Addressing Social Determinants of Health: How to in the Inpatient Arena

October 2024

The meaning of care.®

Objectives

- Understand what Social Determinants of Health entail including the rules and regulations from CMS and TJC.

- Describe what screening tools are available and how they can be operationalized on a large scale.

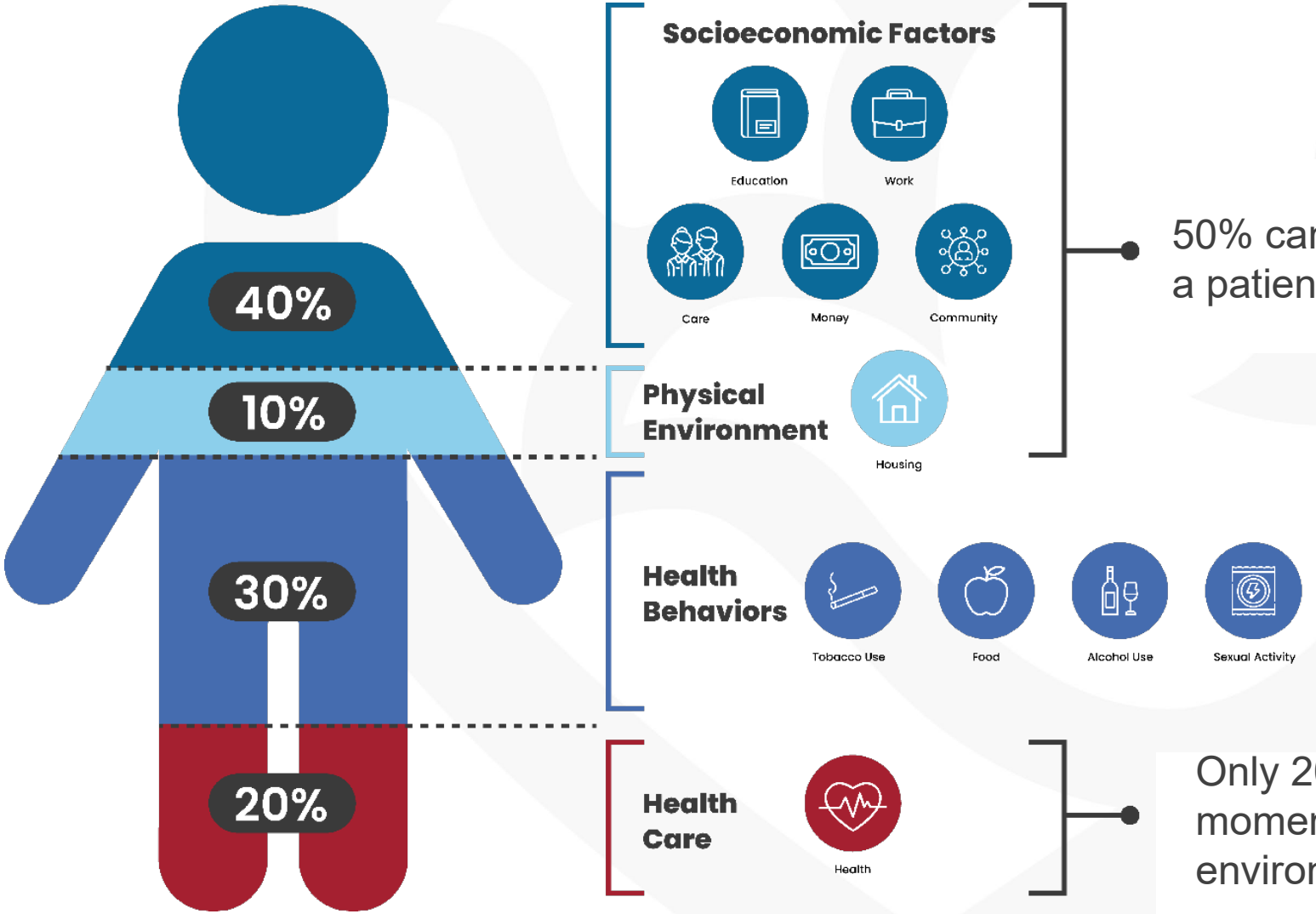
- Understand what z-codes are and how they impact reimbursement.

- Discuss what resources are available for SDOH and what model of care can be operationalized to address the need.

Social Determinants of Health – Health Equity

- Health Equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their full potential of health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
  - Health Equity is essential to improve patient safety, decrease mortality, and improve quality of care. How do we get there?
    - Commitment
    - Screening/ Analysis
    - Intervention

Social Determinants of Health (SDoH)



50% can be traced to a patient's zip code

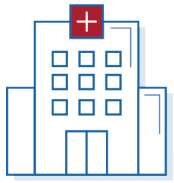
Only 20% include those moments in a health-care environment

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

METHODIST + Nebraska Medicine = NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

2010

The Nebraska Health Network includes:



8 Hospitals

More than 3,200 physicians and advanced practice providers

NHN Patients with Documented Social Determinants of Health

4x

FOUR TIMES THE
COST OF CARE

5x

FIVE TIMES THE
HOSPITAL ADMISSIONS

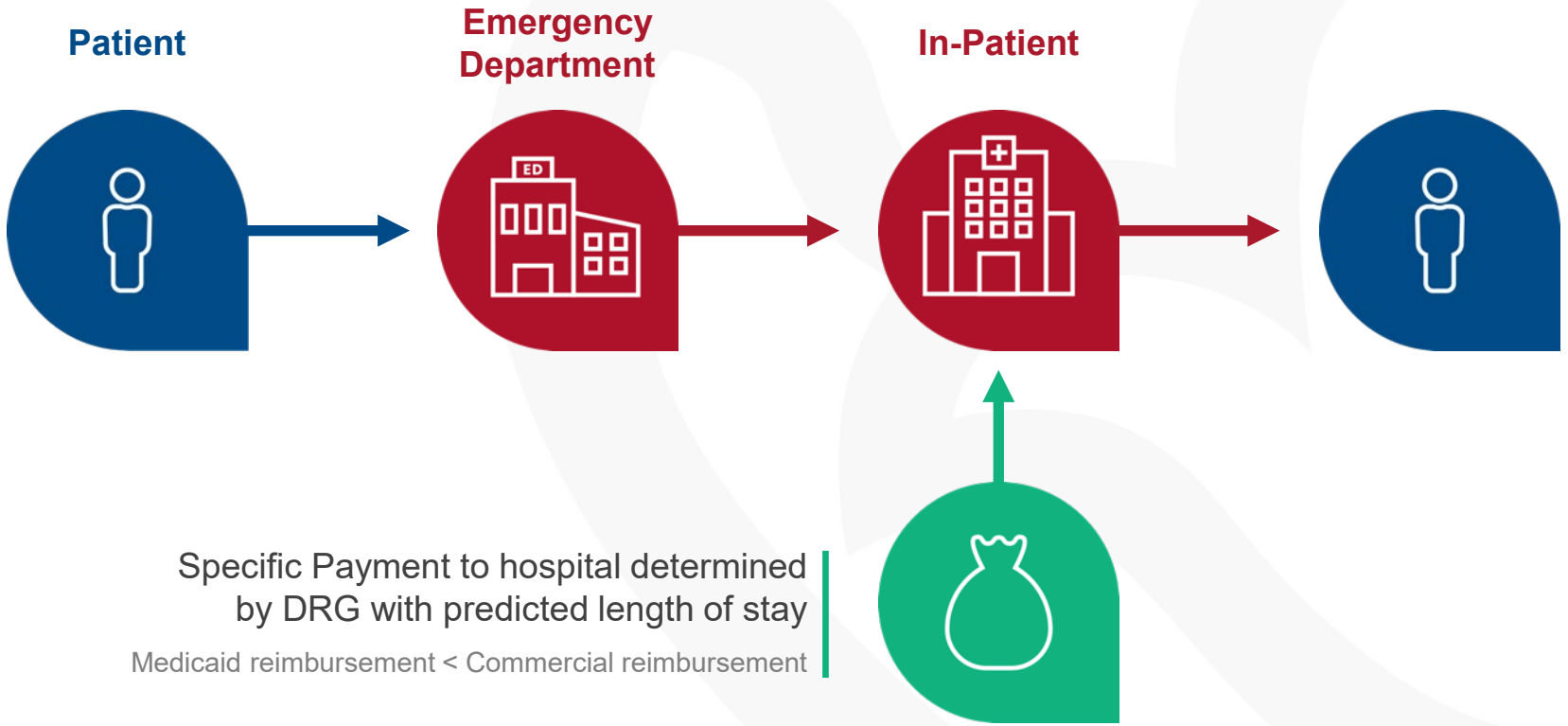
6x

SIX TIMES THE
ED UTILIZATION

Based on an analysis of 200,000 patients in NHN value-based contracts including commercial, Medicare and Medicaid from Nov. 2021 to Oct. 2022.

Multi-Visit Patients: Methodist Main Campus

- 252 Patients have visited your hospital 3+ times in the last 6 months (49 patients 5+ times)
- 686 ED-Only visits among these patients
- Additional 317 ED visits resulted in an Inpatient admission.
- Overall, 32% ED to IP conversion rate among these multi-visit patients



Specific Payment to hospital determined by DRG with predicted length of stay

Medicaid reimbursement < Commercial reimbursement

Length of Stay (days)

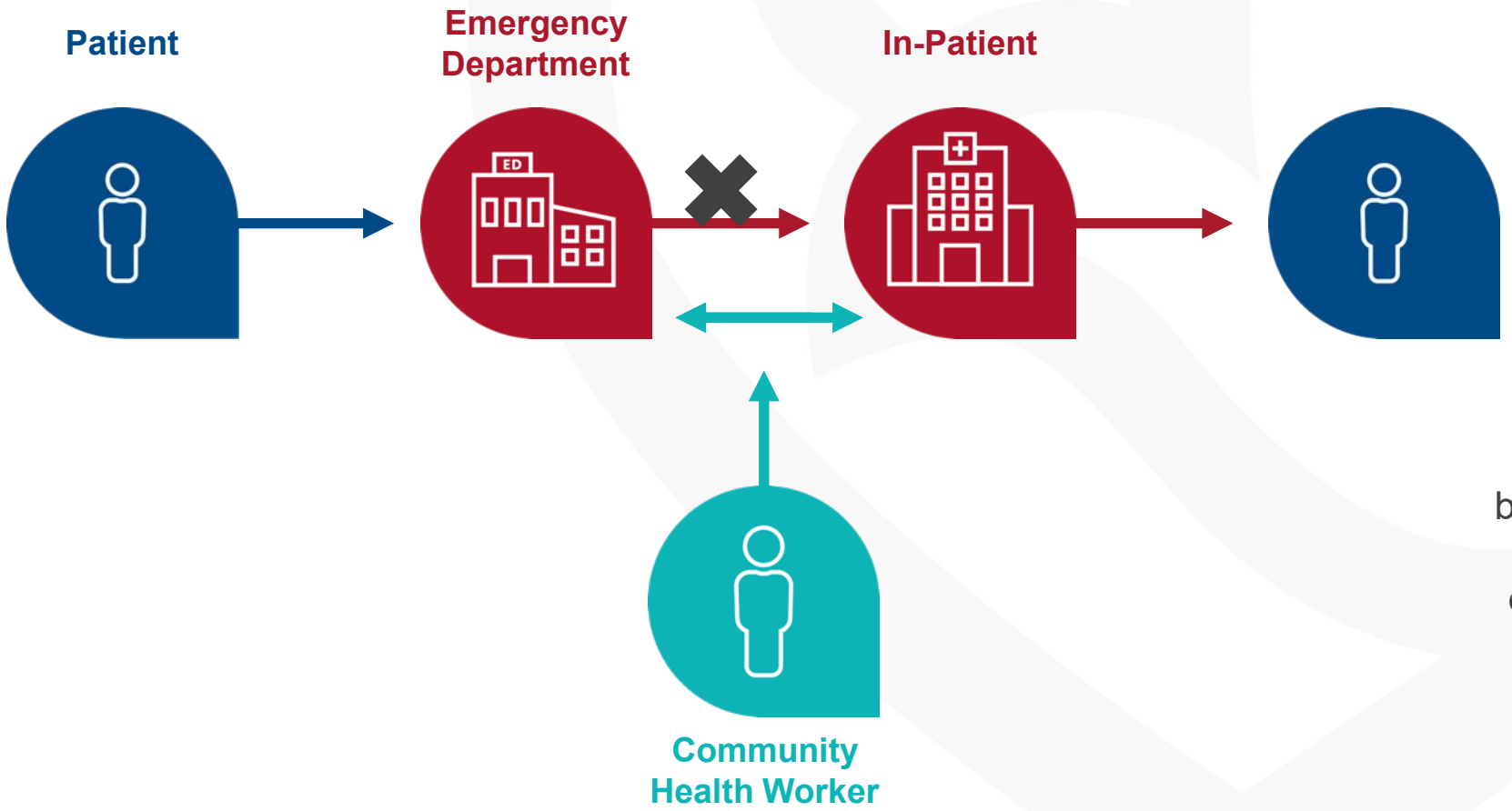
DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
$	$	$	$	X

DAY 6	DAY 7	DAY 8	DAY 9
X	X	X	X

Patient MEDICALLY stable to discharge at end of predicted length of stay, but can't because of SDoH

***Hospital stay in red**

Interdisciplinary Impact from Addressing SDoH



Length of Stay (days)

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
$	$	$	$	X

DAY 6	DAY 7	DAY 8	DAY 9
X	X	X	X

CHW works with SW to remove barriers to decrease hospital length of stay (and non-paid days) establishing ROI and sustainability

NMHS SDOH Steering Committee

Purpose:

- Share new or existing initiatives at each affiliate, delegate action items to SDOH Taskforce as needed, share data, and identify community partners
- Efforts are prioritized by each affiliate to align with the needs of their patient population and with any regulatory/ accrediting bodies.

Membership:

- Committee Chair: Becky Jizba
- NMH/ WH: VP Ancillary Services, Quality, Clinical Staff, Care Management/Social Work
- MJE: VP Ancillary Services, Quality, CNO, Clinical Staff, Care Management/Social Work
- MFH: VP Ancillary Services, Quality, Clinical Staff, Care Management/Social Work
- MPC: Quality
- MHS: Foundation members, Community Benefits, IT/Informatics

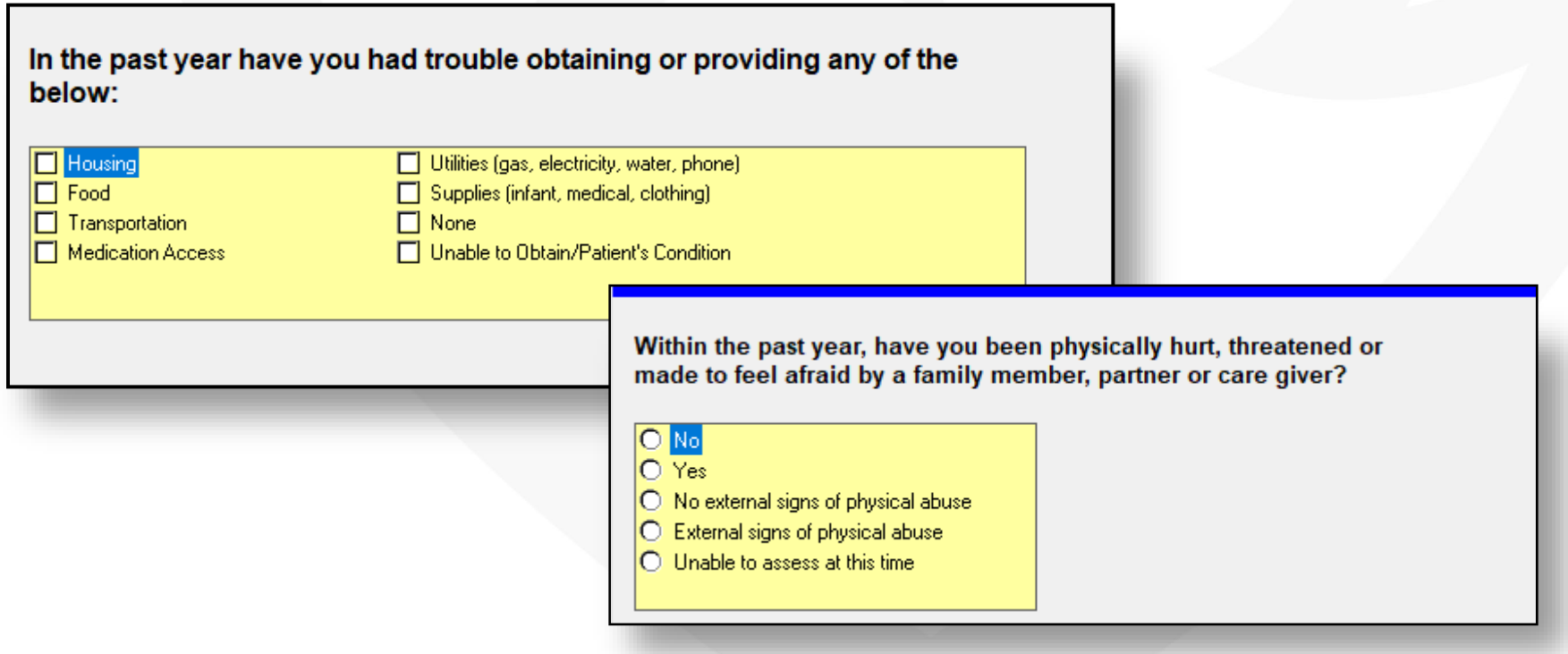
SDOH Steering Committee Goals 2023

Ensure each hospital affiliate developed and implemented a health equity plan outlined by CMS and TJC

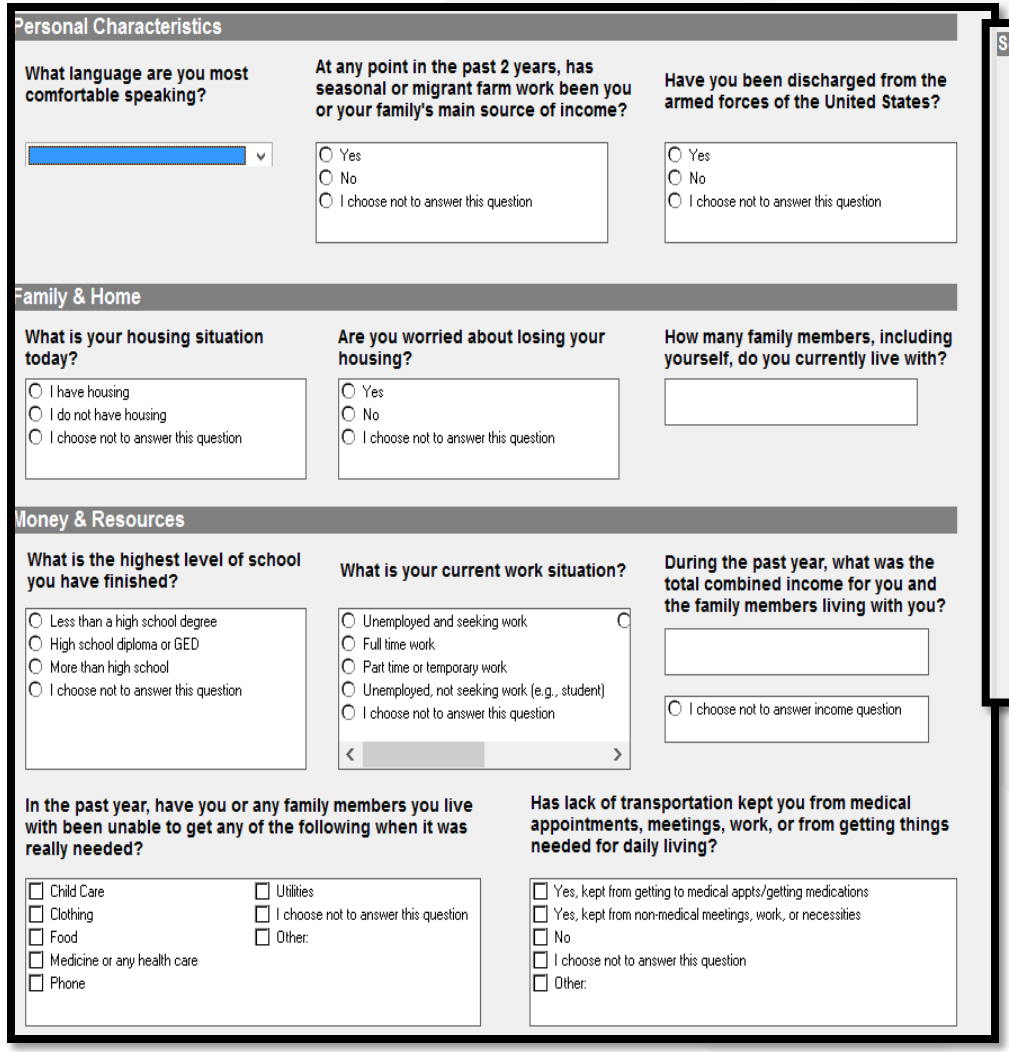
- CMS: Hospital Commitment to Health Equity (HCHE): Social Determinants of Health (SDOH)
- TJC: LD.04.03.08 Reducing health care disparities for the organizations patients is a quality and safety priority: Health- related social needs (HRSN)
- Six EPs
  - EP 1: Designate Leader(s)
  - EP 2: Assess Health Related Social Needs and provide information about resources
  - EP 3: Stratification of Quality/Safety Data
  - EP4: Action Plan and Method to Monitor
  - EP5: Monitor Action Plan
  - EP 6: Leadership Engagement

Inpatient Process for Identification of SDoH

- Initial screening question completed:
  - SDOH Screening Assessment went Live August 8th, 2023.
    - SDOH Assessment incorporated into admission history- mandatory on every hospital admission to all hospital affiliates.
    - For any positive screen (any box checked other than none/no) a social work will then receive a consult to see patient.



SW/CHW assessments - PRAPARE Tool



Personal Characteristics

What language are you most comfortable speaking?

At any point in the past 2 years, has seasonal or migrant farm work been you or your family's main source of income?

- Yes
- No
- I choose not to answer this question

Have you been discharged from the armed forces of the United States?

- Yes
- No
- I choose not to answer this question

Family & Home

What is your housing situation today?

- I have housing
- I do not have housing
- I choose not to answer this question

Are you worried about losing your housing?

- Yes
- No
- I choose not to answer this question

How many family members, including yourself, do you currently live with?

Money & Resources

What is the highest level of school you have finished?

- Less than a high school degree
- High school diploma or GED
- More than high school
- I choose not to answer this question

What is your current work situation?

- Unemployed and seeking work
- Full time work
- Part time or temporary work
- Unemployed, not seeking work (e.g., student)
- I choose not to answer this question

During the past year, what was the total combined income for you and the family members living with you?

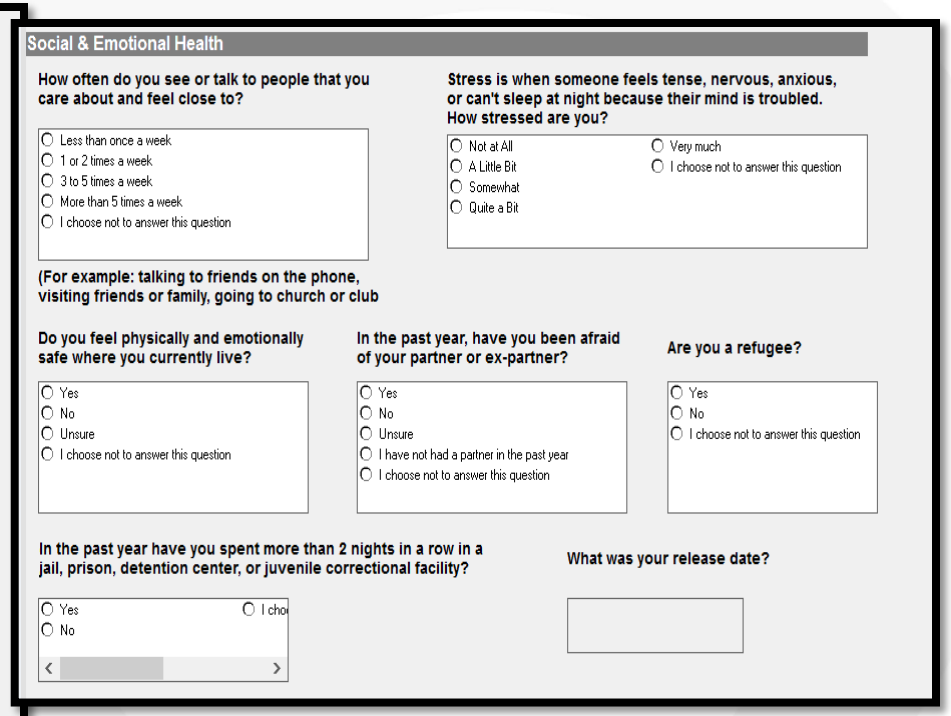
- I choose not to answer income question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

- Child Care
- Clothing
- Food
- Medicine or any health care
- Phone
- Utilities
- I choose not to answer this question
- Other:

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- Yes, kept from getting to medical appts/getting medications
- Yes, kept from non-medical meetings, work, or necessities
- No
- I choose not to answer this question
- Other:



Social & Emotional Health

How often do you see or talk to people that you care about and feel close to?

- Less than once a week
- 1 or 2 times a week
- 3 to 5 times a week
- More than 5 times a week
- I choose not to answer this question

(For example: talking to friends on the phone, visiting friends or family, going to church or club

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

- Not at All
- A Little Bit
- Somewhat
- Quite a Bit
- Very much
- I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

- Yes
- No
- Unsure
- I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Unsure
- I have not had a partner in the past year
- I choose not to answer this question

Are you a refugee?

- Yes
- No
- I choose not to answer this question

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

- Yes
- No

What was your release date?

SW/CHW assessments - WellRX Questionnaire

WellRx Questionnaire-Revised

In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	○ No ○ Yes
Are you homeless or worried that you might be in the future?	○ No ○ Yes
Do you have trouble paying for your gas or electricity bills?	○ No ○ Yes
Do you have trouble finding or paying for a ride (transportation)?	○ No ○ Yes
Do you need daycare, or better daycare, for your kids?	○ No ○ Yes
Are you unemployed or without regular income?	○ No ○ Yes
Do you need help finding a better job?	○ No ○ Yes
Do you need help getting more education?	○ No ○ Yes
Are you concerned about someone in your home using drugs or alcohol?	○ No ○ Yes
Do you need help with legal issues?	○ No ○ Yes
Do you feel unsafe in your daily life?	○ No ○ Yes
Is anyone in your home threatening or abusing you?	○ No ○ Yes
In the last 6 months, have you been at the Emergency Department more than twice?	○ No ○ Yes
If Yes, how many times?	
In the last 6 months, have you been hospitalized?	○ No ○ Yes
If Yes, how many times?	

Provider Note

TESTCERNER, METHODIST

Chief Complaint

History of Present Illness

Review of Systems

Physical Exam

Vitals & Measurements

Lab Results

Diagnostic Results

Assessment/Plan

Weakness of left arm (Other symptoms and signs involving the musculoskeletal system)

Medications and Immunizations Administered

Surgical Records

No surgical procedures qualified.

Procedures

Medications

Ancef (MH/WH), 2000 mg= 20 mL , IV Push, PREOP
chlordiazePOXIDE 25 mg oral capsule, 25 mg= 1 CAP , By Mouth, QID
Lumason, 2 mL , IV Push, Once
Lumason, 2 mL , IV Push, Once
Paxlovid 150 mg-100 mg Dose Pack oral tablet, 2 TAB Dosing for patients with moderate renal imparement (eGFR between 30 to 60 mL/minute). Take 1 - nirmatrelvir 150mg tablet and 1 - ritonavir 100mg tablet by mouth twice daily for 5 days., By Mouth, BID
rivaroxaban 20 mg oral tablet, 20 mg= 1 TAB This comment is in special instructions, By Mouth, DAILYW/SUPPER
sulfur hexafluoride, 2 mL , IV Push, Once
sulfur hexafluoride, 2 mL , IV Push, Once

Social History

Exercise
Exercise participation: Yes. Exercise type: Yoga., 10/20/2023
Substance Abuse
Past, Marijuana, 10/01/2023
Tobacco
Current Vaping/e-Cigarettes, 03/16/2023
Current every day smoker, Ready to change: No. Cigars, Other tobacco amount per day: 1. Never Smokeless Tobacco., 03/16/2023
Current every day smoker, Cigarettes, 08/03/2022

Social Determinants of Health

Current housing situation: I do not have housing (11/29/23 13:21) - **Z59.10**
Worry about loss of housing: Yes (11/29/23 13:21) - **Z59.819**
Unable to acquire necessities: Food (11/29/23 13:21) - **Z59.48**
Lack of transportation impacts: Yes, kept from getting to medical appts/getting medications (11/29/23 13:21) - **Z59.82**

Current every day smoker, Cigarettes, 08/03/2022

Social Determinants of Health

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Cross walk for Coding

2024 mappings		
	PRAPARE tool	
PRAPARE questions	**Response**	**Mapping to ICD-10**
Highest level of school finished	Less than a high school degree	Z55.5 Less than a high school diploma
What is your housing situation today	I do not have housing	Z59.00 Homelessness unspecified
Discharged from US Armed Forces	Yes	Z91.85 Personal history of military service
Current housing situation	I do not have housing	Z59.10 Inadequate housing, unspecified
Worry about loss of housing	Yes	Z59.819 Housing instability, housed unspecified
Highest level of school finished	Less than a high school degree	Z55.5 Less than a high school diploma
Unable to acquire necessities	Food	Z59.48 Other specified lack of adequate food
Unable to acquire necessities	Child Care	Z59.87 Material Hardship Not Elsewhere Classified
Unable to acquire necessities	Clothing	Z59.87 Material Hardship NEC
Unable to acquire necessities	Medicine or any health care	Z59.86 Financial insecurity
Lack of transportation impacts	Yes, kept from getting to medical appts/getting medications	Z59.82 Transportation Insecurity
Current Work Situation	Unemployed, looking for work; unemployed, not looking for work	Z56.0 Unemployement, unspecified;
	WellRx	
WRX Homeless	Yes	Z59.811 Housing instability, housed, with risk of homelessness
WRX unemployed	Yes	Z56.0 Unemployement, unspecified
WRX Eat Less, Skip Meals Due to Funds P2M	Yes	Z59.48 Other specified lack of adequate food
WRx Trouble Pay For Gas, Electric Bills	Yes	Z59.12 Inadequate housing utilities
WRx Trouble Finding Or Paying For A Ride	Yes	Z59.82 Transportation Insecurity
WRx Need Help Getting More Education	Yes	Z55.8 Other problems related to education and literacy
WRx Need Help With Legal Issues	Yes	Z65.3 Problems related to other legal circumstances
WRx Anyone in Home Threatening,Abusive	Yes	Z91.419 Personal history of unspecified adult abuse

ED Past Medical/Social History		
Current Living situation	homeless	Z59.00 Homelessness unspecified
Current living situation	Shelter	Z59.01 Sheltered homelessness
Current living situation	Temporary housing	Z59.01 Sheltered homelessness
Current living situation	Halfway house	Z59.00 Homelessness unspecified

SDOH Screening Data- Methodist Hospital

PERCENT POSITIVE
4.66%

PATIENTS WITH AT LEAST 1 PO
679

SDOH Name	Total	% of SDOH Identified	% of Total Screened	% of Total Listed
Homelessness	26	1.87%	0%	0%
Medication access	236	17%	0.02%	0.02%
Food	233	16.79%	0.02%	0.02%
Housing	231	16.64%	0.02%	0.02%
Supplies	127	9.15%	0.01%	0.01%
Transportation	335	24.14%	0.02%	0.02%
Utilities	200	14.41%	0.01%	0.01%

Nurse Unit	Total	% of SDOH Identified
4NORTH	96	6.92%
5-FLR	128	9.22%
5NORTH	209	15.06%
6-FLR	117	8.43%
6NORTH	143	10.3%
7-FLR	78	5.62%
7NORTH	8	0.58%
8-FLR	347	25%
8NORTH	127	9.15%
9-FLR	103	7.42%
9NORTH	28	2.02%
MH Peri Op	4	0.29%

SDOH Screening Data – Fremont Hospital

PERCENT POSITIVE
12.62%

PATIENTS WITH AT LEAST 1 POSITI
522

SDOH Name	Total	% of SDOH Identified	% of Total Screened	% of Total Listed
Homelessness	127	8.65%	0.03%	0.03%
Medication access	223	15.18%	0.05%	0.05%
Food	235	16%	0.06%	0.05%
Housing	329	22.4%	0.08%	0.08%
Supplies	130	8.85%	0.03%	0.03%
Transportation	254	17.29%	0.06%	0.06%
Utilities	171	11.64%	0.04%	0.04%

Nurse Unit	Total	% of SDOH Identified
FH 3-FLR	341	23.21%
FH 4-FLR	13	0.88%
FH BH	1052	71.61%
FH ICU	12	0.82%
FH L-D	51	3.47%

Role Clarity

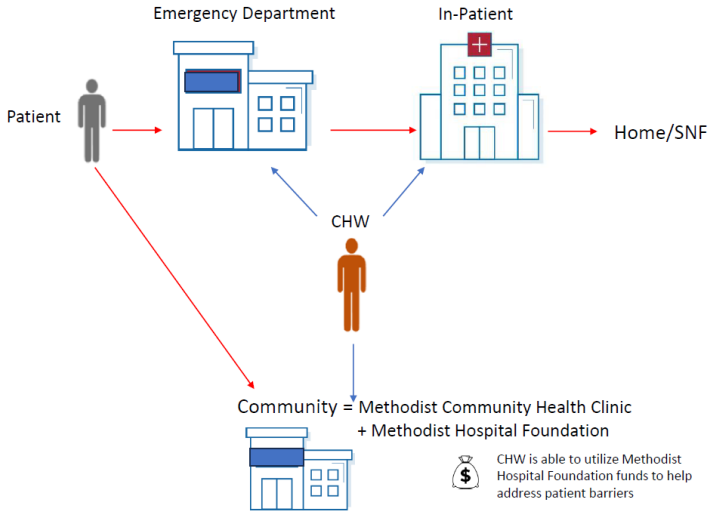
Community Health Worker

- Focus
  - Social Determinants of Health
  - Health Equity
- Background
  - Nonclinical
  - Formal training not required, certificatio available
  - Often a member of the community they serve
- Roles and Responsibilities
  - Screens for the presence and causes of Social Determinants of Health
  - Connects individuals to community resources
  - Builds trust and establishes a relationship for ongoing support
  - Fosters relationships with community organizations

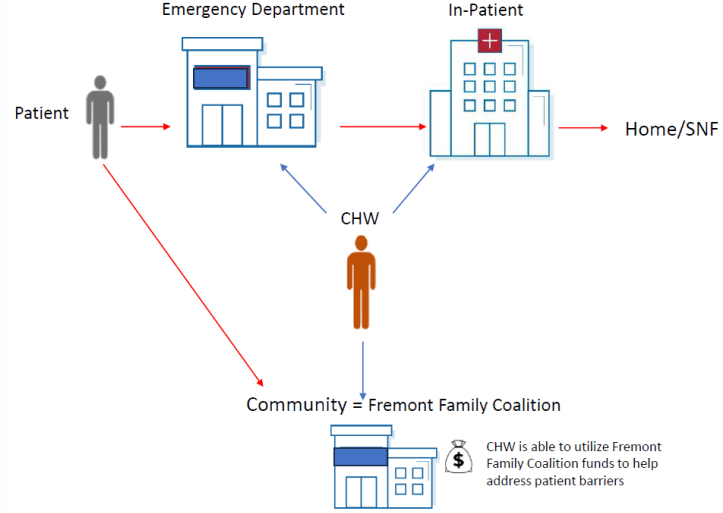
Medical Social Worker

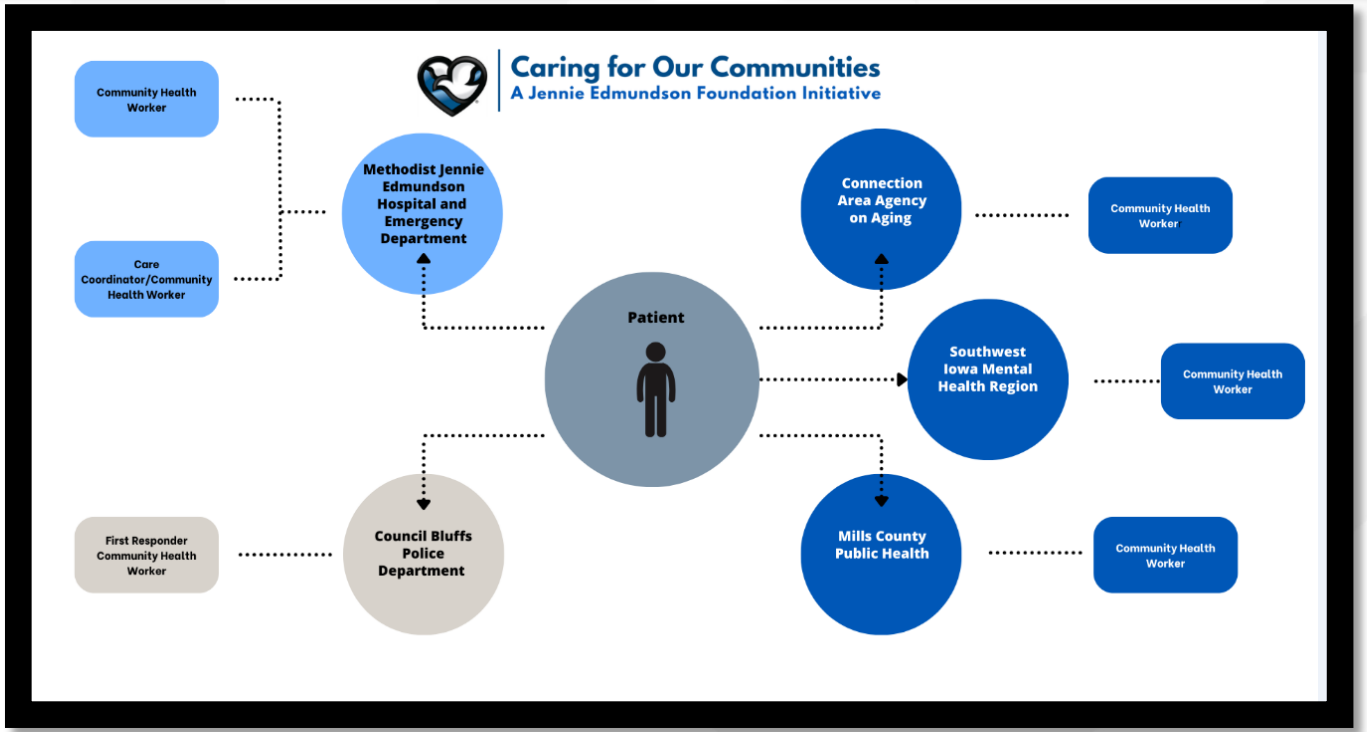
- Focus
  - Facilitating safe discharge
  - Ensuring social, emotional, physiological and psychological well-being
- Background
  - Clinical
  - Hold a bachelor's or master’s degree in social work
  - Certification available
- Roles and Responsibilities
  - Addresses complex social needs for at-risk populations
  - Assists with eligibility determination for funding sources and social programs
  - Manages care transitions for the inpatient individual

Methodist Hospital CHW



Methodist Fremont Health CHW



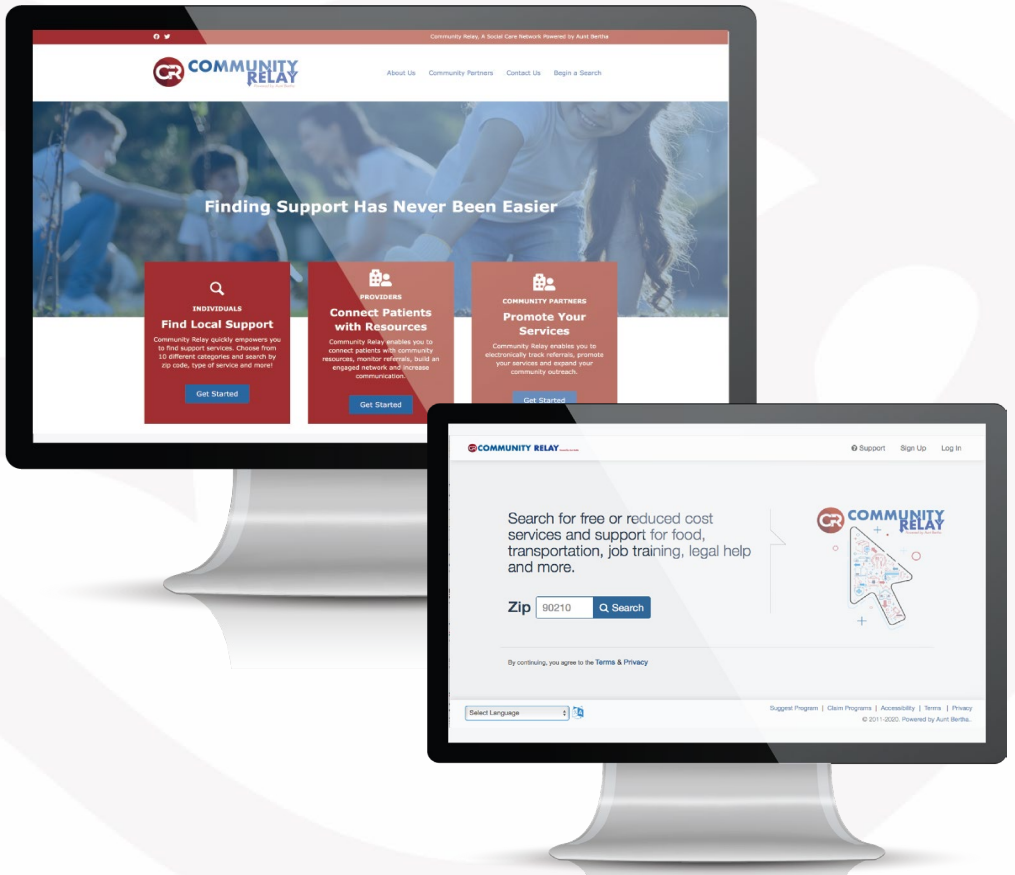


Community Relay

Community Relay, powered by Findhelp, is used by NHN to provide a resource and referral database for their ACO members and communities.

CHWs and other staff can use to:

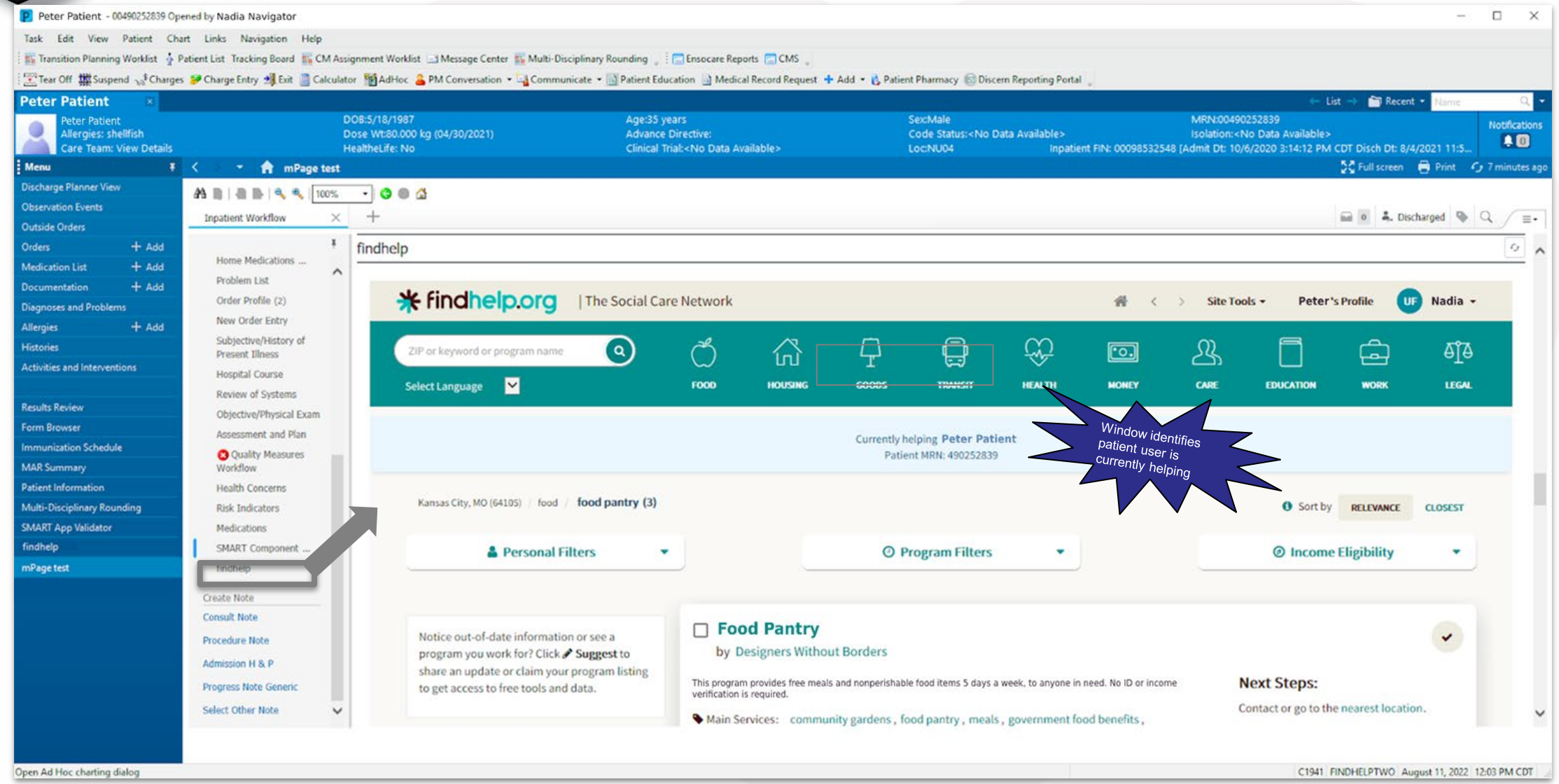
- Search and find free or reduced-cost direct social care programs
- Connect their members with programs and manage their SDOH and health equity needs
- Update the status of referrals placed and see real-time updates as organizations complete them
- Access to analytics around search and usage information



https://communityrelay.com/

COMMUNITY RELAY
Powered by findhelp

Cerner Integration



Displaced female admitted with renal complications due to lack of access to adequate food and stable housing.

Z codes

- Z59.01 – Housing, sheltered homeless
- Z59.4 – Food, lack of adequate food

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Challenges:

Patient was admitted with renal complications because she was displaced from her apartment after flooding and lacked access to adequate food to comply with dietary recommendations. The patient's apartment had flooded, and the Red Cross had paid for one month in a hotel, but now the patient was living at the Open Door Mission while trying to find new available housing for her and her mother. Patient reliant on food pantries and lacked access to prepare healthy meals.

Resolution:

- CHW met with the patient and her mother while inpatient and post discharge at the Methodist Community Health Clinic at Kountze Commons. Together, the CHW referred the patient to additional housing and food pantry options.
- CHW continues to meet with the patient and her mother at Kountze Commons to assist with housing applications and additional counseling referrals.

HOUSING | FOOD | WORK | TRANSIT | LEGAL | CARE | EDUCATION | FINANCIAL | HEALTH | GOODS

Patient was a high ED utilizer who was in her third trimester of a high-risk pregnancy, had two other kids at home and had lost her job

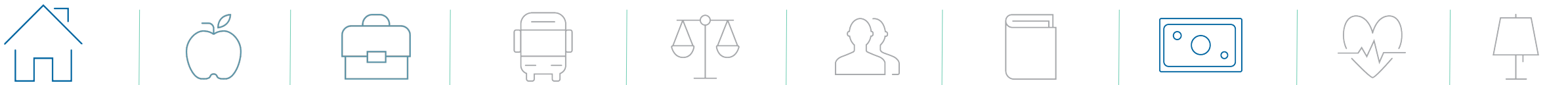
Z codes
Z56.89, Work Environment - employment
Z59.8, Housing - housing instability
Z59.41, Food - food insecurity
Z59.6, Financial - low income

Challenges:

Patient had to quit her job and the loss of income impacted her ability to maintain their basic needs. She applied for rental assistance but had not heard back. Her rent was overdue, but she believed she had made the payments, but did not have documentation to prove payment to her landlord.

Resolution:

- CHW referred the family to local food pantries.
- CHW helped the family secure payment documentation and called the landlord with the patient. The landlord forgave the past-due payments.
- **The patient thanked the CHW and told her she would not have been able to follow through and be so persistent without her.**



Questions?