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Sept. 19–21, 2022

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Addressing SDoH to Advance Health Equity Goals

NORMAN REGIONAL
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Panel presenters

Swedish Hospital, Chicago, IL
Keri Robertson, DO, Physician Quality Advisor
Shameem Abbasy, MD/MPH, Vice President, Quality and Clinical Transformation

Norman Regional Health System, Norman, OK
Kristin O'Neal, BSN, RN, ACM-RN, CCM, Administrator – Post Acute Transitions & Community Engagement
Wendy Fiebrich, MBA, Executive Director of Volunteer Services

Main Line Health, Radnor, PA
Barry D. Mann, MD, FACS, System Medical Director for Health Equity
Eileen E. Jaskuta, MHA, BSN RN, System Vice President, Quality and Patient Safety
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Joseph Macdonald, MBA, LSSBB, Process Improvement Engineer

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Learning Objectives

- Describe how to translate an organizational strategic imperative into measurable opportunities and actionable interventions to address disparities in care.
- Apply process engineering and operational excellence tools to systematically address complex social determinants of health issues to advance health equity.
- Identify team-based strategies related to food insecurity efforts, depending on the different levels of care for patients being screened and the food distributed.

Addressing SDoH to Advance Health Equity Goals

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Swedish Hospital

Utilizing a Vulnerability Index and a Comparative Database to Design and Implement Community Clinic Services

Dr. Keri Robertson
Physician Quality Advisor

Dr. Shameem Abbasy
VP of Quality and Clinical Transformation

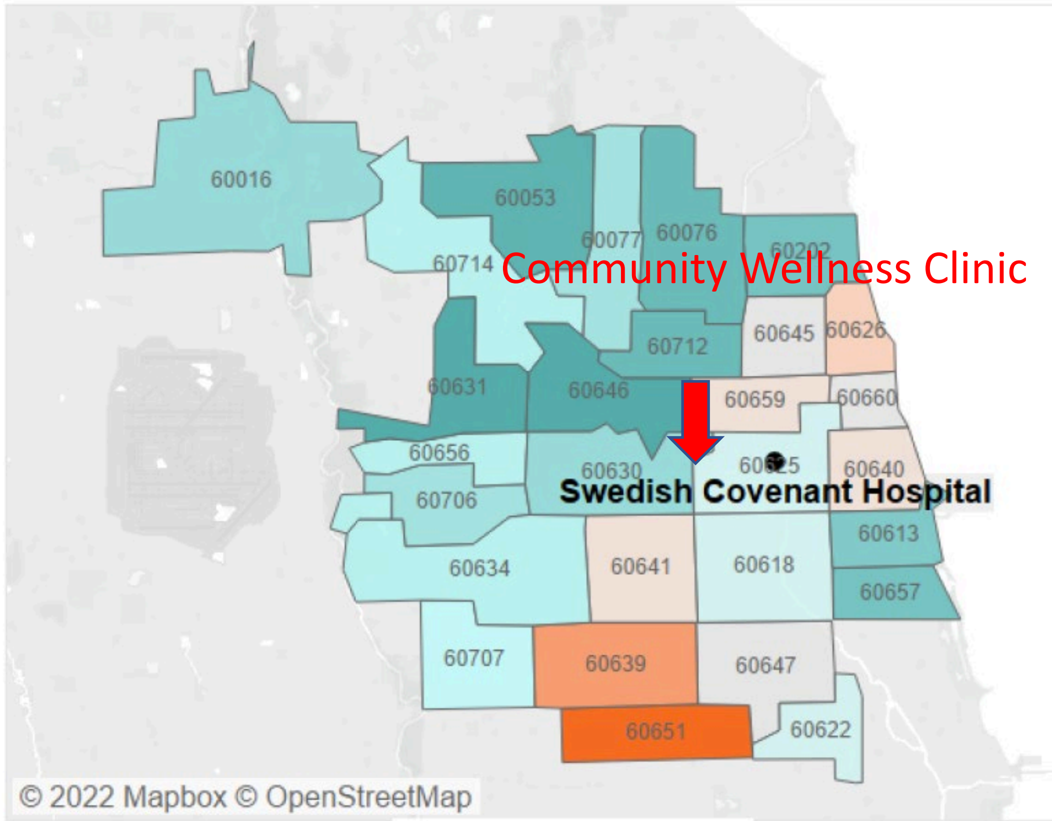
Swedish Hospital

Swedish Hospital Community Wellness Clinic 60625/60630

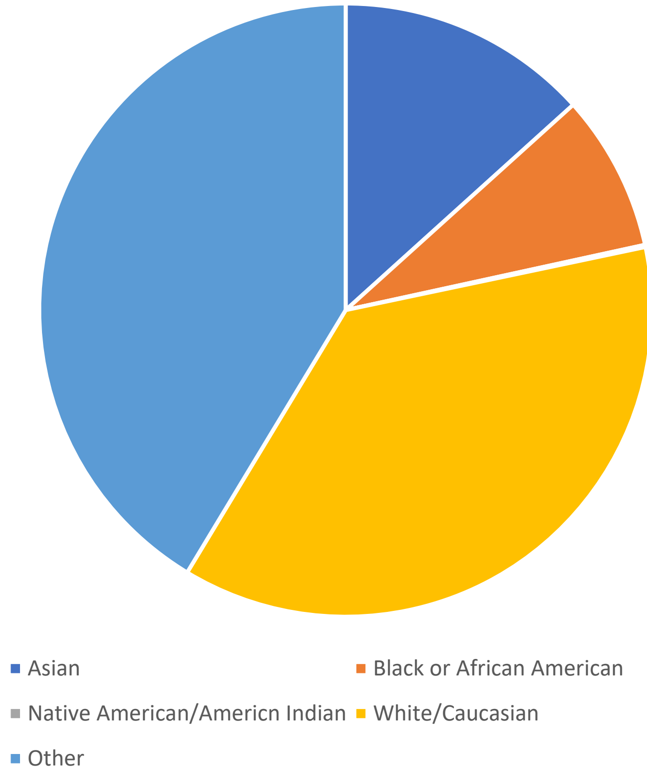
- Risk-adjusted, comparative database utilized to obtain:
  - Race, ethnicity data
  - Service and Sub-service line opportunities
  - Readmission data
  - Insurance data

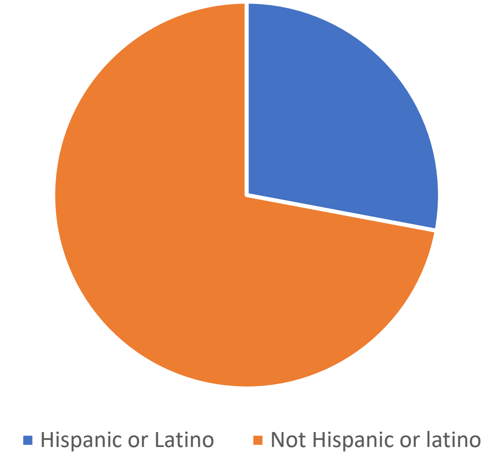
- Vulnerability Index most vulnerable domains:
  - Heath Care Access
  - Housing
  - Transportation

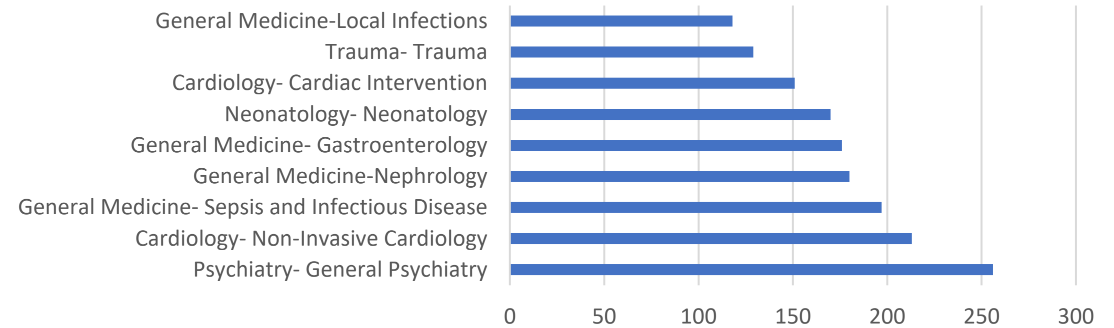
Vulnerability Index



Data insight examples







Source: Vizient Clinical Database

Lessons Learned

- 37% of readmitted hospital patients come from these two zip codes, developing a low barrier follow-up program including community nurse program.
- Studied a Vulnerability Index for areas for high impact for zip codes – ex. Maternal hypertension and LE amputation with DM care, will include services in community clinic to address
- Chicago Health Atlas data and the Community Health Needs Assessment collaborates with a Vulnerability Index and risk-adjusted, comparative database

Key Takeaways

Vulnerability Index combined with risk-adjusted, comparative data gives hyperlocal data for developing clinic services

Large portion of hospital readmitted patients from these zip codes

Combination of a Vulnerability Index and risk-adjusted, comparative data allows hospitals to intersect health equity with quality initiatives

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Where Is My Next Meal Coming From?

Wendy Fiebrich, MBA
Executive Director of Volunteer Services

Kristin O’Neal, BSN, RN, ACM-RN, CCM
Administrator – Post Acute Transitions & Community Engagement

Norman Regional Health System

Background

- The WHO defines social determinants of health (SDoH) as the “wider set of forces and systems shaping the conditions of daily life
- Research shows SDoH can drive as much as 80% of health outcomes compared to 20% of medical interventions[1]
  - Contributes to high health care expenses, readmissions and poor health outcomes.
- These determinants include poverty, housing instability, lack of transportation, health literacy and food insecurity, among many others[1].
- Oklahoma ranks 5th in the nation for food insecurity[2].
- 66% of households must choose between food or medical care[3].

[1] Bradywood, A., Leming-Lee, T., Watters, R., & Blackmore, C. (2021). Implementing screening for social determinants of health using the Core 5 screening tool. *BMJ Open Quality 10*(3). https://doi.org/10.1136/bmjoq-2021-001362

[2] Manager, C. S. (n.d.). *Hunger In Oklahoma*. Regional Food Bank of Oklahoma. https://www.regionalfoodbank.org/about-us/hunger-in-oklahoma/

[3] *Oklahoma Is One of the Most Food-Insecure States*. (n.d.). Www.todaysdietitian.com. Retrieved March 25, 2022, from https://www.todaysdietitian.com/news/040416_news.shtml

NRHS Addressing Food Insecurity – Food Pharmacy

- Developed Food Pharmacy program addressing food insecurity
  - Care Coordination provides a 2-week supply of frozen or non-perishable foods at discharge.
  - Short term fix . . . Long term problem
  - Post discharge call made

- **Results:**
  - **500+** patients provided food to date
  - Multi-phase initiative (expanded recently to ED’s & PCP Clinics)
  - **33%** reduction in hospital readmissions
  - **62%** of patient group had additional needs identified by follow-up calls
  - **46%** of patients connected to verifiable long-term resources

Lessons Learned

- It takes a "village" to be successful
- Long term resources and follow-up is essential for true improvement of outcomes
- Food provided at each level of care is unique and processes should be adjusted for optimal success
- By beginning with food insecurity on SDoH initiatives, this has paved the way to build additional projects to support health equity

Key Takeaways

- Long term SDoH efforts need to be initiated for true patient impact
- Rarely is only one SDoH an issue, by having meaningful patient conversations, this identified additional needs to achieve improved health outcomes.

Main Line Health®

Strategic Journey to Identify, Understand, and Address Healthcare Disparities

Eileen E. Jaskuta MSHA, BSN, RN
System Vice President Quality and Patient Safety,
Barry D. Mann, MD
System Medical Director for Equity

Main Line Health

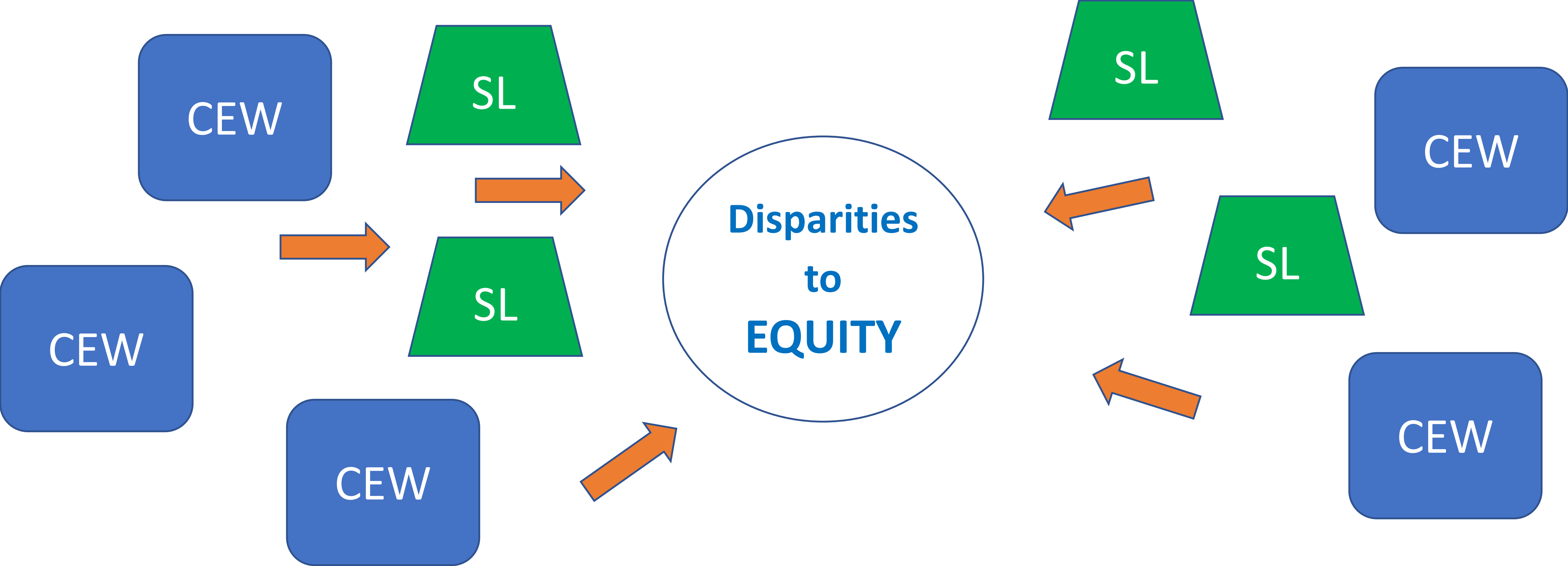
Opportunity

- **Strategic Imperative**: "Build trust, identify and eliminate disparities in care with the understanding that structural racism has affected confidence in the health care system."
  - Build leadership structure to support commitment to address Diversity, Respect, Equity, and Inclusion
- **Internal to System**: Engage Clinical Environment Workgroups (CEWs) and Service Lines to identify disparities in care: analyze opportunities, develop metrics, creating programs and initiatives
- **External to System:** Engage community to build trust and establish partnerships

Initiative

- **Establish Equity Leadership Structure:**
  - A leadership structure and process to work with CEWs and service lines in supporting work on identifying and addressing disparities in care.
- **Disparity Recognition and Elimination**.
  - Identified one equity priority with a measurable metric within each CEW and Service Line. (9 clinical programs have a measure and 7 have an initiative in place)
  - Developed disparities in care profile stratifying more than 80 quality/safety and patient experience metrics by gender, age, payor, behavioral health status, zip code, sexual orientation, and education
- **Building Trust and Partnerships**.
  - *Together for West Philadelphia.* Collaborative coalition amongst the healthcare institutions and community-based organizations of our most underserved geographic region.
  - Philosophy 401: Building Trust in Healthcare, a collaboration between Main Line Health and Cheyney University

Establish System Leadership



Disparity Recognition and Elimination

Equity Metrics examples
% Inpatients (CHF, Pneumonia, Sepsis) with palliative care consults • by race and zip code
Pain Management in the ICU • by race
Urine Drug Test for Patients w/ Admitted Drug Use During Pregnancy • by payor
% Of ED Visits where Food Insecurity Screening was completed

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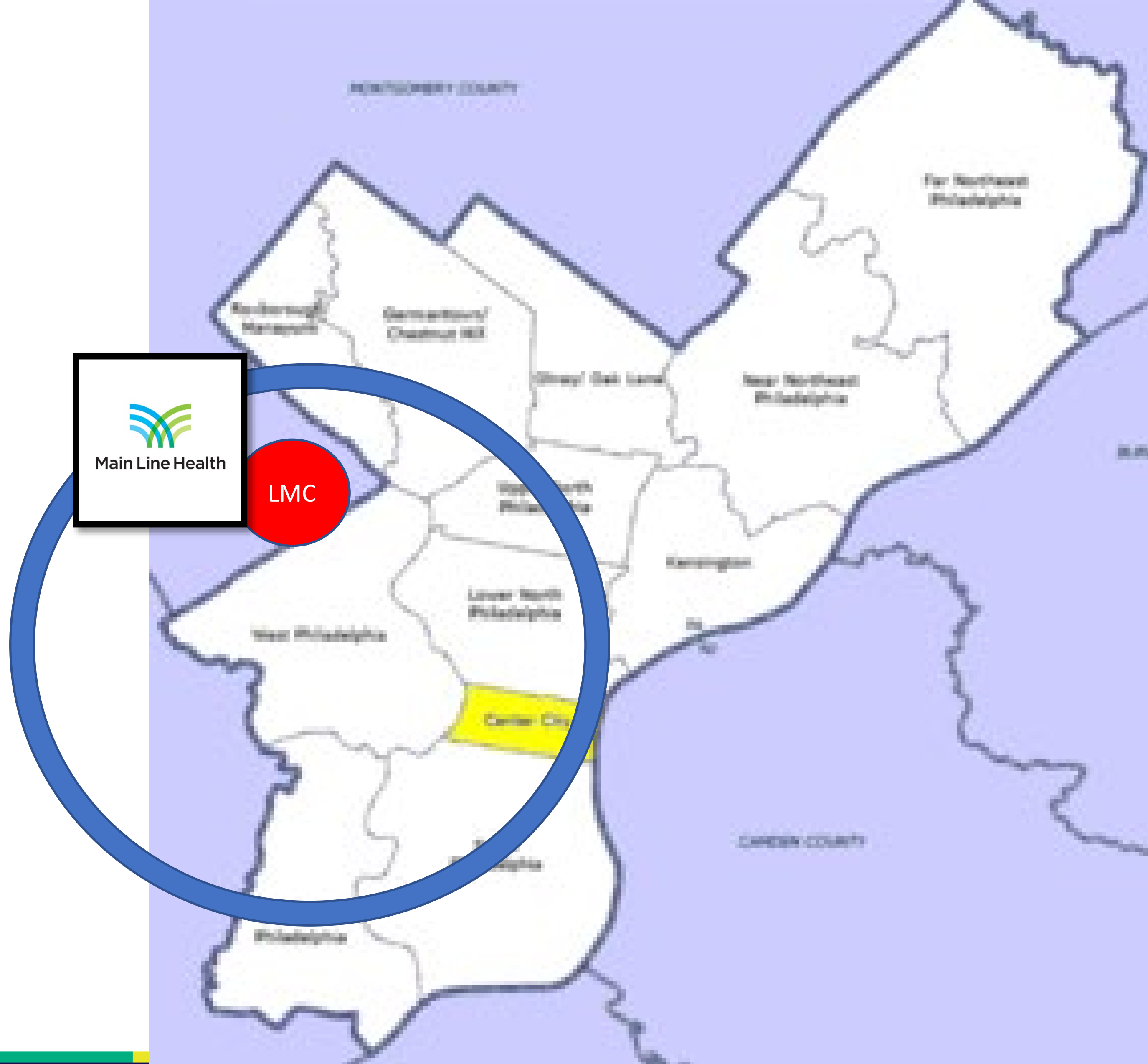
LMC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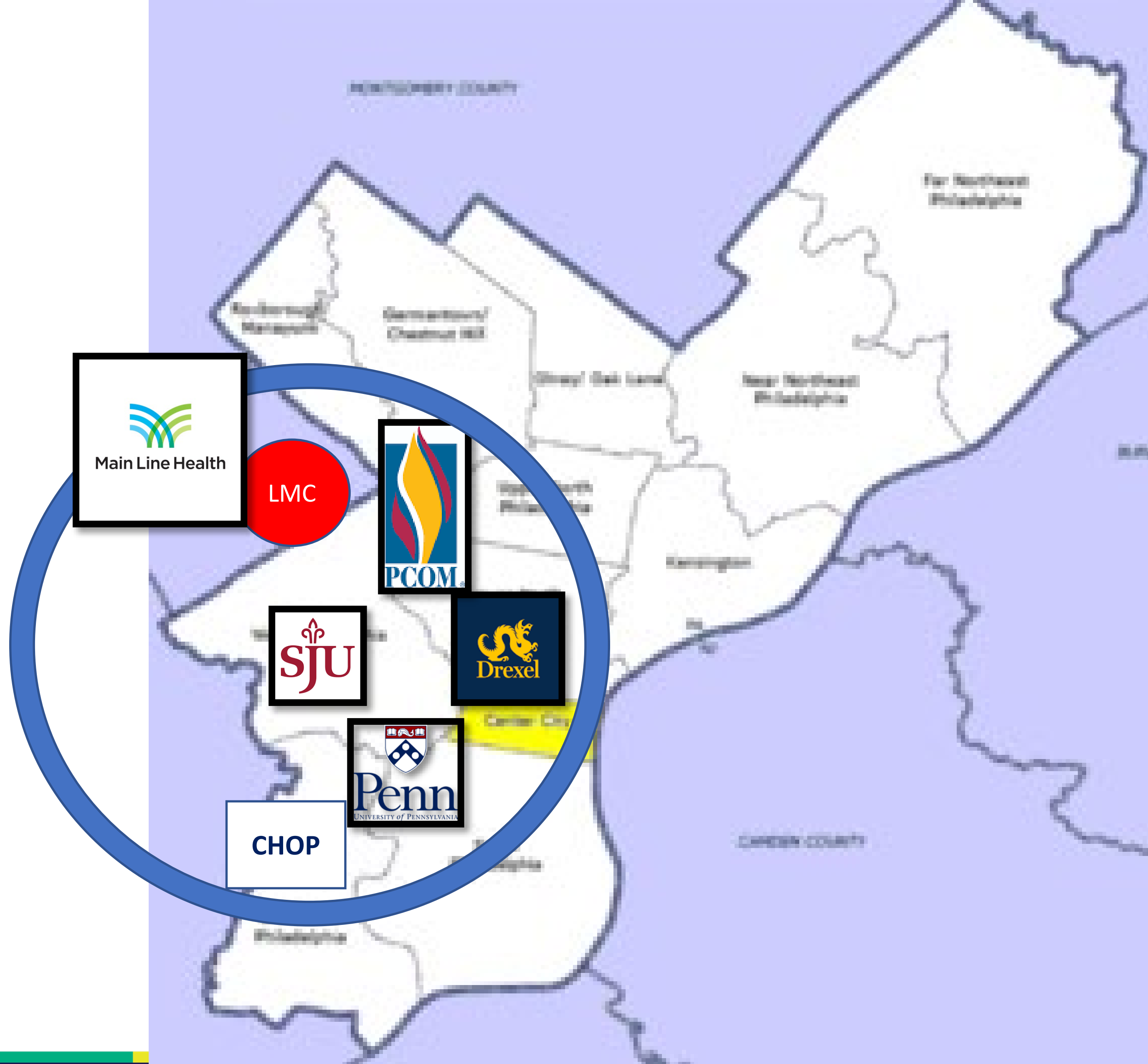

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for West Philadelphia

Together for West Philadelphia

Philosophy 410: Building Trust in Healthcare

MLH Residents (GME)

- How I met my patient
- Establishing trust
- Trust thru testing and diagnosis
- Trust with family
- Barriers

Cheyney Students

Lessons Learned

- Creating a leadership structure and involving representatives from each CEW and service line energizes the work to support identifying and addressing disparities in care.
- Achieving collaboration among healthcare organizations with community-based organizations facilitates the creation of multi-institutional project for the benefit of community.
- An educational program to examine the building of trust benefits both mentees and mentors

Key Takeaways

- Create an accountability structure leveraging the strong structure and processes under Quality and Safety

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MLH's Journey to Address Social Determinants of Health

Shonalie Roberts, MHA, ARM, LSSGB
System Director, Health Equity

Joseph Macdonald, MBA, LSSBB
Process Improvement Engineer

Main Line Health

Opportunity

- Definition: Food insecurity (FI) is defined as the state of being without reliable access to a sufficient quantity of affordable, nutritious food.
  - *Food insecurity does not necessarily cause hunger, but hunger is a possible outcome of food insecurity.*

- Food Insecurity in PA: In 2019, more than 1.35 million Pennsylvanians didn't always know where their next meal was coming from. In 2020, as a result of the COVID-19 pandemic, these numbers grew substantially to more than 1.77 million. [1]

- Food Insecurity and healthcare: Research shows that "efforts to include universal FI screening for Emergency Department patients with immediate connection to resources will enhance overall care quality and address important health needs." [2]

[1] Hunger & Poverty in the United States | Map the Meal Gap (feedingamerica.org). Available from: https://map.feedingamerica.org/?_ga=2.176750821.1565135868.1637522471-1992522435.1617919319

[2] Gonzalez JV, Hartford EA, Moore J, Brown JC. Food Insecurity in a Pediatric Emergency Department and the Feasibility of Universal Screening. West J Emerg Med. 2021 Oct 27;22(6):1295-1300. doi: 10.5811/westjem.2021.7.52519. PMID: 34787554; PMCID: PMC8597682.

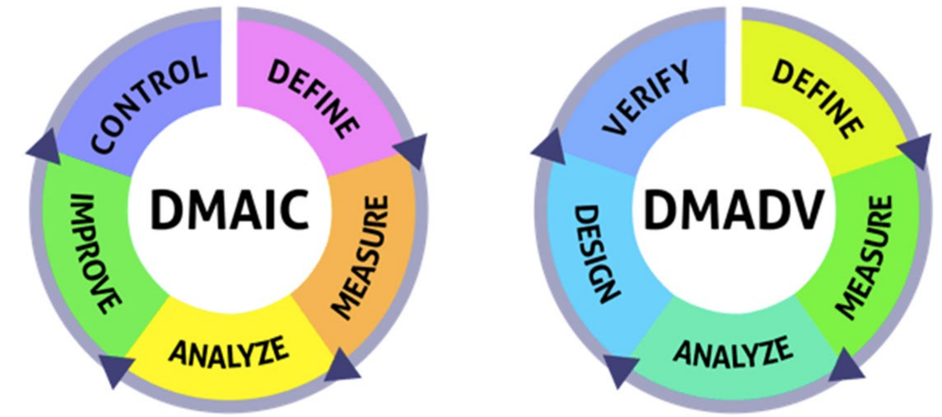
MLH Food Insecurity Initiative - Eat Well, Be Well Program

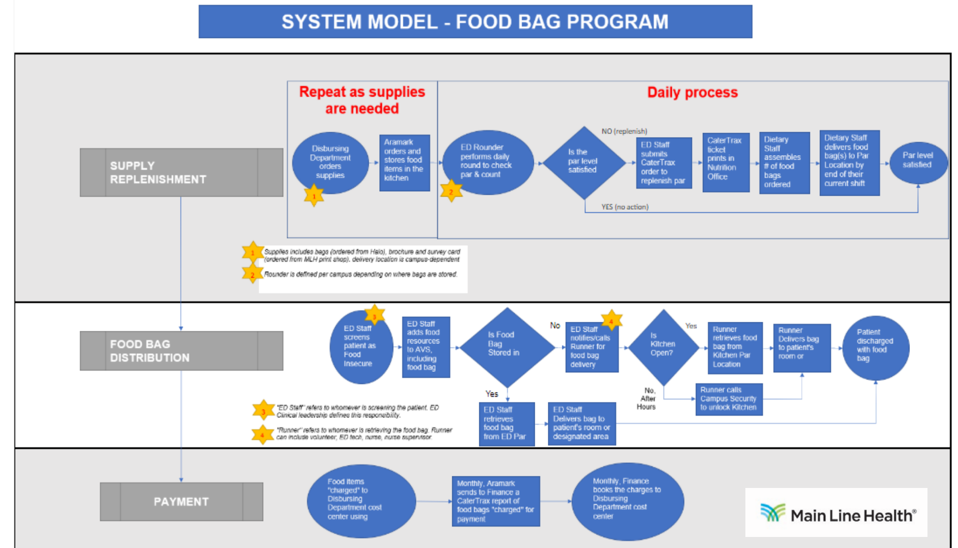
- Developed a robust process to screen patients for risk of food insecurity, provide a FREE bag of food if there is an immediate need, and connect patients to community resources to impact longer-term access to food

- Results (first four months)
  - System screening rates at 85% (target)
    - 530 patients identified as at-risk for food insecurity
  - Launched bag distribution program March 2022
  - Instituted post-discharge follow up calls with social work and community health worker

Lessons Learned

- Obtain senior leadership buy in, up front
- Subordinate new processes to uncontrollable constraints (embed new tasks into existing nursing workflow)
- Leverage process improvement tools and resources (DMADV/DMAIC, A3, Gemba walks, process maps, data driven control plan)
- Ensure warm handoff to localized process owners





Key Takeaways

- Data confirms food insecurity is a need within our service area and among our patients

- The food insecurity initiative provides a proof of concept that Main Line Health can impact other social determinants of health in concrete ways through collaboration and employing the use of process engineering tools

Panel Discussion

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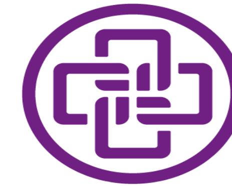

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