SDoH:

A Journey of Trials, Innovation and the Pursuit of Enhanced Patient Outcomes

Presentation Team:
Sandy Jones
Lisa Dinkel
Cody Utz

HOLTON COMMUNITY HOSPITAL

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About Us-

- 14-Bed CAH
- NE Kansas – 30 minutes north of Topeka
- Scope of Services:
  - Inpatient, Swing Bed,
  - ED, Surgery, Treatment Room, Specialty Clinic, Outpatient Ancillary Services, Behavioral Health, 3 Rural Health Clinics
- Diverse community including:
  - Johnsonville Meat Packing Plant
  - Centrally located near 2 Native American Indian Reservations & 3 casinos
  - Rural Farming Community

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Sandy Jones, BSN, RN CCM
Patient Care Coordinator

- Graduate of Baker University with a BSN
- Certified Case Manager (CCM) - 2014.
- More than 15 years in hospital case management with the last 6 years at Holton Community Hospital
- Transition of Care Committee co-chair, Quality Council member and serves as an Onboarding Ambassador

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Lisa Dinkel, APRN-C, FNP
Hospitalist

- Graduate of Washburn University School of Nursing BSN 2007 MSN 2014
- AANP certified
- Past 10 years served as an APRN for General Surgery/Trauma
- Hospitalist APRN at Holton Community Hospital since March 2024

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Cody Utz,
CPHQ, RT(R), RDMS, RVT, RDCS
Director of Quality & Informatics

- 25 years bedside, healthcare experience
- HCH employee - 19 years
- Quality Director - 9 years
- CPHQ certified
- Leadership Team, Quality Council chair, PFAC co-chair, Service Excellence Committee interim chair
- Passion for continuous improvement

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Objectives

Detail a shift from current practice to structured SDoH screening with alignment to regulatory compliance

Demonstrate how data drives continuous forward movement and project implementation

Understand how team collaboration and innovation intersect to address unmet patient needs

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Timeline/Journey

Problem Statement:

At HCH, patients, at all points of entry, are not getting the help needed for SDoH risk factors at their visit at HCH entities. The unidentified risk factors can attribute to overall health and outcomes.

Feb '24
WU Nursing Student project collaboration

Apr '24
Internal SDoH Team formation

May '24
Screening tool of choice: AHC HRSN (CMS screening)

Jun'24
Screening initiated among a small patient population

Aug'24
Screening implemented with admission process

Oct'24
Soft Go-Live

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Screening Tool

The Accountable Health Communities
Health-Related Social Needs Screening Tool

5 Core Domains

- Housing Instability
- Food Insecurity
- Transportation Problems
- Utility Help Needs
- Interpersonal Safety

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Living Situation

1. **What is your living situation today?**
   - I have a steady place to live
   - I have a steady place to live **BUT** I am worried about losing it in the future.
   - I do not have a steady place to live (I am temporarily living with someone else, in a hotel, in a shelter, living outside on the street, on a beach, in a car, in an abandoned building, bus or train station, or in a park.)

2. **Think about the place where you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY**
   - Pests (bugs, ants, mice)
   - Mold
   - Lead paint/pipes
   - Lack of heat
   - Oven or stove not working
   - Smoke detectors missing or not working
   - Water leaks
   - None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - Often True
   - Sometimes True
   - Never True

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - Often True
   - Sometimes True
   - Never True

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   - Often True
   - Sometimes True
   - Never True

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Screening Tool

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Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- Often True
- Sometimes True
- Never True

Safety

Because violence and abuse happen to a lot of people and affects their health we are asking the following questions.

7. How often does anyone, including family and friends, physically hurt you?
- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

8. How often does anyone, including family and friends, insult or talk down to you?
- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

9. **How often does anyone, including family and friends, threaten you with harm?**
- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

10. **How often does anyone, including family and friends, scream or curse at you?**
- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

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Data

Introduced Screening – Jun'24

Goal – screen every patient that occupies a bed on Med/Surg Unit

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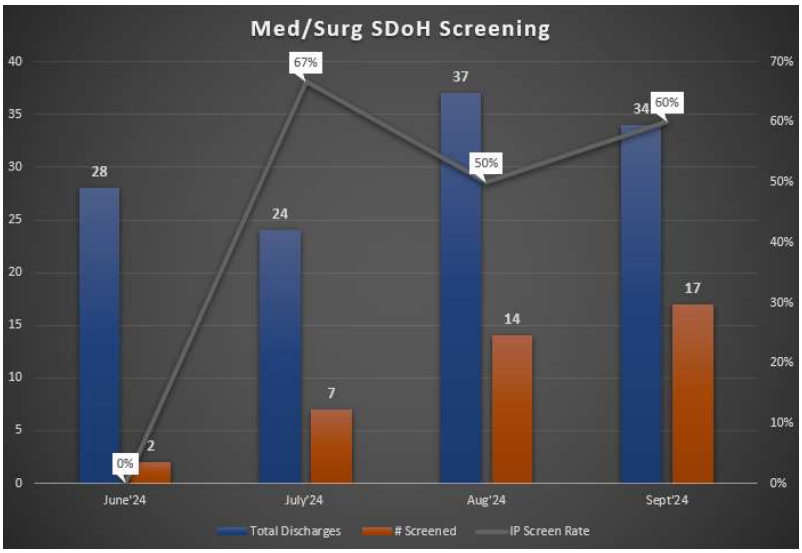
Overall Screening Data



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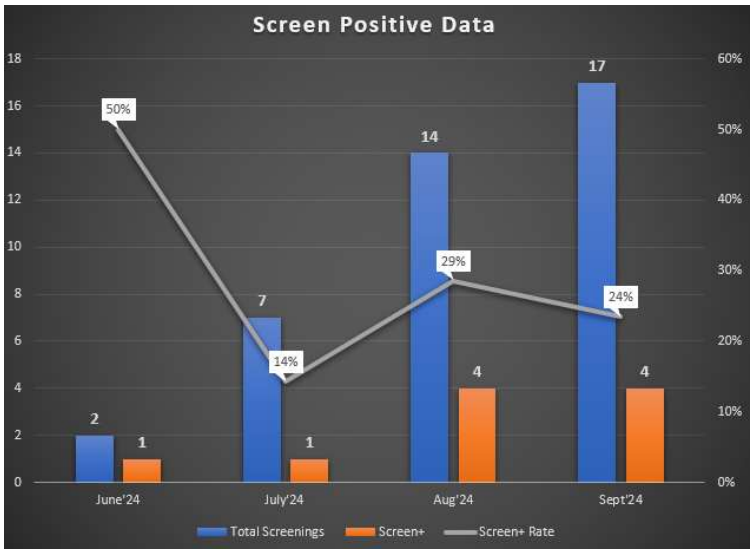
SDoH Positive Data



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Follow-up Phone Calls Strategy/Best Practice

Why? When?

- 2012 - Readmission prevention strategy
- Identify miscommunication issues
- Identify unmet needs
- Day 1 and Day 4 (as needed) post-discharge

Resources

- RED Toolkit from AHRQ
- Various webinars/CEU programs over the years
- ICOMPASS courses: Cross-Continuum Readmission Series; Collecting Social Drivers of Health Data from Patients.

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Follow-up Phone Calls Strategy/Best Practice

Interventions

- Follow-up appointments
- Contact healthcare provider on patient's behalf
- Discharge instruction clarification
- Medication education
- Contacting pharmacy on patient's behalf
- Patient portal assistance
- Coordination of care - home health, outpatient therapy
- Process improvement opportunities

Success Stories

- Antibiotic clarification
- Unfilled prescriptions
- Medication verification/clarifications
- Daily weight checks with CHF diagnosis

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Hometown Heart Fund

- Hospital Foundation special program
- History & Purpose
- Created in 2021

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FOUNDATION

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HOMETOWN HEART FUND (HHF) POLICY BREAKDOWN

The HHF covers up to:

- $200 annually for basic needs including transportation services
  - Jackson County EMS
  - Local transport (punch card)
  - Secured Transports
- $500 annually for
  - DME (oxygen equipment, wheelchairs, crutches, etc.)
  - Pharmacy
  - Therapy
  - Cardiovascular Services
- $200 annually for a screening no cost mammograms

Exceptions apply & granted by foundation board

HHF monies paid on patient's behalf

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HHF Application

HOLTON COMMUNITY HOSPITAL FOUNDATION
HOMETOWN HEART FUND APPLICATION

Patient Information

Date of Application:_____

Name_ _____ Address:_____,

City:_____ State:_____ Zip:_____

Please describe the patient's needs or problem: Be specific and include receipts or bill if possible:

_____
_____
_____
_____
_____
_____
_____

Person Requesting:_____ Amount Requested:_____

($500 max for pharmacy, DME, therapy or CVS Services - $200 max for transportation and basic needs)

$200 Max for Mammogram

Approved By:

_____, Social Worker Date:_____

_____, HCH Foundation Representative Date:_____

Disbursement:
Check Payable to:_____ Amount:_____

Check Payable to:_____ Amount:_____

Total Disbursed:_____ By:_____ Date:_____

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Community Connections

Holton Community Hospital Foundation Board

- Comprised of 10 volunteer members
- Various community member representation
  - Banking
  - Local business owners
  - Medical Staff
  - Retirees
- Vote upon exemptions under extenuating circumstances

Community Support

- Sustainability
  - Monetary donations
  - Planned giving (Wills/ Estate/ Memorial contributions)
  - Employee Pledges
  - Thoughtful Day of Giving
  - Annual Gala fundraising event

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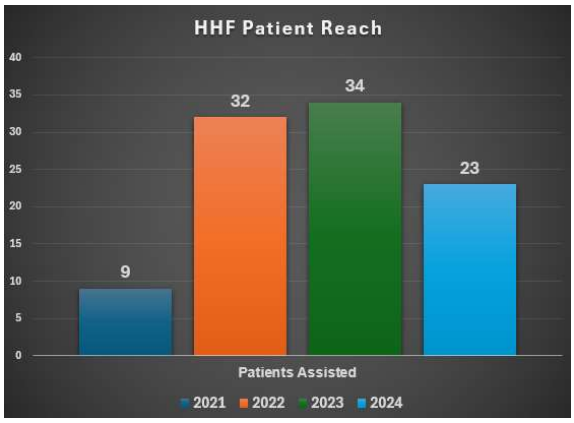
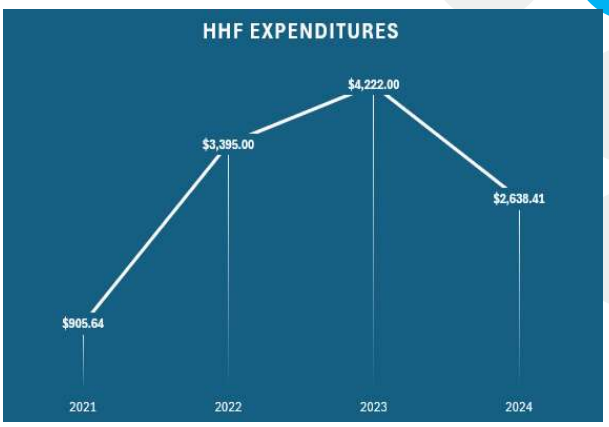
HHF Utilization





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Hospitalist Approach

History

- Hospitalist programs developed in 1996
- First Hospitalist at HCH started Nov 15th, 2021

Positive Impact

- SDoH needs addressed timely
- Daily collaborative huddle
- Weekly care plan that includes patient and family
- Collaboration with Home Health resources
- Hometown Heart Fund

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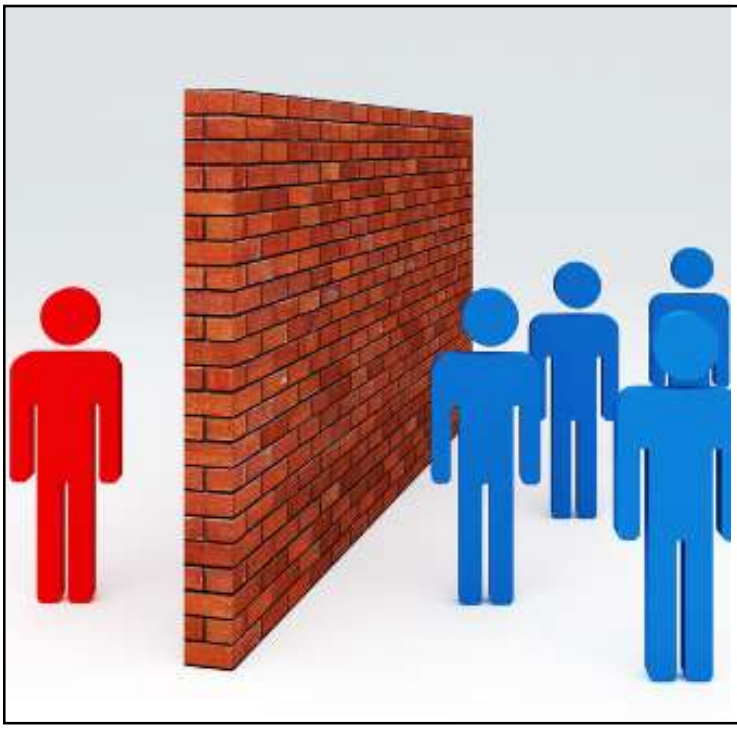

Barriers

- Safety issues- what to do with that information?
- Need for collaboration
- Need more sustainable plan
- Housing
- Community Needs Health Assessment underway – will assist with identifying community health needs
- Weekend admissions

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Patients Stories

- Pharmaceutical coverage assistance
- Handicap accessible ramp at home
- Gas card (Transportation assistance)
- Equipment need (TENS unit)

HHF is a short term/immediate solution, therefore the Foundation Director works directly with our social work/case management team address ongoing/future needs:

- Medicaid application assistance
- Referral to local Health Department for basic needs

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Resources

- Re-Engineered Discharge (RED) Toolkit: Red Toolkit for Follow-up Calls - AHRQ
- CMS AHR screening: Screening Tool
- Hospital Quality Reporting Program: FAQs - SDoH Measures
- A Guide to Using the Accountable health Communities Health-Related Social Needs Screening Tool: Guide

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Questions

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