Best Practices in Health Equity | *Advice from Peer Hospitals*

Addressing health disparities is critical to increasing the quality of care and advancing patient safety. However, when it comes to making strides toward implementing health equity initiatives, many hospitals are either in the beginning stages or are not sure where to begin.

This resource shares brief case study snippets from peer hospitals, diving into how they took steps toward health equity at their own institutions in each of the seven categories of the health equity organizational assessment. Use this resource to brainstorm ideas to get started or move forward in implementing health equity initiatives at your own organization.

> *"You're going to end up caring for people one way or another, so why not do it the right way."*
>
> *– Monica Grey, Vice President, Care Continuum & Digital Health*

HQIC Hospitals Best Practices for: Data Collection & Training

Using self-reporting methodology to collect demographic data from the patient and/or caregiver and providing workforce training regarding the collection of self-reported patient demographic data.

Using Advanced Demographic Data: Case Management Team Focus

One hospital's case management team focuses on the inpatient setting. They are assigned the task of ensuring that the social determinants of health are addressed while helping patients transition to the next level of care. The team keeps a detailed resource list that can be provided to patients, including resources on interpersonal safety, access to food and shelter, psychiatric needs, or referrals to rehabs, nursing homes or hospice. Patients' needs are typically discussed in multidisciplinary daily huddles and case managers are always seeking out resources to serve all admitted patients.

Customizing the EMR: Patient-Centered Medical Home Model

A rural hospital implemented the Patient-Centered Medical Home Model in their primary care clinics. As part of that initiative, clinics collected information regarding health equity through a Comprehensive Needs Assessment upon patients' initial visit and annually thereafter. The process was built into their electronic medical record (EMR). This assessment covers economic stability, the patient's physical environment and housing, food security, social supports and stressors, access to healthcare and health literacy. To dive deeper into the social determinants of health, the team expanded their Social History section within the EMR to capture more information about behaviors affecting patient health, including substance use, risky behaviors or occupations and sexual identity.

The following images are screenshots of this hospital's customized questionnaire. Work with your vendor to customize your EMR to your community's needs. Seek guidance from those who are doing similar work (e.g., reaching out to a facility that has a similar EMR).

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Comprehensive Needs Assessment

Comprehensive Needs Assessment Reviewed/Updated this date.

In the last month, did you or anyone in your household ever eat less than you felt you should because there wasn't enough money for food?

Yes No

In the last 6 months, has your utility company shut off your service for any reason?

Yes No

Are you worried that in the next 2 months, you may not have housing?

Yes No

Do problems getting child care make it difficult for you to work? Leave blank if you do not have children.

Yes No

In the last 3 months, have you needed to see a doctor, but could not because of cost?

Yes No

In the last 3 months, have you ever had to go without healthcare because you didn't have a way to get there?

Yes No

Do you ever need help reading or understanding medical instructions or education?

Yes No

Do you need assistance with affording or managing your medications?

Yes No

Do you require someone to help with your care at home?

Yes No

Do you have access to dental care?

Yes No

Do you have people who can help you when you need assistance with day to day problems?

Yes No

Do you have any concerns with your living conditions?

Yes No

Do you have concerns about violence in your home?

Yes No

Do you have any difficulty remembering or understanding information?

Yes No

Would you like assistance with any of the items above?

Yes No

Are any of your needs urgent? For example: I don't have food tonight. I don't have a place to sleep tonight.

Yes No

HQIC Hospitals Best Practices for: Data Validation

Verifying the accuracy and completeness of patient self-reported demographic data.

Data Validation Using EMR Notifications: Features Streamline Processes

Workqueues (WQ), an EPIC function that assists in listing tasks to perform, are a powerful tool to aid hospitals in running efficiently. Examples of EPIC workqueues include:

- **Schedule Order WQ:** Capture the order for scheduling a test and then scheduling it
- **Patient WQ:** Drive the future encounter to a pre-registration workqueue or capture any missed information for a current encounter
- **Patient and Account WQ:** After pre-registration, review the patient's benefit information, create an estimate for a patient and determine a pre-payment

One hospital uses EPIC workqueues to alert staff when patient demographic information is missing or questionable. Any issues are recorded and the list of issues is compared to other hospitals within the system. This creates a competitive environment where admission/registration staff aim to ensure that patient information is complete and accurate. The team strives toward having zero or minimal issues in comparison to others.

Other Helpful Tips

Maintain data accuracy and consistency by optimizing your EMR system to include flags for when data is missing or needs to be reviewed. Map out your patient workflow across your EMR platform to determine what areas will be flagged. For example, build notifications to flag when a patient's SOGI data is due for an annual update, or when a patient's race/ethnicity data is not on file. Train staff to be attentive to these notifications and be accountable for completing them.

HQIC Hospitals Best Practices for: Data Stratification

Stratifying patient safety, quality and/or outcome measures using patient demographic data.

Stratifying Data and Building Reports: PowerBI Metrics

An urban hospital uses PowerBI for many types of data analytics across their enterprise. Specifically for the purpose of health equity, they have the ability to stratify key performance indicators by race, gender and insurance; this gives them the ability to look at a metric, such as readmissions, and drill below the surface of the aggregate data to look for opportunities for improvement.

Establishing Task-Driven Teams: Programmable Population Health Platform

One hospital utilizes their population health team to focus on following-up with Medicare patients to ensure they come in for their annual wellness visits, conduct transitional care management for patients that have been discharged and coordinate chronic care management for patients who need additional assistance. They use a cloud-based, programmable population health platform (Cerner HealtheIntent) that retrieves data from their EHR to aggregate it across the continuum of care. The platform allows the clinical team to generate patient lists that can be divided by providers, locations and care gap measures. Microsoft Teams is used to create a master Excel list for outreach, showcasing which patients have been contacted, if they have an upcoming annual wellness visit and any other gaps they may need.

HQIC Hospitals Best Practices for: Communicating Findings

Using a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.

Sharing the Health Equity Journey: Population Health Team

One hospital created a brochure that depicts their health equity journey over time, providing summaries of their most recent projects from addressing gaps in food insecurity by helping to fund food pantries, to providing parenting support through programming. This brochure was shared in internal meetings and with community partners.

Other health equity work is also shared with the Board of Trustees, councils and committees, and in community partner meetings.

Additionally, community partners serve on the Board to encourage collaboration in setting targets and moving toward goals.

HQIC Hospitals Best Practices for: Addressing & Resolving Gaps in Care

Implementing interventions to resolve differences in patient outcomes.

Addressing Transportation Needs: Leverage Healthcare Extenders

Through medical home care coordinators and pre-hospital services, one hospital identified that some low-income elderly patients utilize the ambulance service to provide them with basic healthcare assessments that don't necessarily require transfer. This hospital discussed how they could utilize healthcare extenders, such as paramedics, to reach patients that are unable to easily access the system but have healthcare needs. In addition, they are currently reaching more patients by providing telemedicine visits and phone visits with case managers. These two strategies reduce non-emergent ambulance calls and hospital visits.

Addressing Access to Care: Off-Hours Options

One hospital identified that some community members were having difficulty accessing healthcare because of their work hours. The facility worked to open and staff a standalone walk-in clinic that could be accessed on weekends and after work hours to address this issue. When they discovered that the clinic was not meeting demands of patients, including those in surrounding rural communities, the hospital incorporated walk-in clinics within their rural health clinics to reduce the distance patients in low-income rural areas travel for care.

> *"It's not always going to be the obvious, it's important dig deep and search the for the opportunity and question it"*
>
> *– Monica Grey, Vice President, Care Continuum & Digital Health*

Building Community Partnerships to Resolve Care Gaps: Local-Level Collaboration

One example of how an urban hospital collaborates is through their Access Health initiative, Community Care Network. Access Health is supported by The Duke Endowment across North and South Carolina with collaboration at the state and community level. The network brings together a number of health care providers and community agencies at the local level to help participants navigate through barriers to receiving health care. The network has 36 community partner agencies that collaborate to address access to care barriers and social determinants of health.

HQIC Hospitals Best Practices for: Organizational Infrastructure & Culture

Creating organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

Integrating Health Equity Strategy in Infrastructure & Culture: Mental Health Board

One hospital has established a population health strategy that develops partnerships with the community and region to improve the social determinants of health. One of these partnerships is the development of a five-county Mental Health Board that strives to improve access to mental health services for the hospital's county, as well as the other counties represented on the board. The hospital supports the work of Second Harvest, a food bank that provides food through mobile food drops, Backpack Buddies, and other food services that work to decrease the number of people experiencing food insecurity. In addition, the hospital offers a 4th Grade Challenge Program to schools in its county, focusing on social determinants of health behaviors (smoking, healthy food choices, exercise, etc.).

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