tchmb
Texas Collaborative for
Healthy Mothers & Babies

2023 TCHMB Summit
February 16-17

How to Recognize & Assess Social Needs

Thursday, February 16

1:30 - 2:30 PM

MODERATOR: Patrick Ramsey, M.D., MSPH, Chief Medical Officer for the Texas Collaborative for Healthy Mothers and Babies and Professor and Division Chief for Maternal-Fetal Medicine at UT Health San Antonio

AMY RAINES-MILENKOV DrPH,
University of North Texas Health Science Center, Associate Professor, Pediatrics

MISTY WILDER, MSW
Program Director Healthy Start at University of North Texas Health Science Center at Fort Worth

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Community Health Worker, Healthy Startat University of North Texas Health Science Center at Fort Worth

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Texas Collaborative for Healthy Mothers & Babies

2023 TCHMB Summit
February 16-17

How to bring SD into QI
How do we close the loop?

Thursday, February 16

2:30 - 3:30 PM

MODERATOR: Kendra Fohl, MSN, RNC-OB, C-ONQS, CPHQ, CLSSBB, Program Director for the Women's and Children's Service Line at Memorial Hermann Healthcare System

ANN BORDERS, M.D., MSc, MPH

Executive Director and Obstetric Lead, Illinois Perinatal Quality Collaborative Maternal Fetal Medicine, NorthShore University Health System Clinical Associate Professor, Pritzker School of Medicine, University of Chicago

ELENA JENKINS, RN BSN

Nurse Manager - Labor & Delivery, SSM Health St. Mary's Hospital - St. Louis

Birth Equity (BE) Initiative:

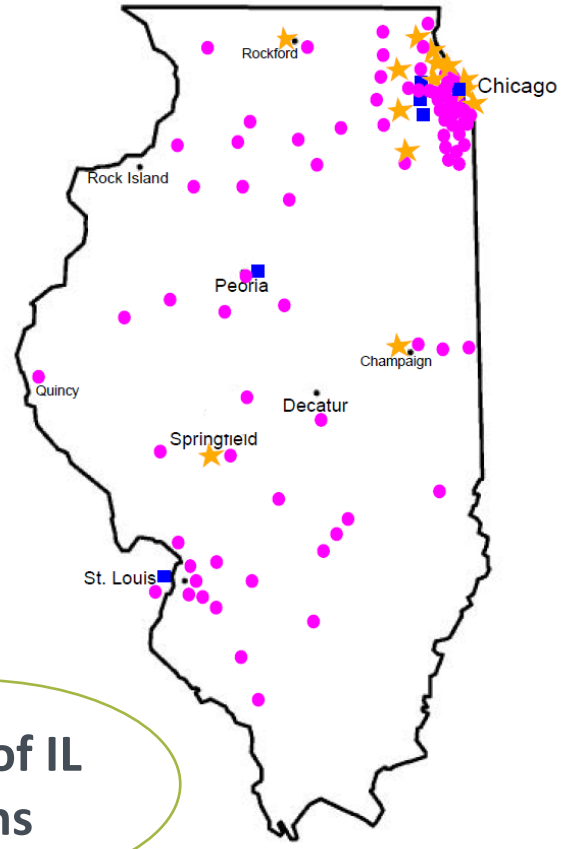
working together to promote equity and reduce disparities

Ann Borders, MD, MSc, MPH
Ian Bernard Horowitz Professor of Obstetrics, NorthShore University HealthSystem, University of Chicago, Pritzker School of Medicine
Executive Director and OB Lead, Illinois Perinatal Quality Collaborative

ILPQC
Illinois Perinatal Quality Collaborative

Illinois Perinatal Quality Collaborative (ILPQC)

- Multi-disciplinary, multi-stakeholder Perinatal Quality Collaborative with 100 Illinois hospitals



>99% of IL births

Birth Equity Initiative

6/2021 – current

86/100 birthing hospitals

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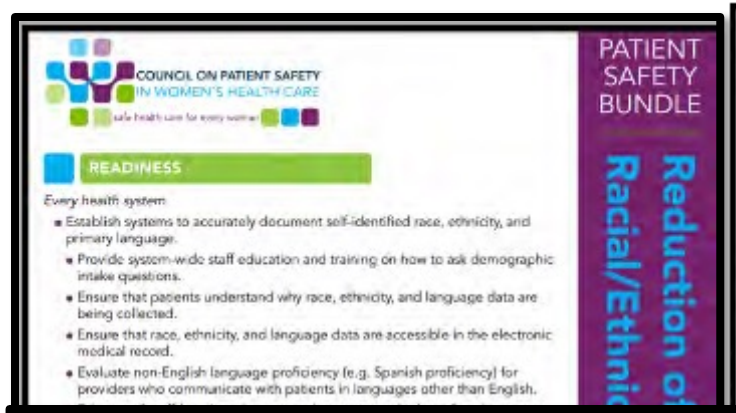
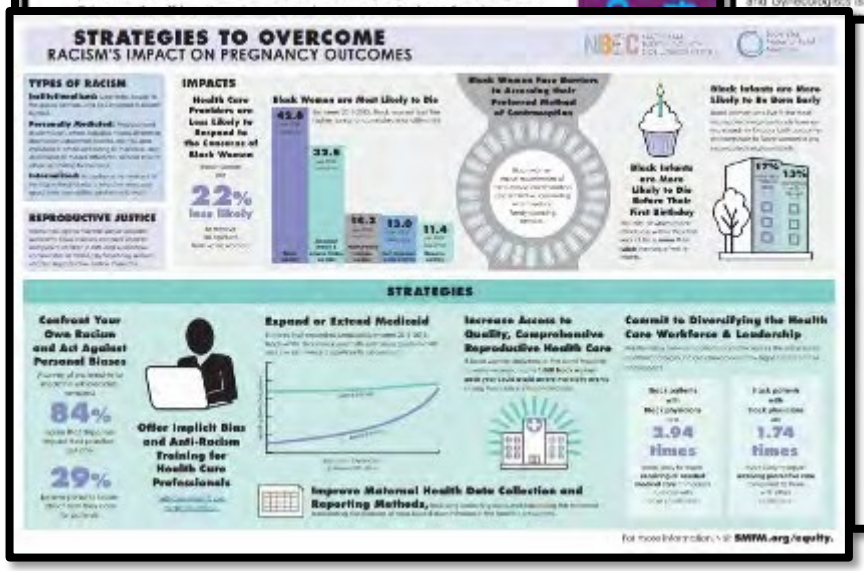
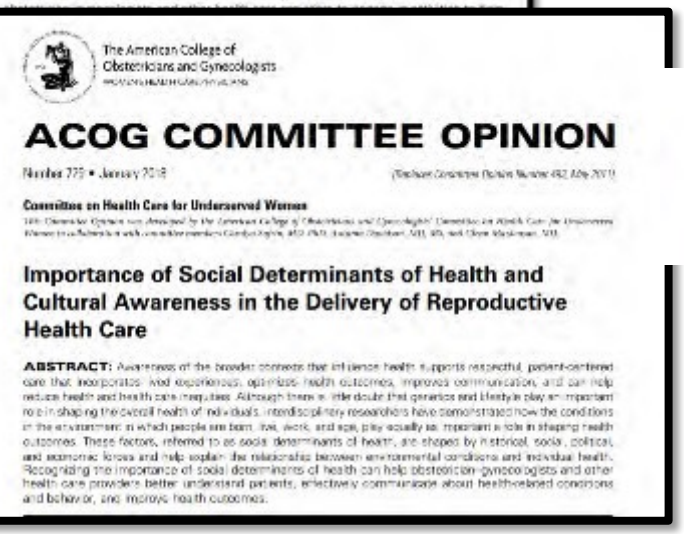
Foundational initiative for that builds on existing hospital efforts and lay the groundwork for ongoing equity work to address maternal disparities and promote birth equity

National Guidelines & PQC Partners







CMQCC
California Maternal Quality Care Collaborative

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

PN QIN
PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

PARTNERS FOR FAMILY HEALTH LOUISIANA

New York State nyspQc Perinatal Quality Collaborative

Expanded resources for engaging patients, families and communities

Patient, Family and Community engagement pilot

Consulting Everthrive to promote community engagement

Patient focus groups and feedback

Maternal Health Task Force engagement

Patient engagement consultant: LaToshia Rouse

Infant and Maternal Mortality Among African Americans Task Force

What is the focus of Birth Equity (BE)?

BE AIM: By December 2023,

- more than 75% of Illinois birthing hospitals will be **participating in the Birth Equity Initiative** and
- more than 75% of participating hospitals will have the **key strategies in place**.

86% of Illinois hospitals participating

Addressing Social Determinants of Health

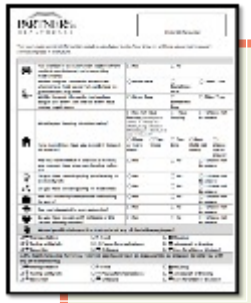
Review race/ethnicity medical record and quality data

Engage patients and communities in patient centered respectful care

Develop respectful care and bias education for providers, nurses, and staff

Key QI Strategies

Optimize race/ethnicity data collection & review key maternal quality data by race, ethnicity & Medicaid status



Universal **social determinants of health screening** tool (prenatal/L&D) with system for linkage to appropriate resources

Share **respectful care practices** on L&D and survey patients before discharge on their care experience (using the PREM) for feedback

Engage patients and community members for input on quality improvement efforts

Standardize postpartum safety education and schedule early postpartum follow up prior to hospital discharge

Implicit Bias / Respectful Care training for providers, nurses and other staff

Addressing Social Determinants of Health (SDOH)

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Addressing social determinants of health (SDoH)

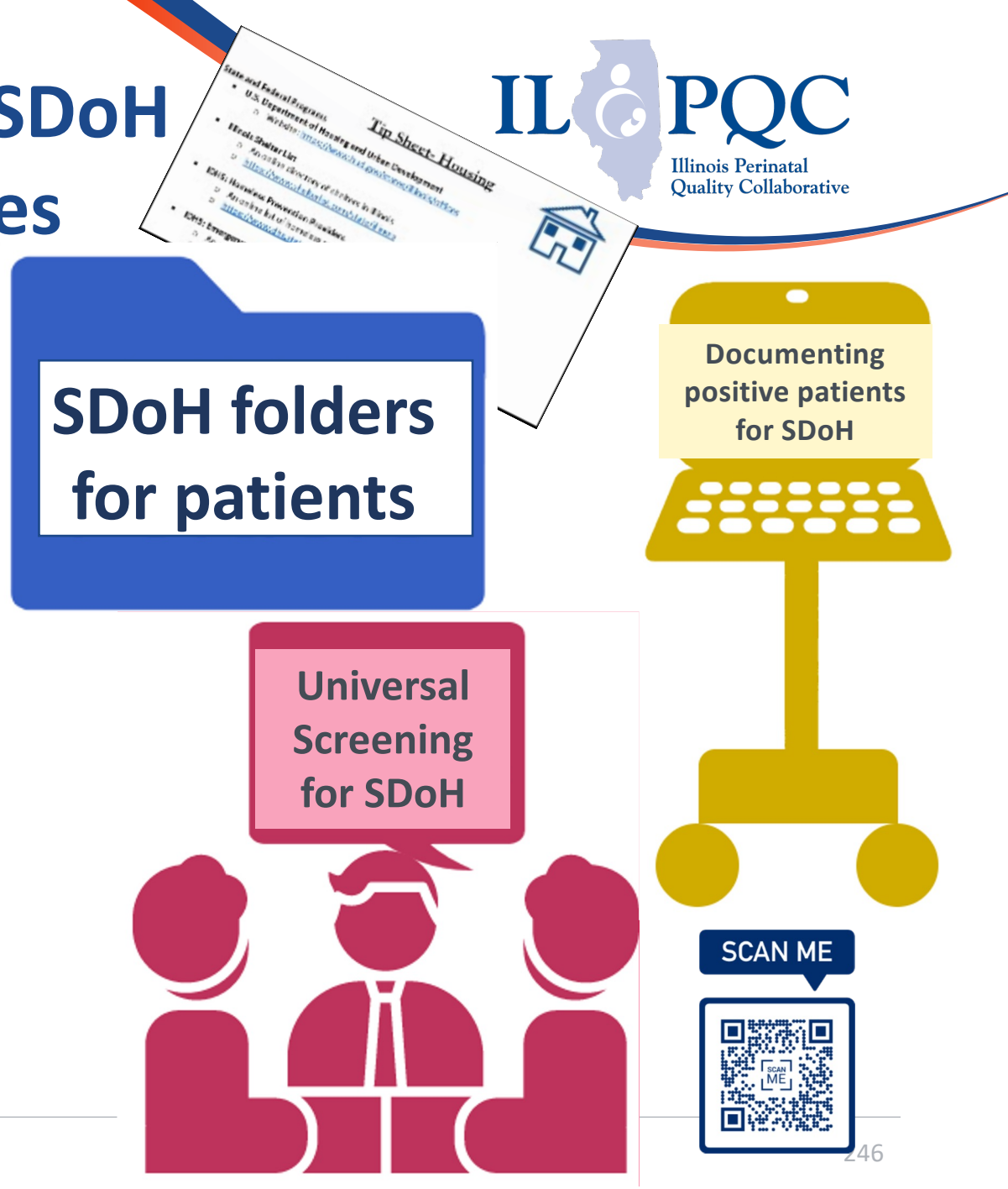
1. **Screen all patients for social determinants of health needs** during prenatal care and at the delivery admission (sample screening tools)

2. **Create process flow to link screen positive patients to needed resources and services** (SDOH folder with tip sheets, mapping tool)

3. **Incorporating social determinants of health and discrimination factors** in hospital maternal morbidity reviews

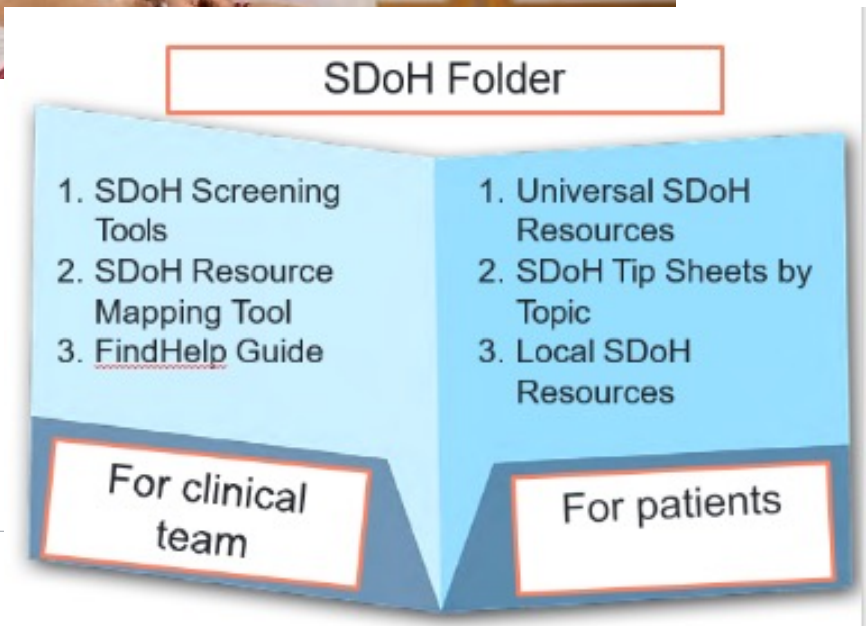
Information to start working on SDoH screening and linkage to resources

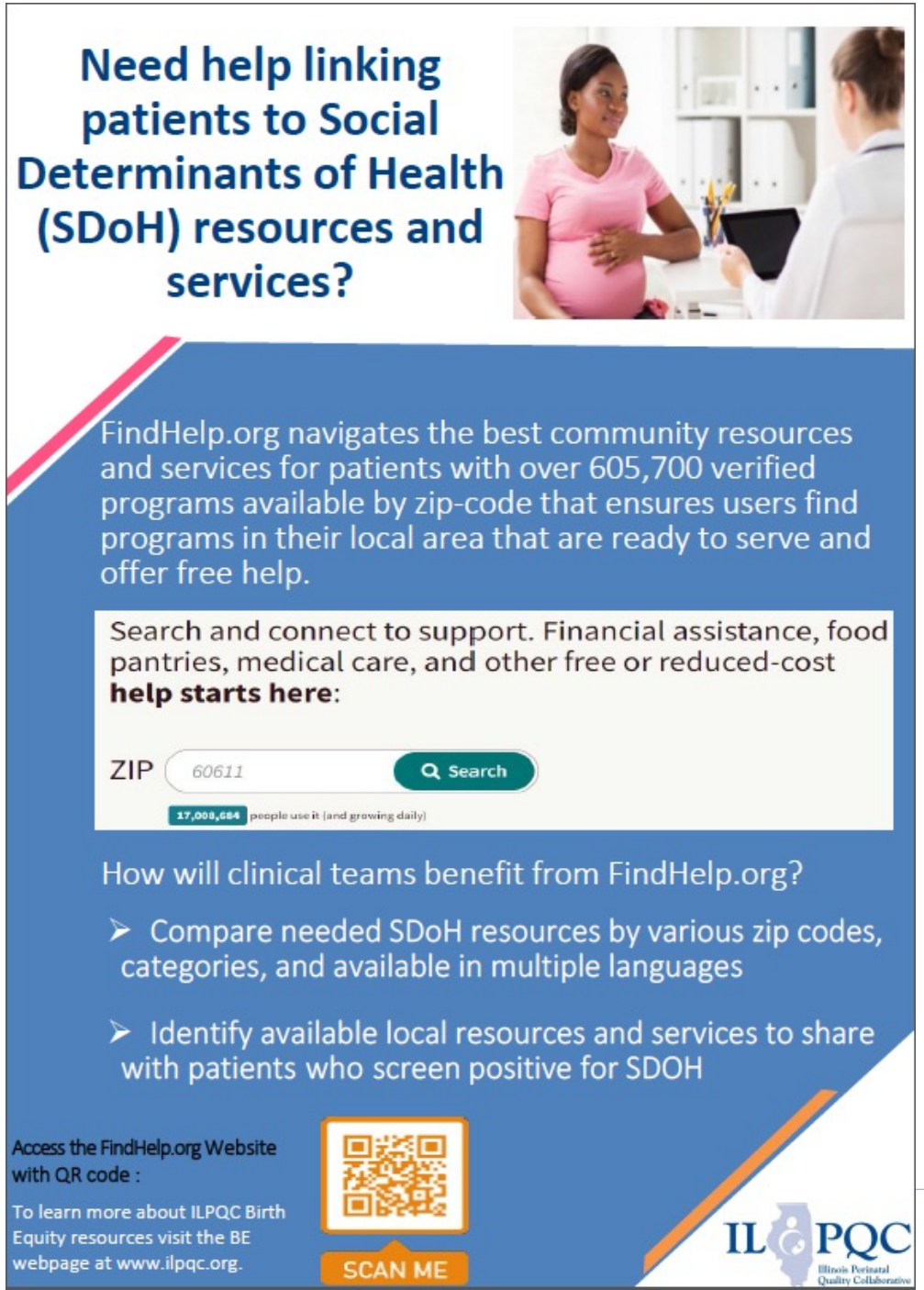
- Folders with patient and provider resources for SDoH screen positive patients
- Sample screening tools
- Community resources and mapping tool
- Patient Tip Sheets
- Electronic resource navigators



Addressing social determinants of health (SDoH) – linking to resources

- ILPQC has provided hospitals teams two options for electronic online SDOH database of resources:
  - ***FindHelp.org*** is a free tool to search for social determinants of health resources by zip code in multiple languages
  - ***NowPow*** with options to assist hospital access





FindHelp.org One-Pager to help link patients to SDOH resources

ILPQC SDoH Tip Sheets

Tip Sheet-Utility

State and Federal Programs

- **Help Illinois Families**
  - Website with programs for eligible individuals seeking emergency assistance to cover costs of utility bills, rent, temporary shelter, food, and other household necessities.
  - https://www2.illinois.gov/dceo/CommunityServices/HomeWeatherization/CommunityActionAgencies/Pages/HelpIllinoisFamilies.aspx
- **Utility Bill Assistance**
  - The Low Income Home Energy Assistance Program (LIHEAP) helps eligible low-income households pay for home energy services (primarily heating during winter months).
  - Call the LIHEAP Hotline at 1-877-411-WARM (9276).
- **Community Action Agencies**
  - Community Action Agencies across the State provide a variety of services, including but not limited to, Rental/Mortgage Assistance, Food, Energy Utility Bill Assistance, Water/Sewer Payment, Employment Training/Placement, Financial Management, and Temporary Shelter.
  - https://www2.illinois.gov/dceo/communityservices/utilitybillassistance/pages/default.aspx

Tip Sheet- Education

State and Federal Programs

- **Illinois Reemployment Services Program Hotline**
  - Search for jobs online
  - Phone number: (877) 342-7533, option 1
  - https://illinoisjoblink.illinois.gov/ada/r/
- **Listing of Community Colleges in IL**
  - https://www.collegesimply.com/colleges/illinois/
- **Adult Learning Resource Center**
  - Provides referral services for students, volunteers, and employers wishing to access adult education and literacy programs throughout Illinois.
  - https://alrc.thecenterweb.org/other/illinois-adult-learning-hotline/

Tip Sheet- Housing

State and Federal Programs

- **U.S. Department of Housing and Urban Development**
  - Website: https://www.hud.gov/states/illinois/offices
- **Illinois Shelter List**
  - An online directory of shelters in Illinois
  - https://www.shelterlist.com/state/illinois
- **IDHS: Homeless Prevention Providers**
  - An online list of homeless prevention providers in Illinois
  - https://www.dhs.state.il.us/page.aspx?item=110583
- **IDHS: Emergency and Transitional Housing**
  - An online list of emergency and transitional housing providers in Illinois
  - https://www.dhs.state.il.us/page.aspx?item=98150

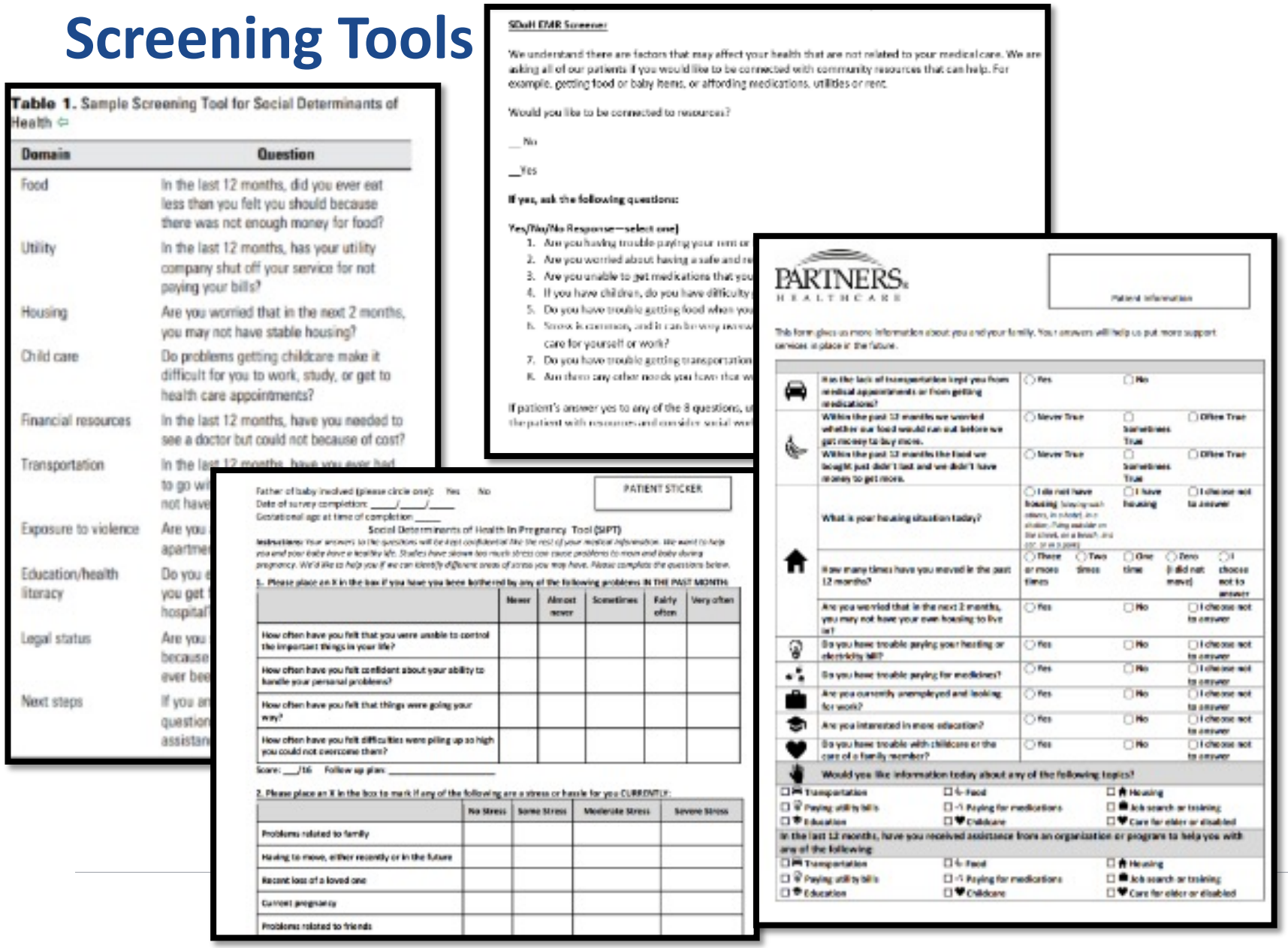
Tip Sheet- Food

State and Federal Programs

- **Supplemental Nutrition Assistance Program (SNAP):**
  - Helps low income people who qualify
  - Money is provided on an Electronic Benefit Transfer (EBT) card, which works like a debit card
  - Eligibility calculator: https://fscalc.dhs.illinois.gov/FSCalc/
  - Apply for assistance: https://www.dhs.state.il.us/page.aspx?item=33698
- **Women, Infants and Children (WIC):**
  - A food assistance program for Women, Infants, and Children
  - Helps low-income pregnant, post-partum, and breast-feeding women, infants, and children up to 5 years old who need food to help stay healthy
  - Provides money for healthy foods, vouchers for formula, and other great benefits
  - Can be used at grocery stores and pharmacies
  - IL WIC Services: (https://www.dhs.state.il.us/page.aspx?item=30513)

ILPQC Tip Sheets (for patients)

Social Determinants of Health Screening Tools



- SDoH EMR Screener (Developed by Erie Health Centers, Chicago)
- ACOG Committee Opinion #729: Sample Screening Tool for Social Determinants of Health
- Social Determinants of Health In Pregnancy Tool (SIPT) with 5Ps (Used by Chicago PCC Communities Wellness Centers) and Actionable Map and Scoring Sheet
- Partner Healthcare SDoH Screening Tool shared by Massachusetts General Hospital Obstetrics & Gynecology

SDOH EMR Screener (Erie Health Center)

We understand there are factors that may affect your health that are not related to your medical care. We are asking all of our patients if you would like to be connected with community resources that can help. For example, getting food or baby items, or affording medications, utilities or rent.

Would you like to be connected to resources?

__ No

__Yes

If yes, ask the following questions:

Yes/No/No Response—select one)

1. Are you having trouble paying your rent or bills right now?
2. Are you worried about having a safe and reliable place to sleep?
3. Are you unable to get medications that you need?
4. If you have children, do you have difficulty getting diapers, formula, or internet for school?
5. Do you have trouble getting food when you need?
6. Stress is common, and it can be very overwhelming. Do you experience stress that makes it hard to care for yourself or work?
7. Do you have trouble getting transportation to medical appointments?
8. Are there any other needs you have that we have not discussed?

If patient's answer yes to any of the 8 questions, utilizing NowPow and other internal resource lists to provide the patient with resources and consider social work consult.

SDOH Screening tool (ACOG CO 729)

Table 1. Sample Screening Tool for Social Determinants of Health ⇦

Domain	Question
Food	In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Utility	In the last 12 months, has your utility company shut off your service for not paying your bills?
Housing	Are you worried that in the next 2 months, you may not have stable housing?
Child care	Do problems getting childcare make it difficult for you to work, study, or get to health care appointments?
Financial resources	In the last 12 months, have you needed to see a doctor but could not because of cost?
Transportation	In the last 12 months, have you ever had to go without health care because you did not have a way to get there?
Exposure to violence	Are you afraid you might be hurt in your apartment building, home, or neighborhood?
Education/health literacy	Do you ever need help reading materials you get from your doctor, clinic, or the hospital?
Legal status	Are you scared of getting in trouble because of your legal status? Have you ever been arrested or incarcerated?
Next steps	If you answered yes to any of these questions, would you like to receive assistance with any of those needs?

Modified from Health Leads. Social needs screening toolkit. Boston (MA): Health Leads; 2016; *and* Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Acad Med 2017;92:299–307.

SDOH in Pregnancy Tool (SIPT) with 5Ps (Chicago PCC Communities Wellness Centers)

Father of baby involved (please circle one): Yes No

Date of survey completion: _____/_____/_____

Gestational age at time of completion _____

PATIENT STICKER

Social Determinants of Health **I**n **P**regnancy **T**ool **(SIPT)**

Instructions: *Your answers to the questions will be kept confidential like the rest of your medical information. We want to help you and your baby have a healthy life. Studies have shown too much stress can cause problems to mom and baby during pregnancy. We'd like to help you if we can identify different areas of stress you may have. Please complete the questions below.*

1. Please place an X in the box if you have you been bothered by any of the following problems IN THE PAST MONTH:

	Never	Almost never	Sometimes	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?					
How often have you felt confident about your ability to handle your personal problems?					
How often have you felt that things were going your way?					
How often have you felt difficulties were piling up so high you could not overcome them?					

Score: ___/16 Follow up plan: _____

SDOH in Pregnancy Tool (SIPT) with 5Ps (Chicago PCC Communities Wellness Centers)

2. Please place an X in the box to mark if any of the following are a stress or hassle for you CURRENTLY:

	No Stress	Some Stress	Moderate Stress	Severe Stress
Problems related to family				
Having to move, either recently or in the future				
Recent loss of a loved one				
Current pregnancy				
Problems related to friends				

Score: ___/15 Follow up plan: _____

SDOH in Pregnancy Tool (SIPT) with 5Ps (Chicago PCC Communities Wellness Centers)

3. Please place an X in the box to mark yes or no if the following have affected you EVER:

	No	Yes
Do you ever dread going home because there is someone living in the house who mistreats you or is unkind to you?		
Is there anyone who often says things that hurt you?		
Have you ever been hit, slapped, kicked, or hurt by someone?		
Since you have been pregnant, have you been hit, slapped, kicked, or hurt by someone?		
Have you ever been forced to have sex?		
Have you or your parents ever been involved in DCFS? If yes, please circle one: you your parents		
Did you ever experience any sexual, physical, verbal, or emotional abuse during your childhood?		

Score: POSITIVE/NEGATIVE Follow up plan: _____

SDOH in Pregnancy Tool (SIPT) with 5Ps (Chicago PCC Communities Wellness Centers)

4. Please place an X in the box to mark yes or no if the following have affected you EVER:

	No	Yes
Did any of your *Parents* have problems with alcohol or drug use?		
Do any of your *friends (Peers)* have problems with alcohol or drug use?		
Does your *Partner* have a problem with alcohol or drug use?		
Before you were pregnant did you have problems with alcohol or drug use? *(Past)*		
In the past month, did you drink beer, wine or liquor, or use other drugs? *(Pregnancy)*		

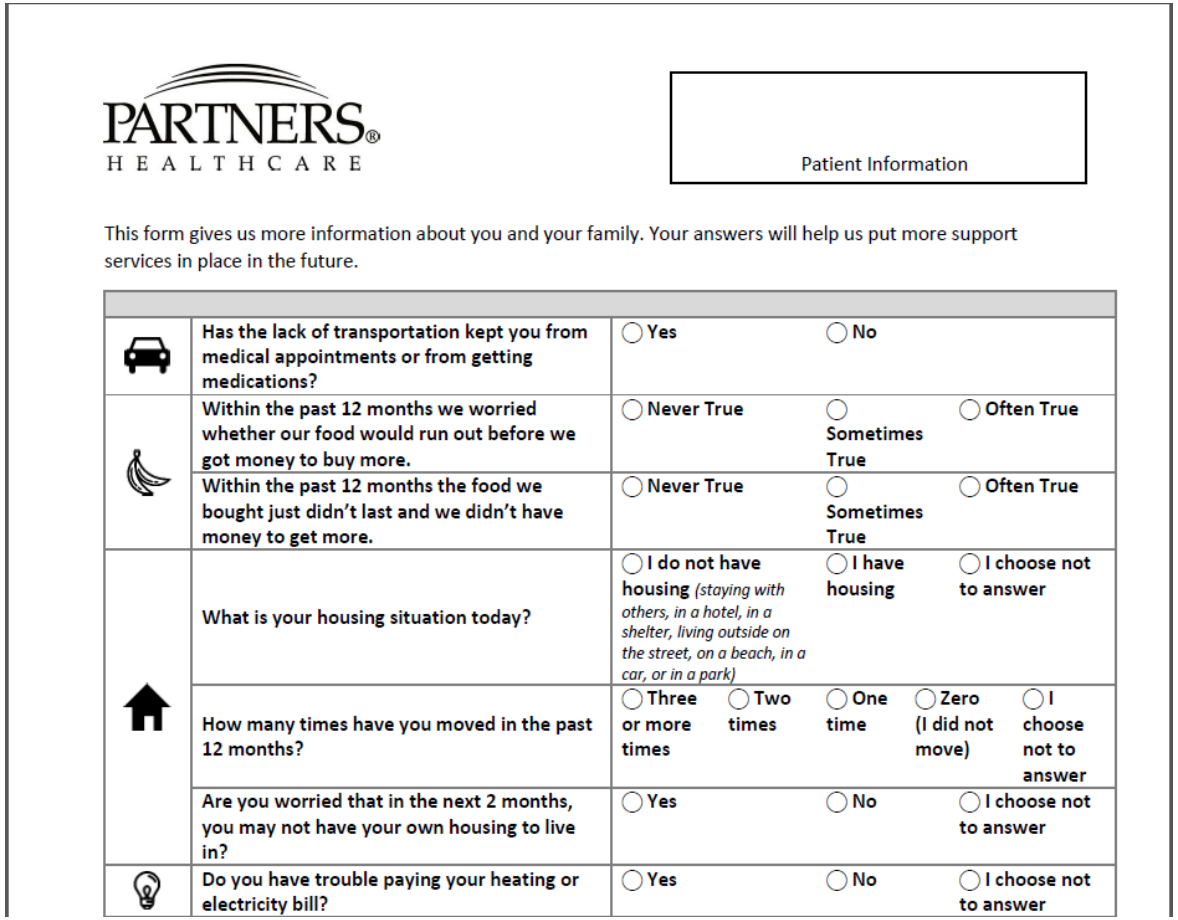
Score: POSITIVE/NEGATIVE Follow up plan: _____

5. Please place an X in the box to mark if you have worried about the following items IN THE PAST YEAR:

	Never true	Sometimes true	Often true
Worry food would run out before you had money to buy more			
Worry about not having a place to live			
Worry about transportation to appointments			
Worry about losing a job			
Other money worries like bills			

Score: ___/16 Follow up plan: _____

Partner Healthcare Screening Tool from Massachusetts General Hospital Obstetrics & Gynecology, and Mass General Brigham



PARTNERS HEALTHCARE

Patient Information

This form gives us more information about you and your family. Your answers will help us put more support services in place in the future.

	Has the lack of transportation kept you from medical appointments or from getting medications?	◯ Yes	◯ No		
	Within the past 12 months we worried whether our food would run out before we got money to buy more.	◯ Never True	◯ Sometimes True	◯ Often True	
	Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	◯ Never True	◯ Sometimes True	◯ Often True	
	What is your housing situation today?	◯ I do not have housing *(staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)*	◯ I have housing	◯ I choose not to answer	
	How many times have you moved in the past 12 months?	◯ Three or more times	◯ Two times	◯ One time	◯ Zero (I did not move)	◯ I choose not to answer
	Are you worried that in the next 2 months, you may not have your own housing to live in?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble paying your heating or electricity bill?	◯ Yes	◯ No	◯ I choose not to answer	

Partner Healthcare Screening Tool from Massachusetts General Hospital Obstetrics & Gynecology, and Mass General Brigham

	Do you have trouble paying for medicines?	◯ Yes	◯ No	◯ I choose not to answer
	Are you currently unemployed and looking for work?	◯ Yes	◯ No	◯ I choose not to answer
	Are you interested in more education?	◯ Yes	◯ No	◯ I choose not to answer
	Do you have trouble with childcare or the care of a family member?	◯ Yes	◯ No	◯ I choose not to answer
	Would you like information today about any of the following topics?			
☐ Transportation		☐ Food		☐ Housing
☐ Paying utility bills		☐ Paying for medications		☐ Job search or training
☐ Education		☐ Childcare		☐ Care for elder or disabled
In the last 12 months, have you received assistance from an organization or program to help you with any of the following:				
☐ Transportation		☐ Food		☐ Housing
☐ Paying utility bills		☐ Paying for medications		☐ Job search or training
☐ Education		☐ Childcare		☐ Care for elder or disabled

ILPQC Social Determinants Screening Tool Comparison

Screening Tool Name:	How many questions/categories?	Other information	Scoring instructions to assist staff?
SDoH EMR Screener (Developed by Erie Health Center)	8 item screening tool Additional categories: • Healthcare access • Household supplies • Stress • Additional needs	• Used by Erie Family Health Centers • SDOH team members are utilizing NowPow	
ACOG Committee Opinion #729: Sample Screening Tool for Social Determinants of Health	10 item screening tool Additional categories: • Exposure of violence • Child care • Legal Status • Financial • Education • Assistance/Next Steps (Would you like to receive assistance with any of the categories?)	• Patient self-report • Sample tool included in American College of Obstetricians and Gynecologists CO 729 • Modified from Health Leads Social Needs Screening Toolkit	
Social Determinants of Health In Pregnancy Tool (SIPT) with 5Ps (Used by Chicago PCC Communities Wellness Centers) and Actionable Map and Scoring Sheet	26 item screening tool Additional categories: • Relationship And Family Stress • Stress • Domestic Violence Screener • Substance Use • Financial Stress	• Used by West Suburban • Patient self-report • Mapping tool integrated within the screening tool • Ps included	✓
Partner Healthcare Screening Tool Used by Massachusetts General Hospital Obstetrics & Gynecology, and Mass General Brigham)	7 item screening tool Additional categories: • Employment • Childcare • Paying for medications	• Used by Massachusetts General Hospital Obstetrics & Gynecology	

Each tool below includes screening for the following common social determinants of health (food, housing, transportation, utilities**) in addition to other categories listed below

ILPQC Social Determinants of Health Screening Checklist

Use this worksheet (checklist) to help determine if your current Labor and Delivery admission process is meeting ACOG Guidelines for universal screening Social Determinants of Health for all patients.

1. Are you using a Social Determinants of Health Screening Tool on admission to Labor and Delivery?
   a. Example screening tools from the ILPQC BE Toolkit:
      i. Sample Screening Tool for Social Determinants of Health from ACOG committee opinion #729
      ii. Social Determinants of Health EMR Screener (Developed by Erie Health Center)
      iii. Social Determinants of Health in Pregnancy Tool (SIPT) with 5Ps (from Chicago PCC Communities Wellness Centers) and Actionable Map and Scoring Sheet
      iv. Partner Healthcare Screening Tool from Massachusetts General Hospital Obstetrics & Gynecology, and Mass General Brigham)

2. Does your current admission process or questionnaire ask about the following social determinants of health? (Items included in ACOG CO #729 recommendations)
   - ☐ Food
   - ☐ Utilities
   - ☐ Housing
   - ☐ Childcare
   - ☐ Financial Resources
   - ☐ Transportation
   - ☐ Exposure to Violence
   - ☐ Education/health literacy

3. If a patient screens positive for any social determinant of health concern, do you have process flow to document that patient is appropriately linked to needed resources and services? Are the following steps included in your process flow?
   - Documentation of positive screen and clinical team informed
   - Patient is provided SDoH Folder (link), Tip Sheets, or appropriate resources
   - Documentation that patient is referred and linked to appropriate resources
   - Social work consult is made as appropriate
   - Plan for follow-up is documented

4. Write out a process flow on what currently occurs during your admission process regarding Social Determinants of Health Screening, linkage to needed resources and services, plans for follow-up, and documentation. Compare to the sample one below.

Example process flow:

1. Patient arrives for the New OB appointment or LD admission
2. Patient is provided the SDoH screening tool (front desk, nurse)
3. Completed screening tool reviewed by nurse and documented
4. If positive, clinical team member provided SDoH folder/Tip Sheets and/or ~~NowPow~~ resources and documents
5. Social work consult made as appropriate
6. Plan for follow-up is documented
7. Follow-up with patient occurs

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ILPQC Social Determinants of Health Screening Checklist

SDOH QI Strategies

PDSA cycle to test SDOH screening tools implementation on L&D

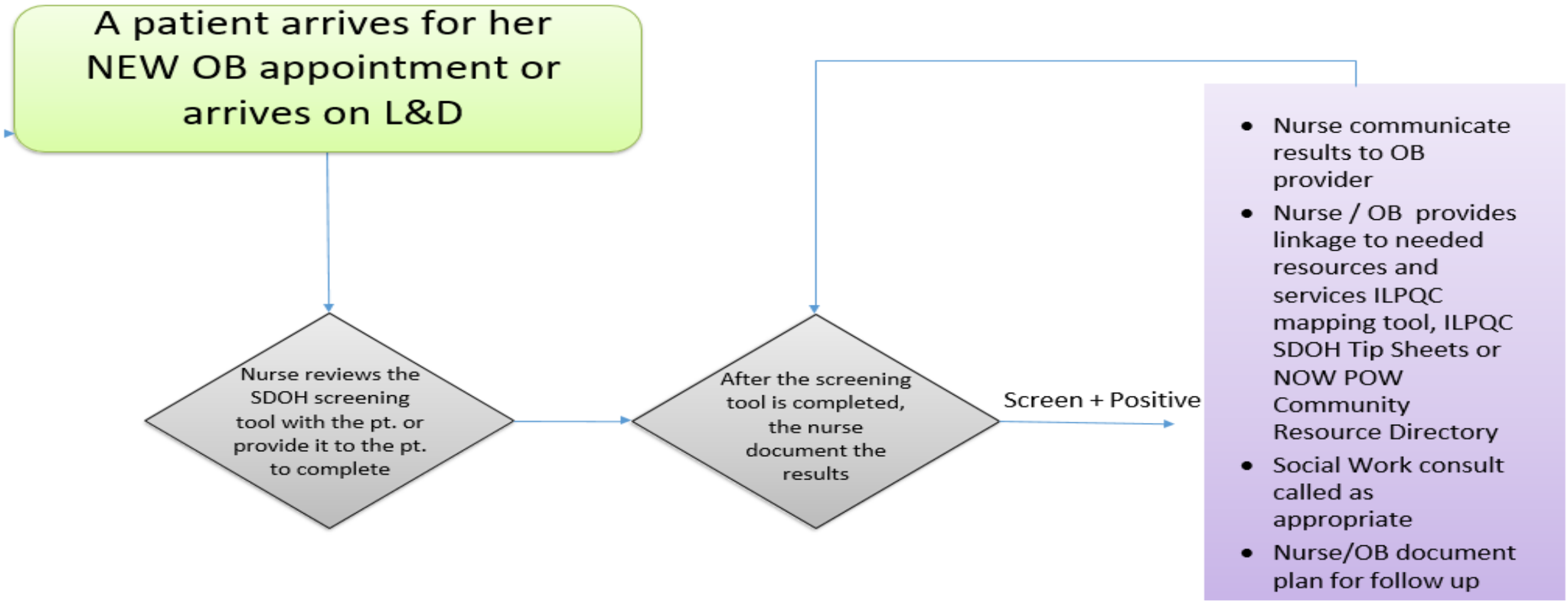
- Start with one nurse, one patient or one day on L&D to trial a screen
- Get feedback on process and determine best tool and screening process
- Share information with outpatient sites

Develop a Process Flow Diagram

- Assist implementation of screening all patients on arrival L&D, with paper screening tool or in EMR
- Who screens? How do you document? How is clinical team informed of + results? Who connects patient to resources and services?
- Who identifies community resources available?

Consider steps needed in 30/60/90 day planning process

Process Flow to Link Patients Who Screen Positive on SDoH Screening Tool



Engaging Patients and Communities

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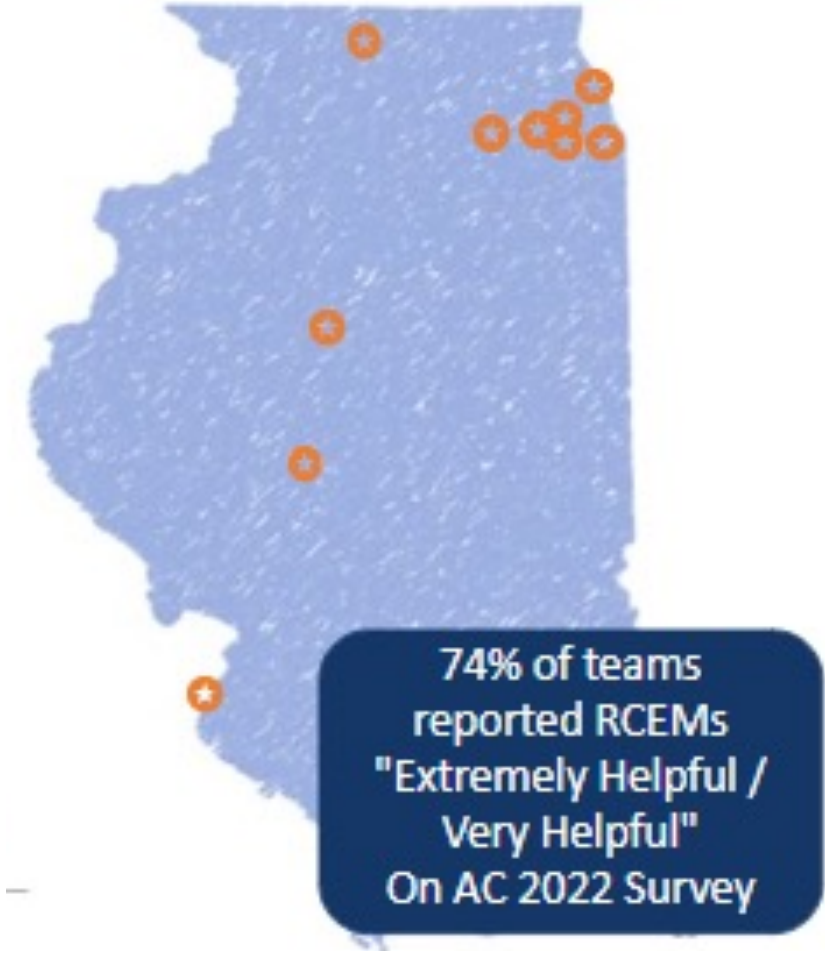
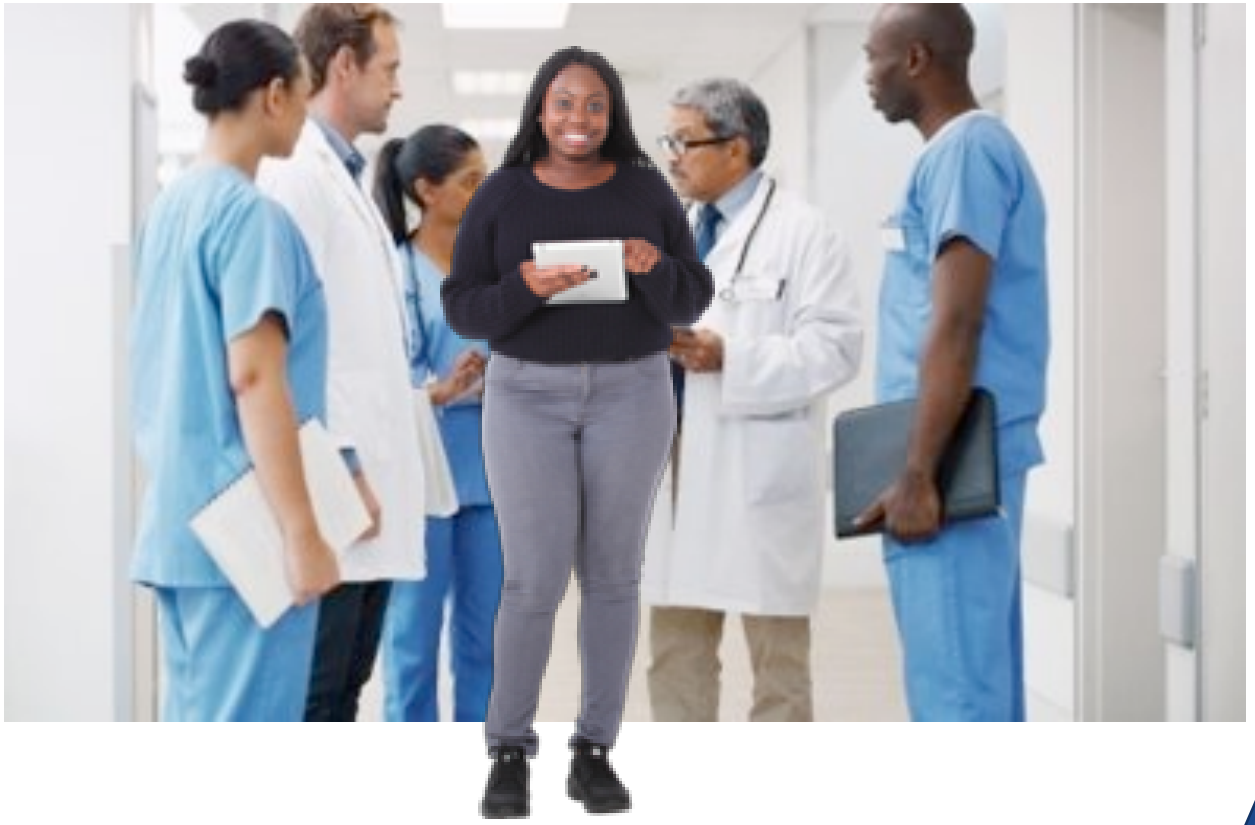
Quality Collaborative

Regional Community Engagement Meetings (RCEMs) across Illinois

- 10 RCEMs February – July 2022
- 37 community member/patient panelists
- 66 (77%) of BE teams participated
- Contributed to the development of relationships between hospitals and local community stakeholders
- Nearly 250% increase in teams working on patient/community engagement from start



Strategies to continue engaging patient advisors and community members for input in QI work



- Invite patents / community members to share at hospital grand rounds
- Host a community meeting (Respectful Care Breakfast)
- Engage as members of your BE QI team
- Develop a patient community advisory board

BE Progress

Monthly Hospital Team Data:

progress on structure measures and random sample of delivered pts

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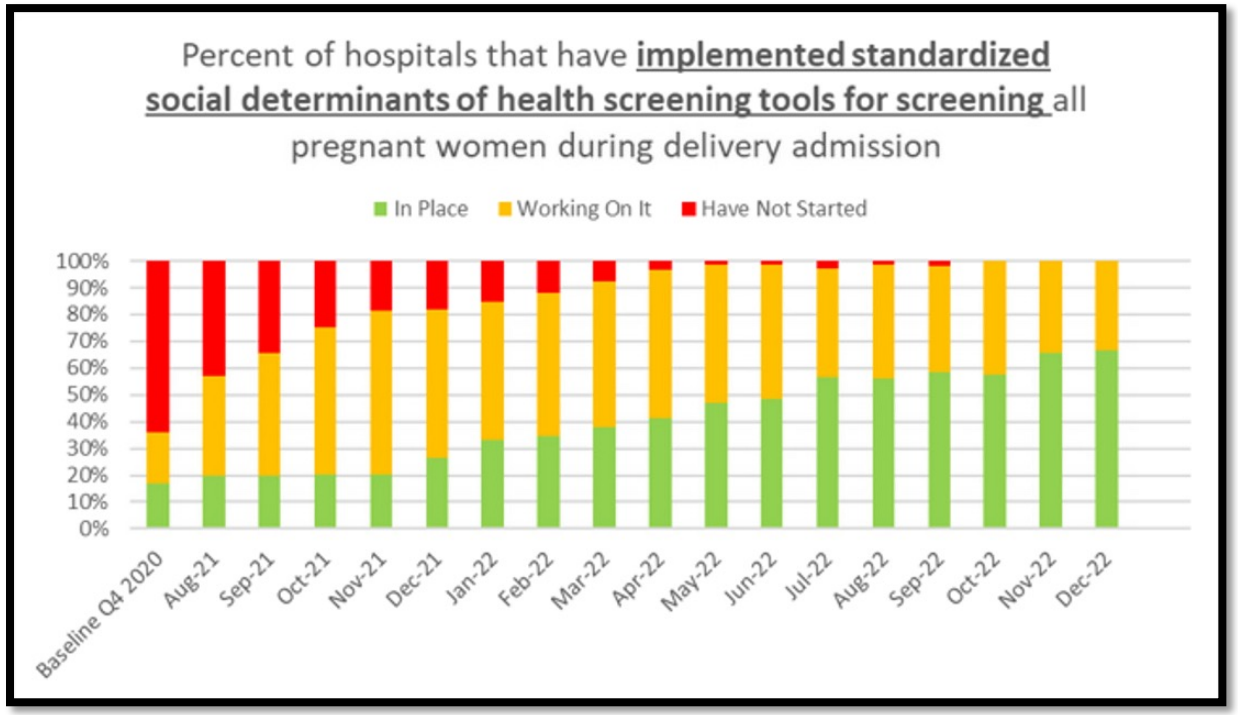
Making Change Happen: Hospital Progress with BE Systems Changes

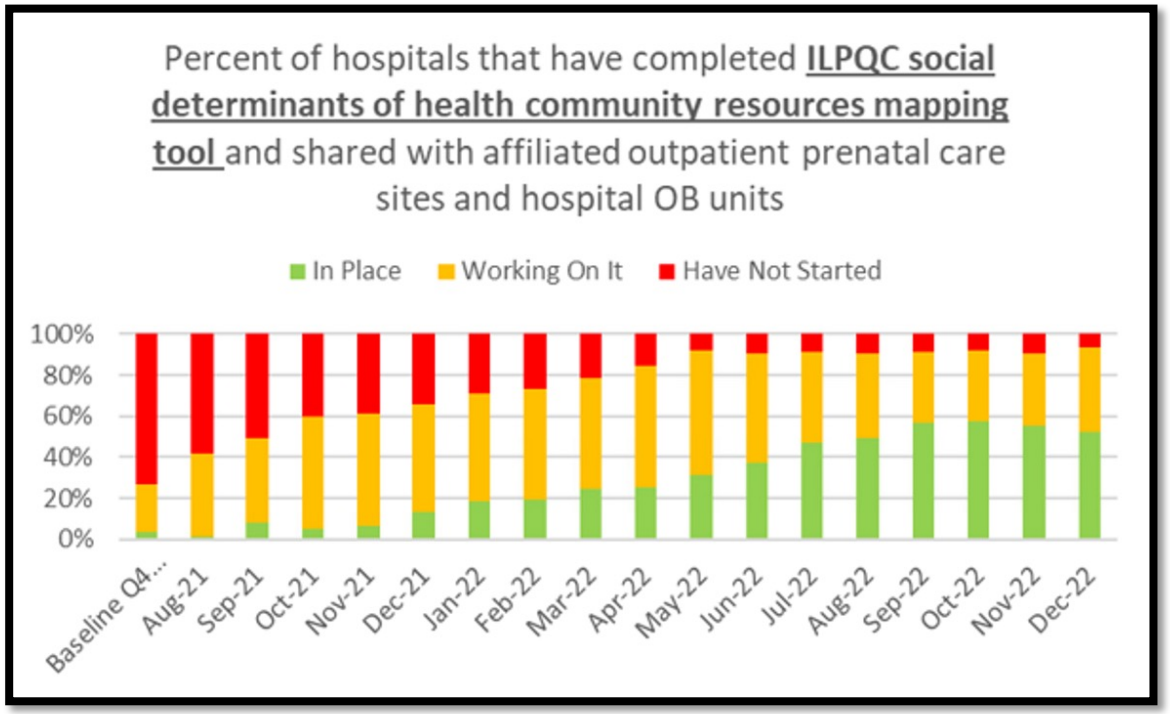
Structure Measures	Baseline (% In Place)	December 2022 (In Place)
SDOH Screening (L&D)	16%	67%
Identifying local SDOH Resources	3%	57%
Optimize Self-Reported Race and Ethnicity Collection	6%	75%
Engage Patients and Community in QI Work	3%	29%
Sharing Respectful Care Strategies with Healthcare Team and Patients	10%	65%
PREM Implementation	8%	55%
Postpartum Safety Patient Education	54%	92%

Structure Measures: Implementing Systems Changes

SDOH Screening



Linkage to Community Resources

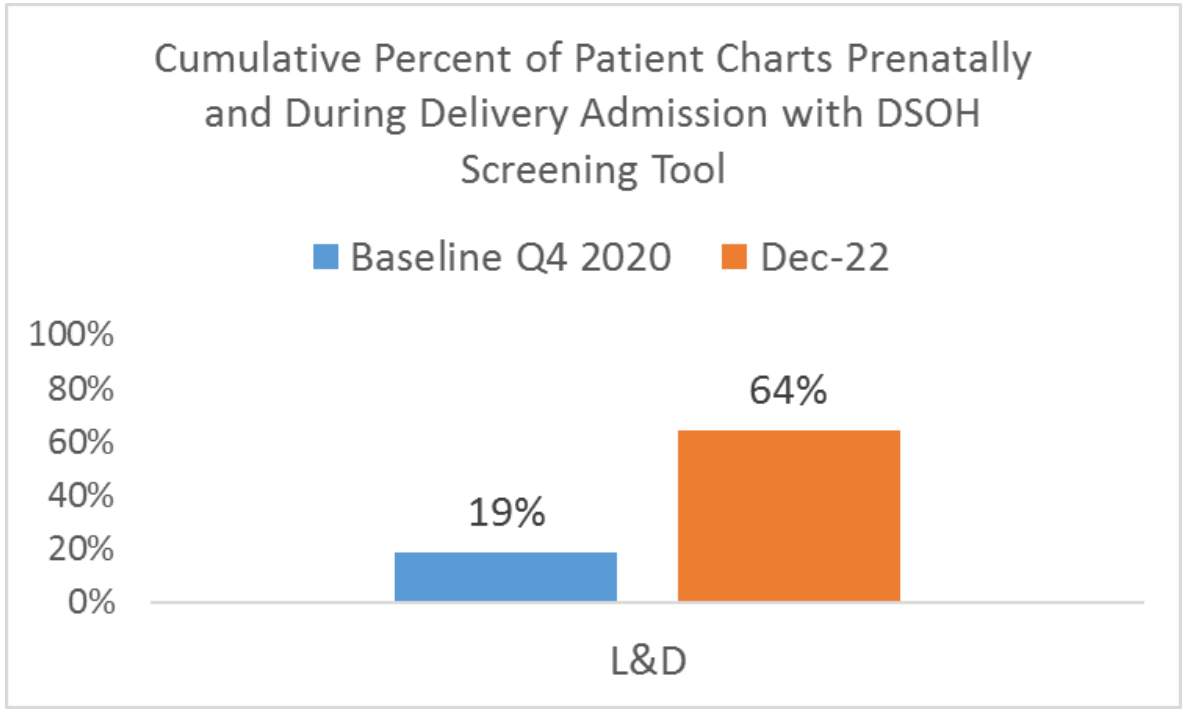


Social Determinants of Health (SDoH): Screening and Linking Patients to Resources

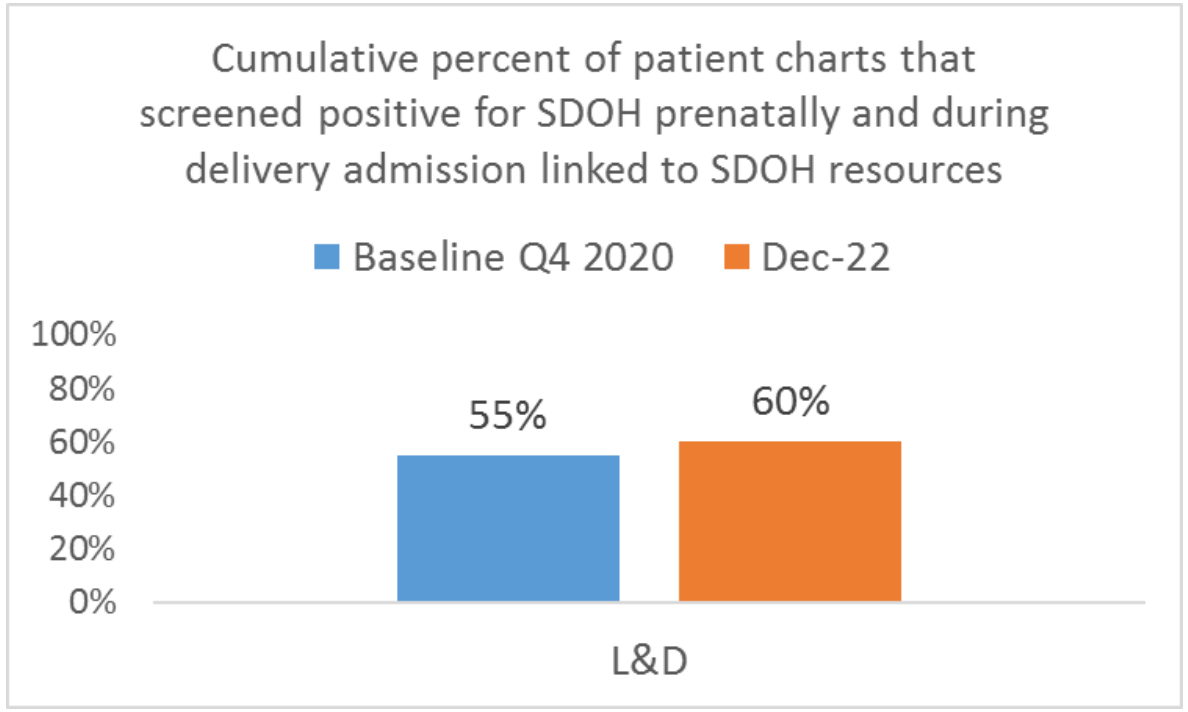
- Since Birth Equity start summer 2021:
- 3,231 patients with documentation of SDoH screening on L&D
- 1,077 (33%) of patients with a positive SDoH screen
- 667 (62%) of patients with a positive screen for SDoH had documentation of connection to resources and services

SDOH Screening / Linkage to resources

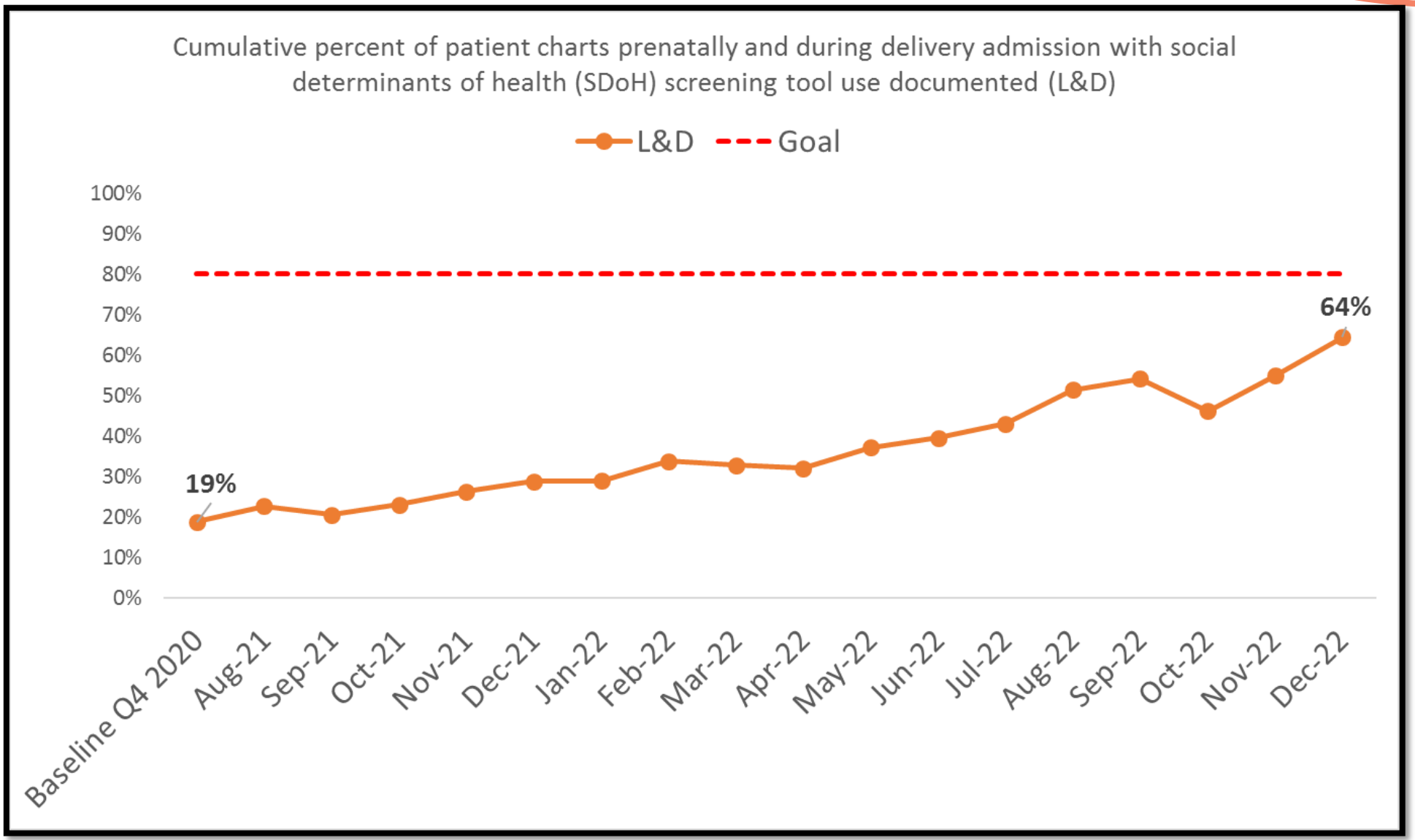
SDOH Screening



Linkage to Community Resources



SDOH Screening from monthly sample all hospitals



Summary

- Disparities in maternal health need urgent action.
- Figure out how to get started, find a way to engage patients and community and get their input
- At your institution how can you move forward?
  - Stratify your maternal quality data by race/ethnicity/insurance status to inform QI
  - Screen for SDOH and intentionally link to resources
  - Engage patients / community stakeholders in QI work
  - Promote Respectful Care Practices and ask patients for feedback
  - Tiered approach to Implicit Bias / Respectful Care training for staff
- We can each work to address these challenges and improve care

Questions?

Website: www.ilpqc.org

Email: info@ilpqc.org

IL PQC
Illinois Perinatal Quality Collaborative

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Thanks to our Funders

IDHS Illinois Department of Human Services

IDPH Illinois Department of Public Health

AIM Alliance for Innovation on Maternal Health

I PROMOTE-IL

CDC Centers for Disease Control and Prevention

In kind support:

NorthShore University HealthSystem

Northwestern Medicine Northwestern University Feinberg School of Medicine

Ann & Robert H. Lurie Children's Hospital of Chicago

Saint Louis University

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Hospital Level Implementation: Integrating SDoH into Quality Improvement

St Mary's Hospital – St Louis

SSMHealth

St Mary's Hospital

2600 Deliveries/year

Labor and Delivery Unit
13 LDR rooms, 6 Triage rooms, 2 ORs

Antepartum Unit
28 Antepartum rooms,10 Perinatal Special Care Unit rooms

Mother/Baby Unit
30 Postpartum rooms

Level III NICU
42 beds

SDoH – Where to Start?

Providing Resources

SSM Health is here for you and your growing family. We are also grateful for the partnerships we have with numerous organizations that provide services in many other areas.

Our Family Resource Guide includes information and links to agencies providing parenting support, transportation, utility and food assistance, education, home health services, and much more.

Scan the QR code to view the guide on our SSM Health website:

NOTE: To ensure you are viewing the resources in your area, please add your zip code to the "My location is" field at the top of the page.

ssmhealth.com/familyresources

SSMHealth.
Women's Health

SSMHealth.

Integration of SDoH into EHR

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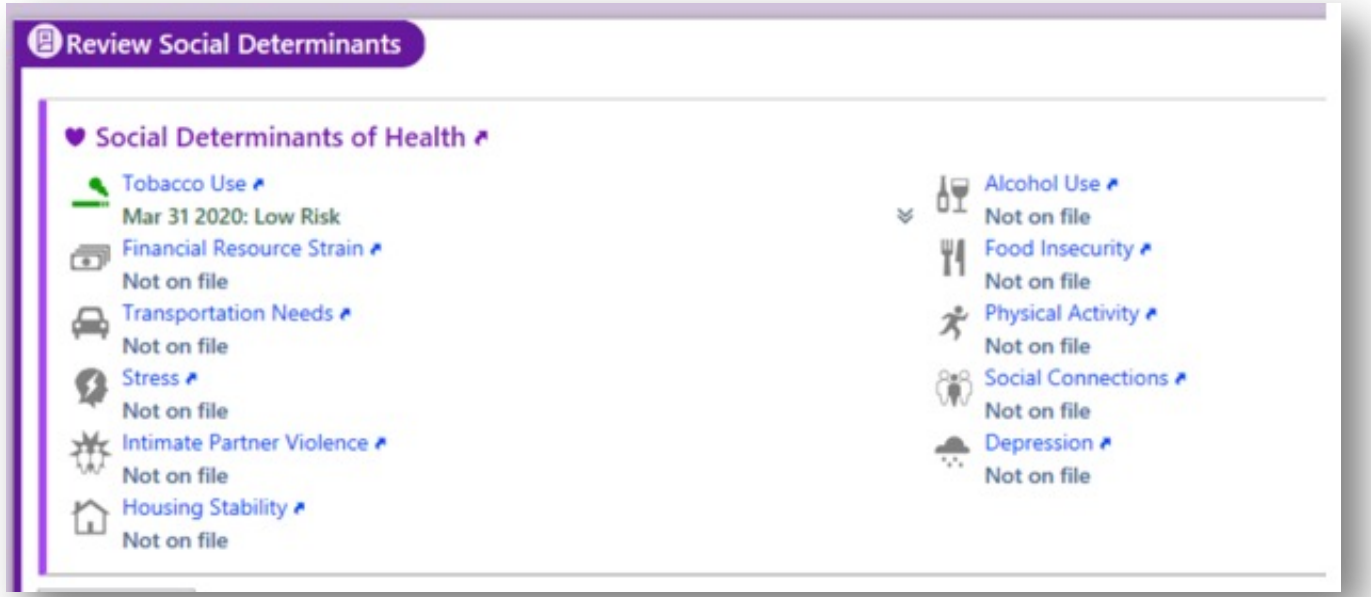
Initiating a Screening Process



SOCIAL DETERMINANTS

Concern present

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What to do with a positive screen?

Clinics

- Provide resource flyers
- Connect with SW (when available)

Inpatient

- Inpatient SW visit
- Resources flyer if needed

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Challenges:

Clinics:

- **No SW consistently present for more urgent needs**
- **Increasing needs identified**

Solution:

- **In process - grant for CHW positions in clinics to act as navigators, creating warm handoffs for community resources**

Inpatient:

- **1 SW for all of Women's services**
- **Inconsistent referrals to SW**
- **Lack of documentation of referrals**

Solution:

- **Increased caseload justified need for increased hiring**

CMS & TJC Framework for Social Equity and Requirements to Reduce Health Care Disparities

CMS Framework for Health Equity

CMS Final IPPS Rule

CMS Definitions of Social Needs Domains

Accreditation Standards & Resource Center | Make Health Equity a Leader Driven Priority

- Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to organizations *in the Joint Commission's* hospital accreditation programs
- For FY2023 IPPS/LTCH PPS final rule, *CMS* finalized several changes to the Hospital IQR Program and adopted 10 new measures
- Several measures support the CMS framework for Health Equity and are complimentary to the Joint Commission standard (LD.04.03.08)

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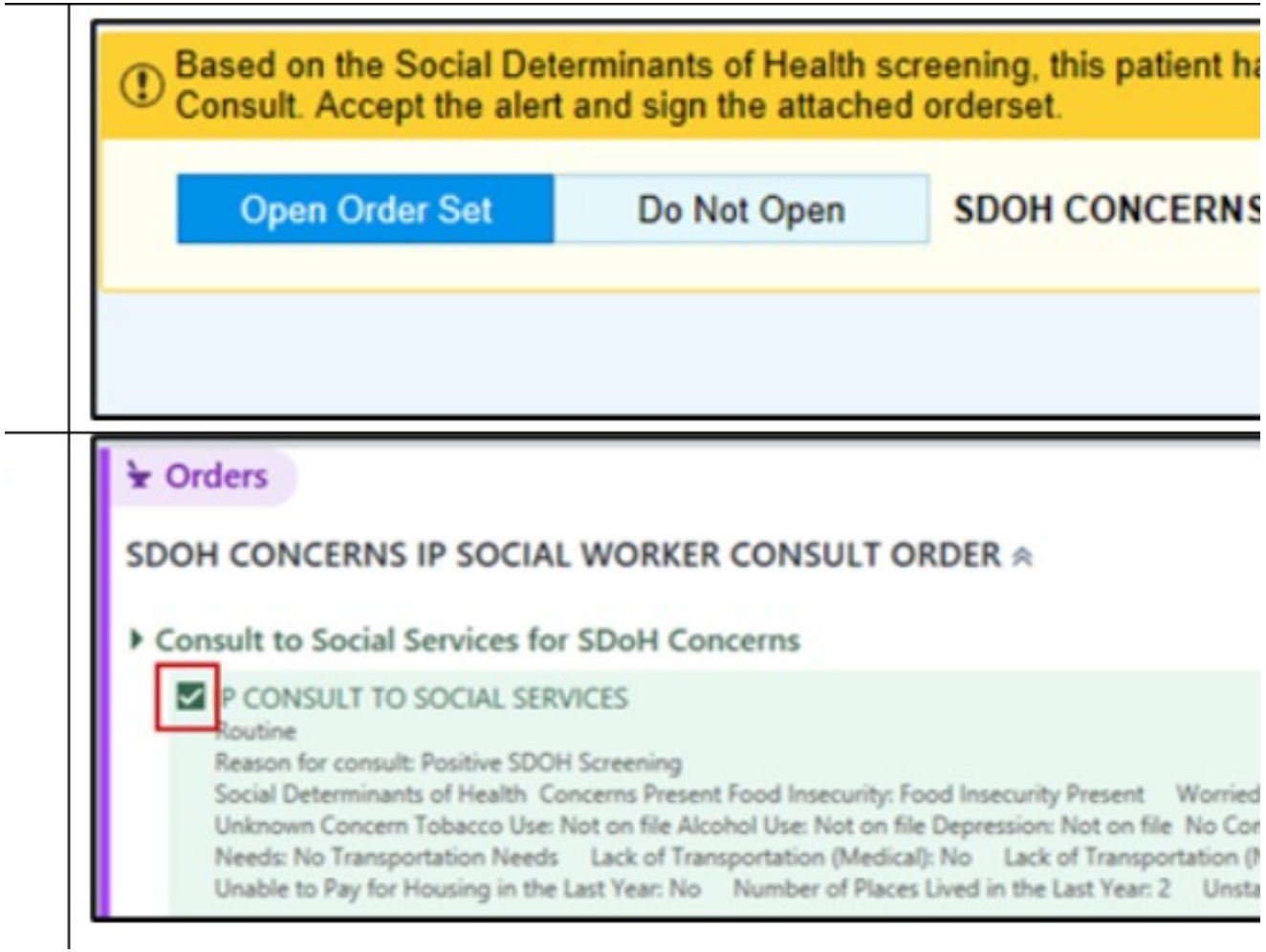
SDoH Integration

Increased Resources:

- Banner notification
- Automatic SW Consult Referral
- New vendor:
  - Increased community connections providing resources
  - Close loop of referrals



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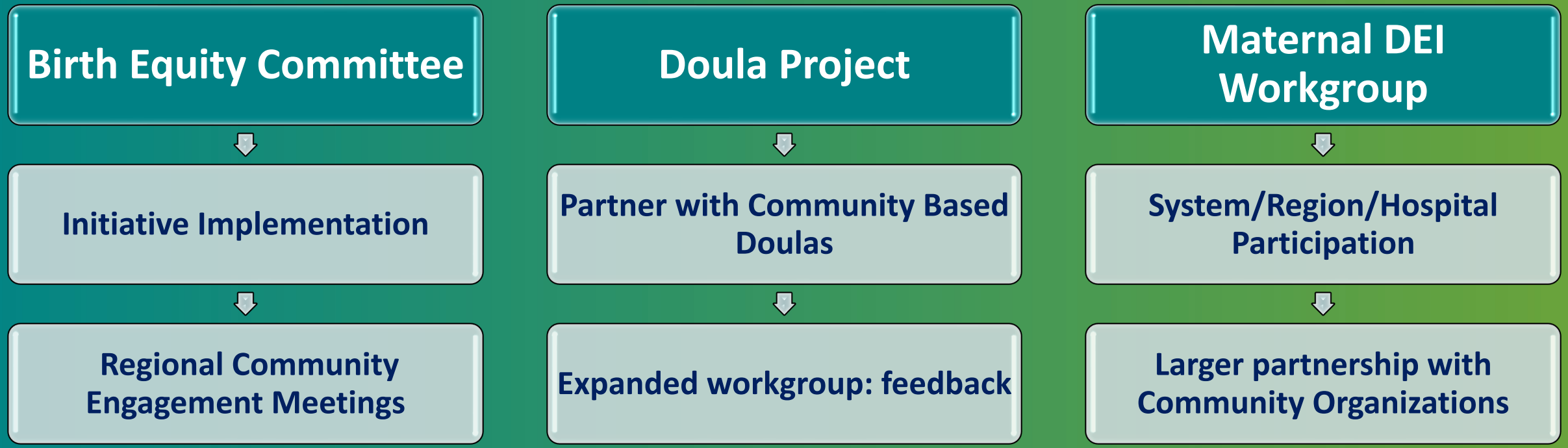
Increasing Support – Expanding the Birth Equity Framework



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Adding the patient perspective

QI Processes

QUALITY IMPROVEMENT 5TH FLOOR OPERATIONS
Saint Louis University/SSM Health Systems

Date: Click here to enter text. **Name:** Click here to enter text. **Record #:** Click here to enter text.
Reviewed By: Click here to enter text.

TRIGGERS FOR REVIEW:
Check all appropriate choices

Maternal
- ☐Maternal Death
- ☐Maternal Cardiopulmonary Arrest
- ☐Excessive Blood Loss (Roughly >2000cc)
- ☐Maternal ICU Admit – Unexpected
- ☐Seizures
- ☐Unplanned Postpartum Return OR
- ☐Unplanned Maternal Readmit Within 14 Days
- ☐Maternal Fall
- ☐Retained Foreign Object
- ☐Anesthesia Related
- ☐Home Birth Admits
- ☐≥4 Units Product Replacement
- ☐Uterine Rupture
- ☐ Transfer Out
- ☐ Code Sepsis
- ☐ Other: Click here to enter text.

Neonatal
- ☐Thromboembolism In House
- ☐Stillbirth of a Baby Admitted Alive (Excluding Extreme Prematurity/Lethal Anomalies)
- ☐Cord pH <7.00
- ☐Evidence of Neonatal Depression/ Unexpected ICU Admission
- ☐Evidence of Neonatal Trauma
- ☐Base Excess <-12.0
- ☐5 Minute APGAR <3
- ☐Shoulder Dystocia
- ☐Medication Errors/Adverse Reactions
- ☐Equipment/Supply Malfunction
- ☐Cord Gas Issues
- ☐Cord Prolapse
- ☐Communication Deficit
- ☐Other: Click here to enter text.

☐No deficiencies found – Care appropriate. Morbidity occurred despite appropriate and timely therapy.
☐Opportunity for Improvement Identified as:

- ☐Insufficient Documentation of Care
- ☐Incomplete Preoperative Evaluation or Prenatal Care
- ☐Inappropriate Care Attributed To:
  - ☐Attending Physician
  - ☐House Staff
  - ☐Nursing
- ☐Communication Deficiencies
- ☐System Deficiencies In:
  - ☐Nursing
  - ☐Ancillary Services
  - ☐Other Departments (ie. pathology, anesthesiology, etc.)
  - ☐Administration
  - ☐Other

Disclosure: Completed ☐ N/A ☐ Preventable: Yes ☐ No☐ Uncertain☐

Action Items	Responsible Party	Target Date	Results	
				☐Issue Resolved ☐Item Corrected ☐Other

Bimonthly review of trigger cases

- Multidisciplinary team
  - OB & Neonatal Physicians, Nursing Leadership, Anesthesia, Perinatal Outreach, Quality Improvement
  - Previously discussed SDOH challenges as they were identified
  - Initiating formal process for integrating SDoH factors

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Thank You

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