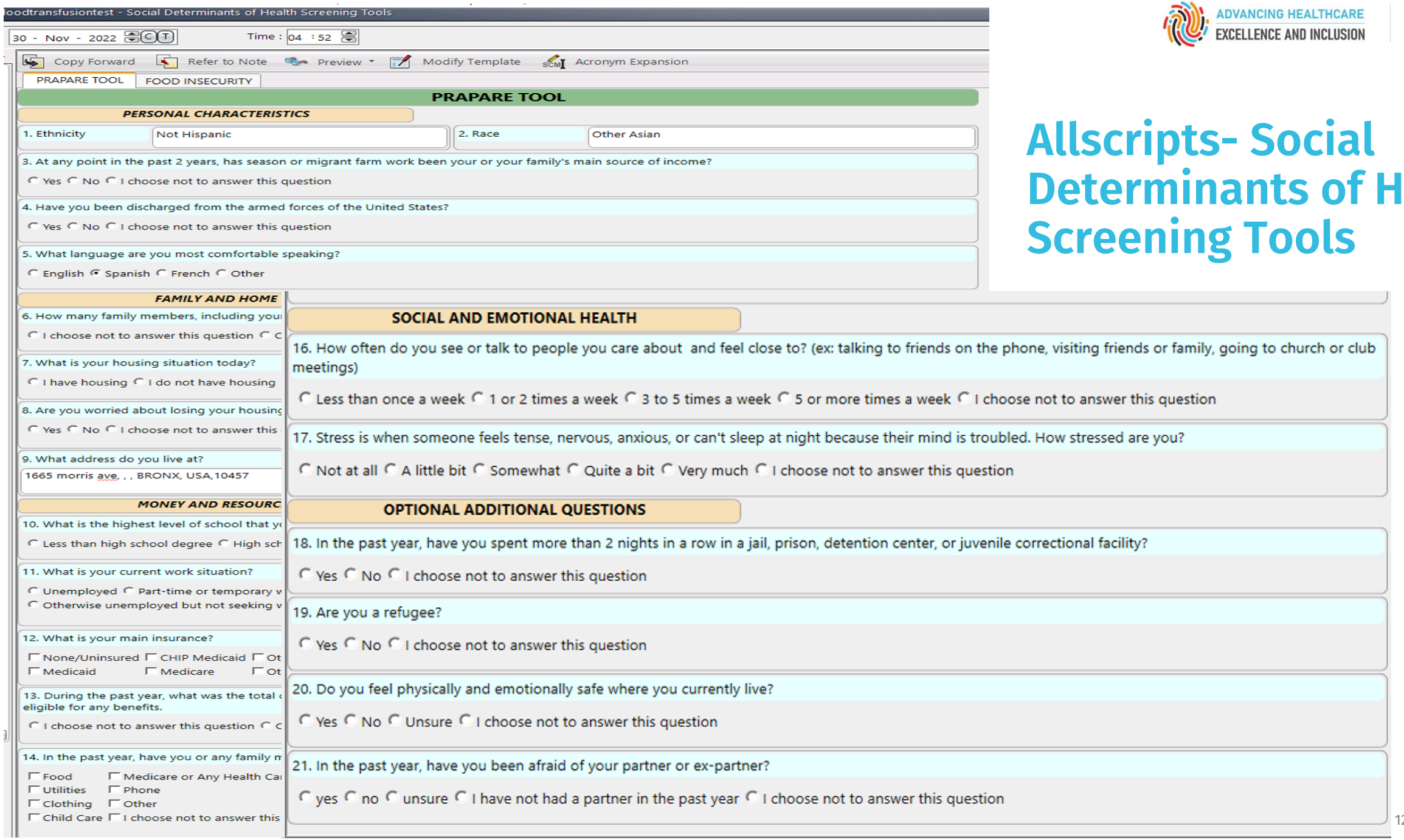
Harvest Home Mt. Eden, Bronx NY
Fresh Produce

What we did this year

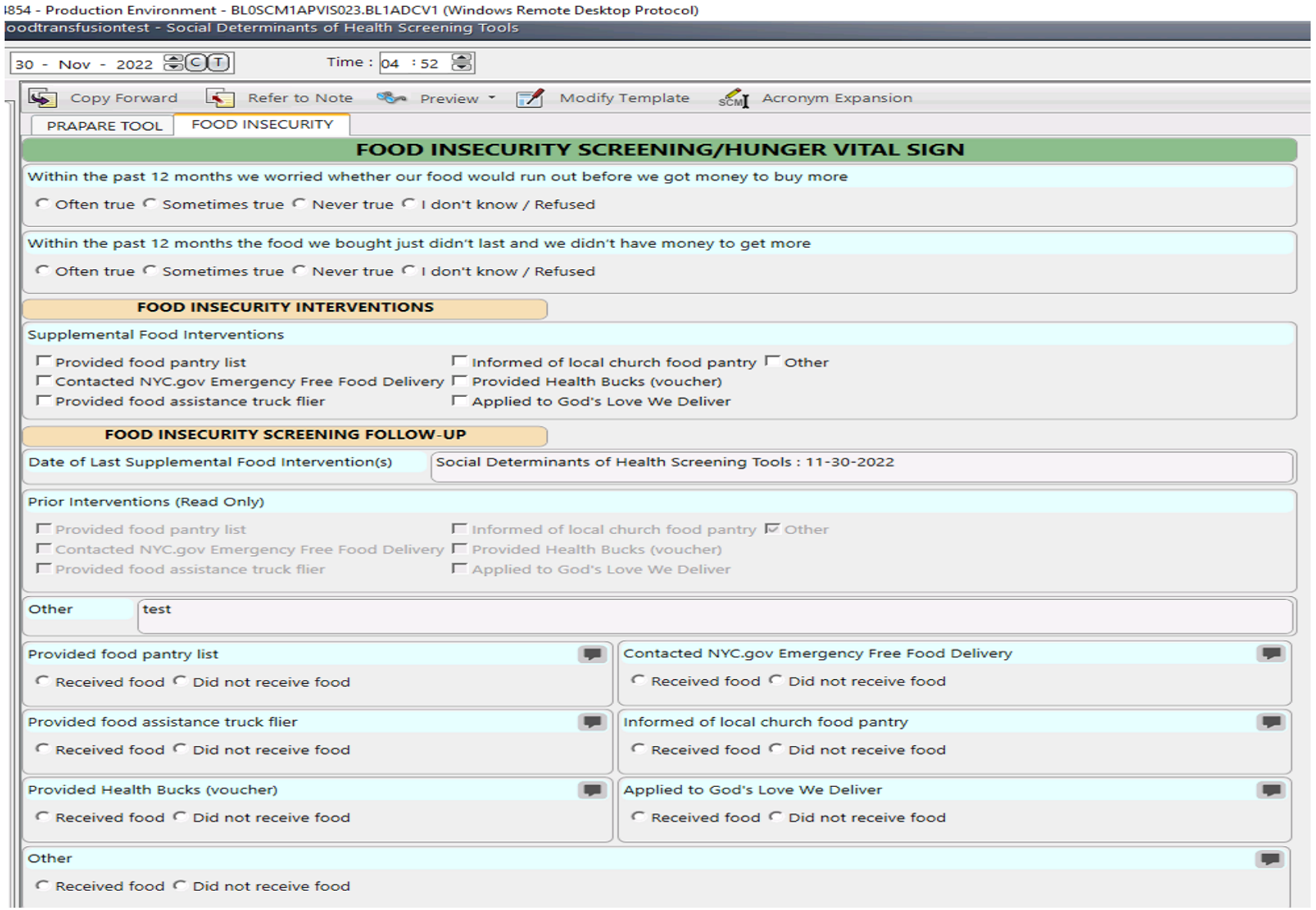
EMR Food Insecurity Hunger Vital Sign Questions Flow

PRAPARE and Hunger Vital Sign questions

Allscripts- Social Determinants of Health Screening Tools



Allscripts- Social Determinants of Health Screening Tools



Childrenshealthwatch.org/ Hunger Vital Sign Questions

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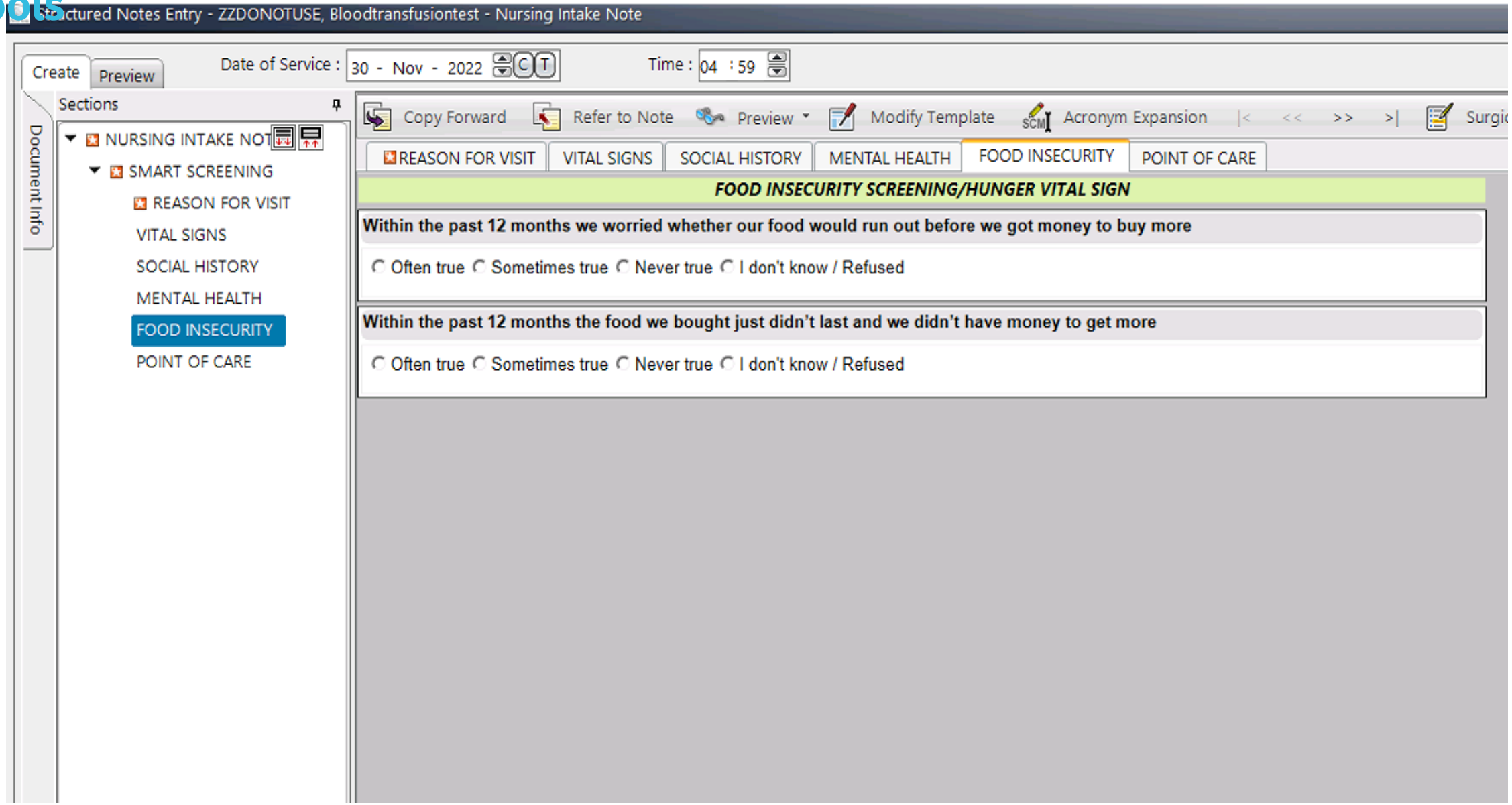

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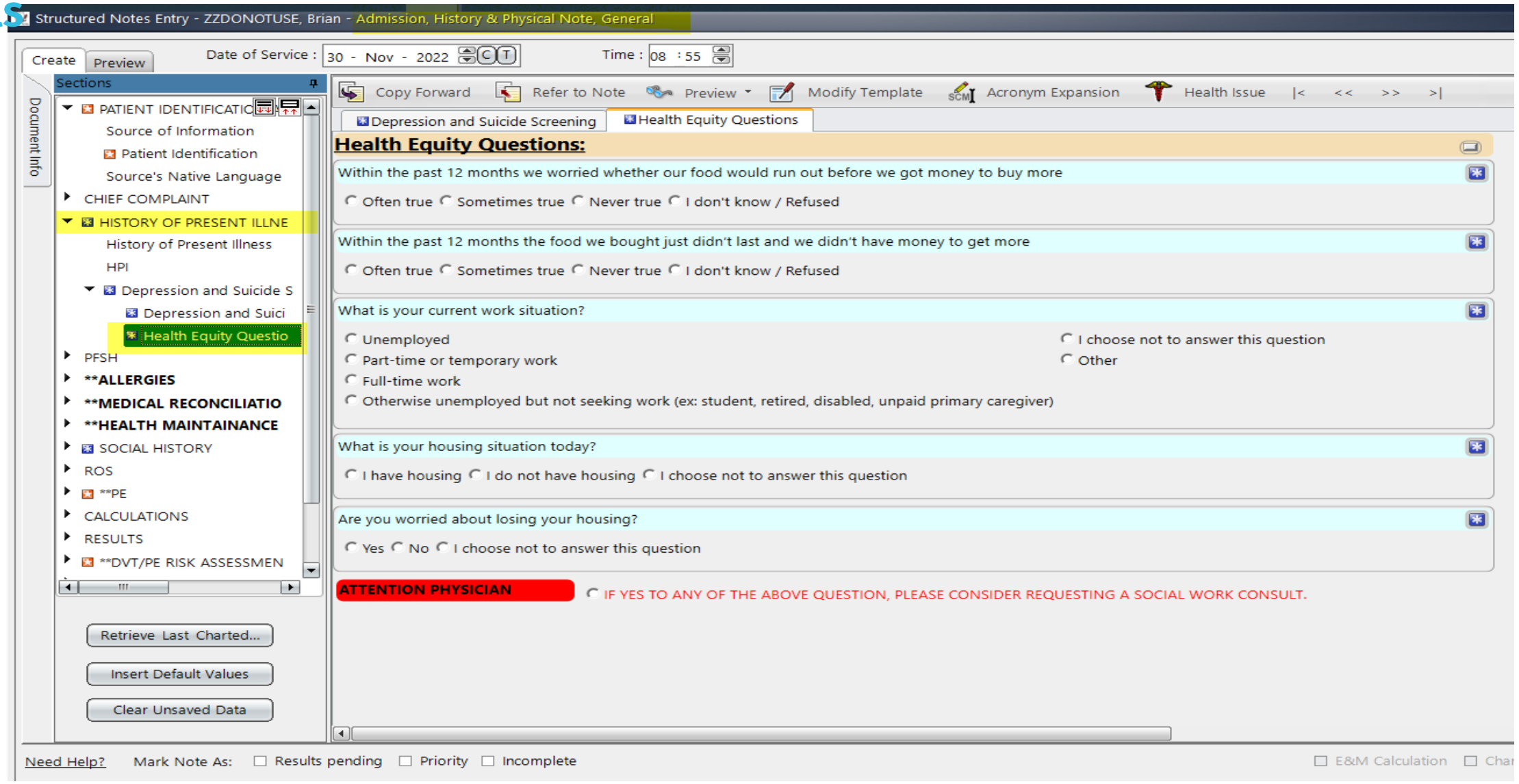
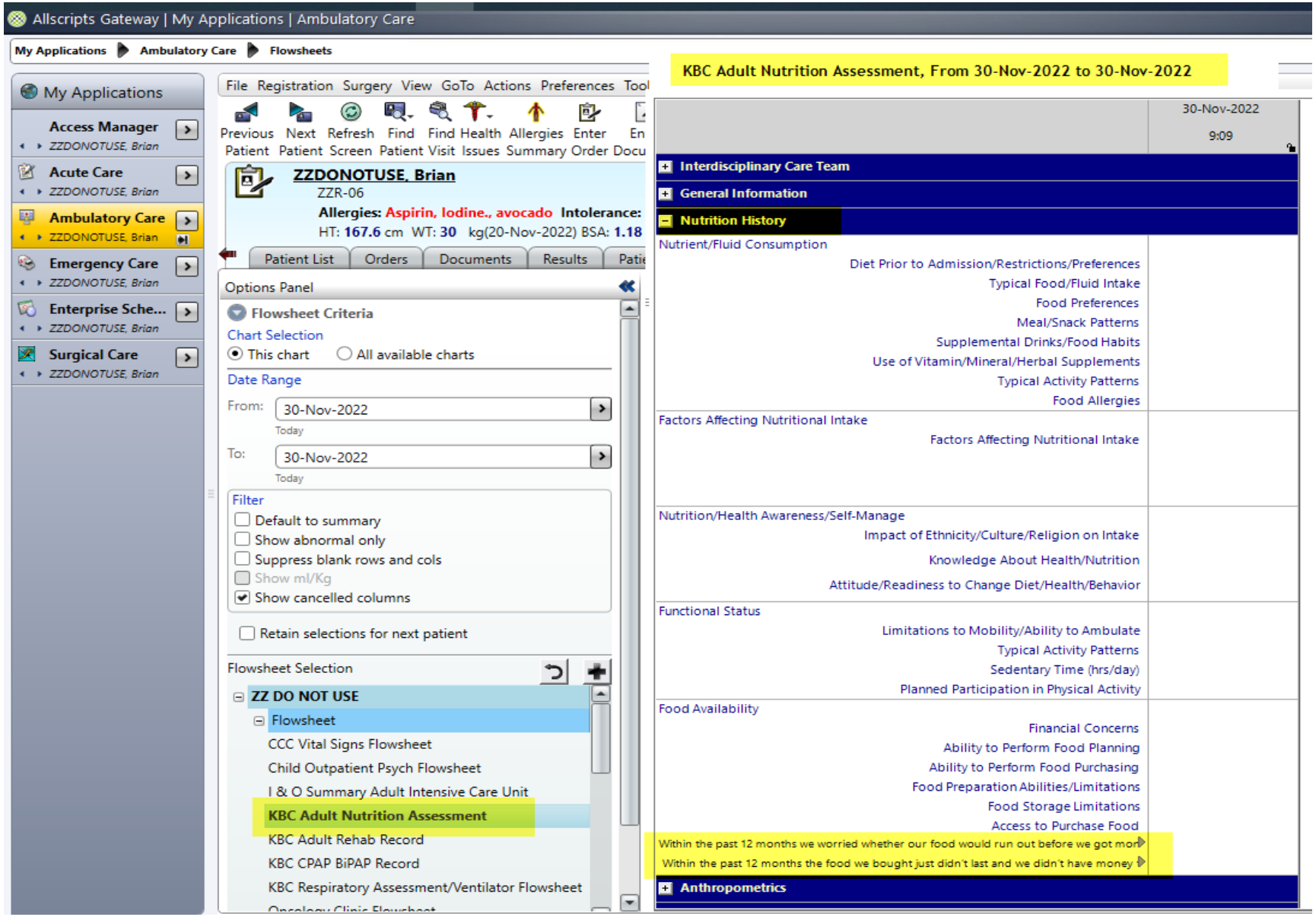


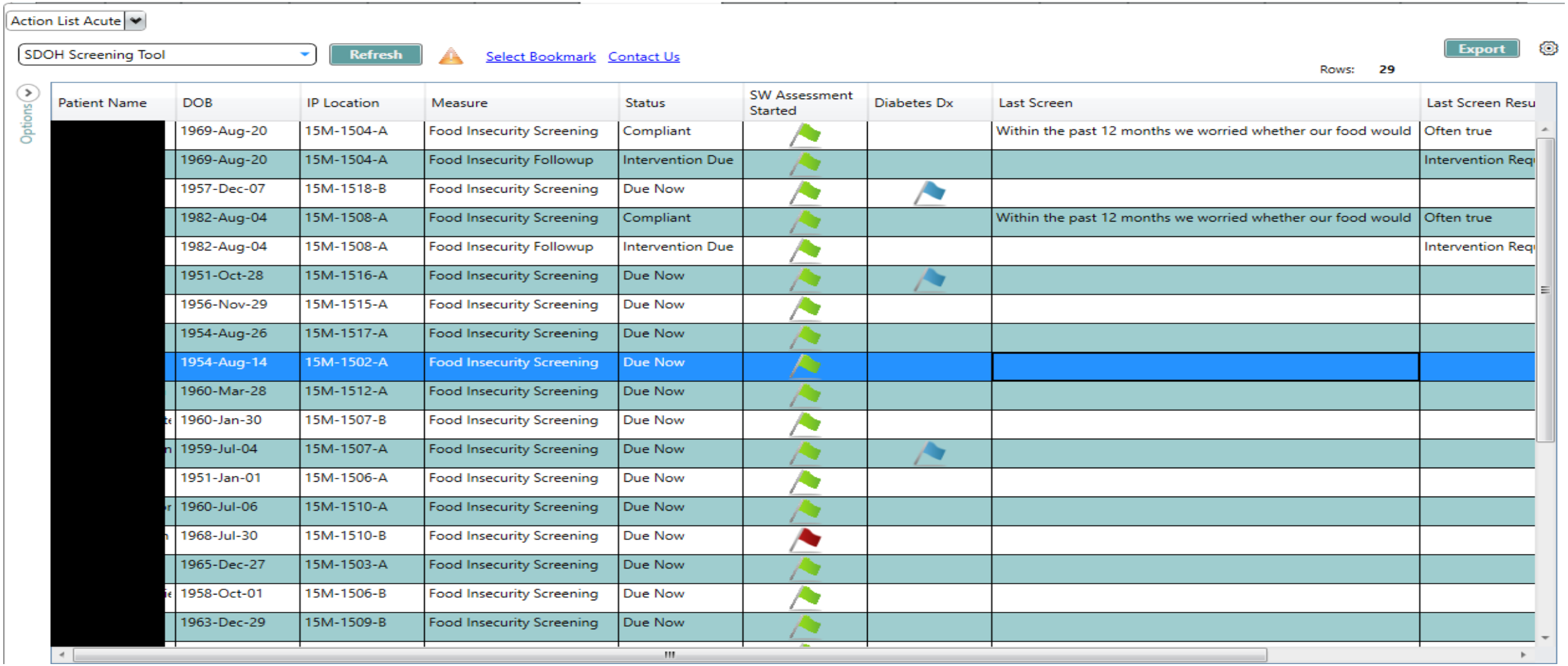
Childrenshealthwatch.org/ Hunger Vital Sign Questions

Allscripts- Nutrition Assessment



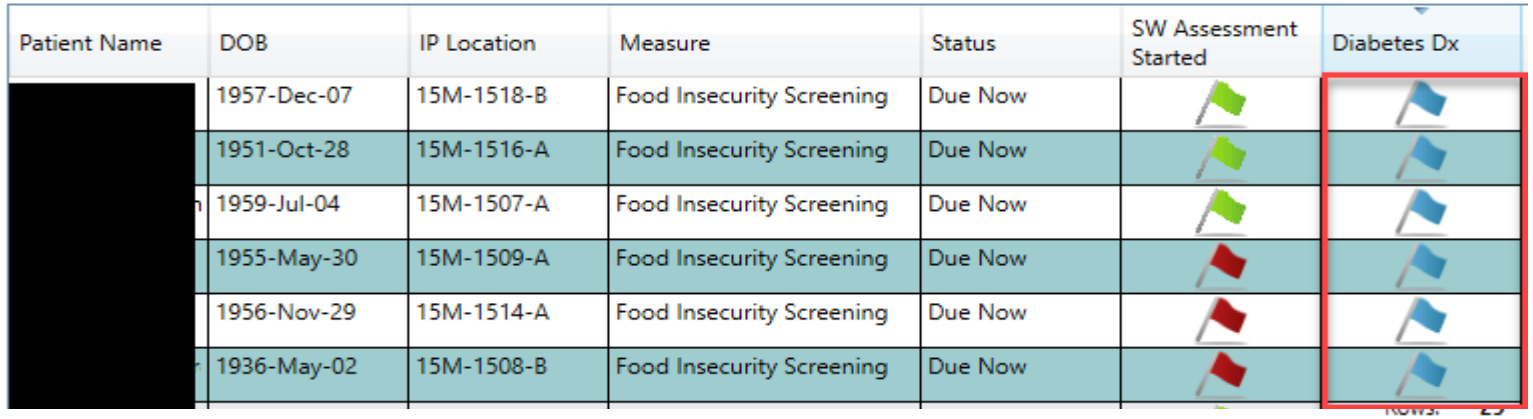
Childrenshealthwatch.org/ Hunger Vital Sign Questions

Social Determinant of Health Inpatient Tracker



Patient Name	DOB	IP Location	Measure	Status	SW Assessment Started	Diabetes Dx	Last Screen	Last Screen Resu
[redacted]	1969-Aug-20	15M-1504-A	Food Insecurity Screening	Compliant			Within the past 12 months we worried whether our food would	Often true
	1969-Aug-20	15M-1504-A	Food Insecurity Followup	Intervention Due				Intervention Req
	1957-Dec-07	15M-1518-B	Food Insecurity Screening	Due Now				
	1982-Aug-04	15M-1508-A	Food Insecurity Screening	Compliant			Within the past 12 months we worried whether our food would	Often true
	1982-Aug-04	15M-1508-A	Food Insecurity Followup	Intervention Due				Intervention Req
	1951-Oct-28	15M-1516-A	Food Insecurity Screening	Due Now				
	1956-Nov-29	15M-1515-A	Food Insecurity Screening	Due Now				
	1954-Aug-26	15M-1517-A	Food Insecurity Screening	Due Now				
	1954-Aug-14	15M-1502-A	Food Insecurity Screening	Due Now				
	1960-Mar-28	15M-1512-A	Food Insecurity Screening	Due Now				
	1960-Jan-30	15M-1507-B	Food Insecurity Screening	Due Now				
	1959-Jul-04	15M-1507-A	Food Insecurity Screening	Due Now				
	1951-Jan-01	15M-1506-A	Food Insecurity Screening	Due Now				
	1960-Jul-06	15M-1510-A	Food Insecurity Screening	Due Now				
	1968-Jul-30	15M-1510-B	Food Insecurity Screening	Due Now				
	1965-Dec-27	15M-1503-A	Food Insecurity Screening	Due Now				
	1958-Oct-01	15M-1506-B	Food Insecurity Screening	Due Now				
	1963-Dec-29	15M-1509-B	Food Insecurity Screening	Due Now				

Social Determinant of Health Inpatient Tracker



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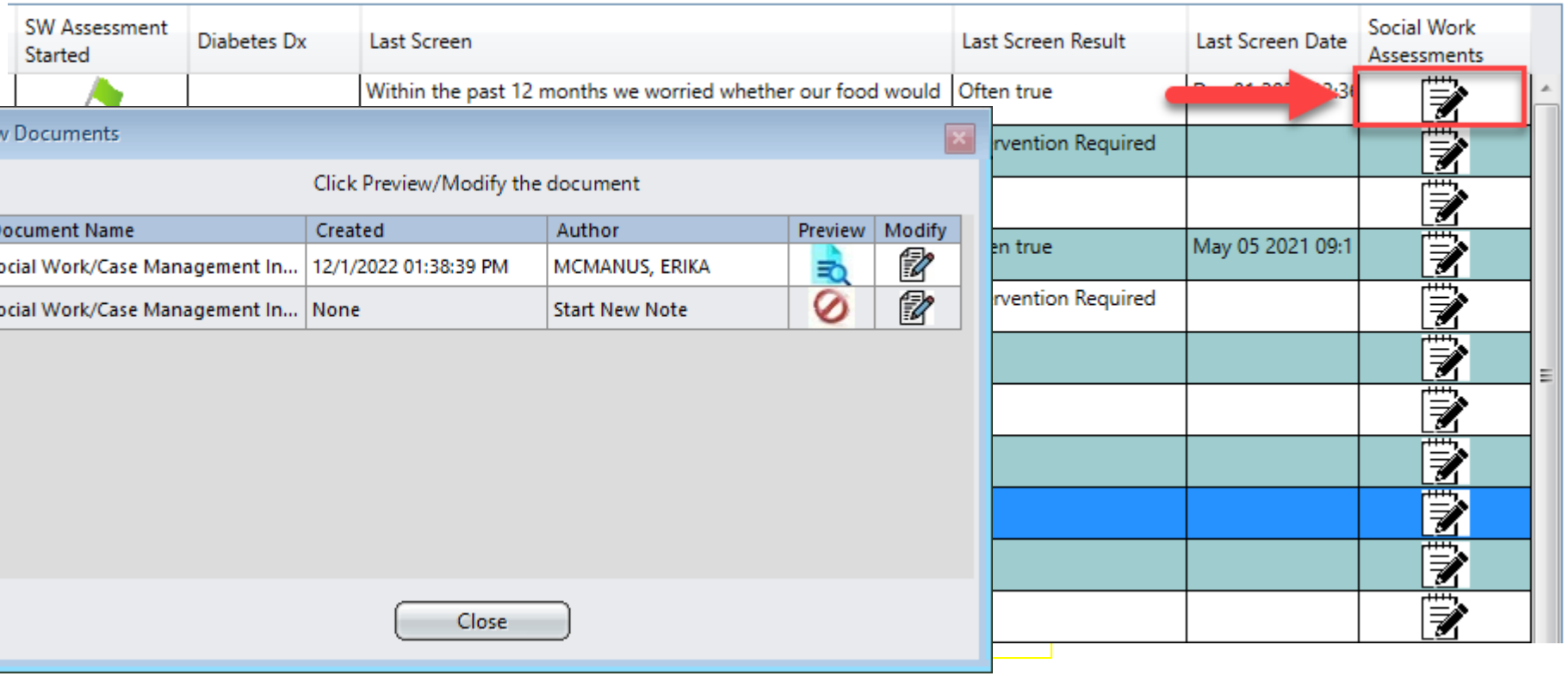
	1956-Nov-29	15M-1514-A	Food Insecurity Screening	Due Now		
	1936-May-02	15M-1508-B	Food Insecurity Screening	Due Now		



What we did this year

- Provided education on all social determinant codes for inpatient coders, outpatient coders, physician coders, and physician education.
- Developed quarterly reports (one inpatient, one for ED) to teach and track coding data across 2022. Added name, DOB, medical record number, and both diagnosis code and social determinant code.
- Used the data for trending and analytics. Good news: we did coding training in the second quarter, and the number of patients in the reports increased in the third quarter.
- We can now identify groups of patients we want to follow, such as diabetic patients, food insecure patients and others as we expand our program.
- We will continue to provide education on coding these conditions. Sometimes we lack sufficient documentation to code.
- Physician education classes will be scheduled quarterly as needed, and physician documentation templates are being developed for inpatient and outpatient events.
- The hospital department Chairperson will receive education in the next Chairperson meeting in December, and this training will be repeated as necessary.

Lessons learned

What went well?

- Quickly formed a core social determinants team and included disciplines such as food and nutrition when the agenda involved their skills.
- Worked with IT to add PRAPARE and Hunger Vital Sign questions to inpatient documentation templates. Added questions to inpatient Social Work/Care Management templates, trained staff the week before it went into production (week of 9/18/2022).

What did not go so well?

- The Action List is intensive and has a ripple effect in the EMR – still in the building phase.
- Standardizing PRAPARE questions across settings in Allscripts - still in the building phase.

Advice for others who are doing similar work:

1. Start ASAP
2. Have support from all levels of the organization
3. Monitor through chart reviews
4. Meet frequently, you may need additional resources, i.e. IT staff

What's next?

Plans for the coming year:

- Enhance inpatient templates, action lists and education.
- Enhance outpatient documentation. Work with IT so shared documentation can flow between inpatient and outpatient settings to ease the burden on the clinical team.
- Ensure accurate reporting in inpatient and outpatient settings. Use data to identify trends, set goals, and respond to community needs.
- Train clinical and support staff on all aspects of SDOH.
- Continue collaboration with HANYS.
- Share data to evaluate the needs of our greater community in NYC and across the continuum of care. Summarize findings and disseminate reports to the proper parties, empower them to react, and implement solutions to meet the community's needs
- Create progress reports to track and trend BronxCare's success in our diabetes and food insecurity, react to our success and create next steps.
- Race and Ethnicity table through the registration process.

ADVANCING HEALTHCARE
EXCELLENCE AND INCLUSION

Questions?

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