ALLIANT HEALTH SOLUTIONS

"I Want To, I Just Don't Know How": A Practical Guide for Advancing Health Equity

Welcome!

- All lines are muted, so please ask your questions in Chat
- For technical issues, chat to the 'Technical Support' panelist
- Please participate in polling questions that pop up on the lower right-hand side of your screen
- This event is being recorded

We will get started shortly!

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ASHNHA

Alaska State Hospital & Nursing Home Association

Idaho Hospital Association

NHA Nebraska Hospital Association

OHA Oklahoma Hospital Association

Wyoming Hospital Association

Mountain-Pacific Quality Health

Agenda

- Welcome and introductions
- "I Want To, I Just Don't Know How": A Practical Guide for Advancing Health Equity
- Resources
- Asked and Answered
- Q&A/Wrap Up

Featured Speaker

Rosa Abraha, MPH
Health Equity Lead
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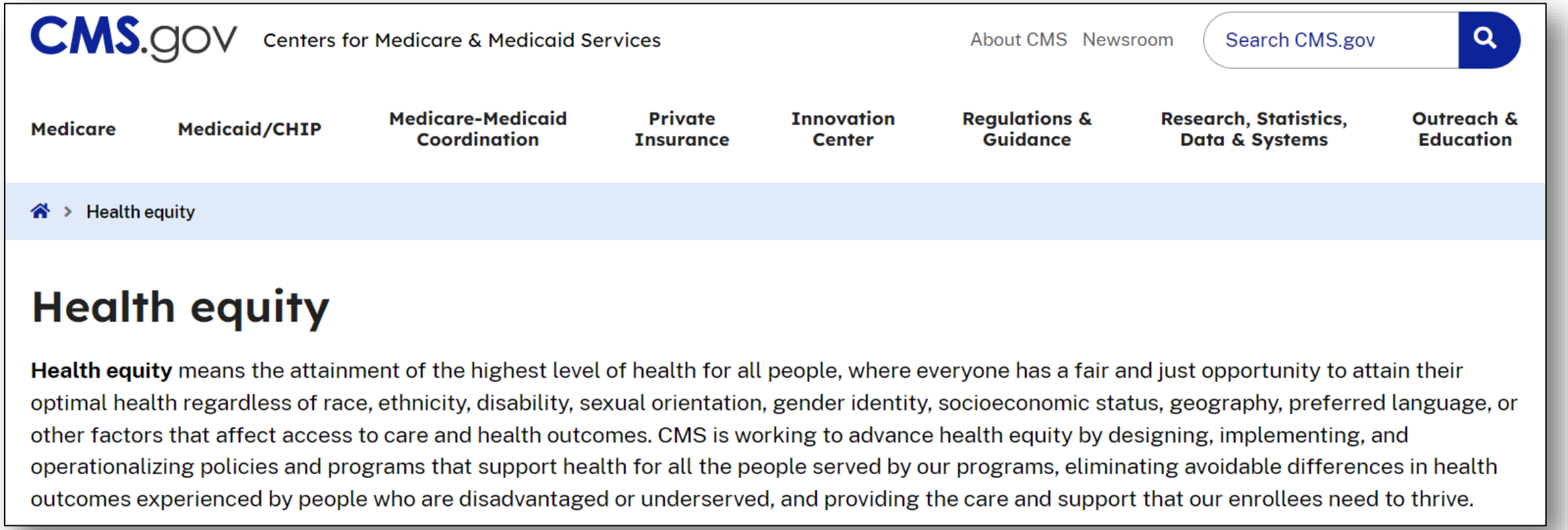
Rosa joined Alliant in December 2021 to lead the company's first health equity strategic portfolio and embed health equity in the core of Alliant's work. Rosa has 10 years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA). She holds a Master of Public Health in Health Policy and Management from Emory University.

Learning Objectives

1. Discuss a model for embedding a health equity champion within a hospital setting to meet the current regulatory requirements.

2. Describe how to expand on the collection of Race, Ethnicity and Language (REaL) data and begin to analyze health-related social needs, e.g., health literacy, transportation needs, food insecurity, etc.

3. Discuss a symbiotic framework for community and hospital partnership to advance health equity needs to improve patient outcomes.



Source: https://www.cms.gov/files/document/health-equity-fact-sheet.pdf

REMINGTON REPORT

Hospitals: New SDOH Quality Measure: Starts 2023

CMS's new SDOH quality measures was published in the 2023 Medicare Hospital Inpatient Prospective Payment System rule, released Aug. 1. Hospitals will be required to report what portion of their population is screened for various SDOH and how many screen positive in each category.

Hospitals will capture screening and identification of patient-level, health-related social needs—such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

Measure Name	Finalized Start of Data Collection
Hospital Commitment to Health Equity	Calendar Year (CY) 23 Reporting Period
Screening for Social Drivers of Health	Voluntary CY 23 Reporting; Mandatory CY 24 Reporting
Screen Positive Rate for Social Drivers of Health	Voluntary CY 23 Reporting; Mandatory CY 24 Reporting

Source Link

The Joint Commission Health Equity Standards 2023

The Joint Commission's new accreditation requirements for providers include:

- designating a leader or leaders to direct activities to reduce healthcare disparities within an organization.
- assessing patients' health-related social needs and providing information about community resources and support services.
- identifying healthcare disparities in the patient population by stratifying quality and safety data using socio-demographic characteristics.
- developing a written action plan that describes how the organization will address at least one of the healthcare disparities identified in its patient population.
- taking action when the goals in its plan to reduce health disparities are not achieved or sustained.

Applies to organizations in its ambulatory care, behavioral health care and human services, critical access hospital and hospital accreditation programs

Link to Full R3 Report

Health Equity Elevated to National Patient Safety Goal

Effective July 1, 2023, Standard LD.04.03.08, which addresses health care disparities as a quality and safety priority, will be elevated to a new National Patient Safety Goal (NPSG), Goal 16: Improve health care equity, and moved to NPSG.16.01.01. As with the original requirement, NPSG.16.01.01 will apply to the following Joint Commission–accredited organizations:

- All critical access hospitals and hospitals
- Ambulatory health care organizations providing primary care within the "Medical Centers" service in the ambulatory health care program
- Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services.

The new NPSG increases the focus on improving health care equity as a quality and safety priority, but the requirements for accredited organizations are not changing. While the original language of the requirements was revised to focus on improving health care disparities, the intent behind the standard and associated elements of performance remains the same.

Source: https://www.jointcommission.org/standards/prepublication-standards/health-care-equity-standard-elevated-to-national-patient-safety-goal/

Health Equity Champion – Organizational Culture

- **A shift in perspective is that health equity is everyone's job.** It must be a strategic priority of the organization with its mission and vision statement that ties back to the hospital's mission and vision.

- Stakeholder buy-in from board members and leadership
  - #123for Equity Pledge Campaign (2015 AHA)

- Identify a department leader/health equity champion to lead this effort.
  - Usually sits in population health OR quality and patient safety
  - Henry Ford Health System for Gold Standard

- **Cross-functional health equity teams (depending on the size and staffing of your hospital)** may include any of the following staff: quality lead, physicians, nurses, social workers, data analysts, language interpreters, registration office staff, physical therapy, home health, social services, dialysis center etc.

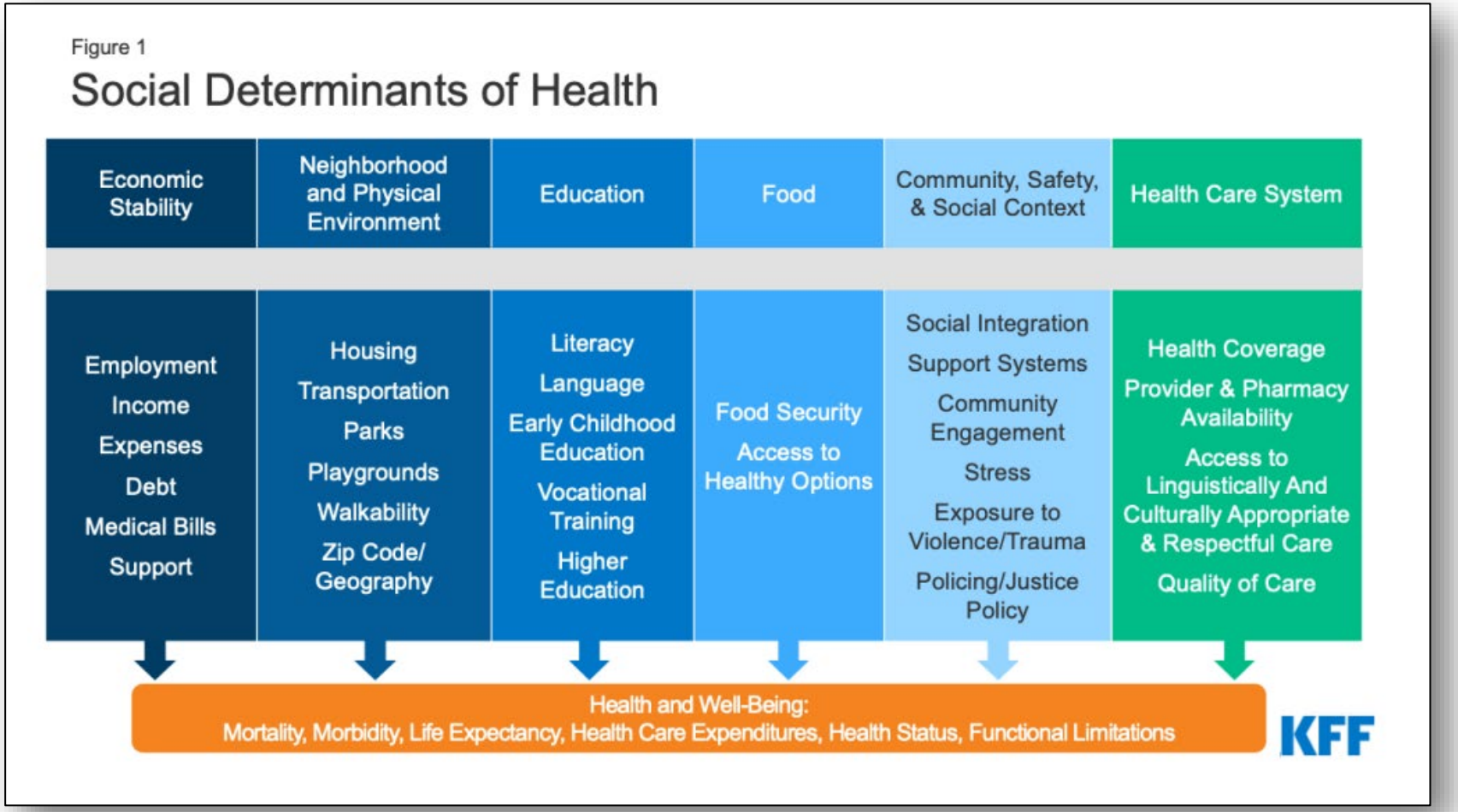
Health Equity Champion – Organizational Training

- Health equity must be embedded into training for an optimal patient experience from the first encounter to the last encounter:

- Registration/Registrar Office Training
  - Scripting with rationale for asking questions
  - AHA Disparities: How to Ask the Questions
  - Henry Ford Health System – "Why We Care" campaign
    - Estimated 90% of patients have REaL data in EHR

- Provider Training
  - Cultural competence and cultural humility
  - Health literacy
  - Implicit bias
  - National Culturally and Linguistically Appropriate Services (CLAS) Standards
  - Z Coding Training

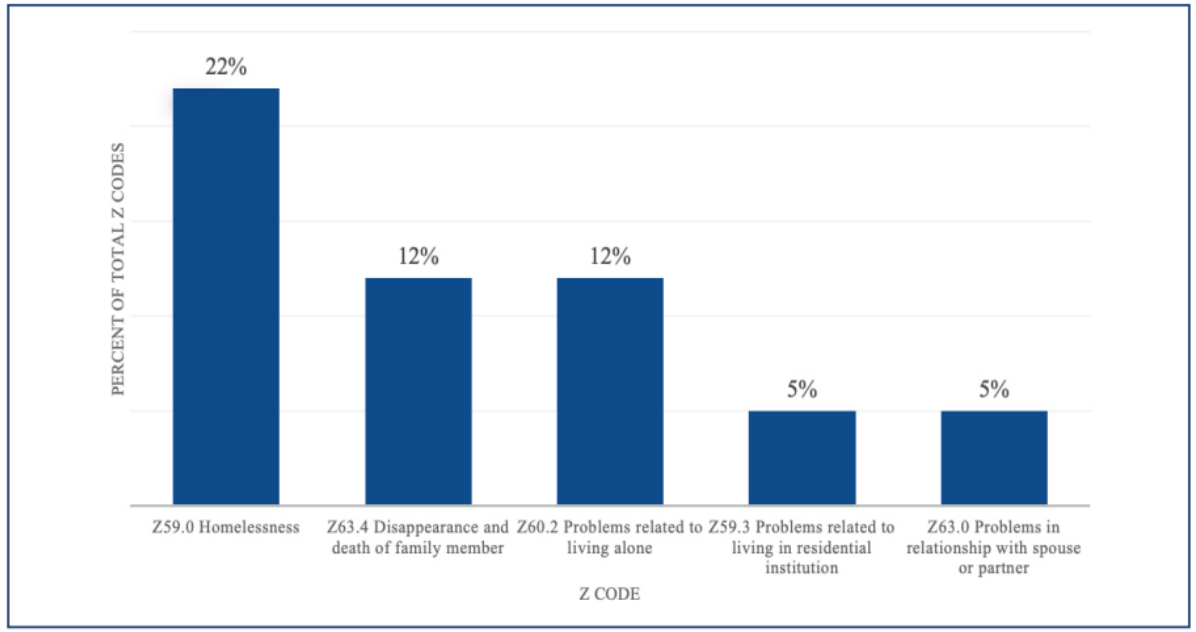
Going Beyond REaL Data: Social Determinants of Health



Source: https://www.kff.org/coronavirus-covid-19/issue-brief/tracking-social-determinants-of-health-during-the-covid-19-pandemic/

CMS Reports Lack of Billing for SDOH Screening (Z Codes)

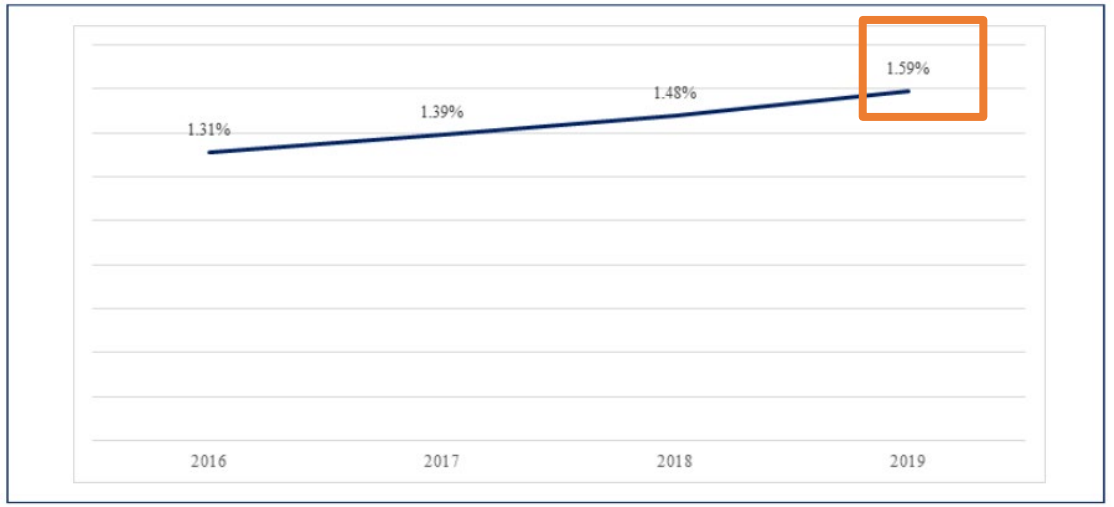
Figure 3. The Top Five Z Codes Representing the Largest Shares of All Z Code Claims, 2019.



The five Z codes that represented the largest shares of all Z code claims (N=1,262,563) in 2019 were:

Z code	Description	*n*	Proportion of all Z code claims
Z59.0	Homelessness	310,089	22%
Z63.4	Disappearance and death of family member	164,829	12%
Z60.2	Problems related to living alone	163,259	12%
Z59.3	Problems related to living in a residential institution	66,842	5%
Z63.0	Problems in relationship with spouse or partner	62,572	5%

Figure 2. Change in Proportion of Medicare FFS Beneficiaries with Z Code Claims, 2016 to 2019.



Source: https://www.cms.gov/files/document/z-codes-data-highlight.pdf

AHA Guidance on Z Codes (*Updated January 2022*)

American Hospital Association™
Advancing Health in America

Table 1
ICD-10-CM Code Categories

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z58 – Problems related to physical environment	Inadequate drinking-water supply, and lack of safe drinking water.
Z59 – Problems related to housing and economic circumstances	Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.

Source: https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

- Categories Z55-Z65 (Z codes) identify nonmedical factors that may influence a patient's health status.
- IHA/Trinity Health developed a self-report screening tool in English, Spanish and Arabic that is integrated with the electronic health record, enabling the health system to track responses, refer patients to community resources and follow up after their visit (*case study linked*).

JAMA Reports Lack in Community Partnerships for SDOH

A study in the fall of 2021, ***Assessment of Strategies Used in US Hospitals to Address Social Needs During the COVID-19 Pandemic,*** revealed "hospitals are integrating screenings to assess patients' social determinants of health, but programs and community partnerships to address SDoH have been slower to develop."

Among 4,295 hospitals, 64 percent reported strategies for three areas:

- Screening for nine SDoH types.
- Creating programs or interventions to address those.
- Collaborating with community partners to mitigate SDoH, participating in **community health needs assessments** (CHNA) or implementing SDoH initiatives.

Source: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2797676

Baptist Medical Center South – Example Screening for SDOH

1.10 - Social barriers *

Check All that Apply

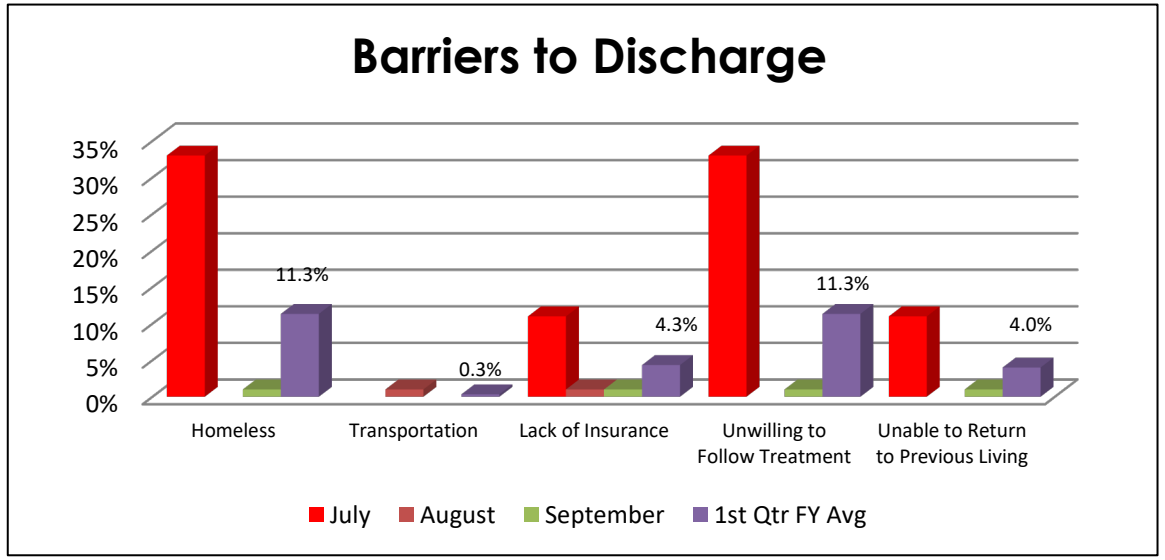
- ☐ Homelss
- ☐ Home is unsafe
- ☐ Unable to return to previous living situation
- ☐ Caregivers unable to meet the patient's needs
- ☐ Suspected neglect/abuse/financial exploitation by self or others
- ☐ Patient unable/unwilling to follow the treatment plan
- ☐ No insurance
- ☐ Inadequate insurance coverage
- ☐ Language barrier
- ☐ Lack of transportation
- ☐ NA

Additional Question – Food Insecurity

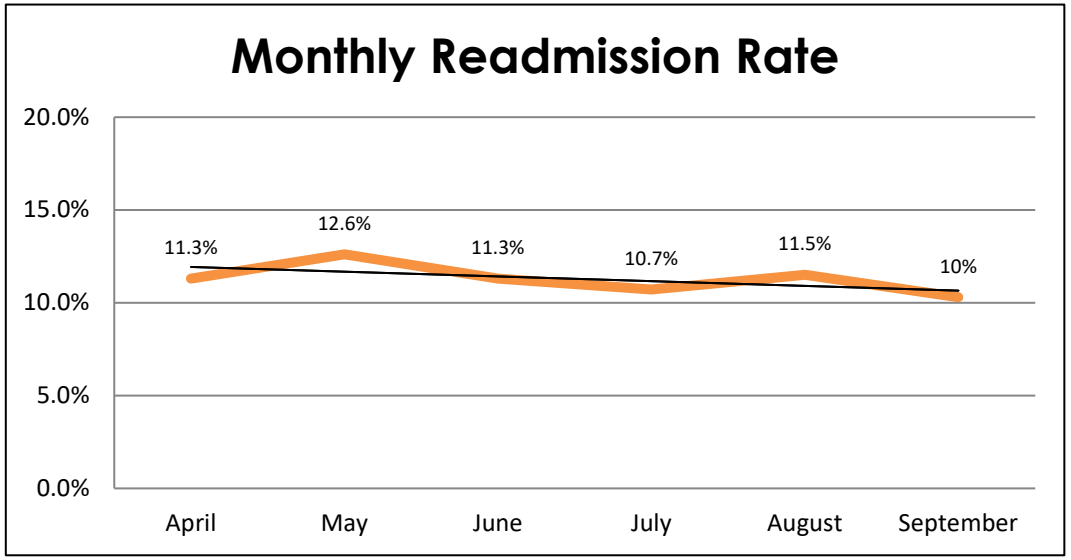
- How are you getting food, and who is preparing your meals?
- What did you eat yesterday?

Success Story: Baptist Medical Center South

Application of Lessons Learned



Top barriers identified were homelessness and unwillingness to follow treatment (compliance)



Focused on addressing those two barriers and decreased 30-day readmissions rate from 12.6% to 10%

Pro-Tip: Focus on addressing one or two social needs at a time and identify community partners to provide resources for those areas.

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A Symbiotic Framework for Clinical-Community Partnerships that Advance Health Equity

- Addressing health inequities requires **a coordinated community response** where health systems actively partner with organizations and people in their communities to address disparities, especially those most disproportionately impacted by the community.
- There is a need for **genuine and authentic community engagement** where our community partners/LINKS feel a co-authorship and buy-in in enhancing the health of their community alongside clinical partners.
- We must **expand our understanding of what creates health and think outside the box on the role of LINKS within clinical settings to help address social needs**, which will be a vital shift within current hospital culture.
    - Engagement must go beyond physical attendance to include generating ideas, contributing to decision-making, and reasonably distributing organization resources to support the clinical gaps in addressing patients' social needs (i.e., lack of transportation, lack of linguistic interpreters, lack of funding for medication).
    - Organize professional, cross-sectoral partnerships that connect different social determinants of health for a more comprehensive understanding that addresses a patient's total health.
- The goal is to build capacity in communities experiencing health inequities and take targeted action that is scalable and sustainable.

A Culture of Health Equity: Key Clinical-Community Partners

Example Clinical Partners

- Providers (nurses, doctors etc.)
- Critical Service Areas (ED etc.)
- Outpatient/Clinic
- Home Health/Nursing Homes
- Dialysis Centers
- Pharmacies
- Mental/Behavioral Health Clinics
- Community Health Workers
- Social Services
- Staff Language Interpreters
- EMS
- Registration Office/Team

Example Community Partners

- United Way
- Area Agency On Aging
- Area Medicaid Reps
- Faith-Based Organizations
- Local Business (i.e., Barbershops, Grocery Stores)
- Local Employee Retiree Organizations
- Local Senior Centers
- Local Political Organizations
- Local Power Company
- Community Health Workers
- Local Transportation Agencies
- Housing Agencies
- Food Pantries/Shelters
- Literacy Volunteers
- Police and Fire Depts.
- Veterans Association
- Universities/Research Centers

Health Equity Tools and Resources

Alliant Health Solutions

Alliant Health Equity Resources
Alliant and AHA Joint Presentation on Health Equity in Hospitals
Alliant Presentation on SDOH Medical Coding

PFCC Partners

https://www.youtube.com/watch?v=W2DuHo8YL6o June 24, 2022, Community of Practice Workshop on Utilizing the Social Vulnerability Index to Identify Community Needs

SDOH Public Data Sources

ATSDR/CDC Social Vulnerability Index
Environmental Protection Agency (Transportation)
Health Literacy Data Map
USDA (Food Insecurity)
County Health Rankings (Severe Housing Problems)
Health Leads Social Health Data Toolkit

Centers for Medicare and Medicaid Services

CMS Health Equity Framework
CMS Health Equity Fact Sheet
Achieving Health Equity Training Course

The Joint Commission

Health Care Equity Standard
Health Care Equity Accreditation Standards and Resource Center
R3 Report Issue 38: National Patient Safety Goal to Improve Health Care Equity

American Hospital Association

AHA Health Equity Topics
Equity of Care: A Toolkit for Eliminating Health Care Disparities
The Health Equity Roadmap

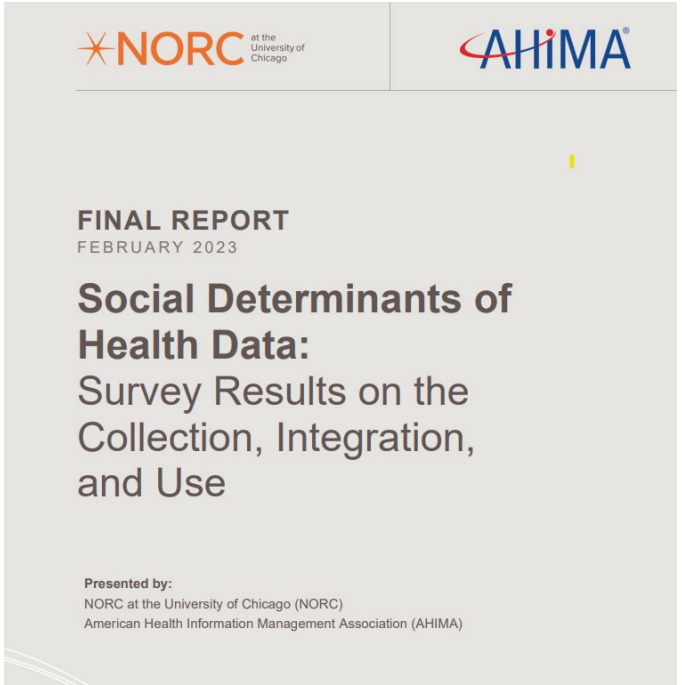
Alliant Health Equity and Health Literacy BSL video toolkit launching March '23!

Social Determinants of Health Data: Survey Results on the Collection, Integration and Use

- American Health Information Management Association (AHIMA) released a study that examines the operational realities of how social determinants of health (SDOH) data is collected, coded and used in real-world healthcare scenarios.
- Surveyed 2,600 AHIMA members and non-members from a pool of 41,000 potential respondents in the early fall of 2022.
- Key findings from the survey include:
  1. Lack of standardization and integration of the data into an individual's medical record
  2. Insufficient training and education on how to capture, collect, code, and use SDOH data
  3. Limited use of SDOH data to communicate between healthcare providers and community-based referral organizations

The paper can be found at

https://ahima.org/media/03dbonub/ahima_sdoh-data-report.pdf



Asked and Answered

1. DNV hospitals still think health equity applies only to The Joint Commission-accredited hospitals.
2. Is there a standard list of questions/assessment tools for capturing SDOH?
3. Who should conduct the SDOH assessment, and at what point during the patient cycle?
4. Hospitals are looking for education/training for staff conducting the SDOH assessment, as these are very personal questions and require a certain skill set.
5. Many CAHs have difficulty integrating the SDOH assessment into their EMR and are looking for other ways to capture and view data, e.g., Excel.

Asked and Answered

6. How can community-facing programs make their information and services more appealing and available to underserved populations? Are there best practice methods for getting evidence-based health information and programs to the audiences they can impact most?
7. Can you discuss primary clinical practice applications as well?

Q&A/Wrap Up

Please type questions and comments in Chat

Leaving in Action/Polling Questions

1. Discuss a model for embedding a health equity champion within a hospital setting to meet the current regulatory requirements.
2. Describe how to expand on the collection of Race, Ethnicity and Language (REaL) data and begin to analyze health-related social needs, e.g., health literacy, transportation needs, food insecurity etc.
3. Discuss a symbiotic framework for community and hospital partnership to advance health equity needs.

Please tell us in the poll…

What do you intend to start doing, stop doing, or do differently?

Do you feel more confident in applying what you learned today (compared to before the session)?

Upcoming Events

The Centers for Medicare & Medicaid Services (CMS) is pleased to invite the public to attend the upcoming webinar: **"From Data to Action: How CMS and its Stakeholders Are Addressing Inequities in Healthcare."** Join us to discuss the CMS Health Equity Framework and how key stakeholders leverage data science and quality measurement changes to drive progress toward more equitable care for all.

- Tuesday, February 28, 2023, from 3–4 p.m. (ET) (Register here)
- Wednesday, March 8, 2023, from 12–1 p.m. (ET) (Register here)

Upcoming Events

Acute Pain Alternatives: The Impact of Avoiding Opioids on Hospital Delirium

March 21, 2023

2 p.m. ET/1 p.m. CT/12 p.m. MT/11a.m. PT

Registration link below

https://telligen.zoom.us/webinar/register/WN_cgT6Cj19T2WHSn2evEDDFA

Hyperlink below

Webinar Registration - Zoom

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