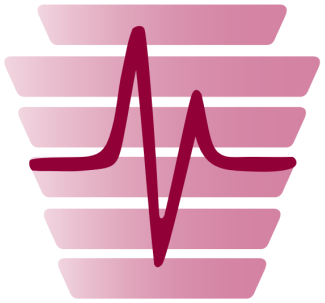


Keystone Health

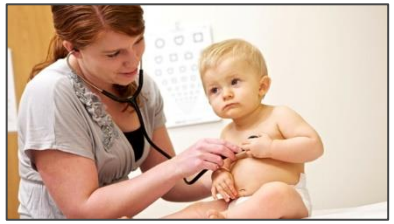
Social Determinants of Health

Assessment, Documentation, and Referrals

Heather Goshorn, RN, BSN
Manager of Enabling Services,
Keystone Health

Introduction

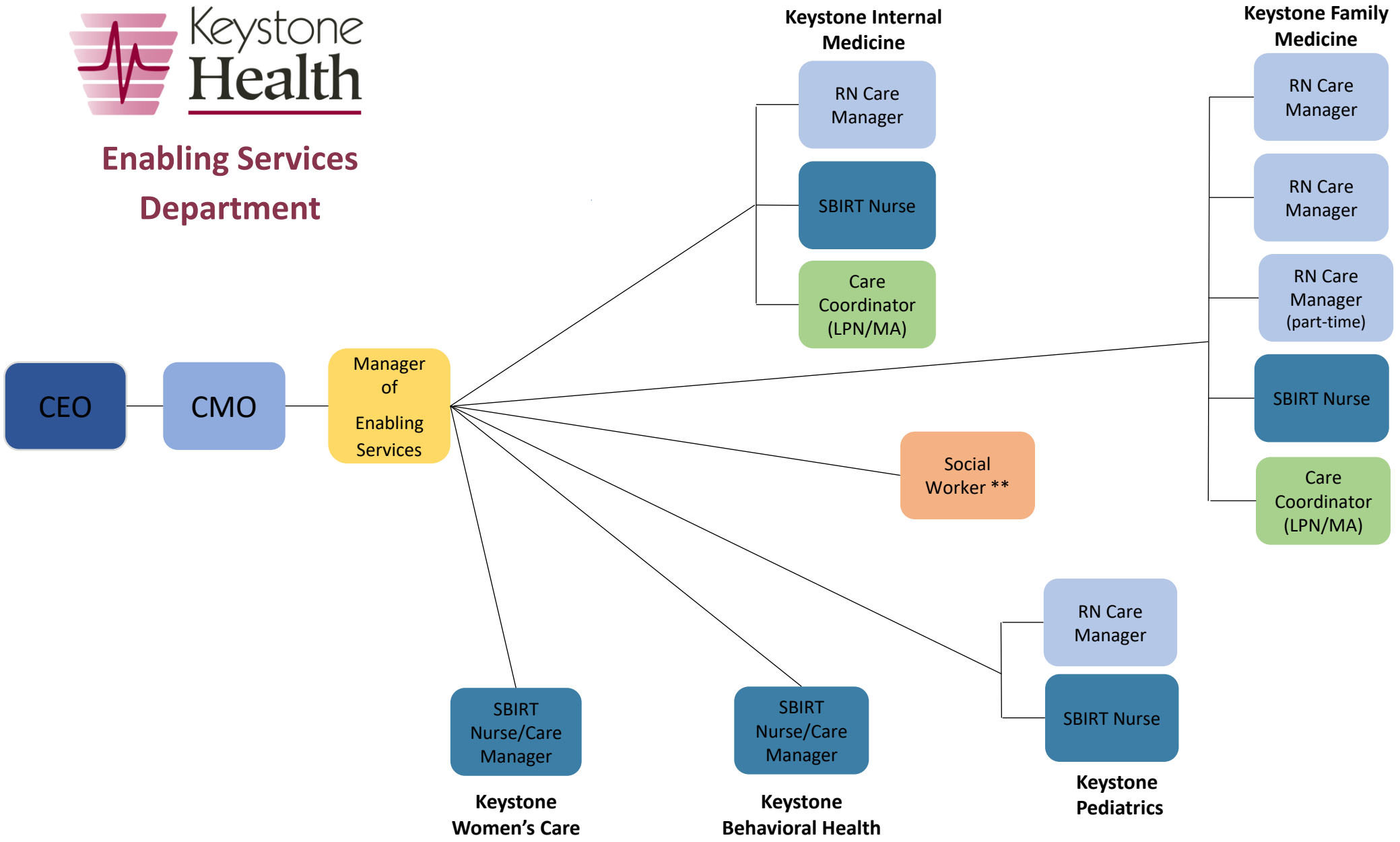
- **Located in** Chambersburg, PA
- **Our Practices:**
  - Family Practice
  - Internal Medicine
  - Pediatrics (2 offices)
  - Women's Care
  - Behavioral Health
  - Community Health Services
  - Urgent Care
  - Infectious Disease
  - Adult and Pediatric Dental Care
  - Foot and Ankle
  - Chiropractic
  - Pharmacy
  - Pediatric Developmental Center



Keystone Health

Keystone Health

Enabling Services Department



SDOH - Assessment

WHY??

- Keystone's focus was moving from volume-based to value-based care.

  How do you provide the best care possible without understanding social determinants and how they impact the patient's outcomes?

- Goals:
  - To identify correlative properties between SDOH characteristics and clinical outcomes in our patient population.
  - To develop more refined risk stratification criteria to help identify patients who would benefit from increased care management resources.
  - To link patients with certain social determinants to available community resources AND identify where our local community resources may be insufficient to meet our patients' needs.

SDOH Screening Tool

- In June 2018, we developed a 10-question patient screening form, based on the PRAPARE tool, in English and Spanish.
- We adapted the form to 8 questions in order to match the SDOH template in the Epic System.
- The form is given to patients at check-in to complete while waiting.
- Our goal is to have patients complete the screening annually.

Screening Questions

- Current work/employment status
- Education level
- Financial difficulty
- Housing
- Transportation
- Food insecurity
- Social connections
- Partner abuse

Keystone Health

Social Determinants of Health Questionnaire

Patient Name: _____ Date of Birth: _____

Parent/Guardian if applicable: _____

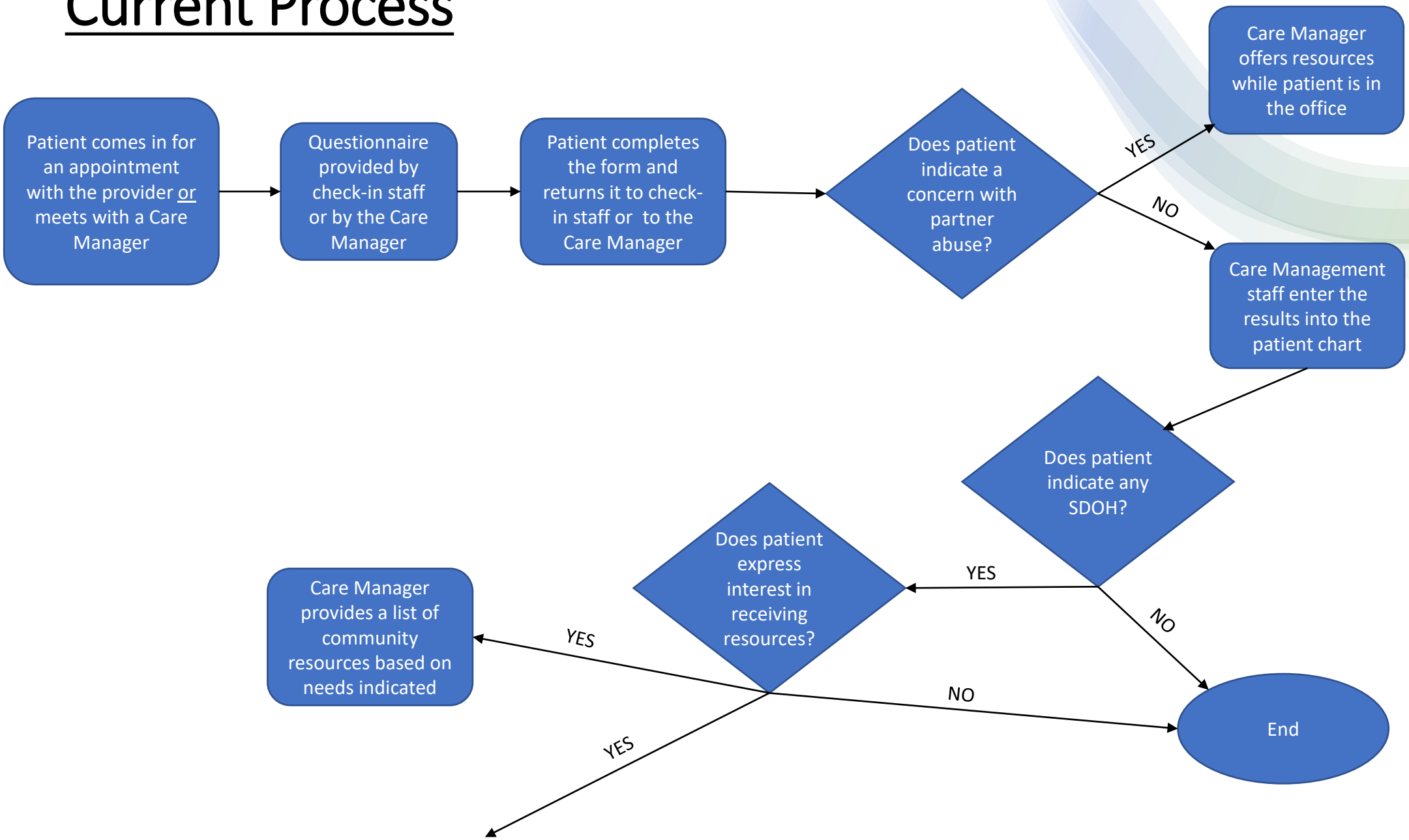
1.	In the past year, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?	☐Yes ☐No ☐I choose not to answer this question
2.	What is the **highest level of school** that you have completed, or the highest degree you have received?	Please list highest level of school completed: _____ (please list actual grade level or degree completed) ☐I choose not to answer this question
3.	What is your **current work situation**?	☐Unemployed and seeking work ☐Part time or temporary work ☐Full time work ☐Unemployed but not seeking work (ex: student, retired, disabled)
4.	In the past year, **you worried that your food would run out** before you were able to buy more.	☐Never true ☐Sometimes true ☐Often true ☐ I choose not to answer this question
5.	In the past year, **have you been afraid of your partner or ex-partner?**	☐Yes ☐No ☐I choose not to answer this question
6.	In a typical week, how often do you talk with or get together with family, friends, or neighbors?	☐Never ☐Once a week ☐Twice a week ☐Three times a week ☐More than three times a week ☐I choose not to answer this question
7.	Has **not having transportation** kept you from doctor's appointments, meetings, work or from getting things you need for daily living? (check all that apply)	☐Yes, it has kept me from medical appointments or from getting my medications ☐Yes, it has kept me from meetings, appointments, work, or from getting things that I need ☐No ☐I choose not to answer this question
8.	How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	☐Not hard at all ☐Not very hard ☐Somewhat hard ☐ Hard ☐Very hard ☐ I choose not to answer this question

Would you be interested in receiving information on resources available to you?

____ YES

____ NO

Current Process



Our NEW process – Coming Soon!

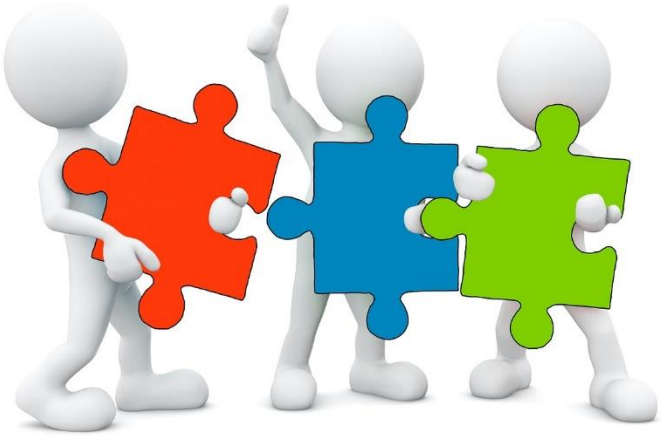
Referral made to the Social Worker

Social Worker contacts the patient to discuss need and refers patient to the appropriate resources

Social Worker tracks the referrals to ensure the patient makes contact

Social Worker tracks and monitors the outcomes of the referrals

The organization evaluates the outcomes to identify gaps and determine ways to better address patient needs



SDOH – Analyzing the Data

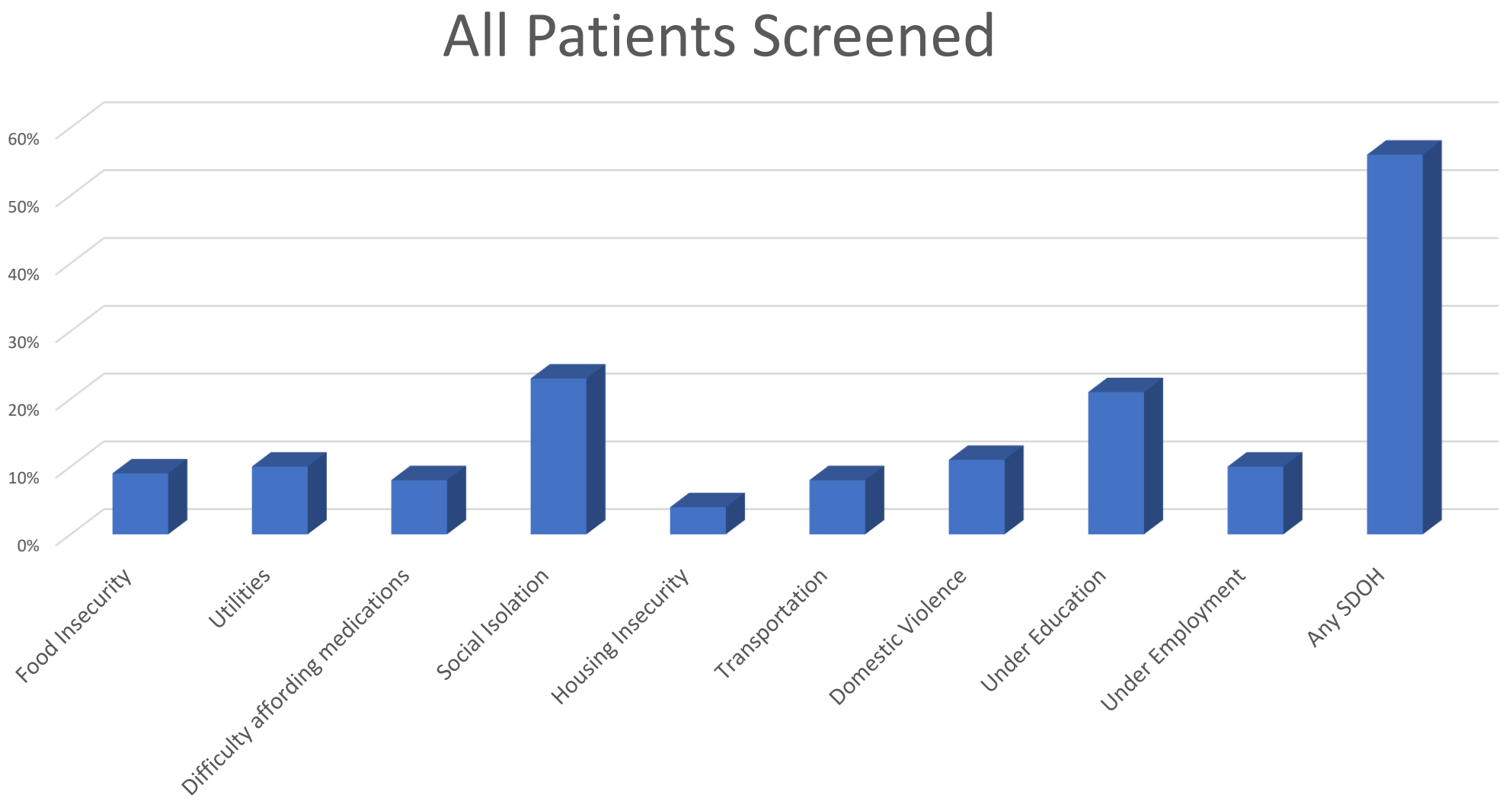
- We developed a template that interfaced with i2i to allow data collection and analysis. (Our interface with i2i is temporarily on hold with our transition to Epic.)
- An iPHA report was built to enable us to stack certain clinical conditions and compare the likelihood of patients with that diagnosis having a SDOH vs. the general population surveyed.
- We also built a report to stack the SDOH onto the NACHC Risk stratification tool to identify those patients who are medically “highest risk” who also have a SDOH.

SDOH – Analyzing the Data

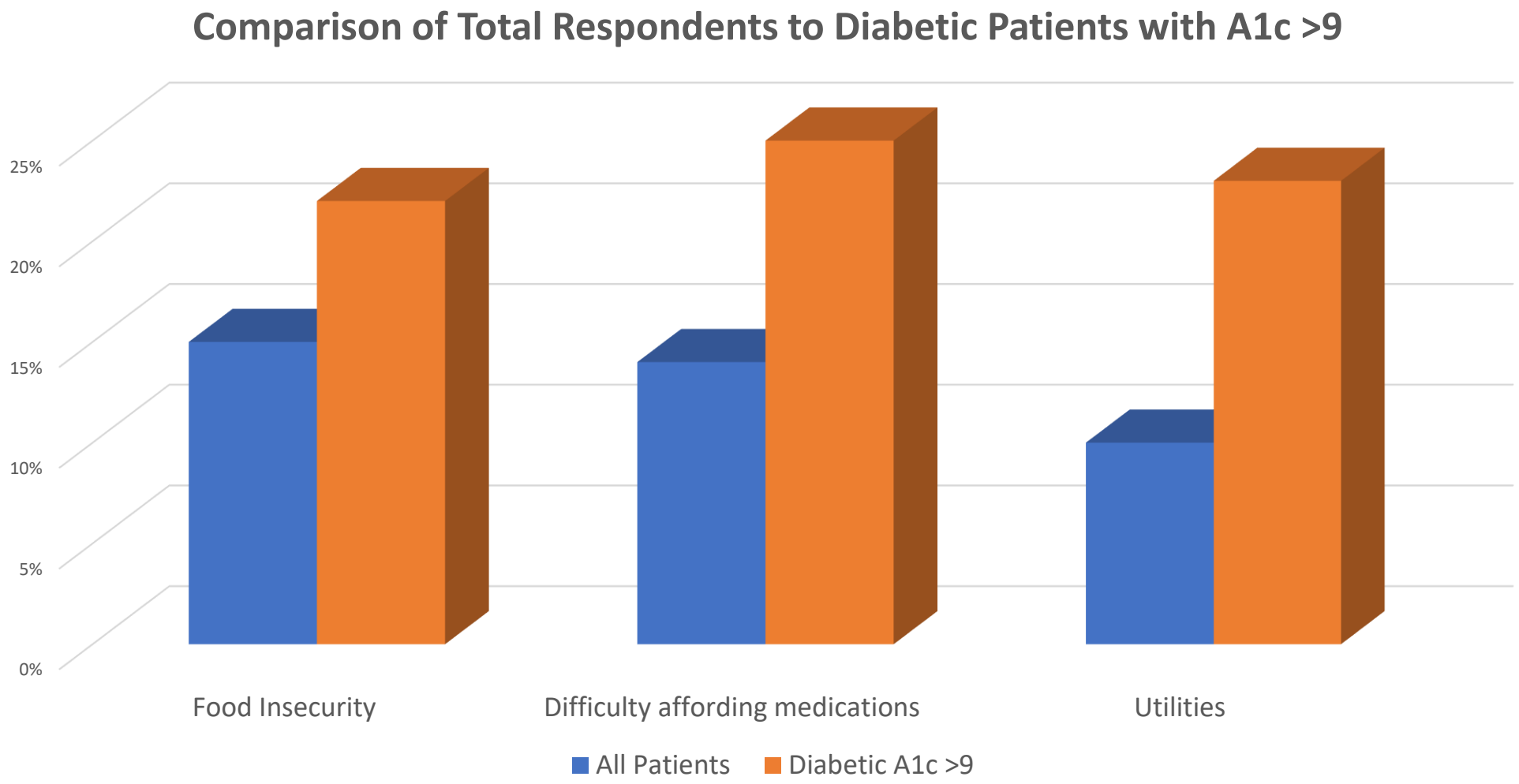
- By October 2020 – nearly 25,000 screenings were completed (15,793 adults and 9,198 children under the age of 19), representing 38% of all patients seen.

- Over 56% of patients screened reported at least one SDOH.

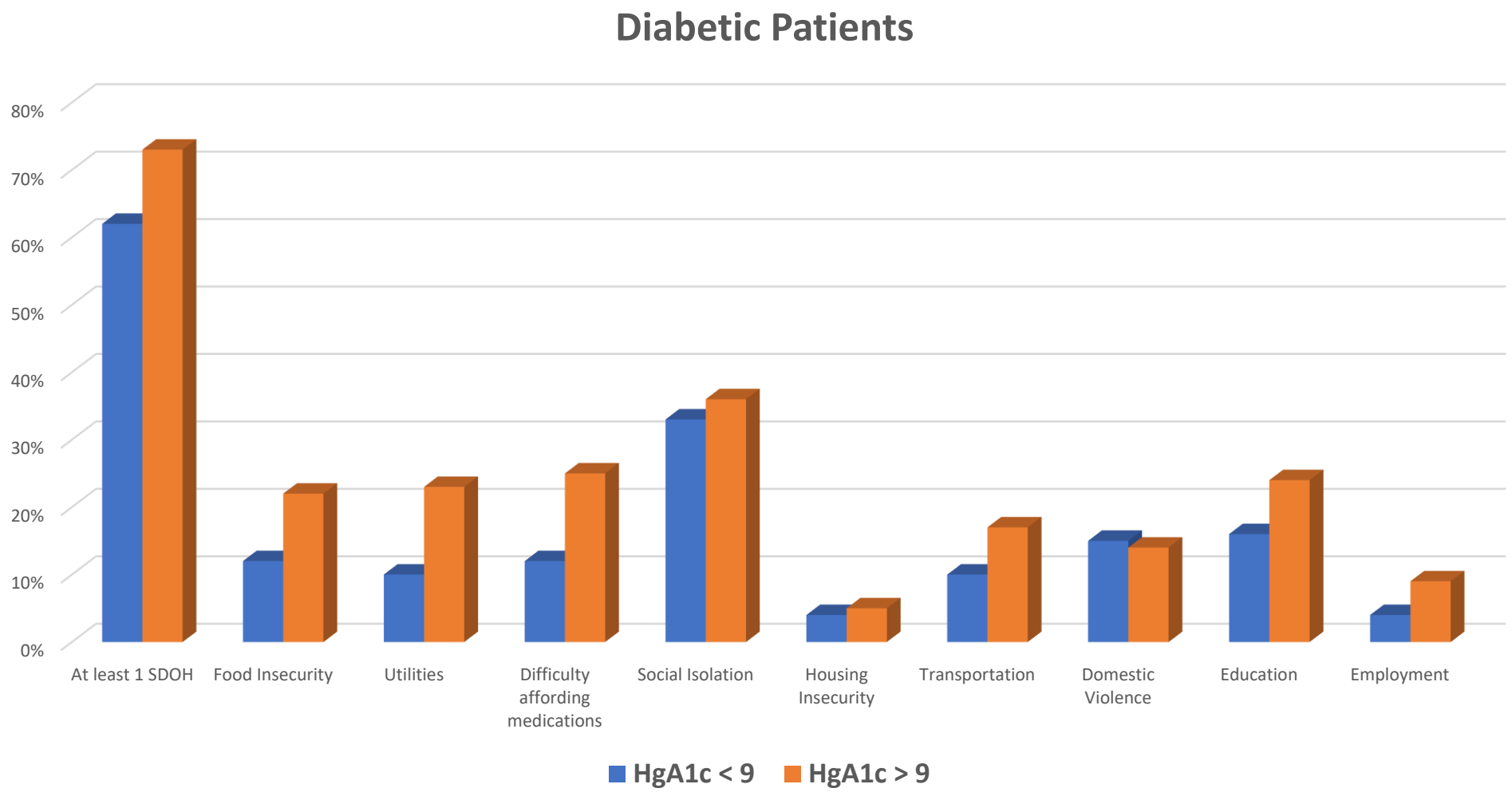
SDOH – Results



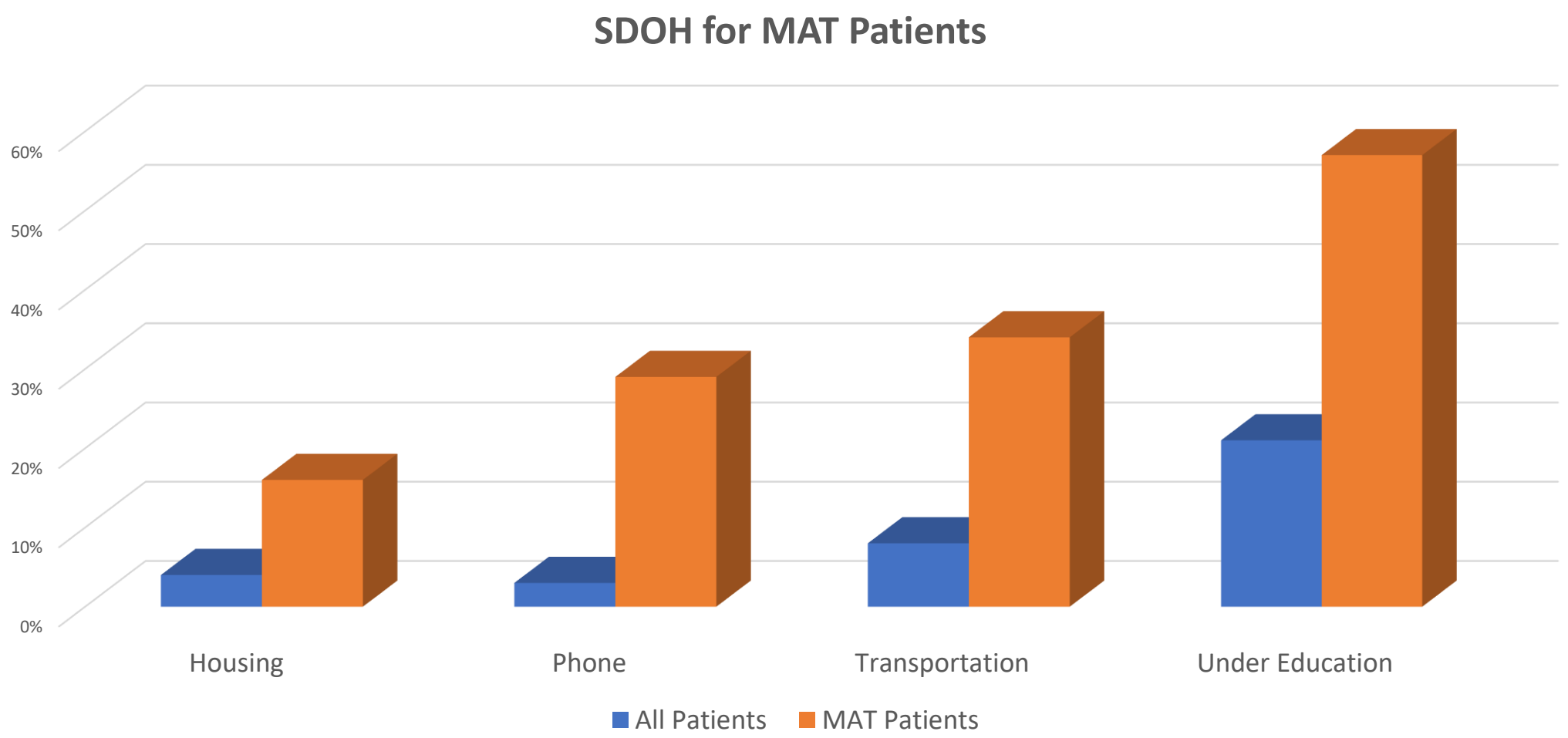
SDOH – Results



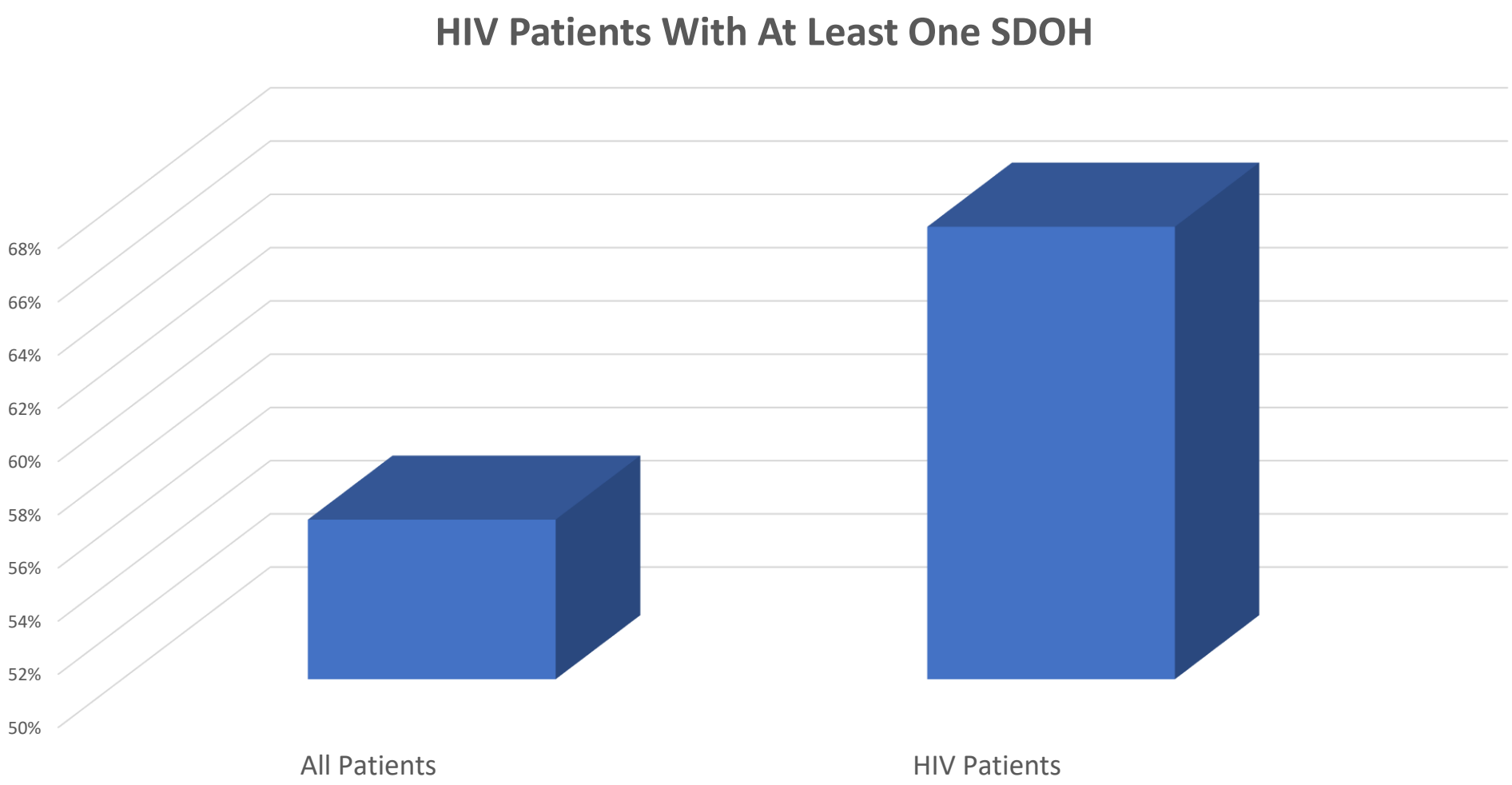
SDOH – Results



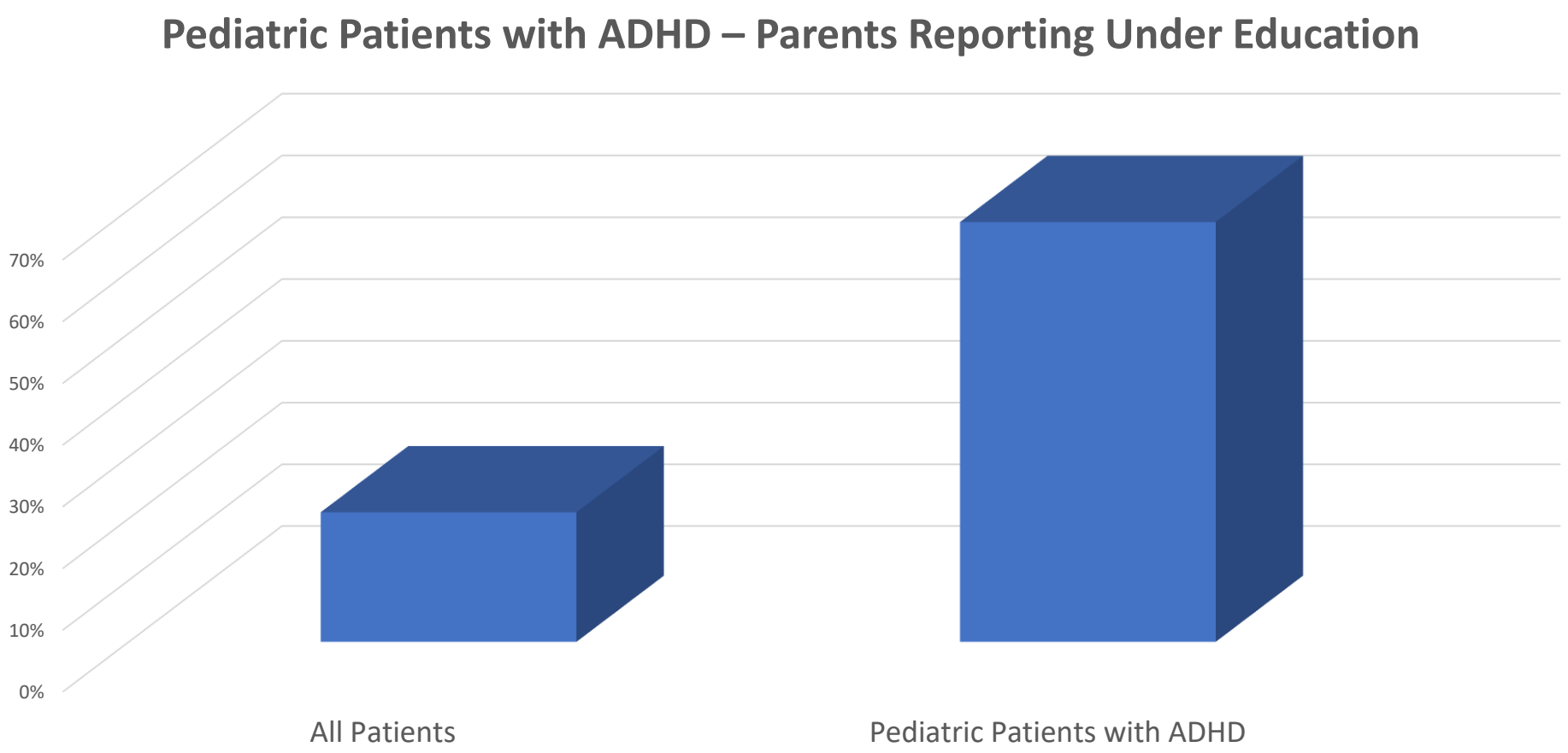
SDOH – Results



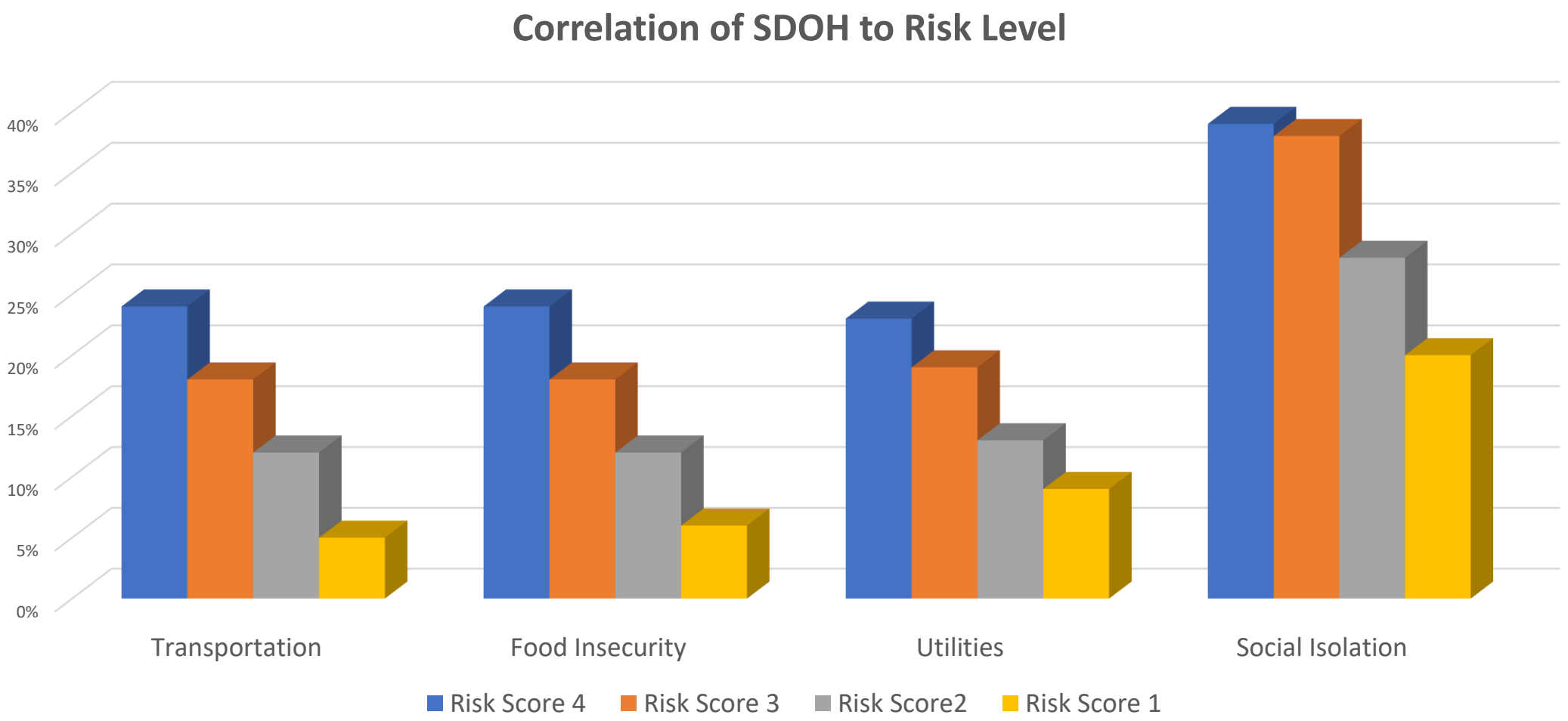
SDOH – Results



SDOH – Results



SDOH – Results



SDOH – Coding and Reporting

- Initial challenge in 2018 – patients expressed concern that the social determinants were indicated on the discharge summary.

- With our new EMR system in place, we are currently in the beginning phases of the coding and reporting process.
- Our initial goal is to have the care management team add the codes to the patient visit, based on the screening tool and patient interactions.
- The Epic system will be providing upgrades to improve the documentation process of identified SDOH and the corresponding ICD 10 codes.

SDOH – Tracking Referrals

- Our Care Managers currently refer patients to appropriate resources to address the SDOH.
- We do not have a way to document this information that will allow us to easily pull the data or evaluate the outcomes.
- We are working with our IT department and expecting upgrades that will better allow us to track the referrals and outcomes.
- Our social worker will have a key role in the development and follow through of this process.

Challenges and Progress

- Creating and modifying the questions to address the most important issues
- Transition to a new EMR (i2i still in transition)
- Entire culture shift for staff and providers = resistance
  - Education!!
  - Provided lunch and learn staff to increase understanding of the impact of poverty
  - Providers were given additional education on the impacts of SDOH on the care they are providing
- Staffing => who is responsible for screening, documentation, and outreach?
- Identifying resources
  - Care Managers networked with local community agencies and arranged monthly meetings to better understand the resources available

Challenges and Progress (cont'd)

- Connecting patients to resources
  - Creation of a Community Resource Guide accessible by staff and patients on our website
  - Resource folders were given to providers and nursing staff to reference during appointments
- Developing a tracking process
- Determining what to do with the data to have the most impact on the patients
  - Justified the need for an organizational social worker to increase focus on the SDOH
  - Worked with our pharmacy to develop ways to assist our patients having difficulty affording their medication
  - Prior to COVID, we were working with a local food bank to create a program for our diabetic patients with food insecurities

Moving Forward…

- Social work position -- in process
- Referral order for providers both internally and externally
- Working with the CMO and IT to develop the process to enter ICD 10 codes without creating more work for providers
- Upcoming system upgrade is to provide better ways to document referrals to community resources and track outcomes
- SDOH information will be incorporated into a general health score in our new EMR system, providing a way to risk stratify our patients
- Continuing our integration with Epic to further enhance our ability to extract data and identify needs for our patients and our community

Questions??