Addressing SDOH in Rural Kansas Communities

Kansas Healthcare COLLABORATIVE

kfmc HEALTH IMPROVEMENT PARTNERS

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Welcome!

- What clinic or facility do you work for?
- What city are you located in?
- What is your role?
- If you are an RHC or FQHC, please let us know

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Today's Webinar Agenda

- Welcome – 5 mins
- Content Presentation 45 mins
  - Emersen Frazier and Shelly McMaster, Stormont Vail Health – Regulatory Considerations and Data
  - Sterling Medical Center – Using CHWs to Address SDOH
  - Nicole Baum, Holton Community Hospital – Community Fund to Address SDOH
- Q&A 8-10 Mins
- Closing Comments 2 mins

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SAVE THE DATE

KHC Summit on Quality
August 8th, 2024
Wichita, KS
Wichita State University
Rhatigan Student Center

Learn More

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SAVE THE DATE

KFMC Health Equity Summit
October 30th, 2024
Wichita, KS
Wichita State University
Eugene M. Hughes Metropolitan Complex

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Other Partners

- Blue Cross and Blue Shield of Kansas
- Community Care Network of Kansas
- Kansas Department of Health and Environment
- Kansas Health Information Network
- Kansas Health Institute
- Kansas Hospital Association
- Kansas Perinatal Quality Collaborative

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SDOH Regulatory Considerations and Data Collection

Emersen Frazier, Stormont-Vail Health
Shelly McMaster, Stormont-Vail Health

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ADDRESSING SDOH IN RURAL COMMUNITIES

Shelly McMaster, RN, BSN, MBA
Emersen Frazier, MPH

Stormont Vail Health

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Stormont Vail Health *2022*

Working together to improve the health of our community.

STORMONT VAIL HEALTH

- Employed Physicians – 283
- Employed Advanced Practice Providers – 251
- Employees – 5,452
- Volunteer Hours – 25,349
- Community Benefit – $55,508,502*

Stormont Vail Topeka Hospital	Licensed Beds	586
	Births	1,498
	Surgeries	17,646
	Inpatient Admissions	19,380
	Emergency Visits	53,405
	Outpatient Visits	156,726
Cotton O'Neil Clinics	Primary Care & Specialty Clinics	30+
	Express Care Visits	86,392
	Clinic Visits	763,858
Unique Patients Served		209,429

- Flint Hills Campus became part of Stormont Vail in 2023, therefore is not included in the 2022 numbers -

010 Stormont Vail Health

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CMS Regulatory Requirement

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within our programs and address inequities in policies and operations to close gaps
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to health care services and coverage

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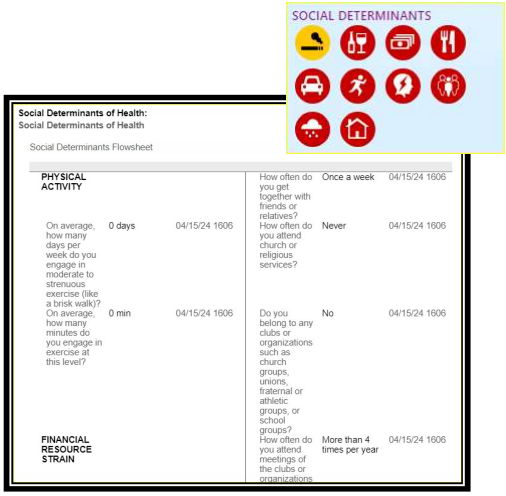
Social Determinants of Health Collection

Screening Requirements:

- Admitted for Inpatient Hospital Stay
  - 18 years or older on date of admission
  - Domains:
    1. Food Insecurity
    2. Housing Instability
    3. Transportation Needs
    4. Utility Difficulties
    5. Interpersonal Safety
- CMS Screening Tool Flexibility



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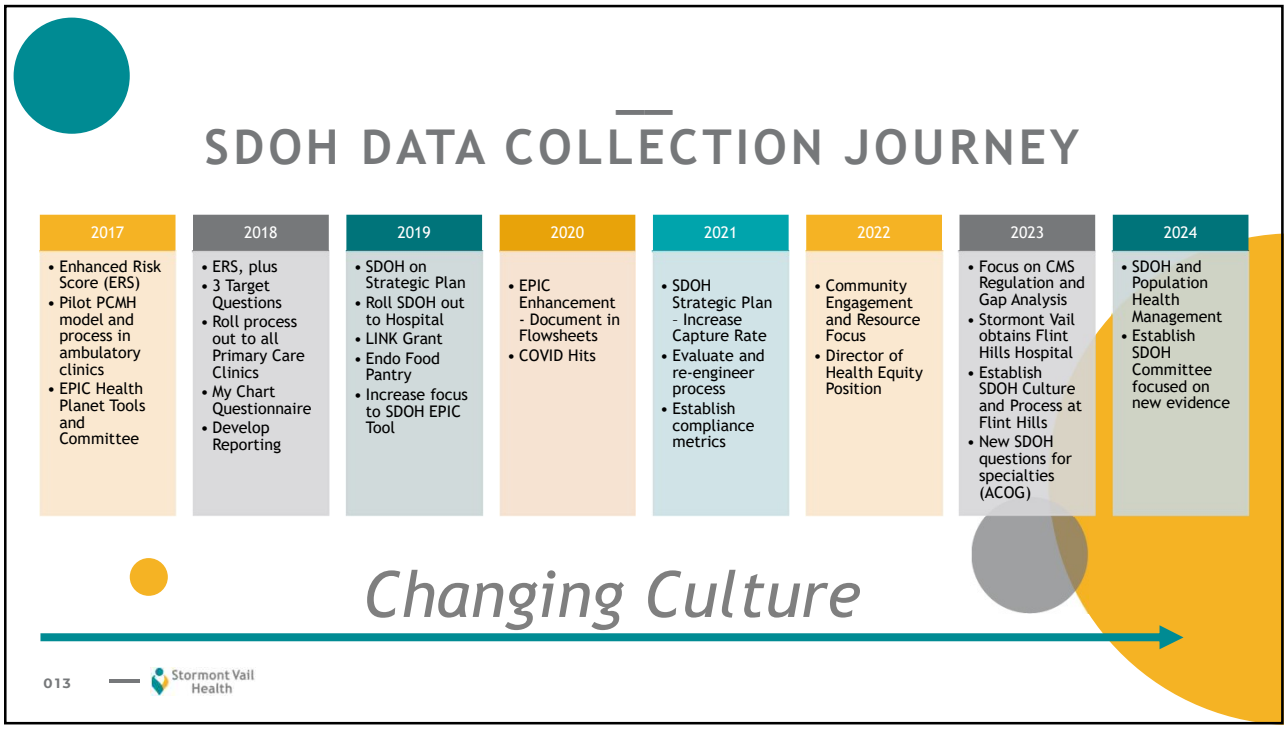
SDOH DATA COLLECTION JOURNEY
2017
• Enhanced Risk Score (ERS)
• Pilot PCMH model and process in ambulatory clinics
• EPIC Health Planet Tools and Committee
2018
• ERS, plus
• 3 Target Questions
• Roll process out to all Primary Care Clinics
• My Chart Questionnaire
• Develop Reporting
2019
• SDOH on Strategic Plan
• Roll SDOH out to Hospital
• LINK Grant
• Endo Food Pantry
• Increase focus to SDOH EPIC Tool
2020
• EPIC Enhancement - Document in Flowsheets
• COVID Hits
2021
• SDOH Strategic Plan - Increase Capture Rate
• Evaluate and re-engineer process
• Establish compliance metrics
2022
• Community Engagement and Resource Focus
• Director of Health Equity Position
2023
• Focus on CMS Regulation and Gap Analysis
• Stormont Vail obtains Flint Hills Hospital
• Establish SDOH Culture and Process at Flint Hills
• New SDOH questions for specialties (ACOG)
2024
• SDOH and Population Health Management
• Establish SDOH Committee focused on new evidence
Changing Culture
013
Stormont Vail Health

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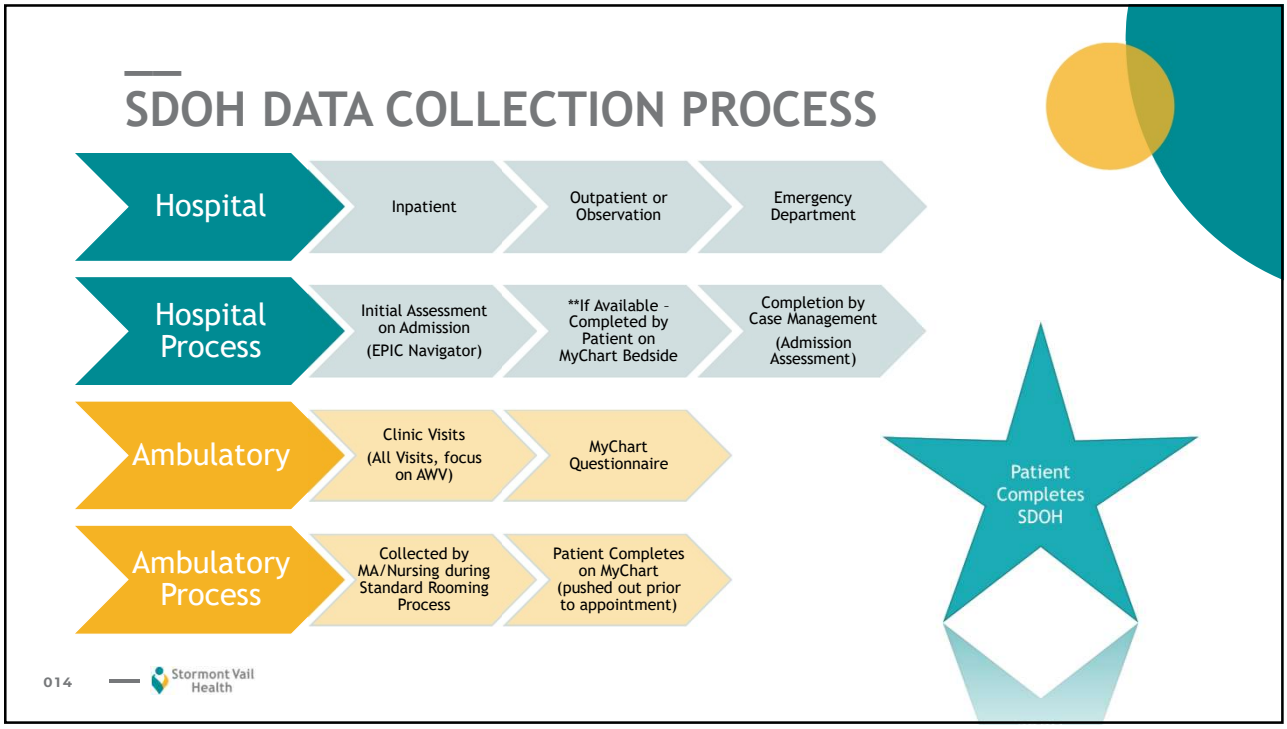
SDOH DATA COLLECTION PROCESS
Hospital
Inpatient
Outpatient or Observation
Emergency Department
Hospital Process
Initial Assessment on Admission (EPIC Navigator)
**If Available - Completed by Patient on MyChart Bedside
Completion by Case Management (Admission Assessment)
Ambulatory
Clinic Visits (All Visits, focus on AWV)
MyChart Questionnaire
Ambulatory Process
Collected by MA/Nursing during Standard Rooming Process
Patient Completes on MyChart (pushed out prior to appointment)
Patient Completes SDOH
014
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SDOH Collection Barriers and Scripting

2017 – No one knew what SDOH was and why it was important

2018 – Staff felt awkward asking questions

2019 – Resistance to collecting during hospitalization

2020 – Covid slowed down progress

2023 – Specialty Practice use of SDOH

Scripting

Social Determinants of Health (SDOH)

Scripting to start conversation-
As part of our efforts to better care for you, we have a few questions to help identify and support your healthcare needs.

Scripting when patients get upset with personal questions-
These questions are asked and help in our efforts to keep you well, the information can be used to improve your plan of care &/or connect you with needed resources, some of which are available in this clinic.

Scripting if need is identified-
We have identified your difficulty with getting to appointments. We have a Social Worker in the building I would like to share this information with.

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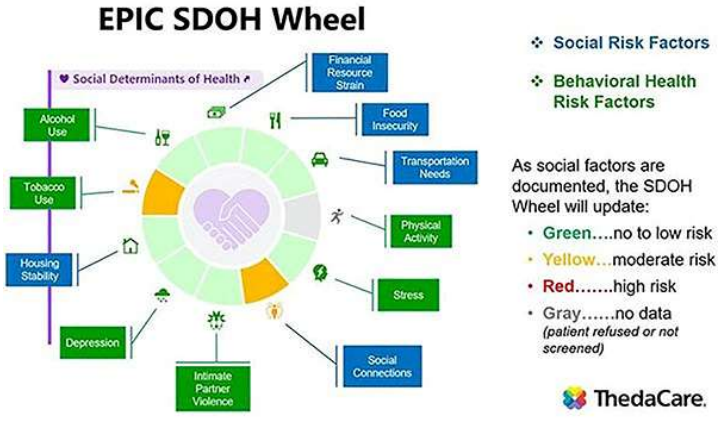
SDOH Questionnaire-

- ✓ SUBSTANCE USE
- ✓ DEPRESSION
- ✓ FINANCIAL RESOURCE STRAIN
- ✓ FOOD INSECURITY
- ✓ HOUSING STABILITY
- ✓ INTIMATE PARTNER VIOLENCE
- ✓ PHYSICAL ACTIVITY
- ✓ SOCIAL CONNECTIONS
- ✓ STRESS
- ✓ TRANSPORTATION NEEDS



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EPIC Screening & Referrals

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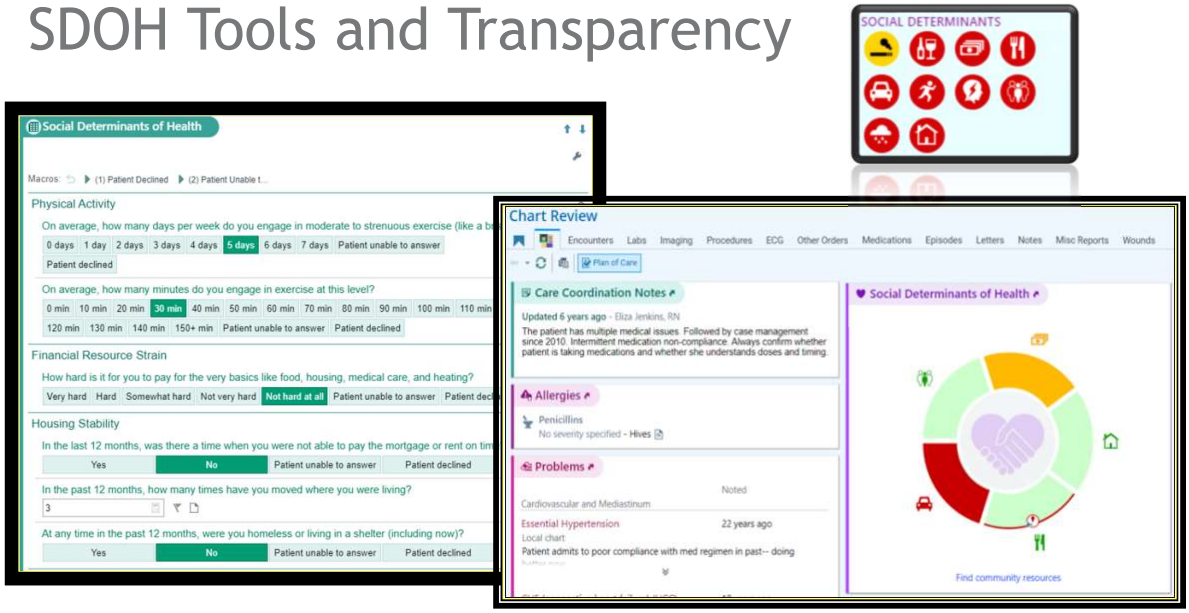
SDOH Tools and Transparency



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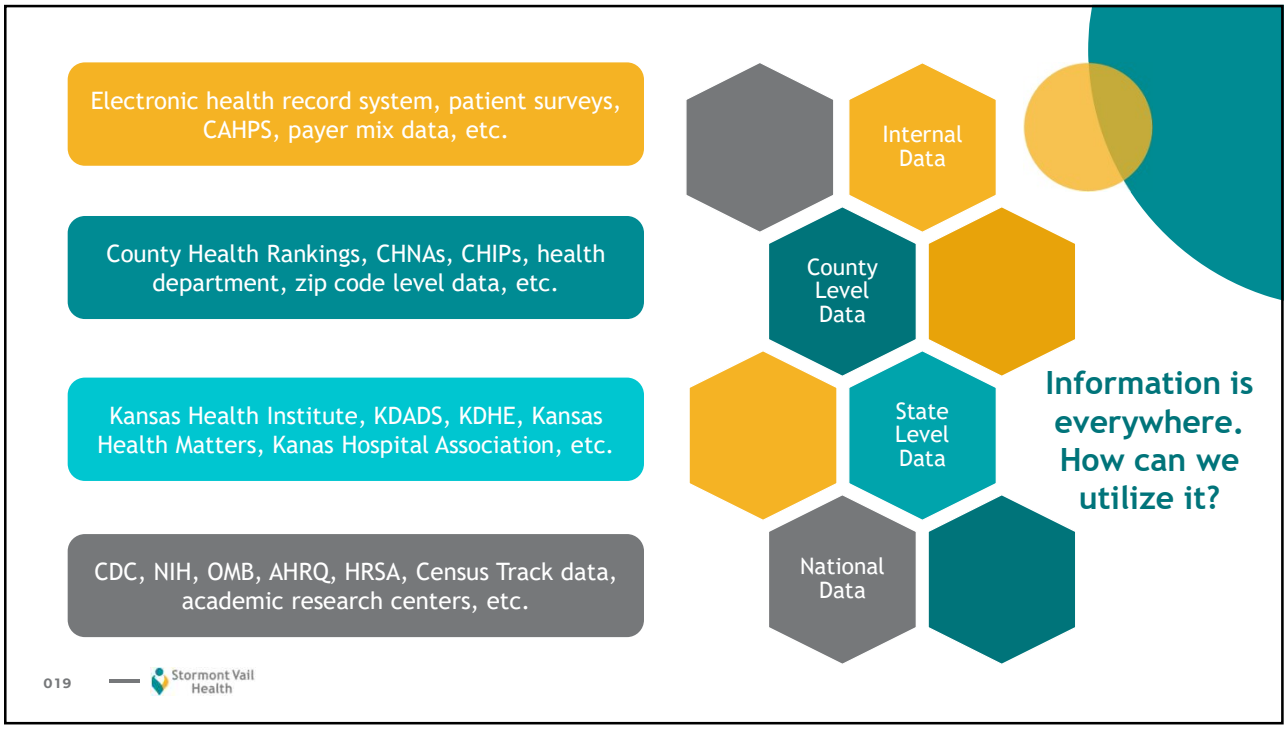

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WHEN PRIORITIZING LOCAL DATA IS HELPUL

- **Small amount of internal resourcing to collect data**
- **Hold a large share hold of patient care in your area (>70%)**
- **Have access to community level data that is updated on a regular basis**
  - Ideally every 6 months to a year
- **Have information on methodology of how data is collected and interpreted**
  - When more resources are available, can use statistician to replicate using internal data.
  - Vital to understand what leading and lagging indicators your organization has the power to impact

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WHAT CAN A DASHBOARD DO?

"The dashboard is able to **capture progress** made in certain areas as well as **identify areas of focus.** The dashboard also serves to **identify patient populations** that may be at increased risk for adverse outcomes. Discussing these dashboards in regularly scheduled quality meetings allows leadership to **continuously address gaps in care** and work to eliminate disparities."

- The American Hospital Association in partnership with Health Research & Educational Trust

Capture Progress
Will be able to easily acquire data that shows how SVH compares to other systems or public health data

Help Understand Populations
High level overview of patient population and which groups are underserved in our community

Identify Trends in Risk
See how various outcomes trend over time to track overall effectiveness of care

Drive Policy Change
Have ready data that supports new or innovative policy recommendations

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EXAMPLE DASHBOARD

County Health Ranking Measures
- Takes data from Shawnee County from 2013-2019 to come up with %
- Defines LBW % as babies born <2500 grams or about 5.51 lbs.
- No distinction between LBW and VLBW, or cause of LBW
- Baby race based on mother no ethnicity data reported

Stormont Vail Mini Dashboard Measures
- All patients from Shawnee County 2013-2019
- Used same categories for LBW %
- Used % unit instead of rate
- Raw numbers = total cases NOT %

022 — Stormont Vail Health

What the County Health Ranking Reports:

	Shawnee (SN) County	Trend	Error Margin	Top U.S. Performers	Kansas
Low birthweight	7%		7-7%	6%	7%

	Value	Error Margin	x
% LBW	7%	7-7%	
American Indian & Alaska Native	6%	2-10%	
Asian	7%	4-10%	
Black	12%	10-13%	
Hispanic	7%	6-8%	
White	6%	6-7%	

Low birthweight (LBW) represents infant current and future morbidity, premature mortality risk, and maternal exposure to health risks. LBW children have greater developmental and growth problems, are at higher risk of cardiovascular disease, respiratory conditions, and cognitive problems such as cerebral palsy, and visual, auditory, and intellectual impairments (County Health Rankings and Roadmaps).

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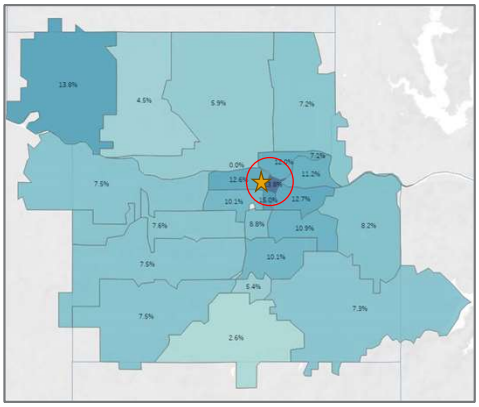
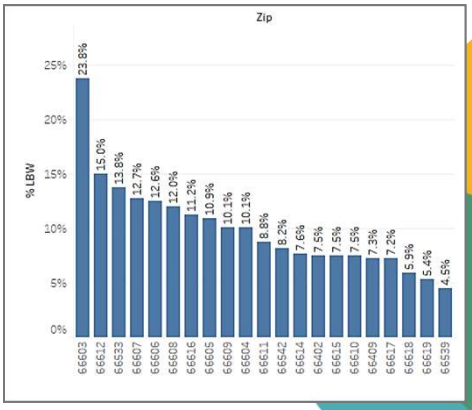
EXAMPLE DASHBOARD

This mini dashboard was created in collaboration with the strategy team to use patient data in Epic compared to data from the Shawnee County Health Ranking. This information plus SDOH needs context can lead to a comprehensive health equity intervention.





023 Stormont Vail Health ★ = SVH approx. location

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Stay in Touch with Us!

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Director, Health Equity & Policy

Email: Emersen.Frazier@stormontvail.org

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THANK YOU
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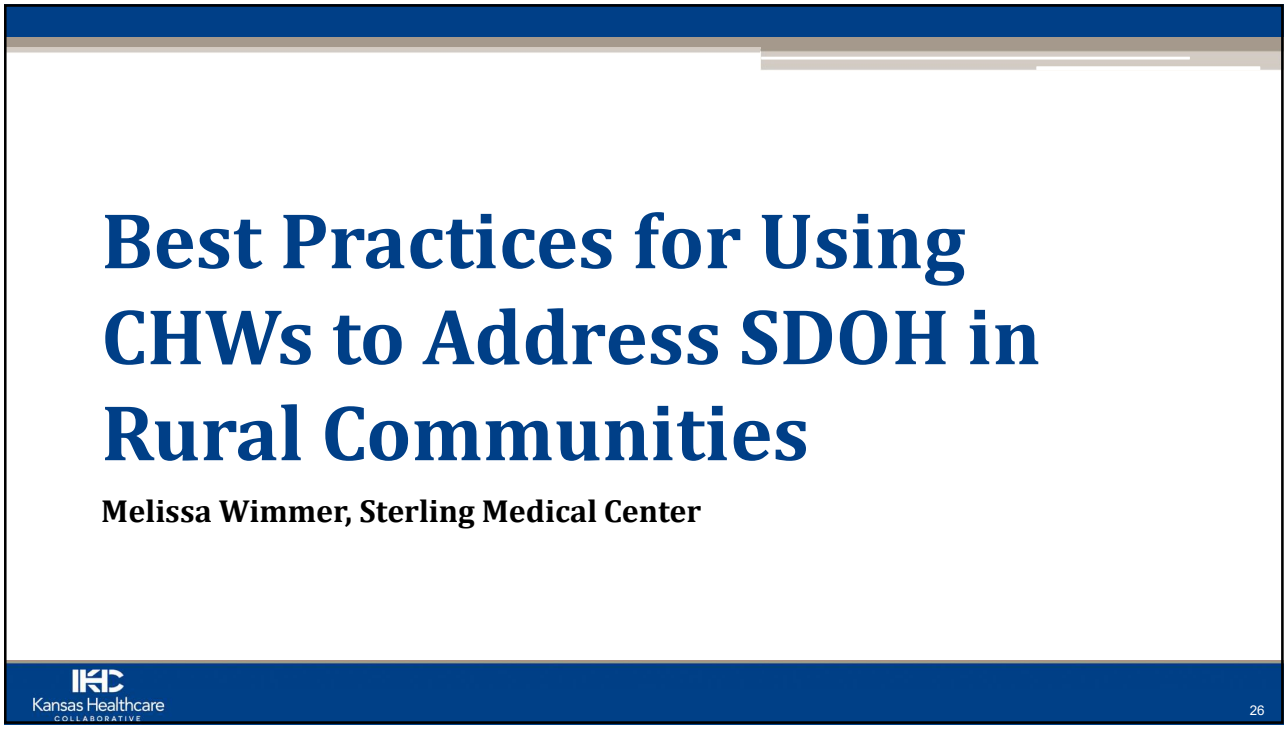
Best Practices for Using CHWs to Address SDOH in Rural Communities
Melissa Wimmer, Sterling Medical Center
Kansas Healthcare COLLABORATIVE
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Community Health Workers Program

STERLING MEDICAL CENTER-LYONS MEDICAL CENTER

RICE COUNTY DISTRICT HOSPITAL

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CHW TEAM

-Melissa Wimmer RN, BSN
Program Director/Home Health RN

-Lisa Stout, Patient Navigator, CHW-C
-Jessica Inguanza, CHW-C
-Julissa Reyes, CHW-C

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Rice County Health CHW

Bridging the gap between resources and wellness

- Chronic Health Issues
  - PreDiabetes
  - Hypertension
  - COPD
- Health Education
- Prenatal/Postnatal Support
- Disability Advocacy/Application
- Food Disparity
- Housing Instability

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RCH CHW cont..

- Medical Appointment Transportation Facilitation
- Mental Health Advocacy
- Insurance Education
  - Presumptive Eligibility

RICE COMMUNITY HEALTHCARE
COMMUNITY HEALTH WORKER PROGRAM

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Who and how are we serving?

- PreDiabetics/Diabetics
- Hypertensives
- COPD
- Pre/Postnatal Patients
- Newborns

- Patients over 60
- Disabled
- Families caring for grandchildren in foster care or kinship

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How do we get patient referrals?

Relationships and Trust

- Clinic Provider Referrals
- ER/Hospital Discharge Provider Referrals
- EMS
- Community Events
- School Staff
- Council on Aging Staff
- Community Members

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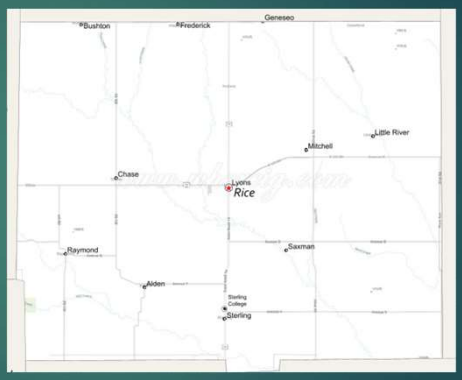
Rice County Overview

Small Town Strength

- Alden (122)
- Bushton (203)
- Chase (399)
- Frederick (9)
- Geneseo (89)
- Little River (472)
- Lyons (3,556)
- Sterling (2,507)



- Total County Population 9,150

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Each Communities Needs

and Resources

- Serve in each community
  - Pt home visits in each town
  - Know resources specific to where they are located
  - Find the community advocates
  - Be the voice between the patient and provider

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Health and wellness can be a long journey when there has been no previous roadmap.

- Walk along side patients through lifestyle changes
- Offer simple education and goals
- Make the process enjoyable
- Provide resources in conversation, then reinforce by providing contact information or making contact calls with patient

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Reaching the Community….

- At the local coffee stops
  - Farmers BP Check/Mental Health
- Local Hispanic Business
  - BP/BS Check Saturday Morning
- High School Mental Health Day
  - CHW Staff Provided Support
- Local Craft Fair
  - Health Trivia and Education
- Thrift Store Support
  - Referral/Donate Time

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Education, Activity, Support

- Hypertension
- Mobility issues
- PreDiabetes
- Helped qualify for Disability

- Meal Planning
- Exercise Support
- Mental Health Championing
- Medication Advocacy

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Since the start of our CHW program….

- Over 130 patients seen for home visits
  - No Patient Charge
  - Scheduled by patients need level
  - SDOH assessment, resource search, and referral collaboration
- Integral Partner with County Health Collaborative
- Outreach through Community Events
  - Created access to health education, tools, and resources
  - More than 300 people reached and multiple populations
  - Increased access to affordable fresh fruits and vegetables

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Challenges are everywhere…

- Lack of Understanding of CHW team goals and expectations
- Resource limitations
- Sustainability/CMS/Medicaid Funding
- Unite Us Barrier
  - Small entities not using computer system to connect
  - Referral process limited
- Patient Transportation limitations

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The Future is Exciting!

- Increased Community Knowledge of Program
- New Centralized and Visual Location in County
- Foundational Healthcare Community Support
- Continued Partnership Growth
  - K-State Extension
  - Rice County Health Department

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Community Health Workers choose everyday to..

- **Believe in the basics of creating trust and support in the home. This choice sets a foundation for navigating communication and stability to achieve a healthier future physically and mentally for every person they come in contact with.**

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Addressing SDOH with a Community Fund

Nicole Baum, Holton Community Hospital

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HOLTON COMMUNITY HOSPITAL
FOUNDATION

AGENDA

- Introduction of myself
- Foundation Mission/HHF Policy
- The Community Tie
- Sustaining Funds
- Patient Stories
- Final Takeaways

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INTRODUCTIONS

- Nicole Baum, RN, BSN
- Program Director for Senior Life Solutions
- Foundation Director
- Born and raised in Holton, KS- returning to my established roots

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THE HOMETOWN HEART FUND

Foundation mission: *The Holton Community Hospital Foundation supports the hospital in achieving its goals of compassion, professionalism and excellence in healthcare through philanthropic giving. Operating in accordance with the mission of Holton Community Hospital, the foundation builds lifelong relationships with contributors, raises funds and dedicates its resources to further advance the needs of the Hospital and those it serves.*

- Creation of the Hometown Heart Fund:
  - Created in 2021
  - Purpose: to assist Holton Community Hospital or physician's clinic patients with expenses for basic needs items, durable medical equipment, pharmaceuticals and travel expenses. Assistance can also be granted for physical, occupational, and cardiovascular service patients due to lack of insurance or for those who are underinsured
  - Special account within this fund for No-Cost Mammograms

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HOMETOWN HEART FUND POLICY BREAKDOWN

- Funds will not be paid directly to patients but rather on behalf of the patients.
- This fund covers:
  - $200 yearly for basic needs and transportation services
    - Jackson County EMS and our local transport directly bill the Foundation
    - Secured Transports
  - $500 annually for assistance with DME (oxygen equipment, wheelchairs, crutches, etc.), Pharmacy, Therapy, and Cardiovascular Services
  - No cost mammograms cover $200 per mammogram which covers the screening process
- Exceptions for the total yearly amount paid on behalf of any one patient or category of items eligible will only be approved under extenuating circumstances and if all other applicable funding sources have been exhausted.

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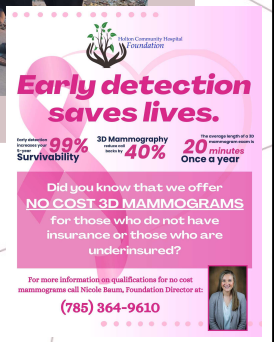
NO COST MAMMOGRAMS

-Funds provided cover the screening/reading process for our patients covering $200 per mammogram

-Patient story- *" In December I went in for my mammogram and they told me to come back for a different one. I did. Then it was "you need to have a biopsy." I was in shock! I did mammograms every year! My chemo doctor told me that I have the pten gene. During my chemo, the breast I was having removed got infected and I got a 102 temp. I had to run to Lawrence for emergency surgery. He said if I would have waited the cancer would have went in my chest wall. So he took it out and I told the surgeon no more and to take the other breast too. I got prosthetics and can say- I am a survivor." - Tracey Shumaker*



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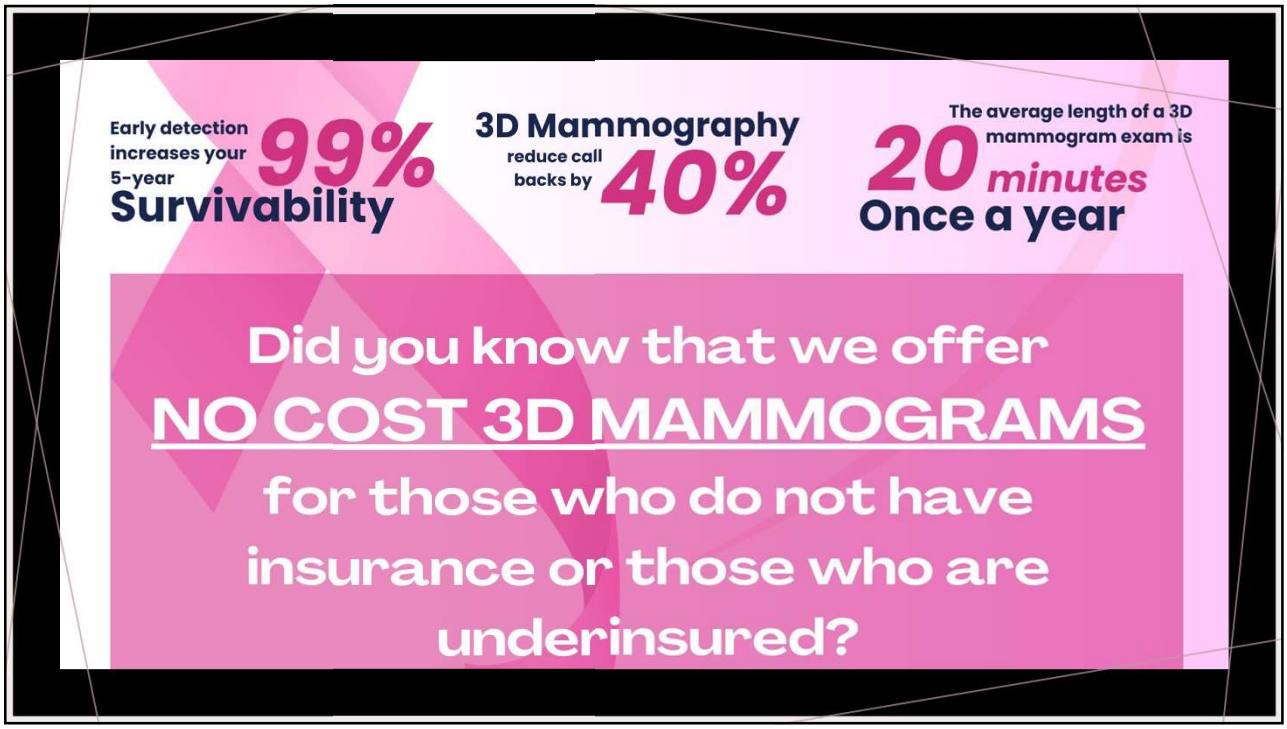

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THE COMMUNITY TIES

Holton Community Hospital Foundation Board

- Currently composed of 10 members
- Board consists of members throughout the community: Banks, local businesses, etc.
- Part of composing the Hometown Heart Fund or any changes made upon yearly review
- Vote upon exemptions under extenuating circumstances

Our community truly supports this Hospital and Foundation:

- Supports through monetary donation, volunteering, estate, memorials etc.
- Funds that come through the Foundation get poured directly back into the hospital and the HHF to give back to our patients.

"Keeping Our Patients Care Close To Home"

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SUSTAINING FUNDS

Two main factors that help to keep our funds with the Hometown Heart Fund sustained/growing:

- Gracious donors
  - Designations within a will/Property-Vehicle/Real Estate
  - Specified Donations
  - Memorials or Tributes
- Events:
  - Color Run 2023
  - Breast Cancer Awareness Events

The HCH Foundation received an amazing donation in the amount of $4,000.00 in memory of Jane Aeschliman-Evans in support of the recent purchase of breast biopsy equipment for our radiology and surgery departments.
This equipment allows our general surgeon, Dr. Denis Jimenez, to provide surgical intervention for patients that have been diagnosed with breast cancer.

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EXAMPLES OF PATIENTS WE HELP

- Patient unable to afford a medication (Short term coverage)
- Patient needing a ramp to be able to safety enter and exit home
- Patient life flighted to Kansas City. Family member could not afford gas to make it to the hospital.
- Patient needing to leave hospital on Lovenox. Pharmaceutical coverage while social work is completing patient assistance.

While the Hometown Heart Fund is used as more of a short term/immediate solution- I work directly with our social work/case management team to meet the needs of the patient moving forward.

- Applying for Medicaid
- Referring on to the Health Department for basic needs
- Etc.

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THANK YOU!

"We care about the future of our rural health care and how it impacts our community, schools, churches, civic organizations, and our patients."

Nicole Baum
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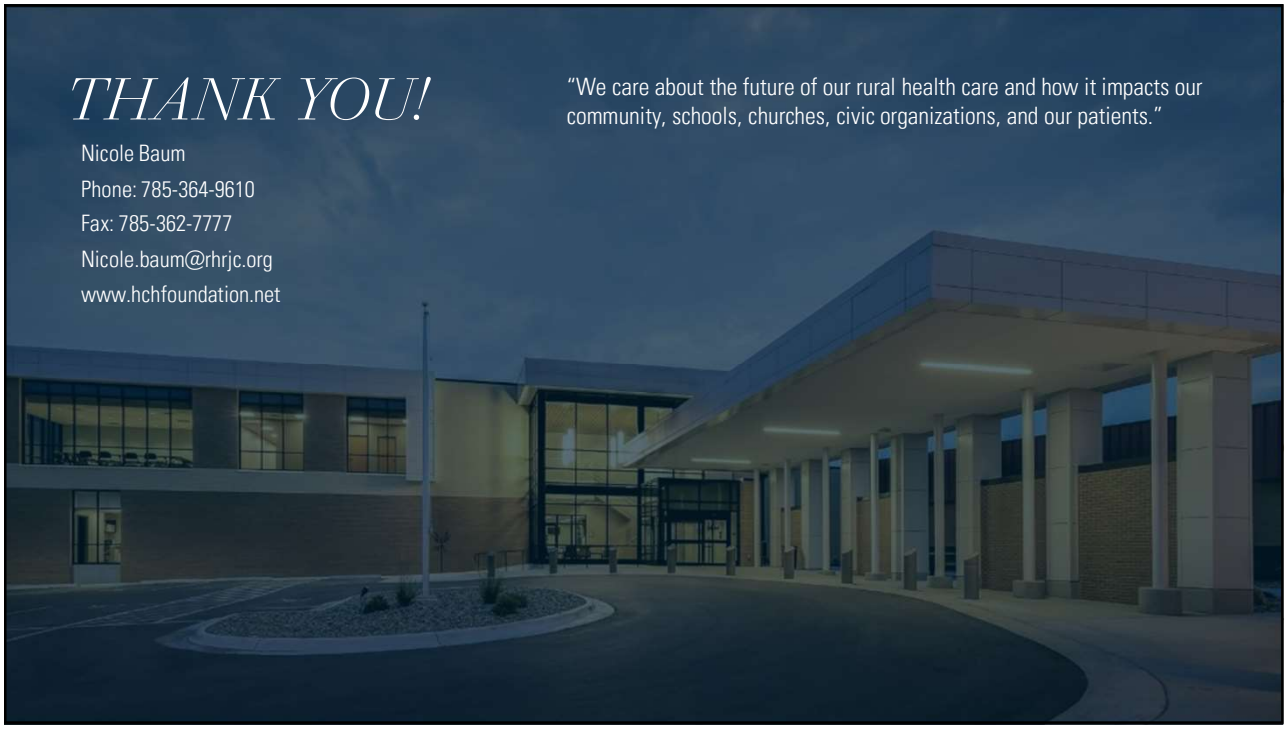

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Questions?

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Resources

- Health Equity Resource Hub
- KHC Health Equity Education Archive
- KHA/KHC: Regulatory Requirements Related to Health Equity & Social Determinants of Health
- KMAP Bulletin: Community Health Worker Services
- CMS Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- Kansas Health Matters

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Health Equity Resource Hub

Dismantle Health Disparities & Foster Equitable Healthcare Solutions

KFMC and our partners believe that everyone deserves the opportunity to lead a healthy life, regardless of their background, identity, or socioeconomic status. Our Health Equity Resource Hub was created to help healthcare professionals, organizations, and communities make informed decisions, raise awareness, and take action.

kfmc Health Improvement Partners

Visit **www.kfmc.org/health-equity-resource-hub** or scan the QR code to access the Health Equity Resource Hub. The Hub will be updated regularly, so be sure to check back as we expand upon the current offering.

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Upcoming Education and Important Dates

- 5/9 Navigating Rural Health Resources Series – HPSAs
- 5/22 KHC Office Hours - Applying High Reliability Concepts in Critical Access Hospitals
- 6/19 IHC Annual Forum - Altoona, IA
- 6/21 Resiliance Learning Action Series
- 6/26 KHC Office Hours - Advanced Directives are for the Living - Improving Workflows in Your Organization
- **July 31, 2024: Next Health Equity Webinar (Transportation)**
- 8/8 KHC Summit on Quality
- October 30, 2024: Kansas Health Equity Summit

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