Improving Care Transitions: Addressing Social Stressors Prior to Discharge at Pella Regional Health Center

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Objective

- Create a process to identify social stressors (social drivers of health) in our patients' lives that have the potential to negatively impact their health.
- Allow the PRHC Case Management team to provide patients with community resource information while in the hospital and connect patients with resources, as needed, to help reduce barriers to receiving assistance.

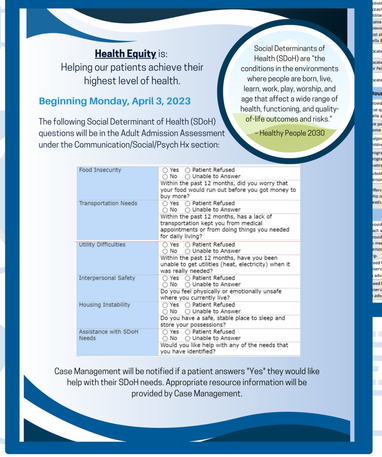
Background

- **Social drivers of health (SDoH)** are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." -Healthy People 2030
- SDoH "serve as an underlying contributor to multiple conditions, including obesity, heart disease, and diabetes." - American Medical Association
- **Health equity** is "the state in which everyone has a fair and just opportunity to attain their highest level of health." - Centers for Disease Control and Prevention
- CMS created the Hospital Commitment to Health Equity measure for 2023.
- The Joint Commission (TJC) added "Improve health care equity" to its National Patient Safety Goals in July 2023, meaning it is one of TJC's highest items of focus. TJC requires that every Critical Access Hospital (CAH) screen patients to identify health disparities and provide information to patients around community resources and support services.

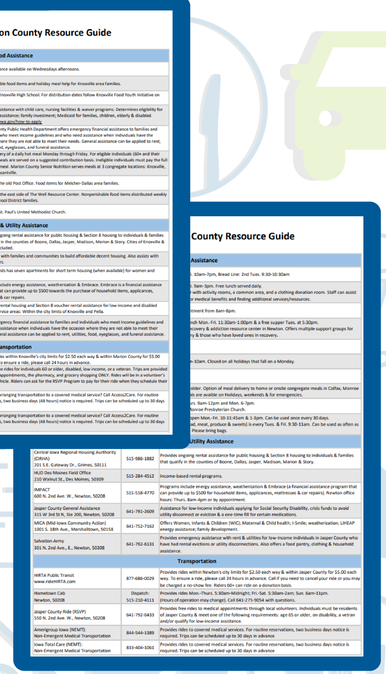
Actions Taken

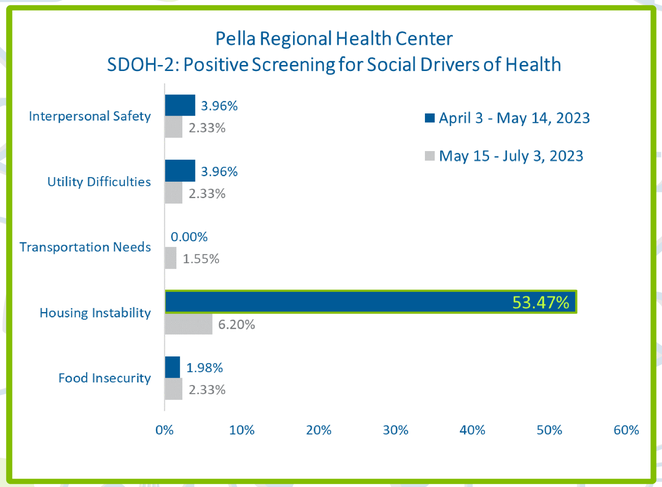
- Researched several Social Drivers of Health (SDoH) screening tools, chose recommended questions, and selected alternate backup questions.
- A multi-disciplinary group met to choose the screening questions, discuss next steps and finalize the timeline for implementation.
- IT built the SDoH questions as part of the Adult Admission Assessment in the EMR for the Med/Surg, ICU, and OB floors.
- Educated nursing staff on the addition to their workflow and that Case Management will be working closely with them to assist patients with SDoH needs while in the hospital.
- Created county-specific resource lists for Case Management staff to provide to patients based on where they reside.
- Built a report to view and analyze the results of patient screenings.

Staff Education



Resource Lists for Patients





Metrics

- Number of patients who identify concerns in each of the following areas: food insecurity, transportation needs, housing instability, utility difficulties, and interpersonal safety.
- Percentage of patients who screen positive for each SDoH

Analysis

- Early in our screening process, we realized our question on housing instability was an inverse question, meaning that a "No" response reflects that a patient *does* have housing concerns. The inverse format of the question had the potential to provide our Case Management team with false positive results.
- The multi-disciplinary group decided it would be best to change the housing question to align with the format of the other four SDoH questions.
  - *Before* changing the housing question: We documented that **53%** of patients had housing insecurity.
  - *After* changing the housing question: We documented that **6%** of patients had housing insecurity.
- **Outcome: Now that we are accurately recording and notifying the Case Management team of our patients' social stressors, our Case Managers can focus on providing resource information to the patients who state they want assistance.**

Next Steps

- Continue creating resource guides for the counties where PRHC patients reside.
- Implement the screening questions in all clinic locations in 2023.
- Spread SDoH resource guides to PRHC clinics.
- Identify and provide training to all staff on culturally sensitive ways to collect demographic and social drivers of health information from patients.

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