HCGC Webinar: Screening for the Social Determinants of Health

Thursday, December 19th 2019

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During the Webinar:

• Please “mute” your phone and/or computer to reduce background noise.

• If you have a question please use the chat feature in Zoom or hold it until the Community Discussion at the end of the webinar.
**HCGC Overview**

**OUR MISSION**

To improve the quality, delivery, and value of healthcare and the overall health for all people in the Columbus region.

**OUR VISION**

Optimal health for all people in the Columbus region.

**WHAT WE DO**

Using a collaborative process, we are:

- Fostering shared learning and communication,
- Collecting and sharing aggregate health data, and
- Scaling knowledge and innovation.
HCGC is also focused on work to improve health disparities and engage employers as key healthcare stakeholders.

**Health Disparities:** HCGC’s mission is designed to serve “all people.” However, we are acutely aware that total population measures can hide wide-ranging disparities among different portions of our community. HCGC is committed to seeking opportunities to close health disparity gaps.

**Employers as Key Healthcare Stakeholders:** HCGC’s focus on healthcare value requires consideration of the cost component of healthcare. Employers play a special role in funding our current healthcare system. HCGC has experienced that the wide variety in the Central Ohio’s self-insured and fully-insured employer market makes singular employer strategies impractical. HCGC seeks opportunities to address cost issues whenever possible.
HCGC Supporters

Columbus Medical Association

pcori
CardinalHealth
Osteopathic Heritage Foundations
THE CITY OF COLUMBUS
COLUMBUS PUBLIC HEALTH
UnitedHealthcare
CENTRAL OHIO PRIMARY CARE FOUNDATION
OhioHealth
Healthcare Collaborative of Greater Columbus

100% of our Board of Directors & Staff
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Anthem
The Healthcare Collaborative of Greater Columbus (HCGC) is proud to manage the Central Ohio Pathways HUB, a neutral, central convener that connects our most vulnerable people with community resources and creates accountability for outcomes.

As of November 11, 2019 we are a Level One Certified HUB.
### HUB: Healthcare Collaborative of Greater Columbus

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<th>Initiated</th>
<th>Finished Incomplete</th>
<th>Delta</th>
<th>Completed</th>
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| Total                         | 3867      | 667                | 2230  |
CORE 5: Screening for social determinants of health in a primary healthcare setting

HCGC Monthly Webinar Series
Dec 19, 2019

Nancie Bechtel, MPH, BSN, RN
Alex Jones, MS, RN, CPH
Objectives

At the end of this session, learners will be able to:

► State CMS’ determined five most basic social determinants of health (SDHs)
► Describe the Core 5 screening tool and process
► State preliminary research findings from implementation of the Core 5 in a primary care clinic setting
Project Background

► RWJF 2015-2017 Public Health Nurse Leaders (PHNL) cohort
► 2 PHNLs of 25 in cohort selected from Columbus, Ohio
► Ohio PHNL project in 2016: Nurse-based, to advance a culture of health
► Ohio Action Committee partnership; working project committee
Project Background

- National lit review of SDH screening tools: none brief

- CMS Accountable Health Communities model of 5 primary and 5 additional SDHs
  - Plethora of CMS-compiled research to support the primary 5 SDHs and 5 additional SDHs as most relative to health
  - No CMS screening tool at the time specific to the primary 5 SDHs
Premises

► Health is affected 20% by clinical care and 80% by SDHs (RWJF, [https://www.rwjf.org/en/our-focus-areas/topics/social-determinants-of-health.html](https://www.rwjf.org/en/our-focus-areas/topics/social-determinants-of-health.html))

► Optimal health cannot be achieved without SDHs being addressed

► Specifically, clients cannot achieve optimal healing, immune system functioning and health if they experience:
  ♦ Chronic poor nutrition
  ♦ Chronic high stress hormone levels (cortisol)

► Individuals’ health would improve if basic SDHs were addressed as a standard of health care
Premises

► Healthcare providers (HCPs) are duty-bound to help clients achieve optimal health

► HCPs do not routinely screen or intervene for the most basic SDHs

► For HCPs to routinely do SDH screening & intervention, the process must be relevant, clear, quick/easy to implement, and evidence-based
  ♦ Targeted, timely & actionable
Base Project Work

- Ohio statewide baseline surveys to measure use of SDH tools & processes at Ohio nursing institutions
  - Convenience sample of 310 hospital CNOs, health dept DONs & RN nursing college/school deans
  - Surveys based on CMS’ Accountable Care Health Communities Model of 5 basic and 5 additional key SDHs
  - 32% response rate across all surveyed institutions: no one routinely screening for most basic 5 SDHs
Baseline Survey Results

► 41% of hospitals & 67% of public health departments do not have a formal policy or procedure to screen for SDH’s
  ♦ Interpersonal violence screening most common
  ♦ Perceived transportation screening question: “Do you have a ride home?”

► Nursing academic programs do not integrate SDH assessment throughout their curriculum

► 64% of hospitals & 77% of public health departments do not provide training about SDHs to newly hired nurses

► 88% of hospitals & 90% of public health agencies do not provide annual training or competency assessments about SDHs for nurses
Base Project Work

► Developed concise, evidence-informed screening tool for Core 5, along with a process algorithm & training module

► Piloted for 30 days at 9 Ohio sites
  ♦ 18 institutions volunteered
  ♦ 10 originally selected: 2 hospitals, 3 colleges, 5 health depts
  ♦ Pilots completed at 1 hospital, 3 colleges, 5 health depts
Base Project Work

- Agency head had to approve participation in writing
- Institutional processes had to be in place
- Staff completion of education module
- Nursing routine assessments for 30 days
- All patients screened on designated unit/program
- Screening tool could be in EMR or via paper
- No patient data collection; just nurses’ perceptual data about the tool & process
Core 5 Screening Tool

► CMS’ 5 basic SDHs are FOOD, HOUSING, UTILITIES, TRANSPORTATION & INTERPERSONAL VIOLENCE

♦ Do you/your family worry about whether your food will run out and you won’t be able to get more?
♦ Are you worried about losing your housing, or are you homeless?
♦ Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?
♦ Has a lack of transportation kept you from attending medical appointments or from work, or from getting things that you need for daily living?
♦ Are you worried that someone may hurt you or your family?
PROCESS ALGORITHM

Patient encounter

Will patient be directly back in the community, i.e., after care in an outpatient clinic, emergency department, outpatient surgery center, inpatient hospital unit prior to discharge, community clinical setting, or home care?

Yes

RN or nursing student conducts CDH Screening Tool (“Core 5”) by asking all five of these questions:
1. Do you or your family worry about whether your food will run out and you won’t be able to get more?
2. Are you worried about losing your house or are you homeless?
3. Are you currently having issues with your utilities such as your heat, electric, natural gas or water?
4. Has a lack of transportation kept you from attending medical appointments or from work, or from getting things you need for daily living?
5. Are you worried that someone may hurt you or your family?

Is the answer to any one or more of the CDH questions a “yes?”

Yes

RN or nursing student provides patient with services or direct referral to address CDH gaps

No

No CDH screening at this time

No additional CDH screening at this time

RN or nursing student ensures documentation of intervention in client medical record

Yes

Is RN or nursing student able through knowledge, institutional policy/procedures and available resources to address the patient’s CDH needs directly?

No

RN or nursing student refers patient for sequel CDH assessment by another member of the healthcare team or community partner, and then team member or partner assists client in meeting CDH needs

PREVENT ENGAGE RESPOND GROW

Franklin County Public Health
Pilot Results: 84 participating nurses

<table>
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<th>Percentage</th>
<th>Comments</th>
</tr>
</thead>
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<tr>
<td>95%</td>
<td>Screening tool was clear and easy to understand</td>
</tr>
<tr>
<td>86%</td>
<td>Tool provided a good measure for evaluating Core Determinants of Health (CDH)</td>
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<tr>
<td>75%</td>
<td>Tool took a reasonable amount of time to complete (≤ 2 mins)</td>
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<tr>
<td>88%</td>
<td>Tool could be easily incorporated into the nursing assessment</td>
</tr>
<tr>
<td>81%</td>
<td>Tool and process are vital components of a nursing assessment</td>
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RWJF provided formal research funding in 2018

- Objectives:
  - Implement the Core 5 Screening Tool at a clinical health care site
  - Examine the impact of Core 5 screening with appropriate referral and receipt of community services
  - Explore the extent to which the receipt of the community resources results in reduced emergency department and urgent care visits over 6 months (3 months pre-screen and 3 months post-screen)

- Partnering with The Ohio State University (OSU) College of Nursing
Current Research Study Design

► Interviewer face-to-face survey that includes Core 5 screening (food, housing, transportation, utilities, safety), prior service use, and sociodemographic information.
  ► Referral to community resources for positive screen based on need

► Phone surveys of participating patients at approximately 2 weeks after screening to assess whether patient received the Core 5 resource needed and related details about that service.

► Using OSU Health System’s EHR (Epic®) to collate data of participating clients’ emergency dept and urgent care usage 3 months prior to and 3 months after Core 5 intervention to quantify improved health
Current Research Study Design

► Goal is to screen ≥ 500 patients to attain a sample size of ~ 250 with a “positive screen” (aka “yes” on one or more of Core 5 tool) AND accepting of at least one referral

► Using trained healthcare students (nursing and health sciences) to conduct the Core 5 screening tool and referral processes with community social services partners

► Screening began June 2019 at The OSU Total Health and Wellness Clinic (an FQHC and an APRN-led primary care clinic)
Number of Patients Approached, Recruited & Referred to Date

92.0% participation rate and 43.0% screened positive w/at least 1 need
Acceptance of Screening and Referral

- Although 92% agreed to participate in the screening...

- Most (98.5%) wanted to self-refer themselves to the respective community agency/ies after their positive screen
  
  ♦ Includes if they needed one or more services
## Sample Characteristics

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<th>Total Sample Screened (N=323)</th>
<th>Sample Needing Referral (N=139)</th>
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<td><strong>Mean Age</strong></td>
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<td></td>
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<tr>
<td>Refuse</td>
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<tr>
<td><strong>Sex</strong></td>
<td><strong>n</strong>  <strong>Mean(range) or %</strong></td>
<td><strong>n</strong>  <strong>Mean(range) or %</strong></td>
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<tr>
<td>Male</td>
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<td>37</td>
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<tr>
<td>Female</td>
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<td>100</td>
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<td>Refuse</td>
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<tr>
<td>White</td>
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<td>Asian, Asian American or Pacific Islander</td>
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<td>1</td>
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Number of Needs among Patients who Need Referral (N=139)

- % 1 Need (n=50)
- % 2 Needs (n=53)
- % 3 Needs (n=26)
- % 4 Needs (n=9)
- % 5 Needs (n=1)
Type of Needs among Patients who Screened Positive

(N=139)
Two Week Follow-Up of Service Receipt

► 134 of the 139 patients who screened positive wanted a referral for services and 132 of these agreed to the 2 week follow-up survey.

► Initially offered email or phone follow-up but of the 16 who preferred email, none responded to any of the 3 emails sent.
  ♦ Changed follow-up process to only by phone due to better success at contacting patients

► Two-week follow-up phone calls have been conducted on 102 patients, and of these, 66 patients were successfully re-contacted (64.7%).
Two Week Follow-Up Survey of Service Receipt (n=66 contacted via phone)
Percent of Patients by Explanation at Follow-up of Why Service was not Attained

- Scheduled but not yet received service
- No resource available for needed service
- Did not meet eligibility criteria of service agency
- Did not want the resource service after all
- Unable to follow up with the resource agency due to personal phone or time issues
- Other

Franklin County Public Health

PREVENT ENGAGE RESPOND GROW
Discussion & Limitations

► **Target number of 500 to screen unrealistic**
  ♦ Although did meet target sample of size of 250 (323 actual)

► **Service need**
  ♦ 43% of the patients who were screened reported at least 1 need, and of those who screened positive, 64% reported >1 need
  ♦ Food and transportation were the greatest needs

► **Difficulties following up with patients**
  ♦ Discontinued offering email follow-up: all follow-up now by phone
  ♦ Increased the number of phone attempts (>3 times if needed) and varied times patients were called
Discussion & Limitations

► Challenges in service receipt

♦ Most patients (98.5%) preferred to self-refer, but for many (49%) barriers limit their ability to receive the service
♦ Only 51% received all or part of the service (19.3% received all of the service; 31.4% received partial service)
♦ Biggest barriers were phone and time issues to do the follow-up

► Would provider referral be acceptable to patients (versus research team and self-referrals), and/or be more successful with service receipt and follow-up?
Next Steps

► Finalize data collection; EMR review up-coming

► Publish our results

► Future goal is to implement a more embedded model in clinical settings w/providers conducting screening and referral (vs. self-referral)
Core 5 “Products”

► Core 5 products include a scope and process white paper, the screening tool, algorithm, training module and related reports from the preliminary baseline survey and pilot.

► All can be found on the Ohio Action Coalition (OAC) webpage on the Ohio League for Nurses (OLN) website at www.ohioleaguefornursing.org/page/OACnew

► Under the Building Healthier Communities tab
ACKNOWLEDGEMENTS

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♦ Ohio Action Coalition and base project committee members
♦ Ohio League for Nurses (OLN)
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THANK YOU!

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Questions and Community Feedback
Thank you!

Please fill out our soon to be emailed evaluation sheet—your feedback is very important to us!

Slides/webinar recording will also be posted at www.hcgc.org