CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

# Making it Work: Practical Solutions to Health Equity for Hospitals (1)

Temi Olafunmiloye, Health Quality Innovators

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# Widening the Health Equity Lens with Supplemental Data

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# AGENDA (1)

- HQI and HQIC Overview
- Health Equity Focus and Analysis
- Supplemental Data: HQI's Quarterly Disparities Reports
- Hospitals in Action

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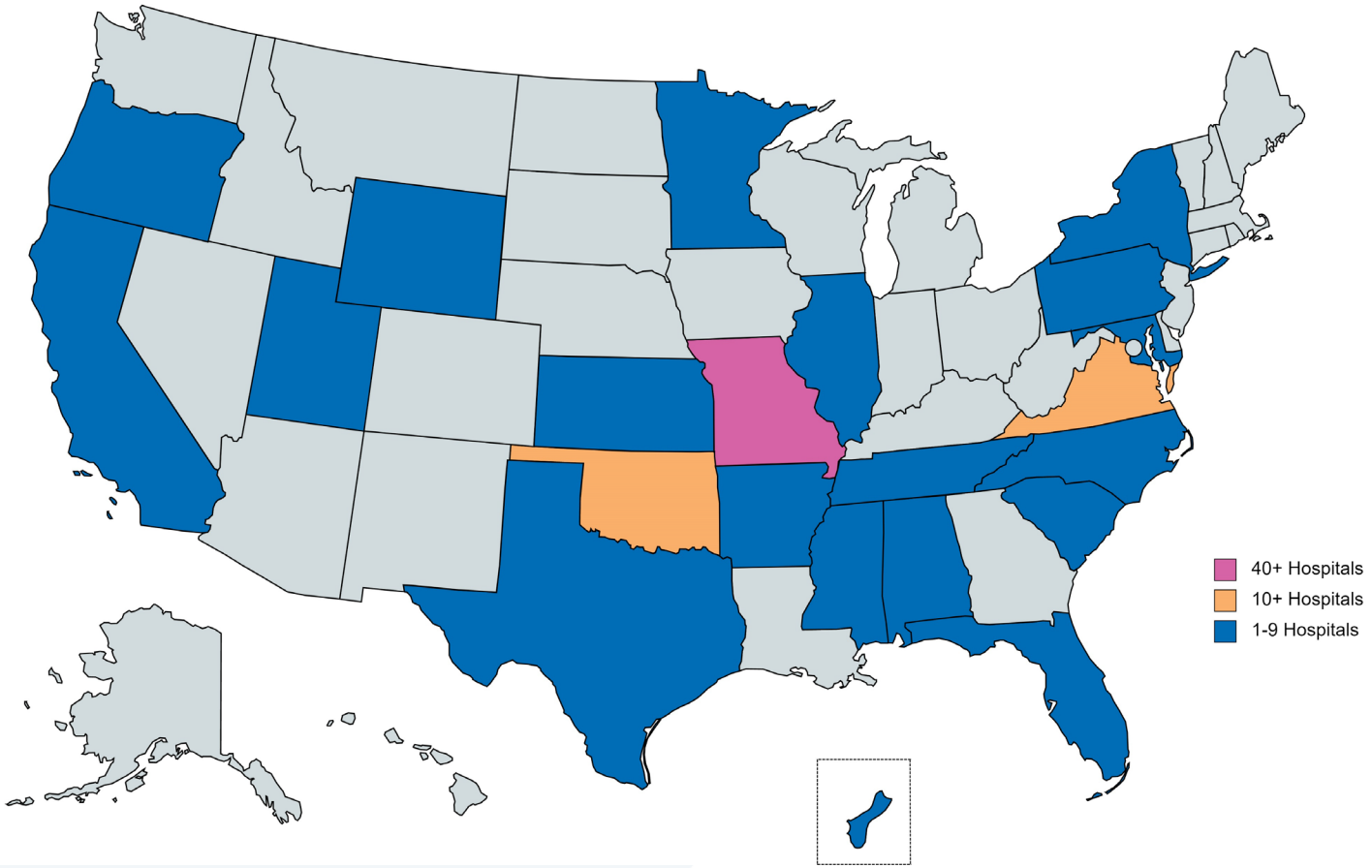
# About HQI




## Hospital Distribution

- 23 States
- 59 CAHs
- 60 Acute Care
- 71 Rural

# HQIC Priority Areas

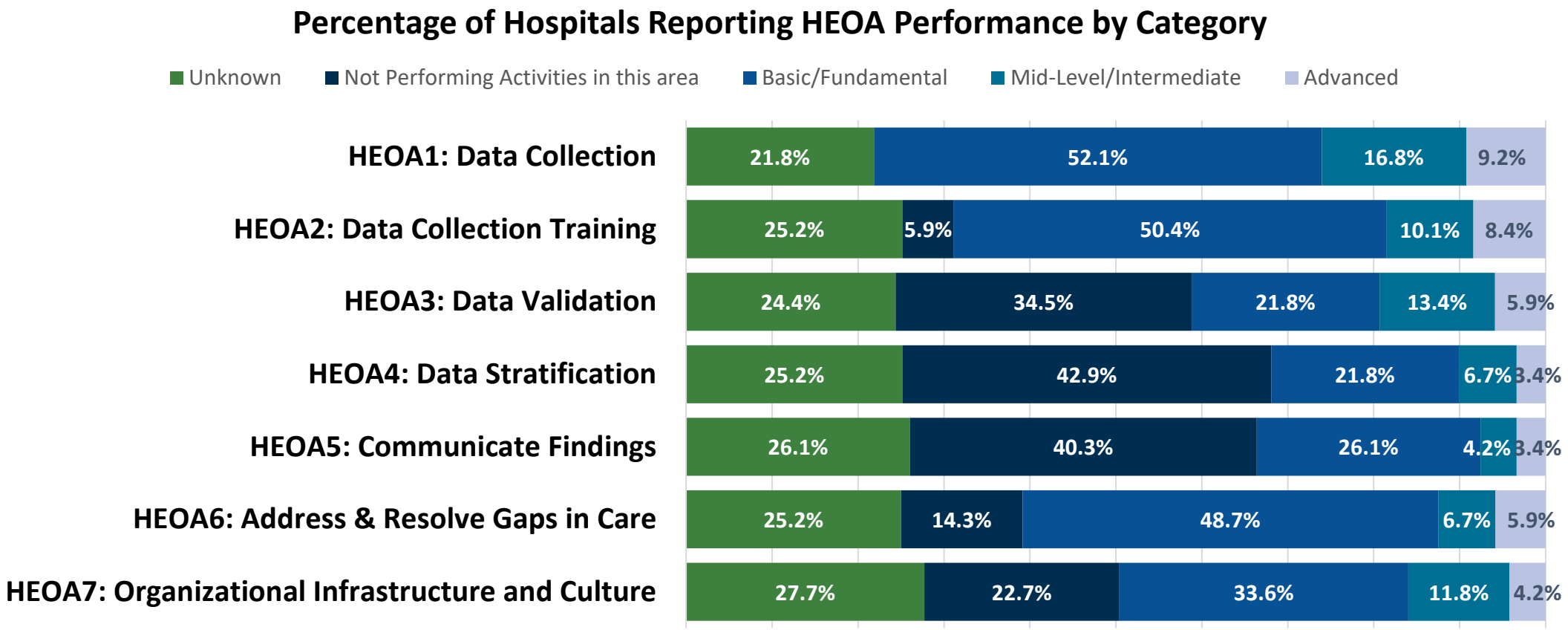
# Health Equity Focus (1 of 2)


- Assess and implement a way to systematically collect Race, Ethnicity, Age, and Language (REAL) data at the point of care
- Use the patient voice to highlight strategies to reduce health disparities

# Health Equity Focus (2 of 2)


- Launched Health Equity Organizational Assessment
  - Data Collection
  - Data Collection Training
  - Data Validation
  - Data Stratification
  - Communicate Findings
  - Address and Resolve Gaps in Care
- Produced Quarterly Disparities Reports

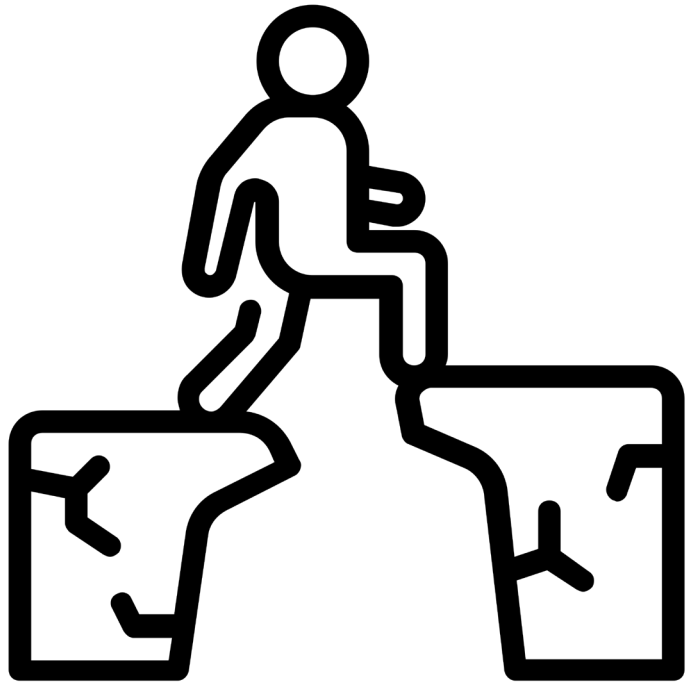
# Health Equity Organizational Analysis



# Addressing Disparities
## Challenges

HQIC hospitals lacked motivation to address equity due to being in non-diverse areas

Small hospitals with low harm rates saw few disparities



# Addressing Disparities
## Solutions

Broaden understanding of health equity

Reassess disparities data to highlight disproportionately represented populations

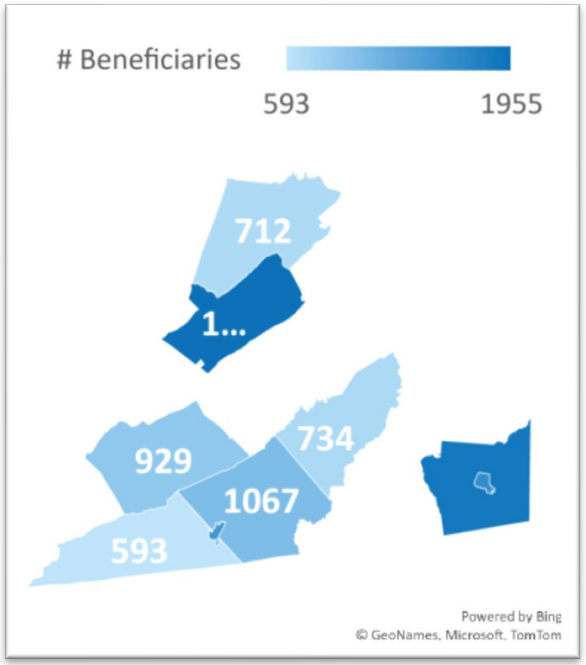
# Reconceptualizing Health Equity

# Hospital Catchment Area

Timeframe: Oct-21 - Sep-22

| | Your Hospital | | 2020 Medicare Geographic Variation | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Gender | | Race/Ethnicity | | | |
| County, State | # Bene-ficiaries | % Bene-ficiaries | Male | Female | White | Black | Hispanic | Other |
| GILES, VA | 1955 | 13.4% | 45.4% | 54.6% | - | - | - | - |
| HENRY, VA | 1852 | 12.7% | 44.3% | 55.7% | 82.9% | 15.3% | 0.5% | 1.3% |
| MARTINSVILLE CITY, VA | 1626 | 11.2% | 42.7% | 57.3% | 63.7% | 33.3% | 1.0% | 2.0% |
| FRANKLIN, VA | 1509 | 10.4% | 47.4% | 52.6% | 92.2% | 4.8% | 0.5% | 2.5% |
| GALAX CITY, VA | 1498 | 10.3% | 42.8% | 57.2% | 92.7% | 4.6% | 1.3% | 1.5% |
| CARROLL, VA | 1067 | 7.3% | 46.6% | 53.4% | 97.9% | 0.3% | 0.2% | 1.5% |
| WYTHE, VA | 929 | 6.4% | 45.5% | 54.5% | 95.8% | 2.1% | 0.3% | 1.9% |
| FLOYD, VA | 734 | 5.0% | 46.4% | 53.6% | 95.0% | 1.8% | 0.4% | 2.9% |
| MONROE, WV | 712 | 4.9% | 48.7% | 51.3% | - | - | - | - |
| GRAYSON, VA | 593 | 4.1% | 47.2% | 52.8% | - | - | - | - |

| | Gender | | Race/Ethnicity | | | |
|---|---|---|---|---|---|---|
| | Male | Female | White | Black | Hispanic | Other |
| **Estimated Distribution for Your Hospital's Catchment Area*** | **45.3%** | **54.7%** | **86.6%** | **10.9%** | **0.7%** | **1.9%** |



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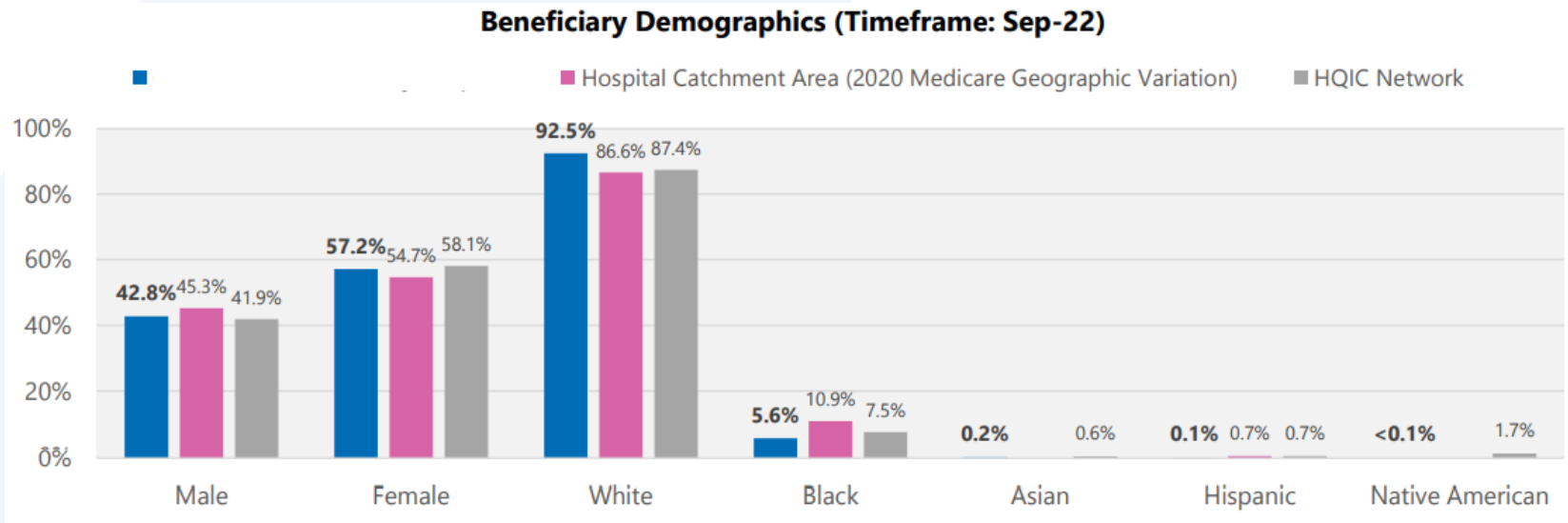
# Beneficiary Demographics

| Demographic Category | All | Gender | | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Male | Female | White | Black | Asian | Hispanic | Native American |
| # of Beneficiaries served as inpatient or outpatient | 14,518 | 6,215 | 8,303 | 13,422 | 809 | 26 | 12 | <10 |
| **% of Beneficiaries served** | - | **42.8%** | **57.2%** | **92.5%** | **5.6%** | **0.2%** | **0.1%** | **<0.1%** |
| **% of Beneficiaries in Hospital Catchment Area** | - | **45.3%** | **54.7%** | **86.6%** | **10.9%** | - | **0.7%** | - |
| **HQIC Network** | | **41.9%** | **58.1%** | **87.4%** | **7.5%** | **0.6%** | **0.7%** | **1.7%** |



# Patient Distribution Across Each Harm Area

| Demographic Category | All | Gender | | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Male | Female | White | Black | Asian | Hispanic | Native American |
| # of Beneficiaries served as inpatient or outpatient | 11,827 | 4,869 | 6,958 | 9,548 | 1,976 | 25 | 17 | <10 |
| **% of Beneficiaries served** | - | **41.2%** | **58.8%** | **80.7%** | **16.7%** | **0.2%** | **0.1%** | **<0.1%** |
| **% of Beneficiaries in Hospital Catchment Area** | - | **46.4%** | **53.6%** | **82.4%** | **14.2%** | - | **0.8%** | - |
| **HQIC Network** | | **41.9%** | **58.1%** | **87.4%** | **7.5%** | **0.6%** | **0.7%** | **1.7%** |

| HQIC Measure | All Harms (n) | Gender | | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Male | Female | White | Black | Asian | Hispanic | Native American |
| **30-Day Readmissions** | 247 | 51% | 49% | 74% | 25% | 0% | 0% | 0% |
| **30-Day Sepsis Mortality** | 91 | 53% | 47% | 66% | 32% | 0% | 0% | 0% |
| **Pressure Ulcers** | <10 | | | | | | | |
| **Perioperative PE/DVT** | <10 | | | | | | | |
| **Postoperative Sepsis** | 0 | | | | | | | |
| **Fall-related Injuries** | <10 | | | | | | | |
| **Anticoagulant ADEs** | <10 | | | | | | | |
| **Hypoglycemic ADEs** | 0 | | | | | | | |
| **Opioid ADEs** | <10 | | | | | | | |

Black patients comprised 16.7% of beneficiaries served, yet are **25% of readmissions** and **32% of 30-day sepsis mortality**

# Social Vulnerability Index (SVI)

- **Social Vulnerability**: External factors that can negatively impact a community's health

**Overall Vulnerability**

| Socioeconomic Status | Household Composition & Disability | Minority Status & Language | Housing & Transportation |
|---|---|---|---|
| • Below poverty<br>• Unemployed<br>• Income<br>• No high school diploma | • Aged 65 or older<br>• Aged 17 or younger<br>• Civilian with a disability<br>• Single-parent household | • Minority<br>• Speak English "less than well" | • Multi-unit structures<br>• Mobile homes<br>• Crowding<br>• No vehicle<br>• Group quarters |

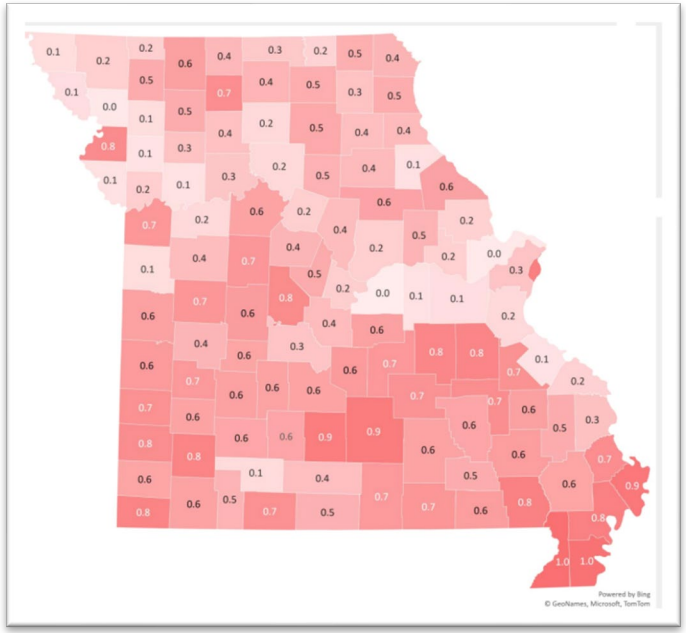
**Scoring**

| Very Low (0.0-0.19) | Low (0.20-0.39) | Moderate (0.40-0.59) | High (0.60-0.79) | Very High (0.80-1.0) |
|---|---|---|---|---|

# Using SVI Data

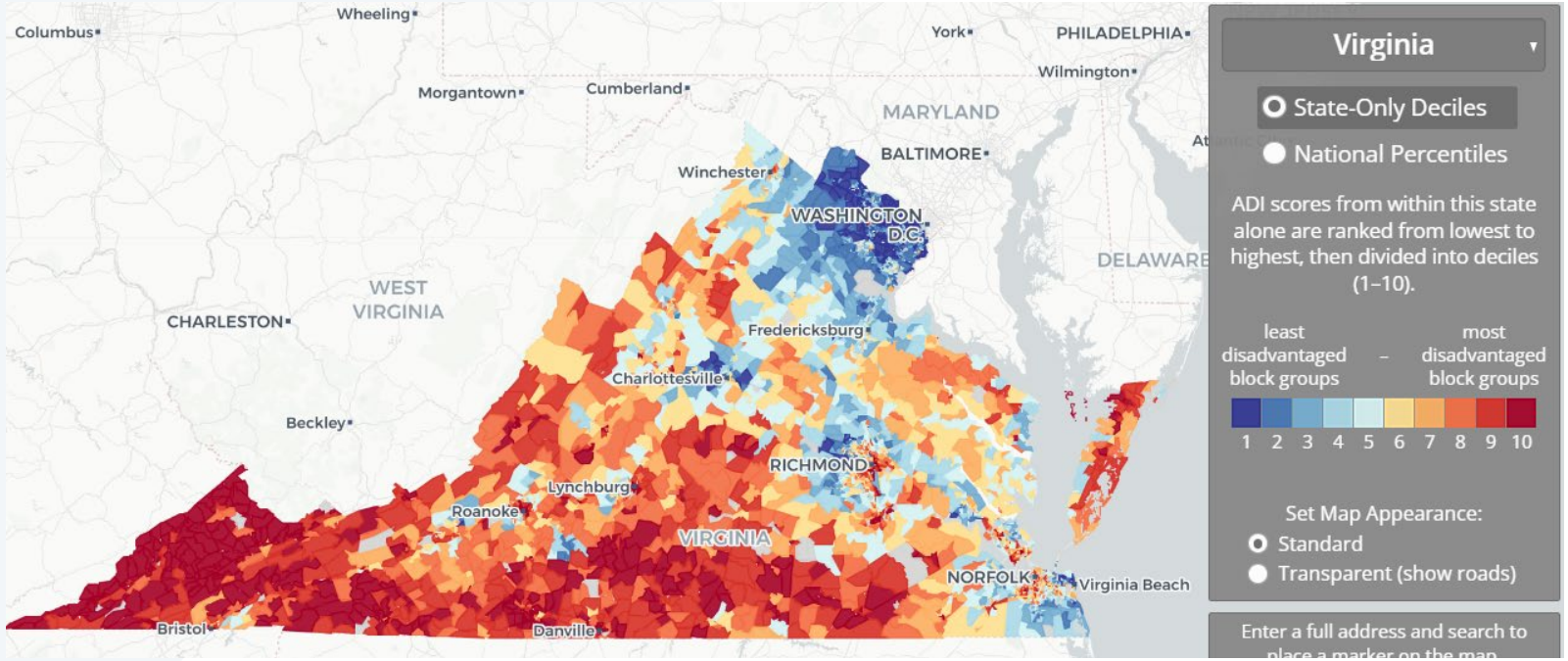
| | Your Hospital | | Social Vulnerability Indices (SVI) | | | | |
|---|---|---|---|---|---|---|---|
| County, State | # Bene-ficiaries | % Bene-ficiaries | Socio-economic | Household Composition & Disability | Minority Status & Language | Housing Type & Trans-portation | Overall Ranking |
| BARTON, MO | 1067 | 66.6% | 0.9036 | 0.8052 | 0.2508 | 0.3431 | 0.7279 |
| VERNON, MO | 188 | 11.7% | 0.6496 | 0.7699 | 0.1655 | 0.6127 | 0.6400 |
| JASPER, MO | 118 | 7.4% | 0.7540 | 0.7788 | 0.4854 | 0.6340 | 0.7514 |
| DADE, MO | 88 | 5.5% | 0.8342 | 0.2072 | 0.1779 | 0.5621 | 0.5713 |
| CEDAR, MO | 34 | 2.1% | 0.7613 | 0.6416 | 0.1181 | 0.6391 | 0.6553 |
| CRAWFORD, KS | 15 | 0.9% | 0.7237 | 0.5124 | 0.4300 | 0.9290 | 0.7683 |

| | Social Vulnerability Indices (SVI) | | | | |
|---|---|---|---|---|---|
| | Socio-economic | Household Composition & Disability | Minority Status & Language | Housing Type & Trans-portation | Overall Ranking |
| **Estimated SVI for Your Hospital's Catchment Area** | **0.8512** | **0.7573** | **0.2531** | **0.4246** | **0.7084** |



# Area Deprivation Index (ADI)

- Measures neighborhood disadvantage by ranking regions by socioeconomic disadvantage
- Incorporates factors such as income, education, employment, and housing quality

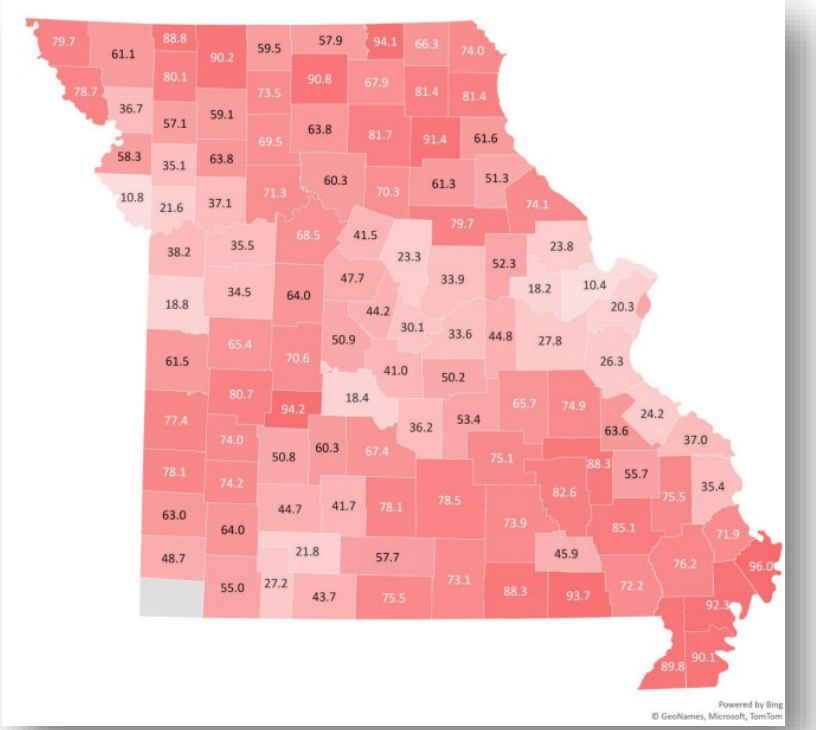



Source: Neighborhood Atlas®

# Using ADI Data

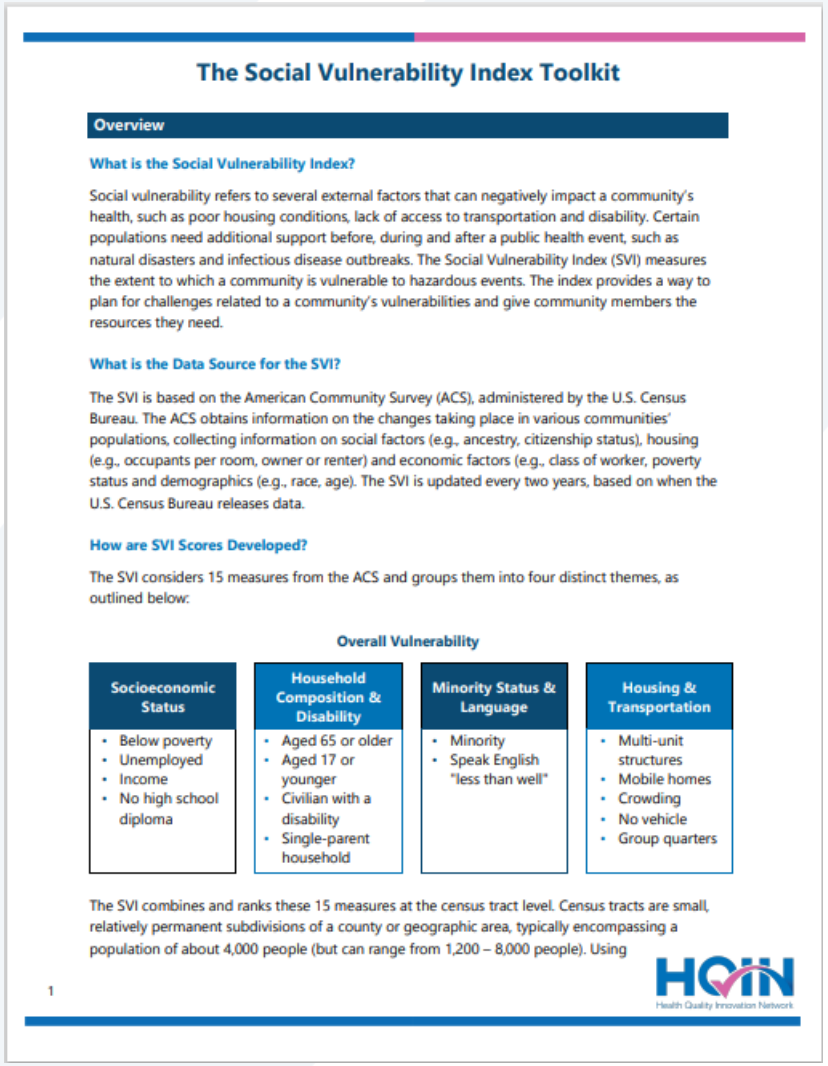
| | Your Hospital | | Area Deprivation Index (ADI) |
|---|---|---|---|
| County, State | # Bene-ficiaries | % Bene-ficiaries | |
| BARTON, MO | 1067 | 66.6% | 78.1 |
| VERNON, MO | 188 | 11.7% | 77.4 |
| JASPER, MO | 118 | 7.4% | 63.0 |
| DADE, MO | 88 | 5.5% | 74.2 |
| CEDAR, MO | 34 | 2.1% | 74.0 |
| CRAWFORD, KS | 15 | 0.9% | 81.3 |

| | Area Deprivation Index (ADI) |
|---|---|
| **Estimated ADI for Your Hospital's Catchment Area** | **76.5** |



# Making Data Actionable

## *HQIN Resource Center*



### The Social Vulnerability Index Toolkit

**Overview**

**What is the Social Vulnerability Index?**

Social vulnerability refers to several external factors that can negatively impact a community's health, such as poor housing conditions, lack of access to transportation and disability. Certain populations need additional support before, during and after a public health event, such as natural disasters and infectious disease outbreaks. The Social Vulnerability Index (SVI) measures the extent to which a community is vulnerable to hazardous events. The index provides a way to plan for challenges related to a community's vulnerabilities and give community members the resources they need.

**What is the Data Source for the SVI?**

The SVI is based on the American Community Survey (ACS), administered by the U.S. Census Bureau. The ACS obtains information on the changes taking place in various communities' populations, collecting information on social factors (e.g., ancestry, citizenship status), housing (e.g., occupants per room, owner or renter) and economic factors (e.g., class of worker, poverty status and demographics (e.g., race, age). The SVI is updated every two years, based on when the U.S. Census Bureau releases data.

**How are SVI Scores Developed?**

The SVI considers 15 measures from the ACS and groups them into four distinct themes, as outlined below:

**Overall Vulnerability**

| Socioeconomic Status | Household Composition & Disability | Minority Status & Language | Housing & Transportation |
|---|---|---|---|
| • Below poverty<br>• Unemployed<br>• Income<br>• No high school diploma | • Aged 65 or older<br>• Aged 17 or younger<br>• Civilian with a disability<br>• Single-parent household | • Minority<br>• Speak English "less than well" | • Multi-unit structures<br>• Mobile homes<br>• Crowding<br>• No vehicle<br>• Group quarters |

The SVI combines and ranks these 15 measures at the census tract level. Census tracts are small, relatively permanent subdivisions of a county or geographic area, typically encompassing a population of about 4,000 people (but can range from 1,200 – 8,000 people). Using

1


Part 4 - Using Z codes to Capture Social Determinants of Health

# Hospitals In Action

## Example: Rural Critical Access Hospital

### Hospital Profile

| Location | Western South Carolina |
|---|---|
| Hospital Type | Rural Critical Access Hospital |
| Number of Beds | 25 |
| Has an Emergency Department (ED)? | Yes |
| Has an Intensive Care Unit (ICU)? | Yes |

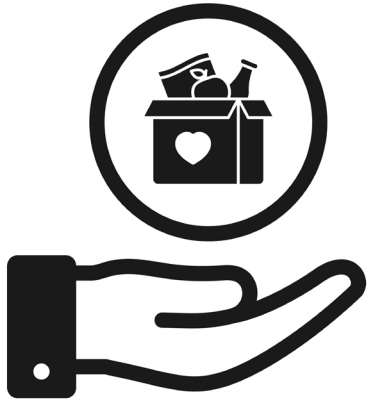
# Hospitals In Action
## Z Codes

Implemented Z codes in physician practices → Utilized 10-question questionnaire to screen for social determinants → Determined **transportation, mental health, and food insecurity** as needs

| | Social Vulnerability Indices (SVI) | | | | |
|---|---|---|---|---|---|
| | Socio-economic | Household Composition & Disability | Minority Status & Language | Housing Type & Trans-portation | Overall Ranking |
| **Estimated SVI for Your Hospital's Catchment Area** | **0.7686** | **0.6425** | **0.7202** | **0.8198** | **0.8033** |

# Hospitals In Action
## Results

- Awarded $100,00 grant to expand transportation services to the rural community
- Awarded grant to provide free mental health services
- Launched monthly drive-through food box distribution



# Hospitals In Action

## Example: Urban Targeted, Acute Care

### Hospital Profile

| Location | Southeast Missouri |
|---|---|
| Hospital Type | Urban Targeted, Acute Care |
| Number of Beds | 188 |
| Has an Emergency Department (ED)? | Yes |
| Has an Intensive Care Unit (ICU)? | Yes |

# Hospitals In Action
## Needs Assessment

- Identified **food insecurity** as a health-related social need through their Community Health Needs Assessment

| | Social Vulnerability Indices (SVI) | | | | |
|---|---|---|---|---|---|
| | Socio-economic | Household Composition & Disability | Minority Status & Language | Housing Type & Trans-portation | Overall Ranking |
| **Estimated SVI for Your Hospital's Catchment Area** | **0.7940** | **0.8157** | **0.5065** | **0.6183** | **0.7815** |

# Hospitals In Action
## Food Bank Initiative

Screened patients using a 4-question screening tool → Patients with food insecurity are referred to the pantry at discharge → Patients receive follow-up calls to connect them to social services (e.g. SNAP)

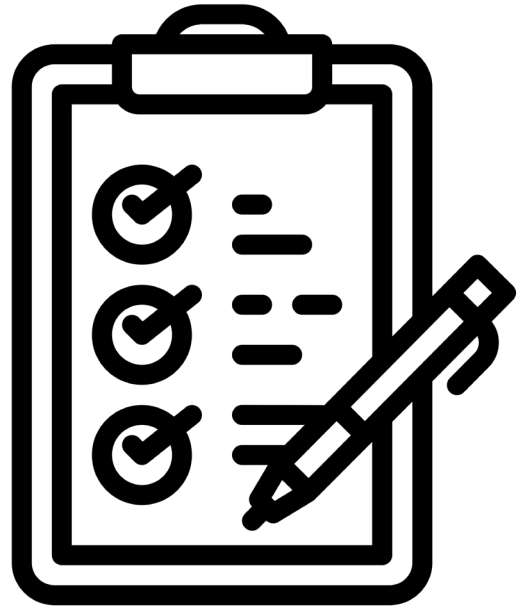
**Goal:** Reduce the # of patients identified for food insecurity by 10% within the next 3 years

**Measures:**

- # of patients with food insecurity
- # of patients that accept the referral to the food bank
- Tracking food that has been distributed to acute inpatients upon discharge

# Takeaways

- Broadening our understanding of health equity makes it more accessible and achievable
- Supplemental data provides context and depth to disparities
- Start small and scale upwards



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# Stay Connected

## Connect With Us For Up-To-Date Information

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# Making it Work: Practical Solutions to Health Equity for Hospitals (2)

Bruce Spurlock, MD





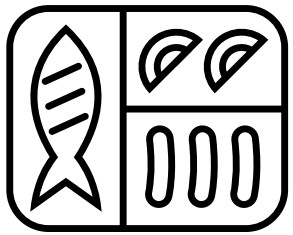


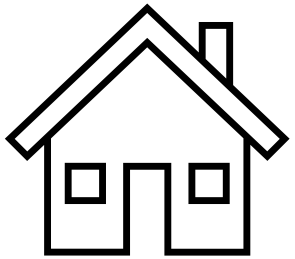


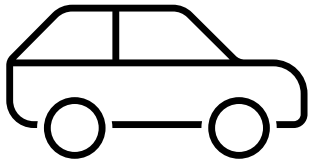



# AGENDA (2)

- Background and challenges
- Hospital readiness
- Your why
- Actions and resources







# CMS Final Rule: Screening for 5 Social Drivers of Health / Health Related Social Needs (HRSN)

Food Insecurity
Housing Instability
Transportation Needs
Utility Difficulties
Interpersonal Safety

Source: 2022-16472.pdf (federalregister.gov), page 1220

# What We've Learned

This is new and complex

Engage community members, patients, and families in every step

Start small

Identify and align with other resources

Screening won't solve all challenges, but it will shine a light on needs

Patients want to know why you're asking

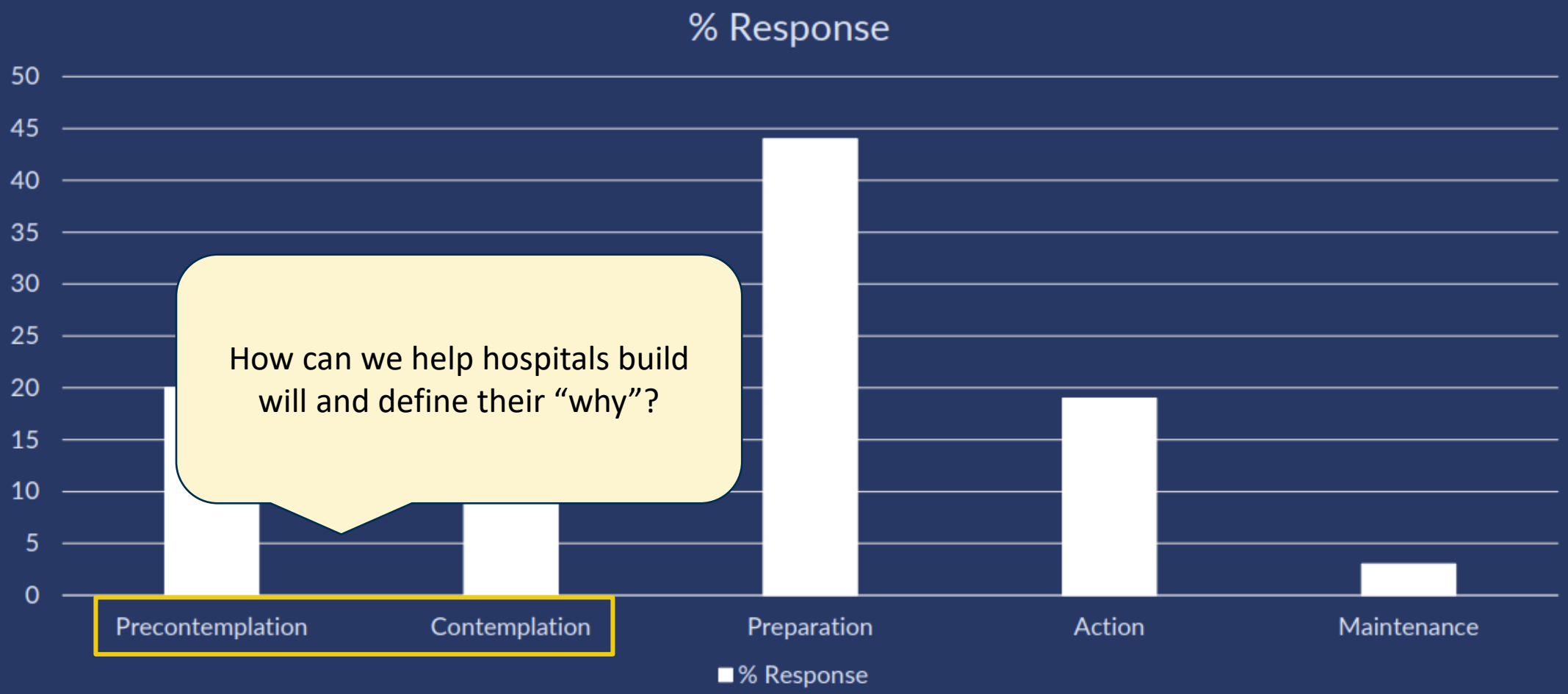
**Continually Evaluate and Streamline Screening Systems, Accuracy, and Completeness**

# Hospitals face common challenges

- Staff availability and systems to collect, analyze, and use data
  - The right people – local context is important
  - The right training – scripting and sensitivity with patients
  - The right tools – EHR, tablet, paper tool, post-discharge call or all of the above
- Availability of community resources and capacity to support patients who are referred
  - Tracking databases are emerging
- Data collection & documentation… determining a disparity is complex

Source: 10/27/2022 Cynosure Health webinar chat question: What is the greatest challenge you face in setting up SDOH screening?

# Most hospitals are in the planning phases




Source: 10/27/2022 Poll Question: Where are you on your journey to implement SDOH screening?


What’s Your “Why”?

# SDOH Screening Aligns with Multiple Requirements & Priorities

- Community benefit
- Community health needs assessment
- Advancing health equity
- Improving quality (such as readmissions)
- Patient-centered care
- Something else?

# Getting Started

## Actions

- **Set a vision** – what does success look like?
- **Convene stakeholders** – nursing, quality, case managers/social workers, IT, population health, education/marketing, patient family partners
- **Identify existing resources**

## Resources

- Existing screening tools- SIREN
- Your Electronic Medical Record (EMR) capabilities
- Existing partnerships and organizations with whom you have not yet partnered
- Perspectives and ideas from patient family partners who have experienced SDOH screening

# Engaging Patient and Family Partners (PFPs) in SDOH Screening Programs

VS

Use data to identify highest community needs

Develop screening program internally

Develop public messaging
Implement program

Evaluate program


Use data to identify highest community need

Validate data with lived experiences

Learn about community resources from the people who are accessing them

PFPs inform community messaging

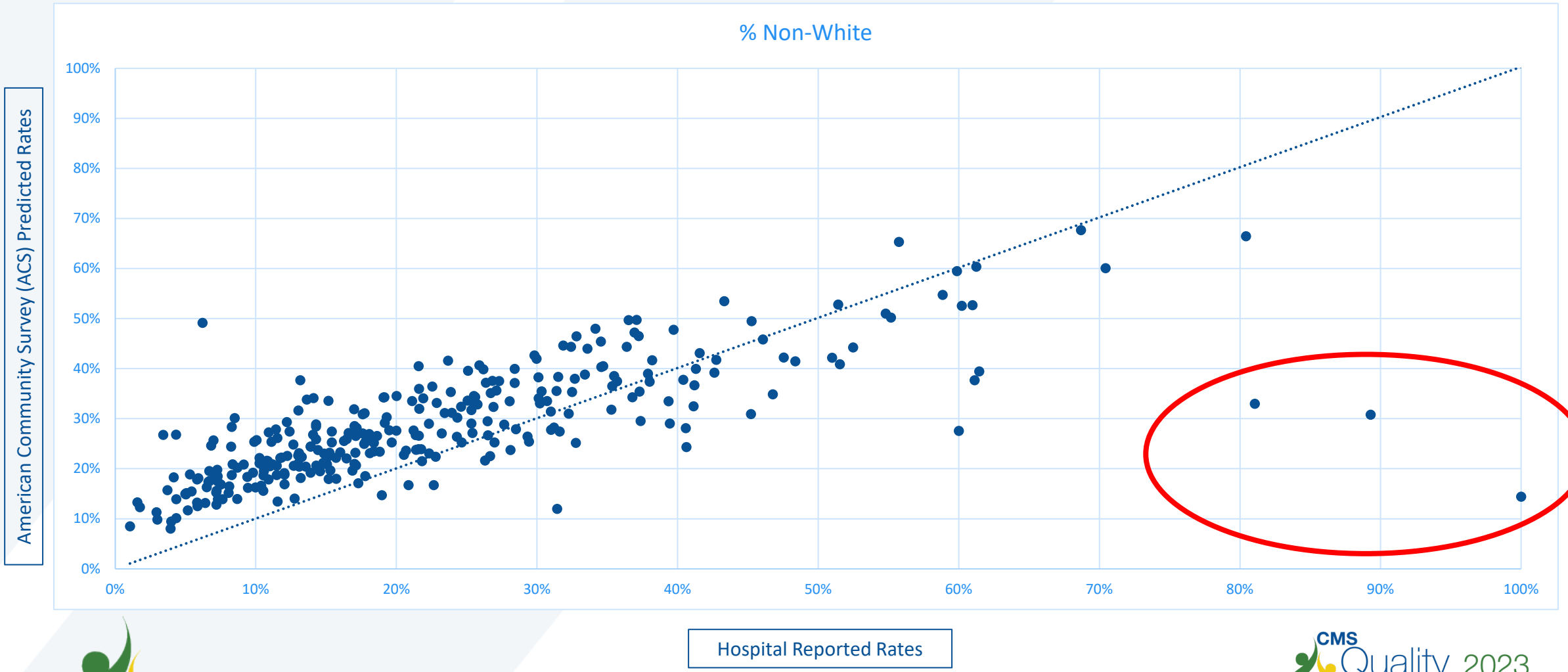
PFPs co design scripting, inform timing and evaluate screening programs

PFCCpartners
Patient & Family Centered Care

# Considerations

- Do your staff and providers have a common understanding of why you're screening patients and how you will use the information?
- How will you explain to patients why you are asking questions about SDOH?
- Do the staff who are completing the screenings have the time, training, and resources to do so effectively?
- If a patient screens positive, what will your response be?
- How will you analyze data over time to identify patterns and to proactively address high priority needs in your community?
- How do you know your screening results are accurate?

# Data Accuracy: Hospital Service Area vs ACS



# What is the role of the hospital?

| | |
|---|---|
| Anchor | Anchor institution in the community |
| Convene | Convene community partners |
| Begin | Begin at home – hospital staff that have health related social needs |

# What's Your Role?

**Exhibit 1: Typology of community-level actions for hospitals to address social determinants of health**


Source: "Community-Level Actions On The Social Determinants Of Health: A Typology For Hospitals", Health Affairs Forefront, October 11, 2022.DOI: 10.1377/forefront.20221006.388060

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# THANK YOU


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