

Health-Related Social Needs (HRSN)

Session 6: Involving Patients, Families, and Communities February 14, 2024

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- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

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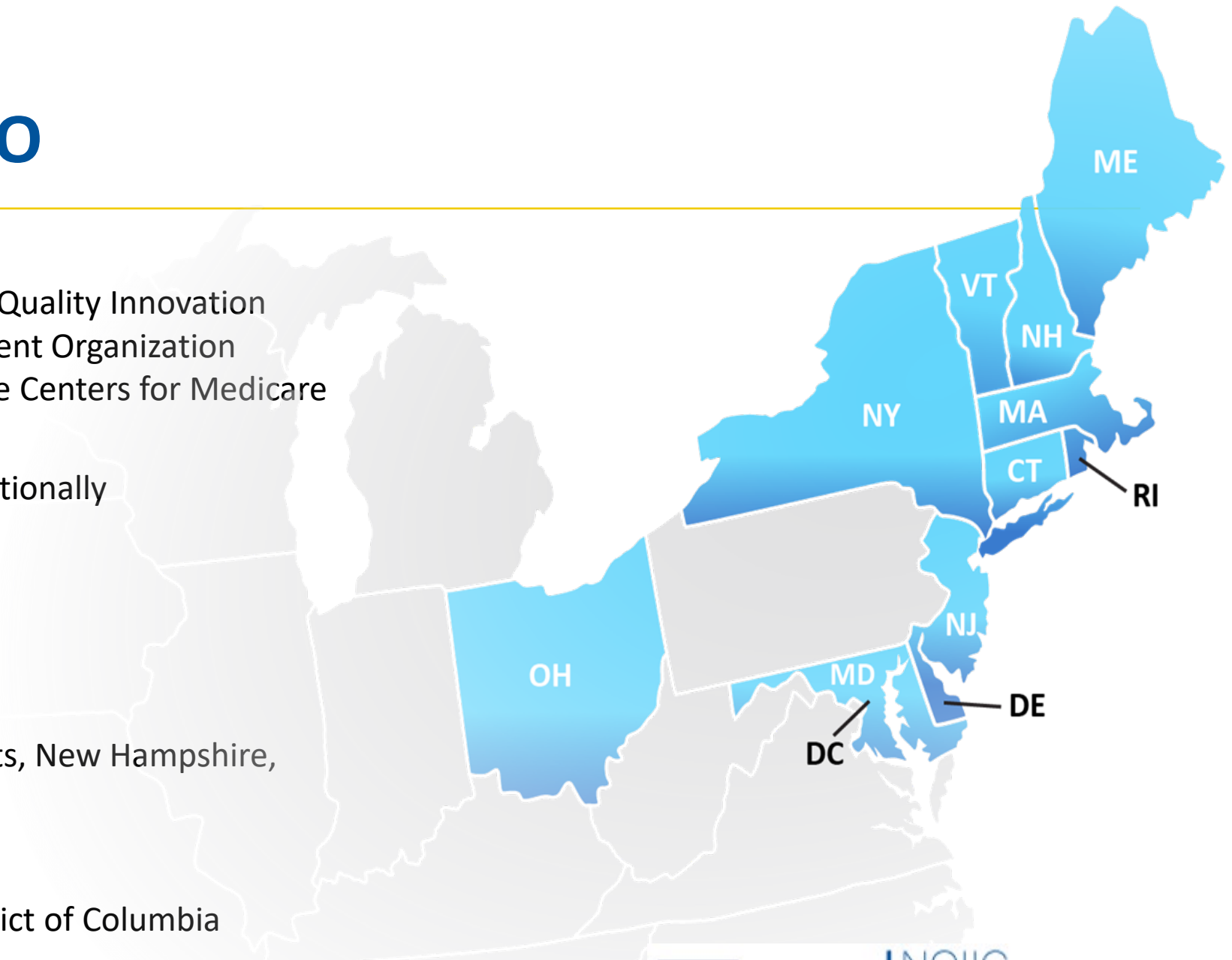
New York, New Jersey, and Ohio

Healthcentric Advisors:

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:

Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries



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- A federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states
- IPRO collaborates with several organizations to reach hospitals.

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■ Kentucky Hospital Association

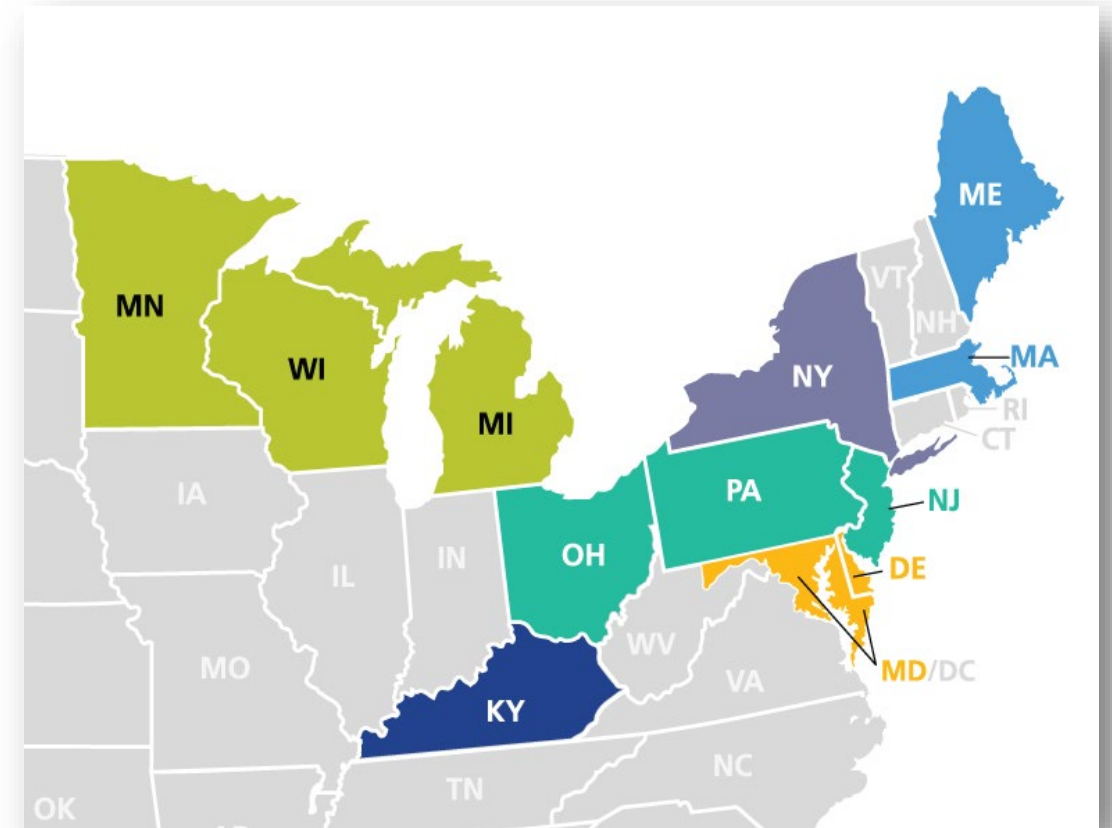
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QSource Health Equity Subject Matter Experts



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Today's Session Objectives

- ❖ Learn from our Patient and Family Engagement SME: Ashley Pantaleao, PhD, AIR
- ❖ Learn from your peers: a conversation with Julia Harbuck-Valley, RN, BSN, Leader of Quality, Scheurer Health



Introductions



Share your **name, title, organization,** and response to:

Describe a strategy your organization uses to engage your patients, families, and communities



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HSRN Series

Date	Time	Topic
9/13/2023	12:00 – 12:45 PM ET	Reviewing HRSN & the HRSN Measure
10/11/2023	12:00 – 12:45 PM ET	Training Providers and Staff to Screen for HRSN and Educating Patients
11/8/2023	12:00 – 12:45 PM ET	Incorporating Screening Tools into Workflow
12/13/2023	12:00 – 12:45 PM ET	Using Z-Codes to Capture HRSN
1/10/2024	12:00 – 12:45 PM ET	Connecting with CBOs to Close the Referral Loop
2/14/2024	12:00 – 12:45 PM ET	Involving Patients, Families, and Communities to Help Improve HRSN Screening and Referrals



Introduction to the AIR Team



Ashley Pantaleao, PhD
Project Staff and Researcher



Engaging Patients and Families as Partners in Improving Hospital Quality and Safety

PFE in hospital settings takes two forms. . .

Direct Care: The Active Patient and Family Care Partner



Patients and designated family members to serve as active partners in safe, quality care

Policies and Procedures: Patient and Family Advisors



Patient and family advisors individually or in a committee to apply their own experiences and perspectives to create patient-centered strategies, policies, or procedures that improve the quality and safety of care



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Raising the Issue: Diverse Patient Partners

- How can a community of diverse cultural backgrounds help us improve quality and safety?
- Who are the unheard voices in our community that need to be represented among our advisors?
- What challenges do we have in engaging patients and families from these populations?



REaL and SDOH Data Collection

- Identify existing data sources about your patient population and community (e.g., Census)
- Use self-reporting methods to collect patient race, ethnicity, and language (REaL) and social determinants of health (SDOH) data
 - Paper, electronic kiosks or tablets, and verbal discussion
 - Refine race and ethnicity category descriptions to help individuals self-identify their appropriate category by themselves
- Train staff with a focus to collect REaL data for at least 95% of patients



Connect with Your Hospital's Community

- Identify **organizations and cultural spokespersons** who can partner with you to better understand the needs of underrepresented patients and families
- Identify **community events** to attend and/or share information about becoming an advisor
 - Highlight that your hospital is looking for diverse perspectives to represent the community



Connecting PFE and Health Equity

Including ALL patients and families as equal partners in their care and as advisors

Equitable PFE means that hospitals:

- Consider the needs, perspectives, interests, values, and beliefs of all patients and families, including those from disparate populations in the community
- Modify PFE best practices to ensure engagement with all patients and families
- Implement actions that reflect on what matters most to all patients



A Conversation with Julia Harbuck-Valley



Julia Harbuck-Valley RN, BSN
Leader of Quality, Scheurer Health



Multidimensional Approach to Improve Health Equity

Julia Harbuck Valley BSN, RN

Leader of Quality

harbuck-valleyj@scheurer.org

Scheurer Health

- 5 Star Critical Access Hospital
 - 25 Bed Acute Care
 - 5 Bed ER
 - Ambulatory Surgery
- 5 Rural Health Clinics
- 7 Specialty Care Clinics
- Residential Living
- EMS
- Walk-In Care
- Fast Care
- Fitness
- Better Health, Better Life
- Stay Involved in Community



The Community

- Huron County, 2,137 square miles
- 30,894 Residents
- 56% Adults
- 26% Sr. Citizen
- 96% Caucasian, 3% Hispanic
- Average household income \$62,296, less than the MI Average of \$80,803
- 43-57 miles to nearest tertiary care facility (stroke, trauma center)



Community Wellness

CHNA 2022

School Programs

Community Events

Other

5210

Girls on the Run

Moving Forward

Sun Safety

Bicycle Safety

First Aid

Stop the Bleed

Health Finances

Local Healthcare

Careers

Nutrition

BP Screening

Community Wellness – School



- No Cost
- Healthy Lifestyle Choices
 - Screen Time
 - Physical Activity
 - Diet Choices
 - Water Intake
- Importance in Repetition
- Engagement of Parents

Community Wellness – Events

- No Cost
- Safety
 - First Aid
 - Bicycle Helmets
 - Stop the Bleed
- Informative
 - Dietician
- Resourceful
 - Financial
 - Local Health Needs
 - Careers



Community Wellness – Other

- Fitness Center
- Community Fitness Classes
- Sr. Living Fitness
- Community Conversations
- First Aid
- CPR
- Babysitter Training



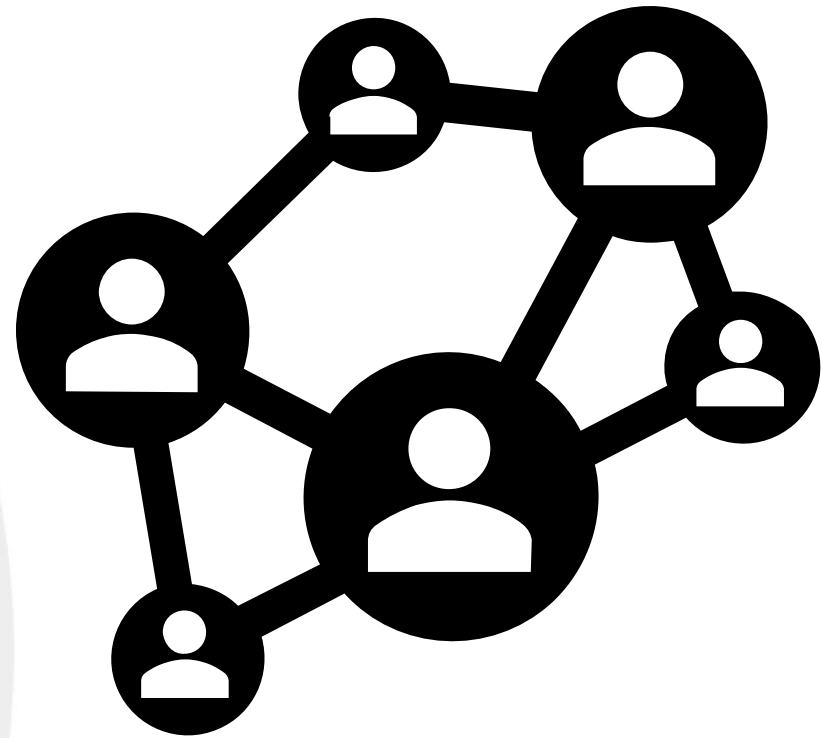
Community Partnership



- External Collaboration
- Variety of Workgroups
- Improve Regional Health Issues
 - Variety of Work Groups
 - Understand Data
 - Prioritize Needs
 - Strategic Plan
- Education/Career Development

Combining Resources

- Health Equity Committee
 - Outpatient Care Coordinator(s)
 - Outpatient Social Worker(s)
 - Inpatient Social Worker(s)
 - Leadership
 - Patient Experience Team Facilitator
 - Patient Family Advisory Counsel Lead
 - School Nurse(s)
 - Community Wellness



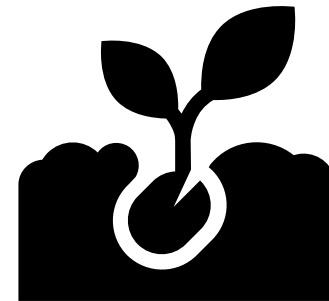
Outcomes

- Review of Data Trends
- Discussion of Experiences
- Exploration of Needs
- Sharing of Resources



Future

- Improved Networking
- Enhance Collaboration
- Reassessment of Data Collection
- Explore New Partnerships





Questions?

New Resource: Screening for Social Drivers of Health

Inpatient Quality Reporting Program: Screening for Social Drivers of Health

The Centers for Medicare & Medicaid Services' (CMS) [Screening for Social Drivers of Health measure](#) assesses whether a hospital implements screening for five health-related social needs for all patients who are 18 years or older at time of admission:


- food insecurity
- housing instability
- transportation needs
- utility difficulties
- interpersonal safety.

Screening patients for health-related social needs is important because unmet social needs can create barriers to high-quality care and contribute to poor health outcomes. Hospitals participating in the Inpatient Quality Reporting (IQR) Program are required to submit data for this measure annually, beginning in calendar year 2024.

To support hospitals in meeting this measure, IPRO has released new resources for each of the five health-related social needs:



Food Insecurity



Housing Instability



Transportation Barriers



Utility Difficulties



Interpersonal Safety

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Energy/Utility Insecurity: A Guide to Screening and Connecting Patients to Support Services

Energy or utility insecurity is the inability of households to meet basic energy needs. Energy encompasses electricity, gas, or other power sources for cooling, heating, lighting, and other uses of appliances and devices. The inability to meet these needs is often because of financial hardships or poverty but can also be a result of old, malfunctioning or non-existent equipment, or poor insulation.

Energy insecurity affects the ability of individuals to reside in comfortable environments leading to potentially dangerous conditions where they face either extreme heat or cold or sacrifice other basic needs (e.g., food or medication) to cover the cost of utilities. In addition, individuals may resort to using potentially hazardous alternatives such as space heaters or ovens as their primary source of heat.

According to the U.S. Department of Energy, one in four households report energy insecurity almost every month, some months, or within the last year based on data from July 2021 through May 2023.¹ Households that identify as Black, Hispanic, or two or more races experience energy insecurity at disproportionately higher rates compared to households that identify as White or Asian. Renters and households that have lower income with children or older family members are more likely to report energy insecurity.

¹U.S. Department of Energy, "Households of Color Continue to Face Energy Insecurity," July 6, 2023 <https://bit.ly/SPSNDM>

A Guide to Screening for Transportation Barriers

When thinking about health and health equity, transportation may not come to mind as a factor. However, transportation barriers can prevent patients from accessing regular medical care and can compromise their health. According to a 2017 report from the American Hospital Association, almost 6 million people in the U.S. report that transportation barriers cause them to delay medical care. Another 3.8 million people report they are unable to obtain any medical care due to lack of access to any form of transportation.

Transportation insecurity can take many forms. It may mean that an individual has a vehicle but lacks the money to purchase gas or maintain it. An individual may live in an area that has low walkability and lacks adequate, safe public transportation or the infrastructure for bikes, wheelchairs, and other mobility devices. Those living in rural areas are especially at risk for transportation insecurity and may have to travel a significant distance to obtain medical care.

Transportation barriers disproportionately affect older adults, those with lower socioeconomic status, people with disabilities, those living in rural areas, and certain racial and ethnic minorities. If a patient is non-adherent to their care plan it could be due to transportation barriers, a factor that healthcare providers should consider addressing. Access to reliable transportation is an important health-related social need; the lack of which perpetuates health disparities.

Impacts of transportation barriers:

- Missed medical appointments and lab tests.
- Delayed diagnosis of serious medical conditions.
- Exacerbation of health disparities and other social risk factors such as food insecurity, social isolation/loneliness, and unemployment.
- Inability to fill prescription medications.
- Increased risk for, and poorer management of, chronic conditions.
- Increased healthcare costs, emergency room use, and hospital readmissions.
- Higher risk for premature death.

Ask your patients about transportation barriers

Interpersonal Safety: A Guide to Screening and Connecting Patients to Support Services

Violence and abuse by family members or friends can cause physical and/or emotional harm. Even insults or threats of violence or abuse can be detrimental to an individual's health. Domestic violence encompasses intimate partner violence, child abuse, elder abuse, and adolescent dating violence. Intimate partner violence is defined as "abuse or aggression that occurs in a romantic relationship" and encompasses a range of behaviors including aggression, stalking, and sexual and physical violence.¹ In the U.S., approximately 30% of women and 15% of men experience rape, physical violence, and/or stalking by an intimate partner. Twelve million people each year are affected by intimate partner violence.² Women aged 18 to 24 and 25 to 34 experience the highest rates of intimate partner violence.³ Children that reside in households with intimate partner violence are more likely to be victims of child abuse and physical and sexual assaults. Intimate partner violence can also have intergenerational health effects such as unintended pregnancy, low-birthweight infants, and/or pre-term births.⁴

Teen dating violence also affects millions of teenagers and can impact their lifelong health and wellbeing. Among U.S. high school students, one in 12 experiences physical or sexual dating violence.⁵ Close to five million adults over 60 years of age, or nearly one in ten older adults, are abused each year; frequently the abuser is someone they trust and/or their caregiver.⁶ This includes financial abuse and neglect, and emotional, physical, and sexual abuse.

Impacts of lack of interpersonal safety

Increases the risk of:

- Physical injuries and disabilities
- Chronic conditions
- Sexually transmitted and other infectious diseases
- Post-traumatic stress disorder, depression, and anxiety
- Suicidal thoughts and attempted suicide
- Substance and opioid use disorders
- Mortality.

¹Centers for Disease Prevention and Control, Violence Prevention, October 11, 2022. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

²National Domestic Violence Hotline, Domestic Violence Statistics, accessed September 18, 2023. <https://www.thehotline.org/takeholders/domestic-violence-statistics>

³National Domestic Violence Hotline, Domestic Violence Statistics, accessed September 18, 2023. <https://www.thehotline.org/takeholders/domestic-violence-statistics>

⁴Office of the Assistant Secretary for Planning and Evaluation, Screening for Domestic Violence in Health Care Settings, July 13, 2013. <https://bit.ly/3s8q0jN>

⁵Centers for Disease Prevention and Control, Teen Dating Violence, October 11, 2022. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/teendatingviolence/fastfact.html>

⁶Centers for Disease Prevention and Control, Teen Dating Violence, October 11, 2022. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/teendatingviolence/fastfact.html>

⁷National Council on Aging, Get the Facts on Elder Abuse, February 23, 2021. <https://www.ncoa.org/article/get-the-facts-on-elder-abuse>

Resource Link:

<https://drive.google.com/file/d/1YA6Q9BQiiHA6hdRh-z27O1dcYknK3At/view>

New Series: Join Us for Collaborating for Equity!

IPRO Short Sessions: Collaborating for Equity

12:00 – 12:30 PM ET

The fourth Wednesday of the month

February 28, 2024	Establishing an Organizational Commitment to Health Equity
March 27, 2024	Building a Strategic Health Equity Plan
April 24, 2024	Using the Principles of CLAS to Advance Health Equity
May 22, 2024	Providing Equitable Care to Individuals with Disabilities
June 26, 2024	Providing Affirming Care for LGBTQ+ Individuals
July 24, 2024	Building Community Connections to Address Unmet Social Needs

Registration Link:

<https://ipro.webex.com/webappng/sites/ipro/webinar/webinarSeries/register/9444268305774528b44a628e75a96c3e>



Thank You

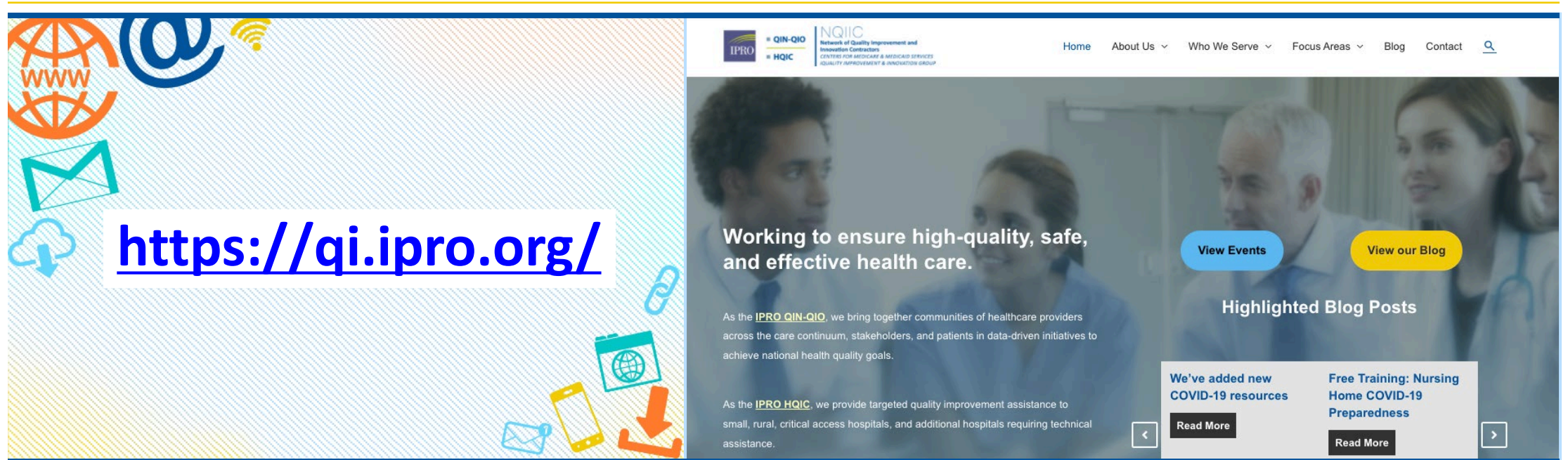
Thank you for your continued partnership and commitment to health equity.



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