Establishing referral processes with SDoH data

Naa Djama Attoh-Okine, MPH

Network Director

Department of Health Equity Initiatives

MediSys Health Network

Agenda

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

HANYS AHEI team

Kathleen Rauch, RN, MSHQS, BSN, CPHQ

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

Christina Miller-Foster, MPA

Senior Director, Quality Advocacy, Research and Innovation

Morgan Black, MPA

Director,
AHEI

Maria Baum, MS, RN, CPHQ

Project Manager,
Mohawk Valley

Rachael Brust, MBA

Project Manager,
North Country

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 HEALTH 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.

DataGen® Insights for Healthcare®

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.

Presenter

Naa Djama Attoh-Okine, MPH

Network Director

Department of Health Equity Initiatives

MediSys Health Network

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.**

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	Individual
Social Risk Factors (SRF)	Adverse social conditions that are associated with poor health	• Socioeconomic position • Cultural context • Social relationships • Residential and community context	Community or Individual
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

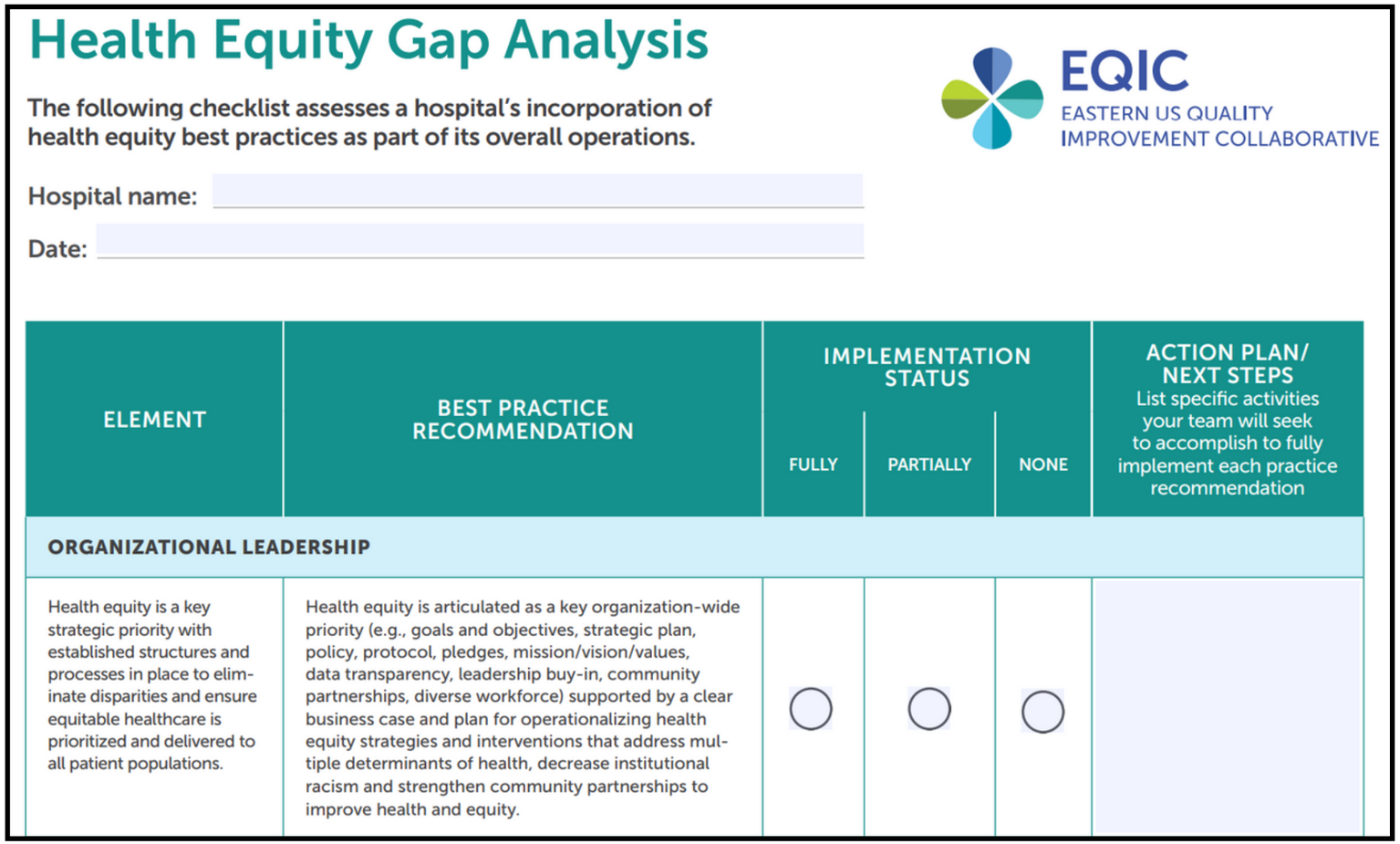
Health-related Social Needs (HRSNs) are the social and economic needs that impact one’s ability to maintain their health and well-being.

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 Analysis

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

Hospital name: _____

Date: _____

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
ORGANIZATIONAL LEADERSHIP					
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address multiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.	○	○	○	

Response to Gap Analysis

1

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

2

Formed a Health Equity and Inclusion Committee.

3

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

Medisys Commitment to Healthy Equity

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

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.

Phase 2: Goals

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

Training/Implementation/Practice Culture Shift

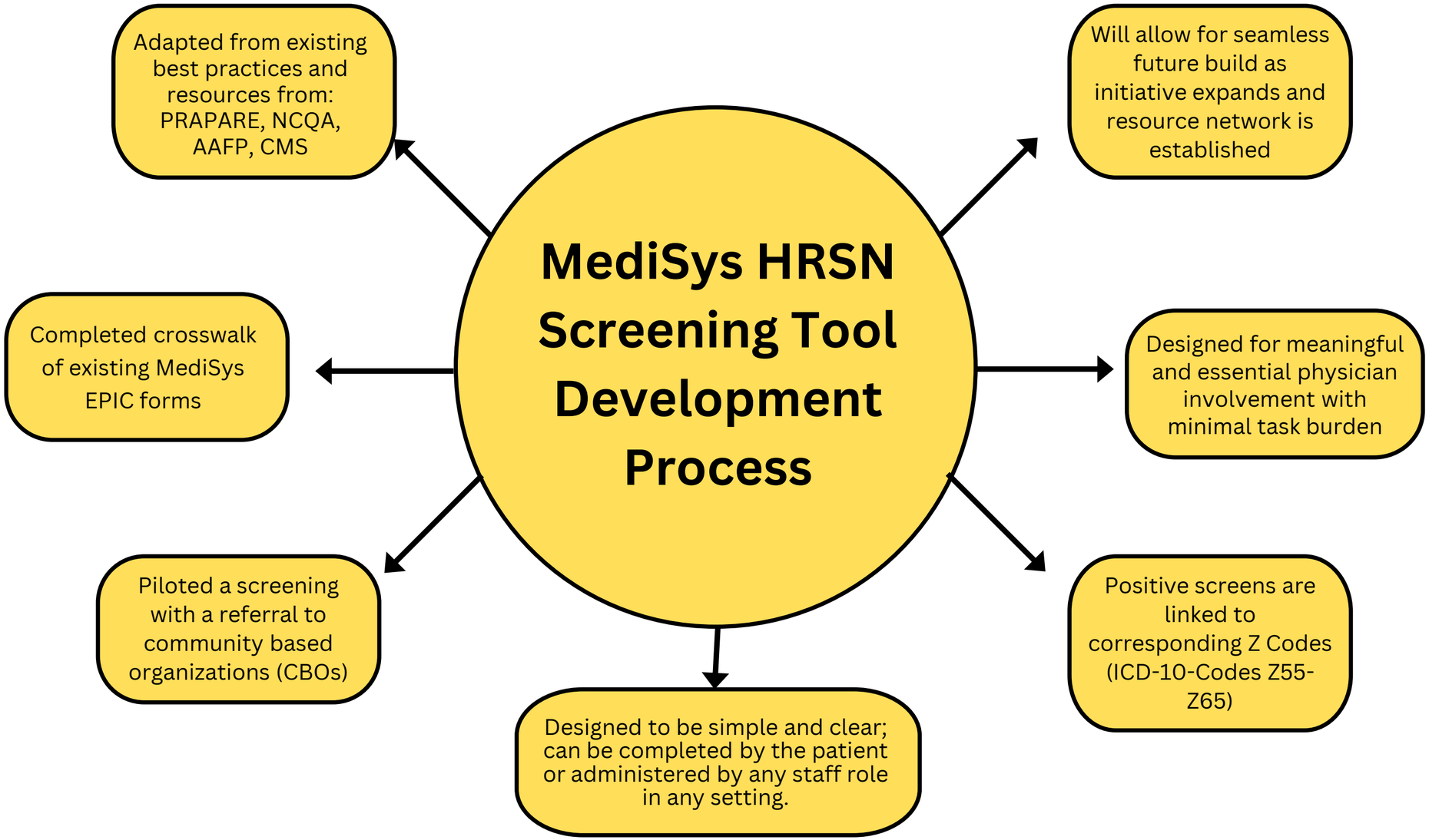
- Ongoing educational programming (e.g. Grand Rounds)
- Interprofessional team feedback loop and review of data used for continual improvement
- Distribution of tipsheets, videos, reminders with new updates/changes to interdisciplinary teams as needed
- Appointment of Network wide Director of Health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

Kick-off

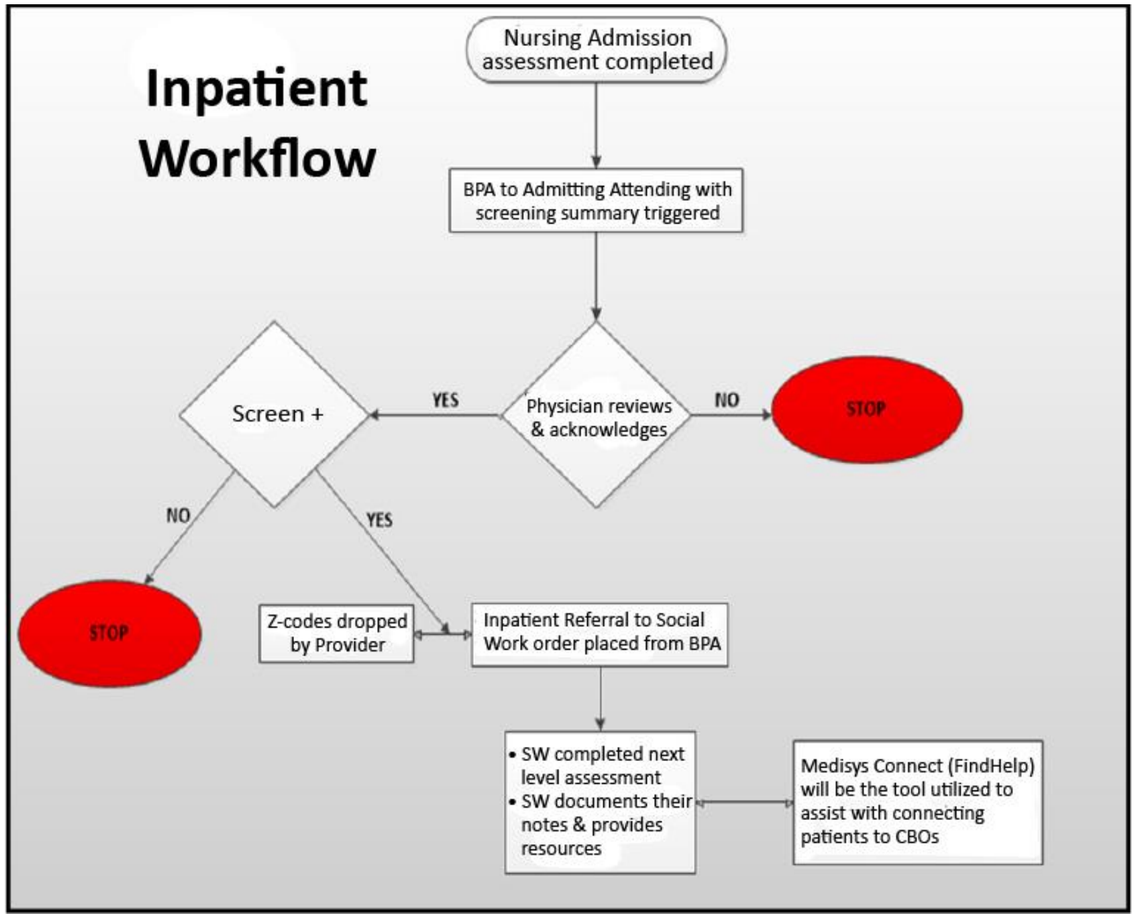
Operational and Clinical leadership met to:

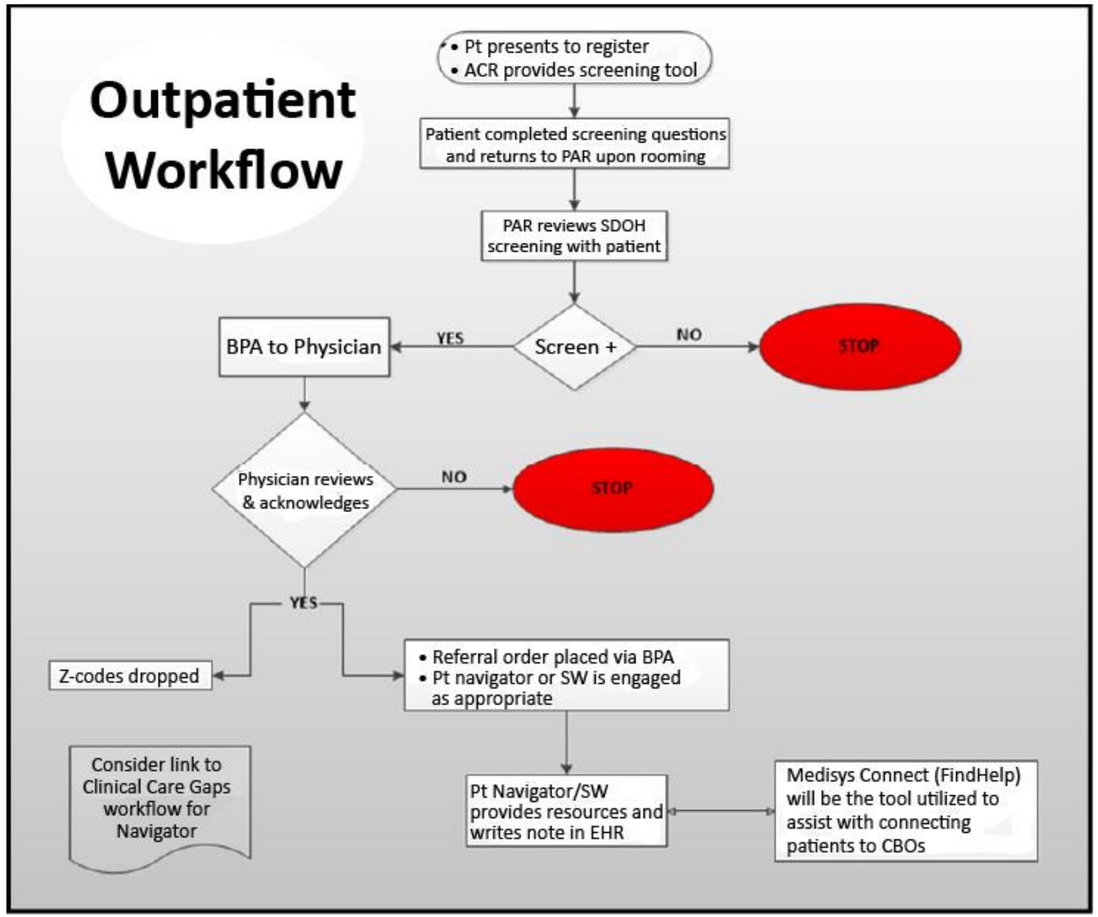
- Assess current processes
- Discuss need to optimize current workflows and improve our SDOH approach
- Initiate the Action plan on change and formulate working Team

Adapting the HRSN Screening Tool



MediSys HRSN Screening Workflow





MediSys HRSN Screening Tool

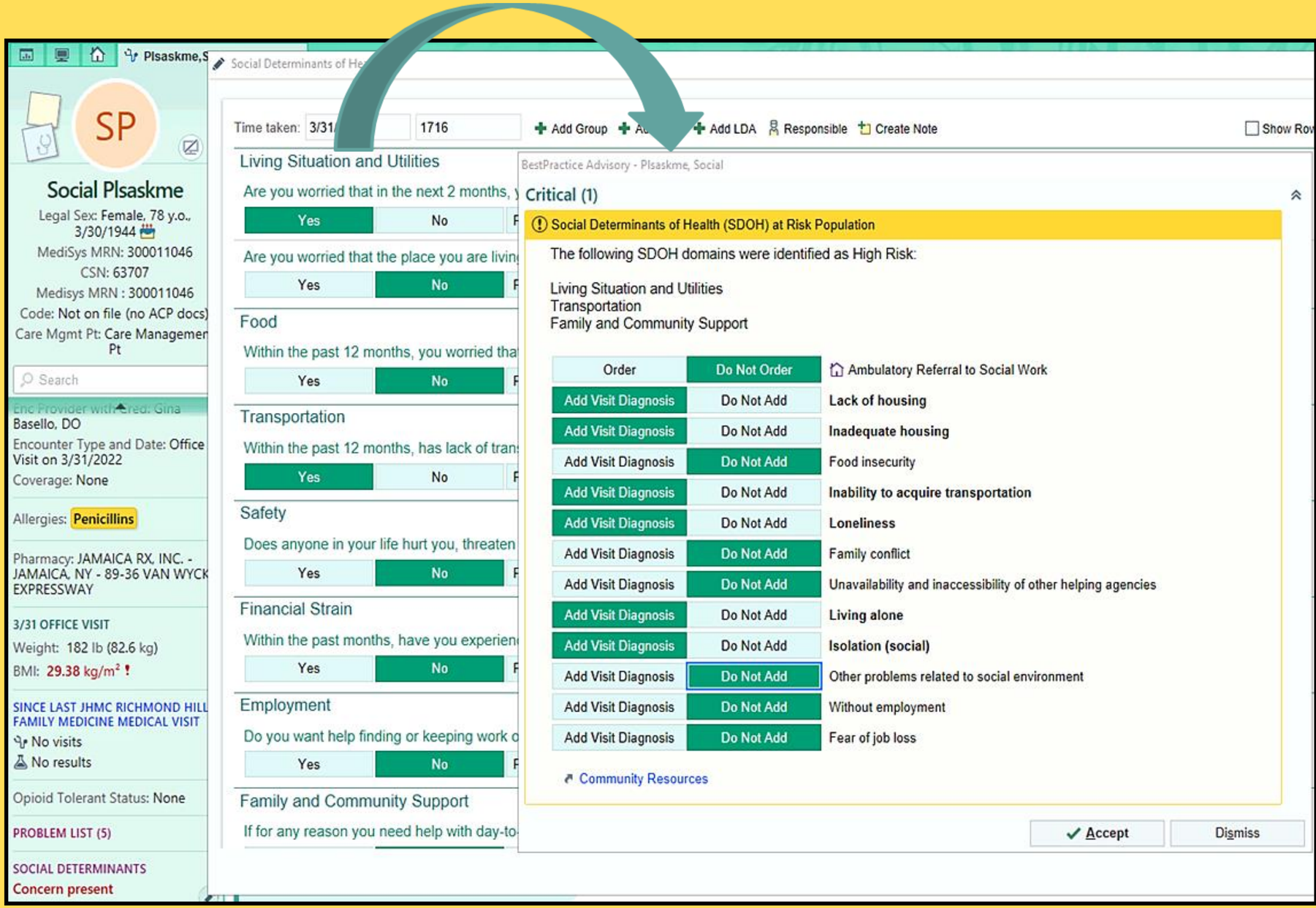
Covered Domains:

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

Question	Response Options
Are you worried that in the next 2 months, you may not have a safe or stable place to live? (Risk of eviction, being kicked out, homelessness)	Yes, No, Prefer not to answer
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes, No, Already shut off, Prefer not to answer
Within the past 12 months, you worried that your food would run out before you got the money to buy more?	Yes, No, Prefer not to answer
Within the past 12 months, has lack of transportation or difficulties with transportation kept you from medical appointments or getting your medications?	Yes, No, Prefer not to answer
Does anyone in your life hurt you, threaten you, frighten you, or make you feel unsafe?	Yes, No, Prefer not to answer
Within the past months, have you experienced any difficulties with paying for the very basics like food, housing, medical care, and heating?	Yes, No, Prefer not to answer
Do you want help finding or keeping work or a job?	Yes, No, Prefer not to answer
Do you need help with day-to-day activities (i.e., assistance with bathing, preparing meals, shopping, managing finances, etc.)?	Yes, No, Prefer not to answer
Do you feel lonely or isolated from those around you?	Yes, No, Prefer not to answer
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from you doctor or pharmacy?	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



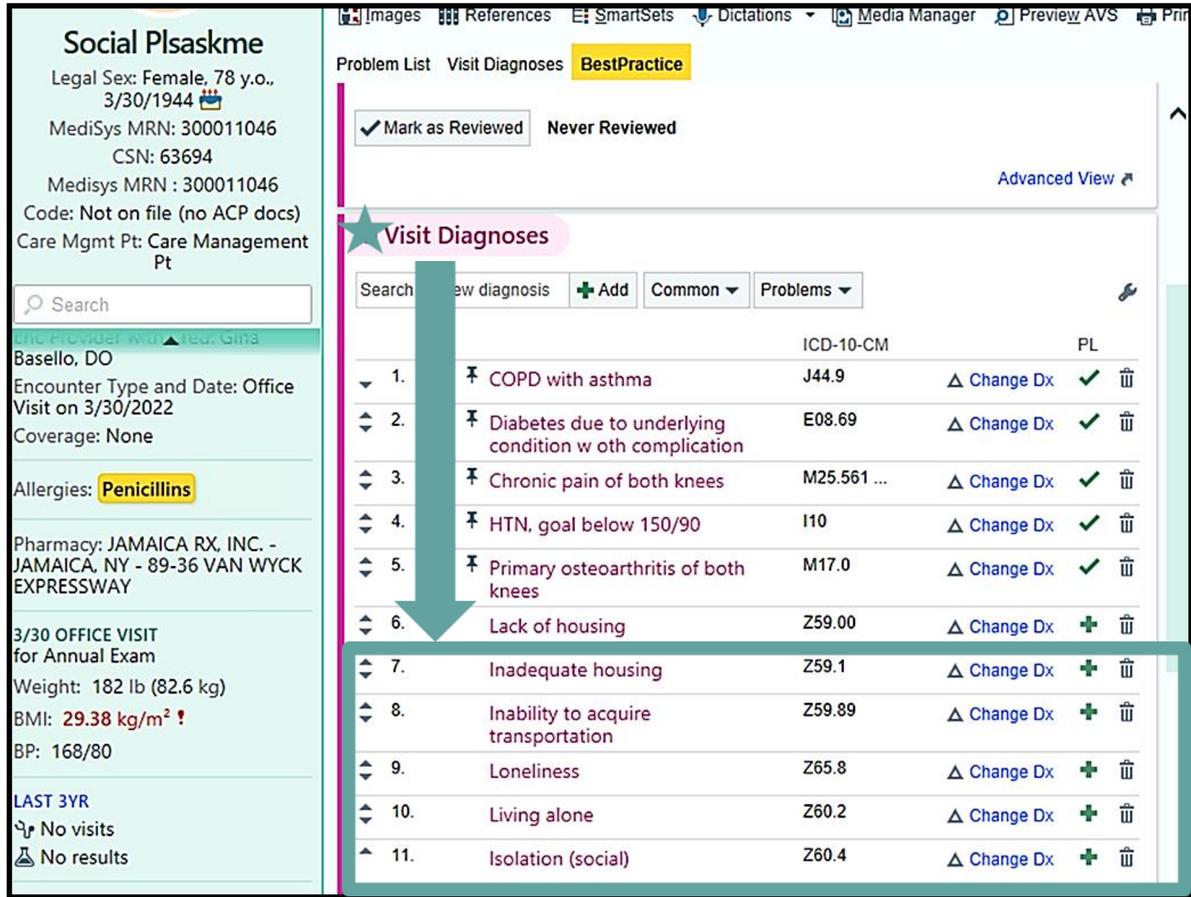
Z-Codes Drop to Patients' Visit Diagnoses

HRSN Domain	Visit Diagnosis	Z-Code	Description
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 health literacy	Z55.6	Problems related to health literacy

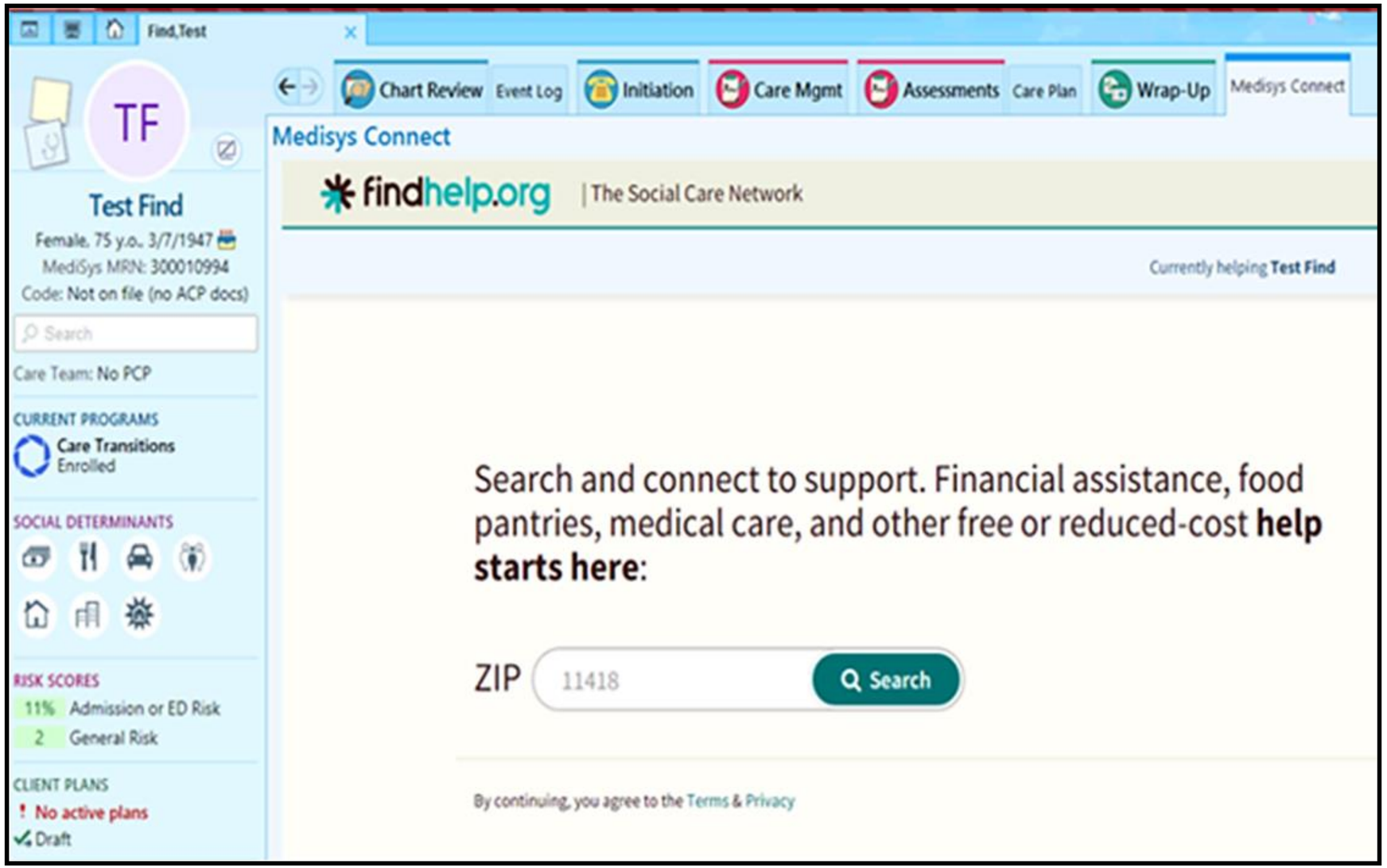
"SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation)

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



Community Referrals through FindHelp



- 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

- 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 patients
- Ongoing communication with stakeholders clarifying their roles and responsibilities in addressing HRSNs in our community.

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

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 here.

ADVANCING HEALTHCARE
EXCELLENCE AND INCLUSION

Questions?

Morgan Black, MPA
mblack@hanys.org

AHEI Team
ahei@hanys.org

HANYS
Always There for Healthcare