PSH SDoH Experiences

Tracy Villarreal, LCSW, CPHQ

Care Management Leader at Providence Seaside Hospital

Workstream #1: Social Drivers of Health Screening & Follow Ups

Quarters	OQR: HOPDs (Screening)+	IQR: Inpatient (Screening & Follow Up)

Q1 2025	• **Caregiver Education (EHOP/OBS):** Provide Nursing and other applicable roles with the education, training and requirements to screen, follow up and document follow up on positive screens
	• **Reporting:** System HE team to produce monthly report as data becomes available in Epic/CPH and share via email
		• **Screening:**
		  • Threshold (Sustainment): 85%
		  • Outstanding: 90%
		  • Local action plan required if screening falls before 85% for more than 2 consecutive months
		• **Follow Up:** *Target to be set on/after Q1*
		• **Reporting:** System HE team to produce quarterly report and share via email

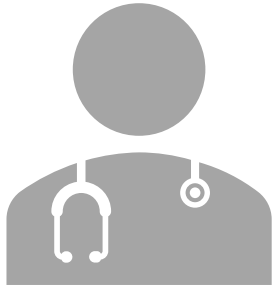
Q2 2025	• **Caregiver Education (Procedural Areas):** Provide Nursing and other applicable roles with the education, training and requirements to screen, follow up and document follow up on positive screens
	• **Screening:**
	  • EHOP/OBS: 70%**
	  • Procedural Areas: 20%
	• **Reporting:** System HE team to produce monthly report as data becomes available in Epic/CPH and share via email
		• **Screening:**
		  • Threshold (Sustainment): 85%
		  • Outstanding: 90%
		  • Local action plan required if screening falls before 85% for more than 2 consecutive months
		• **Follow Up:** *Target to be set on/after Q1*
		• **Reporting:** System HE team to produce quarterly report and share via email

Q3 2025	• **Caregiver Education (ED):** Provide Nursing and other applicable roles with the education, training and requirements to screen, follow up and document follow up on positive screens
	• **Screening:**
	  • EHOP/OBS: 75%
	  • Procedural Areas: 40%
	• **Reporting:** System HE team to produce monthly report as data becomes available in Epic/CPH and share via email
		• **Screening:**
		  • Threshold (Sustainment): 85%
		  • Outstanding: 90%
		  • Local action plan required if screening falls before 85% for more than 2 consecutive months
		• **Follow Up:** *Target to be set on/after Q1*
		• **Reporting:** System HE team to produce quarterly report and share via email

Q4 2025	• **Screening:**
	  • EHOP/OBS: 80%
	  • Procedural Areas: 60%
	  • ED: 25%*
	• **Reporting:** System HE team to produce monthly report as data becomes available in Epic/CPH and share via email
		• **Screening:**
		  • Threshold (Sustainment): 85%
		  • Outstanding: 90%
		  • Local action plan required if screening falls before 85% for more than 2 consecutive months
		• **Follow Up:** *Target to be set on/after Q1*
		• **Reporting:** System HE team to produce quarterly report and share via email

Workstream #1: Seaside Hospital has achieved a 93% screening rate for all Social Determinants of Health (SDoH) and is currently monitoring progress and impact.

Approximately 11-18% of our patients screened had at least one positive SDoH area upon screening.



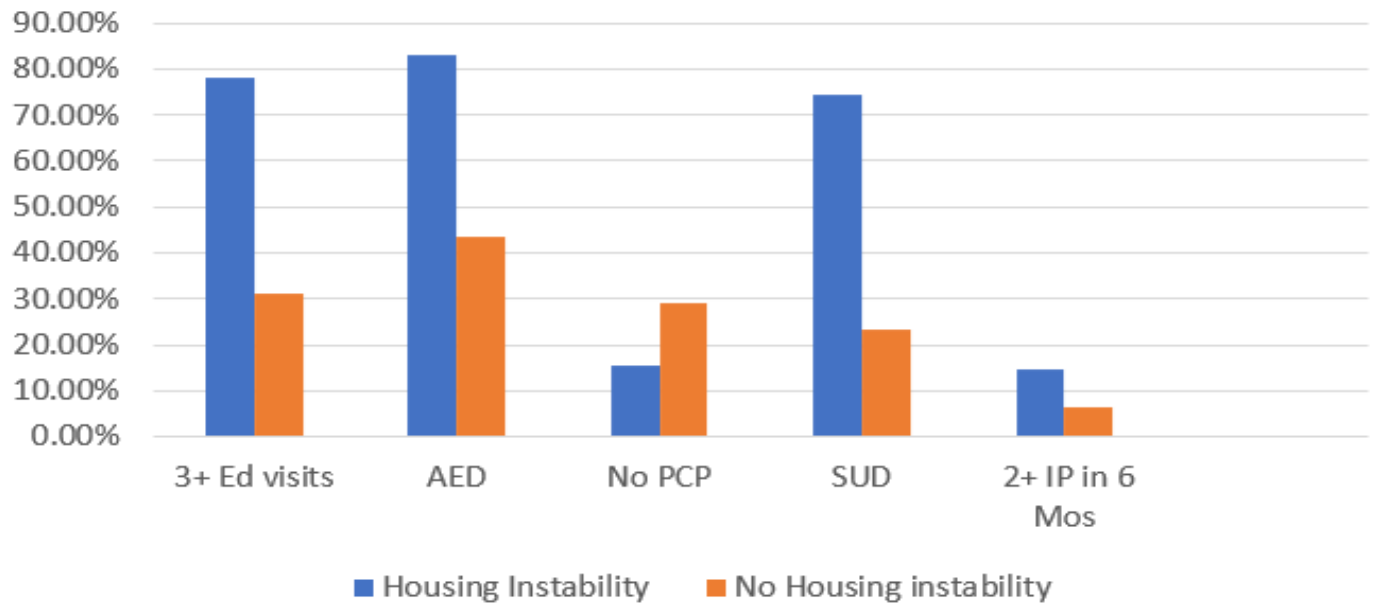
Workstream #2: Providence Seaside Hospital aims to address the disparities in access to healthcare providers for houseless patients, particularly those suffering from Substance Use Disorder (SUD). The objective is to improve access to medical care for this population.

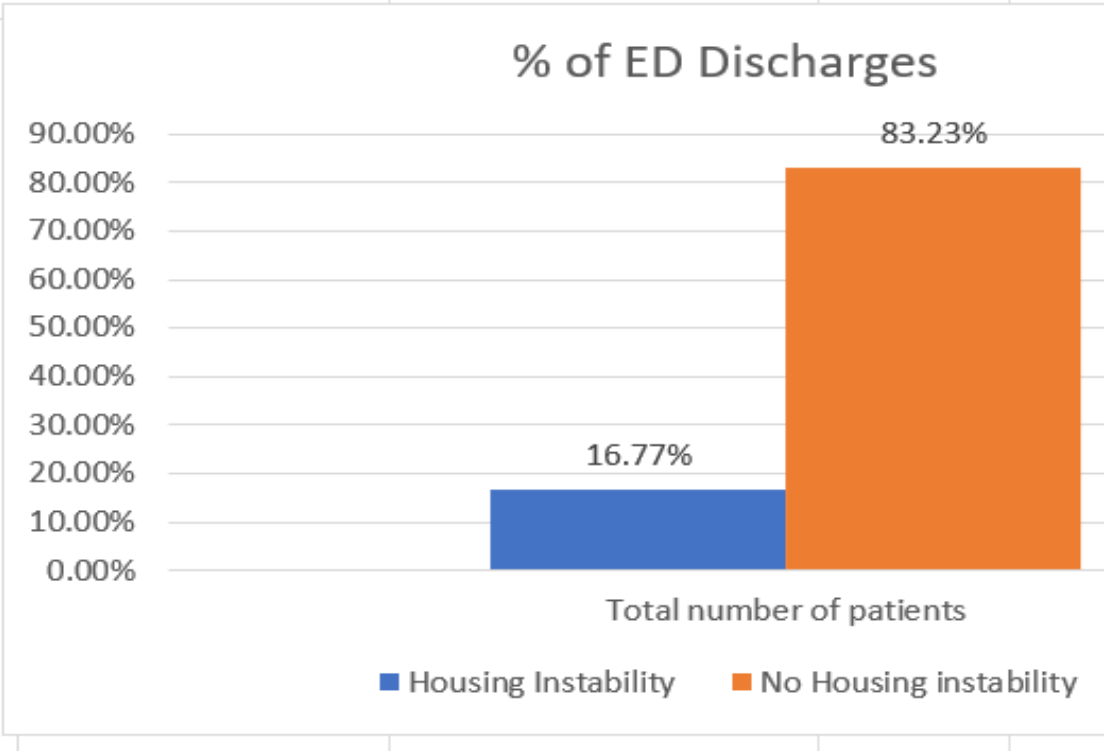
Division	Service Area	Ministry	Year to date	January	February	March	Quarter 1
Central	INWA	Providence Holy Family Hospital (Spokane)	93%	94%	91%	93%	93%
Central	INWA	Providence Mount Carmel Hospital (Colville)	99%	95%	100%	99%	99%
Central	INWA	Providence Sacred Heart Medical Center (Spokane)	87%	88%	89%	85%	87%
Central	INWA	Providence St. Joseph Hospital (Chewelah)	100%	100%	100%	100%	100%
Central	INWA	St. Luke's (Spokane)	100%	100%	100%	99%	100%
Central	MT	Saint Joseph Medical Center (Polson)	96%	96%	95%	100%	96%
Central	MT	St. Patrick Hospital & Health Science Center (Missoula)	89%	89%	89%	88%	89%
Central	OR - EAST	Providence Hood River Memorial Hospital (PHRMH)	89%	93%	96%	84%	89%
Central	OR - EAST	Providence Milwaukie Hospital (PMH)	83%	82%	82%	85%	83%
Central	OR - WEST	Providence Newberg Medical Center (PNMC)	89%	88%	86%	92%	89%
Central	OR - EAST	Providence Portland Medical Center (PPMC)	86%	85%	88%	86%	86%
Central	OR - WEST	Providence Seaside Hospital (PSH)	93%	92%	94%	94%	93%
Central	OR - WEST	Providence St Vincent Medical Center (PSVMC)	88%	88%	91%	86%	88%
Central	OR - EAST	Providence Willamette Falls Medical Center	87%	85%	87%	88%	87%
Central	OR - SOUTH	Providence Medford Medical Center (PMMC)	86%	86%	87%	85%	86%
Central	SEWA	Kadlec Medical Center	95%	95%	95%	95%	95%
Central	SEWA	Providence St. Mary Medical Center (Walla Walla)	97%	97%	100%	97%	97%
Central	TX/NM - Lubbock	Covenant Children's Hospital	96%	97%	96%	96%	96%
Central	TX/NM - Rural	Covenant Health Hobbs	92%	88%	94%	94%	92%
Central	TX/NM - Rural	Covenant Levelland	100%	100%	100%	100%	100%
Central	TX/NM - Lubbock	Covenant Medical Center	99%	99%	99%	98%	99%
Central	TX/NM - Rural	Covenant Plainview Hospital	100%	99%	100%	100%	100%
Central	TX/NM - Lubbock	Grace Surgical Hospital	100%	100%	100%	100%	100%

Data Challenges

- Data Analyst Departure: Analyst left after Q2 of 2024
- Work Stream 2: Good data available up to Q2 2024
- New Analyst: Uncertainty on previous data pulling methods, just starting to resolve in 1st qtr. of 2025
- Analyst working on new way to pull data should be completed by 2nd qtr. of 2025
- Inability to pull accurate data has impeded interventions/modifications in PDCA workstream—can't act on what can't be checked.
- Currently Social Work Team:
  - Identifying houseless patients in ER with no PCP
  - Connecting them with PCP
- Currently Peer Support Team:
  - Helping houseless patients needing/wanting SUD support
  - Facilitating access to necessary resources
- 2nd Qtr. 2025 accurate data will allow for more interventions to be modified, implemented, and checked

Total ED discharges	2552			
	Housing Instability		No Housing instability	
	Number of Patients	Percent of population	Number of Patients	Percent of population
Total number of patients	428	16.77%	2124	83.23%
3+ Ed visits	335	78.27%	660	31.07%
AED	356	83.18%	925	43.55%
No PCP	66	15.42%	614	28.91%
SUD	319	74.53%	494	23.26%
2+ IP in 6 Mos	62	14.49%	138	6.50%
No insurance	0	0.00%	1	0.05%





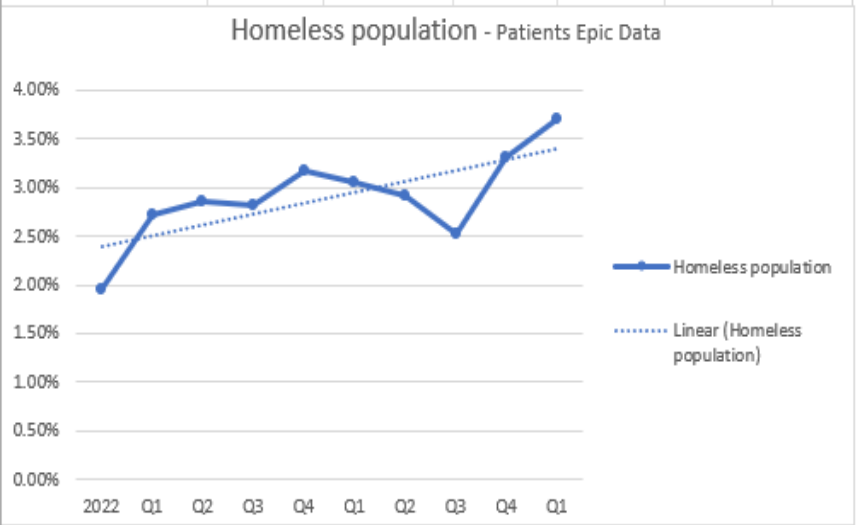
Providence

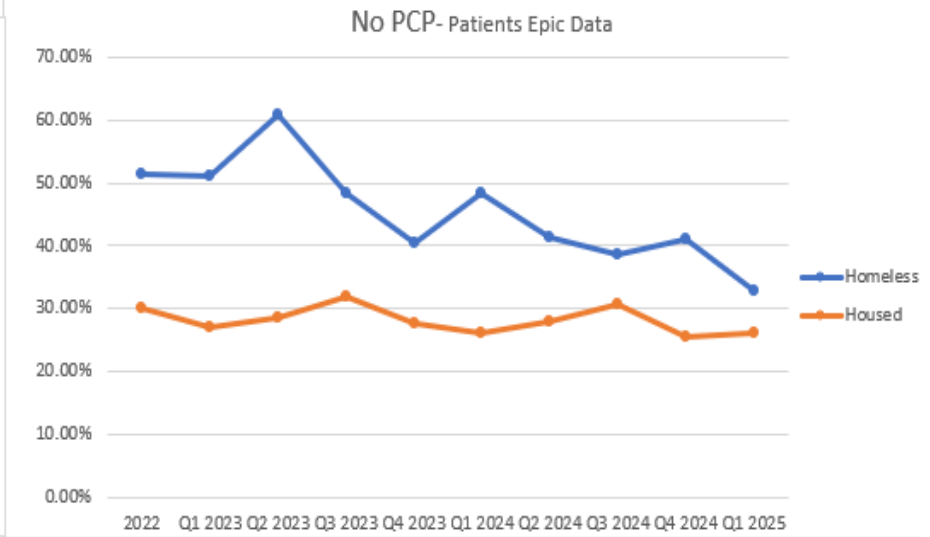
Early Data pre-2024

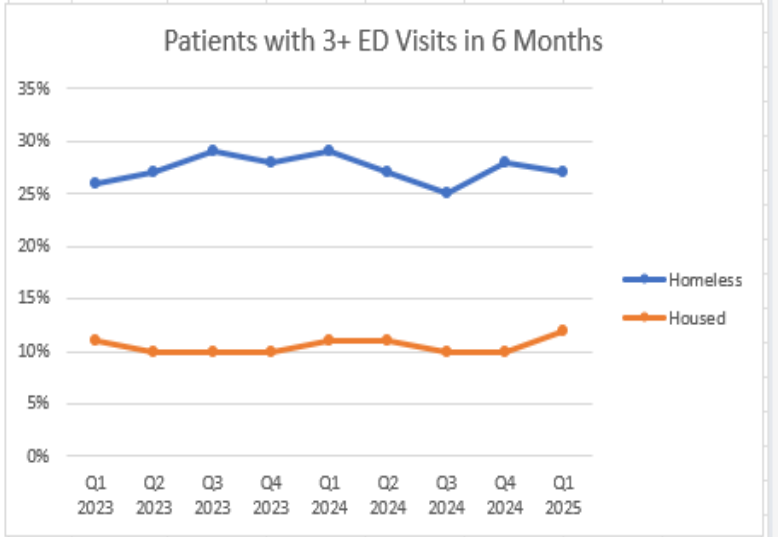
Inequity of Focus: Access to Care			
Workgroup Participation: Social Work, BOB Program, and Community partners (CBH, CODA, and CCO)			
Data Source(s): *EPIC*			
	2025 -YTD	**Target**	**Month: +/- in Performance**
Patient Population of **Focus:** Homeless no PCP and Homeless with SUD	No PCP 41.00% Avoidable ED 3+ ED SUD 19.67%	No PCP decreases to percentage point difference between housed (with limited PCP may not be better than housed) Decrease AED, 3+ ED, and SUD metrics by 3%	**Q1*** No PCP = 33.00% **AED** = 41% **3+ ED** = 27% **SUD** = 20.29%
Comparison/Highest Performing Patient Population: Housed	No PCP 25.50% Avoidable ED 3+ ED SUD 6.33%		**No PCP** = 26.00% **AED** = 24.90% **3+ ED** = 12% **SUD** = 5.13%

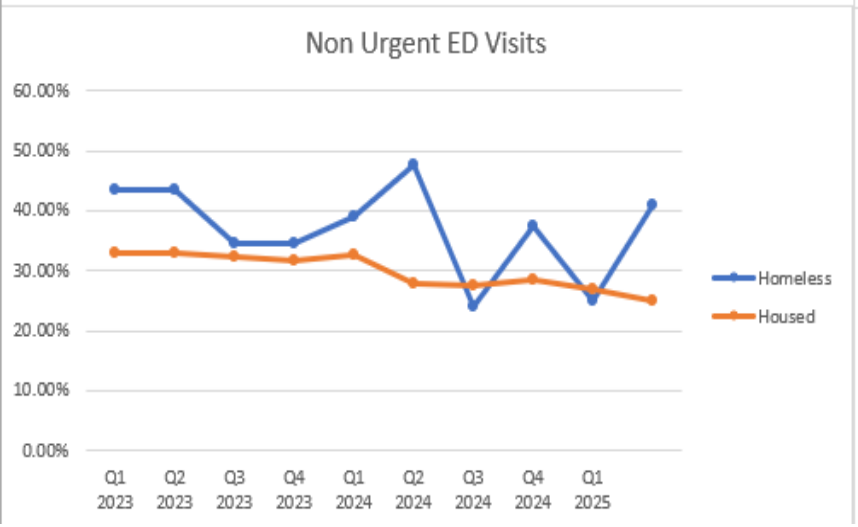
Metric to Impact	Issues/Gaps	Initiatives/Action Plans
No PCP	Connecting the homeless population to resources, some are reluctant, and it takes time to set up. Issues with transport or making first appointment.	Social Work and BOB team connecting homeless to needed resources.
SUD ER Visits	Ensuring patients get support services after induction, issues with rides and making first appointments.	Social Work and BOB work with community partners to close gaps to getting needed support for SUD patients and homeless. Working with CODA, CBH, CCO and other community partners. Offering induction in our ER.

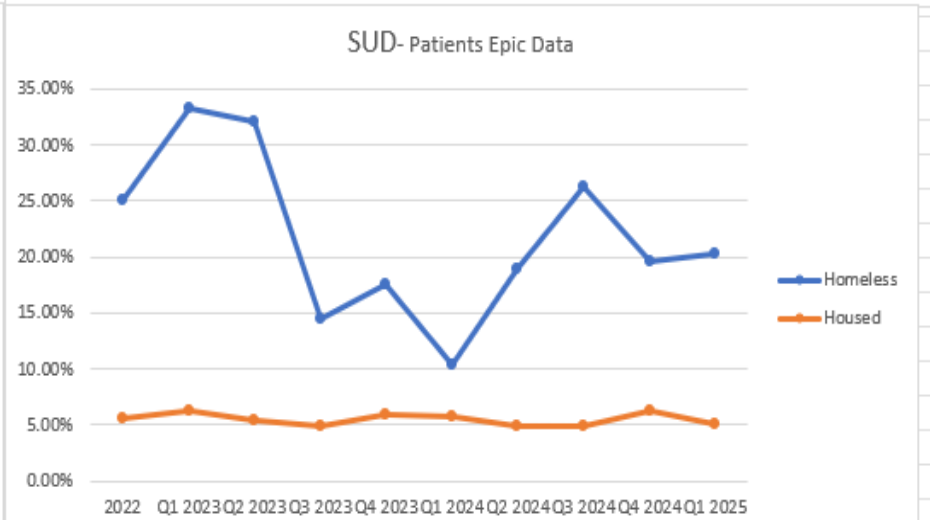
	2022		Q1 2023		Q2 2023		Q3 2023		Q4 2023		Q1 2024		Q2 2024		Q3 2024		Q4 2024		Q1 2025	
	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed	Homeless	Housed
Homeless population	1.95%	98.05%	2.72%	97.3%	2.86%	97.14%	2.81%	97.2%	3.17%	96.83%	3.06%	96.94%	2.91%	97.09%	2.52%	97.48%	3.30%	96.70%	3.71%	96.29%
No PCP	51.40%	29.90%	51.10%	27.00%	60.70%	29%	48.40%	32.00%	40.40%	27.50%	48.30%	26.20%	41%	28.00%	38.60%	30.80%	41.00%	25.50%	33%	26.00%
Substance Use Disord	25.00%	5.50%	33.3%	6.3%	32.14%	5.35%	14.52%	4.9%	17.54%	5.97%	10.34%	5.72%	19%	4.96%	26.32%	4.94%	19.67%	6.33%	20.29%	5.13%
Non Urgent ED			43.60%	33.10%	34.60%	32%	34.50%	31.60%	39.00%	32.80%	47.80%	28.00%	24%	27.50%	37.50%	28.60%	25.00%	27.00%	41%	24.90%
3 ED per 6 months			26%	11%	27%	10%	29%	10%	28%	10%	29%	11%	27%	11%	25%	10%	28%	10%	27%	12%











Providence

Newest Data as of 1st Qtr. 2025