Establishing referral processes with SDoH data

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Network Director Department of Health Equity Initiatives MediSys Health Network





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4/30/2024

Agenda

- Introductions
 - HANYS AHEI team
 - AHEI faculty
- Our partners
- Session 5:
 - Establishing referral processes with SDoH data
- Upcoming sessions





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HANYS AHEI team



Kathleen Rauch, RN, MSHQS, BSN, CPHQ

Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care



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Director, AHEI







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Project Manager, North Country









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Senior Director, Quality Advocacy, Research and Innovation



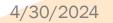
Maria Baum, MS, RN, CPHQ

Project Manager, Mohawk Valley



Kira Cramer, MBA

Project Manager, Downstate



HANYS faculty



Julia E. Iyasere, MD, MBA

Executive Director, Dalio Center for Health Justice, NewYork-Presbyterian Senior Vice President, Health Justice and Equity, NewYork-Presbyterian Assistant Professor, Medicine, Columbia University Irving Medical Center



Theresa Green, PhD, MBA

Director, Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center





Our funder and partner



Mother Cabrini IEALTH FOUNDATION

Our funder

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members in a strategic way. With this learning collaborative, we strive to effect lasting change in health equity at the local level by engaging providers and community stakeholders to address health disparities.



Our partner

DataGen develops custom analytics for participants to help them understand how and where communities are affected by health disparities so they can develop tailored interventions.







Insights for Healthcare®

Presenter



Naa Djama Attoh-Okine, MPH

Network Director Department of Health Equity Initiatives MediSys Health Network





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ESTABLISHING REFERRAL PROCESSES WITH HRSN DATA

at MediSys Health Network

PRESENTED BY

Naa Djama Attoh-Okine, MPH Network Director Department of Health Equity Initiatives MediSys Health Network

AGENDA

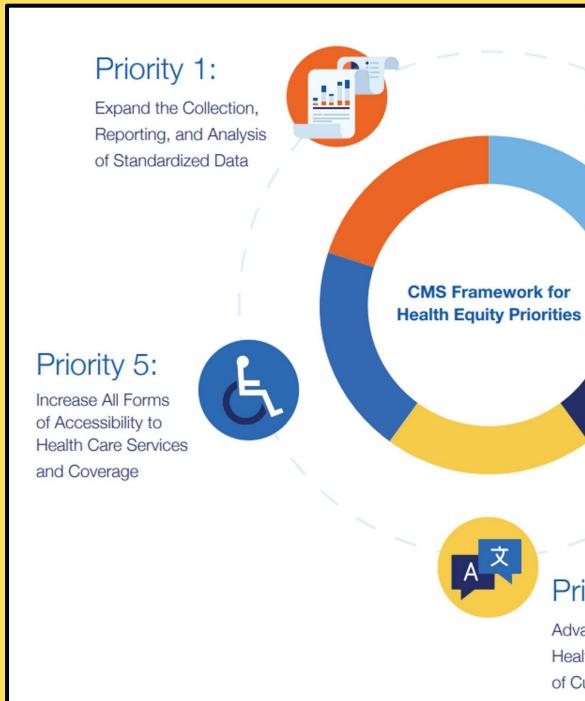
- CMS Mandate to track SDoH
- Background of Health Equity at MediSys
- Developing an SDoH Workflow
- FindHelp and Closed Loop Referral System
- Troubleshooting Common Issues
- Data Measurement and Improvement
- Next Steps

CMS FRAMEWORK FOR HEALTH EQUITY 2022-2032



New CMS Requirements for 2024

- The Centers for Medicare & **Medicaid Services (CMS) have** mandated that hospitals reporting to the Inpatient Quality **Reporting (IQR) program submit** two new measures:
 - SDOH-1: Screening for Social **Drivers of Health**
 - SDOH-2: Screen Positive for **Social Drivers of Health**
- These measures are voluntary in 2023 and will be required by 2024.



Priority 2:

Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps



Priority 3:

Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4:

Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

SDOH-1: SCREENING FOR SOCIAL DRIVERS OF HEALTH

Question: Of all the patients admitted to the hospital, how many did you screen for HRSN?

Numerator: The number of patients screened for the five domains of SDOH Denominator: All patients admitted to our hospital who are 18 years old or older Exclusions: Patients who opt out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

SDOH-2: SCREEN POSITIVE RATE FOR SOCIAL DRIVERS OF HEALTH

Question: Of all patients admitted to the hospital who received an SDOH screening, how many were identified as having one or more social risk factors?

Numerator: The number of patients who are screen positive for any of the five domains of SDOH Denominator: All patients admitted to your hospital who are 18 years or older and are screened for the five domains of SDOH. Exclusions: Patients who opt out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

Source: Heilman, E. (2022, October 7). *An Intro to CMS's SDOH Measures*. Medisolv. https://blog.medisolv.com/articles/intro-cms-sdoh-measures

Addressing Social Drivers of Health: Key Concepts and Definitions

Term	Definition	Domains	Impact Level	
Social Drivers of Health	An umbrella term encompassing SDOH, HRSN, and SRF	See Below	Community or Individual	
Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks	 Social and community context Economic Stability Education Access and Quality Neighborhood and Built Environment Health Care Access and Quality 	Community	
Health-Related Social Needs (HRSN)	Individual-level manifestations of SDOH	 Housing Instability Food Insecurity Utility Needs Interpersonal Violence Transportation Needs 		
Social Risk Factors (SRF)	Adverse social conditions that are associated with poor health			
Social Deprivation	Limited access to society's resources due to poverty, discrimination, or other disadvantage	Not Applicable	Community or Individual	

Source: Sheingold, S., Zuckerman, R., Alberto, C., Samson, L., Lee, E. & Aysola, V. (2022). Reflections Accompanying a Report on Addressing Social Drivers of Health: Evaluation Area-Level Indices. *ASPE: Assistant Secretary for Planning and Evaluation Office of Policy*. https://aspe.hhs.gov/sites/default/files/documents/474a62378abf941f20b3eaa74ca5721c/Area-level-Indices-ASPE-Reflections.pdf

Health-Related Social Needs

HEALTH-RELATED SOCIAL NEEDS

Health-related Social Needs (HRSNs) are the social and economic needs that impact one's ability to maintain their health and well-being.



Education/Training

HEALTH EQUITY AT MEDISYS HEALTH NETWORK



HANYS Health Equity Gap Analysis

- MediSys completed the EQIC Health Equity Gap Analysis to assess the application of best practices.
- Domains included:
 - Organizational Leadership
 - Workforce Training
 - Data Collection and Utilization
 - Data Validation
 - Data Stratification
 - Health Literacy, Cultural Competence and Language
 - Community Partnerships

Health Equity Gap Analy

The following checklist assesses a hospital's incorpor health equity best practices as part of its overall oper Hospital name: Date: BEST PRACTICE ELEMENT RECOMMENDATIC ORGANIZATIONAL LEADERSHIP Health equity is a key Health equity is articulated as a key org strategic priority with priority (e.g., goals and objectives, strat established structures and policy, protocol, pledges, mission/vision processes in place to elimdata transparency, leadership buy-in, co inate disparities and ensure partnerships, diverse workforce) support equitable healthcare is business case and plan for operationalized prioritized and delivered to equity strategies and interventions that all patient populations. tiple determinants of health, decrease i racism and strengthen community part improve health and equity.

ysis pration of rations.			EAS	QIC STERN US QUALITY PROVEMENT COLLABORATIVE
)N	IMPLEMENTATION STATUS FULLY PARTIALLY NO			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
ganization-wide Itegic plan, on/values, community orted by a clear lizing health It address mul- institutional rtnerships to	\bigcirc	\bigcirc	\bigcirc	

Response to Gap Analysis



Appointed a Health Equity Leader and formed a Department of Health Equity Initiatives. 2

Formed a Health Equity and Inclusion Committee.



Implemented targeted performance improvement strategies to promote health equity across our organization.

Phase 1: Project Champions

A smaller action group was formed which consisted of Physician Champion, Chief Quality Officer, Care Transition Director and Informatics to identify next steps in beter developing process.



- Refine screening tool Create efficient and effective workflow for dropping Z-codes and referrals Shared CBO resources across network

Kick-off

Operational and Clinical leadership met to:

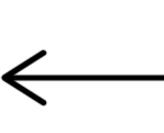
- Assess current processes
- · Discuss need to optimize current workflows and improve our SDOH approach
- Initiate the Action plan on change and formulate working Team

Medisys **Commitment to Healthy Equity**

Organizational decision to optimize collection and utilization of SDOH data towards improving the health of our patients

Training/Implementation/Practice Culture Shift

- Ongoing educational programming (e.g. Grand Rounds)
- · Interprofessional team feedback loop and review of data used for continual improvement
- Distribution of tipsheets, videos, reminders with new updates/changes to interdisciplinary teams as needed
- Appointment of Network wide Director of Health Equity



Phase 2: Goals

Data collection and analysis

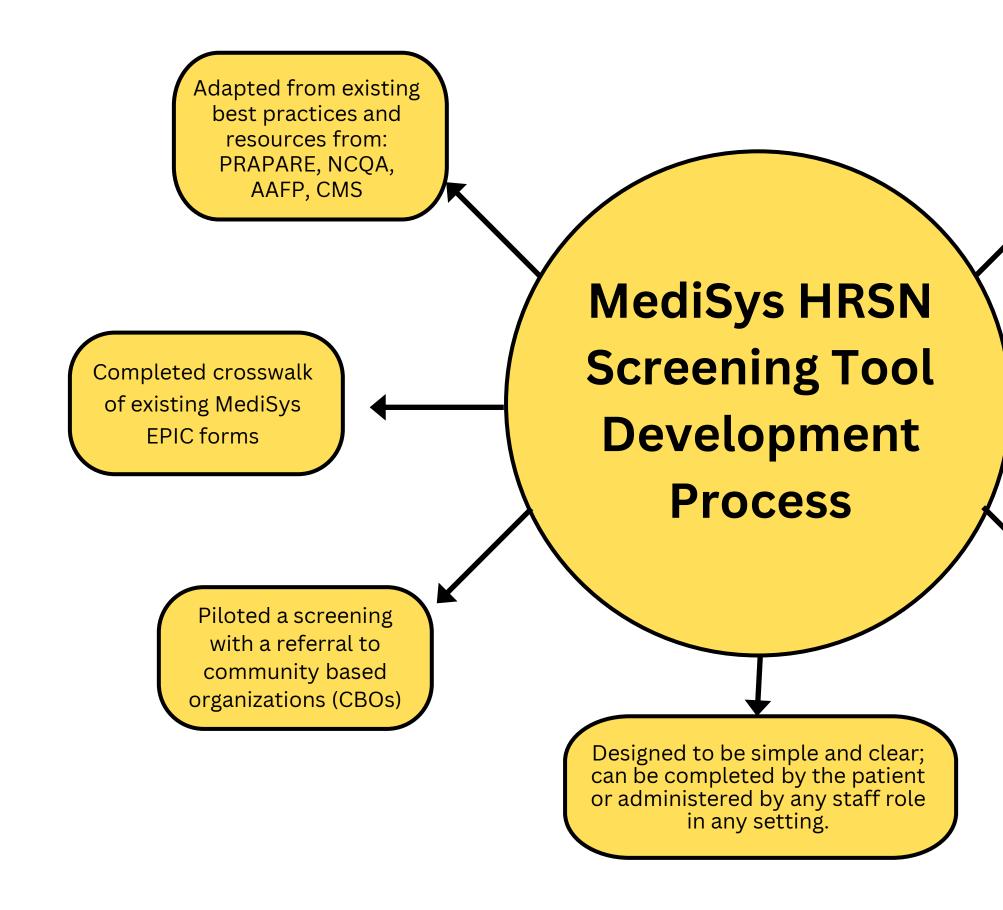
Phase 3: Workflow Process and EHR Integration

- SDOH questions were simplified and made patient-centered
- Process map created to outline standardized and efficient workflow for outpatient and inpatient

Phase 4: EHR Integration

 SDOH questions updated · BPA alert will promote provider to confirm positive SDOH domains with order for referral and Z-codes Streamline visual cues in the EHR so that there is awareess across the network on patient needs Integration in EHR to assist with Community Based Referrals

Adapting the HRSN Screening Tool

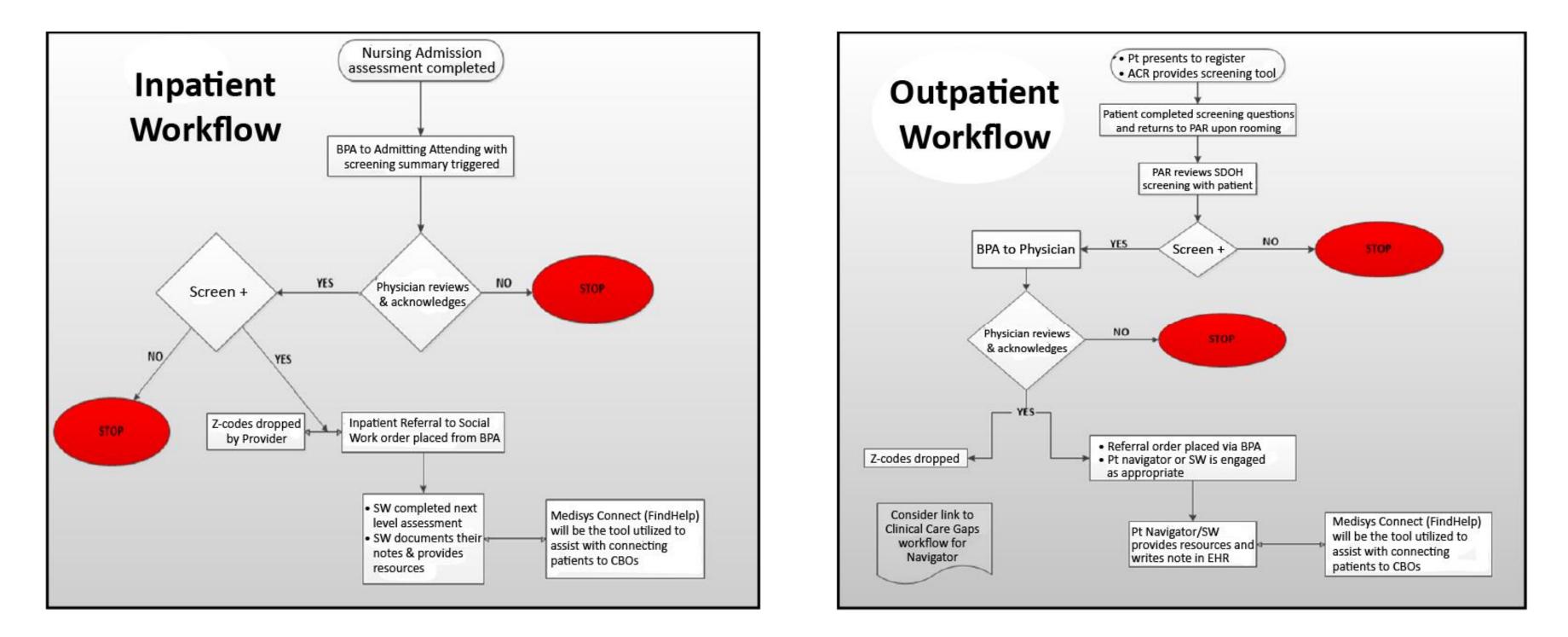


Will allow for seamless future build as initiative expands and resource network is established

> Designed for meaningful and essential physician involvement with minimal task burden

Positive screens are linked to corresponding Z Codes (ICD-10-Codes Z55-Z65)

MediSys HRSN Screening Workflow



MediSys HRSN Screening Tool

Covered Domains:

- Housing Instability
- Utility Difficulties
- Food Insecurity
- Transportation Difficulties
- Interpersonal Safety
- Financial Strain
- Employment
- Family & Community
 Support
- Health Literacy

Question

Are you worried that in the next 2 months, you may not have a live? (Risk of eviction, being kicked out, homelessness)

In the past 12 months has the electric, gas, oil, or water compa services in your home?

Within the past 12 months, you worried that your food would money to buy more?

Within the past 12 months, has lack of transportation or difficult kept you from medical appointments or getting your medication

Does anyone in your life hurt you, threaten you, frighten you,

Within the past months, have you experienced any difficulties basics like food, housing, medical care, and heating?

Do you want help finding or keeping work or a job?

Do you need help with day-to-day activities (i.e., assistance with meals, shopping, managing finances, etc.)?

Do you feel lonely or isolated from those around you?

How often do you need to have someone help you when you r pamphlets, or other written material from you doctor or pharm

	Response Options
a safe or stable place to	Yes, No, Prefer not to answer
any threatened to shut off	Yes, No, Already shut off, Prefer not to answer
run out before you got the	Yes, No, Prefer not to answer
culties with transportation ons?	Yes, No, Prefer not to answer
or make you feel unsafe?	Yes, No, Prefer not to answer
s with paying for the very	Yes, No, Prefer not to answer
	Yes, No, Prefer not to answer
ith bathing, preparing	Yes, No, Prefer not to answer
	Yes, No, Prefer not to answer
read instructions, macy?	Never, Rarely, Sometimes, Often, Always, Patient unable to respond

Best Practice Advisory (BPA) for At-Risk Population

- A clinical decision-making tool for healthcare providers
- The BPA alerts providers that a patient has screened positive for an HRSN
- Easy access to referral for Social Work, Patient Health Navigation, and Community Resources
- Easy access to Z-codes to allow for review and automation
- Direct access to Community Resources link (FindHelp) from the BPA

🔟 🖳 🏠 🧚 Pisaskme, S	Social Determinants of Her					
SP @	Time taken: 3/31/ 1716	+ Add Group + Au	+ Add LDA 🖁 Resp	onsible 📩 Create Note		Show Ro
	Living Situation and Utilities	BestPractice Advisory - Plsaskme	, Social			
Social Plsaskme	Are you worried that in the next 2 months,) Critical (1)					*
Legal Sex: Female, 78 y.o., 3/30/1944 📛	Yes No F	① Social Determinants of I	Health (SDOH) at Risk	Population		
MediSys MRN: 300011046	Are you worried that the place you are living	The following SDOH of	domains were identif	ied as High Risk:		
CSN: 63707 Medisys MRN : 300011046	Yes No F	Living Situation and U	Itilities			
Code: Not on file (no ACP docs)	Food	Transportation Family and Communit	ty Support			
Care Mgmt Pt: Care Managemer Pt	Within the past 12 months, you worried that			_		
O Search	Yes No F	Order	Do Not Order	Ambulatory Referral to Social	Work	
Enc Provider with Red: Gina	Transportation	Add Visit Diagnosis	Do Not Add	Lack of housing		
Basello, DO Encounter Type and Date: Office		Add Visit Diagnosis	Do Not Add	Inadequate housing		
Visit on 3/31/2022	Within the past 12 months, has lack of tran-	Add Visit Diagnosis	Do Not Add	Food insecurity		
Coverage: None	Yes No F	Add Visit Diagnosis	Do Not Add	Inability to acquire transportation	on	
Allergies: Penicillins	Safety	Add Visit Diagnosis	Do Not Add	Loneliness		
Pharmacy: JAMAICA RX, INC	Does anyone in your life hurt you, threaten	Add Visit Diagnosis	Do Not Add	Family conflict		
JAMAICÁ, NY - 89-36 VAN WYCK EXPRESSWAY	Yes No F	Add Visit Diagnosis	Do Not Add	Unavailability and inaccessibility of other helping agencies		
3/31 OFFICE VISIT	Financial Strain	Add Visit Diagnosis	Do Not Add	Living alone		
Weight: 182 lb (82.6 kg)	Within the past months, have you experien	Add Visit Diagnosis	Do Not Add	Isolation (social)		
BMI: 29.38 kg/m ² !	Yes No F	Add Visit Diagnosis	Do Not Add	Other problems related to social e	nvironment	
SINCE LAST JHMC RICHMOND HILL	Employment	Add Visit Diagnosis	Do Not Add	Without employment		
FAMILY MEDICINE MEDICAL VISIT 와 No visits	Do you want help finding or keeping work o	Add Visit Diagnosis	Do Not Add	Fear of job loss		
A No results	Yes No F	Community Resource	1000			
Opioid Tolerant Status: None	Family and Community Support	Community resou				
PROBLEM LIST (5)	If for any reason you need help with day-to				✓ <u>A</u> ccept	Di <u>s</u> miss
SOCIAL DETERMINANTS						
Concern present						

Determinants of Health (SDOH) at Risk Population	
llowing SDOH domains were identified as High Risk:	
Situation and Utilities portation and Community Support	

Order	Do Not Order	Ambulatory Referral to Social Work	
sit Diagnosis	Do Not Add	Lack of housing	
sit Diagnosis	Do Not Add	Inadequate housing	
sit Diagnosis	Do Not Add	Food insecurity	
sit Diagnosis	Do Not Add	Inability to acquire transportation	
sit Diagnosis	Do Not Add	Loneliness	
sit Diagnosis	Do Not Add	Family conflict	
sit Diagnosis	Do Not Add	Unavailability and inaccessibility of other helping agencies	
sit Diagnosis	Do Not Add	Living alone	
sit Diagnosis	Do Not Add	Isolation (social)	
sit Diagnosis	Do Not Add	Other problems related to social environment	
sit Diagnosis	Do Not Add	Without employment	
sit Diagnosis	Do Not Add	Fear of job loss	

Z-Codes Drop to Patients' Visit Diagnoses

Description

Z-Code

"SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation)

Z codes refer to factors influencing health status or reasons for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes."

Source: Centers for Medicare & Medicaid Services. (2023). Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes. CMS. https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

Social Plsaskr Legal Sex: Female, 78 3/30/1944 MediSys MRN: 30001 CSN: 63694 Medisys MRN : 30001 Code: Not on file (no Ad Care Mgmt Pt: Care Man

Pt

-

O Search

Basello, DO Encounter Type and Date Visit on 3/30/2022 Coverage: None

Allergies: Penicillins

Pharmacy: JAMAICA RX, JAMAICA, NY - 89-36 VA EXPRESSWAY 3/30 OFFICE VISIT

for Annual Exam Weight: 182 lb (82.6 kg) BMI: 29.38 kg/m² !

BP: 168/80

LAST 3YR Ƴ No visits 곫 No results

Utility Difficulties	Utility Difficulties	Z59.12	Inadequate Housing - utilities
Housing Instability	Housing Instability	Z59.10	Inadequate Housing - unspecified
Food Insecurity	Food insecurity	Z59.41	Food Insecurity
Transportation Needs	Inability to acquire transportation	Z59.82	Transportation Insecurity
Interpersonal Safety	At risk for abuse	Z63.8	Other specified problems related to primary support group
Financial Strain	Financial Strain	Z59.9	Problem related to housing and economic circumstances, unspecified
Employment	Problems related to employment	Z56.9	Unspecified problems related to employment
Family and Community Support	Requires assistance with activities of daily living (ADL)	Z74.1	Need for assistance with personal care
Family and Community Support	Loneliness	Z60.9	Problems related to social environment, unspecified

Health Literacy Difficulty demonstrating Z55.6

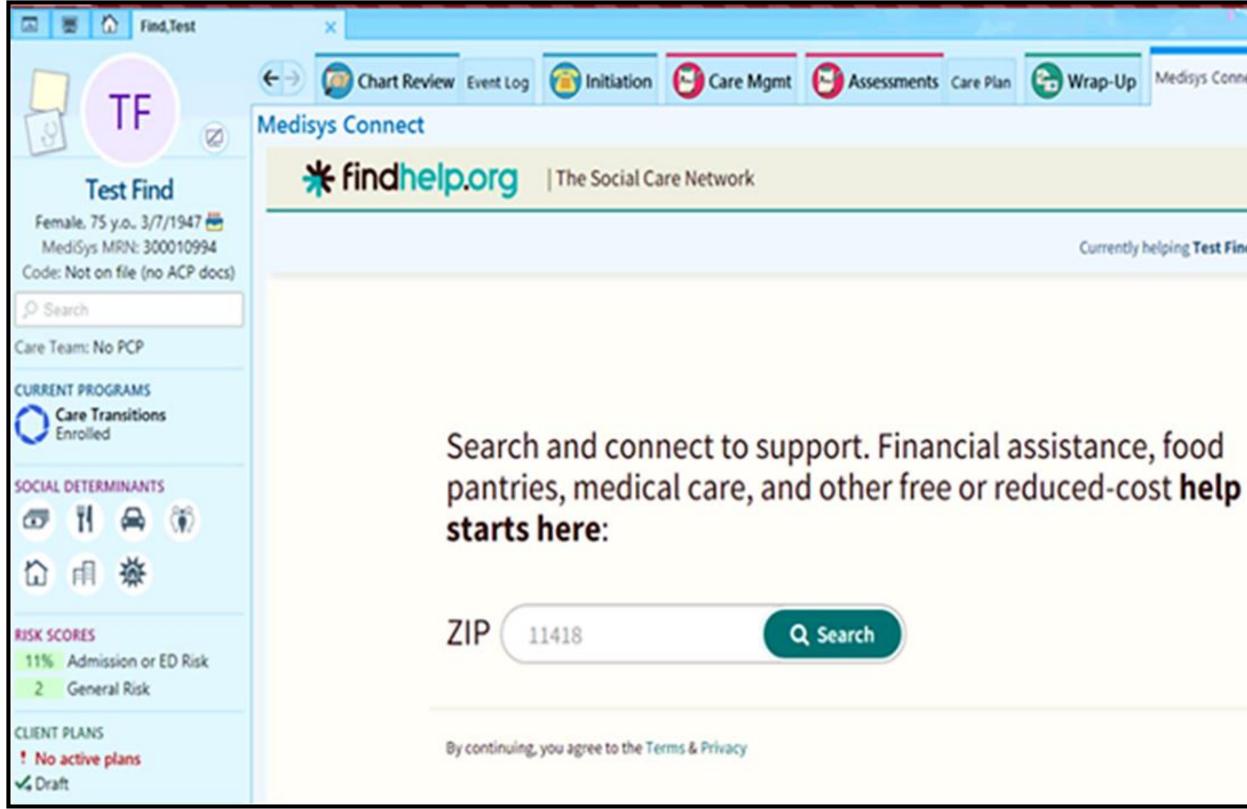
Visit Diagnosis

HRSN Domain

Problems related to health literacy

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)46	✓ Mark as	Reviewed Never Reviewed				
046				Advance	d View	51
docs) ement	Visit D	Diagnoses				
	Search	ew diagnosis 🕂 Add Common 🗸	Problems -			s
			ICD-10-CM		PL	
ffice	→ 1.	♣ COPD with asthma	J44.9	△ Change Dx	~	۵
	\$ 2.	Diabetes due to underlying condition w oth complication	E08.69	△ Change Dx	~	ΰ
	\$ 3.	Chronic pain of both knees	M25.561	▲ Change Dx	~	۵
	\$ 4.	F HTN, goal below 150/90	110	▲ Change Dx	~	ŵ
wyck	\$ 5.	Primary osteoarthritis of both knees	M17.0	△ Change Dx	~	Û
	\$ 6.	Lack of housing	Z59.00	▲ Change Dx	÷	ŵ
	\$ 7.	Inadequate housing	Z59.1	▲ Change Dx	÷	ŵ
	\$ 8.	Inability to acquire transportation	Z59.89	▲ Change Dx	+	啣
	\$ 9.	Loneliness	Z65.8	▲ Change Dx	÷	ŵ
	\$ 10.	Living alone	Z60.2	▲ Change Dx	÷	節
	 ▲ 11. 	Isolation (social)	Z60.4	▲ Change Dx	÷	۵

Community Referrals through FindHelp



/edisys Connect	
ping Test Find	

- FindHelp is an online social care network
- Connects people to social care services
- Features include an ability to label referrals with applicable Z-Codes, filter by location and eligibility requirements, track referrals, and create a closed loop referral system with local CBOs

Implementation: Lessons Learned

Tips and Suggestions

- Secure buy-in from mission-driven leadership and staff members
- Prioritize usability and practicality •
- Regularly meet with key stakeholders in the workflow to identify opportunities for improvement
- Share screening, diagnosis, and referral data

Opportunities for Improvement

- patients
- our community.

Source: Basello, G. and Barone, D. (2022). A Safety-Net Community Hospital's Interprofessional Approach to Health-Related Social Needs.

• Integrating a new workflow into systems with heavy workloads, competing priorities, and limited resources • Cultural competence training is needed to educate staff members on best practices for discussing HRSNs with

 Ongoing communication with stakeholders clarifying their roles and responsibilities in addressing HRSNs in

Data Measurement

- As of March 1, 87.6% of adult inpatients at JHMC and 95.8% of adult inpatients at **FHMC** were screened for HRSNs
- The positive screen rate was **9.5% at JHMC** and **3.6% at FHMC**
- The most common HRSNs endorsed by patients at both campuses were Housing Instability, Financial Strain, Utility Difficulties, and Food Insecurity
- Units are regularly updated about their HRSN screening rates via stoplight reports
- Those who are not meeting their benchmark work with the Health Equity department to develop PDSAs and implement strategies to increase their screening rate

Next Steps

01

Update the Z-Code mapping to improve usability

02

Connect with local CBOs and work with FindHelp to improve referral documentation and patient participation

03

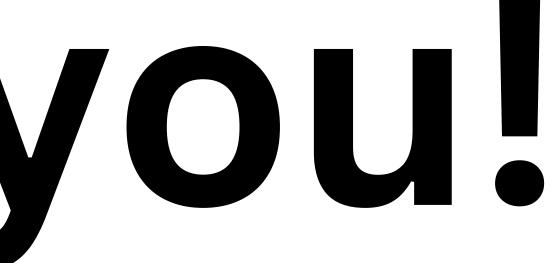
Continue cultural competence training to improve sociodemographic data collection and cultural sensitivity

04

Add Z-Code and CBO referral data onto stoplight reports

Thank you!

Naa Djama Attoh-Okine, MPH Network Director of Health Equity Initiatives MediSys Health Network nattohok@jhmc.org



Upcoming sessions

Tuesday, May 7 | 11 a.m. to noon.

Using data to identify disparities (1/2)

First of two sessions on best practices for disaggregating and analyzing data to identify disparities. Sessions will be held on the following Tuesdays from 11 a.m. to noon:

- May 14 | Using data to identify disparities (2/2)
- May 21 | Community partnerships
- May 28 | Patient and family engagement

Register <u>here</u>.









Questions?

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