THMG Social Determinates of Health Screening

Denise Duchan RN, AMB-BC

Marnita Hartline RN, AMB-BC, PCMH CCE

TOWER HEALTH

Advancing Health. Transforming Lives.

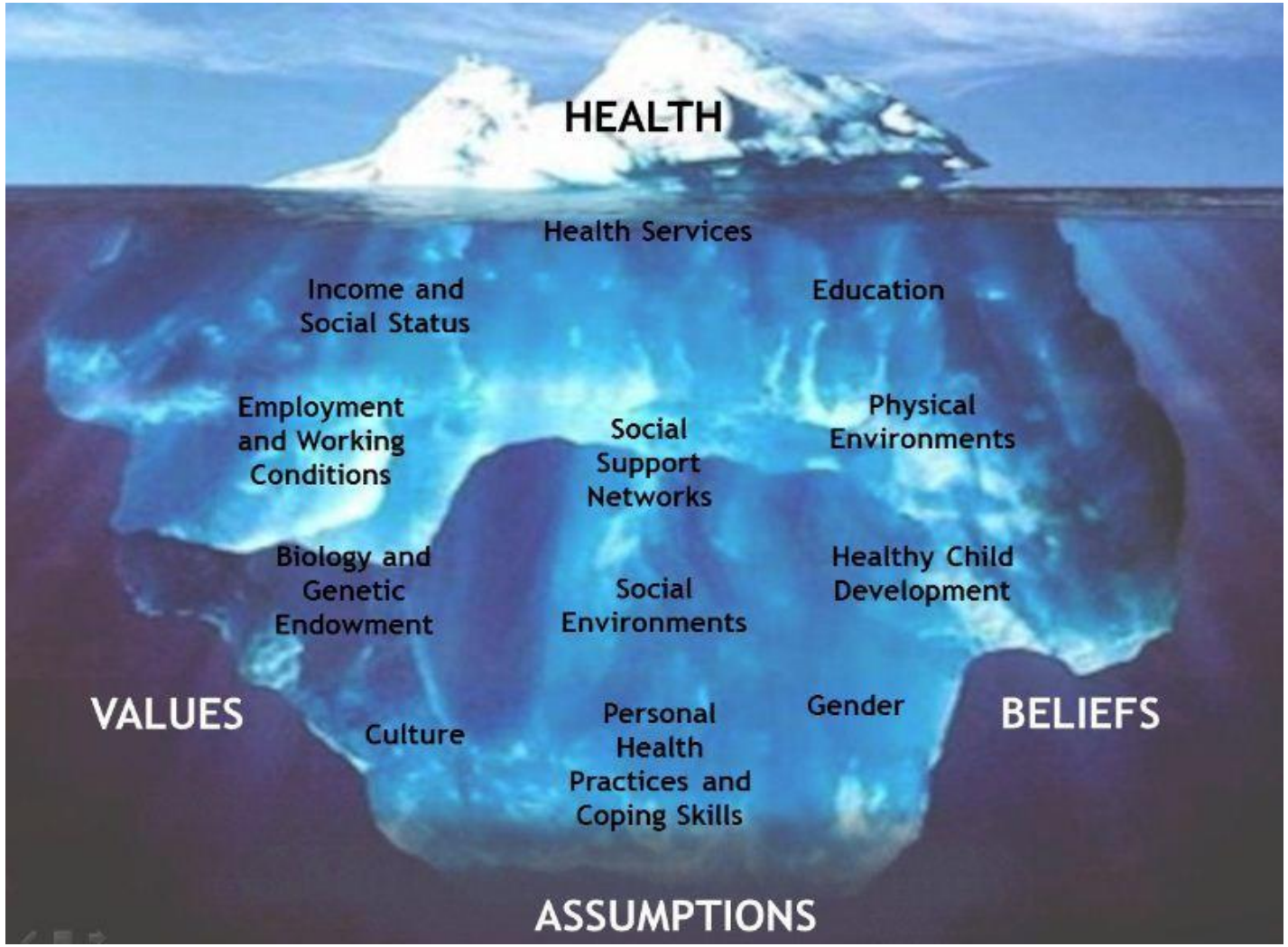
Agenda

- The Patient's Health Iceberg
- Why is Addressing SDOH so important?
- Medication Adherence and SDOH
- Patient Success Stories
- Tower Health SDoH Process/Collection
- Community Health Workers

The Patient's Health Iceberg

- The tip of the iceberg only gives us only 1/4th of the patient's story!

- What we do not see is everything below "water":
  - Living environment conditions
  - Support systems
  - Cultural beliefs
  - Income struggles
  - Social status
  - Employment status and conditions
  - Life stressors
  - Education level



TOWER HEALTH
Advancing Health. Transforming Lives.

Food for Thought…
Medication Adherence & Social Determinants of Health

1. Economic Instability Forces Difficult Decisions

- Simple but TRUE= Patients can't adhere to a medication regimen without their medications.
- *Food vs. Heat. vs. Money vs. Gas vs. Rent vs. Medications=* ***Which do they pick?***
- A recent study estimated 2.3 million seniors and 15.5 million adults were unable to pay for at least one prescribed medication in their household.
- 10% of participants reported skipping dosages in the prior 12 months as a way of saving medicine and money.

2. Housing Insecurity Introduces Challenges

- What happens to medication adherence when someone is forced to move because they can't afford their housing or must pick between having housing and their medications?

This can disrupt:

- Patient's medication regimen routine and stopping important medications
- Where the patient is receiving healthcare services and prescriptions
- Who is assisting with medication management
- Where the patient is filling and refilling prescriptions
- Whether the patient can get where they need to in order to fill and refill prescriptions
- Is the patient staying at a shelter? What are the rules for medications there?

SDOH Success Stories

"42-year-old female screened for unmet food, housing, and utility needs. The patient was interested in receiving food pantry information from Helping Harvest, but patient was referred to Helping Harvest for mobile market and food pantry information. In addition, patient given information for SNAP assistance. Pt was able to resolve their food need. Pt was experiencing a pest issue due to holes in the home. Pt's landlord was contacted; however, patient mentioned that their landlord was not taking action. CHW provided patient with City of Reading- Property Maintenance contact information. Pt stated that this need was resolved and that they have been managing it. Pt mentioned that they were behind on their electric and gas bills. CHW provided patient with PUC and Dollar Energy information. Pt stated that all needs had been resolved."

"78-year-old male screened for an unmet transportation need. Pt was sent information regarding BARTA's Senior Shared Ride transportation program. Patient's transportation need was resolved. Patient's POA confirmed that transportation need had been resolved thanks to CHW's services"

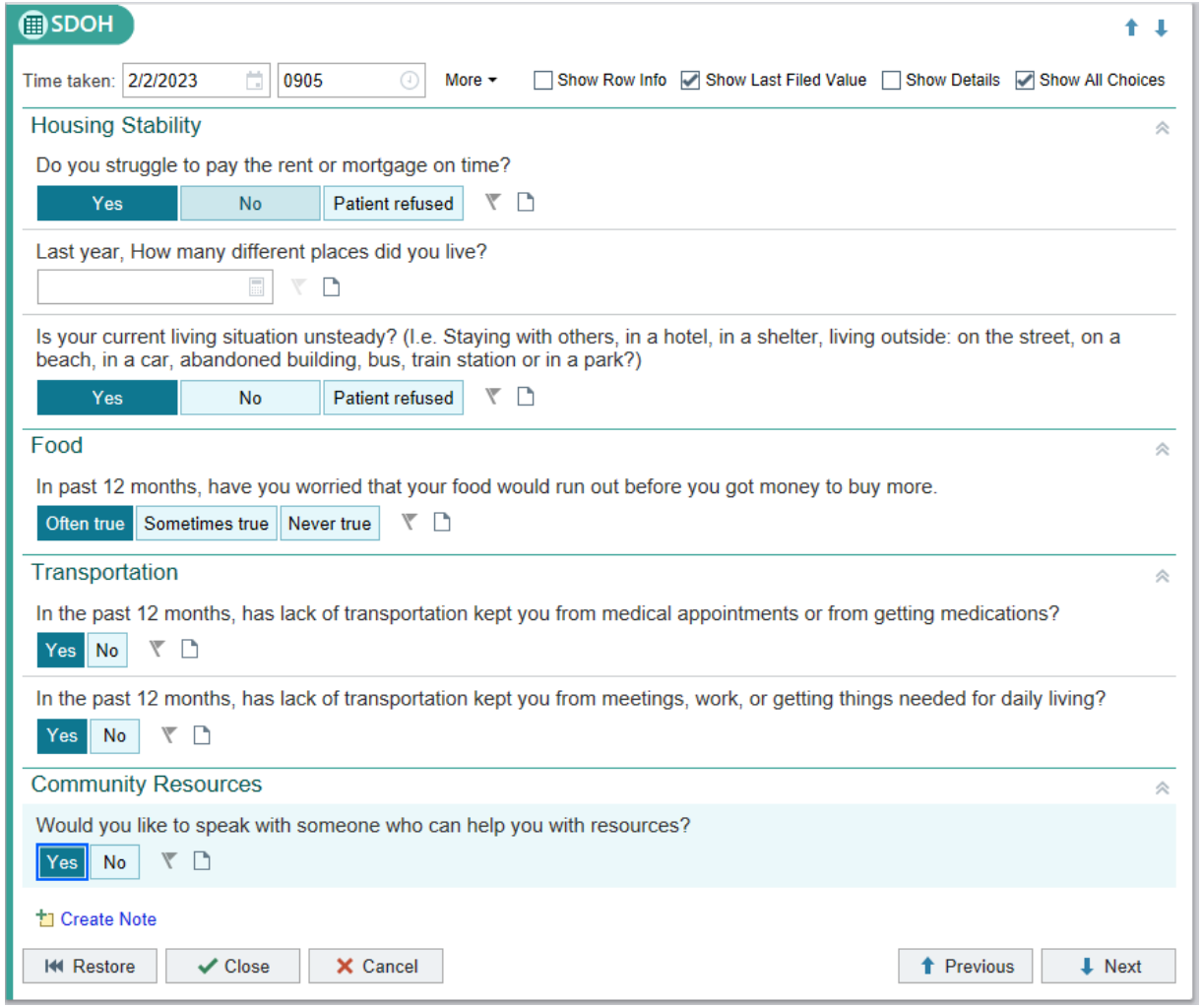
TOWER HEALTH
Advancing Health. Transforming Lives.

SDOH Screening Questionnaire

Completed 1 of 3 ways:

1. MTH Patient Entered Questionnaire
2. iPad - Office Waiting Room
3. Rooming Staff - Exam Room

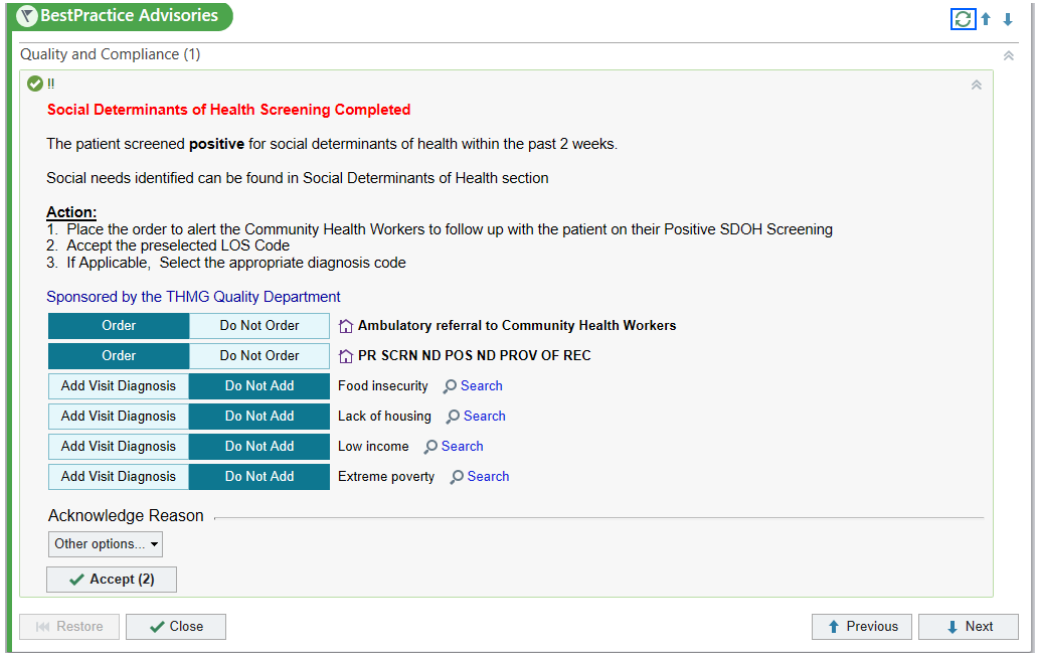
- Patient does NOT need MTH account to answer on the iPad in office.



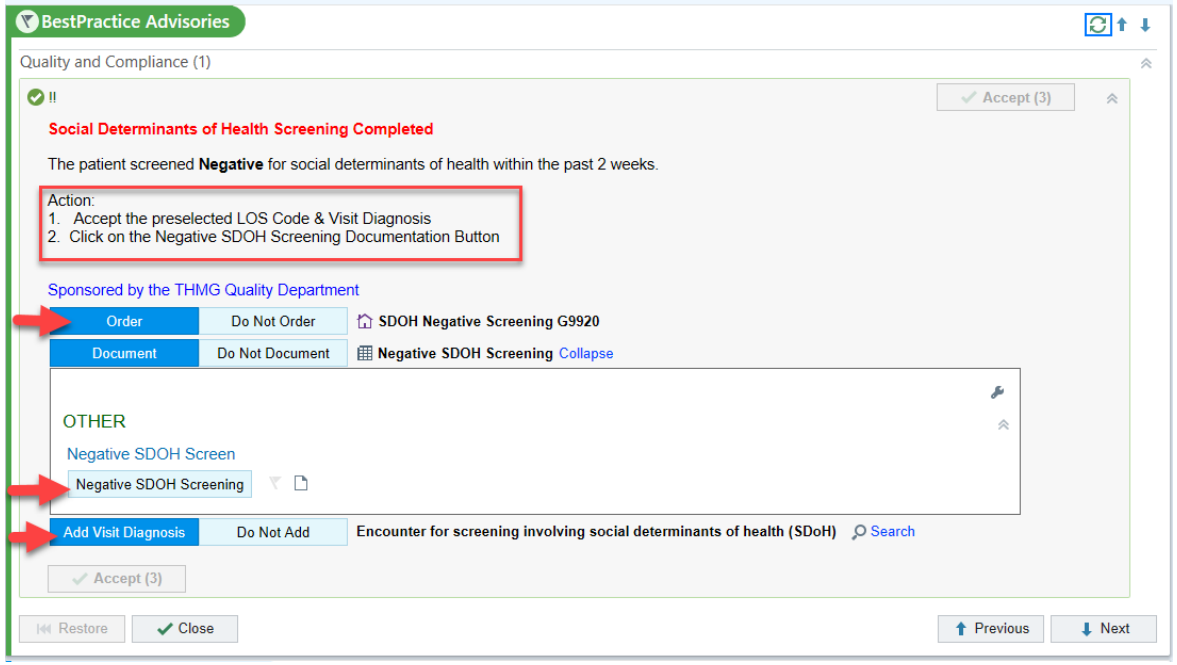
TOWER HEALTH
Advancing Health. Transforming Lives.

Provider BPA Important Notes- Positive BPA

Positive Screen BPA



Negative Screen BPA



*Positive BPA only disappears once the CHW Order and/or positive order is SIGNED

TOWER HEALTH
Advancing Health. Transforming Lives.

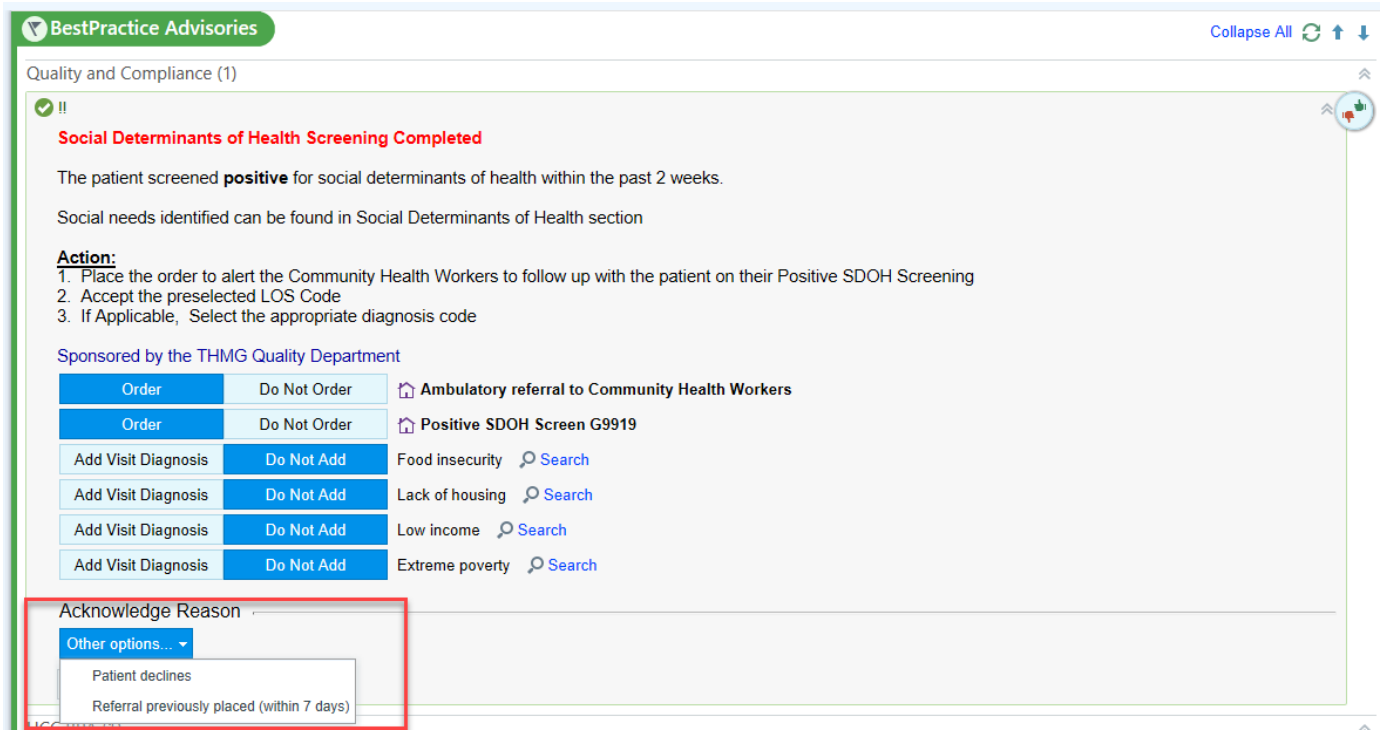
Provider BPA Important Notes- Positive BPA

Acknowledge Reason:

Only to be used if-

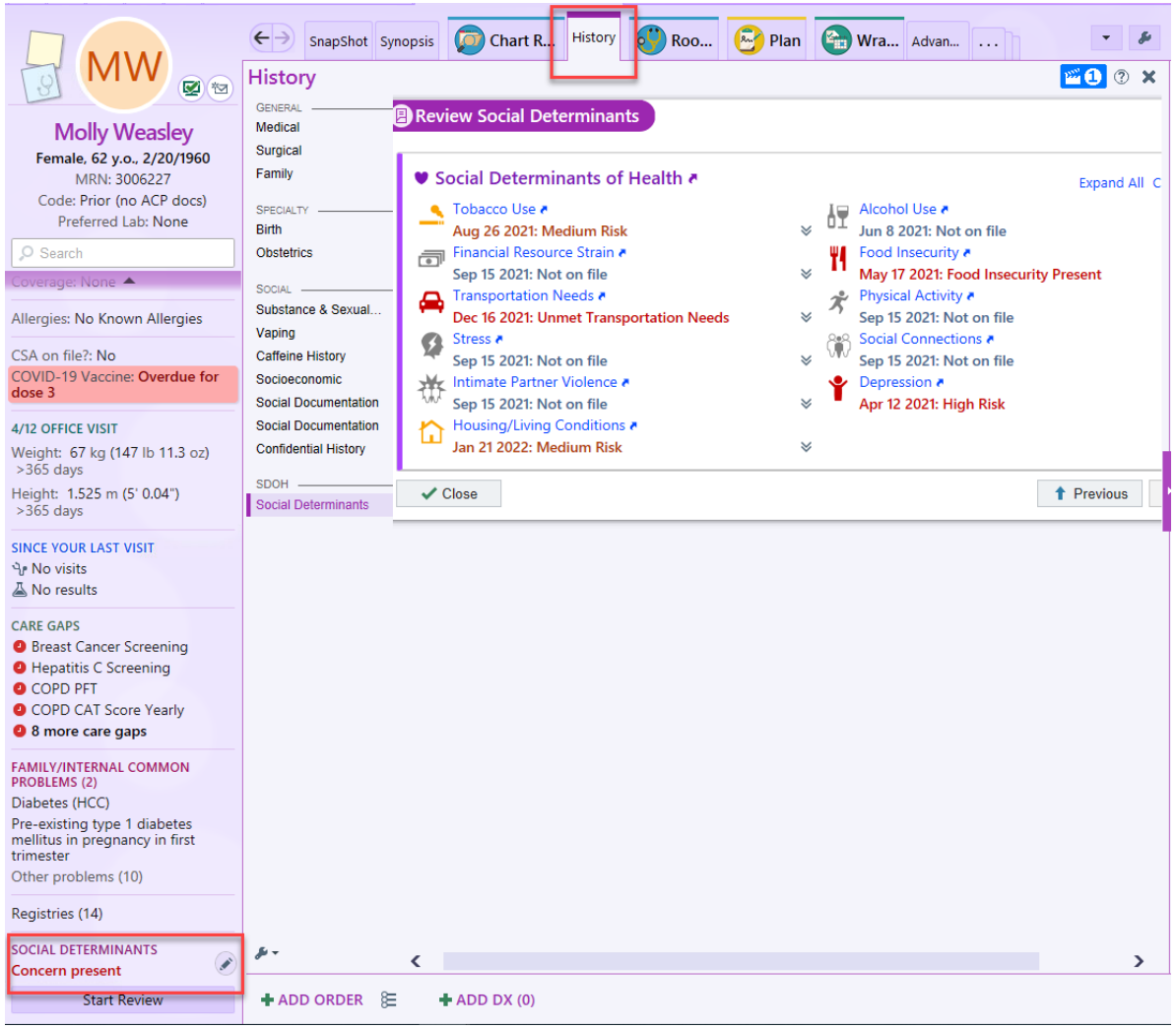
- Patient was screened in the last 7 days OR
- Refused assistance/referral to CHW

SDOH Positive Screen BPA



TOWER HEALTH
Advancing Health. Transforming Lives.

Storyboard/History Activity View



TOWER HEALTH
Advancing Health. Transforming Lives.

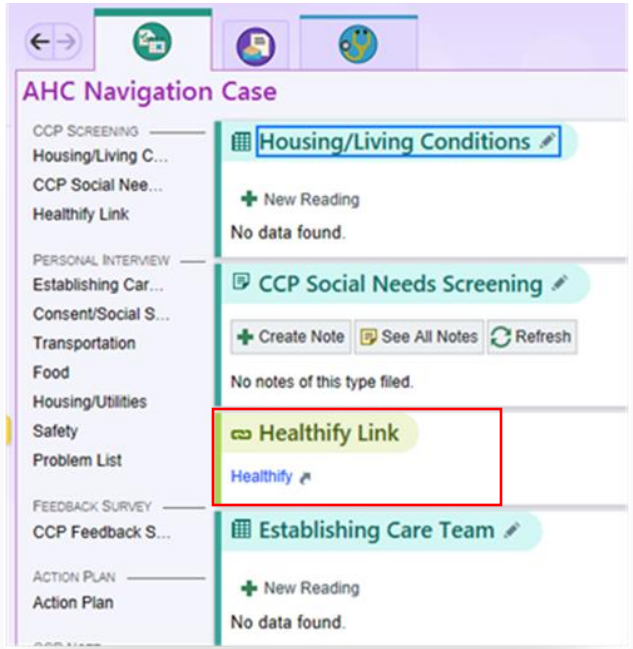
Additional Departments Screening for SDOH

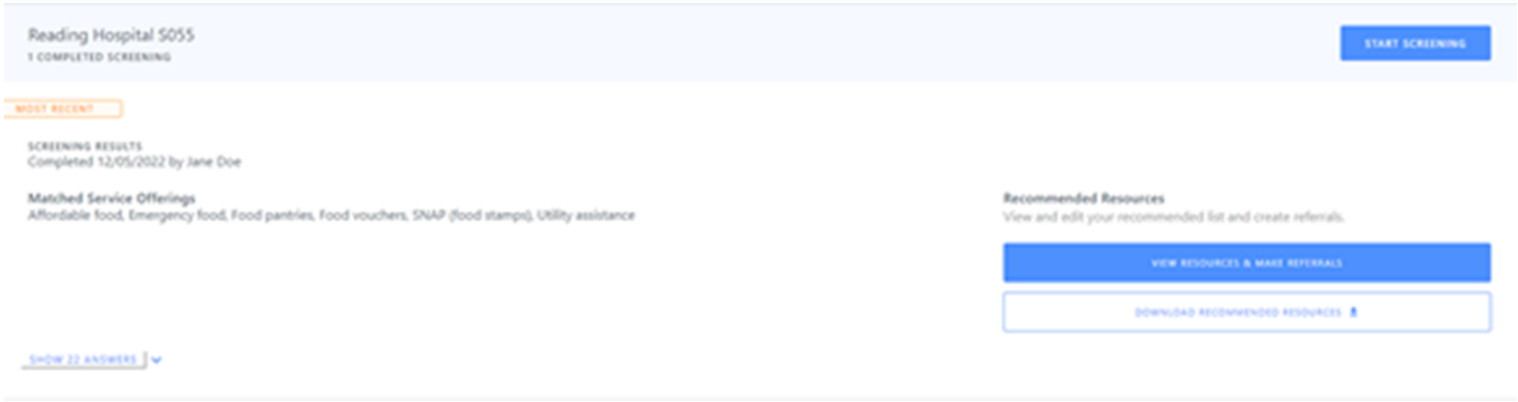
- The SDOH screening can be done by anyone who has access to the SDOH Wheel/Navigators. Population Health & Community Health workers can screen patients in addition to the practices.
- The BPA for SDOH captures when the SDOH assessment has recently been completed **within the last 2 weeks**.
- Due to this workflow, providers should be aware they could see the SDOH BPA in their patient's OV encounter, even if the patient was not screened at their practice that day.
- It is required for the provider to address this BPA and drop the appropriate G-codes and diagnosis.

What is the Community Connection Program (CCP)?

- The CCP conducts SDOH screenings to identify health-related social needs (Food, Housing, Transportation, Utilities, and Safety) that may be impacting our patients' ability to receive high-quality, equitable care. Through screening, referral, and navigation services, patients are connected to over 25+ local community-based organizations, as well as to appropriate care services to meet their needs.
- CCP Staff:
  - 4 FTEs Certified Community Health Workers that are skilled in working with vulnerable/at-risk patients to provide social services and care coordination support to assist with need resolution
  - 15 Trained college interns onboarded as Patient Screeners per year who conduct SDOH screenings in various clinical settings
- **WellSky SCC** is a web-based software search tool for Community Resource Inventory that allows users to engage in a closed-loop referral system with over 25 local community-based organizations who are actively receiving referrals.
  - Integrates with Epic for a seamless experience
- Clinical-Community Linkage
  - The CCP aligns both the hospital-based Health Equity Council (HEC) and the community-based Health Equity Community Collaborative (HECC) to collaborate & provide support to SDOH and health equity driven initiatives to reduce health disparities in the community

- Once need(s) are identified from the SDOH screening, users are able to utilize WellSky to search for referrals and resources to provide in real-time for patients
- A Community Resource Summary (CRS) is automatically generated by WellSky and made available within the patient's chart in the Media tab
- Alternatively, using the “Healthify Link” feature allows users access to the platform to tailor the CRS based off the patients’ needs





Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

For access to the WellSky SCC Network, contact Juliet Simplicio Juliet.crespo2@towerhealth.org

Additional Helpful Information

- If you have a patient with a concern that is outside of the AMW population, please feel free to refer them to the Community Health Workers!
  - This program will help **ANY** patient, any insurance or without insurance.
    - Route the Chart- **Community Health Worker Referral Pool**
    - Epic Secure Chat- **Community Wellness – RDG**

- Documentation- Providers can document in their progress note that the patient screened positive, negative, or declined to screen. They can also add the diagnoses from the BPA to the visit diagnoses and the problem list.

***Goal for Primary Care:**

1. Screen the patient, understand the patient's needs, and understand how this could be impacting their health. Change medications to more cost-effective options, offer virtual care, etc.
2. Refer them as needed and let the Community Health Workers guide the patient from there.

TOWER HEALTH
Advancing Health. Transforming Lives.

Questions?

Feel free to email us if you have questions:

Denise.Duchan@towerhealth.org

Marnita.Hartline@towerhealth.org