ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health
A Division of the Georgia Department of Community Health

GA FLEX Health Equity Improvement Project Monthly Meeting

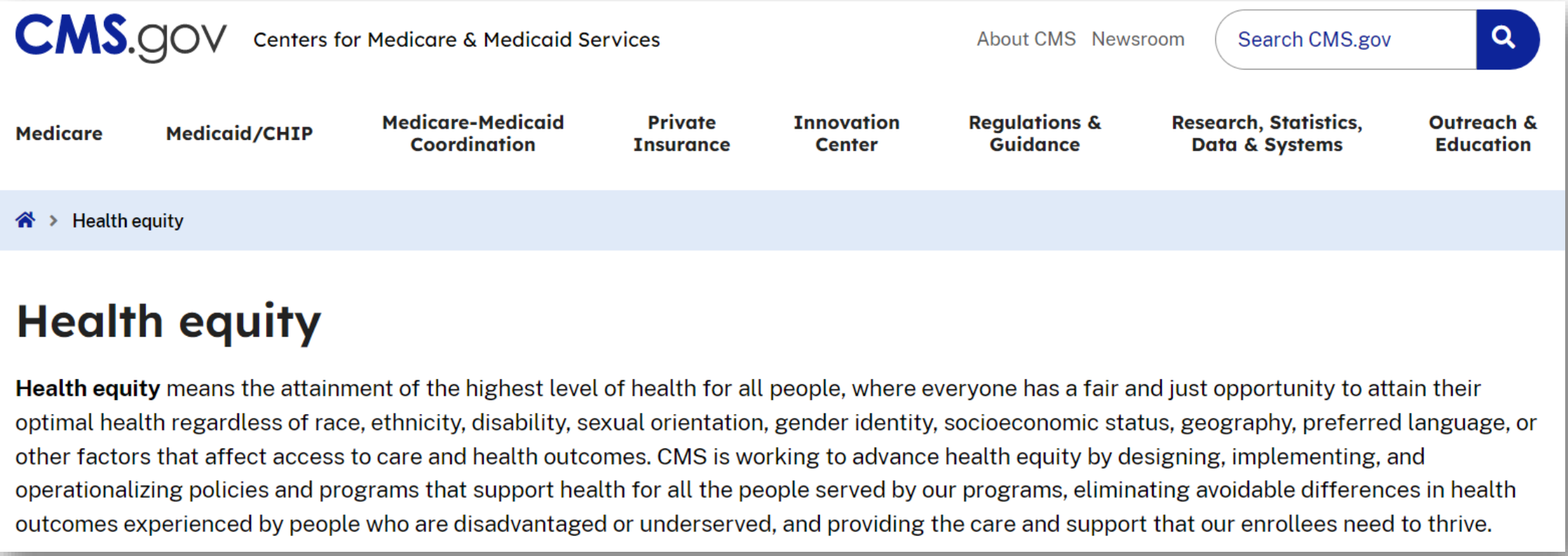
Rosa Abraha, MPH

February 28, 2023

Featured Speaker

Rosa Abraha, MPH
Health Equity Lead
Alliant Health Solutions
Rosa.Abraha@allianthealth.org

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 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.



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

REMINGTON REPORT

Hospitals: New SDOH Quality Measure: Starts 2023

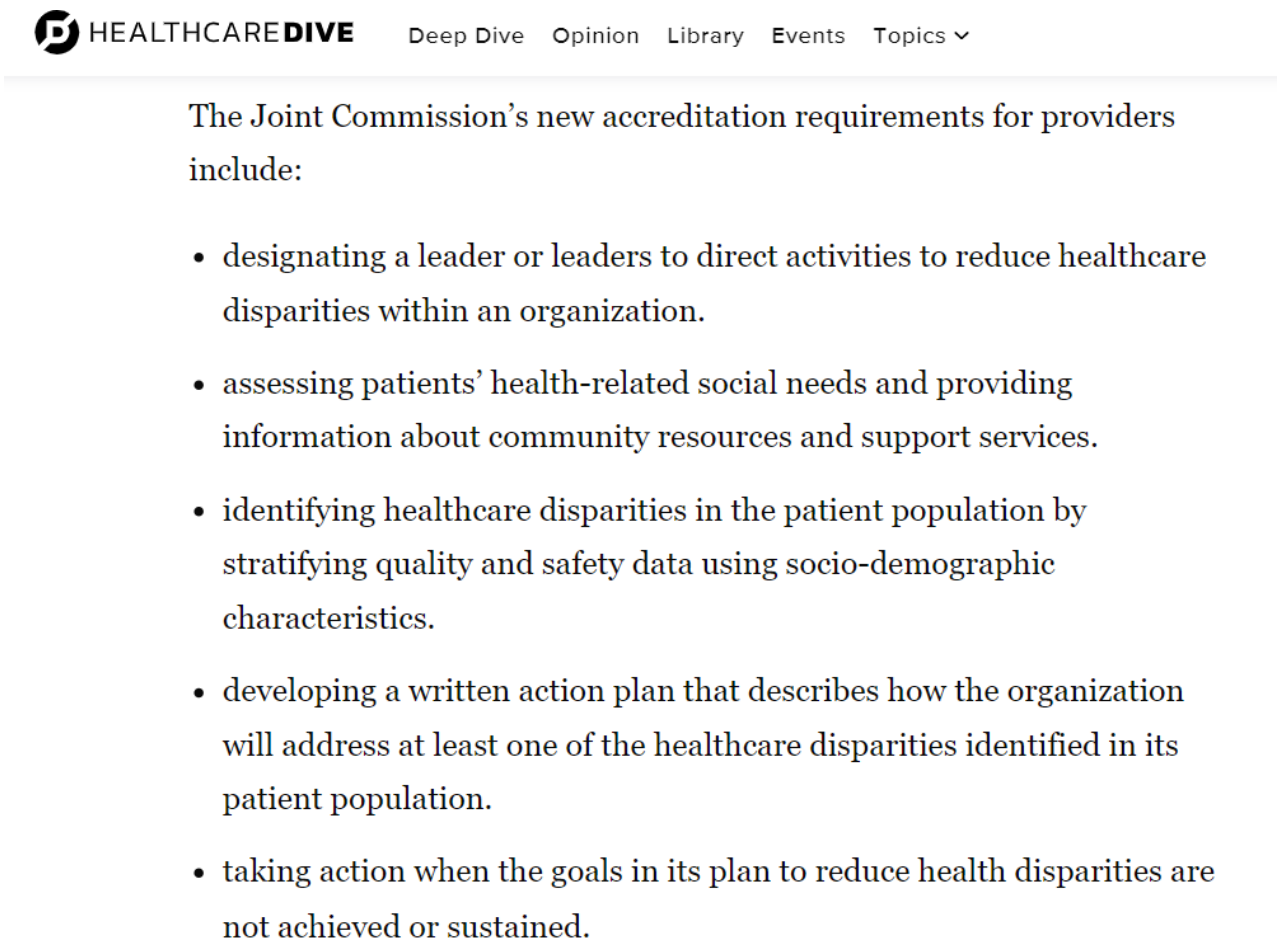
CMS's new SDOH quality measures was published in the 2023 Medicare Hospital Inpatient Prospective Payment System rule, released Aug. 1. Hospitals will be required to report what portion of their population is screened for various SDOH and how many screen positive in each category.

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

TJC Health Equity Standards 2023



HEALTHCAREDIVE Deep Dive Opinion Library Events Topics

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 healthcare and human services, critical access hospital and hospital accreditation programs

Link to Full R3 Report

Health Equity Elevated to National Patient Safety Goal

The Joint Commission | Our Websites | Search this site.

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 equity rather than reducing health care disparities, the intent behind the standard and associated elements of performance remains the same.

Source: Link

So far, we've received **13** total responses for the needs assessment.

If you haven't yet completed the survey, please do so.

All data is helpful as we plan activities to meet your needs.

**The following slides represent data from 13 respondents.*

Visit https://bit.ly/healthequityassessment2023

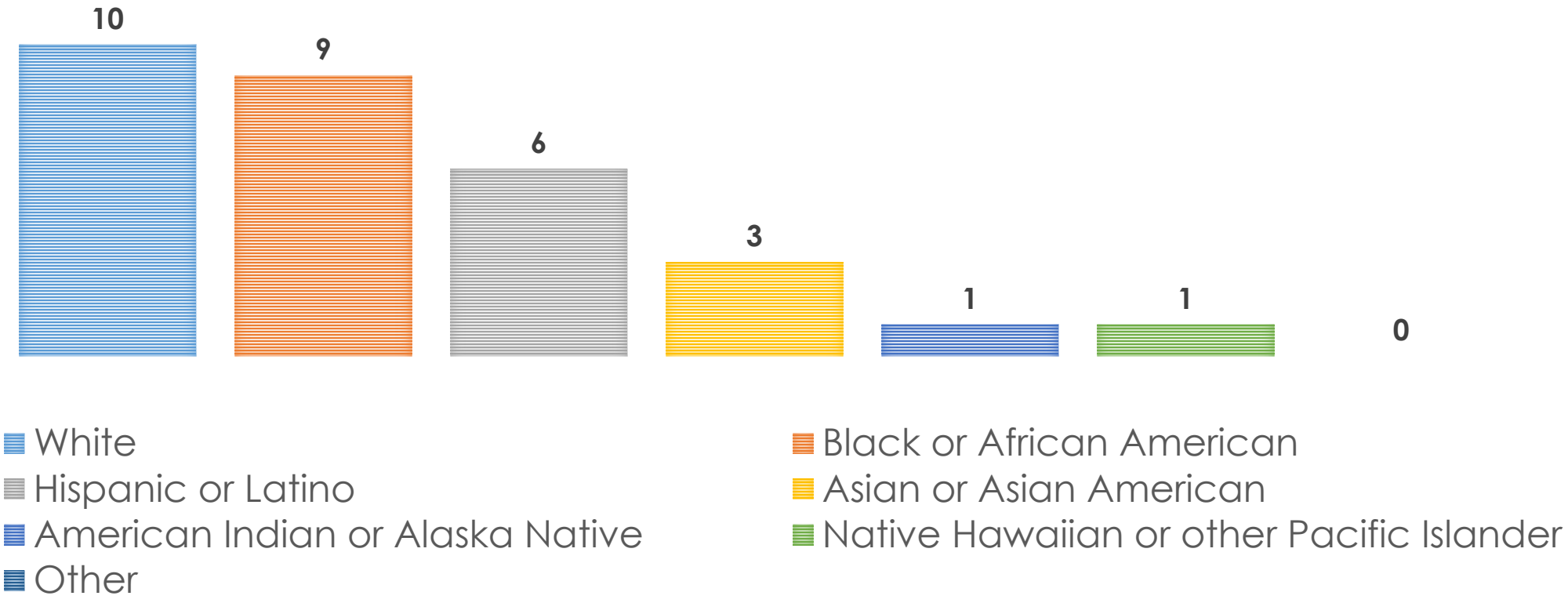
Survey Results: Demographic Information

- Survey participants represented hospitals with daily census of at least **10** patients (*10-15 pts = 46%, 15-20 pts = 38%, 20+ pts = 15%*).

- Only **3 out of 13** survey participants have a current staff member assigned to work on health equity at their hospital.

- **8** survey participants have a social worker on staff at their hospital. Of those, **7** are full-time employees.

Demographic Information



Health Equity Information

Social Needs Issues faced by patients (*most common to least common*)

1. Affordability of Medication
2. Health Literacy
3. Transportation
4. Food Insecurity
5. Homelessness

Other issues mentioned include social/family support, lack of financial resources, and mental health assistance

Current community partnerships with hospitals (*most common to least common*)

1. Language Line/Interpretation Service
2. Faith-based Organizations
3. Pharmacy
4. Van/Transportation service
5. National Organizations
6. Hospital Meds to Bed Program

No survey participants mentioned Food Bank/Food Pantry. Other partnerships include school-based programs and Family Connections, Inc.

Health Equity Information

- **Survey participants reported…**
  - Majority of their patients are enrolled in *Medicare*, followed by *Medicare Advantage* and *Medicaid*.
  - *EMR* and *Registration* are used the most to collect data on race, ethnicity, language or social needs, followed by *Admissions*.
  - Their hospitals need the most help with *Behavioral/Mental Health* followed by *Readmissions* and *Falls*.

Health Equity Information

Training and resources participants would like to receive to address health equity needs include:

- Better understanding of state/federal assistance programs
- How to more effectively track data and utilize z codes for billing
- Strategies to reach groups facing inequities

Step 1: Complete the Hospital Health Equity Pledge

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

- **Hospital leadership and staff can CLICK HERE or visit https://www.surveymonkey.com/r/HealthEquityPledge to commit to this Health Equity Project**

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

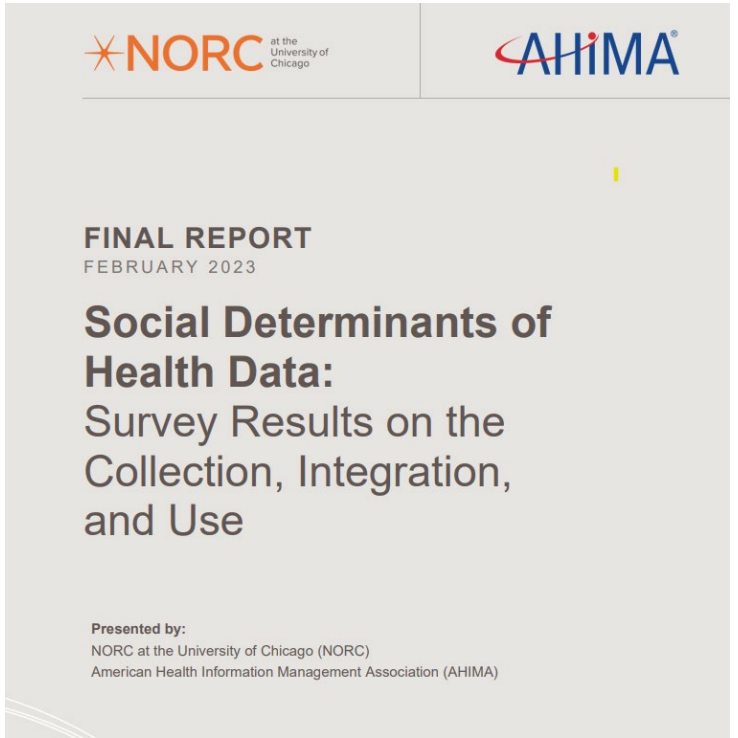
- **Cross-functional health equity teams depend on the size and staffing within your hospital,** but may include any of the following staff: quality lead, physicians, nurses, social workers, data analysts, language interpreters, registration office staff, physical therapy, home health, social services,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

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 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



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

The Joint Commission

Our Websites

Search this site.

Joint Statement on Digital Health Data Exchange of Social Determinants of Health Assessments

Monday, February 20 2023

Collecting and exchanging data on social determinants of health (SDOH) connects individuals, health care organizations and community-based organizations committed to achieving health equity. The National Committee for Quality Assurance, The Joint Commission and the National Quality Forum joined the *Sync for Social Needs* coalition with the aim of integrating digital SDOH data for standardized exchange across health records using a Fast Healthcare Interoperability Resources (FHIR®)-based approach. As leading quality organizations, we believe effective use of person-reported data to meet social needs is a health care quality priority, and that FHIR enables interoperable use of this information.

Collective urge the Office of the National Coordinator (ONC) to recommend FHIR US Core Observation Screening Assessment Profile for inclusion in the Standards Version Advancement Process.

Step 2A: If you are not already so, begin tracking SDOH within your hospitals starting this month.

1.10 - Social barriers *

Check All that Apply

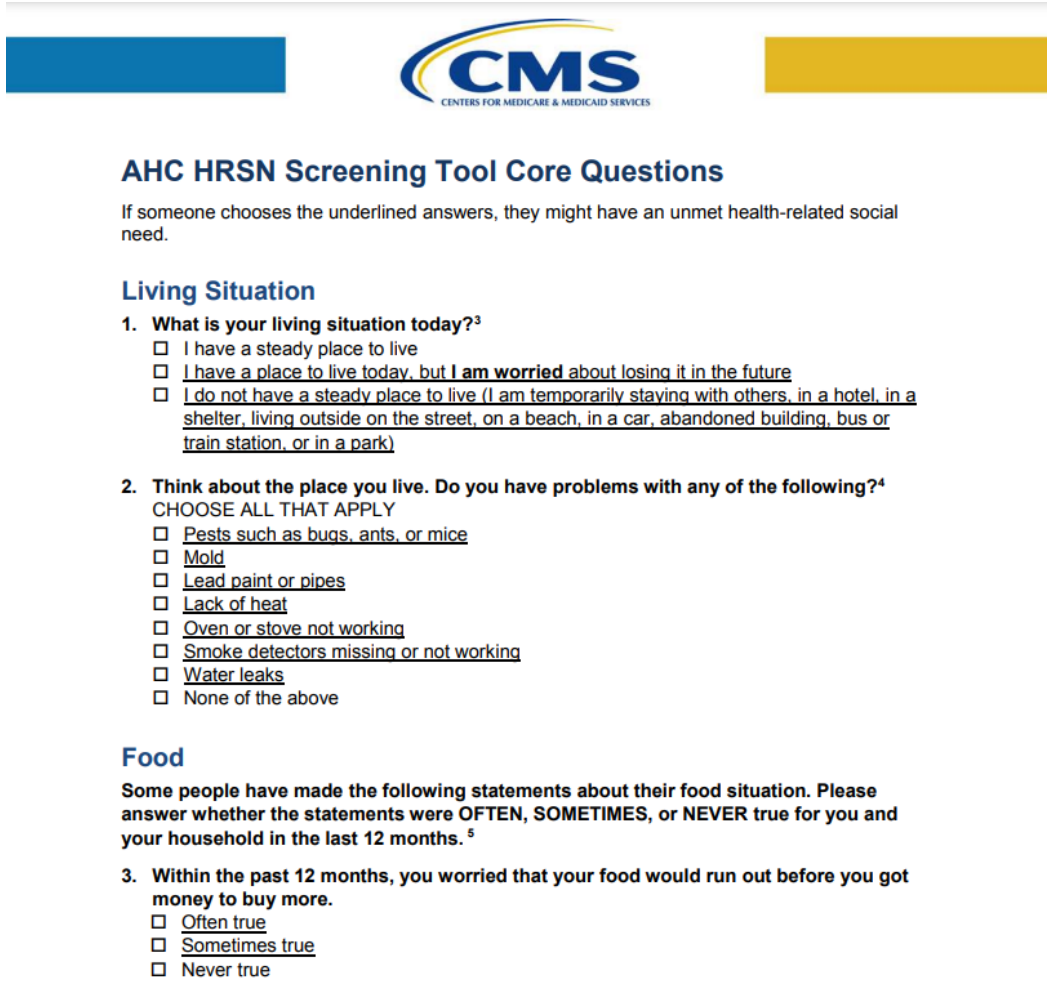
- ☐ Homelss
- ☐ Home is unsafe
- ☐ Unable to return to previous living situation
- ☐ Caregivers unable to meet the patient's needs
- ☐ Suspected neglect/abuse/financial exploitation by self or others
- ☐ Patient unable/unwilling to follow the treatment plan
- ☐ No insurance
- ☐ Inadequate insurance coverage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

This is the example from Baptist Medical Center South who tracked the following social barriers questions in their admissions and readmissions intake process over 4 months.

Tool #1 to Track SDOH Data in Hospitals

- The Health-Related Social Needs (HRSN) Screening Tool is a standard screening tool developed by the CMMI to determine if systematically screening for health-related social needs has an effect on total healthcare costs and health outcomes.

- The HRSN screening tool includes 10 items categorized into five (5) domains: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

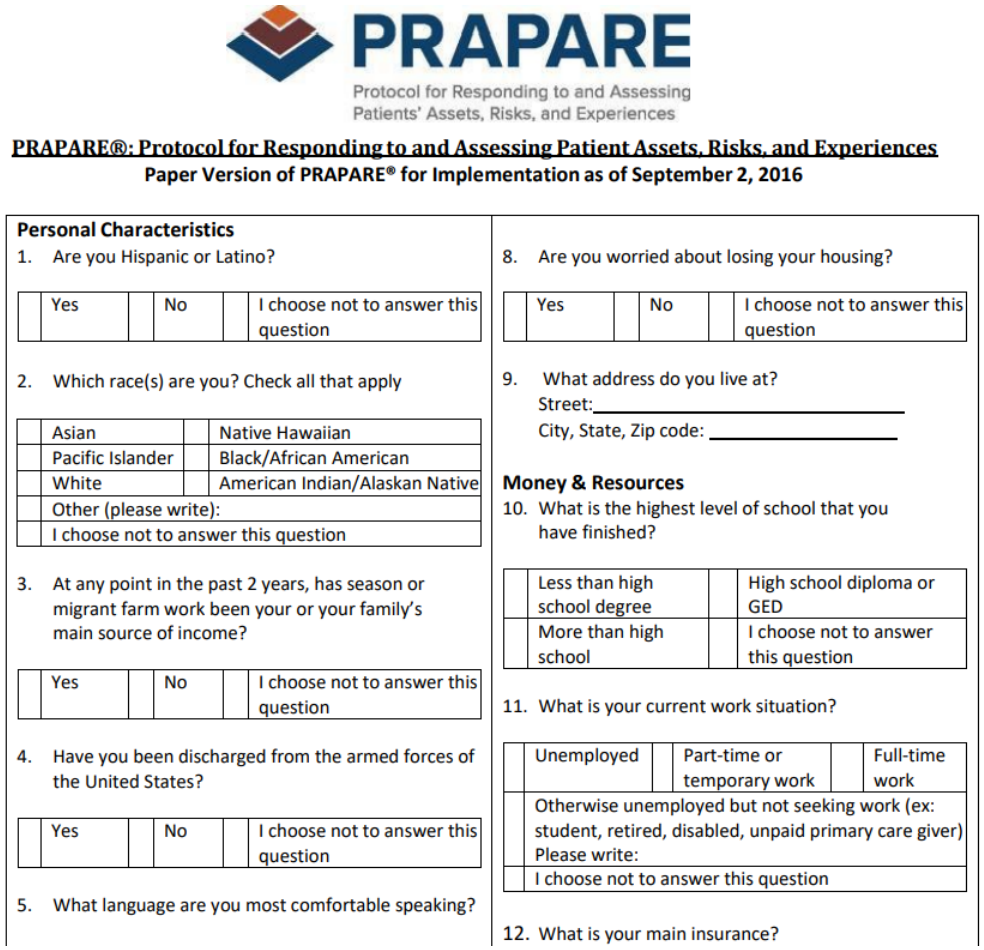
Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Tool #2 to Track SDOH Data in Hospitals

- PRAPARE Implementation and Action Toolkit compiles resources, best practices, and lessons learned from health centers focused on how to implement a SDOH data collection initiative.

- The toolkit is accompanied by an assessment tool. The tool was developed based on a review of existing SDOH that consists of a set of national core measures to help standardize data collection.



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

Tool #3 to Track SDOH Data in Hospitals

- The HealthBegins screening tool was developed to spark discussions among healthcare providers about incorporating SDOH data to better inform patient care.

- The tool consists of questions on topics such as education, employment, social support, immigration, and violence.

HealthBegins

Upstream Risks Screening Tool & Guide

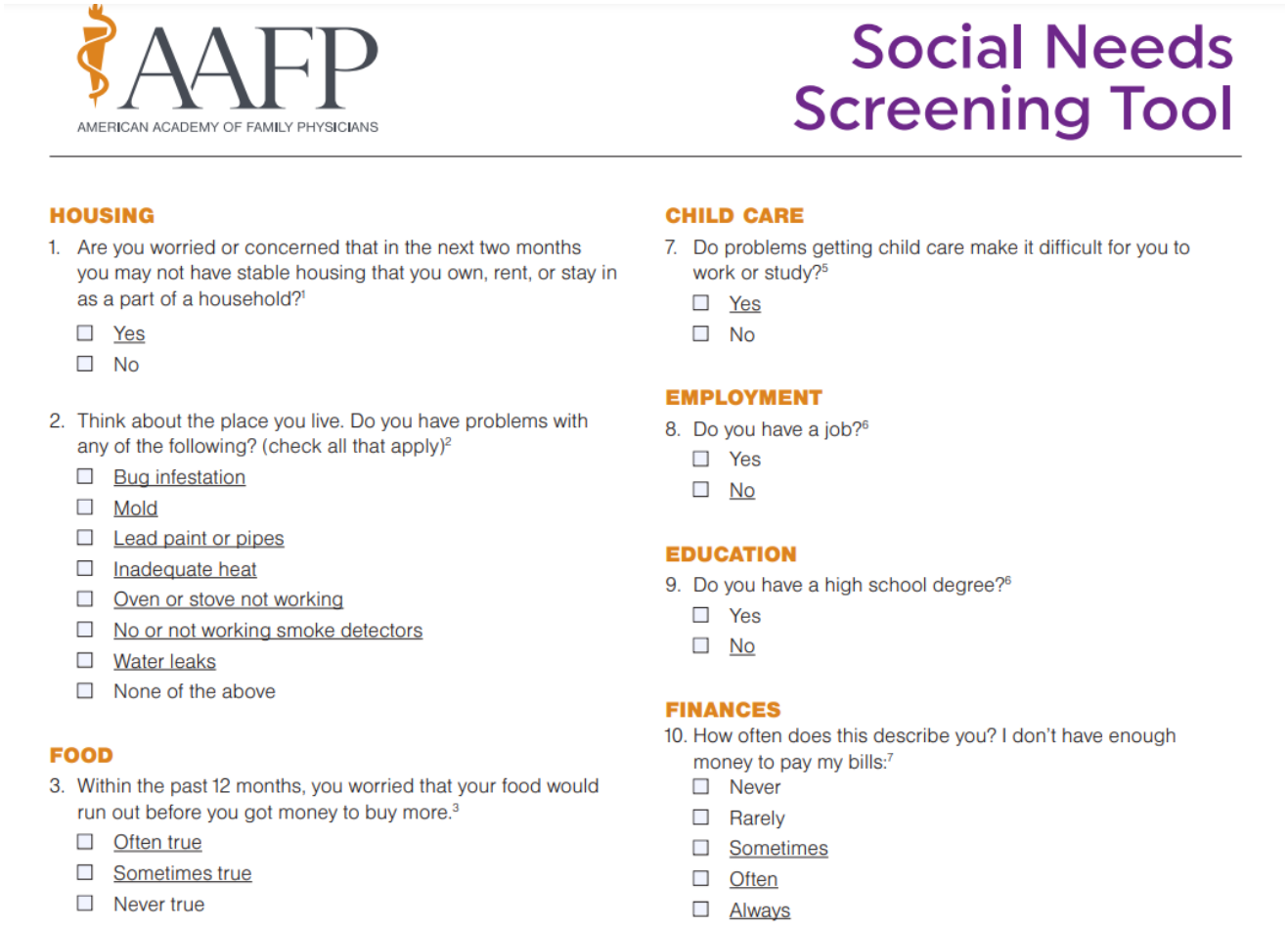
"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	Elementary School High School College Graduate / Professional School	+1 for "Elementary School "	
		1b. What is the highest degree you earned? Check one.	High school diploma GED Vocational certificate (post high school or GED) Associate's degree (junior college) Bachelor's degree Master's degree Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	YES NO Not applicable	+1 for YES	
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	Homemaker, not working outside the home Employed (or self-employed) full time Employed (or self-employed) part time Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	

Tool #4 to Track SDOH Data in Hospitals

- The American Academy of Family Physicians (AAFP) released a Social Needs Screening tool screens for five core health-related social needs.

- These include housing, food, transportation, utilities, and personal safety, using validated screening questions, as well as the additional needs of employment, education, child care, and financial strain.



AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

Step 2B: If your hospital is already tracking SDOH, please provide **at least 3 months of data on top 1-2 social needs** trends

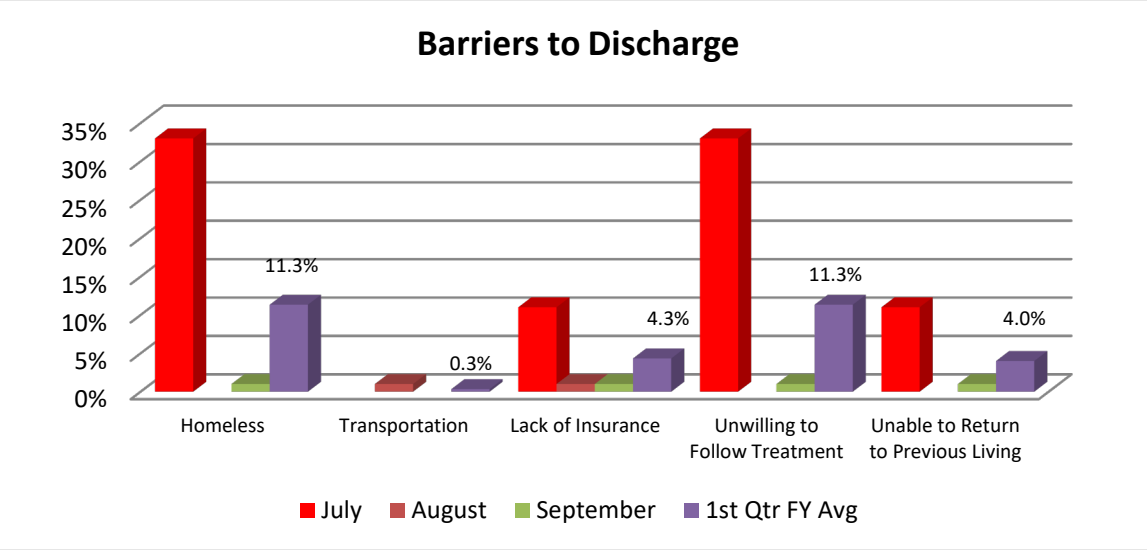
Analyze health inequity trends over a monthly and/or quarterly period to get a picture of the most pressing SDOH issue

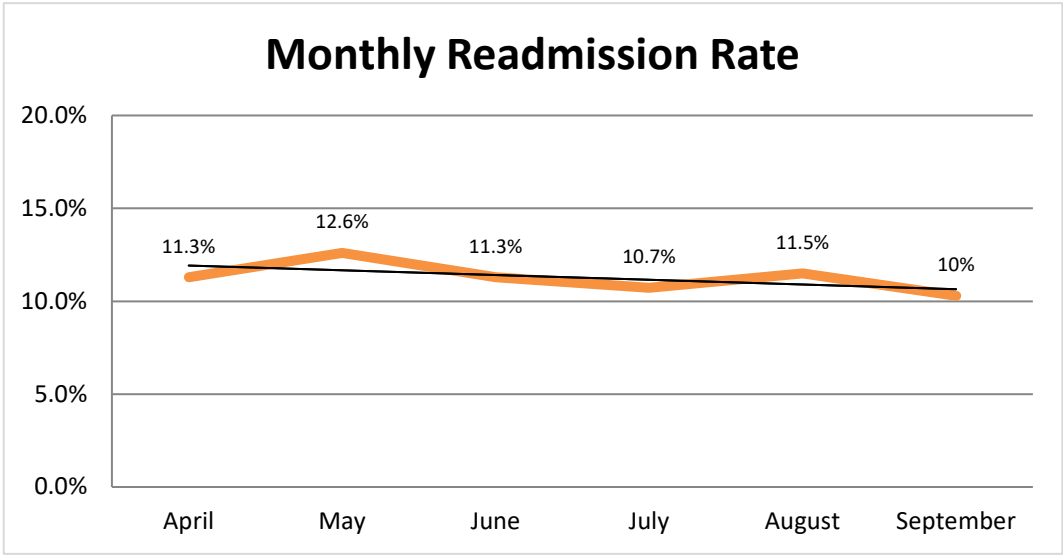
Ex. All patients 65+ who were readmitted to the ED this month broken out by:

- Zip code
- Race/ethnicity
- Gender
- Language Preference
- Insurance type (i.e. HMO)
- Social barrier (i.e. food insecurity, transportation, housing etc.)
- Diagnosis (i.e. heart failure, COPD)

Email your trends report by Friday, March 10, 2023 to:
rosa.abraha@allianthealth.org

Success Story: Baptist Medical Center South





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 1-2 social needs at a time and identify community partners to provide resources for those areas.

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

- **Don't forget to bill to the following Z-codes when conducting this work.** 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*).

Project Timeline and To-Do List

February 2023	❑ If you have not done so already, please complete health equity needs survey - https://bit.ly/healthequityassessment2023 ❑ **Complete hospital leadership health equity pledge by 3/15/2023 -** https://www.surveymonkey.com/r/HealthEquityPledge)
March 2023	❑ Review this PowerPoint (*slides 16-20*) and begin integrating and tracking SDOH questions within your EHR, excel or via paper-based tracking. This tracking will continue thru August. ❑ For those already tracking SDOH data, email rosa.abraha@allianthealth.org trend data for at least 3 months and use that data to identify 1-2 priority social needs ❑ Attend monthly meeting on Tuesday, March 28 from 10 -11a.m. EST
April 2023	❑ Continue monthly tracking on SDOH questions in admissions/intake process ❑ Develop and finalize health equity action plan based on identified 1-2 priority social needs ❑ Attend monthly meeting on Tuesday, April 25 from 10 -11 a.m. EST

Project Timeline and To-Do List

May/June 2023	❑ Continue monthly tracking on SDOH questions in admissions/intake process ❑ Develop existing and innovative clinical community partnerships to aid in addressing priority areas ❑ Embed referral of community resources into patient care planning and discharge planning ❑ Attend monthly meetings on Tuesday, May 23 and Tuesday, June 27 from 10 -11a.m. EST
July/August 2023	❑ Continue monthly tracking on SDOH questions in admissions/intake process ❑ Continue tracking and reporting progress on health equity data sources and progress on action steps ❑ Continue to share tools and resources to address disparities ❑ Complete and submit survey for final report ❑ Attend monthly meetings

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 for a discussion of the CMS Health Equity Framework and how key stakeholders are leveraging changes in data science and quality measurement 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)

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
Alliant Health Literacy 101 Bite Sized Learning Video

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!


Questions?
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State Office of Rural Health
A Division of the Georgia Department of Community Health