HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

How to Complete the *Looking at Quality Improvement Through a Health Equity Lens* Worksheet

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Health Equity Definition

CMS defines health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes”

Source: CMS Framework for Health Equity | CMS

Health-Related Social Needs & Social Determinants of Health

- According to CMS, Health Related Social Needs (HRSN) are *"Individual-level, adverse social conditions that negatively affect an individual's health or health care."1*
- Social determinants of health (SDOH) are defined by CDC as the *"Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age. And the wider set of forces and systems shaping the conditions of daily life." 2*
- While both concepts are related to the social factors that influence health outcomes, they differ in their scope.
  - Health-related social needs are more focused on the individual level and refer to specific circumstances that can impact a person's health.
  - Social determinants of health are broader in scope and encompass a wide range of environmental factors that can impact the health of entire populations.

1. A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (cms.gov)
2. Social Determinants of Health (SDOH) and PLACES Data | PLACES: Local Data for Better Health | CDC

Looking at Quality Improvement Through a Health Equity Lens Worksheet (pages 1-3)

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Looking at Quality Improvement Through a Health Equity Lens Worksheet

Looking at quality improvement activities through a health equity lens helps us identify health-related social needs (HRSN). HRSN's are individual-level adverse social conditions that negatively affect an individual's health or healthcare. Social determinants of health are defined by CDC as the *"Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age. And the wider set of forces and systems shaping the conditions of daily life."* It is important to identify and address social determinants of health, which often show up as health-related social needs (HRSN) in dialysis settings. Health-related social needs (HRSN) are frequently identified as root causes of disparities in health outcomes for individual patients, as opposed to SDOH, which is better suited for describing a population. This worksheet can assist the facility with addressing health-related social needs for a specific patient and social determinants of health when addressing the needs of diverse populations of people at a facility level.

Action Steps for Facility Staff:

Step 1. Choose the clinical measure or area of care you want to improve (i.e., hospitalizations and readmissions) and then identify the patient population that would be focused on in the Quality Improvement Activity (QIA). (i.e., patients using the hospital for primary medical care).

Step 2. Choose one patient from the QIA population and complete a screening for health-related social needs (HRSN) using the list provided below or you can use the Health-Related Social Needs Screening Tool. Are there any health-related social needs that appear to be preventing the patient from achieving optimal dialysis or other health outcomes? Choose the most impactful health-related social need to work on with the patient.

Step 3. Discuss the QIA and health equity activities with the Interdisciplinary Team (IDT) during monthly QAPI meetings. Determine interventions and resources to use and complete the worksheet on page 3.

Step 4. Discuss the QIA interventions and resources to address the health-related social need with the patient. Apply interventions with the patient's commitment and approval. Monitor and check in frequently with the patient. Identify barriers along the way and assist where needed.

Step 5. Maintain the change. Check in monthly with the patient to identify any barriers or concerns. Update the IDT, monitor the QIA for improvements based on the applied interventions and update your worksheet.

Important Note: Addressing one health-related social need can impact other HRSN's. For example, helping your patient find transportation could impact food insecurity, access to healthcare and job insecurity.

Health-Related Social Need:

Health-Related Social Need	Definition of Health-Related Social Needs
Food Insecurity	Food Insecurity is a household-level economic and social condition of limited or uncertain access to adequate food.
Housing Insecurity	Housing insecurity is an umbrella term that encompasses several dimensions of housing problems people may experience, including affordability, safety, quality, insecurity, and loss of housing.
Transportation Insecurity	A condition in which one is unable to regularly move from place to place in a safe and timely manner because one lacks the material, economic or social resources necessary for transportation.
Racism	Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities, and opportunities across racial or ethnic groups.
Environmental Factors	Environment includes factors such as air quality, water quality, climate change, exposure to hazards, and access to green spaces and parks.
Inadequate Access to Healthcare	The National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) define access to health care as the "timely use of personal health services to achieve the best possible health outcomes."
Unsafe Neighborhood	Neighborhood safety is a social determinant of health that affects the physical and mental health of people who live in places with high rates of violence, crime, and other risks.
Job Insecurity	Job insecurity is powerlessness to assure desired continuity of one's job or job components when either the job or its components are threatened. The term job insecurity can refer not only to the potential loss of the job itself, but also to the threatened loss of key components of the job, such as supervisory activities or pay.
Economic Insecurity	Economic insecurity is living in a household with incomes below 200 percent of the federal poverty level. Today one out of every 3 people in the U.S are economically insecure.
Low Education Attainment	Education is a significant social determinant that influences health over the course of a lifetime. Levels of educational attainment have been directly linked with important health outcomes such as self-rated health, infant mortality, and life expectancy.
Inadequate Health Insurance	Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health.
Limited Health Literacy	Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Worksheet:

Timeline for QI Activity: Click or tap here to enter text. Date Completed: Click or tap here to enter text.

Facility Name: Click or tap here to enter text. CCN: Click or tap here to enter text.

Person Completing This Form: Click or tap here to enter text.

Metric or Area of Care to Improve/QIA Topic: Click or tap here to enter text.

Identified Health-Related Social Need: Click or tap here to enter text.

Did you discuss this activity in your QAPI meeting this month? ☐ Yes ☐No

1. Initial Plan: Describe the interventions proposed and who will be involved in addressing the health-related social need.

Proposed Interventions:
Who will address the identified HRSN:

3. Monthly updates: What interventions were completed by the facility during the month to address the health-related social need. (Example: I used large-print materials with pictures to teach patient about the importance of missing treatments and reporting symptoms to avoid hospitalizations).

Month 1:
Month 2:
Month 3:

4. Describe any barriers experienced and the facility's plan to address them.

5. Please describe any impact the interventions have had on the patient and the QIA.

HRSN Worksheet: How to Use with a Quality Improvement Activity (QIA)

- Once you have chosen your clinical measure to improve, also known as a QIA, identify the patient population you will be working with.
- Choose one patient from this QIA population and complete a screening for health-related social needs (HRSN) using the list provided or you can use the *HRSN Screening Tool*.
- Consider choosing the most impactful HRSN for the patient and begin working on interventions with them.
- "Save As" the worksheet on your computer every month to include in QAPI meetings and for documentation.
  - For example: *"HRSN Worksheet-April"*
- Print this worksheet and bring to your monthly QAPI meeting for the QIA discussion.

QIA Scenario: Identify QIA Topic and Patient Population

- The facility identifies hospitalizations and readmissions to focus on for the QIA.
- Upon review of the QIA patient population, there are five patients in the facility that have had one or more hospitalizations or readmissions in the last three months.
- You choose one patient from the five that has missed dialysis treatments and has been hospitalized three times in the last three months due to fluid overload.
- The QIA lead and IDT assign who is responsible for implementing the QIA.

QIA Scenario: Assigning QIA Roles

- In this scenario, the Social Worker (SW) has been asked to complete the HRSN screening with the patient.
  - One person from the IDT can assess the patient and another can assist the patient with interventions.
  - It is important to determine who will be completing the worksheet each month.
  - This process can be done collaboratively, or certain tasks can be assigned based on what works best for the facility and patient.

QIA Scenario: HRSN Screening

- The SW utilized the HRSN list that is on page 2 of the 3-page worksheet to identify a HRSN that may be impacting the patient from coming to regular treatments.
  - The SW could have also used the HRSN Assessment Tool to complete the screening
- During the screening, the patient reports missing dialysis treatments, and other transplant evaluation related appointments due to transportation insecurity.
- SW plans to meet with QIA Lead to discuss patient's HRSN screening.

QIA Scenario: Patient Discussion

- At this point, if someone else is assisting patient, it is helpful to reinforce with patient that it is unknown what services are available, what they qualify for and if there are waitlists.
- Inform patient that everyone will do their best to help him, but there is no guarantee that there will be available services.
- Let patient know that if there are no available resources, someone will be meeting with them to discuss next steps.
  - This is a great team approach.
- After SW completed the assessment, SW spoke with her QIA Lead, and it was decided that the most impactful HRSN to work on with patient would be transportation insecurity.

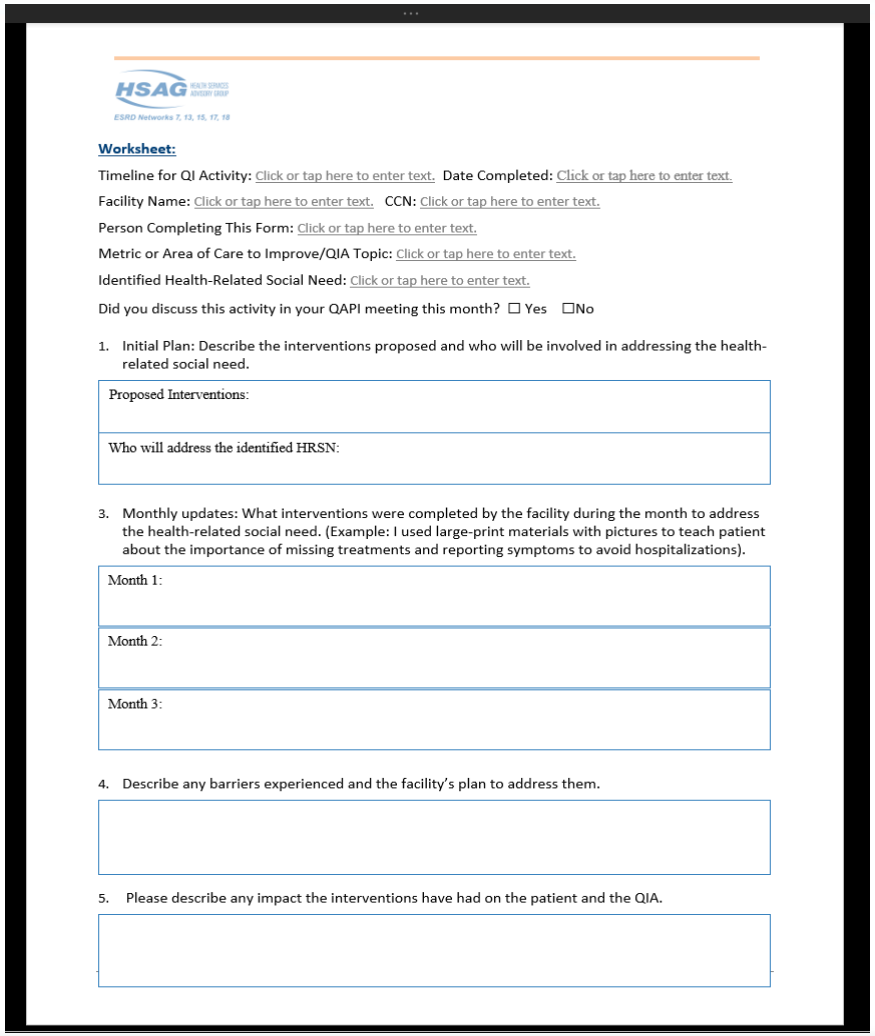
QIA Scenario: QIA Follow-up

- SW kept good documentation during the assessment on all steps/interventions taken, barriers experienced, such as any language barriers or lack of response from agencies, as this will need to be documented in the worksheet every month.
- In this scenario, the QIA Lead and SW planned to meet monthly to complete the worksheet and talk about any future interventions.
  - The worksheet can be shared via email with the person who is assisting the patient and ask that they complete part of the worksheet and return to the QIA Lead or the QIA Lead can complete the worksheet themselves.

QIA Scenario: Patient Impact

- The SW was able to find a paratransit program that the patient was eligible for and assisted them with the application.
  - Patient was counseled on how to use the agency's services.
  - SW reinforced the importance of this service and requested that patient inform SW if there are any issues or concerns.
- Patient stopped missing dialysis treatments, once services were in place.
- Patient was evaluated for transplant, and his mood improved with therapy sessions. Patient's blood pressures improved with regular dialysis treatments, and he reports "feeling great."
- SW met with patient each month to follow-up on services placed, address barriers and to talk about the impact the interventions have had on them.
- Patient's health and quality of life improved.
  - Patient went from missing treatments and being hospitalized several times in three months, to not missing any treatments and not having any hospitalizations, which impacted the facility's hospitalization rate.
  - This is an excellent example of an impactful HRSN.

HRSN Worksheet: How to Complete the Form



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Proposed Interventions:
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3. Monthly updates: What interventions were completed by the facility during the month to address the health-related social need. (Example: I used large-print materials with pictures to teach patient about the importance of missing treatments and reporting symptoms to avoid hospitalizations).

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Month 2:
Month 3:

4. Describe any barriers experienced and the facility's plan to address them.

5. Please describe any impact the interventions have had on the patient and the QIA.

- The Timeline for the QI Activity can be a 4-month PDSA cycle, or any other time frame chosen to make improvements. Include the date completed if sending to the QI Lead.
- The Metric or Area of Care to Improve/QIA Topic is your QIA, such as Hospitalizations or Transplant.
- List the HRSN you identified during the patient's assessment.
- Proposed Interventions are the steps you and your team intend to take to address the HRSN that was identified during the patient's assessment .
- Monthly updates list the interventions that were completed each month while working with the patient.
- Discuss barriers experienced and your plan to address them and impacts the interventions had on the patient and the QIA in the appropriate boxes each month. If there are no new barriers identified or no new impact on the patient, note "none identified".

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References

- *CMS Framework for Health Equity* (2, October 2023). CMS Framework for Health Equity | CMS
- *A Guide to Using the Accountable Communities Health-Related Social Needs Screening Toolkit (August 2022)* A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (cms.gov)
- *Social Determinants of Health (SDOH) and PLACES Data (27, May 2022)* Social Determinants of Health (SDOH) and PLACES Data | PLACES: Local Data for Better Health | CDC

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Thank you!

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