HQIC Community of Practice Call

Innovative Approaches to Addressing Health Equity and Social Determinants in Rural Communities

July 13, 2023

This material was prepared by The Bizzell Group (Bizzell), the Data Validation and Administrative (DVA) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS) specific. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/Bizzell/DVA-1085 06/06/2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

Welcome!

Shaterra Smith
Social Science Research Analyst
Division of Quality Improvement Innovation Models Testing
iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Agenda

- Introduction
- Today's topic: Innovative Approaches to Addressing Health Equity and Social Determinants in Rural Communities
- Presenters:
  - Luciana Rocha, Senior Research Scientist, NORC Walsh Center for Rural Analysis
  - Victoria Bhardwaj, MUSC Health Program Manager, Care Transitions
  - April Roscoe, Quality/Safety Manager for the Specialty Surgery and Spine ICCE and the Center for Telehealth, MUSC Health
  - Anne Timmerman, Director of Quality and Safety, Franciscan Healthcare
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Meet Your Speakers

Luciana Rocha, MPH
Senior Research Scientist
NORC Walsh Center for Rural Analysis

Victoria Bhardwaj, DNP, MSN, BSN, RN
Program Manager, Care Transitions
MUSC Health

April Roscoe, DNP, MSN, RN, CPPS
Quality/Safety Manager for the Specialty Surgery and Spine ICCE and the Center for Telehealth
MUSC Health

Anne Timmerman, CPHQ
Director of Quality and Safety
Franciscan Healthcare

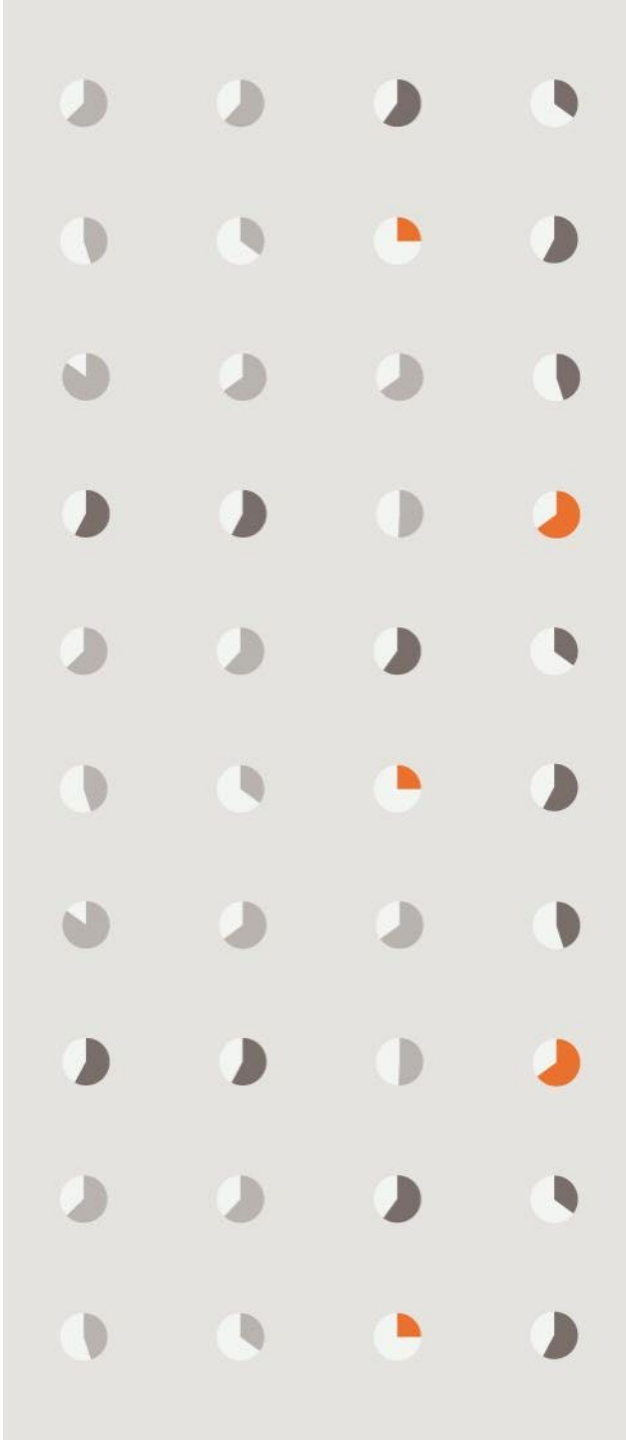
Using Insights from the Rural Health Equity Toolkit

Hospital Quality Improvement Contractor (HQIC) Community of Practice

Luciana Rocha, MPH, Senior Research Scientist

NORC Walsh Center FOR RURAL HEALTH ANALYSIS

Presentation Contents



About the Rural Health Equity Toolkit

NORC WalshCenter FOR RURAL HEALTH ANALYSIS

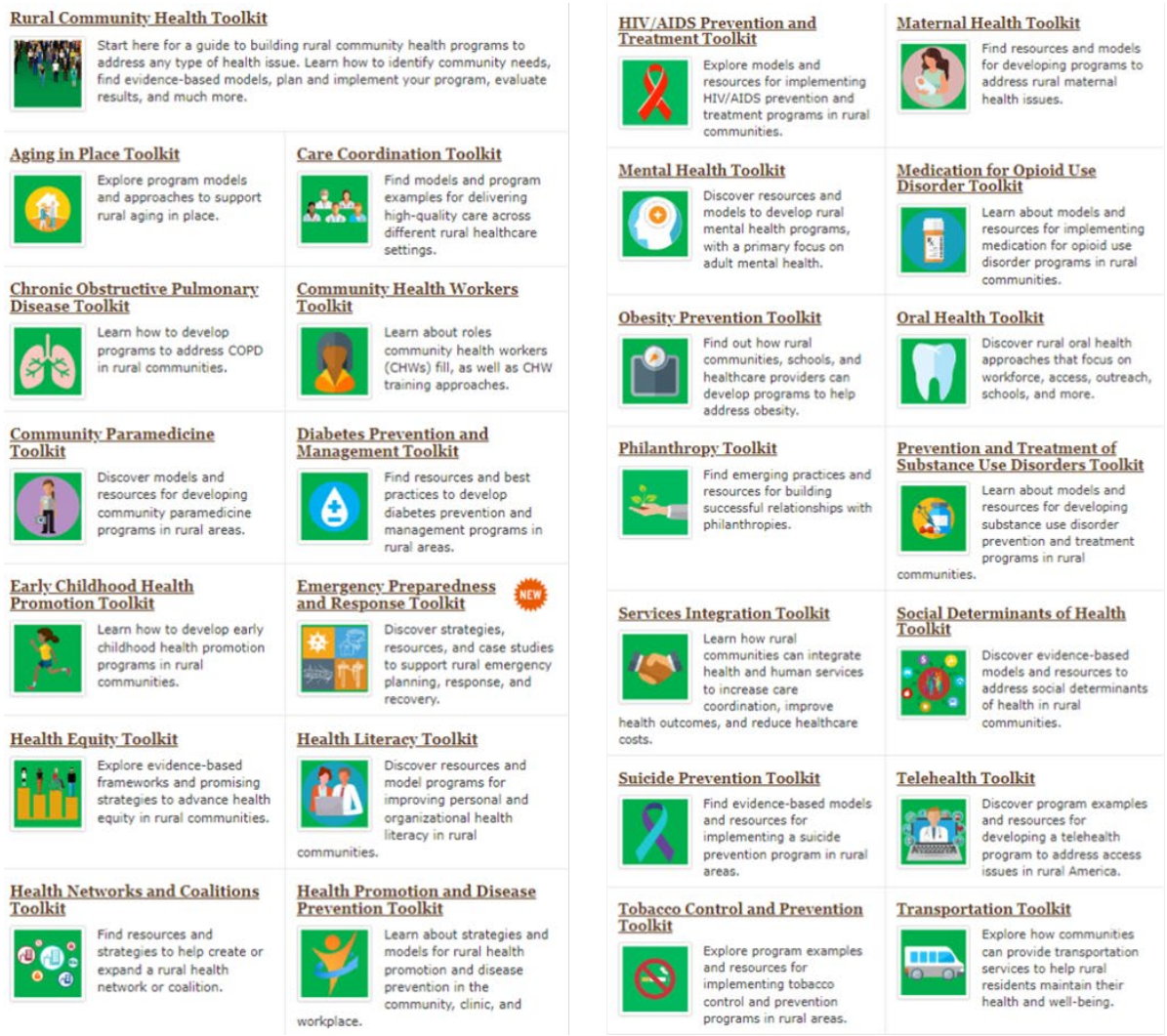
Who We Are

NORC WalshCenter FOR RURAL HEALTH ANALYSIS

- Established in 1996 and now part of NORC at the University of Chicago
- Conducts timely policy analysis, research, and evaluation on issues that affect healthcare and public health in rural America

RHIhub Rural Health Information Hub

- National clearinghouse on rural health issues
- Funded by the Federal Office of Rural Health Policy (FORHP)
- Committed to supporting healthcare and population health in rural communities



Rural Community Health Toolkit

Start here for a guide to building rural community health programs to address any type of health issue. Learn how to identify community needs, find evidence-based models, plan and implement your program, evaluate results, and much more.

Aging in Place Toolkit

Explore program models and approaches to support rural aging in place.

Care Coordination Toolkit

Find models and program examples for delivering high-quality care across different rural healthcare settings.

Chronic Obstructive Pulmonary Disease Toolkit

Learn how to develop programs to address COPD in rural communities.

Community Health Workers Toolkit

Learn about roles community health workers (CHWs) fill, as well as CHW training approaches.

Community Paramedicine Toolkit

Discover models and resources for developing community paramedicine programs in rural areas.

Diabetes Prevention and Management Toolkit

Find resources and best practices to develop diabetes prevention and management programs in rural areas.

Early Childhood Health Promotion Toolkit

Learn how to develop early childhood health promotion programs in rural communities.

Emergency Preparedness and Response Toolkit NEW

Discover strategies, resources, and case studies to support rural emergency planning, response, and recovery.

Health Equity Toolkit

Explore evidence-based frameworks and promising strategies to advance health equity in rural communities.

Health Literacy Toolkit

Discover resources and model programs for improving personal and organizational health literacy in rural communities.

Health Networks and Coalitions Toolkit

Find resources and strategies to help create or expand a rural health network or coalition.

Health Promotion and Disease Prevention Toolkit

Learn about strategies and models for rural health promotion and disease prevention in the community, clinic, and workplace.

HIV/AIDS Prevention and Treatment Toolkit

Explore models and resources for implementing HIV/AIDS prevention and treatment programs in rural communities.

Maternal Health Toolkit

Find resources and models for developing programs to address rural maternal health issues.

Mental Health Toolkit

Discover resources and models to develop rural mental health programs, with a primary focus on adult mental health.

Medication for Opioid Use Disorder Toolkit

Learn about models and resources for implementing medication for opioid use disorder programs in rural communities.

Obesity Prevention Toolkit

Find out how rural communities, schools, and healthcare providers can develop programs to help address obesity.

Oral Health Toolkit

Discover rural oral health approaches that focus on workforce, access, outreach, schools, and more.

Philanthropy Toolkit

Find emerging practices and resources for building successful relationships with philanthropies.

Prevention and Treatment of Substance Use Disorders Toolkit

Learn about models and resources for developing substance use disorder prevention and treatment programs in rural communities.

Services Integration Toolkit

Learn how rural communities can integrate health and human services to increase care coordination, improve health outcomes, and reduce healthcare costs.

Social Determinants of Health Toolkit

Discover evidence-based models and resources to address social determinants of health in rural communities.

Suicide Prevention Toolkit

Find evidence-based models and resources for implementing a suicide prevention program in rural areas.

Telehealth Toolkit

Discover program examples and resources for developing a telehealth program to address access issues in rural America.

Tobacco Control and Prevention Toolkit

Explore program examples and resources for implementing tobacco control and prevention programs in rural areas.

Transportation Toolkit

Explore how communities can provide transportation services to help rural residents maintain their health and well-being.

- 25+ toolkits, with updates and new toolkits released annually
- **Archived toolkits**: Additional toolkits are available in a PDF format but are no longer updated.

https://www.ruralhealthinfo.org/toolkits

IN THIS TOOLKIT

Modules

Published: 10/13/2022

https://www.ruralhealthinfo.org/toolkits/health-equity

Rural Health Equity Toolkit

Welcome to the Rural Health Equity Toolkit. The toolkit compiles evidence-based frameworks and promising strategies and resources to support organizations working toward health equity in rural communities across the United States.

The modules in the toolkit contain information and resources focused on developing, implementing, evaluating, and sustaining rural programs that focus on health equity. There are more resources on general community health strategies available in the Rural Community Health Toolkit.

The Rural Health Equity Toolkit: Background

- **Meet communities where they are**
- **Support rural programs with resources and examples**
- **Build the rural evidence base**
- **Continue to ensure usefulness over time**

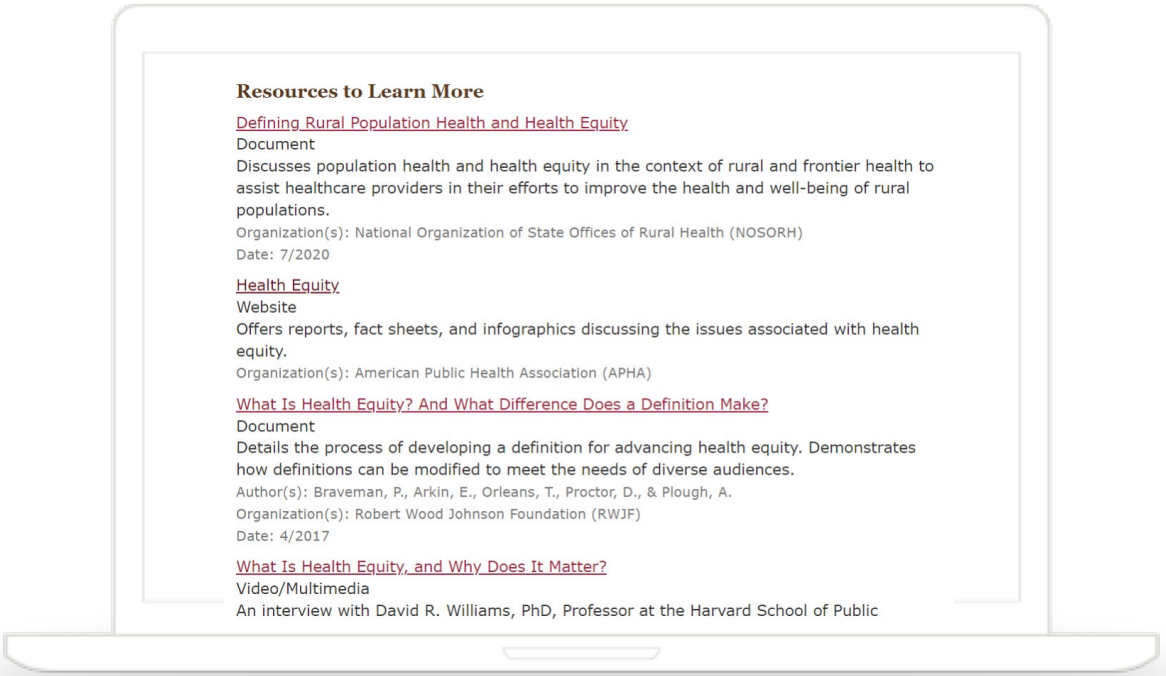
Rural Health Equity in Practice

Program examples

- Clearinghouse
- Other rural community health programs

Publicly available resources

- Guides
- Reports
- Videos
- Presentations
- Webpages



Introduction to Rural Health Equity

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Getting Started

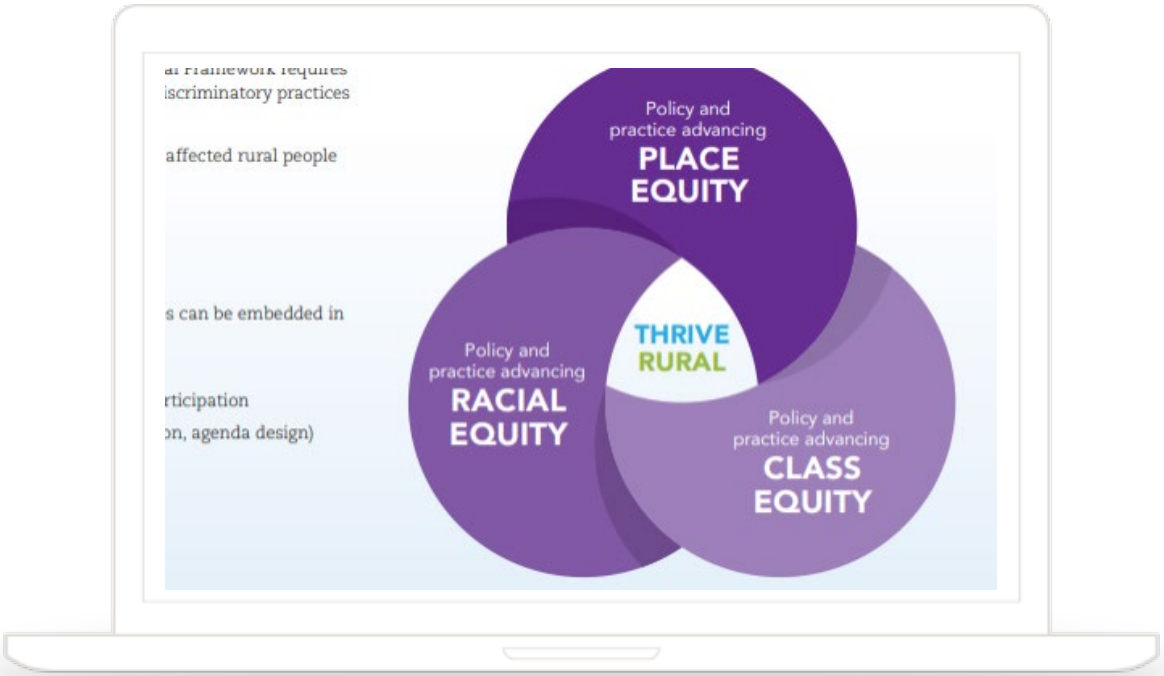
This module provides an overview of health equity and introduces some unique challenges that rural communities may face when addressing health equity. It provides important background information needed for implementing a program to incorporate strategies to advance health equity in a rural community.

For general information on what to consider when starting your program, see Creating a Program: Where to Begin in the Rural Community Health Toolkit.

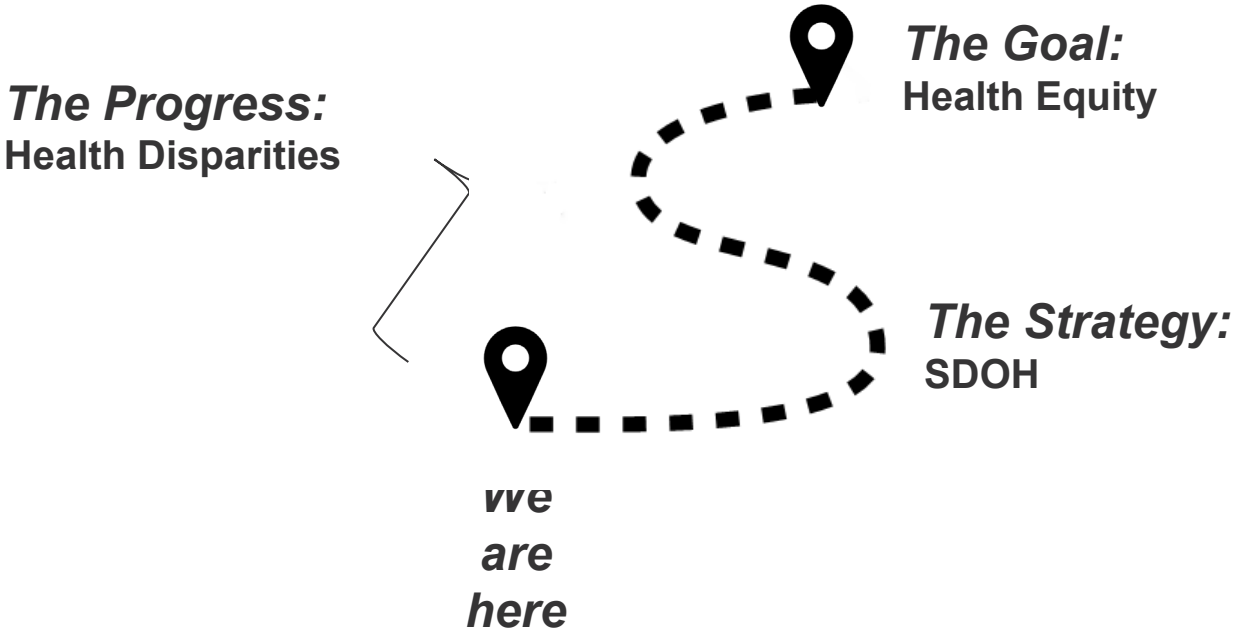
In this module:

Multiple concepts involved in health equity

- Ability to achieve the best possible level of health or live one's healthiest life
- Absence of health and healthcare disparities
- Elimination of challenges that cause inequities, such as poverty and discrimination
- Access to opportunities that promote health, including healthcare and fair employment



→ **Thrive Rural Framework: Foundational Element**
https://www.aspeninstitute.org/publications/the-thrive-rural-framework-foundational-element/


The Progress:
Health Disparities
The Goal:
Health Equity
The Strategy:
SDOH
we
are
here

Rural Health Equity Toolkit

Social Determinants of Health in Rural Communities Toolkit

Strategies to Advance Health Equity in Rural Communities

NORC WalshCenter FOR RURAL HEALTH ANALYSIS

Program Models

1. Framing health equity
2. Creating a shared vision and definition for health equity
3. Using inclusive, non-stigmatizing language to communicate
4. Understanding the community context and identifying health equity priorities
5. Fostering multi-sector collaboration to advance health equity
6. Building organizational capacity to advance health equity
7. Building community capacity to shape outcomes of health equity work

Framing Health Equity and Creating a Shared Vision

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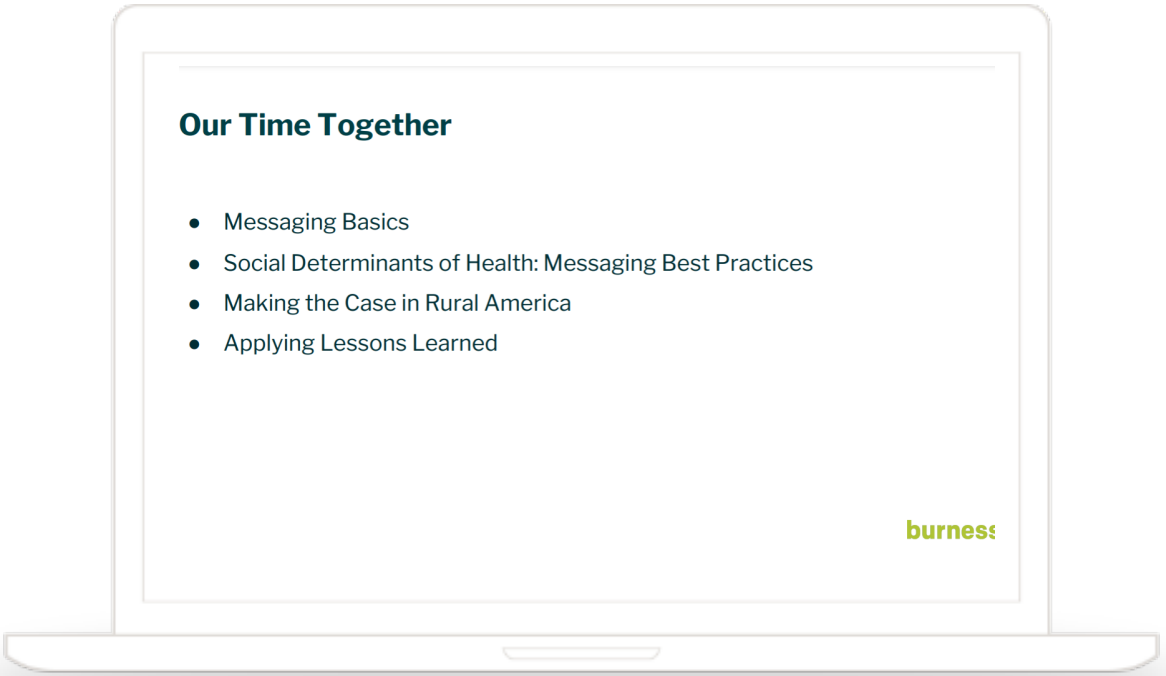
Finding Common Ground

- Understanding what terms resonate with audiences
  - "Equity"
  - "Social determinants of health"
- Finding messages that work for specific communities

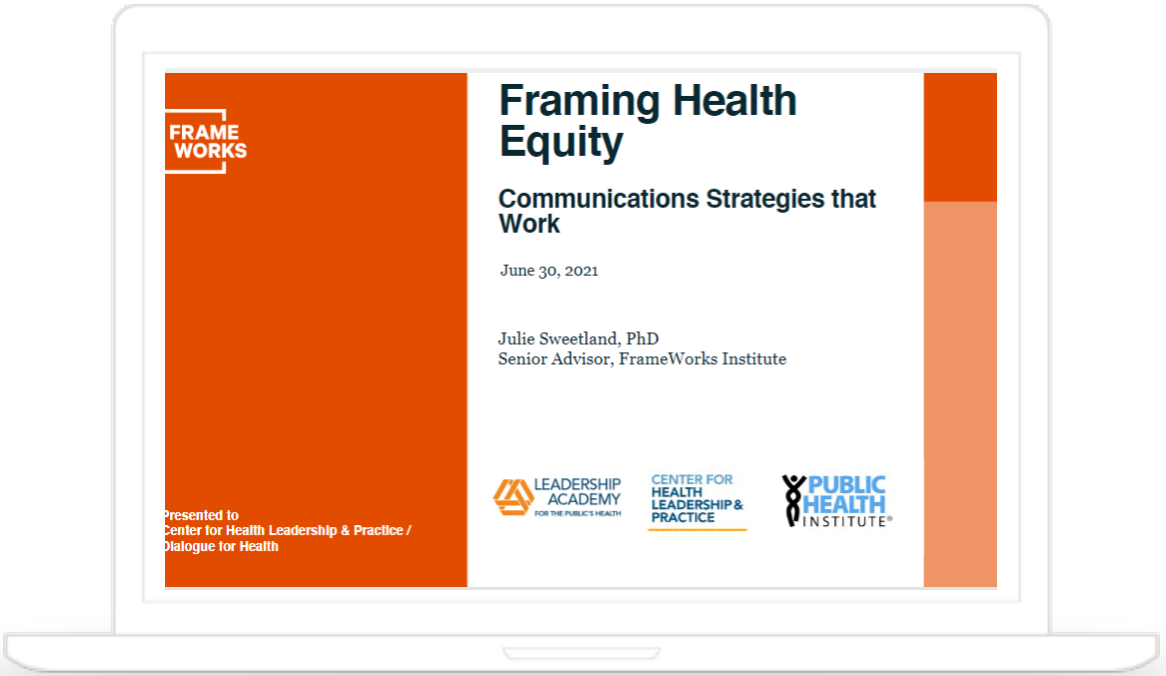


→ **A New Way to Talk about Social Determinants of Health:**
https://societyforhealthpsychology.org/wp-content/uploads/2016/08/rwjf63023.pdf

→ **Talking About the Social Determinants of Health**
https://www.naccho.org/uploads/card-images/public-health-infrastructure-and-systems/Talking-About-the-Social-Determinants-of-Health-FINAL.pdf

Framing Messages

- Being mindful attributing the problem and the solution
  - Avoid common rural refrain: “older, sicker, poorer”
- Focusing on solutions
- Creating different messages based on readiness to have conversations about health equity

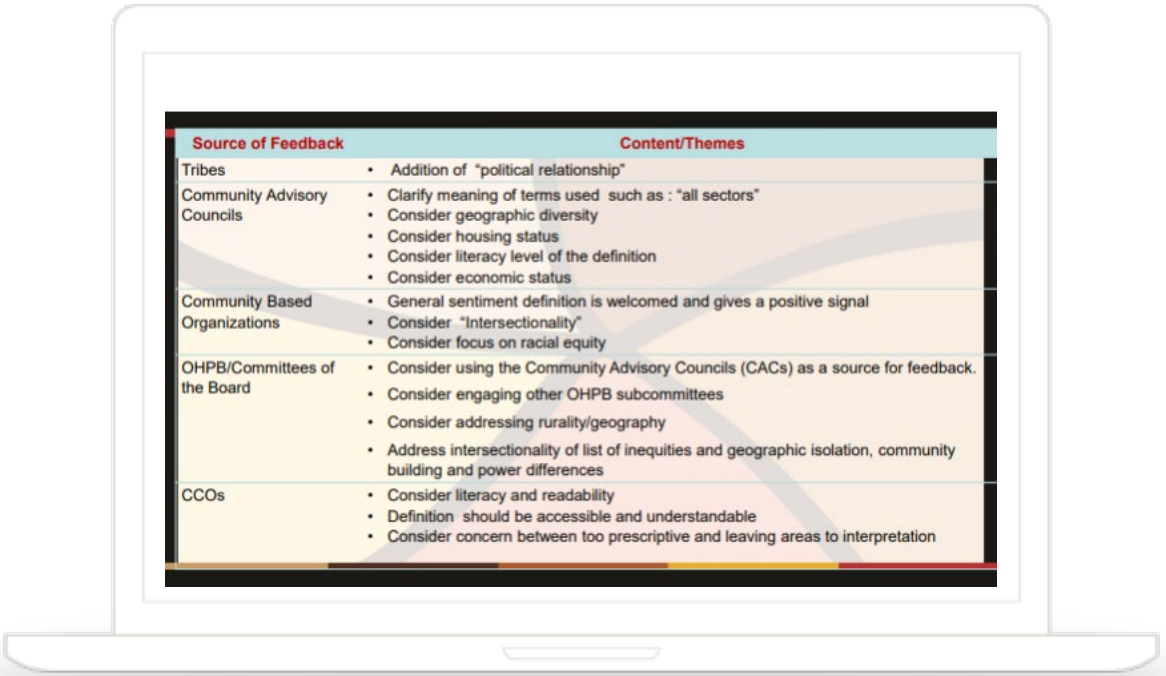


→ **Framing Health Equity: Communication Strategies that Work:** https://dialogue4health.org/web-forums/framing-health-equity-communication-strategies-that-work

→ **Communicating in Conservative Contexts: Strategies for Raising Health Equity Issues Effectively** https://dialogue4health.org/web-forums/communicating-in-conservative-contexts-strategies-for-raising-health-equity-issues-effectively

Creating a Shared Vision and Definition for Health Equity

- Establishing common goals, sense of urgency for change
- Seeking many perspectives on preferred definition and vision



Source of Feedback	Content/Themes
Tribes	• Addition of "political relationship"
Community Advisory Councils	• Clarify meaning of terms used such as : "all sectors" • Consider geographic diversity • Consider housing status • Consider literacy level of the definition • Consider economic status
Community Based Organizations	• General sentiment definition is welcomed and gives a positive signal • Consider "Intersectionality" • Consider focus on racial equity
OHPB/Committees of the Board	• Consider using the Community Advisory Councils (CACs) as a source for feedback. • Consider engaging other OHPB subcommittees • Consider addressing rurality/geography • Address intersectionality of list of inequities and geographic isolation, community building and power differences
CCOs	• Consider literacy and readability • Definition should be accessible and understandable • Consider concern between too prescriptive and leaving areas to interpretation

→ **Health Equity Definition, Oregon Health Authority, Office of Equity and Inclusion**
https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Health-Equity-Definition-October-2019-HEC-Presentation-to-OHPB.pdf

West Marion, Inc.

- Creates a space for community members to share their stories, voice ideas, and build collective power to advance real and lasting changes
- Hosted over 150 community forums
- Emphasizes authentic, intentional, and equitable approaches to community building: https://www.shifthappenstoolkit.org

County:
McDowell County, NC

→ **Health Equity in Rural America, with Alana Knudson, Luciana Rocha, and Paula Swepson**
https://www.ruralhealthinfo.org/podcast/health-equity-jan-2023

Our vision is for a healthy and equitable West Marion. A place where residents are engaged to become leaders to create change through new businesses, empowered youth, affordable housing, teaching gardens, and a community center that honors our ancestors and creates opportunities for our future.

- Vision statement, West Marion, Inc.

Using Inclusive, Non-Stigmatizing Language

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Using Inclusive, Non-Stigmatizing Language

- Centering the person instead of the condition
  - Self-determination, own preferred terms
- Using plain language
- Identifying translation considerations
  - E.g., connotations in different languages

→ **Rural Health Literacy Toolkit**
https://www.ruralhealthinfo.org/toolkits/health-literacy

Understanding the Community Context

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Understanding the Community Context

- Using data to identify priorities and health inequities
- Engaging community members affected by health inequities
  - Authentic vs. tokenistic engagement
  - Shared leadership structure
- Assessing the historical and policy context when addressing health equity

→ **Health Departments and Authentic Community Engagement**
https://phaboard.org/wp-content/uploads/4.30.20.Georgia-Southern.Health-Departments-and-Authentic-Community-Engagement-002.pdf

Health Equity and Access in Rural Regions (HEARR): Water Quality Project

- Builds community capacity to advance environmental justice and health equity
- Conducted a situation assessment
- Piloted program using water testing kits to sample levels of contaminants in private well water
  - Rural steering committee
- Hired local high school and community college students to recruit participants

County:
Fluvanna County, VA

Fostering Multi-Sector Collaboration

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Fostering Multi-Sector Collaboration

- Promoting equitable practices in existing partnerships (in addition to building new collaborations)
- Identifying groups and coalitions that are organizing around similar issues, but may not have a seat at the table

→ **A Primer for Multi-Sector Health Partnerships in Rural Areas and Small Cities**
https://buildhealthyplaces.org/tools-resources/rural-primer/

Healthcare Georgia Foundation: The Two Georgias Initiative

- Funded 11 rural coalitions with the ultimate goal of achieving greater health equity among rural Georgians (e.g., one in Clay County)
- Planning year: governance structure, community health partnerships, Community Health Improvement Plan
- Implementation years: technical assistance in health equity, capacity building, sustainability, evaluation
  - TA providers worked with community ambassadors

County:
Clay County, GA

Five years ago, we were 159 [in county health rankings in Georgia]. Today we're 154. So we have moved the needle a point up each year…Within five years, we've got a drug store, we've got behavioral health, we have green spaces for exercise, we have walking trails, we have a food pantry. We have several opportunities now for access to care. We have a new bank. We're looking at transportation. We're looking at housing.

- Tara Gardner, Two Georgias coalition in Clay County, Georgia
RHIhub Exploring Rural Health Podcast: Health Equity in Rural America, Part 2

Building Organizational Capacity

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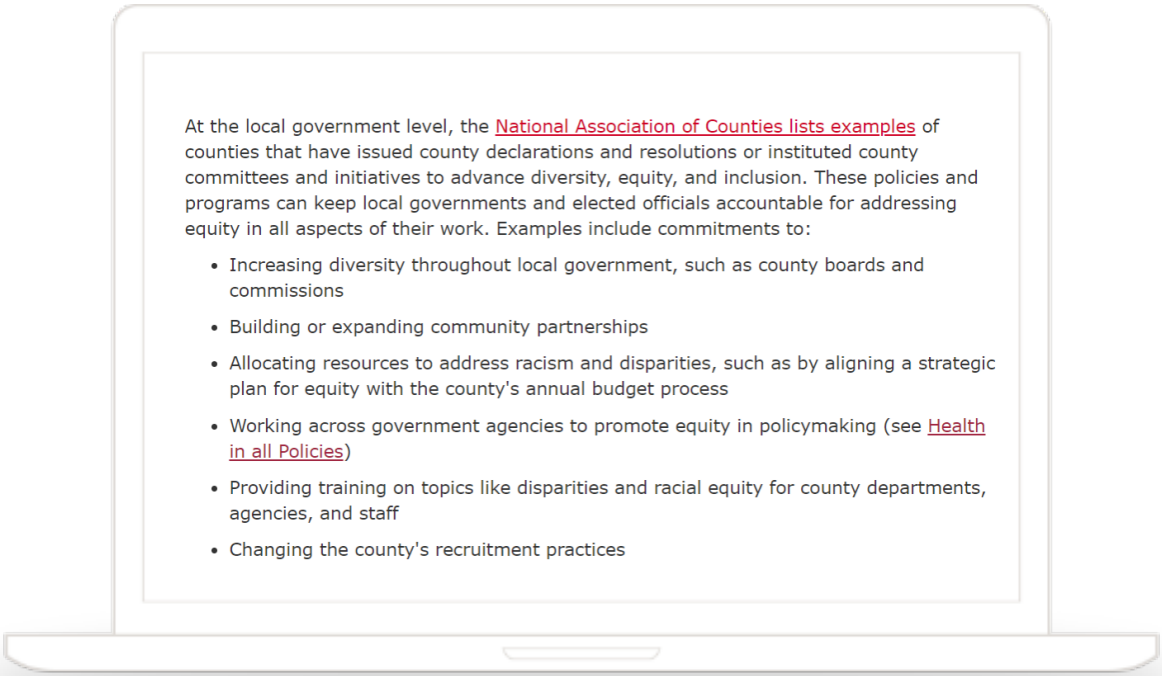
Building Organizational Capacity

- Training staff on different aspects of health equity
- Developing permanent infrastructure for equity
  - E.g., through policies and formal partnerships
- Building and retaining a representative workforce
- Leveraging position as anchor institution



→ **Developing Permanent Organizational Infrastructure for Health Equity**
https://www.ruralhealthinfo.org/toolkits/health-equity/2/organizational-capacity/infrastructure

Rice County Public Health: Health Equity Plan

- Received training and coaching on health equity
- Conducted a Health Equity Data Analysis (HEDA) as part of the Statewide Health Improvement Partnership (SHIP) grant program
- Developed a health equity plan to guide efforts to achieve health equity

County:

Rice County, MN

RICE COUNTY PUBLIC HEALTH - HEALTH EQUITY PLAN
JUNE 2018

Background:

The mission of Rice County Public Health reflects improving the health of ALL individuals, with a stated value of "equity." Building awareness of how health opportunities may be different for people in our community and evaluating practice in order to improve health for ALL is an important role for our department.

The Minnesota Department of Health defines health equity as "the opportunity for every person to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities."[1]

Purpose:

The purpose of this plan is to provide guidance to help strengthen staff understanding and build organizational capacity to address health equities. This includes ensuring that internal work institutionalizes health equity into public health policies, programs and services.

Goal: Implement practices to build internal infrastructure around health equity.

Practices:

1. Develop staff core competencies to help achieve health equity by providing staff education and dialogue.
    a. Core competencies:
        i. Understand the evidence around health inequities.
        ii. Explore the root causes of health inequities — oppression & power — and how to address them.

Building Community Capacity

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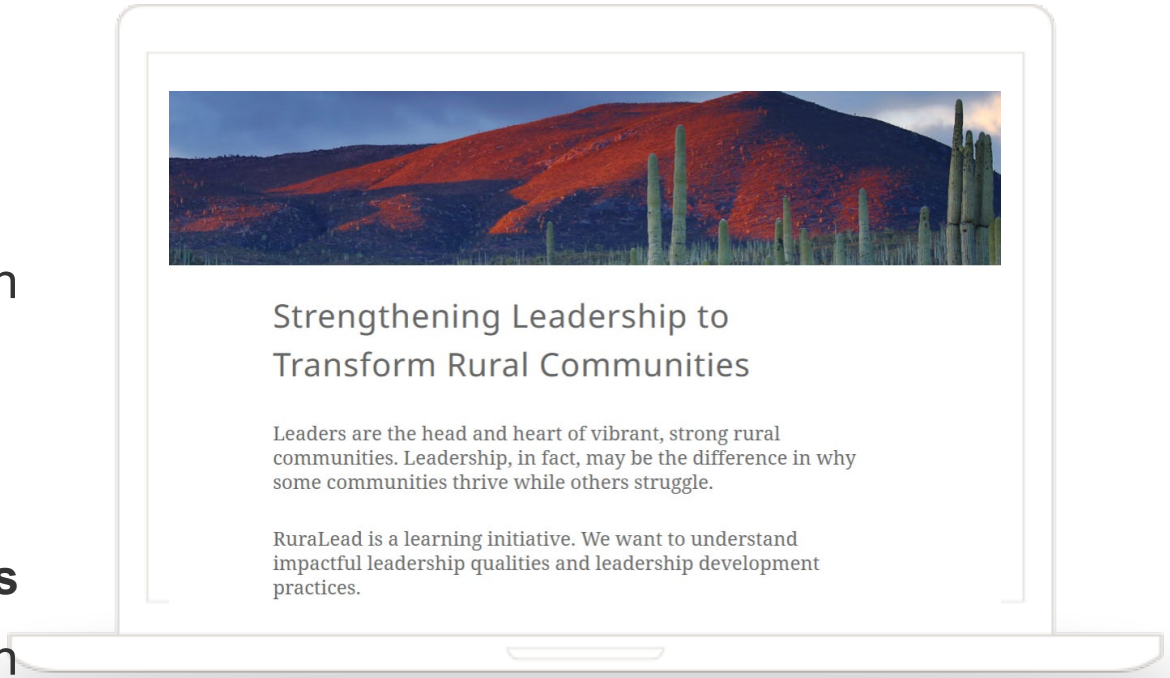
Promoting Civic Engagement

- Looking at representation and involvement of rural communities in decision-making

Developing Rural Leaders

- Increasing representation of communities that experience inequities

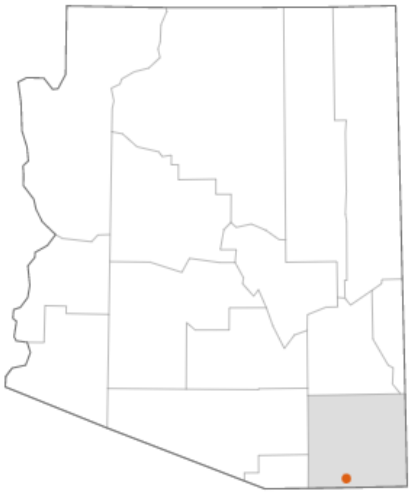


→ **RuraLead**
https://ruralead.org/three-imperatives-for-a-better-rural-future/

Southeast Arizona Area Health Education Center: Healthy Farms Program

- Provided training and capacity building assistance to community members serving as promotores de salud
- Promotores collected information about priority health issues, began mobilizing residents
- Supported community in building a community center (permanent infrastructure)
- Community developed their own 501(c)(3) organization

County:
Cochise County, AZ



Implementation Considerations

NORC WalshCenter FOR RURAL HEALTH ANALYSIS

Implementation

For a broad overview of rural program implementation, see Implementing a Rural Community Health Program in the Rural Community Health Toolkit. The Social Determinants of Health Toolkit provides additional implementation considerations that may be relevant to programs seeking to advance health equity.

In this module:

Technical Assistance

- Many programs we interviewed needed some type of technical assistance or training

Resources

- Legal assistance for formalizing partnerships, coalitions
- Resources and space to support meetings
- Funding for engaging, compensating community members

→ Health Equity Technical Assistance

Health Equity Technical Assistance | CMS

Evaluation Considerations

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Evaluation

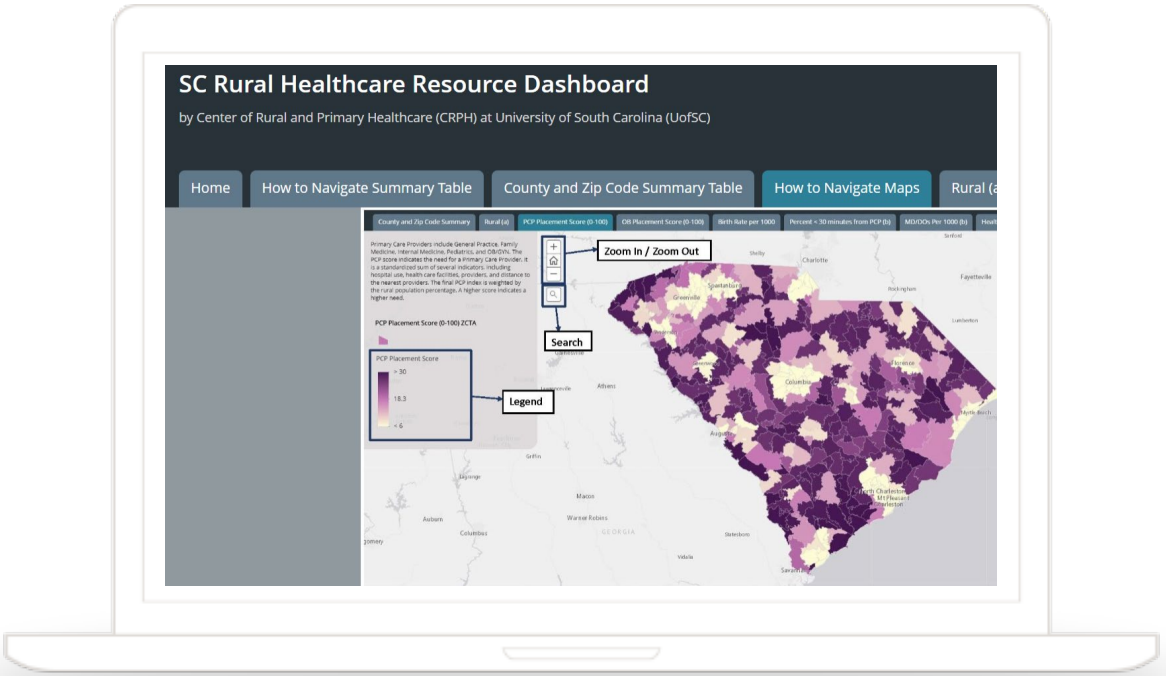
Evaluation is a tool for measuring a program's impact and providing information on where to make improvements. Careful evaluation of programs designed to improve health equity is critical to ensuring that the programs are achieving their goals.

This module provides methods and considerations for conducting evaluations of programs designed to improve health equity. Find more detailed information about program evaluation in the Rural Community Health Toolkit.

In this module:

Health Equity and Data

- Who has ownership of and can access the data?
- What are opportunities for community members to build capacity in evaluation?
- How is the evaluation team sharing the results and findings back with the community?
- How will the community be involved in interpreting and framing these results?
- How will the evaluation benefit community members?



→ **SC Rural Healthcare Resource Dashboard**
https://uscgeography.maps.arcgis.com/apps/MapSeries/index.html?appid=0904d6bdbb52476faf2fd42fb04a43d1

Funding and Sustainability Considerations

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FOR RURAL HEALTH ANALYSIS

Funding & Sustainability

It is important to consider sustainability early in the planning stages of programs that advance health equity and to incorporate sustainability strategies throughout implementation. This module discusses key issues in planning for sustainability and highlights several sustainability strategies.

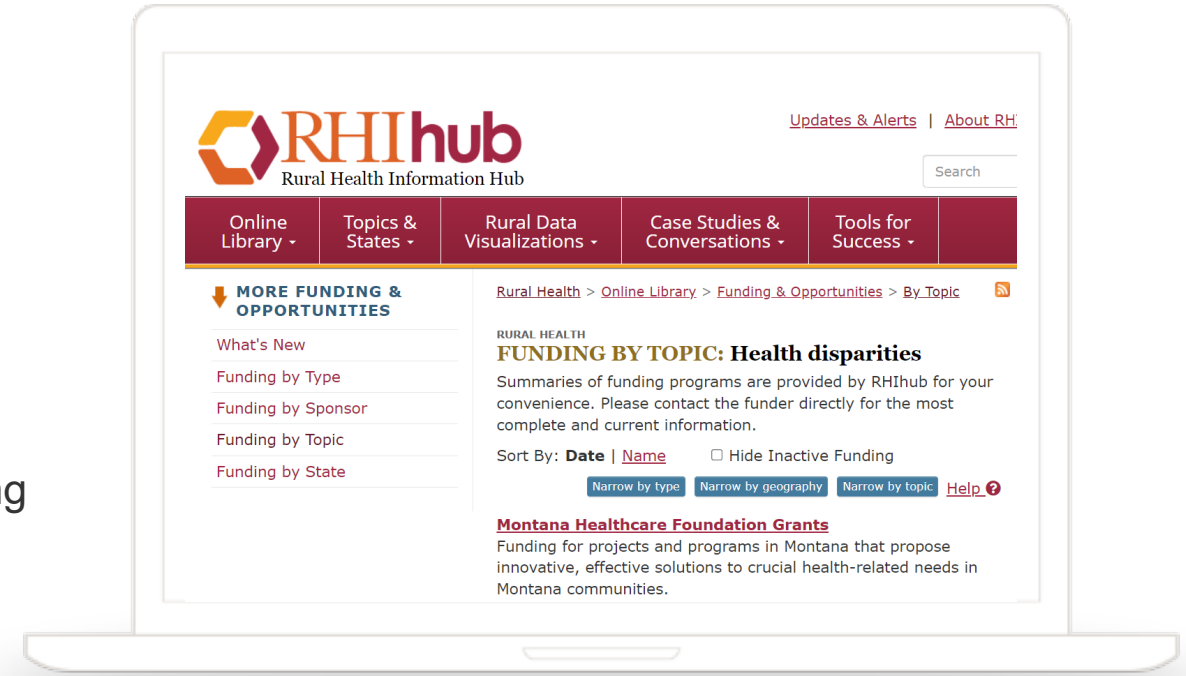
For an overview of how to plan for sustainability and how to create a sustainability plan, see Planning for Sustainability in the Rural Community Health Toolkit.

This module discusses key sustainability strategies to consider for rural health equity programs.

In this module:

Planning for Sustainability: Two Georgias Initiative and Georgia Health Decisions

- *Adaptive stewardship*
  - How do we share responsibility and ownership for achieving health equity in our community?
- *Enduring structures*
  - How do we build our organization for a positive and lasting impact?
- *Sustainable resources*
  - How do we generate monetary and human resources?



→ **Funding by Topic: Health Disparities**
https://www.ruralhealthinfo.org/funding/topics/health-disparities

Thank you.

Luci Rocha
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Research You Can Trust™

NORC WalshCenter

Promoting Health Equity Through Innovation and Intervention

Victoria Bhardwaj, DNP, MSN, RN
Program Manager II, Care Transitions
Readmission Reduction Sustainability
Operations Co-Chair

April Roscoe, DNP, MSN, RN
System Quality & Safety Manager
Specialty Surgery and Spine ICCE
and Center for Telehealth

MUSC Health
Medical University of South Carolina

Changing What's Possible | MUSChealth.org

2018 Study Released by National Institute on Minority Health and Health Disparities (part of the National Institutes of Health)

- The study is the first to estimate the total fiscal/economic burden of health disparities for five racial and ethnic minority groups nationally, all 50 states, including the District of Columbia using a health equity approach
- The cost of racial and ethnic health disparities cost the U.S. $451 Billion
- An increase in fiscal implications of 41% from 2014
- Education-related health disparity burden for having less than a college degree was $978 Billion for adults 25 years and older

States with the highest racial and ethnic health disparities

Texas
California
Illinois
Florida
Georgia

South Carolina had one of the largest health disparity burden costs per capita (based on education level) for

High school diploma = $25,555

Most of the U.S. economic burden of racial and ethnic health inequities =

Black population (74%)

Source: JAMA. (2023). *The economic burden of racial, ethnic, and educational health inequities in the US.*

MUSC HEALTH

Uniquely positioned as the state's only comprehensive academic health system to make a transformational impact for the health of the state and region

MUSC HEALTH

MUSC Health, the clinical enterprise of the Medical University of South Carolina, is dedicated to the pursuit of changing what's possible in health care.

This innovative integrated health care system includes four hospitals in downtown Charleston, more than 100 outreach locations, clinical affiliations with other hospitals and health systems and a robust telehealth network.

The MUSC Health University Medical Center has been named South Carolina's #1 hospital by U.S. News & World Report for six years in a row and most preferred hospital by the National Research Corporation.

In 2020, U.S. News & World Report ranked three MUSC Health Charleston specialties among the best in the country: ear, nose and throat; gynecology; and cancer. Six programs at MUSC Health Charleston and two each at MUSC Health Florence and MUSC Health Lancaster medical centers were designated as high performing.

South Carolina's only transplant program

Patients from outside the Tri-county area

100
Outreach locations

900+
Attending physicians

1,600
Beds throughout the health system

100+
Services offered via telehealth throughout South Carolina

1 Million+
Patient encounters each year

54,000+
Annual patient admissions

Addressing the growing rural health care access and care delivery disparities in South Carolina; presence and connectivity

Rural hospitals in South Carolina are under significant financial pressure with some facing closure, worsening the challenge of health care access/disparities

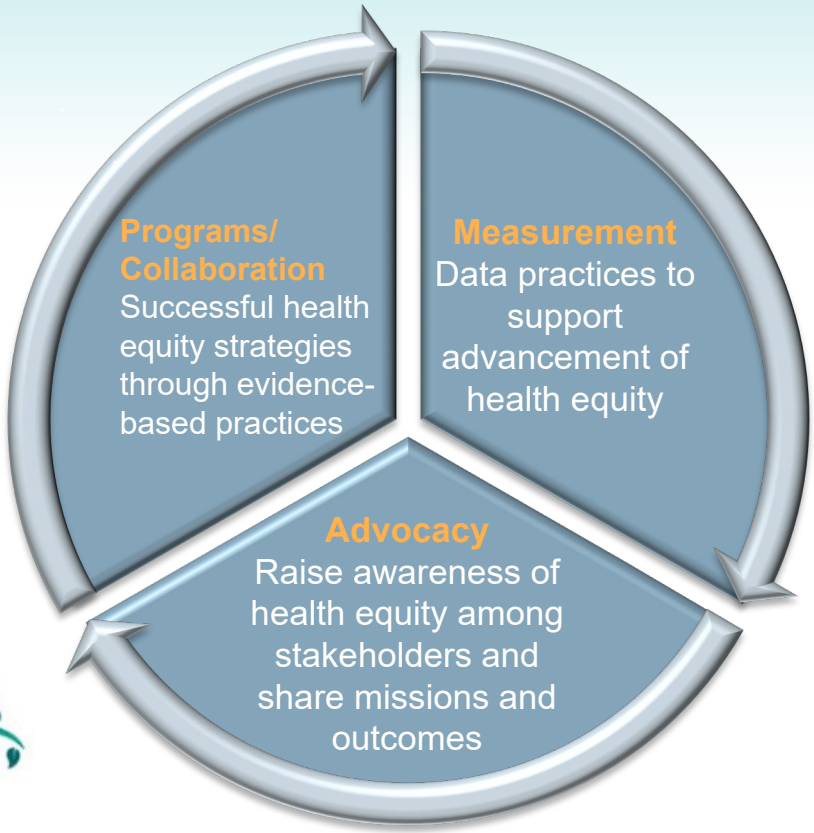
MUSC is investing and innovating in numerous smaller and rural South Carolina hospitals through partnership or presence, providing underrepresented minority and rural populations better access to the highest level of patient care

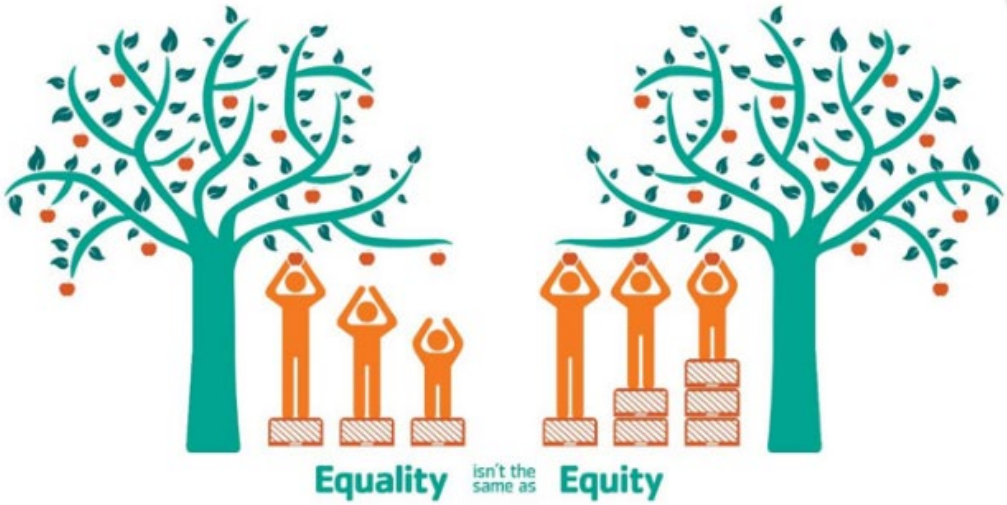
MUSC Center for Telehealth

The Center is one of only two National Telehealth Centers of Excellence in the country. The Center is also the headquarters of the South Carolina Telehealth Alliance (SCTA)

MUSC Health Road Map for Health Equity

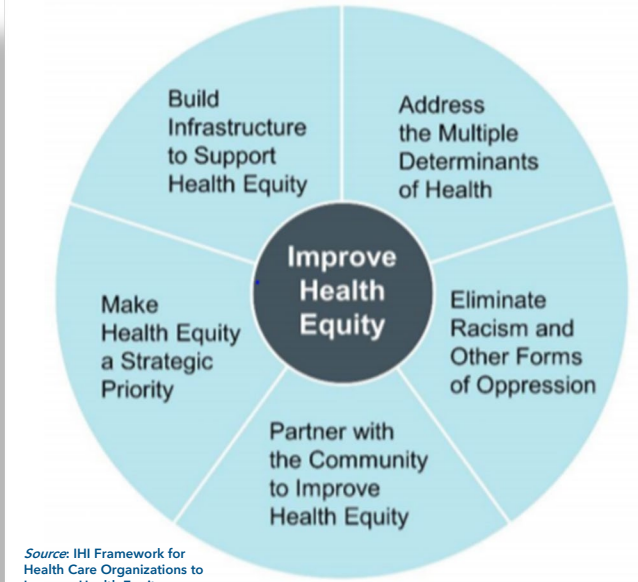
- Programs/Collaboration
- Measurement
- Advocacy





MUSC Collaboration :
Co-branded Primary Care Clinics

- Both MUSC Health and Clemson Rural Health have common interest in helping to improve access to high quality health care in an effort toward health equity
- Improve health outcomes in underserved and rural communities of South Carolina.
- Both organizations have a passion to serve patients in communities with historically poor health outcomes and numerous social determinant barriers to health.
- It is our belief that the combined reach of these two organizations will strengthen the health outcomes in these communities



Source: IHI Framework for Health Care Organizations to Improve Health Equity

MUSC Collaboration :
Co-branded Primary Care Clinics

MUSC Health
Medical University of South Carolina
Changing what's possible
CLEMSON
RURAL HEALTH

LOI Construct

- Brick and mortar clinics in underserved areas meeting the CMS Rural Health Clinic requirements
- Provider support by Nurse Practitioners
- Community support by Community Health Workers
- Capitalize on mobile health units supported by each brick-and-mortar clinic
- Facilitate student clinic experiences (clinic and mobile health unit(s) for students from Clemson, MUSC, and other undergraduate students from HBCUs and communities served
- Both organizations value and support Historically Black Colleges and Universities (HBCUs), and desire to enhance and lift those students with a focus on those opportunities.

Equitable Readmission Reduction Efforts and Sustainability

Understand current readmission rates

(SDOH, Risk of Readmission Score, Region)

Design data management decision support tools

(reporting, dashboards)

Data extraction for usability

(equitable action plans/evidence-based practice)

MUSC Measurement: Readmission Reduction Sustainability Operations

Discharge Planning Dashboard

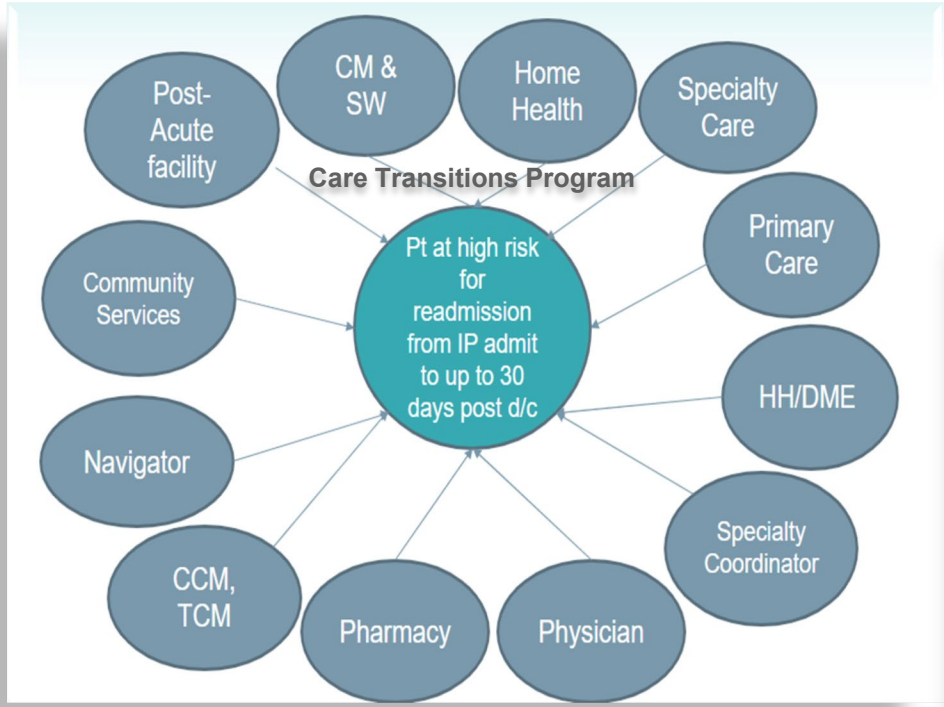
Using predictive modeling and data analytics to support sustainable readmission reduction work throughout the MUSC footprint

**Hospitals that serve a high proportion of minority patients tend to have high readmission rates*

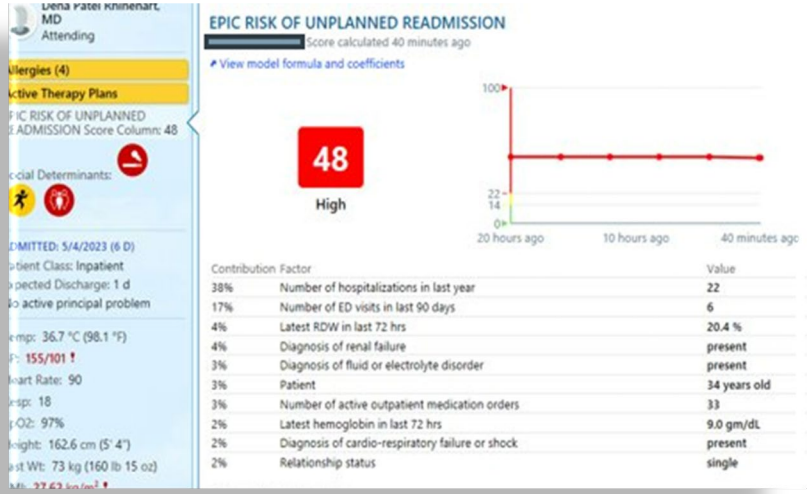
- 30-day, all-cause readmissions
- Risk of readmission score
- ICCE, discharge provider, MS and APR-DRGs
- 7, 14, and 30-day post-discharge follow up appointments made and completed
- Discharge summaries sent by Regions/Divisions

MUSC Programs/Collaboration, Measurement, and Advocacy:
Care Transitions Program

Using predictive modeling, data analytics, and the Care Transitions Framework to support sustainable readmission reduction work throughout the MUSC footprint



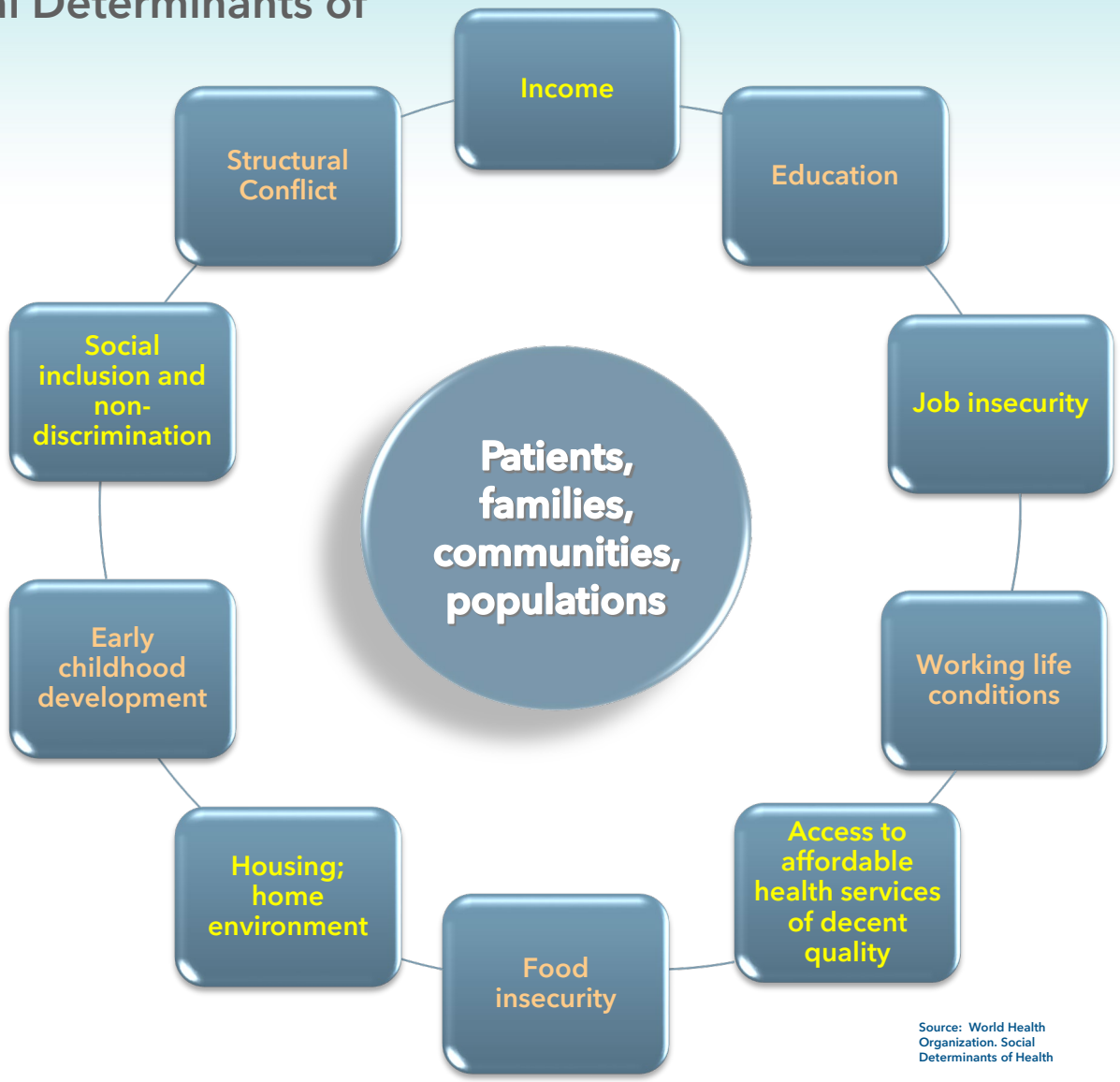
Interdisciplinary care approaches with Care Transitions as 'oversight' to support reduction in avoidable readmissions



Epic EMR Risk of Unplanned Readmission Score- Care Transitions follows HIGH risk-scored patients

MUSC Advocacy: Social Determinants of Health:

- Improving SDOH screenings on all patients utilizing CMS mandatory guidelines and system 'roadshows'
- Care Management Program improvements (chronic, complex, transitional care, diagnosis-specific care coordination)
- Inter and Multidisciplinary Care collaboration efforts for improved rural support from more resource-rich divisions
- More streamlined system operations work to de-silo 'one-off' equity and readmission reduction efforts
- Food insecurity reduction efforts in collaboration with Americorp utilizing data analytics
- Creating electronic medical record embedded tools for improved identification of health equity needs

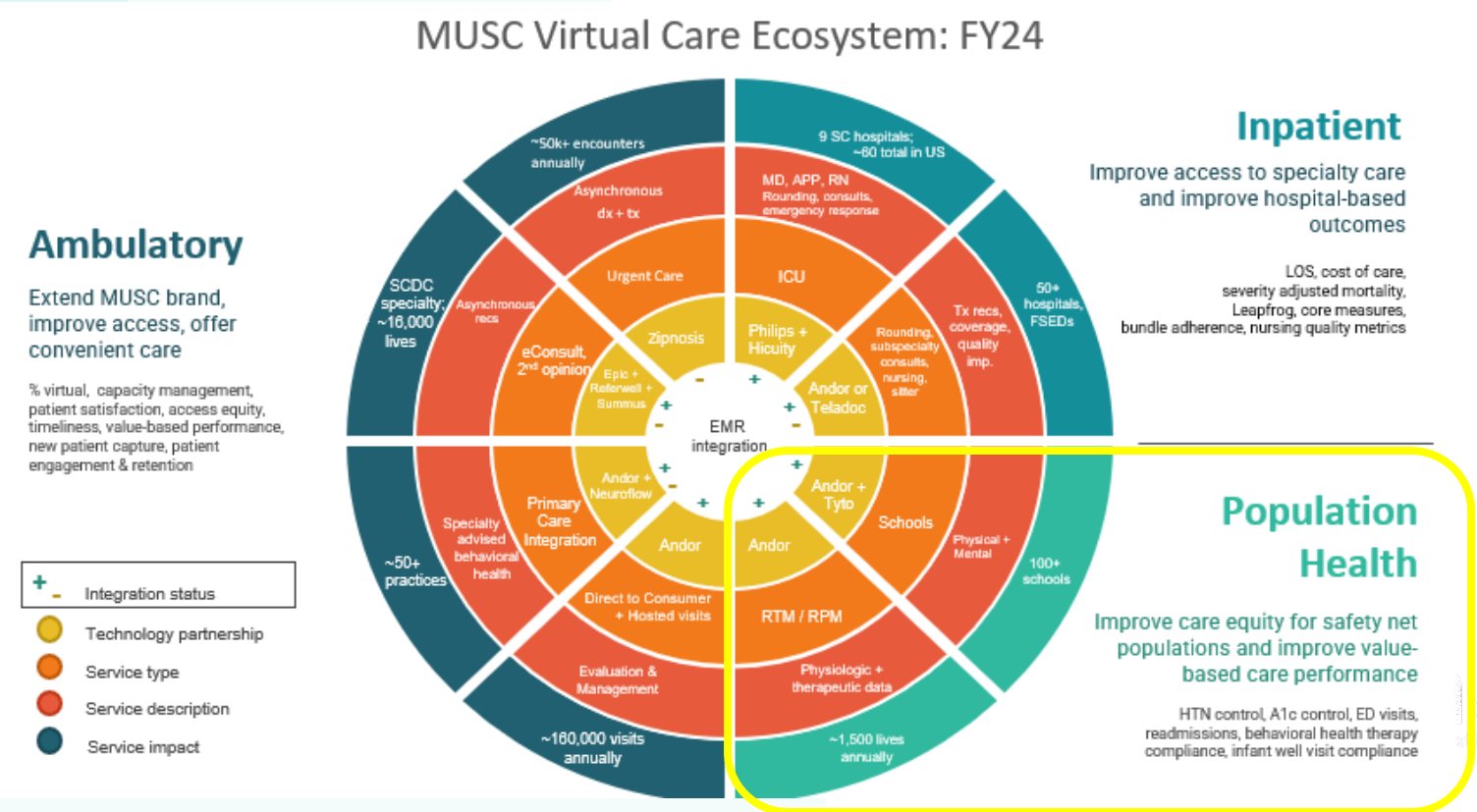


Source: World Health Organization. Social Determinants of Health

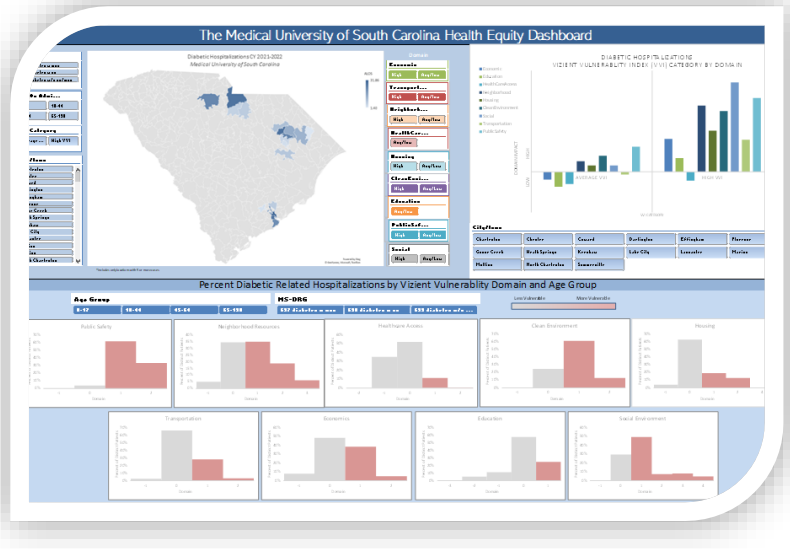
Future State

- What are South Carolina's unmet healthcare needs [SDOH]?
- How can we increase primary care capacity across our rural state?
- Which agencies, organizations, and/or specialist teams will take initiative to launch, recruit, sustain and grow essential programs impacting SDOH?

Ensuring communities have the right knowledge, at the right place, at the right time!



Dashboard for Health Equity Assessment



Objective: To better understand and address these disparities across the MUSC community so that we drive targeted interventions, such as, improving patient engagement and providing more comprehensive and coordinated care.

Overview

- Identify priority populations by MSDRGs
- Further stratify geocoded VVI vulnerability levels by sociodemographic characteristics in association with quality outcomes

Validation and Definitions

- Transparent definitions to understand the data

Impact:

- Develop proactive interventions for high-risk and underserved populations.
- Increase capture of SDOH risk variables for expected LOS /Mortality while advancing the use of coding to identify social risk factors and unmet needs.
- Drive innovation to address complex problems.
- Meet regulatory requirements and accreditation standards.

IMPLEMENTATION OF A PATIENT AND FAMILY ADVISORY COUNCIL

Franciscan Healthcare

Anne Timmerman, Director of Quality and Safety

Franciscan Healthcare

THE BEGINNING

- Identify a willing employee to lead the committee
- Use HRET/HIIN resources to educate ourselves about the importance of PFAC, membership, activities, policies, procedures and best practices. Educate Leadership team as to why we should start a PFAC
  - After obtaining Leadership support, began selecting possible PFAC members using suggestions from Providers and Leadership team.
    - Tried to obtain a diverse group of patients

Franciscan Healthcare

THE FIRST MEETING

- Invited potential members to an evening meeting and meal to learn about PFAC, what they do, and what our expectations would be.
- Then took them on a tour of the hospital asking 3 questions:
  - What do we do well?
  - What do we do not so well?
  - What services would you like to see Franciscan Healthcare provide that we are not currently?
- Reconvened as a group to discuss findings.

Franciscan Healthcare

SELECTION OF PFAC MEMBERS

- First meeting was our interview process.
  - Sister and I were able to determine who would be a good fit for this committee based on their comments and interactions.
    - Not only looking for positive feedback, but a respectful, useful way of sharing negative feedback or experiences.
  - Before members left, they were asked to complete a form that included their demographics, preferred way to contact them, if they would be interested in serving on the PFAC and which hospital committee they were most likely to be interested in serving on.

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SELECTION OF PFAC MEMBERS

- Contacted members following the meeting and formally asked them to join the PFAC.
  - HIPAA training provided for them at the next meeting
  - Spoke with hospital committee team leads and provided them with a PFAC member's contact information so they could invite them to their next committee meeting.

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HOW TO MAINTAIN PFAC

- Hold Quarterly meetings in addition to the committee meetings the PFAC members attend
  - Meetings include a feedback activity for example reviewing OB literature given to patients, new website, tour of the ED remodel.
  - PFAC members share what is happening on their hospital committees
  - Suggestions from walk-arounds/tours are placed in a stop light style excel spreadsheet and reviewed at the following meeting.
    - Three columns: Green- suggestions that were addressed by Franciscan Healthcare, Yellow- suggestion that is in progress, Red- suggestion that cannot be accomplished at this time and explain reason.

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LESSONS LEARNED

- Some committees take time to learn the language (QPI), consider at least a 2-year term for those members.
- Easy to find willing members over age 65- retired, difficult to find younger members with so many dual income households.
  - Evening meetings are not preferred by this group either as it is their family time.
  - Most members choose to come over their lunch period.

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LESSONS LEARNED

- Finding a meeting time that works for everyone is difficult, even if it is only quarterly.
- Not all staff are excited to have a PFAC member serve on their hospital committee.
- Some staff will need additional education about the purpose of a PFAC and Leadership support to make this happen. Letting members know their feedback is taken seriously and forwarded to leadership is a key to PFAC members feeling valued.
  - Our CEO attends the meetings

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BREAKTHROUGH

- Hired new employees with a Hispanic background
  - They shared ideas they had to make our organization more culturally friendly to the Hispanic population.
  - Sister Joy spoke to them about barriers
  - Hispanic employees reached out their family and friends and convinced them to attend a meeting.

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HISPANIC PFAC

- These meetings are held in the evenings to better accommodate their schedules.
- Meeting agenda is different, more educational based on what their needs are.
- Different group of people in attendance every time.

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STARTING…AGAIN

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Franciscan Healthcare

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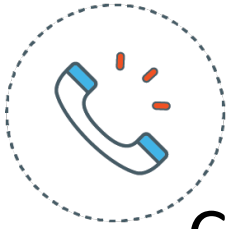
Discussion

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!



Join us for the next
Community of Practice Call on August 10, 2023
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.